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: Greater Manchester Mental Health and NHS England. |
| 1 | CORONER<br><br>I am Christopher Murray, Assistant Coroner, for the Coroner Area of Greater Manchester South. |
| 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 6th February 2020 an investigation commenced into the death of Stephen Thurm. The investigation concluded on the 5th May 2021 and the conclusion was one of suicide. The medical cause of death was 1a Hanging. |
| 4 | CIRCUMSTANCES OF THE DEATH<br><br>Stephen Thurm endured mental health problems commencing in adolescence, which were heightened after his sister, Helena, was killed by a motorist in June 2016.<br><br>Stephen was detained at the Moorside Unit at Trafford General Hospital in September 2016 after he had smashed up his bedroom and threatened to jump from a high building. Over the following months Stephen's mental health fluctuated and he often locked himself in his room at the family home. In December 2016 Stephen took an overdose of medication and was found barricaded in a hotel room in Manchester. He had repeatedly denied suicidal ideation. He spent a further period in the Moorside Unit from December 2016 to April 2017, following which he soon began isolating himself again. He was detained under the Mental Health Act again in May 2017.<br><br>Stephen's engagement with the mental health team was sporadic. He continued to self-medicate with non-prescription drugs, alcohol and illicit substances. A further suicide attempt by Stephen was reported by one of his friends to Stephen's mother. Stephen denied this. He was under the care of consultant psychiatrists and psychologists but there was no face |

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| | to face contact with either discipline after August 2019. Stephen's parents reported their concerns that he remained a suicide risk. Stephen's behaviour became more unusual and he was displaying paranoia. On 26 November 2019 Stephen went missing and was found by the police and brought home. He continued to isolate himself and consume excess alcohol and use cannabis, cocaine and MDMA to self-medicate. On the 5 February 2020 Stephen was found suspended by a rope from a tree near to the 15th hole of Dunham Forest Golf and Country Club. He died at the scene on the 5 February 2020 from hanging which is likely to have resulted in asphyxia. |
| 5 | <u>CORONER'S CONCERNS</u><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. 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.<br><br>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.<br><br>3. [redacted] expressed they were both suffering with a severe effect on their mental health but their care needs as the main carers was not built in to any long term plan. |
| 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. |
| 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 12th July 2021. I, the coroner, may extend the period.<br><br>Your response must contain details of action taken or proposed to be |

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| | 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 namely [redacted] (family of the deceased) and their legal representatives, who may find it useful or of interest.<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 | Dated: 17th May 2021<br><br>Signature:  <br>Christopher Murray HM Assistant Coroner, Manchester South |