Kent and Medway Coroners' Service
Oakwood House
Oakwood Park
Maidstone
Kent
ME16 8AE
[redacted]

Date: 24 March 2026
[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. [redacted] Secretary of State for Health and Social Care;

2. [redacted], Parliamentary Under-Secretary of State for Women's Health and Metal Health; and

3. [redacted], Secretary of State for the Home Department

1. CORONER

I am Mr. Ian Potter, Area Coroner 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 16 January 2025 an investigation into the death of Robert Joseph DAY was commenced. The investigation concluded at the end of the inquest heard by me on 5 and 6 March 2026. The conclusion of the inquest was:

Suicide

The medical cause of death was:

1a Overdose of Prescription Medication

4. CIRCUMSTANCES OF THE DEATH

Robert Day was 60 years of age at the time of his death. He was under the care of community mental health services in relation to his diagnosis of severe depression.

On the afternoon of 14 January 2025, Robert Day disclosed to his mental health nurse during a telephone conversation that he had taken a significant overdose of his prescription medication. An ambulance was called and a joint response unit (police and ambulance service) attended Robert's room at the Travelodge in Sittingbourne (his home address at that time). Robert refused all forms of treatment, including being taken to hospital, despite being advised of the likely fatal consequences of not receiving treatment. The paramedic undertook a mental capacity assessment and concluded that Robert did have the mental capacity to refuse treatment. Robert was given safety-netting advice.

Sadly, Robert was found deceased in his room on the morning of 15 January 2025. He died as a result of the overdose of prescription medication.

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.

While this report has three recipients due to the crossover between the services involved (ambulance service, police, community mental health), I am more than content that one recipient and / or government department may wish to take the lead in providing a single response.

The **MATTER OF CONCERN** is as follows:

(1) I heard compelling evidence from the Head of Mental Health at South East Coast Ambulance Service NHS Foundation Trust regarding the difficulties faced by emergency services generally in situations such as the presentation of Robert Day on 14 January 2025. It must be accepted (with no disrespect intended) that frontline paramedics and police officers are not specialists in the provision of mental health care. Despite this, the evidence was that an increasing number of calls to the emergency services (ambulance and police, in particular) have a mental health element to them.

It was clear from the evidence that the joint response crew (one paramedic and one police officer) who attended Robert on 14 January 2025, did their very best to assist Robert in what can be described as a particularly difficult set of circumstances. A capacity assessment was undertaken and the responders reasonably believed that Robert did have capacity to make the decision to refuse treatment even in the knowledge that, without it, his death within the coming hours was highly likely.

I heard that the police could not have deployed section 136 of the Mental Health Act 1983 to take Robert to a place of safety because, at that time, the hotel room was his home. In any event, section 136 would not allow for treatment. Further, in the circumstances of Robert's case, the process of applying for a warrant under section 135 of the Mental Health Act 1983 was also likely inappropriate given the critical nature and timing of Robert's situation.

While not hearing specific and detailed evidence on other provisions of the Mental Health Act 1983, the witness was clear that these matters would likely be beyond the scope of

understanding of most frontline emergency workers.

The fundamental issue was considered to be 'what can the frontline crew actually do' in such complex situations. I heard evidence that, sadly, Robert's situation is unlikely to have been novel but that there is an absence of national guidance to frontline emergency services in dealing with the complexities of cases such as Robert's.

I acknowledge the complex interplay between the various agencies and services involved, but highlight to you my concern that the absence of any national guidance / advice to frontline emergency crews risks the lives of others who are found to be at time critical risk as a result of underlying mental health concerns.

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 19 May 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:

- Robert's family
- South East Coast Ambulance Service NHS Foundation Trust
- Kent and Medway Mental Health NHS Trust

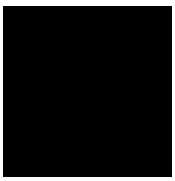
I have also sent it to the following organisations, who may find it useful or of interest:

- Association of Ambulance Chief Executives
- National Police Chiefs' Council

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 she 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.

24 March 2026



Ian Potter, Area Coroner for Kent and Medway