Mr. Ian Potter
Area Coroner for Kent and Medway
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National Medical Director
NHS England
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29th July 2026

Dear Mr Potter,

Re: Regulation 28 Report to Prevent Future Deaths – Robert Joseph Day who died on 15th January 2025.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 24th March 2026 concerning the death of Robert Joseph Day on 15th January 2025. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Robert's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Robert's care have been listened to and reflected upon.

Your Report raises concern that there is an absence of national guidance to frontline emergency services in dealing with the complexities of cases such as Robert's. That being where a patient informs a healthcare professional that they have taken an overdose of prescription medication but refuse treatment by paramedics and are deemed to have capacity following a mental capacity assessment.

NHS England's Mental Health and Ambulance Teams have carefully reviewed the concerns raised within the Report and recognise the tragic circumstances surrounding this case. Having considered the information presented, we believe the issues identified primarily relate to the application of the Mental Health Act and Mental Capacity Act frameworks, professional decision-making, and local arrangements for accessing specialist mental health advice.

From the information available to us, it appears that the ambulance service took reasonable steps within the scope of its role and responsibilities to support and safeguard the patient in a complex and difficult situation.

The National Institute for Health and Care Excellence (NICE) have published guidance on responding to situations where people do not consent to treatment after an overdose Scenario: Management | Management | Poisoning or overdose | CKS | NICE. This guidance is applicable to frontline emergency services, and sets out how to manage a person who refuses admission to hospital after an overdose.

Regional Response

The South East Regional NHS England Team have liaised with South East Coast Ambulance Service NHS Foundation Trust (SECAmb) regarding your Report. They provided a copy of their witness statement provided to you in this case.

SECAmb states *"When considering the responsibilities and powers of the ambulance service in relation to the Mental Health Act (1983), there is not an explicit duty or responsibility on the ambulance service to initiate the detention of patients and ambulance service staff are accordingly not trained in these areas. The ambulance service is also not responsible or commissioned to ensure the compulsory admission of patients who are liable to detention under the Mental Health Act (1983).*

… Ambulance crews are generalist clinicians and not specialists in mental health, therefore when dealing with mental health incidents they are encouraged to utilise dedicated 'mental health single points of contact'. These single points of access provide 24/7 tactical advice and guidance to our crews and in Kent and Sussex a 'Rapid Response' deployment service for applicable incidents; the Kent service is known locally as the '836' line. It is essential that they have a good working knowledge of the Mental Capacity Act (2005) and give great care and consideration to its application. Ambulance crews are required to follow the Mental Capacity Act (2005) policy and complete mandatory training on the subject.

SECAmb also provides access to clinical guidance on how to deal with mental health incidents where patients are suicidal through its "Mental Capacity Act and Suicide Guidance" that went live in August 2025. The SECAmb guidance was developed to be congruent with the National Institute for Health and Care Excellent guidance (225) on 'Self-harm: assessment, management and preventing recurrence' and NHS England's 'Staying safe from suicide: Best practice guidance for safety assessment, formulation and management'. The SECAmb guidance is available on the trust intranet, a mobile app and is linked via prompts in the electronic patient records system.

For the avoidance of doubt, in terms of what was available at the time of the incident, crews will have been able to utilise the '836' line and would have been required to complete mandatory e-learning on the Mental Capacity Act (2005) as well as follow the Mental Capacity Act Policy. Crews will have also had access to a "Mental Capacity Act" pocket guidance but not the specific guidance on "Mental Capacity Act and Suicide Guidance" which was only published in August 2025."

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Robert, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

[redacted]

[redacted]

National Medical Director

NHS England