JM

Pennine Care NHS
NHS Foundation Trust

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15th June 2015

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Miss J Kearsley
Area Coroner
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The Coroner's Court
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By e-mail:
joanne.kearsley@stockport.gov.uk

Dear Miss Kearsley

Re: KESIA LEATHERBARROW

Thank you for your letter of 16th April enclosing your Regulation 28 report.

At page 13 you have dealt with issues relating to Pennine Care NHS Foundation Trust and have stated ………"*the Court heard evidence about two matters involving Mental Health services and other agencies.* [redacted] *gave evidence that in his view there would be interaction between their service and Tameside Youth Offending Team with regards to Kesia. This would either be done once the case had been passed to Amy Valentine or if Tameside YOT contacted their service. This did not occur as the file has not been processed at the time of Kesia's death but also because of the confusion between the Youth Offending Team involved with Kesia which meant that she was never picked up by Tameside. The plan that Kesia should be monitored for any interim changes in her risk did not therefore occur*".

In January 2014 the Trust completed their investigation into their involvement with Kesia and identified a number of problems which reflect your own findings.

These included:-

1. Kesia had prior involvement from Mental Health Services in Chorley and recent involvement with the police in Tameside. Adequate and timely sharing of information was not undertaken.

POSITIVE ABOUT DISABLED PEOPLE

2. There had been no transition of care from Chorley Mental Health and Youth Offending Services or multi-agency support and therefore there was limited information available regarding Kesia's needs.

3. There was no contact with CAMHS services by the police following Kesia having been in police custody the preceding weekend despite an established diversion pathway, and a specific Youth Justice Mental Health Practitioner being in post.

4. Although Kesia's referral was screened in a timely manner, contingency advice about accessing more urgent or emergency mental health assessment within Tameside had not been provided to Kesia and her family.

5. The response to the referrer and written letter to Kesia and her carers regarding the confirmation of her appointment date, details and information regarding the service had not been despatched at the time of her death.

6. A written summary of all letters from Chorley Mental Health Services and a summary from her in-patient admission were not available and may have been relevant in supporting decision making.

An action plan was implemented following the Trust's review which included:-

1. The development of a single point of access. CAMHS and RAID workers now hit SIT together to ensure that patients can be speedily and effectively referred to the appropriate service.

A tracking system has been implemented to monitor and ensure administration time scales are being met. This recommendation has been incorporated into the Tameside CAMHS 16 – 18 referral protocol which deals with routine referrals by the Tameside Access Team, inappropriate routine referrals and referrals by the RAID team. Tracking pro formas are now completed. The pro forma and referral are passed to the administrator who notes the outcome of the MDT discussion (during which the client has been discussed) in the referral book. If felt appropriate, the administrator identifies a suitable time and date following discussion with the team. There follows a standard letter sent to confirm receipt of the referral and advise of the time, date, location and identity of the assessors to the young person. The letter provides information with regards to an interim safety plan. The letter advises the referrer and the young person's GP that the referral has been received, screened and accepted for assessment. A file is then made up by the administrator which contains a copy of the referral and accompanying paperwork. This is placed in the drawer of the 16 – 18 office which contains 12 slings each designated to a particular month. The current month's sling is audited on a weekly basis during the whole team meeting and remedial action is taken in the event of any delay in the referral process.

When referrals are accepted a further letter confirming the appointment is sent within 21 days of the appointment.

2. It is now standard practise that upon receipt of referrals where there has been prior involvement with young people from other mental health services the CAMHS mental health team ensure written clinical summaries, including risk assessments and care plans are requested in addition to telephone contact made to gather background information.

3. The health diversion pathway has been re-published and re-promoted to Tameside Police and the Youth Offending Team to increase use of the pathway.

The Youth Justice Mental Health Practitioner is now jointly supervised by Pennine Care.

4. The multi-agency panel for vulnerable offenders which meets every two weeks now also has capacity to deal with children and young people. Individuals are discussed during these local meetings and ways in which they can be diverted from the criminal justice system considered. The emphasis now is to ensure children do not remain in police custody or other penal institutions.

The Trust accepts and shares the concerns that have been raised by you and has taken appropriate steps to minimise the risk of similar problems arising in the future. Those working at the Trust with young people believe there has been a total cultural shift within GMP with an emphasis on safeguarding children and primary consideration as to how children and young people can be diverted from the criminal justice system.

Yours sincerely

Michael McCourt
Chief Executive