JOHN ELLERY
H.M. SENIOR CORONER

FOR SHROPSHIRE,
TELFORD & WREKIN AREA

H.M. Coroner's Service
Guildhall
Frankwell Quay
Shrewsbury
Shropshire SY3 8HQ

[redacted]

RESPONSE TO A REPORT TO PREVENT FUTURE DEATHS

REGULATION 29 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

THIS RESPONSE IS BEING SENT TO:

The H.M. Senior Coroner John Ellery for the Coroner Area Shropshire, Telford & Wrekin in response to a 'REPORT TO PREVENT FUTURE DEATH REGULATION 28' following an inquest into the death of Alex Alfred ROBINSON that concluded on 20 May 2026.

1	**RESPONDENT** In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, **NAME: [redacted], Group Chief Medical Officer** provides this response within 56 days (plus any extension granted) of the date of the Report to Prevent Future Deaths.
2	**DATE OF RESPONSE: 21 July 2026**
3	**CONFIRMATION OF CORONER'S MATTERS OF CONCERN** **t**he **MATTERS OF CONCERN** were identified in the report are as follows: Alex Alfred Robinson was admitted to the Royal Shrewsbury Hospital (RSH) on the 8 September 2025 when he was seen in the same day emergency centre by the consultant on call. That consultant has made a statement and in paragraph 12 sets out his plan including "arrange review by mental health liaison team (MHLT). Following discussion, MHLT provided advice and a leaflet to be given to the patient as they are not available on site out of hours to review the patient physically". In a later statement (in paragraph 3) the consultant further states "I was not present at that moment when the resident doctor discussed with MHLT service, but she informed me that MHLT informed her they will not be available to see Mr Robinson at that time".
4	**DETAILS OF ACTION TAKEN,** how has the concern been addressed. [If no action is proposed please explain why here]. *Please note that any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.* Thank you for your report sent to the Chief Executive of Shrewsbury and Telford NHS Trust on 28th May 2026, relating to preventing future deaths. This followed the tragic death of Alex Robinson, and I would like to express how sorry I am about the terrible impact that this had on Alex's family and friends. We have reviewed the care provided by SaTH on the 8th September 2025. To add to the information provided to the inquest, I have sought clarity on the sequence of events leading up to the advice

	received from mental health professionals on that day. The resident doctor who saw Mr Robinson estimates that she would have spoken to the Mental Health Liaison Team (MHLT) health care professionals between 9.30 pm and midnight on the 8th September. She advised she called from the doctor's office from one of the doctor's phones in what used to be the old Acute Medical Assessment Area. The resident doctor advised she called the number that is listed on the MHLT page on the intranet. [redacted]. Our resident doctor explained that the healthcare professional who answered the call advised Mr Robinson's presentation would not be within their remit as it was an 'normal and expected reaction' for someone going through a significant life event such as breaking up with a long-term partner as Mr Robinson was. The resident doctor remained concerned and therefore asked if she could visit the MHLT office (by bereavement office at SaTH) to discuss. The resident doctor went to their offices but unfortunately cannot recall any of their names. She relayed the information once again to the MHLT who again reiterated it was not unusual due to the life event and offered some leaflets which she took which are the ones presented in the notes. The resident doctor remained concerned as Mr Robinson was not eating or drinking but relied upon the advice given by MHLT. As MHLT advised it was not within their remit, the resident doctor did not feel the need to make a formal referral. The resident doctor was not aware of the formal online form at the time however did not question any further following the advice she was given by MHLT. We have confirmed that photocopies of the leaflet that our resident doctor indicated had been given to her by MHLT are in Mr Robinson's notes and the original leaflets were provided to Mr Robinson. We have checked our switchboard records, and these confirm that a call was made from extension [redacted] which is located in the doctor's office and made to the MHLT, extension [redacted] at 23:19pm on 8th September 2025. Representatives from MPFT have confirmed that they have no record of the above and confirmed that they have not had a formal referral. We have identified that a formal referral involves completing of the online form. Our conclusion and learning from this is that all contact with MPFT needs to be documented on the online referral form and a copy kept in the notes. We believe this should resolve any ambiguity about advice received and therefore potentially reduce the risk that level of concern for a patient's mental health has not been fully understood. We will also reiterate to staff the importance of recording the name of any healthcare professional who has given advice in the medical notes. We will provide Trust-wide communications to highlight the need to use the online referral form.

5	**DETAILS OF FURTHER ACTION PROPOSED** *Please note that any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.*
	SIGNATURE [redacted]