Metropolitan Borough

Chief Executive

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Steven Pleasant MBE
Chief Executive

Dukinfield Town Hall, King Street,
Dukinfield, SK16 4LA

www.tameside.gov.uk
e-mail : [redacted]

Call Centre [redacted]

Your Ref
Doc Ref
Ask for [redacted]
Direct Line
Date 31 January 2017

By email: [redacted]
Miss Joanne Kearsley
Acting Senior Coroner
Manchester South Coroners
Coroner's Court
1 Mount Tabor Street
STOCKPORT
SK1 3AG

RECEIVED
01 FEB 2016

Dear Miss Kearsley

Rachal Marie Murphy

I am writing in response to the Regulation 28 Report dated 8 December 2016 and in particular to the concerns raised regarding the delay in the allocation of cases within Tameside Early Help Services.

A thorough review has been undertaken of caseloads and allocation of work within the Early Help Service in part due to learning from cases such as this one and more recently our latest Ofsted inspection of children's services. As a result, measures have been put in place which have led to a significant reduction of delay in the allocation of cases.

The table below provides quarterly data in relation to the number of families who have been entered onto a waiting list, having been identified as requiring a service from Early Help. The data gives a snapshot of the total number of families who were on the waiting list at the end of each quarter and gives clear evidence of the efforts that have been made to eradicate the use of a waiting list. The three cases that were on the waiting list at the end of the most recent quarter were allocated as soon as the holiday period came to an end and normal staffing levels were in place.

Time Period	Number of Cases on Waiting List
July – Sept 2015	60
Oct – Dec 2015	44
Jan – Mar 2016	33
Apr – Jun 2016	15
Jul – Sept 2016	15
Oct – Dec 2016	3

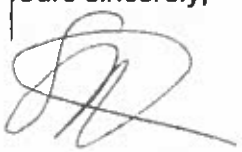
Assurances can be given that in the past six months, any family entered onto a waiting list was allocated a worker within a one month time frame and a manager from the Early Help Service kept in contact with the family during that period to monitor the situation.

Managers within the Early Help Service continue to monitor this and are now vigilant in ensuring that the use of waiting lists is not common practice and that families receive a service at the point that need is identified.

The future monitoring of this performance will be undertaken at a weekly Family Support Panel which will manage all allocations to Early Help and other services in order to maximise the timely response to children's needs. In addition, a report will be submitted to the Tameside Safeguarding Children Board on a six monthly basis to keep the Board updated on the progress of the Early Help Services to ensure a strong multi agency ownership.

I trust that the measures that have been put into place will address the concerns raised within the Inquest in respect of the Early Help Service.

Yours sincerely,



Steven Pleasant MBE
Chief Executive

NHS Foundation Trust

1st February 2017

Corporate Governance
Trust Headquarters
225 Old Street
Ashton-under-Lyne
Lancashire
OL6 7SR

Telephone: 0161 716 3000

Our Ref: [redacted]
Department: Trust Headquarters

PRIVATE & CONFIDENTIAL
Ms J Kearsley
Acting Senior Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Ms Kearsley,

Re: Rachel Murphy (Deceased)

Thank you for your Regulation 28 report dated the 13h December 2016, and for bringing to my attention the concerns you had after hearing all the evidence. Your concerns relevant to Pennine Care have been reviewed, and the Trust's response is outlined below.

Concerns:

- There was a lack of understanding between medical professionals as to the means a referral could be made to Psychological services and to whether there was an unclear message from Psychological services if they were accepting referrals.

- A Lack of understanding amongst medical professionals as to which cases may or may not be appropriate for referral to CAMHS services.

Response:

As part of the Trust's quality improvement work during early 2016 the Trust implemented a new referral process for all aspects of Tameside and Glossop Healthy Young Minds Services (formally CAMHS). All referrals are now managed via one single point of entry and then allocated to a range of possible professionals dependant on the child/young person's needs e.g. Psychologists, Nurse, Psychiatrist or 3rd sector services. This allows for greater clarity and understanding of where to direct requests for help to for all professionals.

The Trust have also produced a service offer document which details, how to make a referral, how to contact the service for advice and importantly the document contains information of the types of problems that are appropriate to refer to Tameside and

Glossop Healthy Young Minds. This service offer document has been circulated widely to all partners and is also held on our website for easy access.

The document has just recently been reviewed and will be expanded to provide a named contact for colleagues in the Paediatric medical services to contact for advice and consultation. The Trust believes that this addresses the confusion and lack of understanding that you have identified in relation to Rachel's care and treatment.

I hope this response assures you that the Trust takes seriously any concerns that you raised.

Yours sincerely,

[redacted]

For and on behalf of
Michael McCourt
Chief Executive

NHS
Tameside and Glossop
Integrated Care
NHS Foundation Trust

Tameside General Hospital
Fountain Street
Ashton-Under-Lyne
Tameside
OL6 9RW

Telephone: 0161 331 6000

Ms Joanne Kearsley
Acting Senior Coroner for Manchester South
The Coroner's Court
1 Mount Tabor
Stockport
SK1 3AG

27 January 2017

Dear Ms Kearsley

Regulation 28: Report to Prevent Future Deaths following Inquest into the death of Rachal Murphy

I write further to your letter dated 8 December 2016 enclosing a Regulation 28 Report issued at the conclusion of the inquest touching upon the death of Rachal Murphy, which took place on 17 to 19 August 2016. We acknowledge that the Report has been issued to us some three months after the inquest was heard, but are, of course, very sorry that you had cause to issue this.

Further to a letter received by you from the Trust solicitors dated 30 August 2016, I hope to be able to further address your concerns, as set out in section 5 of your Report, to your satisfaction, in this letter. I have addressed the areas of concern, adopting the same numbering in section 5 of your Report as follows:

You stated:

1. *There was a lack of understanding between medical professionals as to the means by which someone could be referred to Psychological Services and whether there was an unclear message from Psychological Services as to whether they were accepting referrals.*

As per the letter from our solicitors dated 30 August 2016, Paediatric Psychology Services within the Trust were at this time provided solely by Pennine Care NHS Foundation Trust. The Trust were therefore very limited by the services/policies and practices adopted by Pennine Care. I understand that it was heard in evidence that the clinical psychology services offered at the Trust through Pennine Care were undergoing a reconfiguration during 2015 and therefore the paediatric team were informed that referrals to the Paediatric Psychologist could not take place. I am advised that this was confirmed by the Trust's Consultant Paediatrician in evidence, who stated that to the best of his knowledge the Paediatric Psychologist had been decommissioned and he therefore understood that referrals could not be made. I understand that this contention was supported directly by the statement obtained from the Paediatric Psychologist who stated that *'I had told all paediatricians that I could not take on any more referrals as the referral process was changing'*.

Similarly when approached by the Trust's Specialist Epilepsy Nurse at the request of CAMHS, I am advised that the evidence heard at the inquest supports the contention that a referral could not have been accepted and all referrals were to be sent back to CAMHS. I understand that it was clear from the evidence of the Trust's Specialist Epilepsy Nurse that she felt that there was nothing further she could do as she was ultimately limited by the services provided by both CAMHS (who rejected the referral) and Pennine Care, who were not accepting referrals at that time.

whilst it seems arguable from the evidence summarised above that there was a lack of understanding about Paediatric Psychology Services at this time, the system within the Trust has now changed. Please see the further explanation provided at point 2 below.

2. *Lack of understanding amongst medical professionals as to cases which may or may not be suitable for referral to CAMHS.*

As indicated to you in a letter from our solicitors dated 30 August, it was the Trust's contention that during the course of the inquest there was in fact no evidence to suggest a lack of understanding in relation to CAMHS referrals and where evidence perhaps suggested that knowledge was limited, the Trust demonstrated that practices have now changed. I understand that the Trust's Consultant Paediatrician gave clear evidence that a CAMHS referral was not made by him in March 2015, not because he was unsure of the process, but because he knew how the process works and understood that without evidence of a more acute mental health problem, the referral would be refused (which it ultimately was) and it was therefore important to look at other avenues of how to manage Rachal's behaviour.

I am advised that the Trust's Specialist Epilepsy Nurse spoke frankly about her understanding of CAMHS at this time but provided reassurance in evidence that her knowledge of the service and the way in which she interacts with CAMHS has now changed, resulting in her undertaking a much more active role in terms of liaison with CAMHS, even in cases where a referral would likely not be accepted, and she confirmed in evidence that she will speak with CAMHS regardless of whether an official referral is in place.

The Trust have in response to this case, made changes to their practices to ensure that referrals to CAMHS are made in writing in any case where the Consultant Paediatrician has reasonable cause for concern in respect of a child's psychological wellbeing. The Consultants no longer filter referrals through Pennine Care staff nor do they consider the likely acceptance of referrals before making them. The referral is made and it is for CAMHS to determine how to proceed. I am informed that this change in approach has been successful to date with CAMHS appearing to be accepting more referrals in response.

The Trust now have in place a number of safeguards to ensure that where a child being treated for epilepsy exhibits signs that may be consistent with mental health issues, that they are managed and referred to the appropriate organisation.

Consultant Paediatricians dealing with epilepsy patients develop a plan of care that is specifically tailored to each child and their family's needs. If a referral to CAMHS is required, no matter how small the concern, it is made. If a child exhibits signs that are consistent with them being high risk of self-harm/suicide, they will be admitted to hospital immediately for further assessment.

All children treated for epilepsy are reviewed by the Trust's Specialist Epilepsy Nurse. The Specialist Epilepsy Nurse reviews their progress, liaises with their family and school and if any concerns regarding mental health are identified, these are discussed with the Consultant Paediatrician and a referral to CAMHS is made. The Specialist Epilepsy Nurse also liaises more informally with CAMHS by way of telephone advice, if a concern is identified.

All children treated for epilepsy are given information regarding The Hope Group, a family support group for families with children suffering from epilepsy. The group is run independently from the Trust but the Trust's Specialist Epilepsy Nurse is involved and often encourages families to attend weekly meetings as a further support network for patients and families who may be facing difficulties. The group provides a useful framework of support for children (and their families) to discuss and voice their concerns and worries outside of the hospital environment. The group is successfully attended and is assisting many families who find themselves in similar situations to Rachal and her family.

Since this incident, the Trust have employed a Children and Young People's Mental Health Development Nurse who works closely with the Paediatric Team offering support and training to

develop mental health knowledge and skills to support safe, high quality and evidence based care for vulnerable children and young people.

A business case is currently being developed by the Trust to request funding for the introduction of a Psychologist for Paediatric Epilepsy patients. The introduction of such a role would provide another level of support to the team in dealing with patients who may be suffering with mental health issues. The appointment will be subject to the availability of NHS funding.

3. *There was a significant delay in reporting Rachal's EEG and the Court heard that this remained the case in respect of reporting of EEG's at the time of the inquest.*

24 hour, and in this case, 72 hour EEG's are very specialist tests that require specialist input and reporting. In order to interpret the outcome of these tests, analysis of an expanse of data collected over a 72 hour period has to be performed, the results of which may materially affect a patient's diagnosis.

As indicated to you, in a letter from our solicitors dated 30 August 2016, 24 and 72 hour EEGs are performed and reported exclusively by Manchester Children's Hospital (operated by Central Manchester University Hospitals NHS Trust). Whilst the Trust can chase up the results, they are not in control of the timeframes for reporting and delivery of EEG results, although given their specialist nature a period of analysis is expected. A patient's care is also not affected whilst awaiting the EEG result.

The Trust therefore reiterate in line with para 7(1)(c), Schedule 5 of the CJA 2009, and also the Chief Coroner's Guidance No.5 on Regulation 28 Reports, that the Regulation 28 Report must be sent to *"an organisation who the Coroner believes has the power to take such action"*. For the reasons stated above, the Trust respectfully submit that they have no *"power to take such action"* and therefore should you still have concerns in this respect, the Regulation 28 Report should be directed to the requisite organisation.

I am very sorry that you had cause to issue this Regulation 28 and I would like to take this opportunity to emphasise that I do take your concerns very seriously, I hope that I have responded to your concerns and reassured you of all the work that the Trust has already undertaken and is currently undertaking to reinforce the messages conveyed to you at the inquest regarding Paediatric Psychology Services.

Should you have any further questions arising from the contents of this letter, please do not hesitate to contact me.

Yours sincerely

Karen James
Chief Executive