



Department
of Health &
Social Care


*Parliamentary Under-Secretary of State for
Women's Health and Mental Health*

39 Victoria Street
London
SW1H 0EU


HM Coroner Ian Potter
Kent and Medway Jurisdiction


22 May 2026

Dear Mr Potter,

Thank you for the Regulation 28 report of 24th March 2026 sent to myself and the Secretary of State for Department of Health and Social Care about the death of Mr Robert Joseph Day. I am replying as Parliamentary Under-Secretary of State for Women's Health and Mental Health.

Firstly, I would like to say how saddened I was to read of the circumstances of Mr Day's death, and I offer my sincere condolences to his family and loved ones. The circumstances your report describes are very concerning and I am grateful to you for bringing these matters to my attention.

In your report, you state you 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 and must accept that frontline paramedics and police officers are not specialists in the provision of mental health care.

A capacity assessment was undertaken and the responders reasonably believed that the deceased 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. You also heard that the police could not have deployed section 136 of the Mental Health Act 1983 to take Mr Day 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 Mr Day'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. You acknowledged the complex interplay between the various agencies and services involved but highlighted your 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.

I understand that this report has also been sent to the Home Office.

In preparing this response, my officials have made enquiries with NHS England and the Care Quality Commission to ensure we adequately address your concerns. Upon reviewing your report, our NHSE colleagues felt it was more appropriate to reply directly to you given concerns around the absence of any national guidance/advice to frontline emergency crews. You may want to address your report to NHSE, so that they can also address your concerns. For CQC, you will see that their response to your concerns is highlighted in this letter below.

While I cannot comment on the applicability of section 135 and 136 of the Mental Health Act in this case, it may be helpful to say that the Government have committed to carrying out a consultation to explore the powers available to different professionals in different situations and settings, in particular but not limited to the operation of sections 135 and 136.

The consultation will seek views on powers and joint working approaches to ensure health and social care professionals and police have the appropriate powers to act in order to protect people from harm to themselves and to others when in a mental health crisis.

While the exact scope of the consultation is not yet defined, we are working closely with the police, health and care representative groups and people with lived experience, to define the scope for the consultation and will set out further details in due course.

Whilst NHS England will reply directly to your concern about guidance, it may be helpful if I describe some of the other actions being taken to improve overall care for people in mental health crisis. To supplement the NHS 111 mental health crisis triage service, we are also deploying mental health professionals in 999 call emergency operation centres and clinical assessment services to ensure people experiencing a mental health crisis are directed towards appropriate services.

We continue to increase mental health expertise for ambulance services including ensuring that mental health professionals are embedded in all emergency operation centres and improve training for ambulance staff to enable effective responses to those in mental health crisis.

Substantial progress has been achieved in building a more robust crisis care pathway across all ages ensuring that people in mental health crisis have access to timely and appropriate support. Key developments include the introduction of the NHS 111 'select mental health' option alongside hundreds of alternative crisis services, including crisis cafes, sanctuaries and crisis houses which provide a supportive environment outside of traditional clinical settings. Work is underway with all Integrated Care Boards to roll out crisis text services across England by March 2026.

NHS England has successfully completed the delivery phase of the Mental Health Response Vehicles programme, with 88 vehicles now built and handed over to local systems. These vehicles are providing on-scene support for individuals in crisis and

reducing attendance in A&E for mental health concerns by delivering care directly in the community.

There is also full national coverage of 24/7 liaison mental health teams providing mental health assessments and care in general acute hospitals, as well as high fidelity crisis teams in a community.

We are also investing up to £120m to bring the number of mental health emergency departments up to 85. Mental Health Emergency Departments (MHEDs) provide rapid assessment and support in a therapeutic setting, helping those with mental health needs get the right care quickly and reducing reliance on Emergency Departments. Early evidence shows that MHEDs can improve patient experience and outcomes, while also easing pressure on wider urgent and emergency services.

Alongside this, NHS England is also developing new core standards of care for community mental health services. These will set out the 'must dos' for all services to ensure that at least a minimum quality of care is being provided in all areas for all people with serious mental illness. By providing better care for all people sooner, fewer people will require the highest levels of intensive and assertive community treatment.

CQC response

CQC have shared the following information regarding Mr Day's death:

Mr Day was a person receiving support from Kent and Medway Mental Health NHS Trust at the time of his sad death. We note that it was his community psychiatric nurse who alerted emergency service following the disclosure that he had taken an overdose.

We inspected the trust's community mental health services for working age adults in March 2025. This inspection was completed as part of CQC's Adult Community Mental Health Programme. We also inspected crisis services and health-based places of safety as part of the programme. The programme of inspections contributes to CQC's commitment to inspect the standard of care in community mental health services across the country. We undertook a short-notice, announced comprehensive inspection of this service. You can read the report here:

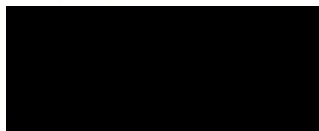
<https://www.cqc.org.uk/provider/RXY/inspection-summary#Community-based-mental-health-services-for-adults-of-working-age>

At this inspection we rated the service as requires improvement. We found 4 breaches of regulation in relation to safe care and treatment, buildings and premises, governance, and staffing. We served a warning notice on the trust for failing to meet the regulations related to risk assessment and management of service users accessing community mental health services.

We have since carried out a follow up inspection in December 2025 and we are satisfied that the Warning Notice has been met, but the report from this inspection has yet to be published.

I hope this response is helpful. Thank you for bringing these concerns to my attention.

Yours sincerely,

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**PARLIAMENTARY UNDER-SECRETARY OF STATE FOR
WOMEN'S HEALTH AND MENTAL HEALTH**