	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** South West Yorkshire Partnership NHS Foundation Trust Fieldhead Ouchthorpe Lane Wakefield WF1 3SP
1	**CORONER** I am Tanyka Rawden, Senior Coroner for the Coroner's area of 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 27 September 2024 I commenced an investigation into the death of Claire Louise DRIVER. The investigation concluded at the end of the inquest on 21 March 2025. The conclusion of the inquest was Open.
4	**CIRCUMSTANCES OF THE DEATH** Claire Louise Driver had a past medical history of schizoaffective disorder and polysubstance misuse. She had been known to mental health services since 2011 and was first admitted to hospital in 2014. She had a lengthy hospital admission between 2018 and 2021 and on discharge was supported by a care co-ordinator from the enhanced community mental health team. By May 2023 she had started to disengage with that team. She was seen by her care co-ordinator on 28 November 2023 whilst in police custody and was not displaying any signs of psychosis. On 5 December 2023 the enhanced community mental health team were contacted by a PCSO reporting Claire was stealing from local shops. A home visit on 7 December 2023 from the enhanced community mental health team was unsuccessful.

	On 8 December 2023 Claire's former partner contacted the enhanced community mental health team reporting concerns for her welfare and that she was being sexually exploited. On 13 December 2023 a housing officer called the enhanced community mental health team to raise concerns about Claire. On 15 December 2023 a housing officer called the enhanced community mental health team to say Claire was intoxicated and there were concerns around substance and alcohol misuse. On 16 December 2023 Claire was arrested for indecent exposure. She was intoxicated. She was not seen by the enhanced community mental health team whilst in police custody. On 11 January 2024 the enhanced community mental health team and fire service visited Claire's address and could not gain access. On 16 January 2024 Claire was arrested. She was assessed under the Mental Health Act and detained under s2, and later s3. During that admission her medication was optimised, she began to engage with treatment, and her symptoms began to improve along with her insight into her condition. She began to take leave in preparation for discharge. She was seen in the community by the enhanced community mental health team on 5 May 2024 and discharged from hospital on 7 May 2024. Post discharge she maintained the allocation of a care co-ordinator from the enhanced community mental health team. Following initial unsuccessful attempts at contact, Claire was seen on 13 May, 14 May and 21 May 2024. She was concerned about side effects from her medication and was reluctant to take it. She was also seen to be drinking beer. After several failed visits she was last seen on 1 June 2024 when no concerns were raised, albeit the enhanced community mental health team did not enter her flat or conduct a lengthy visit. On 13 June 2024 she was arrested and taken to Court where she was granted bail. Claire was reported missing to South Yorkshire Police on 24 June 2024 She was assessed as a medium risk and missing person enquiries began. The last sighting of her by a member of the public was on 24 June 2024. On 2 July 2024 she was reassessed as a high risk missing person due to the amount of time she had been without her medication and that others had been found to be accessing her bank account. A dedicated investigation team was formed and a twenty two day search commenced covering an area 7.8 square miles in and around Silkstone. On 29 July 2024 she was moved to the long-term missing portfolio and presumed to be deceased.

	On 14 September 2024 Claire was found in a state of significant decomposition in a shallow stream in woodland off Kinemoor Lane, Silkstone in Barnsley. She was identified by her fingerprints. The cause of death at post mortem examination was: 1a. Unascertained.
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) The inquest heard there were only two attempts to see Claire by the enhanced community mental health team between 28 November 2023, when she was seen in police custody, and 16 January 2024, when she was detained under the Mental Health Act, despite clear evidence her mental health was deteriorating. It was accepted in evidence a more assertive approach to attempt to engage Claire, and in complex cases generally, could have been used and there could have been better liaison between the police and the enhanced community mental health team when Claire was in custody. A more assertive approach and better liaison could have prevented Claire relapsing to such an extent she needed to be detained under the Mental Health Act. (2) The inquest heard that training on the effect of substance misuse on mental health conditions is not mandatory for all staff and would be of assistance when caring for patients such as Claire.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, South West Yorkshire Partnership NHS Foundation Trust, 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 19 May 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 family of Claire Louise Driver. 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	24 March 2025 Signature  Tanyka Rawden H.M Senior Coroner for