REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Leeds and York Partnership NHS Foundation Trust ("the Trust").
1	**CORONER** I am John Hobson, an Assistant Coroner for the coroner area of West Yorkshire (Eastern).
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 18th March 2019 an investigation was commenced into the death of Miss Layla Stephanie Dobson, aged 23. The investigation concluded at the end of the inquest on 8th October 2019. The medical cause of death established at the inquest was that Miss Dobson's died by way of hanging. A conclusion of suicide was recorded.
4	**CIRCUMSTANCES OF THE DEATH** On 11th March 2019 Miss Layla Stephanie Dobson was found deceased at her home address in Headingley Avenue, Leeds. Layla was a student who suffered with mental health issues and had been engaged with mental health services over the course of a number of years in her home city of Hull, prior to moving to Leeds. On 8th February 2019 Layla completed a self-referral form to the Leeds Personality Disorder Clinical Network ("PDCN") in which she set out a background including self-harm and suicidal ideation in the context of a recent relationship breakdown. She expressed a wish to be supported by the specialist support of NHS mental health services. On the section of the form headed 'Self-harm/suicide (e.g. cutting, misuse of medication/overdosing and eating difficulties)' Layla indicated recorded current matters of 'cutting, recent attempt of hanging, banging head into wall, hair pulling, drugs + alcohol, restrictive eating'. Although aspects of the Trust mental health services do accept self-referrals, the PDCN does not do so to its care co-ordination services. Nevertheless, Layla's referral was discussed at a meeting on 25th February 2019 and it was decided that the Clinical Team Manager, Ellen Scroop would contact the relevant Community Mental Health Team to discuss whether an assessment of Layla's needs could be offered. Miss Scroop gave evidence at the inquest and the question was raised as to any consideration of a referral to appropriate Crisis Team support, in view of the matters disclosed by Layla, and specifically to current self-harm/suicide on the referral form. The records show that contact with the CMHT was followed up in late March 2019.

	Evidence was also heard that Layla had appointments with her GP on 1st February, 8th February, 22nd February and 8th March 2018. At the last appointment her mental health and level of risk was explored and Layla denied any intention of suicide or self-harm.
5	**CORONER'S CONCERNS** In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The matter of concern is as follows. - 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 8th 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. I am under a duty to report this matter upon consideration of the evidence.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 Tuesday 11 February 2020. I, John Hobson, 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 family who were an Interested Party at the inquest. 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	 **John Hobson** **Assistant Coroner** **16 December 2019**