Kent and Medway Mental Health NHS Trust

Mr. Ian Potter
Kent and Medway Coroners' Service
Oakwood House
Oakwood Park
Maidstone
Kent
ME16 8AE

Chief Executives Office
Priority House
Hermitage Lane
Maidstone
Kent
ME16 9PH
[redacted]

6 March 2026

Dear Mr Potter

Inquest into the death of Mr Mark Stuart VIDLER

Kent and Medway Mental Health Trust Response to the Regulation 28 Report to Prevent Future Death

I write in response to the Regulation 28 Report dated 11 January 2026, sent to Kent and Medway Mental Health NHS Trust (the Trust) following the conclusion of the inquest into the very sad death of Mr Mark Stuart VIDLER on 8 May 2025.

In your report to the Trust, you raised the following matters of concern:

1. **Some staff at the Trust were so focussed on 'process' that they lost sight of the need for patient centred care. This was accepted within the Trusts PSII report. I was insufficiently reassured that action has been taken to address this matter.**

2. **The process in place for triaging and considering referrals to the Rapid Response Team is reliant, for the most part, on call handlers working through a script and there is a total lack of clarity regarding clinical decision making in this regard. The Trust acknowledged in its PSII report that there was "no evidence of senior clinical oversight of the decision making or clarity as to where the final clinical decision sits regarding accepting or declining referrals". A senior**

manager from the Trust told me, in evidence, that there is still work to be done to address this concern.

The Trust wide Rapid Response Standard Operating Procedure is being revised and amended to ensure referrals received are accepted by call handlers. No referral will be declined until a senior clinician has had oversight, and alternative care agreed. As such each referral will be reviewed by a Rapid Response clinician in collaboration with the referring clinician, thereby ensuring decision making is person centred.

The revision of the Trust wide Home Treatment Team and Rapid Response Standard Operating Procedure review which is currently underway, is due for completion by 1 April 2026. In addition; to the revision of the SOP's both the Home Treatment and Rapid Response Teams are booked to undertake CRAM training for both qualified and unqualified staff. This will be completed by April 2026. This training will specifically address the need for clinicians to be curious and ask specific risk questions around safety and protective factors as well as co-written plans of care in conjunction with carers and family where to do so. This will ensure person centred care is at the centre of all assessments.

3. **Evidence I considered showed that some risk factors, such as the masking of symptoms, were well documented. However, the HTT clinician still appeared not to acknowledge the extent of such risks. This raises the risk of a repeat of this concern in the future.**

The Home Treatment and Rapid Response Teams have planned and dedicated Clinical Risk Assessment & Management (CRAM) training sessions where masking of symptoms will be covered as a learning outcome. CRAM is the clinical tool that teams use to assess and care plan for risks that are identified.

The Trust has implemented quality audits to determine the quality of the Risk Assessment & Management plans across the Trust, and as such there is an ongoing Trust wide quality improvement drive to establish improvements particularly around risk recognition and safety planning. As part of this work, there is weekly tracking of our improvement trajectory targets for completion of the CRAM documents.

This activity is currently part of the Trusts Quality Action Plan.

4. **I heard evidence that the decision to discharge Mark from the HTT was made at a multidisciplinary team (MDT) meeting prior to the HTT nurse visiting Mark on 6 May 2025. This raises the concern that the decision was pre-determined. I heard no evidence that this situation has changed.**

   The HTT have initiated a twice weekly MDT discussions with Community services which focuses discussion on aspects of individual patients care including those patients for whom discharge is planned from HTT. This allows for the wider support system to debate and consider the decision to discharge.
   In addition, as part of the Trusts ongoing development, of understanding and managing risk with our patients, a risk assessment is completed at discharge. If the clinician completing the risk assessment identifies a deterioration in mental state this can and should delay that decision- the team have a mechanism for discussion and decision making regarding clinical care, on a daily basis, and access to a Consultant Psychiatrist for advice and guidance in complex cases.

5. **Both the nurse from MHT+ and the consultant psychiatrist gave evidence that the MHT+ were not included, as the receiving team, in the MDT decision on 6 May 2025. They considered that this would have been useful and is something that can and has happened in the past. I was told that this left Mark 'in limbo' following his discharge from HTT and I was told that this is something that has not changed since.**

   Following this Inquest outcome, the Home Treatment Team service have implemented a twice weekly clinical MDT interface meeting with local MHT and MHT+ teams to enable and ensure timely discussion of specific cases. Feedback from the clinical teams has been positive as these forums are the opportunity to discuss patients of concern where risk continues to be identified.

   The Rapid Response Team will have senior clinical input into these interface forums where decisions impacting on patient care can be discussed and decisions made clinically to ensure the person has an agreed discharge plan that promotes clinical safety and is based on senior clinical consideration. The revised Standard Operating Procedure will detail that MHT+ colleagues including medics must be invited to these forums to assist with community treatment planning and will be audited 3 monthly to ensure quality, patient safety and positive patient outcomes agreed across the interface of services.

This practice improvement will be included in the revised Trust wide Home Treatment Team and Rapid Response Standard Operating Procedures review which are currently underway review, and due for completion by 1 April 2026.

6. **I heard evidence that the Trust does not have care co-ordinators and the clinician felt that this could lead to similar situations arising in the future.**
   The Trust has and is undergoing transformation in line with the Community Mental Health Framework (CMHF) which includes a national directive to move away from care co-ordination. As part of our continuous improvement agenda and refinement of the community model of care the Trust has identified a number of service improvement which we will be making and which will include the introduction of a named worker.

   There have been a number of workshops held across the organisation, by Directorate and work is underway to finalise the refinement model, and implementation timeframes.

7. **The Collaborative Assessment and Management of Suicidality (CAMS) work undertaken by the Trust lacks "dedicated resource in place to manage or support implementation" (quote taken from Trust PSII report). I also heard that the CAMS programme cannot currently be integrated with the Trust's computerised records system, due to copyright issues. This matter was due to be resolved by June 2025; however, it remains unresolved with a current target date of June 2026. I was told that there is no system in place to safety net the use of both paper and computerised records in the meantime.**

   By the end of February 2026, the CAMS clinical documentation forms will be accessible as stand-alone documents on Rio clinical record system. These can only be completed by those undertaking specialist CAMS training or those who have fully trained in use of the National CAMS model.

   The Trust are currently considering options in relation to a dedicated workforce of CAMS trained workers across our services. In addition, the continued roll out of this specialist service is under review by the organisation. This will inform the finalised CAMS Standard Operating Procedure. In the meantime, a 6-month secondment role has been agreed to support the CAMS service (band 7 clinician). This role is split equally between CAMS practice and training staff in CRAM.

8. **I heard evidence that as a result of the referral to the Rapid Response Team being declined, Mark's mental health care technically rested with the MHT+ team, which only works until 17:00. As a result, the Approved Mental Health Practitioner service (responsible for arranging MHA assessments) would have been unable to speak to the referrer. While this was not an issue in the specific circumstances of this case, I consider that it raises risks for others in the future.**

   With clarity being established through the Home Treatment Team & Rapid Response Standard Operating Procedure, we expect that this will not occur in the future. In addition to the robust adjustment to the Rapid Response referrals received process outlined above, the Trust continues to promote the use of the Urgent Mental Health Helpline, by patients known or unknown, and their families 24/7.

Thank you for bringing your concerns to my attention and I am sincerely sorry for the shortfalls in the care of Mr Vidler.

I hope that the detailed information provided, including the attached timetable for action, offers you a level of assurance about both the seriousness with which the Trust has received and responded to your concerns, and the significant improvements that have been made since the sad passing of Mr Vidler.

Please do let me know if I can be of any further assistance.

Yours sincerely

Chief Executive