



39 Victoria Street London SW1H 0EU

Our ref:

HM Coroner Simon Milburn Area Coroner, Cambridgeshire & Peterborough Coroner's Service, Lawrence Court Princes Street Huntingdon PE29 3PA

By email:

13 January 2024

Dear Mr Milburn,

Thank you for the Regulation 28 report of 23<sup>rd</sup> October 2024 sent to the Department of Health and Social Care about the death of Declan Morrison. I am replying as the Minister with responsibility for adult social care.

I would like to say how saddened I was to read of the circumstances of Declan's death and I offer my sincere condolences to Declan's family and loved ones. The circumstances your report describes are very concerning and I am grateful to you for bringing these matters to my attention.

In preparing this response, my officials have made enquiries with the Care Quality Commission to ensure we adequately address your concerns. NHS England will be providing a separate response.

Your report highlights a shortage of suitable placements in the community and in the NHS for people with complex needs, leading to the longer-term use of a Section 136 Suite. I am clear that we want people to be supported in the community with the care that is right for them.

In order to achieve this, we are committed to building consensus on the long-term reform needed to create a National Care Service based on consistent national standards. We will set out next steps for a process that engages with adult social care stakeholders, including cross-party and people with lived experience of care.

Under current NHS England statutory guidance, published 9 May 2023, Integrated Care Boards (ICBs) are expected to assign an executive lead role for learning disability and autism to a suitable board member. The named lead is expected to support the board in planning to meet the needs of its local population of people with a learning disability and

autistic people and to have effective oversight of, and support improvements in, the quality of care for people in a mental health, learning disability and autism inpatient setting.

I was concerned to read that Declan spent several months in crisis. To support those needing mental health crisis support, there are now around 600 new or expanded crisis alternative services in England such as crisis cafes, safe havens, crisis houses. £150 million in capital funding was made available across 2023/24 and 2024/25 for new projects to support mental health crisis response and urgent and emergency mental health services. And an additional £26 million investment for new mental health crisis centres was announced in the Autumn Budget to reduce reliance on accident and emergency departments.

As highlighted in your report, when no suitable placement could be found Declan was then detained under Section 2 of the Mental Health Act .Through our proposed reforms to the Mental Health Act 1983 (MHA), as set out in the Mental Health Bill introduced to parliament on 6<sup>th</sup> November 2024, integrated care boards (ICBs) will have a legal duty to ensure hold Dynamic Support Registers of people with a learning disability and autistic people who have risk factors for detention under Part II of the MHA. The Dynamic Support Register is intended to improve monitoring of the needs of, and support for, people who may be at risk of going into crisis and being detained under Part II of the MHA.

Further, the Mental Health Bill would place a duty on ICBs and local authorities to have regard to information on the Dynamic Support Register when exercising their commissioning and market shaping functions under the NHS Act and Care Act respectively. Both ICBs and local authorities would have a duty to seek to ensure the needs of people with a learning disability and autistic people can be met without detaining them under Part II of the MHA.

Individual trusts and local health systems are expected to effectively assess and manage bed capacity, the 'flow' of patients being discharged or moving to another setting and the availability of specialist units. NHS England's 2024/25 priorities and operational planning guidance reinforces this focus on improving patient flow as a key priority – with local health systems directed to reduce the average length of stay in adult acute mental health wards to deliver more timely access to local beds. And in areas where there is a clear need for more beds, this has been addressed in part through investment in new units, as part of a whole system transformation approach.

I also noted your report highlighted that staff were not appropriately trained to care for Declan. This is clearly vitally important in ensuring people get the right support.

The Health and Care Act 2022 sets out that, from 1 July 2022, CQC registered service providers are required to ensure their staff receive learning disability and autism training appropriate to their role. This includes staff working in mental health inpatient settings.

In October 2024, the Care Quality Commission (CQC) held a decision review meeting and have asked the Cambridgeshire and Peterborough NHS Foundation Trust to supply further information, including any investigation reports and what learning they have taken to mitigate future risk to others. The CQC continue to monitor the service as part of their ongoing

engagement with the Trust and will consider any areas of concern and how these have been addressed.

Thank you once again for your report and the concerns that you have highlighted. I am determined that we improve the care and support to address the concerns raised in your report in relation to the care of Declan. The right support in the community can help prevent needs escalating so that detention is only ever where absolutely appropriate, and it must be high quality should that admission take place.

Yours sincerely,

