Coroner Service
West Sussex, Brighton & Hove

Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** The Chief Executive NHS England
1	**CORONER** I am Joseph TURNER, Area Coroner for the coroner area of West Sussex, Brighton and Hove
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 4 June 2024 I opened an investigation into the death of Sally Burr, aged 47. The investigation concluded at the end of the inquest on 11 June 2025. The conclusion of the inquest was that Sally Burr had died by suicide.
4	**CIRCUMSTANCES OF THE DEATH** Sally Burr had struggled with her mental health for much of her life. In January 2024 she was in crisis due to a number of stressors. Between January and April 2024 she attended the Emergency Department of local hospitals at least 3 times following overdoses or other attempts at serious self-harm. She was treated by a variety of the mental health services local to her in East Sussex, before being sectioned under s.3 MHA 1983 on 2 April 2024 and then admitted to Meadowfield Hospital in Worthing some days later. She had requested a transfer as she had worked as an Occupational Therapy Assistant in her local area and hence knew and feared that mental health staff there would know her, such that she felt unable to contemplate returning to work. Once at Meadowfield, she was allowed use of her mobile phone and access to the internet, in line with Sussex Partnership NHS Foundation Trust's (SPFT – the Trust) policy. She was able to order legally available, but toxic, plant material (including [redacted]) online and have them delivered to her home address. She also contacted a number of organisations and forums around ending her life. She extensively researched means and methods of ending her life. She did not inform or indicate to staff that she was doing so. On return from limited leave on 12 May 24 she managed to bring some of the needles bought online back in to Meadowfield, hidden in her socks; despite personal and room searches these were not found. She then consumed these whilst detained on 30 May 24 with fatal results, despite emergency treatment.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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:

	Whilst the Trust applied its policy on mobile phone use and internet access to Sally Burr correctly, it was clear that Sally was able to exploit this in order to research and obtain the means to end her life whilst a sectioned and detained patient. Staff at Meadowfield lacked any practical ability or means to know of, monitor or respond to Sally's internet use. Whilst encouraged to express curiosity with patients as to their use of the internet, there were no technical means to control or monitor use, other than removal of devices or denial of internet access. However, this obviously risked a negative effect on Sally's wellbeing and progress due to the wider impact of denying contact or information which would help and support her recovery (there was evidence that Sally was in contact with online support for her mental health). I heard evidence from the Trust as to revision of their policy and improved steps to try and prevent access to harmful or malign internet sites, but – rightly – such steps have to be balanced against the patient's right to privacy, including communication. Those improved steps include blocking certain search terms and sites when using Trust wi-fi, identifying any attempted access by noting URLs, further restricting the time available for use, and heightening staff vigilance and awareness. However, the blocks can be easily circumvented by using 4G or 5G, and – as I know you will be aware – malign sites and searches often use euphemisms or seemingly innocent language and descriptions to avoid detection. I noted that the revised policy as regards patients under 18 includes only permitting phones which do not have internet access and/or that internet access is only available via public equipment which can obviously be monitored and checked after use. As such, my concern remains that permitting adult patients who have been detained under section access to the internet clearly provides an opportunity for them to be exposed to malign influences, and to obtain the means and methods to cause serious self-harm. I fully accept the difficulty and balance in recognising a patient's right to a private life and how the least restrictive regime possible (including permitting communication) is intended to facilitate their recovery. I also and unreservedly accept the impossible task of policing the internet, but I identify that clearer and stricter rules, guidance and investment in technology (perhaps including AI) at a national level may be needed, to enable Trusts to be able to act consistently and uniformly in at least reducing the potential for patients to secure the means to end their lives whilst detained.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by August 08, 2025. 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] (brother) [redacted] (father) Sussex Partnership NHS Foundation Trust 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 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 by the Chief Coroner.
9	Dated: 13/06/2025  Joseph TURNER Area Coroner for West Sussex, Brighton and Hove