

5 Boroughs Partnership **NHS**

NHS Foundation Trust

Chief Executives Office
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08 July 2014

Our Ref:

Your Re:

PRIVATE AND CONFIDENTIAL

Mr A P Walsh HM Coroner Great Manchester (West) HM Coroners Court Paderborn House Civic Centre Howell Croft North Bolton BL1 1JW

Dear Mr Walsh,

Re: Magdalen Bernadette Dwerryhouse - Deceased

Thank you for your letter dated 30 May 2014 with regards to your findings into the death of Magdalen Dwerryhouse and the directions given under the Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. I would like to advise you of the actions the Trust has taken both prior to the inquest and since receiving your letter.

Taking your points in turn I can confirm the Trust have completed the following:

I. Arrangements for Appointments / Contact with Family Members / DNA

We have implemented a full review of the operational guidance that all community teams work to. To address the areas of concern raised within our internal investigation and also by yourself, we have significantly amended the advice and guidance issued to our clinicians around what action to take if a service user does not attend an appointment, or is not at home when a planned appointment occurs.

As an interim measure before we are able to fully implement this new guidance across all community teams, the Assistant Director of Operations has instructed an immediate change in practice within all our Assessment Teams. The changes are stated below

- If a visit to a service users does not occur, that a telephone call to the referrer must occur within 24 hour of the visit to alert them of this fact.
- If a service user has been referred to our service 3 times within 6 months and repeatedly not attend appointments, or home visits, then a professionals meeting is to



be called to review the service user's case for referral and potential need for assertive outreach in conjunction with the original referrer.

In circumstances where a visit does not occur the practitioner should make use of the information provided at the point of referral in view of rearranging a further appointment. This may include contact with family members. The impact of a failed visit should be considered in line with the overall case and appropriate actions taken and documented which may include rescheduling the failed appointment.

II. Formation of a Partnership with Greater Manchester Fire and Rescue Service

Since Mrs Dwerryhouses death, significant work and progress has been made with Greater Manchester fire service in preparation for the final partnership agreement being signed.

We have completed an Information Sharing Agreement and this has been agreed in principle and will form part of the overall partnership agreement.

To accompany the agreement, operational protocols to assist staff with how to best utilise this partnership agreement have been drawn up and are also ready for introduction on completions of the partnership agreement.

There was a further meeting between 5 Boroughs NHS Partnership foundations Trust and Greater Manchester Fire and Rescue Service on the 18th July to establish agreement for the principles set out in the partnership agreement, leading to formal signing in the near future.

As part of this agreement, we will provide GMFRS with assistance if they feel they someone who has utilised their service may have a mental health concern, and reciprocally, our Trust will consider a referral to the GMFRS if a fire safety assessment is considered appropriate. This arrangement also provides reciprocal training arrangements for both organisations. Similar processes are either in place or in draft with other Fire and Rescue services in other parts of our catchment area.

This will be reviewed by an Executive Director and signed for on behalf of the organisation. If I can be of any further assistance or you require further information about the steps we have taken, please do not hesitate to contact me.

Yours sincerely

Director of Nursing & Quality

