	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **South West Yorkshire Partnership Trust**
1	**CORONER** I am Marilyn Whittle, Assistant Coroner for South Yorkshire West
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 10 July 2023 I commenced an investigation into the death of Rachel Louise MORTIMER. The investigation concluded at the end of the inquest on 12 January 2024. The conclusion of the inquest was suicide. The medical cause of death was: 1a Hanging in the context of cocaine and alcohol usage 1b 1c II
4	**CIRCUMSTANCES OF THE DEATH** On 25 June 2023 Rachel Mortimer took her own life . She was found by her son in her garden hanging [redacted]. In December 2022 Rachel Mortimer took an overdose of [redacted]. A Mental health act assessment was undertaken but she was not deemed to require sectioning at this time. On 18 June 2023 Rachel was seen by the Mental Health Liaison Team (MHLT) at Barnsley Hospital after taking an overdose of prescribed [redacted] and trying to hang herself. She said she had been having suicidal thoughts for a long time, she did not regret her actions and that thoughts of her family did not stop her. She was assessed by the MHLT as having risk of future impulsive self harm and suicide when using alcohol and risk of further deterioration of her mental state without timely appropriate mental health support to develop coping skills. She was referred to IHBTT and was discharged from hospital. No MHA assessment was undertaken. She was seen by IHBTT and her risks of emotional dysregulation without engaging in therapy and risk of harmful alcohol use were identified. She was

	to be referred to BSARCS and told to refer herself to recovery services as mitigation. She was assessed as low risk of suicide even though she had initially stated she was not regretful of what done and disappointed that she had not died, she was assessed as not having current suicidal thoughts or intentions of suicide and wanted to engage in therapy. She was provided with contact numbers to call if she wanted to discuss her mental health at any time. Unfortunately, whilst she was referred to BSARCS she was not accepted. Despite this being a risk factor no other mitigation was offered at this time and therefore the risk was not mitigated. On 21 June at 4pm IBHTT Rachel's mother contacted IHBTT with concerns, she was told that Rachel should contact the GP for access to services and that they could not provide any information due to data protection. At no point was Mrs Mortimer provided any information on what to do if she was concerned for Rachels safety such as taking her to ED or that Rachel could contact certain mental health services to discuss her feelings in a crisis. A further call was made at 5.30pm, an hour and a half later, by Rachel's son, who expressed concerns that she was expressing suicidal ideas, again no signposting was given. A further call was made on the same day by paramedics with concerns and again they were told that she had been advised to contact her GP. No signposting was provided or consideration given to the fact previously identified risks which had not been mitigated and she was drinking which had been identified as having a risk of future impulsive self harm and suicide. Despite these 3 contacts by family and paramedics, at no point was any safety netting in terms of the options available if they were concerned provided, such as to take her to ED or for her to call any mental health services given. A phone call was made that evening to Rachel but as Police were with her she was unable to discuss and asked for a call back later which was not answered. IHBTT discussed Rachel on 22 June 2023 and decided she should be called for a review of her mental state and risks and to offer secondary mental health follow up. 7 telephone calls were made between 22 and 26 June with no success. IHBTT knowing that she had had 2 previous suicide attempts, had risk factors that had not been mitigated and had recently been contacted on by family with significant concerns that she was suicidal the IHBTT treatment team took no further action and on 26 June, with no contact, assessed her as low risk due to lack of contact. .
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. 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 **MATTERS OF CONCERN** are as follows. – 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. 2. Despite identifying the risk of emotional dysregulation and that BSARCS would mitigate this risk. When IHCBTT were informed BSARC was not available no further consideration was given to any other service to minimise the risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 18 March 2024. 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; the family of the deceased. 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	20 January 2024 Signature  Marilyn Whittle H.M Assistant Coroner for