Kate Robertson
Assistant Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Betsi Cadwaladr University Health Board Elysium Healthcare
1	**CORONER** I am Kate Robertson, Assistant Coroner for North Wales (East and Central)
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 1 September 2023 an investigation was commenced into the death of Philip David Taylor (DOB 12/6/55) who died on 23 August 2023. The investigation concluded at the end of the inquest on 30 January 2024. The conclusion of the inquest was suicide.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as follows :- Philip David Taylor had a short history of mental health difficulties from April 2023 for which he was receiving support from the Community Mental Health Team and Home Treatment Team, part of the Betsi Cadwaladr University Local Health Board. On 28 July 2023 he was admitted as an informal patient to a private psychiatric unit at Elysium Ty Grosvenor Hospital, Wrexham. He was admitted to there as there were no beds available within the NHS North Wales area. He was discharged on 15 August 2023 to the care of the Home Treatment Team. On 23 August 2023 Philip Taylor died by suicide at his home address.
5	**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 will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

	The **MATTERS OF CONCERN** are as follows – a. The Health Board utilises facilities out of area for acute psychiatric care when there are no available beds in the NHS in North Wales. I was informed that the patients, however, remain the responsibility of the Health Board. During the deceased's time at Ty Grosvenor it does not appear that any/all relevant information was shared between the two organisations e.g. deceased's progress, medication, treatment etc, except for few telephone conversations. b. There was no joined up planning or joint meeting between the Health Board and Ty Grosvenor prior to the deceased's discharge. c. The prescription and administration record together with a copy of the pre-admission paperwork were only sent to the Health Board two days after the deceased was discharged. d. The discharge summary was emailed to the Health Board three days after discharge, but this was either not received by the Health Board or received and not acted upon. In fact, it is the deceased's wife who had informed the Home Treatment Team that the deceased had been discharged. On knowing this, no one sought to request the discharge summary from Ty Grosvenor, even where there was a change in medication dosage. e. There was no evidence at Inquest of any written agreement or standard operating procedure or similar between the Health Board and private facility as to minimum standard requirements or expectations between both organisations e.g. what documentation should be shared, how it is to be shared, when documentation should be shared, the timeliness of sharing documentation etc. f. It is concerning that such minimum standards are not set out and agreed between the Health Board and this private psychiatric unit in a situation where many patients are likely to be treated there. It is not known whether or not such minimum standards or Agreement exists with other out of area private units. g. In the event that patients are to be treated in private units out of the area then there will be a risk of future deaths if such minimum standards regarding sharing of information and communication are not set and agreed between the Health Board and private facility. There had been no consideration of this as part of the actions arising from the Health Board's own investigation.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 29 March 2024. I, Kate Robertson, 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 Family of the Deceased and to the Chief Coroner. I am also under a duty to send the Chief Coroner a copy of your response. 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 2 February 2024  Signature Assistant Coroner for North Wales (East and Central)