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Date: 11 January 2026
[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

- **Chief Executive, Kent and Medway Mental Health NHS Trust, Farm Villa, Hermitage Lane, Maidstone, Kent, ME16 9QQ**

1. CORONER

I am Mr. Ian Potter for Kent and Medway

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 9 May 2025 an investigation was commenced into the death of Mark Stuart VIDLER. The investigation concluded at the end of the inquest heard by me on 2, 3, and 19 December 2025. The conclusion of the inquest was:

Suicide, contributed to by a failure in care

1a Hanging

1b

1c

1d

II

4. CIRCUMSTANCES OF THE DEATH

Mark Vidler had severe depression, which presented atypically. He was under the care and treatment of Kent and Medway Mental Health NHS Trust (the Trust) between July 2024 and his death on 8 May 2025. Mark had previously been detained under the Mental Health Act 1983 (MHA) (August - September 2024, and November 2024) following serious and impulsive attempts to end his life. He was well known to 'mask' his symptoms and feelings.

On 30 April 2025, Mark made a very serious attempt to end his life by hanging: the only reason the attempt was unsuccessful was due to the ligature snapping after Mark had fallen unconscious. Mark's treatment was escalated to the Home Treatment Team (HTT) due to his increased risks. Some days later, Mark requested to be discharged by the HTT. This request to be discharged was a significant risk factor that was not fully appreciated by clinicians in the HTT when they agreed to discharge Mark on 6 May 2025. Given the events of 30 April 2025 and Mark's evolving risks, his discharge from the HTT was premature.

On 7 May 2025, Mark made a further serious attempt to end his life by hanging, which included leaving a final note for his family. Mark was seen by a nurse from the Mental Health Together Plus (MHT+) that day, who immediately recognised that Mark was at a real and immediate risk of death by suicide. The nurse escalated her concerns to a psychiatrist who agreed with that view and planned for Mark to be assessed urgently with a view to detaining him under the MHA. Neither the psychiatrist nor the nurse considered Mark's home was a place of safety for him. The plan was for Mark to be referred to the Trust's Rapid Response Team, who could have seen him that night for safety and risk management input, pending the MHA assessment. The referral to the Rapid Response Team was declined by the clinician and there was no valid reason for that decision. This meant Mark was not seen or reviewed by an 'out of hours' clinician on the night of 7 May 2025. This was a failure in care that more than minimally contributed to Mark's death.

In the early afternoon of 8 May 2025, Mark's son entered Mark's home address due to concerns for his welfare. Sadly, he found Mark suspended by ligature and Mark's death was verified by a paramedic shortly thereafter. Mark had intended to end his life.

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.

Before setting out my concerns, it is only right that I acknowledge that I heard evidence about good aspects of care treatment provided to Mark. Further, the Trust has undertaken some work to address the risks and concerns it has identified by way of its own internal processes.

The **MATTERS OF CONCERN** are as follows:

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

(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.

(4) I heard evidence that the decision to discharge Mark from the HTT was made at a multi-disciplinary 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.

(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 the his discharge from HTT and I was told that this is something that has not changed since.

(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.

(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.

(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.

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 9 March 2026. 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: Mark's family. I have also sent it to the Care Quality Commission who may find it useful or of interest.

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. She 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.

12 January 2026

Signature 

Ian Potter Area Coroner for Kent and Medway