REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Pennine Care NHS Foundation Trust** **Tameside General Hospital** **Grosvenor Medical Centre, Stalybridge** **Tameside Council – Early Help Services**
1	**CORONER** I am Joanne Kearsley Acting Senior Coroner for Manchester South
2	**CORONER'S LEGAL POWERS** 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** On the 25th August 2016 I concluded the Inquest into the death of Rachal Marie Murphy date of birth 24 January 2000 who died on the 8th September 2015. I recorded that the deceased on or around the 8th September 2015 at her home address had taken a quantity of medication which was prescribed to other family members. At the time she had a number of medical and social issues which were being investigated. The medical cause of death was confirmed as 1a) Acute Hypoxia due to 1b) Morphine overdose Conclusion – Deceased had taken her own life
4	**CIRCUMSTANCES OF THE DEATH** The Inquest into the death of Rachal Murphy heard how a number of agencies were involved with Rachal and her family. Rachal had not been attending school for a long period of time. She was being investigated for epilepsy and it was reported by her family that she was having seizures on a daily basis. These were not confirmed on any of the investigations undertaken. By 2014 there were concerns by professionals as to both the underlying cause of any medical condition but also her lack of schooling, her lack of interaction and underlying stressors which may have been impacting on any medical condition.

There was also some evidence that she had attempted to self harm but this was denied by her family.
The Court heard that by March 2015 they were concerned that there was no counsellor involved with rachal. By this stage it was accepted by Rachals Consultant that there should have been a referral to Child Adolescent Mental health Services. The Court also heard that there was some confusion as to whether a direct referral could be made to the Clinical Psychology Services.

A CAF process had been commenced because of concerns about Rachal but there was a complete lack of progression for this process until the involvement of the Early Help Services. A meeting did take place on the 17th June 2015 but having heard the evidence the Court found that at best from March 2015 there was a fractured, disjointed plan as to how to proceed with Rachals care.

By the time of Rachals death there was a complete lack of action in respect of the plan for Rachal. Those involved with her medical care wanted input from Mental health services to whom no referral had been made. Those involved with her social matters had wanted an outcome on her medical conditions.

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5 **CORONER'S CONCERNS**

The concerns noted by the Court during the course of the Inquest are as follows:

GP SERVICES

1. There was a failure to undertake annual liver function tests in 2014 and 2015
2. The CAF documentation was completely overlooked and simply placed in the medical records as read only which led to no GP involvement in the inter-agency framework and handling of this case.

Tameside NHS FT and Pennine Care NHS FT

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 a unclear message from Psychological services as to whether they were accepting referrals.

	2. Lack of understanding amongst medical professionals as to the cases which may or may not be suitable for referral to CAMHS. 3. There was as significant delay in the reporting of Rachals EEG and the Court heard that this remained the case in respect of reporting of EEGs at the time of the Inquest. Tameside MBC – Early Help Services 1. The Court heard that there was a significant delay in the allocation of cases within Early Help Services and from the evidence the Court was not satisfied that this had been resolved.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **2nd February 2017** I, the coroner, may extend the period. 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** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely, **the family of Rachal Murphy** I am also under a duty to send the Chief Coroner a copy of your response. 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. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**08.12.2016** **Joanne Kearsley Acting Senior Coroner**