

18<sup>th</sup> March 2024

Marilyn Whittle  
HM Assistant Coroner, South Yorkshire (West)  
Medico-Legal Centre  
Watery Street  
Sheffield  
S3 7ES

████████████████████  
Chief Nurse / Director of Quality  
and Professions  
Trust Headquarters  
Fieldhead Hospital  
Ouchthorpe Lane  
Wakefield  
WF1 3SP  
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Dear Ma'am,

**Regulation 28 Response – Rachel Mortimer**

We write in response to the Regulation 28 report following the inquest touching the death of Ms Rachel Mortimer. We would like to start this response by offering Ms Mortimer's family our sincere condolences for their loss.

We hope the information supplied in this response provides assurance that the Trust has carefully considered, and appropriate actions will be taken in response to these. We will take each concern in turn below.

**1. Following concerned calls by family no advice was provided on what options were available to them if they were concerned for their family members safety and no provision of services that could be called to discuss her mental state.**

Practitioners in the Barnsley Intensive Home-Based Treatment Team (IHBTT) have access to a resource pack with comprehensive and up to date information regarding local mental health support services for people in psychological distress, which may not require a secondary care mental health response.

Your concern will be shared with all practitioners in Barnsley IHBTT through team meetings and email communication. This will include an emphasis on the importance of practitioners always referring to the resource pack, to ensure the most appropriate advice is provided to service users and their families about how to access support at all times should they have concerns about their loved one's safety and wellbeing.

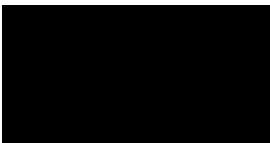


- 2. Despite identifying the risk of emotional dysregulation and that BSARCS would mitigate this risk. When IHBTT were informed BSARC was not available no further consideration was given to any other service to minimise the risk.**

Following receipt of your concern, it has been agreed that where the Barnsley IHBTT are informed that an onward referral has been declined by Barnsley Sexual Abuse and Rape Crisis Service (BSARC), the service will reconsider the suitability of the advice they have given to service users and families and review any proposed treatment plans to consider whether further risk mitigations or interventions are required to support the service user. This requirement will be embedded into team practice and communicated to all practitioners through team meetings and email communication.

I do hope the above information is of assistance and answers the concerns raised within your Regulation 28 report following the sad death of Ms Rachel Mortimer.

Yours sincerely,



Chief Nurse / Director of Quality and Professions  
South West Yorkshire Partnership NHS Foundation Trust

