East Kent
Hospitals University
NHS Foundation Trust

Chief Executives Office
Trust Offices
Kent & Canterbury Hospital
Ethelbert Road
Canterbury
Kent
CT1 3NG

HM Coroner Patricia Harding
Kent and Medway Coroners
Oakwood House
Oakwood Road
Maidstone
Kent
ME16 8AE

[redacted]

28 January 2026

Dear Ma'am,

Regulation 28 – Prevention of Future Deaths (PFD) Response regarding the inquest into the death of Mr Ernest Gray

On behalf of East Kent University Hospitals NHS Foundation Trust (the "Trust"), we would like to reiterate our apology to the family of Mr Ernest Gray [redacted]. We want to assure the coroner and the family that steps have and will continue to be taken to ensure that this situation does not arise again.

The matters that gave rise to the PFD and the Trust's response to each point are outlined below.

This PFD response should be read in conjunction with a letter already provided to the Court dated 4th November 2025 from [redacted], Chief Nursing and Midwifery Officer which was sent following conclusion of the inquest, setting out responses to concerns raised during the inquest. Steps had been taken already and the letter referenced those and others which were in progress or planned at that point (a copy of which is enclosed for ease of reference). Further steps have been taken to address the concerns raised in the Coroner's PFD letter.

CORONER'S CONCERNS

(1) ***Mr. Gray's next of kin was his daughter but he lived with his 86 year old partner. His daughter was consulted in the discharge process but the hospital did not attempt to contact his partner who was his carer.***

Response

The Trust's review of this incident identified that it was not recognised by the Multi-Disciplinary team (MDT) that the actual carer living at home with Mr Gray was his partner who was herself frail with hearing and sight problems, and not necessarily in a position to support him. It was not recognised that they would be unsupported for long periods of time. To ensure that situations such as these are mitigated to the best of our ability, the Trust has taken the following actions:

1. We have requested IT record changes to correctly identify the carer(s) involved so they can be involved in appropriate discussions and decisions. Our current IT systems do not allow us to differentiate ‘carer’ from ‘next of kin’ (they can be different as was the case with Mr Gray). We recognise that this will be key in clearly identifying the carer for future discharge conversations so have raised this urgently with the Sunrise team to investigate. The request has been made and is being prioritised.

2. We carried out a snapshot audit in January 2026 of a sample of up to 50 patients aged 70 or over to specifically investigate how their carer is currently identified on our IT systems and from then, what support the carer may require to give assurances that the Carer’s Policy and Discharge Policy is being followed. Early findings as is frequently seen; is that families of confused patients are becoming exhausted and unable to cope. They are currently only identified as ‘NOK’, followed by their relationship (son, daughter) and not whether they are the carer. The planned addition of the NOK field will allow for easier audits and monitoring in the future.

3. We have allocated an experienced discharge advisor to a new Carer’s Champion post. This individual has been identified, and they commenced their role in early January. They will support the ward multi-disciplinary teams to identify the patient’s carer and ensure that the carer themselves is involved in the discharge discussions from early in the admission.

4. As a pro-active measure, the QEQM site is piloting a regular 90yr+ meeting where elderly patients are identified by senior consultants in the Trust and community, for a rapid discharge supported by community teams who can provide direct care in the patient’s own home. This includes discharging patients in a timely manner, avoiding prolonged admissions and the resulting deconditioning. This too has now commenced.

5. We have implemented a post- discharge plan to support the patient and carer. It is proposed the Carer’s champion (or delegate) will call the patient (or carer) on the day following their discharge to ensure everything is as expected and pick up any shortfalls in the provision early.

6. The telephone number of the Carer Champion and an updated discharge leaflet will be provided to signpost the patient or carer to support services they may need once at home.

For points 5 and 6 it is planned that both actions will commence by mid-February 2026.

The Trust has made significant progress to ensure that carers and patients discharged are appropriately supported.

(2) Although a number of persons from different disciplines were involved in planning Mr. Gray’s discharge, there was no evidence of a holistic approach being taken of the discharge or in communication of the patient’s ongoing needs following discharge.

Response

1. Each patient is already discussed by the whole MDT at every board round, these staff, especially the therapists, identify the discharge pathway needed and will take the needs of both the patient and carers into consideration. The discharge advisors then co-ordinate the discharge, including keeping families informed, arranging transport and ensuring medication has been ordered and electronic discharge records are completed. If the patient has no carer or support system this is recognised before discharge so the appropriate agencies can be signposted and arranged.

2. A new innovation to support all patients' discharge is the Discharge Planning Form, a new 'live' form on the Trust's electronic patient record. All members of the MDT utilise this form and it is a live document enabling joint and rapid decision making where everyone can see others comments in one place.

(3) *Mr. Gray's daughter was informed two days before the discharge that he had hyperactive delirium and that it would resolve itself but could take a few weeks. She was not made aware that Mr. Gray had at times been agitated and violent in hospital, nor was she told that although the hyperactive delirium was resolving it could fluctuate because it was likely triggered by a metabolic cause (renal function), heart failure or myocardial infarction. Neither she nor Mr. Gray's partner were informed as to how symptoms may manifest or what to do if Mr. Gray was symptomatic. Had they known that Mr. Gray may become aggressive or violent to others particularly his carers, an early discharge would not have been encouraged*

Response

While a therapy assessment appointment had been arranged to attend Mr Gray's home following discharge, this unfortunately did not take place in time to prevent the tragic death of his partner. It is a common occurrence that patients are discharged with ongoing confusion, and it is recognised that this will often be eased, by being in familiar surroundings. There had been no previous evidence of any aggression in Mr Gray, and the tragic events that followed were absolutely not predicted.

We recognise we need to address the post discharge care of patients with confusion; this is a common occurrence and future episodes of unforeseen aggression might happen. So far, we have taken the following actions:

1. Review of the existing Delirium leaflet will be shared as appropriate on patient discharge. This leaflet has been reviewed and is easily accessible on the Trust intranet. A hard copy will be handed out to families/carers for information.

2. On December 16th 2025 at a Transfer of Care meeting, we presented this case and Coroners findings to our community partners to outline what happened and to explore what resources already exist in the community to support in the discharge of patients with confusion.

3. A wider piece of work is underway to provide all patients with contact numbers in case they require additional community support, on their discharge. This will include the contact number of the carer champion but also signpost patient and carers to services such as Carer Support, the Kent County council (social care) number and an East Kent wide urgent response number. This number will be appropriate for carers of patients with delirium or confusion who are deteriorating unexpectedly.

4. A care advice leaflet has already been developed to support this and is available on the Trust intranet. Going forward this will be provided to all patients with a carer following discharge.

5. A workstream has been set up with multiple partners; Kent Community Health Trust, East Kent Hospital University Foundation Trust (EKHUFT) Kent and Medway Mental Health Trust, Kent County Council and Carers Support. The purpose of this group is to identify resources, where we can work together to improve the discharge of patients with delirium, to ensure on going patient and carer support. This Workstream is chaired by the Director of Adult Services for Kent Community and is anticipated to start in a few weeks.

6. We have already explained the role of the Carers Champion above who will be involved as well.

7. We are working to strengthen knowledge and use of the nationally recognised 4AT tool to help 'score' patients with delirium. This is an existing part of our documentation that helps identify and monitor patients with delirium. An audit has been carried out to understand current use of the tool, with a view to improve staff training. This was presented last week. The format of the proposed training has already been outlined by the Head of Nursing for mental health.

8. There is wide sharing of ongoing learning within EKHUFT via Associate Director or carer experience and associated meetings.

9. Mapping of Progress by re-audit by the Carers Champion will take place in February, March and April this year.

We hope that we have assured you that whilst the Trust has not completed all of the actions that you have identified, we are learning and improving and sincerely hope that a case such as Mr Gray's does not happen again.

Yours sincerely

[redacted]

Acting Chief Executive