Birmingham Women's and Children's
NHS Foundation Trust

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Mrs Louise Hunt
Senior Coroner for Birmingham and Solihull
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1 November 2019

Dear Mrs Hunt

Re: Gurdeep Dundhal; Regulation 28 Report to Prevent Future Deaths

I write in response to your Regulation 28 Report issued to Birmingham Women's and Children's NHS Foundation Trust, Walsall Metropolitan Borough Council, Birmingham City Council and Priory Group of Hospitals on 10 September 2019, following the inquest into the tragic death of Gurdeep Dundhal.

We would like to express our sincere condolences to the family of Gurdeep, who sadly have lost a very special young man.

The matters of concern you raised in your Report are as follows;

"There was a delay in organising the assessment of Mr Dundhal when he was detained on S5(2) of the Mental Health Act on 11/04/19. The evidence confirmed there appeared to be confusion as to who was to undertake the assessment between Walsall MBC and Birmingham City Council. In addition there was a lack of resources to enable the assessment to be carried out in a timely manner. This meant the assessment was carried out just a few hours before the time period for the S5(2) was to expire.

Evidence at the inquest from the approved Mental health practitioner confirmed that key

information and documentation were either unavailable and/or not asked for during the mental health act assessment on 14/04/19. I was unable to confirm which at the inquest. This meant the true nature of Mr Dundhal's long term condition was not known and the assessors were unable to see the "bigger picture". The delay in arranging the assessment contributed to the lack of available information.

When Mr Dundhal was admitted to hospital on 15/03/19 he was placed on S2 of the Mental Health Act when his clinical team had specifically recommended he be placed on S3. No explanation was available for this. Evidence at the inquest suggested this was a decision made by the Approved Mental health practitioner from Birmingham City Council. Consideration needs to given as to why a S3 was not put in place in accordance with the recommendation.

Walsall MBC has failed to undertake an internal investigation into the delays and resources concerns during the assessment in April 19. They have also failed to engage with other agencies to ensure lessons are learnt. It is essential in complex cases like this that all agencies work together after a tragedy to ensure lessons are learnt to protect others."

In preparing this response, we have obtained the call logs from 14 April 2019, providing the telephone numbers which called in to the Access Centre on that day. We were concerned to hear at the inquest that the request for Mr Dundhal's records was made and not complied with. Unfortunately, we have not been able to establish the telephone number which the Approved Mental Health Practitioner called from and as such we are limited in our investigations on this point.

We understood from the evidence provided at the inquest that the Approved Mental Health Practitioner made a call to the Access Centre on 14 April 2019 in order to make attempts to obtain Mr Dundhal's records held by FTB. Whilst it is the case that the Access Centre is closed at weekends, I can confirm that calls made to this number out of hours are routed to FTB's urgent care team. Therefore any call made to the Access Centre would have been picked up by the shift coordinator in the adult crisis team. All calls to this number are recorded as a relevant clinical record. All calls that came through the Access line to urgent care on 14 April 2019 have been reviewed and we have not been able to identify the call on our audio file.

I would like to reassure you, however, that FTB records are held electronically and these are easily available to be shared where appropriate. Although we are unable to establish the precise circumstances of this call, as a direct result of your report, we have redistributed the safer inter agency information sharing guidance within the urgent care team and at the local governance meetings to ensure that any lessons to be learnt are implemented.

Since the issue of your Report, we have been contacted by Walsall MBC and have been invited to participate in a multi agency meeting to discuss this matter. We await a date for the meeting, following which further actions may become apparent. I will write to you again to provide the details of the outcome of this meeting.

I hope this letter serves to reassure you that the concerns you raised have been acted upon.

We will continue to engage with other agencies to enable the Trust to learn from incidents and improve patient care.

Yours sincerely

Dr Fiona Reynolds
Chief Medical Officer
Birmingham Women's and Children's NHSFT