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25 March 2024

Ms R Robertson
Assistant Coroner for North Wales (East and Central)
HM Coroners Office
County Hall
Wynnstay Road
Ruthin
Wales
LL15 1YN

Dear Madam

Report for the Prevention of Future Deaths (PFD)
Inquest of Philip David Taylor

I refer to the letter from Mr Gittins, HM Senior Coroner for North Wales (East and Central) enclosing your Regulation 28 report dated 2 February 2024.

This letter comprises the response on behalf of Elysium Healthcare Limited, which operates Ty Grosvenor Hospital, Wrexham where Mr Taylor was an informal patient (that is, he was not detained under the Mental Health Act (**MHA**) (and his status is of particular relevance here)).

Elysium takes inquests very seriously. These are managed by our in-house legal team (with assistance from external solicitors where appropriate) to ensure courts have all the documentation and evidence requested, and families therefore have the closure of an inquest that is as full and effective as possible. Further, we support our staff attending as witnesses and send legal representation whenever this is required. Unfortunately, I regret, for the reasons set out below, that something seems to have gone wrong in this particular instance as the inference behind and basis upon which the report has been issued does not properly reflect the factual position. For some reason, none of our staff were called to attend the

inquest, or asked in advance about these matters, and thus we were not given the opportunity to address the issues to which the PFD report refers.

I am sorry that it has thus appeared necessary to address a report to Elysium but I will deal with the matters of concern that you have raised as follows:

Not sharing information except a few telephone calls

That is not a fair reflection of the factual position. The reality is:-

1. There were three ward rounds during Mr Taylor's stay at the hospital on 31 July, 7 August and 14 August 2023. Betsi Cadwaladr University Health Board ("Betsi") were invited to all of them (via a Teams invitation) but did not attend any.

   Under the terms of the NHS Wales Framework Agreement (see further below), to which Elysium is a party, Elysium enters ward round details through the informatics system in use by NHS Wales (the Commissioning Care Assurance and Performance System or "CCAPS") live during a ward round but Betsi do not avail themselves of this facility (unlike other Welsh Commissioners) because they do not enter their patients into that electronic system. NHS Wales are frustrated by this and have apparently provided training to Betsi but, as they failed to register Mr Taylor, their lack of use of the system meant they did not have that ward round information live.

2. The third ward round took place on 14 August. Mr Taylor wished to leave. He was an informal patient. He did not meet the criteria for detention under the MHA. Nor did he lack capacity so a deprivation of liberty under the Mental Capacity Act was not available. He had to be discharged as there was accordingly no lawful basis to refuse this. It was agreed that to enable this to take place in an orderly fashion he would leave the next day. Elysium had no alternative but to proceed with this.

3. On 15 August, before Mr Taylor left the hospital, Elysium's charge nurse at Ty Grosvenor phoned the Betsi home treatment team (HTT) to inform them of the discharge. They said they would not be seeing Mr Taylor until the following day, so on the next day the hospital followed up by emailing to the HTT the requisite risk matrix and care notes. These documents would serve to provide a full brief to the HTT. No request for additional information was forthcoming from the HTT.

4. On 17 August Elysium received a telephone call from Betsi who stated they were assessing Mr Taylor at 11 o'clock that day (not the previous day as they had previously assured Elysium they would be doing). The documents referred to above had not been received so these were re-sent immediately.

5. This is, therefore, as far as Elysium is concerned, not a case where the facts suggest a risk of future deaths in relation to the role of Elysium. Mr Taylor was an informal patient and was assessed as low risk. His details were already well known to Betsi who had summarised his position when referring him to Elysium in the first place. They had been informed by

telephone of the discharge and provided with the information set out above before their post-discharge visit. There was ample time for an assessment and any intervention to take place based on the information circulated prior to the date of Mr Taylor's sad death on 23 August.

There was no joint discharge meeting.

That is factually correct but the context is important because:-

i. Betsi did not attend the multi-disciplinary team (MDT) meetings to which they were invited
ii. Betsi did not have the live ward round information because of their failure to register the patient through CCAPS
iii. Mr Taylor was a voluntary patient who wanted to leave. There was no legal basis to detain him, and therefore no basis to delay that discharge to seek to arrange a joint discharge meeting
iv. This is not a case where the facts indicate that the lack of a discharge meeting gives rise to a risk of future deaths because relevant information was passed on to Betsi, Mr Taylor was assessed as a low risk informal patient who had the right to leave anyway, and the Betsi HTT had ample time to intervene (if indeed that was necessary, foreseeable or reasonable) prior to his death.

The prescription, pre-admission and admission paperwork was only sent to Betsi after the death
and
The discharge letter was only sent after the death
This is also factually correct. However, as is apparent from what is set out above, Mr Taylor was a voluntary patient who wished to leave. There was no legal basis to detain him and his departure therefore took place quickly. There was no legal framework to insist to the contrary. Information was sent to Betsi by email and telephone as set out above.
The discharge letter was not sent at the point of discharge as this is almost always not possible except with a long-planned discharge or transfer. Discharge letters have to be prepared, typed and checked carefully before they can be sent and that almost invariably takes at least 48-72 hours. The Elysium internal policy is to ensure the relevant information is given to home teams so that they can follow up within 72 hours (as was done here). In case it is of assistance to put the issue in context, the contract we have with Surrey requires that information only within 5 days of discharge.

It was Mr Taylor's wife who informed the HTT of discharge.
This is factually incorrect. As is apparent from the information above, the HTT were informed of the discharge by telephone on 15 August before Mr Taylor left the hospital.

In addition, it should be noted that Mr Taylor was discharged with two weeks of medication to take out.

There is no standard operating procedure or agreement regarding sharing information.

This is incorrect. Following a formal procurement exercise, a framework agreement of 138 pages was put in place with Elysium for Welsh NHS patients by Velindre University NHS Trust dated 1 April 2022. Betsi is one of several Welsh Authorities that expressly have the benefit of this Framework Agreement. The agreement sets out at length at paragraph 14 and schedule 6 the information sharing requirements. It should be noted that despite the careful procurement exercise by the qualified NHS professionals who led this, there is no contractual requirement for discharge letters to be sent concurrently with the discharge of the patient.

It should also be noted that schedule 2 of the contract has a detailed service specification. At paragraph 1.4 this provides that all professionals involved in a patient's care should attend the MDT. Sadly, as is apparent from what is set out above, Betsi did not attend the three MDT meetings for Mr Taylor.

I hope that this information provides helpful background evidence to this matter which I infer was not available at the inquest. As I have indicated above, given what is set out in this letter, as far as Elysium is concerned, there is no risk of future deaths created by the processes outlined above if they are properly followed.

Yours faithfully

[redacted]

[redacted]
Chief Executive Officer
For and on behalf of Elysium Healthcare