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:

Chief Executive, Kent and Mental Mental Health NHS Trust

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 from the Trust 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.

The **MATTERS OF CONCERN** are as follows:

I acknowledge that some of the concerns that arose during the course of the inquest have been addressed. As such, those concerns do not feature as part of this report.

(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 consider 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".

While I did not find that the lack of professional curiosity contributed to Robert's death, it is not difficult to envisage that such a concern could cause or contribute to deaths in the future, if not addressed. There was some evidence that this may be addressed in the future, but I was not reassured by evidence from a manager that they did not want to make changes in all teams in case this was seen as a 'knee jerk' reaction. I was insufficiently reassured that the acknowledged 'lack of professional curiosity' has been adequately addressed or that the risk has reduced.

(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.

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; and
- South East Coast Ambulance Service NHS Trust.

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.

24 March 2026

Ian Potter Area Coroner for Kent and Medway