NHS England

Regional Director of Specialised Commissioning and
Health and Justice
NHS England - North East and Yorkshire
Oak House
Moorhead Way
ROTHERHAM
S66 1YY

HM Assistant Coroner
Ms. A Combes
South Yorkshire (West) District

**VIA EMAIL**

14 October 2022

Dear Ms. Combes

**Re: The inquest touching upon the death of Chelsea Mooney**

Thank you for your Prevention of Future Deaths Report dated 18 August 2022 which was sent to Cygnet Health Care and NHS England following the conclusion of the above inquest.

This letter provides a response to the concerns you have raised which are relevant to NHS England, namely concerns numbered 9 and 10. Our response is as follows:

9. ***There were opportunities for commissioners to support Cygnet earlier when case managing Chelsea's package of care. The new behaviour of using ligatures should have invited professional curiosity from Commissioners who should have sought assurance about the overall practice of ligature use and intervention from Cygnet but also what that meant specifically for Chelsea and how Cygnet were keeping her safe. This may have led to a review by Cygnet and a better understanding of Chelsea's ligature use.***

As set out in our letter to the Coroner's Court dated 23 June 2022 (see copy attached for ease of reference), the NHS England Case Manager attended weekly meetings at Cygnet Hospital Sheffield, and this included discussions about Chelsea's care. The Case Manager was unable to physically visit Chelsea due to COVID19 visiting restrictions after March 2020. However, weekly virtual contact was maintained through the meetings with Cygnet and with attendance at Care Programme Approach (CPA) meetings. The case manager saw Chelsea frequently and they discussed the care she was receiving. Chelsea reported to her Case Manager that she had a good relationship with ward staff, and she was able to talk to them and always said she was happy on the ward.

NHSE Case Managers are not made aware of every ligature attempt, only incidents that result in direct harm. There was an overview given at the weekly meetings and the Case Manager did receive weekly ward round summary and the Care Programme Approach reports. The NHSE Case Manager was involved in discussions about the risks and the level of enhanced observations.

Ligature incidents that meet the threshold as STEIS reportable are considered. This was described in detail in our letter to the Coroner's Court dated 23 June 2022 (see copy attached for ease of reference).

The learning from quality concerns in the CAMHS In-patient services including relevant aspects of this regulation 28, is informing the revised NHSE Case Management Standard Operating Procedure. It is expected that this will be implemented before the end of the year.

NHSE has ensured that the National in-patient quality programme that is due to be launched, tackles the root causes of unsafe poor-quality care. The work captures stakeholders' views about what support, education and information best helps prevent poor standards of in-patient mental health care. NHSE is fast tracking the roll-out of the programme and this will be shaped by clinical experts, people with lived experience and all relevant partners.

10. ***Commissioners also ought to have spoken to Chelsea themselves and assured themselves about the decision not to share information with her family; particularly her mother who had been a huge support for Chelsea prior to Covid-19. The impact of the cessation of face-to-face visits on anyone detained under the mental health act, but particularly young people like Chelsea appears to have been underestimated.***

Chelsea was aware that she could change her mind about sharing information with her family and that she could see her family whenever she wanted. The Case Manager discussed this with Chelsea, for example on 18 November 2020 where it was noted that Chelsea had started contact with her mother again. The Ward supported Chelsea in rebuilding her relationship with her mother and contact resuming.

As set out in our letter to the Coroner's Court dated 23 June 2022 (see copy attached for ease of reference), the Case Manager was assured about Chelsea's decision and that she had capacity to make this decision. As a 17-year-old, the Mental Capacity Act applied to Chelsea's decision making, including the presumption of capacity. Chelsea's capacity to make this decision was discussed at the regular meetings and ward rounds but we acknowledge that the documentation around this could have been clearer.

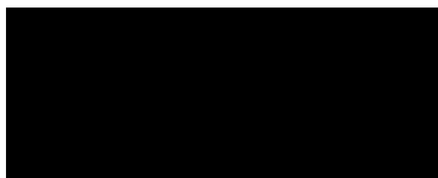
The revised NHSE Case Management Standard Operating Procedure and the in-patient quality programme will strengthen the importance of engagement with families and carers.

NHSE is also working closely with local and national partner organisations to improve quality across specialised services.

We have had sight of the draft action plan prepared by Cygnet, in response to your report. NHSE is supportive of the work being undertaken by Cygnet and will continue to work with them in this regard.

I hope that this response is of assistance.

Yours sincerely



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