

**Birmingham & Solihull Mental Health NHS Foundation Trust**

**Mental Health Legislation Group to be held**

<b>Report: Jan 2023 – April 2023</b>
<b>Strategic or Regulatory Requirement to which the paper reports – mental health legal updates</b>
<b>Action:</b> This report is for discussion
<b>Claims/PFDs:</b> We have received 2 PFD's during this period.
<b>MHA/MCA queries of note/trends:</b> XXXX Section Redacted as it does not relate to PFD XXXX
<b>Legislation:</b> XXXX Section Redacted as it does not relate to PFD XXXX
<b>Caselaw:</b> XXXX Section Redacted as it does not relate to PFD XXXX
<b>Points of interest:</b> XXXX Section Redacted as it does not relate to PFD XXXX
<b>Board Director:</b> XXXX, Medical Director

<b>Previously discussed:</b>
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**PFDs:**

We have had 2 PFD's since January 2023.

**XXXX:-** This PFD was issued against the Trust due to the restrictions in the MHA from allowing people to be detained in A&E whilst awaiting an informal bed. The patient in this case was waiting in A&E as an informal patient for a bed. The plan was for XXXX to wait in PDU for this but XXXX absconded from A&E before XXX was transferred to PDU.

The Coroner highlighted 3 main areas for the Trust, ICB and UHB to respond to; Lack of inpatient mental health beds and lack of Psychiatric decisions unit (PDU) Spaces, lack of a Safe Space in A&E whilst patients wait for their transfer and finally lack of a Multi agency protocol for informal missing patients. The ICB are leading on the response, which was originally due in March. However the Coroner has now agreed two extensions on this to 28 April 2023. There were two other points raised the PFD but these were for WMP.

**XXXX XXXX XXXX:-** This PFD was issued against the Trust for a prisoner who had been identified as requiring initially transfer to the Hatherton Centre, but then also transfer to Ward 2 on the Prison wing. Neither took place and took XXXX own life. The Coroner issued a PFD in relation to two points; the mental health team multi-disciplinary team (MDT) in the prison does not include a psychiatrist and that there was an absence of any ongoing risk assessment documentation for patients with mental illness within the SystemOne records at HMP Birmingham. The response to these points has now been drafted and is due to go out to the Coroner prior to the end of April.

**Clinical negligence:**

XXXX Section Redacted as it does not relate to PFD XXXX

**MHA/MCA queries of note/trends:**

XXXX Section Redacted as it does not relate to PFD XXXX

**Legislation:**

XXXX Section Redacted as it does not relate to PFD XXXX

**Caselaw:**

XXXX Section Redacted as it does not relate to PFD XXXX

**Points of interest:**

XXXX Section Redacted as it does not relate to PFD XXXX