



Legal Department B1 – Unit 1 50 Summer Hill Road Birmingham B1 3RB

James Bennett
Area Coroner for Birmingham and Solihull
The Birmingham and Solihull Coroner's Court
Steelhouse Lane
Birmingham
B4 6BJ

BY EMAIL ONLY

Our Ref: Yousef

Your Ref: 222719 - Khalid Seneen YOUSEF ■

Date: 15 August 2022

Dear Mr Bennett,

Re: Prevention of Future Deaths in the inquest of Khalid Yousef (deceased)

Thank you for sharing the Prevention of Future Death's report with us on 23 June 2022. We would like to assure you that the Trust takes your concerns very seriously. The incident which led to the inquest was a tragic set of circumstances and the Trust has taken action to respond to the concerns you have raised within your report. I intend to respond to each of the points in turn.

1. The L&D police custody suite model has not commissioned psychiatrists.

The Birmingham and Solihull Mental Health NHS Foundation Trust gave evidence in court during the inquest that the Liaison and Diversion Service follow the national model. The Trust is therefore unable to respond to the point around commissioning of psychiatrists within the model. We note that NHS England was also sent a copy of the Prevention of Future Deaths Report and we hope that they will be able to provide more information to you in due course.

2. Liaison and clarity is needed between Chief Constables and the Trusts providing L&D services on who has responsibility for mentally unwell persons in custody.

The Trust has placed the matter onto the agenda at the next JSOG (Joint Strategic Operational Group), where the Trust meet with the Police and other stakeholders on a regular basis. The next meeting is due to take place on 18th August 2022. The meeting will discuss how to share this information between agencies to ensure that the message is shared clearly and clarity is gained around what the Liaison and Diversion Service are responsible for.

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3. West Midlands Police officers and BSMHFT staff do not sufficiently understand the role and limitations of the L&D police custody suite model.

As stated in point 2 above the Trust intends to discuss this in more detail at the JSOG meeting in August. This meeting will address your concerns around cross-agency information. However, in order to address the internal issue around understanding the role of the Liaison and Diversion Service, the Manager of the team will be carrying out internal work with the Trust Communications Team to put a piece together as part of the weekly bulletin outlining what the team do. This will be completed in line with the outcome of the current tender for the new integrated offender health service, which will incorporate liaison and diversion in custody. This will ensure the greatest visibility, clarity and impact with the communication. We expect to be in a position to complete this in September 2022.

4. BSMHFT have not learnt sufficient lessons from the incident and need to review experience, training and supervision of L&D practitioners.

The Trust takes these issues very seriously. Up until the point of the inquest hearing the Trust was not made aware of any concerns around experience, training or supervision for On hearing the issues raised during the inquest, the Head of Patient Safety met with the Team Manager to raise these matters for reflection and to ascertain if any improvements are required. This would be part of our usual process for reflective practice within the Trust.

The Team Manager is now working on a project which will be completed by the end of October 2022 to review the current induction programme and produce an up to date induction programme which is suited to different team roles and areas of work. This will include an induction pack, shadowing and training package for all new staff and students. As part of the new tender process which is also currently taking place, the Trust have also planned to have psychologists join the L&D for reflective practice groups which are to take place. Through this work there will be assurance that training, supervision and experience are a priority and changes are made where necessary.

Please be assured that the Trust will continue to make any necessary changes or improvements to ensure patient safety and learn lessons from incidents in the future.

