PRIORY

[redacted]
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Monday 4 November 2019

Ms Louise Hunt
HM Senior Coroner for Birmingham & Solihull
Coroner's Court
50 Newton Street
Birmingham, B4 6NE

By email: coroner@birmingham.gov.uk

Dear Ma'am

Re. Mr Gurdeep Dundhal (deceased)

I write to you in response to the Regulation 28 Prevention of Future Deaths Report dated Tuesday 10 September 2019 that you issued following the Inquest touching the death of Mr Gurdeep Dundhal. We note that your report was addressed to Walsall MBC, Birmingham City Council, Birmingham Women's and Children's NHS Foundation Trust and the Priory Group of Hospitals (PGH).

You will appreciate that in respect of points 1, 3 and 4, PGH is not in a position to comment and that (i) any delays in arranging the MHA assessment; (ii) the use of Section 2 rather than a Section 3 detention on admission; and (iii) the failure by Walsall MBC to undertake an investigation are matters for the other interested persons noted above to address.

In respect of point 2 and the concern in relation to key information being unavailable or not asked for, please note that clinical staff at Lakeside View have considerable experience in liaising with professionals undertaking Mental Health Act assessments and have advised that relevant information relating to Mr Dundhal was made readily available to the assessing team. Additionally, Mr Dundhal's responsible clinician, [redacted], made himself available on the day of the assessment and in fact was contacted by ward staff who asked him to speak to the assessing doctor, [redacted]. PGH has also enquired as to whether there was an IT systems outage on Sunday 14 April 2019 at Lakeside View which may have impacted on the ability to retrieve electronic clinical notes (CareNotes) for the assessment thereby making them "unavailable" but has found no evidence to suggest the hospital's IT systems were not working normally on that day.

Yours sincerely,

[redacted]
Director of Risk Management