IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Sarah Louise Sutherland
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** **1 Chief Executive, UK Council of Psychotherapy** **2 President Royal College of Psychiatrists** **3 Chief Executive NHS England** **4 Chief Executive CQC** **5 Brainwaves -** [redacted]
2	**CORONER** Dr Karen Henderson, H.M. Assistant Coroner for Surrey
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
4	INVESTIGATION and INQUEST On 17th December 2023 I resumed an investigation into the death of Sarah Louise Sutherland. On 17th January 2024, the investigation was concluded: The medical cause of death given was: 1a. Suspension I recorded the following in Box 3 of the Record of Inquest: Sarah Louise Sutherland had significant mental health challenges with an ongoing history of suicidal ideation and self-harm. On the 17th December 2022, Ms Sutherland was found to have died by intention through self-

	suspension at her home address in Redhill having last been known to be alive on the 15th December 2022. I concluded Ms Sutherland died by way of Suicide.
5	CIRCUMSTANCES OF THE DEATH 1. In 2017 Ms Sutherland was referred to NHS Mental Health Services with suicidal ideation and depression and until her death remained under the care of the Community Mental Health Recovery Service and in times of crisis the Home Treatment Team with a diagnosis of Emotionally Unstable Personality Disorder (EUPD) and Post Traumatic Stress Disorder. 2. At the same time, Ms Sutherland sought the assistance of a private psychotherapist providing 'humanistic integrative' therapy and had twice weekly appointments from September 2017 until 2 days before her death 3. The psychotherapist kept no clinical records of the initial assessment or treatment throughout the five years on the grounds that this was not necessary, and it would contravene GDPR regulations with no change of practice following Ms Sutherland's death. 4. Throughout the five years as a client, Ms Sutherland's psychotherapist could not provide any evidence of ongoing analysis, evaluation, assessment or review of Ms Sutherland as to whether this psychotherapeutic approach was beneficial. Nor was there any any

consideration as to whether alternative psychotherapeutic approaches would have been more beneficial to manage Ms Sutherland's mental health and other difficulties.

5. The psychotherapist was unable to adequately explain the benefit of 'humanistic integrative' psychotherapy for Ms Sutherland's underlying mental health difficulties.

6. The psychotherapist did not undertake any risk assessments as to whether the psychotherapeutic approach was appropriate (e.g. exploring 'trauma;') given the underlying diagnosis of EUPD with the knowledge of a long history of suicidal ideation and acts of self-harm.

7. The psychotherapist did not provide evidence of an agreed and appropriate therapeutic boundary or to appear to respect one given that Ms Sutherland was given regular access to walking her dogs and to bring treats for her cat outside of therapeutic sessions, leading to a real concern that Ms Sutherland had become dependent on the psychotherapist outside of a therapeutic relationship.

8. Whilst there are sensitivities involved with 'shared' care between a private and NHS service there was no useful communication either formally or informally from either party to ensure both knew what each were doing to work in Ms Sutherland's best interests with the psychotherapist being dismissive of so doing.

9. In the latter half of 2022 Ms Sutherland's mental health deteriorated requiring intensive treatment from the Home Treatment Team. Although there was some stabilisation in her mental health with a reduction in negative thoughts, Ms Sutherland ended her life shortly thereafter.

6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph 1 have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise, you must explain why no action is proposed.

9	COPIES I have sent a copy of this report to the following: 1. See names in paragraph 1 above 2. [redacted] 3. [redacted] In addition to this report, I am 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 at the time of your response, about the release or the publication of your response by the Chief Coroner.
10	**Signed:** Dr Karen Henderson DATED this 15th March 2024