

Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1. [REDACTED], Chair of the General Medical Council
2. 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

A handwritten signature in black ink, appearing to read 'David Reid', written in a cursive style.

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