NHS
Surrey and Borders Partnership
NHS Foundation Trust

1 October 2025

[redacted]
Chief Executive

Chief Executive's Office
Surrey and Borders Partnership NHS Foundation Trust
18 Mole Business Park
Randall's Road
Leatherhead
KT22 7AD

Ms Caroline Topping
HM Assistant Coroner
Surrey Coroner's Court

Sent by email: [redacted]

Dear Ms Topping

Tracey Ostler (deceased)
Regulation 28 Report to Prevent Future Deaths
Response from Surrey and Borders Partnership NHS Foundation Trust ("the Trust")

Thank you for the Regulation 28 Report to Prevent Future Deaths (PFD report) dated 8 August 2025, in relation to the inquest touching upon the death of Tracey Ostler. I have considered the report carefully, together with the Trust's Chief Medical Officer, the Chief Nursing Officer and other senior colleagues.

I have addressed the two concerns contained within the PFD report relating to the Trust.

Lack of Inpatient Mental Health Beds

You have raised concerns about the lack of mental health inpatient beds in Surrey, and the arrangements for patients who are assessed as requiring detention under the Mental Health Act in the Emergency Department of Epsom General Hospital.

The demand for mental health inpatient beds continues to outweigh availability at a national level. The need for improvement in patient flow through mental health crisis and acute pathways is recognised in NHS England's national priorities for 2025/26. Through the Mental Health Investment Standard, NHS England requires Integrated Care Boards ("ICB") to invest in mental health in line with their overall increase in baseline allocation. I welcome that your PFD report has also been sent to the Secretary of State for Health and he will have an opportunity to address this within his response.

The Trust has taken steps to mitigate the demand for beds at a local level, including by embedding Operational Pressures Escalation Levels (OPEL) procedures into practice, recent investment in an increased number of funded beds for the Trust's population, and improvement work aimed at reducing the length of inpatient stay.

Further improvement work continues through the Mind and Body Provider Collaborative, which is a programme of work chaired by our Chief Nursing Officer and undertaken with our acute care partners.

The programme embeds clear clinical frameworks to operate within for our acute partners, escalation protocols and risk management frameworks to ensure lawful, timely escalation including by way of detention under the Mental Health Act to an acute hospital bed. During any period of detention on an acute ward, Psychiatric Liaison services provide mental health care by way of a High Risk Care Plan.

A person can only be detained once admitted to an acute hospital bed. While the Trust's position is that steps should be taken to ensure an appropriate legal framework, the decision to detain to an acute hospital bed lies with the management of the acute hospital. This is not an issue unique to Surrey; one of the proposed amendments to the Mental Health Bill was to allow people to be detained in emergency departments in recognition of the current gap in legislation.

There is ongoing collaboration through the Mind and Body programme between the Trust and Epsom & St Helier University Hospitals NHS Trust ("Epsom"). A Mental Health Lead has been recruited at Epsom General Hospital and representatives from Epsom attend regular system calls for Surrey Heartlands ICB. Both Trusts remain committed to working collaboratively, together with other system partners and senior oversight, to provide appropriate care to those awaiting inpatient mental health beds in an acute hospital setting.

In addition, there is an ongoing programme of work aimed at improving the flow through our services and aligning our operational processes. We now have alternative crisis beds at the Retreat which we fully utilise for those who do not need detention under the Mental Health Act or admission to an inpatient mental health ward. We continue to focus on reducing the length of stay by working with partners so that people are not unnecessarily delayed in hospital. The latest national data available from May 2025, indicates we now benchmark nationally at the median for the percentage of patients with a length of stay over 60 days.

Multi Agency Safeguarding Plans

Your PFD report also outlines that the expert consultant psychiatrist gave evidence about a joint plan between organisations for use in emergency situations. You raise concerns that there is no related protocol between the Trust and SECAMB.

The use of the Healthcare Professionals Line (HCPL) is crucial in ensuring appropriate and safe multi agency decision making. A joint plan, prepared at an earlier juncture, cannot be relied upon to enable the ambulance service, or other professionals, to make decisions in emergency or crisis situations.

Contemporaneous, situation specific information is necessary to enable safe and appropriate decision making. Previously prepared joint plans cannot take into account any new or emerging information, including relating to risk, that was not known at the time it was produced. It is absolutely crucial that decisions are made in the context of the situation as it presents with the benefit of the most current information available. The Trust's expectation is that our emergency care partners, including SECAMB, contact the Healthcare Professionals Line, which is available to healthcare professionals 24 hours a day, 7 days a week. This promotes safe and appropriate decision making including in relation to capacity to make decisions about mental health care and treatment.

We are aware that South East Coast Ambulance Service (SECAMB) has recently approved a written protocol relating to mental capacity and suicidality which provides that the HCPL should be consulted when safety planning for patients in Surrey. The Trust has seen an overall increase in the number of calls from ambulance staff in recent months, from 52 calls in April 2025 to 105 in August 2025. A weekly operational meeting is held between the two trusts to discuss processes and resolve any issues that may arise.

The Trust is committed to continuing to work with SECAMB, and our other system partners, to ensure that the care and treatment that we deliver includes timely and safe joint decision making. I hope that

this response provides assurance to you and Ms Ostler's family that we have carefully reflected on your concerns and our processes.

On behalf of the Trust, I would like to offer our sincere condolences to Ms Ostler's family for their loss.

Yours sincerely,

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Chief Executive