	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Midland Partnership NHS Foundation Trust, Chief Executive, Trust Headquarters, St George's Hospital, Corporation Street, Stafford, ST16 3SR**
1	**CORONER** I am Mr Andrew Haigh Senior Coroner for the coroner area of Staffordshire South
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 30th of December 2020 I commenced an investigation into the death of Susan Janet ADAMS. The investigation concluded at the end of the inquest on 20th April 2021. The conclusion of the inquest was 'alcohol related' with the cause of death being Combined toxicity of ethanol, pregabalin and fentanyl with hepatic cirrhosis and steatosis.
4	**CIRCUMSTANCES OF THE DEATH** In 1989 while working as a Police Officer Susan Adams was severely assaulted and she never fully recovered from this. She suffered pain and developed a problem with her mental health and excess alcohol consumption. On 4th November 2020 she was unable to live in her home in Tamworth and she was found dead in a hotel in Sutton Coldfield where she was temporarily staying. Death resulted from the consequences of drinking too much alcohol.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed a matter 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 **MATTER OF CONCERN** is as follows: Mrs Adams and her family lived in Dosthill, Tamworth, Staffordshire. I was told that this was approximately 50 feet from the border with Warwickshire (and not far from West Midlands as well) and that her GP Practice was in Kingsbury Warwickshire. She needed regular psychiatric assistances from secondary mental health services and I was advised there were significant commissioning difficulties with this because of the home address and GP Practice being in different counties. Mrs Adams could access the crisis team in Staffordshire but long term treatment was supposedly to be provided in Warwickshire. This may have impacted on the care that Mrs Adams received and

	could be relevant for others who live close to county boundaries. I wonder if anything can be done to facilitate arrangements for secondary psychiatric care in these circumstances.
6	**ACTION SHOULD BE TAKEN** 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** You are under a duty to respond to this report within 56 days of the date of this report, namely by 10th June 2021. 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] and to [redacted] at Pear Tree Surgery. 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	**21st April 2021** Andrew A Haigh ..... HM Senior Coroner Staffordshire (South) Coroner's Office No 1 Staffordshire Place Stafford ST16 2LP Tel No: 01785 276127 [redacted]