5 Boroughs Partnership NHS
NHS Foundation Trust

Our Ref:

Your Ref:

Chief Executives Office
Hollins Park Hospital
Winwick
Warrington
Cheshire
WA2 8WA

Tel: 01925 664001
Fax: 01925 664052
Email: [redacted]

21 September 2016

PRIVATE AND CONFIDENTIAL

Mrs R C Griffin
HM Assistant Coroner
Great Manchester (West)
HM Coroners Court
Paderborn House
Civic Centre
Howell Croft North
Bolton
BL1 1JW

Dear Mrs Griffin

Re: Lee Francis Grimes – deceased

Thank you for your letter of 26 July 2016 regarding your findings at the inquest into the death of Lee Francis Grimes on 13 July 2016 and the directions given under the Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

In response to your request to review the policies and procedures in place regarding the processing of referrals to Wigan Recovery North, I can confirm that a review of these procedures has been undertaken by [redacted], Matron for Quality, in conjunction with the respective team manager

This review took the form of examining how messages are received into the team, identifying the person who is responsible for responding to referrals by phone call and how these are recorded.

The review found that referrals by phone call to Wigan Recovery North are received by the team secretary who is responsible to then transfer the call to a Duty Officer. The Duty Officer is a registered mental health nurse who will deal with the referral ensuring appropriate subsequent action is taken. A Support Time and Recovery (STR) worker is also available to support this process and will always liaise with the registered mental health nurse to discuss appropriate actions.

If the call is of an urgent nature and both Duty Officer and STR worker are engaged with other clients, the team secretary will immediately transfer the call to an available registered mental health nurse in order that the matter can be dealt with effectively. However if the caller deems their message as of a less urgent nature, this is logged into the communication message book, which is checked by the Duty Officer regularly throughout the shift.

This procedure is well established within the team and [redacted] was satisfied that all staff members were able to describe this in detail and demonstrate awareness of the correct procedure and their subsequent responsibilities in this regard.

We note from the evidence presented at the hearing that an answerphone message was left for the team on the morning of Friday 18 March 2016 at approximately 10 am, however it has not been possible to determine where the message was left.

Wigan Recovery North does not utilise an answerphone service before 5pm. An answerphone is only utilised and available outside of normal office working hours, i.e. on weekday evenings after 5pm and at weekends. All messages left during these times are reviewed and addressed at the start of the next working day. The Trust has considered the possibility that the worker in this case may have used an incorrect number for the team.

In exercising learning from this review, we have ensured that the team's correct contact details, including the telephone number, has been re-circulated to all our partner agencies and that the lessons learned from this inquest are shared.

This learning has also been discussed within The Trust's Quality and Safety Meeting with the Wigan Borough and the team manager has shared your findings from the inquest with the team directly involved in the care of Mr Grimes.

I hope you will find the above information useful in providing assurance that all referrals received by phone into Wigan Recovery North are appropriately dealt with. If I can be of any further assistance or you require further information about the steps the Trust has undertaken, please do not hesitate to contact me.

Yours sincerely

[redacted]

[redacted]

Chief Nurse, Executive Director of Clinical Operational Services