Date: 11th February 2020

Ref:17524

Leeds and York Partnership NHS Foundation Trust
2150 Century Way
Thorpe Park
Leeds
LS15 8ZB

Mr Kevin McLoughlin
Senior Coroner, Western Yorkshire (Eastern District)
Coroner's Office and Court
71 Northgate
Wakefield
WF1 3BS

Dear Mr McLoughlin,

RE: REGULATION 28 REPORT TO PREVENT FUTURE DEATHS: Layla Stephanie DOBSON, (deceased)

Thank you for the correspondence regarding the outcome of the inquest which was concluded on Tuesday 8 October 2019, touching upon the death of Ms Layla Stephanie Dobson. I would firstly like to take this opportunity to express my sincere condolences to Layla's family and friends at the tragic loss of Layla.

Following the Regulation 28 Report to Prevent Future Deaths issued on the 16 December 2019 to Leeds and York Partnership NHS Foundation Trust (LYPFT), please find below the details of the response to address the concerns raised.

The Matters of Concern are in bold text with the Trust's response following:

> **Although the PDCN considered Layla's referral, notwithstanding it does not take self-referrals to its care coordination services, the evidence provided at the inquest indicated that there was no formalised or tangible process to guide or otherwise inform practitioners as to which route of support would be appropriate for an individual.**
>
> **Whilst the approach to the CMHT was decided upon and actioned, my view upon the evidence was that the area on the form relating to current self-harm/suicide is not further flagged or referenced to those taking relevant decisions and this could strengthen the scrutiny of information when deciding upon which service may be contacted.**

Whilst the evidence at the inquest was clear that Layla was under the care of her GP who later assessed her mental health/risk on 08th March 2018, I am of the view that the process whereby an individual seeks to request/access mental services could be strengthened by guidance or referencing such that each pathway of support is systematically considered.

The Personality Disorder Clinical Network service has carefully considered the matters of concerns outlined and agreed an action plan (appendix 1) at the service Clinical Governance forum held on the 30th January 2020. Firstly the service is developing guidance to further inform the decision making process with regards to referral to relevant crisis support services. The guidance will include for example:

- Ascertaining whether an imminent risk of suicide is identified in the referral information.
- Whether mental health service support is already currently available for the service user.
- Whether the referral is a 'self-referral'.

This guidance will routinely be considered at the referral meeting stage and is intended to support decisions taken by the membership of the referral meeting as to a proportionate response to the risk information available at that point in the referral process. It will include reference to recommended 'steps' to consider should a referral be identified as indicating an imminent risk of suicide and where support from appropriate mental health services is not already in place. Reference to this guidance will then be routinely made in the clinical case record pertaining to each referral.

The service is also aware that there may be instances where the referral may not be considered by the referral team for up to 7 days or where direct contact with the service user was considered the most appropriate course of action and they 'did not attend'. As such the service referral form and information leaflet (available via the LYPFT website) will be updated to provide details of relevant crisis support services in Leeds.

The service will additionally change its process for responding to self-referrals by developing a standard referral receipt letter which will automatically be emailed and/or posted to service users outlining relevant crisis support services. This measure is intended to additionally ensure that service users referred to the service will always be made aware of the relevant services in the City who may be able to provide a crisis service level of response, pending the referral outcome.

I hope that this response provides assurance of improvement, consistent with the concerns highlighted in the Regulation 28. We would be pleased to provide any further information or clarification required.

Yours Sincerely

Dr Sara Munro
Chief Executive

c.c Mr John Hobson, Assistant Coroner