Dudley and Walsall NHS
Mental Health Partnership NHS Trust

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27th October 2016

Mr Z Siddique
HM Senior Coroner
Black Country Coroner's Court
Jack Judge House
Halesowen Street
Oldbury
West Midlands
B69 2AJ

Dear Mr Siddique

Ref: Glen Jordon Regulation 28 Ruling – Dudley and Walsall Mental Health Partnership NHS Trust Response

I am writing on behalf of Dudley and Walsall Mental Health Partnership NHS Trust in response the recent HM Coroners Regulation 28 Report issued following the recent coronial inquest into the death of Mr Glen Jordan.

I would, first of all, like to pass on my sincere condolences and state that the Trust is fully committed to providing optimum and effective Mental Health care to the service users of Dudley and Walsall in an environment that is safe and secure for patients, staff and the public.

I would like to confirm that the Trust search policy is written in line with the requirements of MHA Code of Practice (COP) and, following the conclusion of our investigation, it was ascertained that this had been implemented appropriately. Whilst the policy is unable to be prescriptive in terms of all the items patients can bring into hospital, the Trust acknowledges that items such as removable bag straps may pose a risk to some patients where the patients risk profile and history indicates so. As such, the Trust will include a statement within the policy, that enhances the definition of "belongings" and extend it to include the items that the belongings are actually kept or transported within (i.e. patient's bags and cases).

I can also confirm that the Trust has, in addition, taken immediate action to review its policy for the management of presenting clinical risks. Both of the policy reviews have been undertaken to ensure that our Trust policies are explicit in establishing the roles and responsibilities staff should take to maintain patient's safety, in a dignified least restrictive manner and in line with the Mental Health Act Code of Practice.

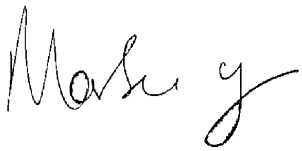
Following the ratification and approval of the revised Trust policies, a process for the implementation of the policies has now commenced. This involves educating the operational staff in respect to the changes of the policy and a clinical audit is planned to be

undertaken in April 2017 to evaluate the effectiveness of the implementation of the policy change. (I have also enclosed a copy of the Trust action / implementation plan for your information).

In addition, and for further assurance, I would like to inform you that the Trust is in the process of preparing for its Care Quality Commission assessment and, as part of the preparation for this process, a multidisciplinary review of all inpatient areas has been recently undertaken. As part of this review, patients, carers and relatives were spoken to and the inpatient records and case notes were examined. There was a particular focus on searches and risk assessments to ensure they are person centred and effective in the management of the patients presenting risks. I am pleased to say, the outcome of this review was very positive and staff were able to demonstrate to the multidisciplinary team a proficient understanding of their required roles and responsibilities.

Whilst remaining fully aware of the constant and continuing risks within mental health provision, the measures and actions taken by the Trust are designed to remind staff about the risks certain additional items can pose in some circumstances. Of course, risk assessments are highly personal and the very best of risk assessments cannot always cover every eventuality (as in this tragic case).Our aim is to reduce the likelihood of a reoccurrence of an incident of this nature, whilst continuing to maintain care that is provided in a dignified, professional and least restrictive manner and in line with our Trust's visions and values.

Yours sincerely



Marsha Ingram
Deputy Chief Executive Officer