IN THE SURREY CORONER'S COURT

IN THE MATTER OF: NATASHA JENNIFER IRENE CRABB

The Inquest Touching the Death of NATASHA JENNIFER IRENE CRABB

A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: • **The Right Honourable Matt Hancock MP, Secretary of State for Health and Social Care** • **The Right Honourable Priti Patel MP, Home Secretary**
1	**CORONER** Caroline Topping HM Assistant Coroner, for the County of Surrey
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** An investigation into the death of Natasha Jennifer Irene Crabb was opened on the 6th July 2018. The inquest was opened on the 3rd October 2018, resumed with a jury on the 22nd February 2021 and concluded on the 11th March 2021. The jury concluded that Natasha died on the 29th June 2018 at Princess Gardens, Woking, Surrey and that the medical cause of her death was;

	1a Fatal Heart Arrhythmia 1b Hydrocarbon Gas Inhalation II Myocardial Fibrosis The jury concluded that she died of an accident.
4	**CIRCUMSTANCES OF THE DEATH** The jury found that Natasha Jennifer Irene Crabb had a history of substance abuse and a diagnosis of Emotionally Unstable Personality Disorder. She was released from prison into an agreed address and a plan was made for her to be in contact with agencies to manage her dependencies. Natasha began abusing butane very quickly after her release from prison. From 26th to 29th June 2018, Natasha came into contact with the Police, Ambulance and Hospital services. On 29th June 218 Natasha was taken to St. Peters Hospital, was found to have capacity, and was informed that inhaling butane was harmful and could be fatal. Natasha self-discharged from St. Peters Hospital without accepting treatment on the afternoon of 29th June 2018. Inhaling butane is lawful and there are no legal powers to prevent a person with capacity inhaling butane nor to remove butane from them. Natasha continued to inhale butane gas after leaving hospital and collapsed and died at Princess Gardens, Woking that evening.
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. – The evidence showed that: 1. Inhaling butane is lawful and there are no legal powers to prevent a person with capacity inhaling butane nor to remove butane from them. The effects of inhalation can be fatal. 2. There is no restriction on the amount of butane gas that can be purchased making it easy for a person addicted to inhaling butane gas to obtain large amounts of the gas at one time.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 8th June 2021. 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] the Chief Constable for Surrey, South East Coast Ambulance Service, St Peter's Hospital, Surrey and Borders Partnership NHS Foundation Trust and Kent Sussex and Surrey Community Rehabilitation Company. 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	**Signed:** **Caroline Topping** **Dated this 13th April 2021.**