HMAC Ms Caroline Topping
Assistant Coroner
Surrey

Group Chief Executive's Office

9 December 2025

Dear Ms Topping

Ms Tracey Ostler (Deceased)
Response to Regulation 28 Report to Prevent Future Deaths

This letter comprises of the formal response of Epsom and St Helier University Hospitals NHS Trust ('the Trust') to the issues raised in the Regulation 28 Report to Prevent Future Deaths, dated 7 August 2025 ('the Report'), made after the inquest into the death of Ms Tracey Ostler. The inquest was opened on 24 August 2023, with a hearing held at Surrey Coroner's Court on 25 April 2025 to 2 May 2025 before HM Assistant Coroner, Caroline Topping. The inquest concluded on 23 May 2025.

The Trust would like to express its deepest sympathy and condolences to Ms Ostler's family.

This response addresses the concerns within the PFD report relating to the Trust.

Medical cause of death was found to be:

1a. Multiple Organ Failure
1b. Paracetamol Toxicity
II. Emotionally Unstable Personality Disorder

The Report raises the following concerns addressed to Epsom General Hospital, Surrey and Borders Partnership, South West London Integrated Care Board and the Secretary of State for Health and Social Care:

"Lack of Psychiatric Hospital Beds in Surrey and arrangements for detaining patients assessed to require Mental Health Act section in the Emergency Department of Epsom General Hospital."

1. *I heard evidence that there is an acknowledged concern in Epsom General Hospital's emergency department that patients with psychiatric presentations, who are assessed to require compulsory admission under the Mental Health Act 1983, are detained without being under section in the emergency department awaiting psychiatric beds. The longest wait by such a patient in these circumstances has been 6 weeks. There have been up to 10 psychiatric patients at any one time being held in the emergency department awaiting a psychiatric*

bed.

2. *I remain concerned that there is no plan to stop this practice and that therefore:*

   a.) *Psychiatric patients in an acute state are being held in an unsuitable environment without access to appropriate ward based care under a multi-disciplinary psychiatric team.*
   b.) *One to one nursing is meant to be provided by mental health nurses however, they are not always available and emergency department staff who are not trained in mental health nursing provide the nursing to them. This reduces the number of nurses available for physical health care nursing and means nurses from the wrong discipline and experience are caring for acute psychiatric patients.*
   c.) *The emergency department environment is noisy and confusing and inimical to the health and recovery of psychiatric patients.*
   d.) *The patients cannot be detained under the Mental Health Act 1983 whilst in the emergency department. There is a significant risk that some of them are being detained unlawfully, without recourse to the legal safeguards provided by the Mental Health Act 1983. In addition, they do not have a Responsible Clinician.*
   e.) *Medical staff make decisions about how to prevent these patients leaving the department if they decide to leave, instructing security staff to prevent this, using powers said to derive under common law which I was told was a grey area.*
   f.) *The ability of the emergency department to fulfil the needs of their physically ill patients is significantly compromised by this arrangement.*
   g.) *There is an acknowledged risk that psychiatric patents being cared for in the emergency department are under the care of both medical and psychiatric teams which can impact decision making and obscure who has ultimate responsibility for the patient.*

NHS Surrey Heartlands ICB ('**the ICB'**) is the responsible ICB for the geographical area in which the Trust sits. It is responsible for commissioning the mental health care provision for the population within its geographical area.

Epsom and St Helier University Hospitals NHS Trust is an acute trust, offering inpatient physical healthcare services at Epsom Hospital and St Helier Hospital. For patients within our locality, mental health services are provided by Surrey and Borders Partnership NHS Foundation Trust ('**SABP'**). Whilst we are not commissioned to provide care for patients who do not have physical health needs, we acknowledge and are mindful of the situation that is faced across the country where the demand for mental health services far exceeds the availability. We work collaboratively with our partners in SABP to provide care for patients whilst they remain in the Trust. I welcome the opportunity to respond to your concerns on behalf of the Trust.

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2a.) Psychiatric patients in an acute state are being held in an unsuitable environment without access to appropriate ward-based multidisciplinary care

2g.) Patients are under the care of both medical and psychiatric teams, creating ambiguity over responsibility

The Trust recognises that the ED is not an appropriate or therapeutic environment for patients experiencing acute psychiatric crisis. Such patients require admission to specialist mental health facilities, where they can be supported by a multidisciplinary team in surroundings designed to promote recovery.

The high demand for psychiatric inpatient provision across Surrey (and the wider country) means that patients assessed as requiring admission often experience delays in transferring to an appropriate mental health inpatient bed. This can lead to extended stays in the ED environment.

The Trust works collaboratively with SABP to ensure that these delays are kept to a minimum. Every patient awaiting psychiatric admission is subject to daily escalation through Trust site meetings and concerns are raised with SABP and the ICB. Executive led weekly meetings between the Trust and SABP provides further oversight of plans for mental health patients at the Trust. The Trust continues to advocate for timely transfer to inpatient psychiatric units recognising that ED cannot provide the ward-based, multidisciplinary care these patients require.

When patients are jointly under the care of ED and psychiatric teams, there has historically been uncertainty over who was ultimately responsible for decision-making. This ambiguity led to risks of delays in care or important aspects of treatment being overlooked.

Given the situation the NHS currently finds itself in, where demand for mental health services exceeds availability, the Trust and SABP have worked together to ensure there is high quality of oversight where patients awaiting a mental health bed are cared for at the Trust. This is delivered through an Emergency Medicine- Medical–Psychiatry Joint Care Guideline, developed in collaboration with SABP. The guideline makes explicit the responsibilities for clinicians:

- The EM consultant retains responsibility for initial assessment, physical health care and immediate risk management.
- The Psychiatric consultant assumes responsibility for psychiatric assessment, treatment planning and mental health risk management once they are involved.
- Once the decision has been made to admit the patient under psychiatry then the Medical Team will be involved in managing the associated medical assessment of the patient. This includes drug charts, VTE assessment and daily reviews

This guidance has been widely disseminated across both Trust sites, is incorporated into the induction for senior ED staff and is kept under review in partnership with SABP. This has led to greater clarity about who should take the lead in decision-

making for patients and improved escalation processes and through a structured framework supports safer, more consistent, practice and strengthens accountability, which in turn benefits our patients.

Several additional actions have also been taken with regard to mental health patients in ED to support their needs being met and to improve quality and safety:

- All mental health patients have a registered nurse ('**RN**') allocated to them as part of their patient cohort each shift for nursing oversight of physical health.
- The ED team have introduced a specific daily morning huddle with the nurse in charge and Psychiatric Liaison Team to discuss plans for all mental health patients in the department whilst these patients remain in ED.
- ED medical care is Consultant led with daily ED Consultant review of all patients.
- Mental health support workers have been recruited, with specific training and expertise to support mental health patients
- Improved liaison through multiagency engagement meetings on takes place at both sites to review any identified issues.

2b.) One-to-one nursing is not consistently provided by mental health nurses, leading to ED staff without specialist training delivering care

The Trust's nursing and clinical teams working with the ED are not trained mental health professionals. Through working with Psychiatric Liaison Teams with this experience, training has been delivered to nursing and medical teams, to ensure our staff at the Trust are equipped with the skills to support mental health patients whilst they are at the Trust.

To provide further support for patients, the Trust has established a dedicated pool of Mental Health Support Workers ('**MHSW**'). These are Band 3 staff recruited for their mental health experience and knowledge on mental health conditions. They are trained in de-escalation, therapeutic engagement, and supporting patients with complex needs.

The introduction of MHSWs in the emergency departments at St Helier Hospital in February 2025 and Epsom Hospital in June 2025 has made a tangible difference. MHSWs provide continuity and meaningful engagement. They talk with patients, play games, watch films, or accompany them on short walks. These interactions help to calm patients, reduce agitation and create a more compassionate and humane experience. The model operates 24 hours a day and provides the expert care for patients as well as reducing the reliance on ED nurses to provide this care.

2c.) The ED environment is noisy and confusing, inimical to recovery

The Trust recognises that the ED is an inherently busy, high-stimulus environment and not a therapeutic setting for patients experiencing acute psychiatric crisis. This is a particular concern for patients who may remain in ED for extended periods while awaiting a mental health bed.

In recognition of these risks, the Trust has made practical adjustments to provide as safe and supportive an environment as possible for these patients.

Dedicated psychiatric observation rooms are available at both Epsom Hospital (two rooms) and St Helier Hospital (one room), offering a quieter, lower-stimulus setting. When these rooms are occupied, patients are accommodated in alternative areas with arrangements made to permit the safest possible observation. These areas will be dependent on the clinical risk of the patient and will be within sight of the nurses' station or other high visibility areas. To mitigate the negative impact of the ED environment, the Trust has introduced sensory kits, distraction equipment and greater therapeutic engagement through trained MHSW (as discussed above).

We also continue to raise the limitations of the ED environment through local and system governance forums and we will support the development of longer-term solutions to address the issues.

2d.) Patients cannot be detained under the Mental Health Act in ED, creating a risk of unlawful detention and absence of safeguards

2e.) Reliance on common law restraint with security staff asked to prevent patients leaving

The Trust acknowledges that patients cannot be detained under the Mental Health Act in the ED and this creates a difficult situation for patients and staff.

Whilst patients are awaiting a mental health inpatient bed, their presence in any ED is voluntary. Where they are presenting as an *immediate* risk of harm to themselves or others, common law can be relied upon to restrain a patient and prevent such immediate harm. At the Trust, such restraint is deployed as a last resort by security staff who are trained to deliver restraint safely. There remains a lacuna in the current legal framework for patients who do not fall into either of these categories.

2f.) The ability of the emergency department to fulfil the needs of their physically ill patients is significantly compromised

The Trust recognises that the number of patients with mental health diagnoses in the ED department can impact the capacity treat those with physical health conditions, particularly in majors area in ED.

To mitigate the impact of this, the following initiatives have been introduced:

- An ED risk assessment process to identify patients who require a space in majors (e.g. those requiring cardiac monitoring, close observation, or who are unable to walk or sit in a chair). Patients who do not meet these criteria are moved to the Same Day Emergency Care ('**SDEC**') area.

- Epsom ED have signed up to a national quality improvement (QI) programme as a Surrey collaborative (through the Mind and Body programme) to look at

improving flow through ED with a particular focus on high intensity users (this includes SABP, the five acute Trusts, SECAMB and Surrey County Council.)

The Trust is committed to the ongoing collaborative working with SABP and system partners to provide care to ensure that we provide a safe environment for patients who are within our hospitals with mental health. Ms Ostler's case has been a powerful driver for reflection and on behalf of the Trust I would like to extend our condolences to Ms Ostler's family

Yours sincerely,

[redacted]
Group Chief Executive Officer (Interim)
St George's, Epsom and St Helier University Hospitals and Health Group