**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS**

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. Dudley and Walsall mental Health Partnership NHS Trust** |
| 1 | **CORONER**<br><br>I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On the 20 September 2017, I commenced an investigation into the death of the late Ms Penelope Benton. The investigation concluded at the end of the inquest on 31 October 2017. The conclusion of the inquest was a short narrative conclusion of suicide.<br><br>The cause of death was:<br><br>1a Tramadol Overdose |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>i) Ms Benton had a complex medical history including diagnosed paranoid schizophrenia and also a history of self-harm including drugs overdoses. She also had a stoma fitted following an obstruction to her bowel. This had caused significant pain over a number of years.<br><br>ii) On the 22 September 2016 she was admitted to Bushey Field Hospital after a relapse and sectioned under S3 Mental Health Act. She disclosed to her care co-coordinator on the 26 September 2016 that she had taken an overdose of 60 Tramadol tablets and that she had had enough of her pain and wanted it to go away.<br><br>iii) After making improvement she was discharged with support in the community on the 18 October 2016. The discharge note did not record any details of the Tramadol overdose and the GP continued to give her Tramadol medication for pain relief.<br><br>iv) On the 12 July 2017, Ms Benton took a significant quantity of Tramadol tablets (40.4mg/L) and fatalities have been associated with concentrations of greater than 6 mg/L.<br><br>v) Sadly, she was pronounced deceased on the same day and the cause of death was later confirmed as Tramadol overdose. |

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| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>1. Evidence emerged during the inquest that the General Practitioner wasn't made aware of the previous tramadol overdose on the discharge letter from Hospital. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.<br><br>1. You may wish to consider urgently reviewing the discharge process and information shared with primary health services on discharge of patients. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 29 January 2018. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons; Family.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **30 November2017**<br><br>**Mr Zafar Siddique**<br>**Senior Coroner**<br>**Black Country Area** |