Regulation 28: Prevention of Future Deaths report

Joshua James David Forsdyke (died 31 August 2024)

	THIS REPORT IS BEING SENT TO: 1. **Fresh Student Living** 2. **University of the Arts, London**
1	**CORONER** I am: Melanie Sarah Lee Assistant Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 10 September 2024 an investigation was commenced into the death of Joshua James David Forsdyke "Josh" (aged 19). The investigation concluded at the end of the inquest on 8 January 2025. I made a determination at inquest Joshua took his own life whilst his judgment was impaired due to drugs and alcohol.
4	**CIRCUMSTANCES OF THE DEATH** Josh moved to London to study in September 2023. He was exposed to easy access to drugs, particularly ketamine, whilst in student halls of residence. He began buying ketamine and his addiction to illicit drugs and alcohol appears to have spiralled from there and continued when he moved out of halls. On 26 August he took ketamine and had an argument with his girlfriend about his drug use. The following day, he began drinking alcohol in the morning, before taking tramadol tablets belonging to a third person. He then left the flat and went to London Bridge, telling his flat mate that he intended to jump. After behaving bizarrely on the bridge, he jumped into the River Thames. His body was

	recovered from the Thames near Butlers Wharf on 31 August 2024. Toxicology tests showed that Josh had consumed a significant level of alcohol, a toxic of tramadol plus ketamine, shortly before his death.
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 will occur unless action is taken. In the circumstances, it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. I heard evidence that Ketamine was easily and openly available to students as it was being dealt from and/or by persons with access to, and moved between, student halls of residence.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that your organisations 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 6 March 2024. 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 following. • Family of Joshua Forsdyke • HHJ Alexia Durran, the Chief Coroner of England & Wales I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest.

	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.
9	**DATE** **SIGNED BY ASSISTANT CORONER**  10 January 2025