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, Surrey and Borders Partnership NHS Foundation Trust**
2. **Chief Executive, Hampshire Clinical Commissioning Group Partnership**
3. **Joint Accountable Officer, NHS Guildford and Waverley Clinical Commissioning Group, NHS North West Surrey Clinical Commissioning Group and NHS Surrey Downs Clinical Commissioning Group**
4. **Chief Executive, Frimley Health NHS Foundation Trust**
5. **Chief Executive, Royal Surrey County Hospital NHS Foundation Trust**
6. **Chief Executive, Ashford and St. Peter's Hospitals NHS Foundation Trust**
7. **Chief Executive, Epsom and St. Helier University Hospitals NHS Trust**
8. **Chief Constable, Surrey Police**
9. **Chief Constable, Hampshire Constabulary**
10. **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 00:00 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.

(7) Throughout the time during which she was granted s.17 leave, Sasha attended a number of different hospital Emergency Departments (including the Royal Surrey County Hospital, Frimley Park Hospital and the Royal Berkshire Hospital, Reading, sometimes having self-harmed, sometimes because she was struggling with suicidal thoughts and wanted to speak to Psychiatric Liaison. Her reasons for choosing a particular hospital were not always predictable.

5 CORONER'S CONCERNS

The MATTERS OF CONCERN are as follows:

Evidence received at the inquest suggested that the various hospitals and police forces which had regular dealings with Sasha were not always aware of their powers and responsibilities towards her in circumstances when her s.17 leave was being revoked, or else had not agreed and, where required, updated a common plan of action to be followed in those circumstances.
As a result, there was inconsistency in the actions taken when her s.17 leave had been revoked, which led to an increased risk that Sasha might act in such a way which would result in her death, whether intentionally or not.

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.

In a letter to me dated 22.5.19 the Deputy Chief Executive of SBP wrote that SBP considered that "collaboration between partners to enhance the system's understanding of the application of s.18 [which relates to the revocation of s.17 leave], using the Mental Health Act Code of Practice as a guide, is required." He further stated that SBP intended to "commit to the development of joint working protocols across the system for the management of complex AWOL [i.e. Absent Without Leave – where s.17 leave has been revoked] cases."

Clarification is required as to the actions which you and/or your organisations intend to take in order to achieve the goals set out in that letter.

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]

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.

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