REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Rachel REDMAN, Assistant Coroner, for East Sussex.
2.	**DATE OF REPORT** 05 June 2026
3.	**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.
4.	**THIS REPORT IS BEING SENT TO** 1. NHS England 2. Department of Health and Social Care You are under a duty to respond to this report within 56 days of the date of this report, namely by July 30, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
6.	**SUMMARY OF CORONER'S CONCERN** At an inquest touching the death of Neeshat Dalal, who died on 14.12.2022

	aged 69, which I heard with a jury, evidence was given that Sussex Partnership NHS Foundation Trust (SPFT) did not have funding for a dietician even though mentally ill patients with nutritional needs required support from a suitably qualified healthcare professional. The failure to properly assess Neeshat's inability to eat and reasons why she was not eating whilst an in patient on Heathfield Ward, Eastbourne District General Hospital from 30.11.2022 to 13.11.2022, and her subsequent admission to the hospital's Emergency Department on 13.12.2022 may have contributed to her death on 14.12.2022 of an acute myocardial infarction due to a blocked coronary artery and ischaemic heart disease. On further questioning of the Trust's Clinical Director, I heard evidence that SPFT's lack of funding for a dietetic resource extends to Trusts nationwide and that this is not a local problem experienced by this Trust alone. My concern is that severely mentally unwell patients such as Neeshat who was sectioned under s2 Mental Health Act 1983 are not receiving dietary and nutritional support from a qualified dietician when experiencing difficulties in eating and drinking.
7.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	**INVESTIGATION AND INQUEST** The inquest was opened on 23.12.22 and was resumed with a jury on 27.05.2026 – 02.06.2026. The jury made the following findings within a narrative conclusion: Neeshat Dalal was admitted to Heathfield Ward, Eastbourne District General Hospital on 30.11.22 under S2 Mental Health Act 1983 for the treatment of severe depression. She was having difficulty in eating and drinking and underwent 3 courses of ECT on 6th, 9th and 13th December 2022. She collapsed during the anaesthetic and was transferred to A&E resus department at Eastbourne District General Hospital at approximately 1pm on 13.12.22. She stayed there until the early hours of the following morning, having been reviewed by the anaesthetic, medical and ITU teams. She was transferred to the AMU at 0217hrs on 14.12.22 after varying NEWS scores, but with an increasing respiratory rate and heart rate. She arrested at 0330hrs and in spite of 8 cycles of CPR, her death was confirmed at 0510hrs. Inadequate consideration was given by SPFT staff that Neeshat was unable to eat or drink due to vomiting, rather than refusing to eat in order to end her life. Neeshat's nutritional needs were not appropriately met. She required support from a dietician and a more timely referral to the gastroenterology team. The consultant psychiatrist and anaesthetist did not have satisfactory medical information for Neeshat prior to the ECT treatment on 13.12.22, and so postponement was not considered in light of this.

	ESHT did not consider the need to administer vasopressors between 1338hrs - 2200hrs on 13.12.22. ESHT staff failed to move Neeshat to HDU earlier than 0217hrs on the 14.12.22. These conclusions about Neeshat's care may possibly have contributed to the cause of her death.
9.	**CIRCUMSTANCES OF DEATH** Neeshat Dalal began to complain of difficulty in eating and drinking in September 2022. She also became depressed at this time and made 3 attempts to end her life with an insulin overdose. On the third attempt she was admitted to East Surrey Hospital on 14.11.2022 and sectioned under S2 MHA 1983 where she remained until a bed could be found in a psychiatric inpatient ward. She was transferred to Heathfield Ward at Eastbourne District General Hospital which is part of Sussex Partnership Foundation Trust where she remained, undergoing 3 treatments of ECT until she collapsed during the 3rd session on 13.12.2022 and was admitted to the Emergency Department of Eastbourne District General Hospital which is part of East Sussex Healthcare NHS Trust. She remained in Resus in the Emergency Department for 14 hours before being transferred to the Acute Medicine Unit where she died several hours later.
10.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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: Funding is required for the specific provision of appropriately qualified dieticians who can meet the nutritional needs of inpatients undergoing psychiatric care in SPFT and in other Trusts where such support does not already exist.
11.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: *[please do not use individual's names, but instead roles/titles]* • **Family** • **Sussex Partnership NHS Foundation Trust** • **East Sussex Healthcare NHS Trust**

	I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	**SIGNATURE** [redacted] **Rachel REDMAN** **Assistant Coroner for** **East Sussex Coroners Service**