Department of Health & Social Care

[redacted]
Parliamentary Under-Secretary of State for
Patient Safety, Women's Health and Mental Health

39 Victoria Street
London SW1H 0EU

Our ref: [redacted]

Adrian Farrow, Assistant Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

By email: [redacted]

18 March 2025

Dear Mr Farrow,

Thank you for the Regulation 28 report of 20 December 2024 sent to the Secretary of State about the death of Antony Williamson. I am replying as the Minister with responsibility for mental health.

Firstly, I would like to say how saddened I was to read of the circumstances of Mr Williamson's tragic death, and I offer my sincere condolences to his family and loved ones. The circumstances your report describes are very concerning and I am grateful to you for bringing these matters to my attention.

Your report raises concerns over the lack of liaison or communication between the specialty teams involved in Mr Williamson's care; the absence of a formal framework (other than in cancer care and one specialist area of surgery) to facilitate inter-specialty communication; and problems with existing channels of communication between different NHS Trusts even within the same geographical area.

In preparing this response, my officials have made enquiries with NHS England to ensure we adequately address the concerns in your report.

I understand your concerns. Good communication between different healthcare services is really important, especially in cases of comorbidity.

I am aware that Manchester University NHS Foundation Trust has provided officials with a contribution towards the Department's response to your report, which sets out the arrangements it has in place to facilitate communication between specialties and with partner organisations. This also includes holding multidisciplinary team discussions to progress patient care, which are decided on a case by-case basis.

In its contribution, the Trust has acknowledged that, with regard to this case, communication between its various specialties and the two trusts was not as effective as it could have been. Its response sets out a number of changes that have been made locally to address the learning arising from this case. This includes the Matron for Mental Health Safeguarding leading work with members of the Trust's senior leadership, governance and pain service

teams to collaborate and explore ways to enhance communication between services – both within the Trust, and with partner organisations such as Greater Manchester Mental Health NHS Foundation Trust. The Manchester Safeguarding Team has also developed a simplified suicide risk assessment for the pain clinic to use for its patients, which recognises the adverse impact prolonged pain can have on a person's emotional and physical well-being. Work is ongoing across both Trusts to finalise this.

More broadly, NHS England has informed me that all community mental health services should be transforming their offer to people with severe mental health problems in line with the vision set out in the NHS community mental health framework[1], which includes the importance of services taking into account people's holistic needs, including both their mental and physical health.

I hope this response is helpful. Thank you for bringing these concerns to my attention.

Yours sincerely,

[redacted]

PARLIAMENTARY UNDER-SECRETARY OF STATE FOR
PATIENT SAFETY, WOMEN'S HEALTH AND MENTAL HEALTH

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[1] *https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adultsand-older-adults.pdf*