Leicestershire Partnership
NHS Trust

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Via email c/o [redacted]
12th July 2024

Dear Miss Butler

Lily Precious Jahany

Inquest date: 17th May 2024

On behalf of the Leicestershire Partnership NHS Trust ('the Trust'), I am responding to your Report to Prevent Future Deaths (hereafter "your Report") dated 17th May 2024 concerning the death of Miss Jahany. In advance of responding to the concerns raised in your Report, I would like to express my deepest condolences to Miss Jahany's family and loved ones. The Trust wishes to assure the Jahany family and HM Coroner that the concerns raised about his care have been listened to, reflected upon and action has been taken as a result.

In your Report, you raised two Matters of Concern. The first of these Matters of Concern is better addressed by Student Roost who no doubt will respond direct. I will therefore respond to the second matter of concern which is relevant to the Trust.

In your report, you have raised a Matters of Concern:

1. *I have spent a lot of time in this inquest investigating the information which was known about Lily, about her mental health and who had access to what information in the context of assessing her risk.*

   In September of 2023, Miss Evans, Assistant Coroner sitting within the Rutland and North Leicestershire jurisdiction heard an inquest concerning a student at Loughborough University. Similar to Lily's case he was under the care of a private psychiatrist elsewhere in the country where he had lived prior to attending university. As a result of concerns in that case (his death occurring 1 year before Lily') around lack of contact by the Crisis Team at the time of assessment or otherwise with the private psychiatrist, the Coroner wrote to the Leicestershire Partnership Trust to share her concerns.

The Trust referenced the Crisis Team Standard Operating procedure in the inquest in September 2023, the Coroner was concerned about the level of awareness that staff members had of any expectation required of them set out within that procedure to seek information from other agencies.

I now have sight of the Crisis Team Standard Operating Procedure. It sets out the keyworker responsibilities. The section is drafted presupposing that patients are receiving care and treatment from the Crisis Team and only at that point does the responsibility for seeking relevant information from other agencies kick in. Furthermore, the emphasis upon that requirement is limited to one line which reads 'responsibility for referrals and liaising with other agencies involved'. That is anything but clear as to any expectation upon staff to ensure they have at their disposal all of the relevant risk information at the time of making that assessment; nor does it in my view set out any expectation upon staff to proactively make contact with treating clinicians in the private sector to gain information. It would not capture situations such as Lily's, who was discharged from the Crisis Team after an 1 hour assessment and therefore was not under their care and treatment, I having found a failure to obtain all relevant information pertinent to her risk in assessing that risk.

Access to necessary information:

We understand and accept the importance of having access to all the necessary information, including previous contact with NHS and private providers during a comprehensive assessment and for safety planning.

We have undertaken a full review of the Crisis Resolution Home Treatment Team Standard Operating Procedure and the Mental Health Central Access Point Standard Operating Procedure (SOP). These SOP's have been updated to explicitly clarify the professional expectations regarding information gathering by liaising with key professionals which includes private providers and psychiatrists. The SOP's also include a process for what to do when we are unable to contact key professionals including private sector care providers.

The Trust continues to be a stakeholder in the Leicester Leicestershire & Rutland (LLR) University workstream, led by the LLR Integrated Care Board. This ensures that collaborative working continues to streamline and optimise access to mental health support and advice for students and university staff across LLR.

Thank you for bringing this important patient safety issue to our attention, and I trust that the action we have taken responds to the concern set out by HM Coroner in her Report, with a focus on avoiding a recurrence of the circumstances around Miss Jahany's death.

Yours sincerely

[redacted]

[redacted]

Chief Executive