Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Central North West London NHS Foundation Trust** **2 Milton Keynes University Hospital Litigation** **3 Thames Valley Police**
1	**CORONER** I am Sean CUMMINGS, Assistant Coroner for the coroner area of Milton Keynes
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 12 February 2021 I commenced an investigation into the death of Brian Thomas RINGROSE aged 24. The investigation concluded at the end of the inquest on 24 April 2025. The conclusion of the inquest was: Unlawful killing
4	**CIRCUMSTANCES OF THE DEATH** On 27 January 2021, at approximately 9:00, Thames Valley Police officers were called to a domestic incident at a Travelodge involving Mr. Ringrose and his partner. Mr. Ringrose was placed under lawful arrest after having taken an overdose of his prescribed medications (lamotrigine and quetiapine). Mr. Ringrose was exhibiting symptoms of overdose including alternating between reduced consciousness and intermittent agitation, which were observed by the arresting officers and later by paramedics. While waiting for paramedics, Mr. Ringrose fell from a seated position on stairs and hit his head. Mr. Ringrose was taken by ambulance to Milton Keynes University Hospital Emergency Department, accompanied by an arresting officer, arriving at approximately 10:00. On arrival, his Glasgow Coma Scale score was recorded as 3. Despite medical guidance stating Mr. Ringrose should remain in the ED for 6-12 hours and should only be discharged once he had a high level of alertness, was able to walk and hold a

	conversation, had a GCS of 15, and had a repeat ECG, Mr. Ringrose was incorrectly perceived to be medically cleared for discharge while still exhibiting symptoms of overdose. During his time in the ED, Mr. Ringrose was subjected to a prolonged prone restraint by police officers that began at approximately 15:25. The restraint included: Elevation of Mr. Ringrose's arms to extreme positions (at times between 90 and 180 degrees) Being dragged across the floor by his arms Continued restraint in a prone position even when opportunities arose to move him onto his side Failure by officers to monitor his welfare appropriately At approximately 15:45, additional police officers arrived to transport Mr. Ringrose to custody. None of these officers questioned the length or manner of the restraint, nor did they make attempts to assess and monitor Mr. Ringrose's welfare. Mr. Ringrose was placed in a police van at approximately 15:53, by which point his condition had already severely deteriorated. CPR was commenced shortly afterward when an officer noticed his condition, but resuscitation efforts were unsuccessful. Mr. Ringrose was transferred to the Intensive Therapy Unit where he died on 2 February 2021. The cause of death was determined to be hypoxic ischemic brain injury caused by cardiorespiratory arrest resulting from prolonged restraint and struggle in the prone position with the arms in an abnormal position.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) **<u>Thames Valley Police</u>** **Inadequate application of police restraint training** The evidence demonstrated that the officers who initially restrained Mr. Ringrose failed to follow their training in multiple critical respects: a) Officers maintained Mr. Ringrose in a prone position for a prolonged period (over 20 minutes with only a brief interruption) despite training that warns of the dangers of positional asphyxia in a restrained prone position. b) Officers positioned Mr. Ringrose's arms in extreme and abnormal positions (between 90-180 degrees) while handcuffed behind his back, causing severe shoulder injuries including torn ligaments, muscles, and deep internal bruising. c) Officers failed to place Mr. Ringrose on his side as soon as practicable after handcuffing and applying leg restraints, contrary to their training. There were opportunities when this could have been done. d) One officer inappropriately dragged Mr. Ringrose by his arms across the floor without informing the other officer or Mr. Ringrose he was about to do so despite being within a few

feet only of both, causing significant pain to Brian.

Failure to apply the National Decision Model

Officers failed to apply the National Decision Model to reassess their actions during the restraint, particularly:

a) When Mr. Ringrose was briefly on his side or back at around 15:31 and had become calmer, officers returned him to the prone position without reasonable justification.

b) When hospital security staff arrived at approximately 15:35, providing an opportunity to reassess the situation, appoint a safety officer, and move Mr. Ringrose to his side, the officers failed to do so.

Ineffective welfare monitoring

The officers failed to adequately monitor Mr. Ringrose's welfare during restraint:

a) Officers did not appropriately listen to, interpret, or react to Mr. Ringrose's breathing despite their close proximity, instead attributing his deteriorating condition to purposeful actions.

b) Officers failed to check that Mr. Ringrose's airways were clear or monitor his breathing rate, despite their training to monitor the welfare of anyone in police custody without relying on medical professionals.

c) Officers failed to voice concerns about Mr. Ringrose's changing pallor, which progressed from extremely pale to blue, red, and even purple.

Failure of officers to "speak up and speak out"

The officers failed to challenge inappropriate restraint techniques:

a) None of the officers present, including those who arrived later, questioned the circumstances, duration, or manner of the restraint, despite police training requiring officers to "speak up and speak out."

b) No officer raised concerns about the extreme position of Mr. Ringrose's arms or the prolonged prone restraint, despite this clearly contravening their training on positional asphyxia risks.

c) No officer sought advice on Mr Ringrose’s clinical condition from the many clinical staff who were stood around watching the event.

Inadequate communication and handover

There were significant failures in communication between officers:

a) When additional officers arrived to transport Mr. Ringrose, the initial restraining officers did not inform them of how long Mr. Ringrose had been restrained in the prone position or that his arms had been elevated and the arriving officers were passive in not making any enquiry as to that.

b) Officers relied on the passive inaction of hospital staff who were stood about watching, rather than actively requesting them to assess Mr. Ringrose's condition.

Inappropriate prioritisation of transport over welfare

After the arrival of additional officers at approximately 15:45:

a) All officers became primarily focused on applying the Flexible Lift and Carry System (FLACS) and transporting Mr. Ringrose to police custody rather than monitoring his welfare.

b) During the ongoing restraint and application of the FLACS, none of the officers monitored Mr. Ringrose's welfare instead focussing on how to apply a device none had adequate experience of.

Central and Northwest London NHS Foundation Trust

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 Ringrose.
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.

Milton Keynes University Hospital NHS Foundation Trust

a) **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.
b) **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.
c) **Unsafe Form Design:** The process of generating discharge forms and additional notes requires staff to advance through a structure that may include boxes not meant to be ticked but none the less resulting in production of a document purporting to be a "Discharge Notice" which the police then understandably but erroneously relied on. This poses a risk to patient safety through potential misunderstanding of care requirements.
d) **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.
e) **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. f) **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. g) **Premature Discharge**: Brian was not medically fit for discharge (still symptomatic, GCS still not recovered, ECG not done as required, Toxbase recommendations not followed)
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by September 26th 2025. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons Family of Mr Ringrose and their legal team [redacted] and his legal team [redacted] and his legal team Thames Valley Police Federation [redacted] who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response about the release or the publication of your response by the Chief Coroner.
9	**Dated: 01/08/2025**

	Sean CUMMINGS **Assistant Coroner for** **Milton Keynes**