	REGULATION 28 REPORT TO PREVENT **FUTURE DEATHSTHIS REPORT IS BEING SENT** **TO:** **1. [redacted], Secretary of State for Health and Social Care** **2. [redacted], Chair of the Health Services Safety Investigations Board** **3. [redacted], Chair of South West London Integrated Care Board** **4. [redacted], Chief Executive Officer of Health and Care Professionals Council** **5. [redacted], Chief Executive Epsom General Hospital** **6. [redacted], Chief Executive, South East Coast Ambulance Service** **7. [redacted], Chief Executive Officer Surrey and Borders NHS Foundation Trust**
1	**CORONER** I am Caroline Topping Assistant Coroner, for the coroner area of Surrey.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** An inquest into the death of Tracey Ostler was opened on the 24th August 2023 and resumed on the 25th April 2025. The inquest was concluded on the 23rd May 2025. Ms Ostler died on the 18th June 2023 at St Helier's Hospital, Carshalton and the medical cause of his death was: 1a. Multiple Organ Failure 1b. [redacted] Toxicity II. Emotionally Unstable Personality Disorder The narrative conclusion was that: 1. There were failings in the care given to Tracey Ostler as follows: 2. The Surrey and Borders Partnership and the South East Coast Ambulance Services failed to ensure Ms Ostler's safety in the community by:

a.) Failing to liaise and have in place a plan to ensure that front line staff knew:
    i.) that she had a severe Emotionally Unstable Personality Disorder
    ii.) how that impacted on her behaviours and that impacted on her ability to make decisions.
    iii.) who to contact in an emergency
    iv.) who to consult when deciding if Ms Ostler had capacity to refuse hospital treatment in life threatening circumstances.

3. The paramedics who attended Ms Ostler on the 16th June 2023 failed:

    i.) to undertake an adequate capacity assessment
    ii.) to comply with the policy that advised them to make collaborative decisions in life threatening circumstances
    iii.) to seek clinical advice before concluding that Ms Ostler had capacity to refuse hospital admission
    iv.) to advise either the mental health teams or Epsom General Hospital that they were leaving Ms Ostler in a life-threatening position.

4. Insufficiency of mental health beds available to the Surrey and Borders Partnership more than minimally contributed to Ms Ostler's death.

5. There were missed opportunities to ensure that Ms Ostler was conveyed to hospital on the 16th June 2023 due to:

    a.) failures of communication between:

        i.) the paramedics and the mental health teams.
        ii.) the community mental health team and the home treatment team.

    b.) a lack of enquiry as to her whereabouts when she failed to answer a call from her care coordinator at 16.12 on the 16th June 2023.

6. Ms Ostler died as a result of a self-inflicted act, her intention cannot be determined.

SYSTEM FAILURE
The death was caused or more than minimally contributed to by a systemic failure which led to a lack of communication and information sharing between mental health and ambulance services and, as a consequence, there was a failure to provide Ms Ostler with lifesaving care.

4	**CIRCUMSTANCES OF THE DEATH** 1. Tracey Ostler suffered from Emotionally Unstable Personality Disorder at the severe end of the spectrum. This made her extremely emotionally dysregulated and impulsive. From 2003 onwards she presented to accident and emergency 320 times typically having self-harmed. She had taken numerous serious overdoses. She was under the care of the community mental health team and was subject to a positive risk-taking plan aimed at maintaining her in the community. Following an admission to hospital earlier in 2023 she was upset because some of her belongings were missing. This triggered a number of episodes of self-harm and overdoses. 2. On the 12th June 2023 she was taken to Epsom General Hospital having taken an overdose and cut her wrists. On the 13th June 2023 she was assessed under the Mental Health Act 1983 and recommendations were made that she be detained under s2 of the act. No mental health hospital bed was available for her, so she remained in the emergency department, nursed one to one. 3. On the 16th June 2023 she was told that her belongings had been found and were being delivered to her home. She was assessed by two consultant psychiatrists who knew her from the community and home treatment teams. They decided that her mental state was improved and agreed she go home. She remained a high risk in the community, and it was predictable that if her belongings were not returned as she hoped she would harm herself. 4. She left hospital at noon and at 13.01 rang the community team telling them her belongings had been returned damaged. At 13.08 she rang the hospital extremely upset, threatening to take an overdose. Police were called and asked to undertake a welfare check. Ms Ostler also contacted the social services mental health team. An ambulance was called. 5. The Police found Ms Ostler in bed surrounded by empty medicine packages claiming to have taken [redacted] and some [redacted]. When the paramedics arrived, Ms Ostler refused to go to hospital with them. They were unaware of her diagnosis of Emotionally Unstable Personality Disorder and had no knowledge of the effect it may have on her ability to make informed choices. They did not seek any clinical advice about her mental health. Contrary to their protocol the paramedics made the decision that she had capacity to decline hospital treatment without any clinical input. Thereafter the paramedics contacted her community mental health team for safety netting advice. They did not tell the community team they intended to leave her at home and were not told that her mental health disorder may impact on her capacity to make the decision to refuse medical treatment. The paramedics left her at home at 15.00. 6. The Home Treatment team who had care of her on the 16th June 2023 was not informed of these events. At 16.12 her care

coordinator called her to talk about the damaged belongings. Ms Ostler did not answer the phone. She assumed she was in hospital and took no further action.

7. On the 17th June 2023 Ms Ostler was found unconscious at home and taken to hospital. Despite appropriate treatment she died at St Heliers Hospital on the 18th June 2023. If she had been conveyed to hospital before 20.00 on the 16th June 2023 she would have had effective treatment for the overdose and would not have died.

CORONER'S CONCERNS

During the course of the inquest the evidence 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:

In light of the failings I identified, I invited evidence to be filed in relation to any improvements that have been put in place to ameliorate these matters.

Evidence was provided by Epsom General Hospital, Surrey and Borders Partnership Trust and South East Coast Ambulance Service.

The organisations have taken the matters that led to Ms Ostler's death seriously.

However, some of the matters I have raised have not been capable of resolution since the inquest concluded, and proposed improvements could therefore not be evidenced, although some are being planned.

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 , South West 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 in 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.

Training for Paramedics to undertake Capacity Assessments.

Addressed to the Health and Care Professionals Council and South East Coast Ambulance Service

3. I found that the paramedics who attended Ms Ostler on the 16th June 2023, and assessed her capacity to refuse lifesaving treatment after taking a serious paracetamol overdose, failed to undertake a thorough capacity assessment. In particular, they failed to assess adequately whether she had the ability to weigh up the information being given to her.

4. Ms Ostler was recorded in written evidence provided by the more senior attending paramedic who attended as saying that she would not discuss why she wanted to die. A more senior paramedic, who reviewed that evidence for the purposes of the inquest, regarded the written evidence as demonstrating that the capacity assessment had been undertaken appropriately.

5. Neither the attending paramedic nor the reviewing paramedic appreciated that unless the patient was able to tell them why she had decided that she wanted to die, that she had not demonstrated to them how she had weighed up the information available to her. Therefore, a full capacity assessment could not be completed.

6. I am concerned that the training they had received, both whilst students and subsequently, had not been adequate to equip them to undertake adequate capacity assessments.

South East Coast Ambulance Service's protocol on undertaking capacity assessments in relation to life threatening decisions.

Addressed to the South East Coast Ambulance Service

7. The Trusts policy on Mental Capacity is being reviewed to improve articulation of how to assess mental capacity in life threatening circumstances. It is not yet available. I regarded the current policy as inadequate and remain concerned about this because I have not been able to review the revised document.

Multi Agency Safeguarding Plans

Addressed to the Surrey and Borders Partnership Trust and South East Coast Ambulance Service

8. Ms Ostler suffered from a severe Emotionally Unstable Personality Disorder, this was a longstanding diagnosis, and the effects were well known to her mental health team. She was placed in the community on a Positive Risk Taking Plan. She presented a continuous and serious risk to herself in the community and was prone to impulsive acts of self harm. Ambulances were frequently required to attend her home after such acts. The disorder impacted her ability to make capacitous decisions about her own care.

9. The independent expert consultant psychiatrist called at the inquest regarded it as good practice in these circumstances to have a joint plan in place, including liaison between the ambulance service and mental health teams, for dealing with emergencies.

10. No system currently exists in Surrey to create such plans.

11. The paramedics who attended Ms Ostler on the 16th June 2023 did not know she had a diagnosis of Emotionally Unstable Personality Disorder, nor that this such a diagnosis would be likely to affect her decision-making capacity because it made her prone to be volatile and impulsive.

12. The psychiatric evidence was that she would be likely to lack capacity.

13. Paramedics assessing her lacked this vital information. In consequence, she was left at home to die.

14. I have not been provided with any Protocol between the services to ensure safety planning in these circumstances that would ensure that front line paramedics are made aware that they are dealing with a seriously unwell mental health patients who is at high risk living in the community.

15. I therefore remain concerned that such a death could occur again.

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.

6	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 2nd October 2025. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting outthe timetable for action. Otherwise, you must explain why no action is proposed.
7	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: Ms Ostler's Family Surrey Police Surrey County Counsil Adult Safeguarding Team 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 other person who I believe may find ituseful 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 usefulor of interest. You may make representations to me, the coroner, at the time of your response, aboutthe release or the publication of your response.

8	Caroline Topping, Assistant Coroner for Surrey.