NHS
Kent and Medway
Mental Health
NHS Trust

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15 May 2026

Dear Mr Potter

Inquest into the death of Mr Robert Day

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 24 March 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 Robert Day on 15 January 2025.

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

1. **Professional Curiosity**

I heard evidence that led me to conclude that in the weeks prior to Robert's death some of the mental health professionals from the Trust that were involved in his care did not display sufficient professional curiosity. This included, but was not limited to:

- **Conducting what should have been 'home visits' in public places, which denied the clinician(s) the opportunity to fully and holistically assess Robert and his needs;**
- **Overly strict adherence to the Trust's Did Not Attend (DNA) policy, which lacked any meaningful thought being given as to the reason(s) why an appointment**

might not have been attended. One witness considered that the policy itself was an issue;

- **Robert's sister raised concerns about him to the Trust on 2 January 2025. Later that day, two mental health nurses from Medway and Swale MHT+ team conducted a 'cold call' visit to Robert. They documented a plan as a result of that visit, but I heard in evidence that this plan was "not reasonable" at that time and that a referral to the Rapid Response team would have been expected; and**
- **Some staff appear to have looked at Robert's presentation on one given day, without looking at his previous presentation, which I was told in evidence showed a "lack of professional curiosity".**

Trust Response

The Trust accept that opportunities were missed to demonstrate an appropriate level of professional curiosity. Even though the plan to meet Mr Day at a public place was eventually changed to the local Community Mental Health Team based at Sittingbourne Memorial Hospital, there was insufficient clinical probing that would have helped clinicians in recognising, querying, and escalating emerging concerns from Mr Day's presentation before discharging him. In line with the Patient Safety Incident Response Framework (PSIRF) principles, a learning response was undertaken through a multidisciplinary case conference with the local Community Mental Health Team on the 20th January, 2026. The focus was on understanding the care context, identifying contributory system factors, and agreeing shared learning to inform service improvement.

In regards to the application of the Trust Did Not Attend (DNA) policy, it is expected that patients' vulnerabilities, care and support needs, symptoms, safeguarding concerns, risks, the Mental Health Act (1983) and Mental Capacity Act (2005) will be considered in the implementation of this policy and not in isolation. The Trust has introduced a daily DNA huddle within the local Community Mental Health Team to allow for consideration of risk of patients and instigate relevant action required to maintain patient safety.

Following the concerns raised by Mr Day's sister on the 2nd January 2025, we have acknowledged there was inadequate challenge of assumptions, limited triangulation of care, and a lack of proactive questioning that may have contributed to a failure to fully appreciate the level of risk presented by Mr Day at the time. A referral to the Home Treatment Team (HTT) should have follow to allow for a more intensive treatment and follow up.

We also recognise that professional curiosity is essential in mental health care, particularly where presentation may be complex, fluctuating, or influenced by multiple factors such as lack of appropriate housing, social isolation as in the case of Mr Day. We regret that this was not consistently demonstrated in this case. In response to the coroner's findings therefore, the organisation has taken the following actions:

Strengthening Training and Awareness regarding professional curiosity

- **Professional curiosity** is being strengthened by focusing on developing a culture that supports personalised care and informed clinical decision-making. This is reinforced by senior clinical leaders through daily safety huddles, ward rounds, and team meetings. It will also be an agenda item at clinical summits, senior nursing leadership forum (June 2026) and the annual nursing conference (October 2026).
- Case based learning will be introduced, using real clinical scenarios to support staff in recognising when to question, probe, and escalate concerns as part of directorate leadership learning.

Clinical Supervision and Reflective Practice

- Supervision frameworks will be refreshed to ensure professional curiosity and reflective questioning are routinely addressed.
- This will provide a focus on patient case discussion, supporting wider MDT and team decision making, personalised care planning and formulation that forms part of the Trust wider quality plan.

Leadership and Oversight

- Senior clinical leaders, including Matrons and lead nurses are providing enhanced oversight and visible support, focusing on curiosity, challenge, and risk escalation. They do this by offering visible professional oversight of nursing and Allied Health Professionals (AHP) practice, setting clear expectations for standards of assessment, care planning, acting as a point of escalation in managing high-risk and high-complexity cases.

Policy and Documentation

- In January 2026, the Trust introduced and is embedding the Collaborative Risk Assessment and Management (CRAM) risk assessment framework. The quality of the CRAM is routinely being audited in respect of patient/carer involvement, formulation and a safety plan is present to support effective reassessment, challenge of assumptions, and clear clinical reasoning.

- The Trust is in the process of comprehensively refining the model of care within the Community Mental Health Teams with clinical pathways escalations to be clarified and clinical leadership reinforced. The Trust has also recognised that Curiosity is fundamental to effective care delivery as it enables understanding of the person, not just the presentation and has consequently adopted 'curiosity' as one of its values. Work is now being undertaken to embed this to ensure a change of culture within the organisation.

Ongoing Monitoring and Assurance

We will continue to monitor the effectiveness of these actions through:

- **CRAM Quality audits** – 10 patients per month for each team. These audits focus on the quality of the risk assessment, formulation and plan and are overseen by senior nursing colleagues.

- **Incident reviews** are undertaken in line with the Trust's Patient Safety Incident Response Framework (PSIRF) to ensure learning is identified, followed through, and effectively embedded following patient safety incidents.

- **Progress against the Trust Quality Improvement Plan** is being strengthened through a revised governance structure implemented during May–June 2026. Four Senior Responsible Officers at Deputy level have been identified to provide assurance on delivery of quality milestones, including discharge and care planning. Each milestone is supported by defined key performance indicators to monitor impact.

2. **Record Keeping (the '836 line')**

I received compelling evidence in the form of contemporaneous notes by both the paramedic and police officer that attended the 999 call to assist Robert on 14 January 2025 (following his taking of an overdose), which led me to conclude that the paramedic

had sought advice from the Trust's so-called '836 line'. There was no record of the call or the advice given within Robert's electronic notes.

I concluded that, in this particular case, the lack of record keeping did not contribute to death. However, record keeping in healthcare is a fundamental basic of patient care and is a central part of keeping patients safe. Again, it is not difficult to see circumstances in which a lack of clinical record-keeping would contribute to a death. As such, I raise my concern that ongoing record-keeping issues will contribute to future deaths.

Trust Response

Actions that are completed and in place as business as usual:

- All calls received by the 836-line are now recorded.

- A monthly meeting takes place with the Trust, British Transport Police, Kent Police and SECAMB they review 10 calls with the support of the Trust Information Governance team. These are then triangulated with the progress notes on Rio (the electronic patient notes system).

- The information governance team listen to 10 calls a month separate to the meeting for quality purposes.

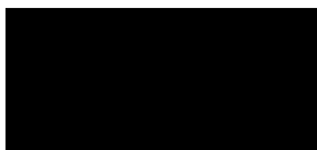
Actions to be completed and monitored weekly by the Acute Directorate Clinical Governance Team:

- **The Trust Information Governance Team** is undertaking a review to verify that all staff within the 836-line team hold an in-date licence, ensuring all calls are appropriately recorded. Where a valid licence is not in place, calls will not be recorded. This action is being led by the General Manager for the 836-line.

- **A monthly audit of 10 patients** will be undertaken within the directorate to review call recordings and associated progress notes for quality and safety. This action is being led by the Clinical Governance Lead for the Acute Directorate.

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

Yours sincerely



Chief Executive