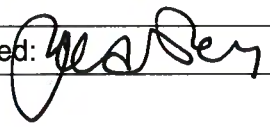
Bundle Index

SECTION A – Case			
Document	**Date**	**Author**	**Pages**
REG 28 - HMC REPORT	15/05/2024		A1 – A2
REG 28 RESPONSE - DHSC	29/07/2024		A3 – A4
REG 28 RESPONSE - ICB	17/07/2024		A5 – A6
REG 28 RESPONSE - PRIORY	10/07/2024		A7 – A9
PRIORY - Appendix 1: H-SOP34 Safer Adult Acute Inpatient Ward Discharge Planning - Follow Up Arrangements	10/07/2024		A10 – A12

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] Secretary of State for the Department of Health and Social Care 2. [redacted] Chief Executive Officer, Priory Head Office, Floor 5, 80 Hammersmith Road, London W14 8UD 3. [redacted] Chief Executive, NHS Greater Manchester Integrated Care Board
	CORONER I am Joanne Kearsley, Senior Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 9th October 2023, I commenced an investigation into the death of Mr Benjamin Sulzbacher who died on the 27th September 2023. The investigation concluded on the 2nd May 2024. The medical cause of death was confirmed as 1a) Hanging. A conclusion of suicide was recorded.
4	**CIRCUMSTANCES OF DEATH** Mr Sulzbacher had suffered from a deterioration in his mental health for a number of years. This became more acute during 2023. Throughout this time he had accessed assistance from professionals within his community and this was done on a private basis. On the 24th August 2023 having tried to tie a ligature at home, he was taken to the Accident and Emergency Department at North Manchester General Hospital. He was assessed and it was recognised he required an inpatient admission which he agreed to as a voluntary patient. Due to the only available acute inpatient bed being in the South, his family funded a private admission at the Priory hospital in Altrincham. He was an inpatient from the 26th August until the 18th September 2023. On his discharge from the Priory part of the discharge plan was for a follow up phone call within 48 hours. This occurred on the 21st September 2023. Learning from how this call was conducted has already been recognised by the Priory. The court heard evidence that no referral was made to the NHS mental Health trust for follow up via the Home Based Treatment Team. In this case due to where Mr Sulzbacher lived, a referral would have been to Pennine Care NHS Trust Foundation Trust. This would have occurred automatically if he had been an NHS inpatient. The court heard if a referral had been made to the Home Based Treatment Team they would have conducted a face to face follow up within 72 hours and if necessary, would have remained engaged with Mr Sulzbacher for up to 4 weeks. The court also heard evidence that the NHS Trust would have accepted such a referral even though Mr Sulzbacher had been a private paying inpatient. The evidence from the family was that Mr Sulzbacher's mental health declined on his return home and he died having tied a ligature on the 27th September 2023.
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:- **For the Priory** 1. There was a lack of understanding from the Priory witnesses as to what the NHS community services could offer on discharge. The court heard that the Home Based Treatment Team was understood to simply be a "Crisis team" which was incorrect. **For All:** 1. It was unclear to all services as to whether a private paying inpatient (who would have qualified for care under the NHS but due to bed availability went private) would be entitled to be referred to the discharge services offered by the NHS. The NHS provides more than the private sector in respect of community discharge packages and can be engaged with someone for longer. Importantly the face to face contact enables a better understanding of how a patient is actually presenting when considering their mental health.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 **12th July 2024**. 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 namely:- Family of Mr Sulzbacher Pennine Care NHS Foundation Trust 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 from. 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	Date: 15.05.24 Signed: 

Department of Health & Social Care

From Baroness [redacted]
Parliamentary Under Secretary of State for
Patient Safety, Women's Health and Mental Health

39 Victoria Street
London
SW1H 0EU

[redacted]

Our Ref: [redacted]

Joanne Kearsley,
Senior Coroner, North Manchester area
The Coroner's Office
2nd and 3rd Floor, Newgate House
Newgate
Rochdale
OL16 1AT

29 July 2024

Dear Ms Kearsley,

Thank you for your Regulation 28 report to prevent future deaths dated 15 May 2024, about the death of Benjamin Sulzbacher. I am replying as the newly appointed Minister with responsibility for mental health.

Firstly, I would like to say how saddened I was to read of the circumstances of Benjamin's death, and I offer my sincere condolences to his family and loved ones. The circumstances your report describes are deeply concerning and I am grateful to you for bringing these matters to my attention. I am thankful to you for the extension granted to the Department to provide a response.

Your report raises concerns over a lack of clarity and understanding within mental health services as to whether a privately paying patient would be entitled to be referred to the discharge services offered by the NHS.

In preparing this response, departmental officials have made enquiries with NHS England.

In accordance with the principal duty under section 1 of the National Health Service Act 2006, the NHS must provide a comprehensive health service that is free of charge. Patients should not lose their right to access NHS services by accessing private services. The Department of Health guidance published in 2009 sets out the principles that apply to NHS patients who wish to access additional private care. Part 7 of this guidance makes particular reference to clinical governance which we would expect to be applied in the case of transfers between private and NHS care. The guidance can be found here:
https://assets.publishing.service.gov.uk/media/5a74ccb340f0b61df4778971/patients-add-priv-care.pdf

We recognise how important it is that organisations across the health system work together to ensure effective discharge planning and the best outcomes for people who are discharged from hospital, and that people and their chosen carers are fully involved in the process. The Department has worked with NHS England and other system partners to develop statutory guidance for discharge from all mental health inpatient settings, which was published in January 2024. This sets out how NHS bodies and local authorities can work together to support the discharge process, improving flow and ensuring the right support in the community. It also includes best practice on how patients and carers should be involved in discharge planning.

This guidance applies to NHS bodies and local authorities exercising health and social care functions for children and adults in England and should be used to inform local service planning and delivery. However, even though the statutory duty to have regard to this guidance applies to NHS bodies and local authorities, the guidance is applicable to independent providers. NHS commissioners of inpatient services should ensure that all mental health inpatient providers are aware of this guidance, including those in the independent sector. Commissioners are expected to have regard to this guidance when commissioning services from the independent sector. The guidance is available at: https://www.gov.uk/government/publications/discharge-from-mental-health-inpatient-settings.

I would expect the Greater Manchester Integrated Care Board to provide details about how this works from a local perspective in its response to you. However, the Department will consider, in collaboration with other partners, whether, in light of this tragic case, the guidance could be made clearer to ensure that all mental health commissioners and providers are aware of how it applies to the independent sector.

More widely, NHS England has advised that, while much progress has been made in implementing new models of care in community settings, further clarity is needed on some aspects of delivery within integrated community mental health services. To support systems in this work, NHS England intends to develop further national guidance to set out core standards for community mental health services, building upon the Community Mental Health Framework, to provide clarity on areas critical to delivering high quality and safe care. This includes clarifying roles and responsibilities at the interfaces between community mental health services and other services, as well as greater clarity on pathways of care for people with severe mental health problems. In addition, all integrated care boards have been tasked with developing 3-year plans to localise and realign inpatient mental health care, including care provided by the independent sector, as part of NHS England's mental health, learning disability and autism inpatient quality transformation programme.

I hope this response is helpful and demonstrates my sincere desire to improve care for patients so we can avoid such tragedies from occurring. Thank you for bringing these important concerns to my attention.

All best wishes

[redacted]

[redacted]

NHS
Greater Manchester
Integrated Care

E: [redacted]

Date: 16/07/2024

Private & Confidential
Ms Joanne Kearsley
H M Senior Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Ms Kearsley

Re: Regulation 28 Report to Prevent Future Deaths

Thank you for your Regulation 28 Report dated 3rd May 2024 regarding the sad death of Benjamin Sulzbacher. On behalf of NHS Greater Manchester Integrated Care (NHS GM), We would like to begin by offering our sincere condolences to Benjamin's family for their loss.

Thank you for highlighting your concerns during the inquest which concluded on the 2nd of May 2024. On behalf of NHS GM, we apologise that you have had to bring these matters of concern to our attention. We recognise it is very important to ensure we make the necessary improvements to the quality and safety of future services.

During the inquest you identified the following cause for concern: -

It was unclear to all services as to whether a private paying inpatient (who would have qualified for care under the NHS but due to bed availability went private) would be entitled to be referred to the discharge services offered by the NHS. The NHS provides more than the private sector in respect of community discharge packages and can be engaged with someone for longer. Importantly the face to face contact enables a better understanding of how a patient is actually presenting when considering their mental health.

In relation to the referral process for private patients into NHS services- patients in private settings are not excluded from accessing usual NHS services. An example of this is a patient in a private care home needing a referral to a specialist would do so through their GP. All people living in the borough are registered with a GP who can provide services or refer on for any service not delivered in primary care e.g. an x-ray or to see a specialist

The principles of discharge from an NHS funded mental health setting would remain the same for a discharge where the care has been privately funded. In general, the provider would be expected to provide a safe discharge plan which might include for example: a Section 117 discharge meeting if appropriate, 72 hour follow up arrangements, appropriate referrals/appointments and communication with care teams and family/friends involved. Please not this is an example of what may be put in in

place, arrangements put in place depend on the individual patient and their needs.

(A Section 117 discharge planning meeting is held before a person is discharged from hospital. The meeting involves all relevant professionals, the person, and their family as appropriate, to discuss and agree on what care is required and how their identified needs can be met. The meeting is arranged by the team that has supported the person on the ward and their Community Care Coordinator, who are representatives from the Clinical Commissioning Group (Health) and Local Authority (Social Care). The purpose of the meeting is to meet a need arising from or related to the persons mental disorder and reduce the risk of a deterioration of the persons mental health condition.

Locally, Pennine Care NHS Foundation Trust (PCFT) now have an out of area placement team who help bridge the gap between the private hospitals and PCFT.

We will be raising this case at our quality assurance visits to providers over the coming weeks, highlighting how private providers can refer all patients (both NHS and privately funded) into NHS services and the importance of robust discharge planning. We will also be sharing this learning at the Greater Manchester System Quality Group in July and at the Greater Manchester Mental Health Programme Board.

Thank you for brining this matter to our attention.

Best wishes

[redacted]

[redacted]
Interim Deputy Chief Executive Officer and Chief Nursing Officer
NHS Greater Manchester

4th Floor, Piccadilly Place, Manchester M1 3BN
[redacted]

10 July 2024

Ms Joanne Kearsley
Senior Coroner
Greater Manchester North Coroners

Via email: [redacted]

Private and Confidential

Dear Ms Kearsley,

Mr Benjamin Sulzbacher - Response to Regulation 28 report

I write to you in response to the Regulation 28 report Priory received dated 15 May 2024. The report was issued following the Inquest touching the death of Mr Benjamin Sulzbacher.

You raised two matters of concern. The first was addressed to Priory:

i) There was a lack of understanding from the Priory witnesses as to what the NHS community services could offer a patient on discharge.

The second concern you raised was addressed to Priory, the Secretary of State for the Department of Health and Social Care and Greater Manchester Integrated Care Board:

ii) It was unclear whether a private paying patient would be entitled to be referred to the services offered by the NHS at the point of inpatient discharge.

Priory's response to your first concern:

Following the inquest, e-mail communications have been shared with all Priory consultant psychiatrists by the Clinical Director of the Private and Wellbeing service network, [redacted] to explain the importance and professional requirement for them to maintain up-to-date knowledge and understanding of the services local NHS mental health community teams are able to offer.

Additionally, in order to facilitate contact and communication with NHS mental health services, all Priory hospitals have been asked to create a local NHS Mental Health Services Directory. This will focus on (and clearly distinguish between) Crisis Teams, Home Treatment Teams, Community Mental Health Teams, specialist mental health services and any other relevant mental health services in the region/local area. This directory will be updated annually and shared with all relevant healthcare professionals at the hospital, including Visiting Consultants at the point of their induction and annually thereafter.

This learning point will be raised during Priory's Service Network Discussion Forum, which is chaired by the Chief Medical Officer, [redacted]. This meeting is next scheduled to occur on 11th July 2024. This learning point will also be raised during Priory's Acute service network meeting and the Private & Wellbeing service network meeting (both scheduled to occur in August 2024). These meetings are chaired by the Network's Clinical Directors ([redacted] and [redacted] respectively) for

discussion and noting by all in attendance (which includes service network representatives to include Hospital Directors, Consultant Psychiatrists, Director of Clinical Services, Ward Managers, Senior Nurses and other healthcare professionals).

Priory's response to your second concern:

As a general principle, we consider that it is well-established that in the majority of cases, private mental health inpatients may access NHS services following discharge but we accept that it would be helpful if options could be explained more clearly to patients and families so that they can make informed choices about aftercare.

As such, Priory has created a Standard Operating Procedure (SOP) (**Appendix 1**) which makes the aftercare pathways clearer and includes provisions that:

i) All inpatients are to receive a follow-up contact within 72 hours of discharge (whether the contact is from Priory or the NHS)

ii) A referral into NHS mental health services should be considered for all inpatients regardless of funding arrangements when planning inpatient discharge: the SOP details the non-exhaustive criteria to support this clinical decision making.

Where private patients indicate that they want to re-engage with NHS services following discharge and they meet the referral criteria, referral letters will be sent not only to GP's (as is standard practice) but also to NHS community treatment teams so they can follow up directly with the patient within 72 hours.

However, we acknowledge that there will be occasions when an NHS referral is not achievable such as:

i) The patient does not meet the criteria for referral into NHS community services,
ii) The patient does not consent to such a referral,
iii) Instances where a NHS community team receive but then refuse the referral,
iv) Or there might be instances where a NHS community team have not yet confirmed the date and time of the initial contact

In these circumstances, a follow-up telephone call will be made to the patient by the Priory ward staff within 48 hours of their discharge. This reflects current practice as recorded in Priory policy (H02 Admission, Transfer and Discharge).

Should a concern be raised during the 48-hour phone call, this will be relayed promptly to the consultant psychiatrist who was responsible for the inpatient care for the consultant's review and guidance on any required subsequent action.

Priory continue to work closely with NHS community teams to ensure safe inpatient discharge and we will carefully review the responses submitted by the Secretary of State for the Department of Health and Social Care and Greater Manchester Integrated Care Board to this Regulation 28 report to ensure our approaches align. Priory are committed to making any relevant changes to our approach across the Healthcare division as required in order to ensure robust discharge and aftercare arrangements between Priory and the NHS.

I trust that the actions outlined above will provide the assurances you seek in respect of this matter.

Yours sincerely,

[redacted]

[redacted]
Chief Executive Officer
Priory

Standard Operating Procedure: Safer Adult Acute Inpatient Ward Discharge Planning - Follow Up Arrangements

Introduction:
The transition from mental health inpatient facilities to home environments or other destinations may give rise to a heightened risk of self-harm. Research from the National Confidential Inquiry into suicide and mental health safety indicates that a significant proportion of suicides post inpatient discharge occur within the initial week of discharge, peaking on the third day (within 72 hours) and before there has been any follow-up with the patient.

Priory therefore considers that there should be more robust aftercare arrangements to ensure follow-up contact within 72 hours for all patients leaving acute inpatient care.

Priory have two types of acute adult inpatient wards:

- **Acute inpatient wards:** These wards host NHS funded patients either on a contracted bed or a spot purchase arrangement. NHS Trusts or Integrated Care Boards (ICB's) fund NHS patients. Following treatment, patients are discharged back to the relevant NHS Trusts/ICB who are responsible for the ongoing care of the patient.
- **Private acute inpatient wards:** These wards admit patients whose admissions are funded by the patient themselves, or via their private medical insurance or any other self-funding arrangements. On most occasions, local NHS Trusts or ICB's do not fund these patient admissions.

All acute inpatient wards (NHS funded and Private):

All Priory acute inpatient wards irrespective of funding arrangements must consider discharge planning as soon as possible after admission, and this must be documented in CareNotes (electronic patient care record). This should include consideration for who and which services are most appropriate to complete the 'within 72 hour' follow up contact. This must be documented in the discharge plan.

CareNotes must be updated with information about the patient's family, carers and other relevant and involved health and social care services. The discharge destination (such as a patient's home address or alternative address) must be documented on CareNotes as soon as possible once established.

Patients with a current or historical risk of suicide and/or self-harm will be offered the opportunity to complete a 'My Safety Plan' with support from their Named Nurse during their inpatient admission. This plan will develop during the course of their admission in order to document their risks, protective factors and risk management strategies found to be effective during the course of the admission. This plan will be devised collaboratively with the patient and a copy will be provided to the patient following initial completion, following reviews and on discharge. This document will support discharge planning and a copy will be shared with the patient's family (subject to patient consent).

All discharge plans including the 'within 72 hour' follow up must be discussed and agreed with the patient and with their consent, with the patient's family, carers and relevant care agencies involved in the care of the patient.

Discharge plans must be documented clearly in CareNotes and shared with the patient, including with the referrer and their family/carers (with the patient's consent). In cases, where a patient does not provide consent for crisis discharge plans to be shared with their family/carers, consider sharing generic discharge planning information with the patient's family/carer where appropriate.

All hospital sites will have an updated local NHS Mental Health Services Directory with the focus being on Crisis Teams, Home Treatment Teams, Community Mental Health Teams, specialist mental health services and any other relevant mental health services in the region/local area. The information required to populate this can be gathered from local NHS Trusts, GP's and other healthcare services. This directory must be updated annually and shared with all healthcare professionals at the hospital, including Visiting Consultants, to ensure up-to-date awareness of the local NHS services available.

Private acute inpatient wards (non-NHS funded patients):

Patients who would have qualified for NHS funded care and were admitted to a private acute inpatient ward due to non-availability of NHS beds and/or patient choice, must be considered for referral to NHS services for 'within 72 hour' follow up and/or longer-term care when planning their discharge.

The multidisciplinary team (MDT) should consider whether a patient requires a higher level of support, follow up and care from NHS services as there are limitations in the community support that private services can provide (see section 3 for criteria). Where such community intervention is required, patients should be referred to the local NHS Home Treatment Team, Crisis Team or Community Mental Health Team prior to discharge. Irrespective of whether NHS services accept or decline the referral, the referral should be clearly documented with a rationale in CareNotes.

In the case of a decline of the referral by NHS services, or in instances where a NHS community treatment team have not yet confirmed the date and time of the initial contact or where a patient does not meet the criteria (see section 3) or should the patient refuse such a referral, the Priory MDT must develop a clear follow up plan, which includes 'within 72 hour' follow up. This will usually take the form of a phone call from the ward staff within 48 hours post discharge in accordance with Priory policy. Any actions, which may be needed in the event that staff are unable to contact the patient, will be considered on an individual basis and documented within the discharge MDT meeting. The MDT must also document a confirmed date and time of any future outpatient appointment with the Visiting Consultant/Therapist and update the patient and their family/carers on crisis management plans including advice on accessing local urgent NHS Crisis Team services or A&E services if required.

Should a concern be raised during the 48 hour call, this will be relayed to the consultant psychiatrist who was responsible for their inpatient care for their review and guidance on any required subsequent action.

Visiting Consultants, sessional therapists and all staff on private acute inpatient wards must familiarise themselves with the local NHS Mental Health Services Directory which will include details about the local Crisis Teams, Home Treatment Teams, Community Mental Health Teams, specialist mental health services and any other relevant mental health services in the region/local area.

Criteria to consider referral of patients to NHS services for private acute inpatient wards (non-NHS funded patients)

NHS mental health services include Crisis Teams, Home Treatment Teams, Community Mental Health Teams, specialist mental health services and any other relevant mental health services in the region/local area.

The following list is not exhaustive:

1. The patient is already under the care of NHS mental health services
2. The patient has been admitted whilst awaiting a NHS bed and such inpatient beds are not available
3. The patient was detained under the Mental Health Act 1983 either prior to private admission or during private admission
4. The patient may meet the criteria for detention under the Mental Health Act 1983 in the present or near future
5. There is a high risk of self-harm or suicidal ideation with or without plans and intention
6. There is a high risk of harm to others
7. There is a high risk of disengagement with mental health services and this may lead to increased risks/deterioration of mental health condition
8. The patient may need specialised services such as perinatal care, treatment for resistant conditions, or a lack of social care and presenting with risks
9. The patient is subject to MARAC, LADO, or any other significant safeguarding concerns that require multidisciplinary support and engagement
10. The patient requires multidisciplinary intensive support that cannot be offered by private services
11. At the request from the patient, or their family/carers or referrer
12. The patient has co-existing mental health challenges along with substance misuse and may present with risks to self and/or others
13. The patient requires follow up or observations in between private outpatient appointments, as private services at Priory do not offer emergency care and/or treatment
14. Circumstances in which safer prescribing is not possible