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24 September 2025

Dear Dr Cummings,

Regulation 28 Report following an inquest into the death of Mr Brian Ringrose

I am writing following receipt of the Regulation 28 Report dated 1 August 2025, relating to the inquest into the death of Brian Ringrose which concluded on 24 April 2025.

The circumstances of Brian's death were harrowing, and I would like to express my profound regret that Brian did not receive the care he deserved while he was a patient in the Emergency Department, and to again extend my heartfelt apologies to Brian's mother, Mary, and to his children and wider family.

I would like to assure you that as a Trust we have learnt from Brian's death and that Brian's death has left an enduring legacy of improvement in how we care for patients in police custody, particularly in the Emergency Department.

In your Regulation 28 Report to prevent future deaths, you set out a number of areas of concern and I would like to detail the changes and improvements made in each of those areas, appending evidence where I believe it is helpful.

1. Non-existent Documentation Referenced in Policy

The hospital policy makes reference to a "discharge for police custody form" that does not actually exist. This suggests the policy was hastily created, possibly for the purposes of satisfying the inquest requirements, without appropriate consideration of its content or implementation

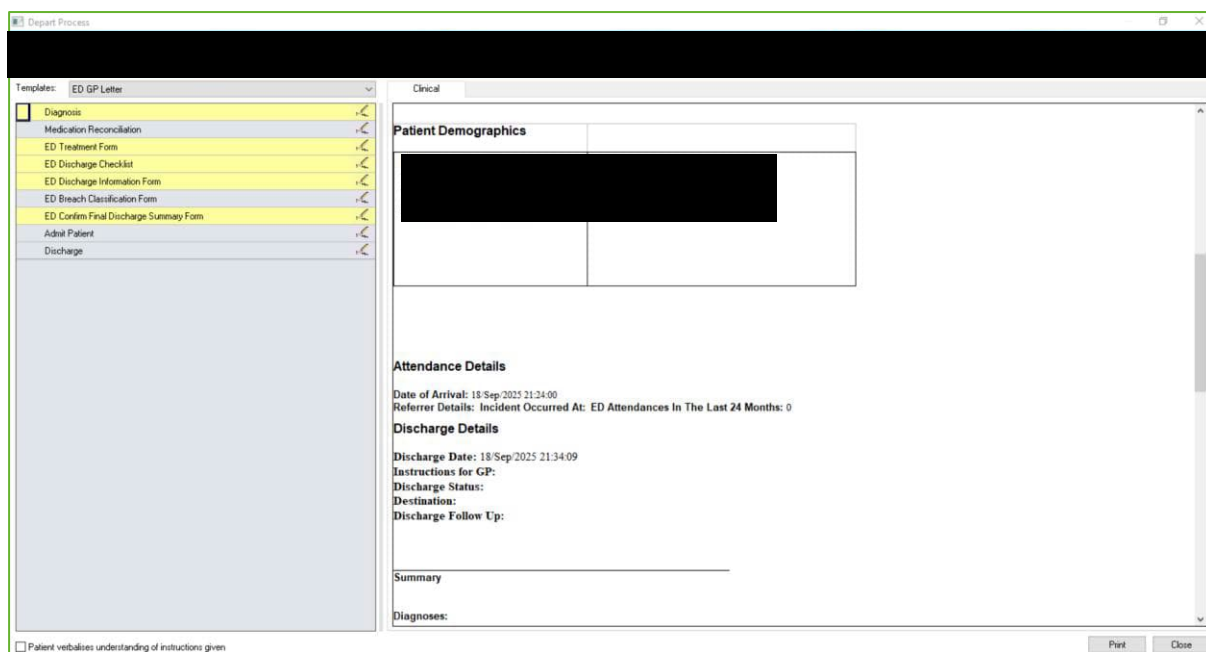
This concern refers to a Standard Operating Procedure (Police Custody – Care in and Discharge from the ED) which was created using the Royal College of Emergency Medicine Guideline of the same name. I can assure you that it was not created in haste, but had not been updated to reflect work with Thames Valley Police which had continued to evolve and develop local processes and procedures after the guidelines had been published as a local SOP.

The Emergency Department has subsequently amended the local SOP to ensure that the language now used reflects local practices between Emergency Department healthcare staff and Thames Valley police offices. Local guidance is appended as Appendix 1, including the Thames Valley Police transfer protocol and patients in police custody guideline.

2. Misleading Discharge Documentation

The discharge form generated by hospital staff was interpreted by police officers as a formal discharge notice, as the jury found. The current system allows for the generation of forms that may be misinterpreted by third parties as official discharge documents when they may not be.

The ED Discharge Summary is created in the 'DEPART' section of Firstnet the ED Module of Oracle Cerner Millenium our Electronic Patient Record known locally as eCare. If opened immediately after admission it looks like this:



On the left are the various sections that need completing and on the right is a preview of how the discharge summary is developing. Sections highlighted in yellow are mandatory, those in grey are optional. At this stage there is no actual discharge summary as the final document is not created and stored in eCare until the patient is admitted or discharged. The Discharge Date time displayed in the template will be the time the depart tool was opened and it will move on each time the tool is opened as the patient passes through the ED pathway.

As sections are completed the yellow sections turn grey and one can preview the discharge summary developing e.g.

Depart Process

Templates: ED GP Letter

Diagnosis

- 2837251018 Closed fracture of metacarpal bone

Clinical

Summary

Information and Advice Given:
 Fell at home (tripped on loose carpet) onto outstretched hand
 Pain & swelling right hand, tender over 5th metacarpal
 Xray confirms undisplaced right 5th metacarpal fracture
 Hand cast and broad arm sling applied, oral analgesia given
 For review in fracture clinic 3am tomorrow

Diagnoses:
 Primary:
 18-Sep-2025 Closed fracture of metacarpal bone (Confirmed) - Presented On: 18-Sep-2025

Investigations:
 Point of Care Tests: ECG, Cardiac Monitor, Oximetry / Sats, Vascular Observations, Vital Signs

Procedures:
 None

Treatments:
 Sling / Collar & Cuff, Splint / Surgical Appliance

Allergies and Adverse Reactions:
 Active:
 No Known Allergies (Allergy) - Recorded: 19-May-2018

Medications and Medical Devices:

☐ Patient verbalises understanding of instructions given

Print Close

The final section when opened appears like this:

ED Confirm Final Discharge Summary

*Performed on: 18/09/2025 21:46 BST

ED Confirm Final Discharge Summary

NHS: MRN: 907256

Confirm Final Discharge Summary

If the ED Discharge Summary is in a complete state, you must click "Final Emergency Department Discharge Summary" below.

If not, then please go back and complete the ED Discharge Summary.
 The ED Discharge Summary will then be sent when you click the 'Discharge/Transfer Outside Trust' button in the Depart Process.

☐ Final Emergency Department Discharge Summary

Was the patient provided with a copy of their Discharge Letter?

☐ Copy of discharge letter provided to patient
☐ Not given

This allows staff to indicate the summary is completed and also whether a copy will be given to patient. Once complete when previewing the summary it shows as 'Finalised':

The screenshot shows the 'Depart Process' window. On the left, under 'Templates: ED GP Letter', a list of forms is shown with checkboxes. 'ED Confirm Final Discharge Summary Form' is checked and highlighted with a red box. The main area displays the 'Final Emergency Department Discharge Summary' form. The header includes 'Milton Keynes University Hospital' and 'NHS Foundation Trust'. Below this, it lists 'Standing Way', 'Milton Keynes', 'Buckinghamshire', 'MK6 5LD', and 'Emergency Department'. It also shows 'Direct Line: 01908 660033', 'Clinical Director: [redacted]', 'Matron: [redacted]', and 'Date: 18/Sep/2025 21:49:07'. A large black redaction box covers the bottom half of the form content.

In the 'DEPART' tool there is a 'Print' button and an in-progress discharge summary could be printed from here if required prior to actual discharge but should not routinely be needed and would quite likely be incomplete and /or subject to change. The same tool can be used to generate a 'Pharmacy Discharge Summary' which ED nursing staff or pharmacy staff need if medication to take home is being prescribed – it can only be printed from here, hence the need for a print button.

Once the patient is admitted or discharged the appropriate option is chosen from the DEPART tool:

The screenshot shows the 'Depart Process' window with the 'Templates' dropdown set to 'Pharmacy Discharge Summary.txt'. The list of forms on the left is the same as in the previous screenshot, but 'ED Confirm Final Discharge Summary Form' is now highlighted with a red box. The main area is mostly blank, with a 'Clinical' tab visible on the right.

If 'Discharge' is selected the following window opens with various mandatory fields to enter with the remaining discharge details, on completion and signing the patient will be discharged from the system and disappear from 'Launchpoint' – essentially the dashboard

view of all the patients in ED. This is the 'Discharge conversation' window and staff completing shouldn't be in any doubt they are discharging the patient. e.g.

The 'Discharge' form includes the following sections and fields:

- MRN:** 907256
- NHS Number:** - -
- NHS No Status:** (dropdown)
- Encounter Type:** Emergency Department
- Financial Number:** (redacted)
- Name:** (redacted)
- DOB:** (redacted)
- Age:** (redacted)
- Gender:** (redacted)
- Building:** GH
- Department/Ward:** RD8-GH ED
- *Lead Clinician:** (redacted)
- Treatment Function:** Accident and Emergency
- *Discharge Method:** (dropdown)
- *Discharge Destination:** (dropdown)
- Discharge to Location Code:** (dropdown)
- *Discharge Follow Up:** (dropdown)
- Comment/Discharged To:** (text area)
- *Admission Offer Outcome:** (dropdown)
- RTT Status:** (dropdown)
- Deceased Info:** (checkbox)
- Discharge Info:**
 - *Discharge Date:** (calendar)
 - *Discharge Time:** (time picker)
 - Delayed Discharge Reason:** (dropdown)
 - User ID:** 019729050039
- *Discharging Staff Member:** (dropdown)

It is at this point that the document titled 'Emergency Department GP Letters' is created and stored in the record – it can be printed if required
Looking in the 'Documentation' section following this the following are seen:

Service Date/Time	Subject	Type	Facility	Author; Contributor(s)	Status	Diagn
18/Sep/2025 22:07:18 BST	Emergency Department GP Letters	Emergency Department GP Letters	RD8-GH	(redacted)	Auth (Verified)	
18/Sep/2025 21:46:00 BST	ED Confirm Final Discharge Summary Form	Emergency Department Other Letter	RD8-GH	(redacted)	Auth (Verified)	
18/Sep/2025 21:42:00 BST	ED Discharge Information Form	Emergency Department Other Letter	RD8-GH	(redacted)	Auth (Verified)	
18/Sep/2025 21:41:00 BST	Discharge Checklist	Discharge Checklist Forms	RD8-GH	(redacted)	Auth (Verified)	
18/Sep/2025 21:40:00 BST	ED Treatment Form	Accident and Emergency Forms	RD8-GH	(redacted)	Auth (Verified)	

The final document 'Emergency Department GP Letters' is the actual discharge summary, also sent to GP and to Patient portal. The earlier four documents are each of the text rendered forms completed as part of the 'DEPART' process. The forms themselves are stored in 'Form Browser' in eCare but these do not pull into the medical record when extracts are prepared for Subject Access requests, Coroners Reports etc, instead the information they contain is in these text-rendered documents.

Although the information they contain is repeated in the final overall discharge summary, in circumstances where that was never created (for whatever reason) then the information on any completed component forms would be missing from the record.

The DEPART tool is one of the older sections of Oracle Cerner Millenium and is gradually being replaced by a Dynamic Documentation workflow. Similar workflows are currently in use for inpatients and outpatients and consist of workflow views from which users create a variety of notes. The first area in the Trust to use the newer discharge workflow is the Same Day Emergency Care (SDEC) department. Like ED they also use Firstnet so most other aspects of their workflow are very similar to ED; this went live in January 2025.

If a similar patient were in SDEC this would be the working view:

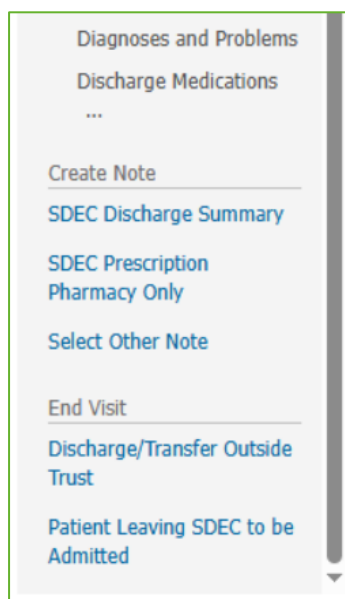
The screenshot displays the SDEC Clinical Notes interface. The left sidebar contains a menu with various clinical note types. The main area shows a list of documents (7) with columns for Time of Service, Subject, Note Type, Author, Last Updated, and Last Updated By. Below this, the SDEC Treatment Form (5) is shown, which includes a table of results (4) and a table of forms (1).

Time of Service	Subject	Note Type	Author	Last Updated	Last Updated By
18 SEP 2025 22:23	SDEC Treatment Form	SDEC Treatment Form - Text		18 SEP 2025 22:23	
18 SEP 2025 22:22	SDEC Definitive Assessment	SDEC Definitive Assessment		18 SEP 2025 22:22	
18 SEP 2025 22:07	Emergency Department GP Lett...	Emergency Department GP Lett...		18 SEP 2025 22:07	
18 SEP 2025 21:46	ED Confirm Final Discharge Su...	Emergency Department Other L...		18 SEP 2025 21:46	
18 SEP 2025 21:42	ED Discharge Information Form	Emergency Department Other L...		18 SEP 2025 21:42	
18 SEP 2025 21:41	Discharge Checklist	Discharge Checklist Forms		18 SEP 2025 21:41	
18 SEP 2025 21:40	ED Treatment Form	Accident and Emergency Forms		18 SEP 2025 21:40	

Result/Form Name	Result	Author	Date/Time
AETI Discharge20	Oral Medications		18 SEP 2025 22:23
AETI Discharge02	Vital Signs		18 SEP 2025 22:23
AETI Discharge08	Advice - Verbal		18 SEP 2025 22:23
AETI Discharge24	Prescription FP10		18 SEP 2025 22:23

Form	Date/Time
SDEC Treatment Form	18 SEP 2025 22:23

In the Discharge workflow page mandatory sections are indicated with a red star if incomplete or a green tick if completed; at the point of discharge when ready to complete the discharge summary one must 'create' SDEC Discharge summary, this then brings a preview which one can still edit and then sign, it then exists as a note and can be printed if required.



To discharge the encounter or admit the patient one can separately select options to 'end visit, the resulting window that opens to collect final discharge details is the same as in ED. In SDEC each form still text renders for the same reasons, the naming of the resultant documents is perhaps clearer and there are slightly fewer than the current ED workflow.

Documentation					
+ Add Submit Forward Modify In Error Preview					
List					
Display: All Advanced Filters					
Service Date/Time	Subject	Type	Facility	Author; Contributor(s)	Status
18/Sep/2025 22:27:12 BST	SDEC Discharge Summary	SDEC Discharge Summary	RD8-GH		Auth
18/Sep/2025 22:26:00 BST	SDEC Discharge Information	SDEC Discharge Information Form - Text	RD8-GH		Auth
18/Sep/2025 22:23:00 BST	SDEC Treatment Form	SDEC Treatment Form - Text	RD8-GH		Auth
18/Sep/2025 22:22:02 BST	SDEC Definitive Assessment	SDEC Definitive Assessment	RD8-GH		Auth

In both SDEC and ED, but ED especially, patients may be discharged without all details of the discharge summary being completed, in such cases a different workflow allows the patient to be discharged from ED but to go onto a 'Missing Documentation' list so the discharge summary can be completed when time allows.

Discharge summaries are also created in eCare for inpatients (adult and paediatric), day-cases and maternity cases. All currently use the older DEPART tool but the creation of the discharge summary and discharging of the patient from the system are carried out separately. Overtime we would expect all areas to migrate onto the newer Discharge Workflow mPage and associated Dynamic Documentation.

With the exception of SDEC the discharge summary, processes have not changed materially since the Trust went live with eCare in 2018.

The system workflows are somewhat challenging to set out in writing. Training and awareness on how the system must be used will continue – for the discharge process in ED,

aligned with the Discharge Standard Operating Procedure and the protocols for discharge with third party agency involvement (notably the police and mental health services, covered in the SOP and related operational protocols). Roll out of Dynamic Documentation to the ED will include training and awareness on discharge processes and will use this case as an illustrative learning tool.

Whilst eCARE workflows gives structure to a process to ensure consistency in discharge, human override and miscommunication remain potential risks. In mitigation, having learnt from Brian's death, staff in ED are acutely aware of the necessity of following our Trust processes, and our new suite of documentation supports and cements this.

3. Inadequate Discharge Review Process

The decision on whether patients should have a final review by doctors before formal medical discharge is reportedly scheduled to be made by a committee by June 2025. Given that four years had already passed since Brian's death at the time of Inquest, this timeline for implementing such a critical safety measure is unreasonably prolonged and, in my view, cannot be supported. An immediate decision by the clinical director should have been made to institute final medical reviews before discharge.

I would like to address the reference to the timeline for making a safety decision, as described above, relating to discharge. As you are aware, the Emergency Department discharges more than 100,000 patients annually, with regulated professionals working within their professional scope and competencies to provide care along the patient pathway to discharge. The Trust has an established Discharge Policy, which has been in place for many years.

In the course of investigating Brian's death and preparing for the inquest, the decision-making, documentation and processes surrounding his discharge were an area of focus for the Trust in the context of the individual decision making and the actions and inactions of the healthcare professionals involved in his care. To be plain, the omissions were felt to be particular to this case and not a systemic issue requiring a change in wider policy and practice. The forensic level of examination of this issue at inquest enabled the Trust to reflect further on this and to consider whether wider change was in fact necessary to improve safety and make professional expectations explicit in a local context. To that end, the Emergency Department has developed and implemented a Standard Operating Procedure for the discharge of adult patients. This is appended at Appendix 2.

Linked to point two, this SOP will be reviewed when Dynamic Documentation is rolled out in ED to ensure both are aligned.

Particularly relevant extracts from the SOP are included below for ease of reference:

1.0 Roles and Responsibilities:

1.1 ED Clinicians

The responsibility for documenting that a patient is medically fit for discharge rests with the ED clinician who conducted the initial assessment and reviewed all relevant investigations. In cases involving suspected overdose, the clinician must document and adhere to the guidance provided by Toxbase. If the original assessing clinician is no longer available, the responsibility for confirming medical fitness for discharge passes to the clinician to whom the

case has been formally handed over, or to the Emergency Physician in Charge (EPIC).

1.2 ED Nursing Staff

Are responsible that a clear discharge plan is in place. They must ensure the patient receives any required take-home medications (TTOs), along with a discharge summary, as appropriate, that includes safety netting advice and details of any necessary follow-up.

1.3 Mental Health Liaison Team

Should respond within one hour of referral from the ED for urgent mental health assessments; conduct a full mental health and risk assessment; work collaboratively with ED clinicians in the decision to admit, refer, or discharge patients with mental health concerns; and document their findings in a timely manner.

3.0 Discharge Processes and Procedures:

3.1 Minimum Documentation Requirements

All discharge summaries must include:

- Presenting complaint
- Summary of history and clinical findings
- Investigations performed and key results
- Diagnosis (working or confirmed)
- Treatment provided in ED
- Follow-up arrangements (including who is responsible)
- Clear safety netting advice
- Mental Capacity assessment (if relevant)
- Interpreter involvement (if required)

3.2 Special Considerations

- **Mental Health Patients:**
 - Must have a documented Mental Health Liaison Team (MHLT) assessment or clear reasoning why referral was not required.
 - Risk assessment must be completed.
 - Follow-up and safety netting should include mental health crisis contacts.
 - The final discharge decision should be made jointly by the Emergency Department (ED) clinician and the Mental Health Liaison Team (MHLT). A clear rationale for the discharge must be documented in the patient's notes and electronic record. The patient should be given the opportunity to ask questions, and all relevant documentation must be completed before discharge.
- **Patients Under Police Custody:**
 - Refer to the MKUH SOP titled Patients in Police Custody (referenced below).
 - Confirm mental capacity and document any assessment regarding fitness for custody.
- **Patients Discharged Against Medical Advice (DAMA):**
 - Mental capacity must be clearly documented.
 - Detail discussion of risks, advice given, and patient's decision.
- **Vulnerable Adults (e.g. elderly, learning disability, substance misuse):**

- Consider safeguarding concerns.
- Liaise with community services or GP if necessary.

3.3 Safety Netting

All discharged patients must receive:

- Advice on when to return (e.g. red flag symptoms)
- Contact points (e.g. 111, GP, crisis line)
- Written discharge summary (or digital equivalent)

3.4 Standardised Discharge Statements for Clinical Notes:

For patients presenting with mental health needs who required medical assessment:
“Patient medically assessed and deemed fit for discharge. Cleared by MHLT – Discharged home.”

For patients presenting with mental health needs not requiring medical assessment:
“Mental health assessment completed – no medical concerns identified. Cleared by MHLT – Discharged home.”

For patients presenting with non-mental health conditions:
“Medically fit for discharge – Discharged home.”

4. Ambiguous discharge process

The ED doctor’s plan for discharge was vague (“more awake”), not aligned with ToxBase guidance, and not clearly documented and not clearly communicated. The ED doctor told the jury that he did not assess or intend that Brian was fit for discharge at the time he was removed from the ED. I note however that when Brian was being removed he did not intervene or seek to prevent it.

This is addressed in the Emergency Department SOP for the discharge of adult patients described above and appended at Appendix 2. The individuals involved in this case have reflected at great length about their actions and inactions. Brian’s death was a seminal event for the Trust and learning from it has been widely shared within the Emergency Department. Further learning events using Brian’s case (anonymised) will continue in the Emergency Department, both to raise awareness of risk of unclear documentation and communication, and to ensure that there is an enduring legacy of improvement following Brian’s death.

5. Unsafe supervision

There were a number of senior clinicians and nursing staff present and seen to be watching the restraint of Brian. None of those senior individuals asserted their authority and made enquiry or intervened.

As described above, Brian’s death has resulted in deep reflection by individuals, within the Emergency Department and across the Trust, with continued awareness-raising and learning.

The Trust’s Restraint and Restrictive Practices policy has been re-drafted post the inquest (appended at Appendix 3) to incorporate Emergency Department specific guidelines (NICE NG10) and to make the roles and responsibilities of healthcare staff during any restraint unambiguously clear. The Trust’s training programme on restraint and restrictive practices for clinical staff is being reviewed under the new draft policy (Appendix 3). Breakaway and

conflict resolution training remains mandated for Emergency Department staff and security officers receive bespoke training to their roles.

Every incident of restraint is reported on the Trust's incident system, Radar. Incidents of restraint by the police have been reported, and include instances where healthcare staff in the Emergency Department have intervened to raise concerns about the safety and welfare of the patients, and have appropriately escalated through professional management structures to seek immediate support.

6. Premature Discharge

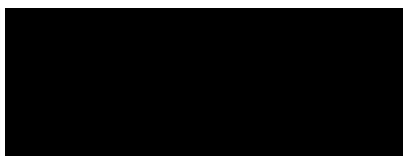
Brian was not medically fit for discharge (still symptomatic, GCS still not recovered, ECG not done as required, Toxbase recommendations not followed)

Brian should not have been discharged. This is accepted and actions described above have been taken to mitigate the risk of a similar event occurring again. Toxbase guidelines have been reiterated to all Emergency Department clinicians, with a quick guide available on the Radar documentation system.

A recent audit on discharge compliance is included at Appendix 4 for information and assurance.

Thank you for the opportunity to demonstrate continuing improvements and learning from this case. I hope this response provides you with assurance of both what is already in place and our ongoing commitment to improvement. We will happily share further updates and information on any area explored in the Regulation 28 Report or meet with you to provide further detail or clarification if required.

Yours sincerely,



Chief Executive Officer