REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Secretary of State for Justice, Ministry of Justice** **2. [redacted], Commissioner of the Metropolitan Police**
1	**CORONER** I am Sarah Bourke, HM Assistant Coroner, for the coroner area of Inner North London.
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 19 October 2022, I commenced an investigation into the death of Zahra Sharif Mohamed aged 53 years. The investigation concluded at the end of the inquest on 16 August 2024. The jury returned a suicide conclusion supported by a narrative, which I attach. I drafted this report in early October 2024. However, it was not issued at that time owing to an IT error.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Mohamed developed mental health problems after being diagnosed with breast cancer in 2014. In early 2022, she was suicidal and was detained under Section 2 of the Mental Health Act in March 2022. She was released from hospital the following month and went to visit family abroad. On returning to the UK in July 2022, she was irrational and paranoid and her children's social worker referred her back to mental health services. Mrs Mohamed was again detained under section 2 MHA on 21 September 2022. Mrs Mohamed's full mental health history was not easily available due to a cyber-attack. On 30 September 2022 Mrs Mohamed was sent on home leave for a week pursuant to Section 17 Mental Health Act. On the evening of 3 October 2022, Mrs Mohamed made a succession of distressed telephone calls to her children's social worker. On 4 October, she sent text messages to her children's social worker threatening to kill her children and expressing the need to return to hospital. Attempts were made to persuade Mrs Mohamed to return to

	hospital voluntarily but she refused. Over the following days, she expressed suicidal thoughts and threatened to jump from the balcony outside her 5th floor flat to professionals. The community mental health team was of the view that Mrs Mohammed needed to return to hospital. However, the ward did not apply for a warrant under s135(2) Mental Health Act to return her to hospital and instead asked the community mental health team to persuade her to return to hospital voluntarily. On 12 October 2022, Mrs Mohamed jumped from the balcony. Her death was confirmed at the scene. The medical cause of her death was 1a) Multiple severe traumatic injuries 2) excessive Mirtazapine intake. At the time of her death, the ward had not applied for a warrant to return her to hospital under s135(2) Mental Health Act.
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 could 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) It was accepted that a s135(2) warrant should have been applied for on 4 October 2022. However, if an application had been submitted to the magistrates' court that day, it is unlikely that the warrant would have been executed before Mrs Mohamed's death. In evidence, I was informed by a number of mental health professionals that the time taken for a s135(2) warrant to be obtained from the magistrates' court and executed by the police was in the region of 2 weeks. (2) The process for obtaining a warrant is that an application has to be made for a video hearing at either Uxbridge or Westminster Magistrates' Courts. It could take several days for a hearing to be arranged as the courts consider applications from all 32 London Boroughs. Once the Magistrates issued a warrant, an appointment would then be arranged for the police to execute the warrant. (3) I was informed that a 2-week timescale for obtaining s135(2) warrants was still the case in the summer of 2024. (4) I also heard evidence that the mental health team could attend Highbury Corner Magistrates' Court in person to apply for a warrant in urgent cases but that they were actively discouraged from using this process by the court. (5) The court heard that the process and timescale for issuing and executing warrants had led to the hospital team adopting a practice of asking the community team to encourage a patient to return to hospital voluntarily before making an application for a warrant. (6) There is an ongoing risk that patients will harm themselves or others in the period before the warrant can be executed. This includes a risk of fatal harm.

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 15 April 2025. 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 (a) Family of Zahra Mohamed (b) London Borough of Camden (c) Camden and Islington NHS Foundation Trust 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. She 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	**18 February 2025** **Sarah Bourke**