Mr Z Siddique
H.M.Coroner
Black Country Coroner's Court
Jack Judge House
Oldbury
West Midlands
B69 2AJ

June 2nd 2019

Dear Mr Siddique

RE: Regulation 28 Report – Sylvia Mitchell

I am in receipt of your Regulation 28 Report following the Inquest and your ruling on 27 November 2018, in respect of the late Mrs Sylvia Mitchell. It has taken too long to then reply to you, but we have in truth been working on this issue in the intervening time, and debating the implications with clinical colleagues including GP leaders. Your finding clearly has implications for all disciplines.

In respect of Mrs Mitchell, I do believe that we attempted to review her at appropriate intervals and listed her for surgery to remove the pessary. Unfortunately she was unwell and unable to attend on the date organised and we requested that both the patient and the GP let us know when she was well enough to undergo surgery. As you know, this did not occur. We apply NHS-standard protocols for the 'chasing' of patients in these circumstances.

Every person attending for pessary insertion now receives an information leaflet which clearly outlines the need for follow up appointments and the risks of having a pessary, including ulceration, bleeding and discharge. These are being translated into multiple languages. We will share these leaflets with primary care colleagues for provision in consult rooms locally.

In addition, we had already amended our processes to tighten further our follow up procedure. Women self-book their 6 monthly appointments via partial booking, but if this does not happen we follow up with a letter. For women who do not attend for a planned appointment, we send a further appointment for 4 weeks' time. This is repeated should they fail to attend again and then will write to the GP requesting them to review and let us know if a further appointment is required. We have now asked our Planned Care Board to undertake a twice yearly clinical review of any patient who does not reply to all of those efforts. This list, pseudo-anonymised, will also be provided to Primary Care Network colleagues. In other words we will be more overtly curious about the reasons for non-response.

As part of this, looking forward patients who we have identified have not had a follow up as planned are being recalled for a review appointment with our Clinical Nurse Specialists. We are also discussing ways to enable us to easily see which women need follow up, and when this need

ceases, either because the pessary has fallen out, is no longer required for personal or alternative treatment reasons.

You asked us to ensure that any patients who may have missed opportunities to be seen, as Mrs Mitchell was, are safe and this is in progress and will likely continue through this year. I am satisfied that we have a process in place which is recalling women appropriately and that we are developing further ways to identify those women who need following up in our service, rather than with their GP, to give a further safety net.

In six months' time we will review at the Trust's Board data on non-responders within gynaecology services for the prior 18 months to see if there are any further omissions we might consider.

My colleague, [redacted], Deputy Director of Governance, would be best placed to provide advice or further details on our actions, or indeed updates on the progress moving forward. [redacted]

Yours sincerely

[redacted]
Chief Executive

cc. Family of Mrs Mitchell
[redacted]

[redacted], Clinical Chair, Sandwell and West Birmingham CCG

[redacted], Group Director, Women and Child Health

[redacted], Deputy Chief Operating Officer