Dudley and Walsall NHS
Mental Health Partnership NHS Trust

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19/01/2018 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: Penelope Benton 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 to the recent HM Coroners Regulation 28 Report issued to the Trust, following the recent coronial inquest into the death of Ms Penelope Benton.

I would, first of all, like to pass on our sincere condolences and state that the Trust is fully committed to providing excellent Mental Health care to the service users of Dudley and Walsall in a way which is safe and effective for patients and their families.

The Trust acknowledges the fact that in this instance the General Practitioner was not made aware of the previous tramadol overdose in the discharge letter from hospital. The Trust has agreed standards in relation to ensuring good communication with General Practitioners which includes the standards expected when writing discharge letters. A copy of these standards can be found within appendix 2 of this response. Unfortunately in this instance, whilst the discharge letter addressed all the key areas outlined within the standard/template, the information contained within the letter was inaccurate in this single point and failed to include details of this overdose.

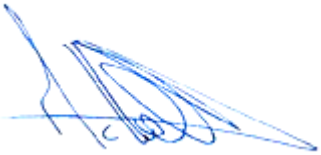
As a Trust which constantly looks to improve its services and learn lessons from incidents, the Trust will conduct a review of its standards around discharge communications and reiterate the importance to medical staff that incidents and risk factors are included within discharge letters where this is necessary.

It should also be noted that consultant teams also undertake audits in relation to the quality of discharge letters and communication with GPs to ensure / monitor the quality of discharge communication and ensure that the standard of these letters remains high. A required frequency / standard of audit and checking will be agreed as part of this review

and will be communicated to medical teams. A summary of these proposed actions is outlined within the enclosed appendix 1.

I trust that the proposed course of action addresses the areas of concern outlined within your regulation 28 report to the Trust however should you have any further concerns please do not hesitate to contact us for more information.

Yours sincerely



Mark Axcell
Chief Executive Officer