**ANNEX A**

**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

*NOTE: This form is to be used **after** an inquest.*

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br>**1. Cygnet Health Care**<br>**2. NHS England** |
| 1 | **CORONER**<br><br>I am Abigail Combes, assistant coroner, for the coroner area of South Yorkshire (West District) |
| 2 | **CORONER'S LEGAL POWERS**<br><br>I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 19 April 2021 I commenced an investigation into the death of Chelsea Blue Louise Mooney born on 11 September 2003. The investigation concluded at the end of the inquest which commenced on 7 March 2022. The conclusion of the inquest was:-<br><br>On the 10th of April 2021 in Cygnet Hospital, Sheffield, Chelsea Blue Louise Mooney performed an act of self-harm by tying 2 non-fixed ligatures. As a result of insufficient care, crucially inadequate observations and the delays in emergency response, this led to her unexpected death two days later on the 12th of April in the Northern General Hospital, Sheffield.<br><br>There was also a jury questionnaire which was completed and is appended to this Regulation 28 report for information.<br><br>The medical cause of death was:<br><br>1a: Hypoxic ischaemic encephalopathy |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br><u>Mental Health Overview</u><br><br>It is clear from the evidence that was heard during the inquest that Chelsea initially developed a type of eating disorder that required support. She was admitted to a number of mental health inpatient units leading to her admission to Cygnet in Sheffield.<br><br>Whilst in this facility a number of material things happened:-<br><br>1. Chelsea began to self-harm using ligatures which was a new behaviour<br>2. Chelsea's working diagnosis became PTSD<br>3. Chelsea made a number of allegations of abuse by members of her family and others which required investigating |

4. Chelsea declined to share information with her family

Chelsea's family were advised that young people are not given a fixed diagnosis and that the working diagnosis was PTSD. Chelsea's family were keen to explore a diagnosis of autism however despite there not being a fixed diagnosis for Chelsea this was not explored by the treating team and Chelsea's diagnosis of PTSD does not appear to have been routinely reviewed through her admission. To be clear; I mean that her diagnosis was not reviewed, not that her treatment and plans were not reviewed. There also seems to have been a move away from a diagnosis of an eating disorder and following the inquest I am not clear that I understand the rationale for this other than PTSD appeared to be a better 'fit' for Chelsea's symptoms.

Ligatures

Chelsea started to use ligatures in Cygnet having not done so previously. Again, this does not appear to have been a cause of significant concern and appears to be the norm within Chelsea's peer cohort. There was one particular issue for Chelsea however which came to light during the inquest which was that male members of staff felt concerned about interacting with Chelsea alone: even where that delayed support in risky situations.

Engagement with Chelsea's Family

I heard evidence that there came a time when Chelsea did not which for her parents to be aware of what was happening in Cygnet or have any information about her health and that she had capacity to make this decision. I have subsequently received the Capacity Assessment that supports this view. I also heard in evidence that the Capacity Assessment ought to have been revisited and that there were circumstances when a patient's wishes could not be respected. This was particularly relevant to Chelsea's mother having limited information and then supporting her on s17 leave. I also heard that Chelsea was supported by a legal advisor for the purposes of her detention under the Mental Health Act.

I also heard no evidence that her age was considered and whether or not she was competent to make this decision even if she had capacity. Chelsea was 17 at the time of her death; this required careful exploration with her and there was no evidence of this.

Emergency Response on the Day of the Final Ligature Incident

I heard evidence that the check on Chelsea was delayed due to another emergency on the unit, namely the tying of a ligature by another individual. I also heard evidence that the timing of Chelsea's checks were not in accordance with recognised policy and ought perhaps to have prompted a different review and approval process (although the timings were appropriate and designed to keep Chelsea safe).

I heard evidence, and the jury expressly accepted, that the alarm being pulled for the other patient using a ligature would be heard by Chelsea and was a relevant factor in her ligature event.

I then heard that when she was checked the member of staff who checked on her would not lay hands on her as he was a male member of staff alone in the room and was worried about repercussions. He therefore sought support from a female member of staff who went to check on Chelsea and realised that she was not conscious. She then shouted for help and a ligature knife. There were then further delays as others came to observe Chelsea, collected the ligature knife, and removed the ligature then commenced CPR with the red bag. The jury found that these delays were unreasonable in the circumstances. One of the most compelling pieces of evidence about the co-ordination of CPR was that every member of staff present believed one individual was leading the CPR response; however, that particular individual was not aware of that. Whilst this did not materially change the CPR in this case it was certainly not indicative of a well-

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| | rehearsed and practiced response to an emergency situation. |
| 5 | **CORONER'S CONCERNS**<br><br>During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are as follows: –<br><br>1. The diagnosis whilst described as not being fixed; was not adequately reviewed. The primary witness for Cygnet in relation to diagnosis lacked professional curiosity even when asked questions in evidence. For example dismissing the potential that Chelsea may be hyperbolic in some of her descriptions of incidents and could that be relevant to diagnosis or treatment; evidence from the family about another member of the family with an autism diagnosis was not followed up (the evidence from Cygnet being that they had not been aware the family wished to explore this); nonetheless in evidence it was dismissed as a possibility.<br>2. Whilst it is important that the young person is believed and has confidence in those with a therapeutic relationship that she will be believed when she makes disclosures; there was almost no professional curiosity about the allegations and whether they spoke to something else going on with Chelsea. The allegations that were made were blindly accepted by the team and one example where this was problematic is that part of Chelsea's PTSD diagnosis was based on flashbacks. One of the flashbacks which she described related to finding her aunt dead. Her Aunt was not dead and in fact attended the inquest proceedings however this had not been clarified with the family and the treating team accepted this information from Chelsea unequivocally. It is clear there is a very fine balance to tread as it is clear that Chelsea was suffering from flashbacks and had suffered trauma, there was no demonstrable exploration of this.<br>3. The decision not to share information with family was made based on one capacity assessment. This did not fully address the issues with Chelsea of understanding the consequences of that decision and neither does it adequately break down the information which Cygnet may wish to share with family. This appears to have been a blanket decision and once a capacity assessment determined that Chelsea had the capacity to make that decision there is not evidence available to me of conversations with Chelsea to establish exactly what she would and would not share with family and that the consequences of those decisions were adequately explored with her. I would have expected; at Chelsea's age, that a social worker would be involved in supporting her with this decision and reviewing it regularly. This decision about her capacity and information sharing were also not revisited which they ought to have been regularly. Not least because Chelsea's mother was responsible for supporting her with s17 leave and was entitled to fully understand the risks to Chelsea or herself through this.<br>4. There was no evidence of debrief after prior incidents of ligatures or other self-harm attempts and therefore crucial information about Chelsea's state of mind, motivation and methods was missing from future planning and risk assessments.<br>5. There was limited concern about the number of ligature incidents collectively across the ward. They appear to have been accepted as normal behaviour. There was no record of Chelsea using ligatures prior to her admission onto this ward. This reality for staff appears to have led to a downgrading of the seriousness of the use of ligatures. With staff describing in evidence when they would and would not intervene and what would and would not constitute a serious incident in relation to ligatures (i.e., a hospital admission would be required before it was regarded as a serious incident requiring immediate changes to risk levels and observations). It may be that this approach to ligatures also contributed to the delay in Chelsea's final ligature being removed. |

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| | 6. Male staff were nervous and uncertain of how to approach Chelsea when they were alone. Clear guidance needed to be made available to them on how to deal with this. Although in evidence staff said that if there was an emergency they would attend even if alone this was not the case in practice as the male member of staff sought female support before recognising that Chelsea was in crisis.<br>7. The approach of three members of staff checking Chelsea before the ligature knife was brought and used led to avoidable delay. I am aware from the evidence that there are practice exercises involving the 'Red Bag' however I am not clear that the same is practised in relation to the check, identification of a ligature and obtaining and using the ligature knife in these situations.<br>8. Whilst in evidence I have heard about the practice exercises using the 'Red Bag' it is clear that there was limited confidence and clarity around the CPR needed for Chelsea. There was not a clear structure of one person leading and others knowing exactly what and how to do tasks.<br>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.<br>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. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe your organisation have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 14 October 2022. I, the coroner, may extend the period.<br><br>Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed. |
| 8 | **COPIES and PUBLICATION**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: Family of Chelsea Mooney, NHS England, and Cygnet Health Care.<br><br>I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.<br><br>I may also send a copy of your response to any other person who I believe may find it useful or of interest. In this case I have sent a copy of this report to Sheffield City Council Children's services.<br><br>The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest.<br><br>You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response. |

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| 9 | **18 August 2022**<br>  <br>**HM Assistant Coroner Abigail Combes**<br>**South Yorkshire (West) District** |