	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] Chief Executive Midlands Partnership NHS Foundation Trust Trust Headquarters St. George's Hospital Corporation Street Stafford ST16 3SR
1	**CORONER** I am Mr John Penhale Ellery, Senior Coroner, for the coroner area of Shropshire, Telford & Wrekin.
2	**CORONER'S LEGAL POWERS** 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** On 1st November 2021 I commenced an investigation into the death of Liam Joseph LYES-WATSON, 26. The inquest concluded with evidence being heard on the 19th of July 2022 with subsequent reasons in writing following a review of body worn video footage. The conclusion of the inquest was Suicide. The medical cause of death was Ia) Fatal Opioid Toxicity
4	**CIRCUMSTANCES OF THE DEATH** On the 26th October 2021 Liam was found deceased in [redacted], [redacted] Shrewsbury, Shropshire. There were no suspicious circumstances and no evidence of third party involvement in his death. The inquest heard that Liam had been struggling with his mental health in the weeks preceding his death. He and his mother, and subsequently his step-father, contacted the Access Team on the 20th & 25th October 2021. Following the second telephone call by Liam's step-father the call handler said that without Liam's consent they could not take action and if the situation was acute they should ring emergency services as they had previously done on the 20th October 2021.

5	**CORONER'S CONCERNS** 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. The MATTERS OF CONCERN are as follows; (1) Four areas of concern are; a. The call handler on the second occasion was not trained and needed to take professional advice from a colleague which colleague did not then speak directly with the caller. b. The apparent blanket response that they could not discuss the case with the caller yet they could take information from him. c. With that information more should have been done. d. Consideration should be given whether incoming calls to the Access Team should be recorded.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 22nd November 2022. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons; [redacted] – mother of deceased I am also under a duty to send the Chief Coroner a copy of your response. 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	 Mr John Penhale Ellery Senior Coroner Shropshire, Telford & Wrekin 27th September 2022