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

Date: 2 February 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, HM 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 April 2025 an investigation into the death of David ROOMES, aged 67 years, was commenced following his death on 14 April 2025. The investigation concluded at the end of the inquest, heard by me, on 9 and 14 January 2026. The conclusion of the inquest was

Suicide

1a Hanging

1b

1c

1d

II

4. CIRCUMSTANCES OF THE DEATH

David had a longstanding diagnosis of bipolar affective disorder, which had required input from mental health services in the past. However, David's bipolar was relatively well controlled with medication for a significant period of time prior to about January 2025.

David had a relapse in depressive symptoms and saw his GP, who referred him to the Kent and Medway Mental Health NHS Trust (the Trust) in early January 2025. David was well known to the Trust.

David's family raised numerous concerns about his mental health with staff at the Trust.

David was sadly found deceased in the garage of his address on 14 April 2025, having suspended himself by ligature.

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 that I acknowledge that the Trust has undertaken some work to address risks it identified as a result of its own internal review processes.

The **MATTERS OF CONCERN** are as follows. -

(1) There was a significant delay in David's referral to the Trust being triaged. When the triage did take place, I was told in evidence that David's referral was not triaged well, which had numerous implications for David's treatment later on. I was told that the Trust now provides more support for staff triaging referrals; however, this did not provide sufficient reassurance that the risks have been addressed. I am also mindful of Prevention of Future Death report (2026-0023), written by me on 12 January 2026, which contained a similar concern about the process for triaging referrals (albeit in relation to a different team within the Trust). This indicates that this may not be a localised, team specific, issue in terms of the triaging of referrals.

(2) David's Dialog+ assessment (an assessment tool, which includes questions to assess risk) was not undertaken by a clinician. I was told in evidence that, given the complexities of David's case, his Dialog+ assessment 'would have benefitted' from assessment by a clinician and that he should have been seen by a qualified clinician at that appointment.

I heard evidence that the Band 4 member of staff who undertook the assessment was content with their assessment and the plan that was formulated as a result of it. However, that plan did not include referral to be seen and assessed by a qualified clinician, whereas the evidence I heard was that there was an expectation that David should have been referred to a qualified clinician.

While I heard and accepted the evidence that a patient in a similar situation to David would now be able to access the MHT+ team directly, the issue here is one of potential training concerns where non-clinical decision makers are potentially over-confident or may not fully understand the nature and effect of the decisions they are required to make. I was not reassured that this matter has been addressed.

(3) It was accepted in evidence that there was a delay in David being seen by a qualified clinician. It was further accepted that there were numerous 'missed opportunities' for David to

be referred to, or seen / spoken to by, a qualified clinician. Again, I accept that a similar patient now, would be able to access the MHT+ team directly. However, the concern remains that there is potentially a wider training issue that could lead to continued 'missed opportunity' exposing future patients to continued risks.

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 10 June 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: David'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 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.

15 April 2026

Signature 

Ian Potter, Area Coroner for Kent and Medway