NHS South West London
Integrated Care Board

Chief Nursing Officer's Office
NHS Southwest London Integrated Care Board
120 The Broadway
London
SW19 1RH

6th October 2025

Caroline Topping, Assistant Coroner for Surrey
Surrey Coroner's Service,
HM Coroner's Court, Station Approach,
Woking, Surrey, GU22 7AP
[redacted]

Dear Madam

Re: Regulation 28 Report to Prevent Future Deaths – Ms. Tracey Elizabeth Ostler

I am writing in response to the Regulation 28 report sent to South West London Integrated Care Board (SWL ICB) on the 7th of August 2025 regarding death of Ms. Tracey Elizabeth Ostler.

As you may be aware, as a commissioning organisation, the ICB can only comment on the commissioning and oversight of the relevant services. We cannot comment on clinical matters, which are for the relevant Trusts. Our response to the relevant sections of the report are set out below.

I can assure you that we are committed to ensuring the learning and improvements are embedded moving forward. As Ms Ostler was a Surrey resident, rather than a South West London resident, we have engaged with Surrey Heartland ICB and have been made aware that a Safeguarding Adult Review (SAR) will be led by the Surrey Safeguarding Board, which we will fully engage with.

I would like to take this opportunity to offer my sincere condolences to Ms. Ostler's family, friends and those who knew her. We acknowledge and welcome the findings of the inquest and recognize that some of the care that Ms. Ostler received fell below the standards we would expect, and for this I am sincerely sorry.

I understand that one of our commissioned provider organisations, Epsom and St Helier University Hospitals NHS Trust, has requested an extension to submit their response. Should any further clarification be required following the receipt of their submission, the ICB would be pleased to provide any additional information necessary.

Sincerely

[redacted]

Acting Chief Nursing Officer
Southwest London ICB

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Matter of Concerns (Regulation 28 notice section referencing the ICB)

I therefore remain concerned as follows:

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,

Addressed to Epsom General Hospital, Surrey and Borders Partnership, Southwest London Integrated Care Board and the Secretary of State for Health and Social Care

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.

   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.

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Southwest London Integrated Care Board – Response

Psychiatric beds for patients who require inpatient care and present at the emergency department at Epsom General Hospital (EGH) are commissioned separately depending on GP registration. SW London patients are admitted to South West London & St George's NHS Mental Health Trust (SWLStG), commissioned by SW London ICB. Surrey patients are admitted to Surrey and Borders Partnership NHS Foundation Trust (SABP), commissioned by Surrey Heartlands ICB.

SW London ICB recognises the demands and pressures on acute mental health inpatient beds and the impact on delays at emergency departments. There are a range of reasons for the pressures across the system including increased demand, increased acuity of patients and delays caused by people who are clinically ready for discharge but are delayed accessing their onward accommodation.

The cross-boundary arrangement at EGH requires coordination between the two mental health providers (SABP and SWLStG) and the two commissioners (SW London ICB and Surrey & Borders ICB). Routine actions underway include regular system calls and agreed escalation arrangements between EGH and mental health providers.

SW London works closely with SWLSTG to address delays in the urgent care pathway and minimise delays in access to beds. This work is focused on both improving the inpatient pathway and maximising use of crisis alternatives where appropriate and able to meet patient needs. Such services include the 24/7 crisis lines, '111 press 2 for mental health service', community-based crisis cafés, and Home Treatment Teams.

In October 2025, SW London ICB and SWLSTG are due to commence a major piece of service development work, in conjunction with the national NHS England "Mental Health Improvement Support Team", to undertake a comprehensive self-assessment using the UEC Mental Health Services Assessment Tool (Men-SAT).

The outputs of this work will identify gaps within current pathways and support future commissioning plans, including winter planning. It will also provide tailored improvement plans aimed at enhancing mental healthcare delivery within SWLSTG and reducing demand and delays in emergency departments across SW London.