

Birmingham & Solihull Mental Health NHS Foundation Trust

Mental Health Legislation Group to be held

Report: Jul-Sept 2024
Strategic or Regulatory Requirement to which the paper reports – mental health legal updates
Action: This report is for discussion
Claims/PFDs: We have received 2 PFD's since 1 st April 2024 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
Board Director: XXXX, Medical Director
Previously discussed:



PFDs:

The Trust has received two PFD Regulation 28 Reports since 1st April 2024

XXXX XXXX

Service User Death. The incident involved a XXXX service user, aged XXX, married, who died following a stay on PDU in which an informal bed had been agreed. Transportation to the informal bed placement was agreed to be through transfer in XXXX XXXX car. He left with XXXX XXX in XXXX car at 7.45. shortly after 8pm after speaking to XXXX XXXX, XXXX opened the passenger door. XXXX attempted to stop XXXX and moved to the hard shoulder where XXXX exited, walked round car and into path of lorry and thereafter was struck by car. Confirmed Dead at scene having succumbed to injuries.

Coroner Concerns

The concerns raised were that the Risk Assessment that was carried out to assess onwards transportation by the service user's XXXX was inadequate and the actions taken by the Trust in regard to changes to the transportation policy did not assure him sufficiently. Concerns were also raised regarding documentation not being updated in a timely manner

PFD update:

Response has now been sent to the Coroner this month.

XXXX XXXXX

Service user death in community. Incident involved a XXXX, aged XXXX, single. XXXX had a row with XXXX XXXX on 14.2.24 and left the family home. XXXX was reported missing on 16.2.24 and found on the same day in park with medication packets around XXXX. XXXX had been under the care of CMHT had been last reviewed in Jan 23. Not reviewed since as RC left. XXXX has not identified any contributory factors but identified XXXX not getting an appointment prior to her death as an incidental finding. COD 1a. Codeine and duloxetine toxicity. 2. Presence of paracetamol, pregabalin, quetiapine, zopiclone, tramadol and ethanol.

Coroner concerns

The Coroner accepted that a new process had been put in place to assist with appointments. However an action on the action plan; to carry out a review of the new process, had not yet arrived. Given XXXX powers lapse at the end of the inquest XXXX chose to issue a PFD against the Trust in order to ensure that the Trust provide an update.

PFD update:

The action was brought forward so that the response could be sent on time. The draft being sent to the Chief Executive this week for signature and will be shared with the Coroner one signed.

Clinical negligence:

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:

Updates on reforming the Mental Health Act

XXXX Section Redacted as it does not relate to PFD XXXX