NHS
Central and
North West London
NHS Foundation Trust

Executive Office

24 September 2025

Sean Cummings
HM Assistant Coroner for Milton Keynes
HM Coroner's Office
Civic Offices
1 Saxon Gate East
Central Milton Keynes
MK9 3EJ

Dear Mr Cummings,

Re: Regulation 28: Report to prevent future deaths

Thank you for your Regulation 28 report dated 1 August 2025 following the inquest into the death of Brian Thomas Ringrose on 2 February 2021. The inquest concluded on 24 April 2025.

Central and North West London NHS Foundation Trust (CNWL) deeply regrets the death of Mr Ringrose and we would very much like to extend our condolences to his family.

I am writing to provide the Trust's response to the concerns that you raised in your report.

Matters of Concern

a) Delay in Assessment: There was a significant delay in the mental health team attending to Brian in the Emergency Department (ED), despite the urgency of his condition.

b) Inadequate Assessment: When the mental health team did attend, they felt unable to assess Brian due to his unresponsiveness but did not escalate their concerns or communicate effectively with medical staff or police. They did not plan to return to follow up on Brian.

c) Failure to Escalate Concerns: A member of the mental health team believed Brian was not medically fit for discharge but failed to voice this to medical staff or police.

d) Unsafe Communication Practices: Reliance on verbal communication and delayed written notes (within a maximum 24 hours) is inherently risky in emergency settings, as contemporaneous notes are essential for critical information to be promptly shared with other clinical and nursing staff dealing with patients.

e) Inappropriate Discharge Recommendation: The mental health team suggested reassessment in police custody, despite Brian's ongoing medical instability. In my view this represented a very high risk to Brian's safety.

I am responding to the concers in the order that you have raised them. I would also like to make you aware that the Mental Health Liaison Team (HLT) Operational Policy has been updated and shared with Milton Keynes University Hospital (MKUH). The updates have been discussed at all staff meetings and interface meetings in June and July 2025 to ensure shared understanding.

a. Delay in Assessment
We have revised our approach to ensure that referrals are accepted even when patients are not yet medically cleared. This enables earlier engagement, risk planning, and support. A key performance indicator for the HLT is timely response to referrals. In the past six months, over 95% of ED referrals have been responded to within one hour. This reflects not only operational improvements but a cultural shift towards proactive, parallel working with ED colleagues.

b. Inadequate Assessment
Our revised protocol mandates that when a patient cannot engage due to intoxication (alcohol or drugs) or other factors rendering them unfit, the HLT must escalate concerns to the ED team, advise that the patient remains under ED care for ongoing medical management, and the HLT remain available for reassessment. This ensures continuity of care and avoids missed opportunities for intervention. This applies equally in cases where the patient is under police arrest within the ED.

c. Failure to Escalate Concerns
We have strengthened our escalation pathways. A standing agenda item has been added to monthly cross-team meetings to review HLT practices. Our Operational Policy now explicitly requires immediate escalation of concerns to the treating medic or nurse in charge.

We have also embedded trauma-informed care principles through RESPOND training and the dissemination of the Side-by-Side guidance for hospital settings, ensuring staff are equipped to act decisively and collaboratively.

d. Unsafe Communication Practices
To enhance the robustness and integrity of our documentation process, we have implemented a joint entry protocol. Under this approach, both assessors will contribute directly: the second assessor will either formally approve the initial entry or provide a complementary entry to ensure a more comprehensive and balanced record. Verbal handovers to the treating medic, or to the Nurse in Charge if the medic is unavailable, are now mandatory immediately post-assessment, followed by contemporaneous entries in ECare summarising the handover with a more detailed entry to follow based on the SystmOne entry. These changes aim to improve the

accuracy, timeliness, and reliability of clinical communication. HLT entries are randomly audited for quality assurance.

e. Inappropriate Discharge Recommendation
We have reinforced the principle that discharge from ED should never proceed where there are unresolved concerns about a patient's safety, whether related to physical or mental health. This has been reiterated in team meetings and supervision sessions. Refresher training and Human Factors Training are taking place to support consistent application of this principle.

All clinical matters are discussed in regular supervision with individual clinicians and in multidisciplinary team meetings. There is a monthly interface meeting with MKUK attended by senior management and Consultants from the Hospital Liaison Team for oversight.

Thank you for bringing your concerns to our attention. I hope that the content of this letter provides sufficient assurance that CNWL takes the concerns raised seriously and has taken action following the death of Mr Ringrose. CNWL has accepted the points raised and continues to work to improve the service we provide. Should you have any questions or comments, please do not hesitate to contact me.

Yours sincerely,

Claire Murdoch
Chief Executive