ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Berkshire Healthcare NHS Foundation Trust of Mental Health Services, 2nd Floor, The Old Forge, 45-47 Peach Street, Wokingham RG40 1XJ**
1	**CORONER** I am Samantha Marsh, acting area coroner, for the coroner area of 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 the 23rd July 2019 I commenced an investigation into the death of Sophie Hannah May Boothe. The investigation concluded at the end of the inquest on the 18th February 2020. The conclusion of the inquest was that Miss Boothe's death was as a result of suicide, with the medical cause of death being 1(a) Nitrite Toxicity
4	**CIRCUMSTANCES OF THE DEATH** Sophie had a history of mental health issues. She had been under the care of CAMHS as a teenager when she suffered with anorexia nervosa. Sophie went to Australia on holiday in 2019 and, whilst she was there, she took an overdose of propranolol, which it is believed she had been stockpiling from prescriptions issued by her UK GP as well as obtaining further propranolol whilst in Australia. Sophie was in hospital in Sydney for 18 days upon being declared medically fit for discharge she was "Scheduled" (the Australian equivalent of a patient being "Sectioned" under the provisions of the Mental Health Act 1983 (as amended) and taken to a Mental Health Clinic. She remained in Australia for a short period before being declared as Fit to Fly, whereupon she returned home to the UK under the escort of her mother. Sophie had emailed Talking Therapies from Australia on the 19th April 2019 and was advised to self-refer to see her GP upon her return to the UK. Sophie saw her GP on the 8th May 2019 who referred her to the CPE for an urgent assessment. The GP in his urgent Red referral enclosed the full discharge summary from Australia (which stretched to some 17 pages). This referral was downgraded by an assessing CPE clinician to Amber, without any rationale being entered onto supporting records as to why this decision to downgrade was taken. This meant that she had to wait around 3-4 weeks (depending on fluctuating wait times) for an appointment/telephone assessment. A telephone assessment took place between Sophie and a Mental Health Nurse on the 7th June 2019 at 09.30am. Sophie presented as friendly, bubbly and plausible. She had good insight into her actions on the 1st April 2019 and identified many protective factors. Sophie was adamant that she did not want Mental Health input at this time. Sophie had completed two degrees in psychology and had previously worked for the CAMHS and so knew the answers to give to the clinician's questions to avoid any further engagement

	with, or input from, the mental health services. Both of Sophie's parents acknowledged that she was manipulative in this regard. The plan following this telephone assessment was to discharge Sophie at that time, but with signposting to further support should she feel that she needed it. Sophie's mother remained concerned at attended the GP to discuss Sophie on the 18th June 2019 as a result of which the GP re-referred Sophie to the CPE. Sadly, no further assessment could be made as Sophie was reported missing by her family later that afternoon. She was discovered on the 19th June 2019 at a hotel in Hook, where she had checked in, alone, the night before. The post-mortem result revealed that Sophie had died as a result of nitrite toxicity.
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. – It became very clear in evidence that the overseas involvement was not properly flagged up when the CPE came to triage Sophie's referral; this includes both the discharge summary and Sophie's own self-referral via email whilst she was in Australia. The full discharge summary from Australia was sent by the GP along with his referral on the 8th May 2019 to ensure that all relevant information was shared at the earliest stage. These notes were either not fully reviewed and/or understood by the CPE and this appears to have contributed to the downgrading of Sophie's referral. It became clear in evidence that the UK services did not understand that "Scheduled" is the Australian equivalent of being "Sectioned" and there was a lack of probity and curiosity to as what this meant and what treatment Sophie had in Australia; albeit that the evidence was not convincing (or even persuasive) that the Australian discharge summary had been thoroughly read at all on being received by the CPE. Overall, there appears, on the evidence, to be very poor communication between the departmental services and, as a result, opportunities appear to have been missed to fully appreciate Sophie's full clinical presentation when making an assessment about the timeliness of appropriate interventions and assessments. I believe that whilst the service remains disjointed, with insufficient exploration of information sent from foreign jurisdictions, there remains a risk that future death will continue to occur.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND/OR 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 27th April 2020. 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 who may find it useful or of interest:

	(i) [redacted] 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	**2nd March 2020** **Samantha Marsh**