	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Chief Executive of the NHS Kent and Medway Integrated Care Board** **Kent & Medway NHS & Social Care Partnership Trust**
1	**CORONER** I am Patricia Harding Senior Coroner for **Central and South East Kent**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 17th October 2022 an investigation was commenced into the death of Benjamin James HART. The investigation concluded at the end of the inquest 28th March 2023. The conclusion of the inquest was a short form conclusion of Suicide 1a **Suspension by the neck** b c II
4	**CIRCUMSTANCES OF THE DEATH** Benjamin Hart, 25 had a medical diagnosis of post-traumatic stress disorder, enduring personality change after a catastrophic experience, emotionally unstable personality disorder borderline type and generalised anxiety disorder. He likely had Asperger's syndrome. At the time of his death was under the care of the community mental health team following a suicide attempt by hanging in December 2021 following which he was formally sectioned. After his release he was allocated a care coordinator who between May 2022 and his death in October 2022 saw him on only three occasions (his care plan envisaging weekly involvement). The Trust was aware that the relationship between Ben and his care coordinator had broken down but a new care coordinator was not appointed and Ben had no contact from the community mental health team for 5 weeks before his death on 12th October 2023 when he hanged himself at his mother's home address. He had telephoned the Crisis team three times in the two days before his death, calls which included complaints of having been abandoned by the mental health team, expressions of hopelessness about his future and indications that he felt suicidal. He was informed that the community mental health team would contact him. Although the community mental health team and the care coordinator were notified of Ben's calls the day before his death, no one attempted contact until after this death had occurred. Kent & Medway NHS partnership Trust accepted at the inquest that the care provided to Ben fell below the standard he could have expected to receive and there were missed opportunities to treat him
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. – The Trust had a shortfall of nursing staff in the Dover and Deal area at the time that Benjamin Hart was under the community mental health team such that although 16 nurses were required to run the service, the Trust only had 8 nurses employed at the time, 2 of whom were long term sick. This left a working complement of 6 nurses to cover the whole area, which required them to take on additional duties. There was no resilience within the team and therefore when the relationship between Ben and his care coordinator broke down there was no capacity within the team to allocate him another care coordinator.

	Although the Trust has regrouped, reorganised and there has been some limited recruitment the shortfall endures; the evidence given at the inquest being that this is a national issue but it is particularly difficult to recruit within this area of Kent
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 26th May 2023. 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] (mother). I am also under a duty to send the Chief Coroner a copy of your response. 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	31st March 2023  Signature: Patricia Harding Senior Coroner **Central and South East Kent**