	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Walsall MBC** **2. Birmingham City Council** **3. Birmingham Women's and Children's NHS Foundation Trust** **4. Priory Group of Hospitals**
1	**CORONER** I am Louise Hunt Senior Coroner for **Birmingham and Solihull**
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 8th May 2019 I commenced an investigation into the death of Gurdeep Singh Dundhal. The investigation concluded at the end of an inquest on 9th September 2019. The conclusion of the inquest was suicide.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was known to suffer from paranoid schizophrenia and to take illicit substances. He was admitted as an inpatient under section 2 of the Mental Health Act on 15/03/19. Mr Dundhal applied to be discharged from his section and a mental Health tribunal discharged him on 08/04/19. He remained on the ward as a voluntary patient and a further mental health act assessment was made on 14/04/19 due to concerns about his condition which concluded he was not detainable. He remained on the ward for a further few days until he self-discharged on 17/04/19. He had ongoing care from the Home treatment team and last saw the consultant looking after him on 26/04/19 when no concerns were noted about his risk of harming himself. On 27/04/19 the deceased was in town with his family when he left them saying he was going to see a friend. They were suspicious and followed him to a car park at Newhall Street and also called police who attended. He jumped from the 5th storey at 13.24 shortly after arriving at the car park. He was given emergency treatment at the scene and conveyed to University Hospital Birmingham where he was found to have a serious brain injury and other injuries from the fall and despite all care he passed away on 28/04/19.. Following a post mortem the medical cause of death was determined to be: MULTIPLE INJURIES FALL FROM HEIGHT
5	**<u>CORONER'S CONCERNS</u>** 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. – 1. 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. 2. 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. 3. 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. 4. 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.
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 by 5 November 2019. 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: The family Of Mr Dundhal. I have also sent it to the CCG, NHS England and the Minister for Mental health who may find it useful or of interest. 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	10/09/2019 Signature  Louise Hunt Senior Coroner **Birmingham and Solihull**