National Medical Director and Interim
Chief Executive, NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

HM Assistant Coroner Mr Christopher Murray

Manchester South Coroner's Office
1 Mount Tabor Street
Stockport
SK1 3AG

[redacted]

8th September 2021

Dear Mr Murray

Re: Regulation 28 Report to Prevent Future Deaths – Stephen Thurm (5 February 2020)

Thank you for your Regulation 28 Report dated 17 May 2021 concerning the death of Stephen Thurm on 5 February 2020. Firstly, I would like to express my deep condolences to Stephen's family at their tragic loss.

The regulation 28 report concludes Stephen's death was a result of hanging which is likely to have resulted in asphyxia.

Following the inquest, you raised concerns in your Regulation 28 Report to NHS England regarding:

1. The inquest heard that information regarding the risk of self- harm to Stephen was passed by his family to his treating clinicians and his care coordinator but this was not taken into account as Stephen denied a recent attempt to take his own life. What steps could be taken to ensure family information is taken into account in the relevant care plan and risk assessments.

2. The inquest heard that there is no designated gap between service user appointments to allow care coordinators to write up their detailed notes contemporaneously.

3. Mr and Mrs Thurm expressed they were both suffering with a severe effect on their mental health but their care needs as the main carers was not built into any long-term plan.

I have had the opportunity to view the response from the Greater Manchester Mental Health Trust and would like to add the steps to be taken by NHS England and NHS Improvement with specific reference to carer input:

Carers are often vital in supporting people with severe mental health problems in the community. There was existing national CPA guidance which sets clear expectations around carer involvement, however, there was a need to bring this guidance (although helpful) up to date. As part of the newly published Care Programme Approach Position Statement, NHS England and Improvement has set out clear expectations for systems to provide support for carers of people with severe mental health problems and to better involve carers in care and support planning from April 2021. Specifically, to use Long Term Plan funding to develop and implement plans to improve the lives of carers of people with severe mental health problems and also to look at specific inequalities' carers may face. This includes improved communication, services proactively seeking carers' and family members' contributions to care and support planning, and organisational and system commitments to supporting carers in line with national best practice.

Thank you for bringing this important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

National Medical Director and
Interim Chief Executive, NHS Improvement