REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:
1. Kent and Medway NHS and Social Care Partnership Trust (KMPT)
2. East Kent Hospitals University NHS Foundation Trust (EKHT)

CORONER

I am Sarah Clarke, Area Coroner, for the coroner area of North East Kent.

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.

INVESTIGATION and INQUEST

On 29 May 2024 I commenced an investigation into the death of Sarah Heaver, aged 59. The investigation concluded at the end of the inquest on the 23rd July 2024. The conclusion of the inquest was a narrative conclusion as follows: Sarah Heaver died in hospital on 27 May 2024 having been found unresponsive in the sea at Whitstable. Although it is clear that Mrs Heaver entered the sea of her own volition with the intention to end her life, it is likely that an undiagnosed pituitary tumour putting pressure on her adrenal gland contributed to her declining emotional state.

The medical cause of death was recorded as:

1a. Immersion;

2. Pituitary adenoma with adrenal gland atrophy.

CIRCUMSTANCES OF THE DEATH

Sarah Heaver was 59 years old at the time of her death. She had been experiencing a significant deterioration in her mental health in the days and weeks prior to her death and had openly expressed suicidal ideation to friends and family. On 21 May 2024, Sarah Heaver was found unconscious at her home address and conveyed to Queen Elizabeth The Queen Mother Hospital. Her GCS was recorded as 3 on attendance by paramedics and later between 5–8/15 following admission. A CT head was not undertaken and no thorough neurological assessment took place. Sarah was later deemed medically fit for discharge and was seen by the hospital liaison psychiatry team on 23 May 2024. She was subsequently discharged under the care of the Crisis Team. Over the following days she

continued to express suicidal ideation. On 27 May 2024, Sarah entered the sea at Whitstable in a deliberate attempt to end her life. She was found unresponsive and despite resuscitation attempts was pronounced deceased in hospital.

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:

(1) Sarah Heaver was admitted with a GCS of 3, later improving to between 5–8/15, with unknown downtime and an unclear history. A CT head scan was indicated and not undertaken. I am concerned that appropriate neurological investigation was not carried out.

(2) I am concerned that no structured neurological observations were undertaken on a patient presenting with such a low GCS, risking deterioration being missed.

(3) Throughout this investigation I was presented with inconsistent, unreliable and incomplete medical records. This significantly hindered my ability to investigate the death and creates a risk of future patient harm.

(4) I am concerned that patients are discharged from acute hospital settings on the understanding that they will receive psychiatric input equivalent to hospital admission, only for it to later become apparent that there is no access to a psychiatrist or prescriber for several days, particularly over bank holiday periods.

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.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report. 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the Interested Persons. I have also sent it to those organisations 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.

The Chief Coroner may publish either or both in a complete or redacted or summary form.

DATE AND SIGNATURE

Dated: 9th January 2026

Signed: [redacted]