



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: ██████████ MP Secretary of State for Health and Social Care
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 8th August 2024 I commenced an investigation into the death of Sarah Louise Healey aged 32. The investigation concluded at the end of the inquest on 10 October 2025. The conclusion of the inquest was that: On 4th May 2024 Sarah Healey was admitted to Worthing General Hospital with severe malnutrition and complex infections. She remained in hospital and was treated for various serious conditions, including a period under Mental Health Act detention, which was discontinued on 30 July 2024. She underwent procedures but, despite active treatment, she deteriorated on 1 August 2024, became extremely hypoxic and sadly died the same day of respiratory failure, secondary to pleural effusions, caused by hypalbuminaemia and malnutrition, contributed to by a lack of physiological reserve. Her complex medical issues arose from Avoidant Restrictive Food Intake Disorder, arising in turn from longstanding mental health issues including Generalised Anxiety, Post Traumatic Stress Disorder and agoraphobia. These were due to a series of abusive and violent incidents in her teens, and other stresses. These had recently resurfaced, exacerbating her mental and related physical conditions. It was admitted that Sarah had not received appropriate, consistent mental health care between January 2022 and March 2024 and that this more than minimally contributed to her death.
4	CIRCUMSTANCES OF THE DEATH Prior to her admission to hospital in May 2024, Sarah had lived a reclusive life, confining herself to her bedroom at her parent's house, since around the age of 20. Although not formally diagnosed at the time, in addition to the conditions listed above, Sarah had shown behaviours strongly suggesting autism since childhood. For the last 12 years Sarah had followed an extremely limited diet, leading to increasing malnutrition. Her GP had referred her multiple times over the years to Mental Health Services. There was an extensive history, given Sarah's physical and mental conditions, with the



involvement of her parents, her GP, the local Mental Health Trust, Private Counselling Services and the Police (in relation to the events causing her PTSD). Each of them had some insight into or knowledge of the nature and extent of one or more of Sarah's conditions but none had complete oversight, or a full knowledge or awareness of all of them. Sarah had capacity, prior to the period under MHA section during her admission post-May 2024 and the evidence also showed she could be strongly opinionated and decline to admit or accept the seriousness of her situation. Allied to her likely autism and given her agoraphobia and hence difficulty in attending external appointments, the evidence was that Sarah could be 'hard to reach'.

She had received some treatment in 2010 and 2012, her GP had engaged routinely when Sarah made contact, and she had engaged latterly with programmes aimed at helping with her traumatic experiences, as well as attend some online assessments and appointments with a locum clinical psychiatrist. Overall, however, Sarah had not been able to deal with her range of conditions and/or it had not proved possible for those supporting and treating her to ensure she received sufficient, consistent and applied treatment, therapy or other care to help her recover from, adapt to or overcome her multiple difficulties. Moreover, as was admitted at the inquest, Sarah had not received appropriate, consistent mental health care in the 2 years before she died.

In terms of her actual death, the historical matters giving rise to her PTSD re-emerged in late 2023 when Police were notified that a graphic account, clearly relaying criminal acts and abuse within a personal account of events, had been posted on a popular online forum for mothers. The moderators referred this as a matter of concern to the Police who investigated and identified that one linked IP address was assigned to a device on the home network at Sarah's parents' house. Police attended and made enquiries. It emerged that an unknown individual had cut, pasted and embellished a personal post by Sarah on a PTSD-related forum a year earlier, but Sarah confirmed that the essential facts were those which had occurred to her. Police, rightly and understandably, wished to make further enquiries, whilst acknowledging the historic nature of the events. The prospect of a criminal investigation appears to have caused Sarah extreme anxiety and concern, exacerbating her existing mental and physical health conditions, such that she stopped eating and drinking for 2 weeks before, eventually, her GP and parents were able to persuade her to be taken by ambulance to hospital. Despite extensive treatment over three months she sadly died.

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 I heard evidence that local Mental Health (MH) Services (the Sussex Partnership Foundation Trust) had aimed to ensure the recognised 'triangle of care' (MH Services, Individual and Family) was in place, this did not (and I understand that national policy and approach may not) extend to other services such as the GP, private counselling, or e.g. social services being formally involved and engaged in a comprehensive assessment and hence effective package of treatment and care.

I fully appreciate that there are ethical, legal and patient confidentiality issues in patient care.



	Without, first, better information sharing and a wider, collaborative and joined-up approach – ideally with one individual [whether MH clinician, GP or even carer/family member] able, empowered and with the right legal authority to ensure they have a comprehensive and detailed knowledge of the individual’s various issues – and, second, the development of policy, protocols and guidance to better safeguard mental health patients with accompanying physical health issues, especially those who may have capacity and are neuro-diverse, there is a risk of patients like Sarah not receiving the right, consistent and individually tailored care and treatment which may prevent self-neglect or other serious self-harm. I also heard evidence that there is, nationally, a move away from traditional in-person or face to face appointments as standard and regular practice, to the increased use of online platforms and tools enabling remote attendance. I completely recognise that there are huge benefits in the use of such systems, which bring savings, efficiency and immediacy of access for a huge number of patients. My concern is that they work for some but not all. I was encouraged by evidence I heard from SPFT that in their development of a Care Plan Approach and the inception of Community Mental Health Teams there will be a local policy requirement for MH Practitioners to see patients in person at least six monthly. Sarah’s case graphically demonstrated that there is no substitute for physically seeing a patient, especially when there are other conditions and lifestyle issues so clearly impacting on or resulting from her mental health, such that it seems that an agreed national approach and similar policy requirement may also further help to prevent future deaths of patients like Sarah.
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 December 06, 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] Chief Executive of Sussex Partnership NHS Foundation Trust (SPFT) [REDACTED] (Parents) Willow Green GP Practice, East Preston, West Sussex I have also sent it to The Royal College of General Practitioners who may find it useful or of interest. 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.



Coroner Service

West Sussex, Brighton & Hove

	The Chief Coroner may publish either or both in a complete or redacted or summary form. They may send a copy of this report to any person who they believe 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: 11/10/2025  Joseph TURNER Area Coroner for West Sussex, Brighton and Hove