Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This from is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1. **Chief Executive, Guildford and Waverley Clinical Commissioning Group**
2. **Chief Executive, North East Hampshire and Farnham Clinical Commissioning Group**
3. **Chief Executive, Surrey and Borders Partnership NHS Foundation Trust**
4. **The Rt. Hon. Matt Hancock MP, Secretary of State for Health and Social Care**

1 CORONER

I am David REID, HM Assistant Coroner for the coroner area of Central Hampshire

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 07/04/2017 I commenced an investigation into the death of Sasha Sabrina FORSTER aged 20. The investigation concluded at the end of the inquest on 23 May 2019. The conclusion of the inquest was that Sasha died as the result of suicide, following her deliberate ingestion of a fatal overdose of Propranol tablets.

4 CIRCUMSTANCES OF THE DEATH

(1) Sasha was a young woman who had struggled for many years with a number of mental health disorders, and had been under the care of mental health services since early adolescence. Her diagnoses were:
   (i) severe Obsessive Compulsive Disorder;
   (ii) complex Post Traumatic Stress Disorder;
   (iii) Autistic Spectrum Disorder (although the results of the assessment which confirmed this diagnosis were not available until after Sasha's death);
   (iv) traits of Emotionally Unstable Personality Disorder (although this was strongly disputed by Sasha and her family)

(2) Sasha had a lengthy history of self-harm, both through cutting herself and through taking deliberate overdoses of paracetamol. More recently, she had taken a number of overdoses of Propranolol (a drug which she had managed to source despite it not being prescribed to her, and which in overdose carried a significant risk of death); one such overdose in January 2017 had resulted in her suffering a near-fatal cardiac arrest.

(3) Sasha's OCD meant that she remained at risk even when detained in hospital under the Mental Health Act 1983. This is because she felt compelled to refuse food or drink provided to her, and any resulting application of restraint to ensure forced feeding/hydration would prove extremely distressing and potentially damaging. As a result, Sasha having been detained under s.3 MHA 1983 following the near-fatal overdose in January 2017, those treating her sought to balance the risks she presented by granting her regular periods of s.17 leave, initially to allow her to leave the hospital ward for a fixed period of time so that she could buy her own food and drink, and latterly to allow her to stay overnight at home in an environment which she found less distressing, this being conditional on her returning to the ward at agreed times.

(4) On occasions, however, Sasha's behaviour whilst away from the ward on s.17 leave prompted her responsible clinician to revoke that s.17 leave, and require her to return to the ward. In those circumstances, legal responsibility for ensuring Sasha's prompt return to the ward lay

with Surrey and Borders Partnership NHS Foundation Trust (SBP). Whilst SBP could ask the police to assist in doing this, the police were not legally obliged to do so, and often would decline such requests.

(5) On such occasions, SBP did not generally arrange for authorised persons to collect Sasha and return her to the ward, but would instead seek to rely on her mother returning her and, in order to secure Sasha's agreement to this course, would agree not to insist on her immediate return. Sometimes, this would involve allowing Sasha to go home overnight and be brought to the ward the next day.

(6) On occasions during such "negotiated extension" periods, Sasha would continue to self-harm (both through cutting and taking overdoses) or go missing from home, and therefore could not be returned to the ward as agreed.

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) Evidence was given during the inquest by SBP staff on the ward concerned, that the reason SBP staff did not arrange to collect Sasha and return her to the ward when her s.17 leave had been revoked, was that they did not have the resources to allow them to do this, despite it being their legal responsibility so to do.

(2) Sasha's mother gave evidence that SBP's reliance on her bringing Sasha back to the ward when s.17 leave had been revoked, placed an unfair and intolerable burden on her, in circumstances when she and the rest of the family were struggling to keep Sasha safe. Knowing that SBP would not send someone out to collect Sasha made her feel that she had no choice but to agree to their request.

(3) The last such occasion when SBP staff on the ward decided that Sasha's s.17 leave should be revoked was on the afternoon of her death on 31.3.17. Although formal revocation of leave was never finalised, Sasha's mother was given to believe that it would be, and again reluctantly agreed to bring Sasha back to the ward. Whilst with her mother, Sasha was able to run off and take the substantial Propranolol overdose which proved to be fatal.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisations) have the power to take such action.

SBP has a legal responsibility to arrange for the return to hospital of patients whose s.17 leave they have revoked. If resources are not provided to allow them to fulfil this legal responsibility, there is a risk that future patients, whose s.17 leave has been revoked and who remain at risk of self-harm or suicide whilst in the community, will find the opportunity to act in such a way as results in their death, whether intentionally or not.

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 July 2019. 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:

[redacted]

Gavin Stephens, Chief Constable of Surrey Police;

Olivia Pinkney, Chief Constable of Hampshire Constabulary.

and to the Local Safeguarding Board (where the deceased was 18).

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

David REID
Assistant Coroner for
SOUTHAMPTON AND NEW FOREST
Dated: 23 May 2019