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Tel: [REDACTED]

Mr Adam Hodson,  
Deputy Coroner,  
Birmingham and Solihull Areas,  
BIRMINGHAM  
B4 6BJ

BY EMAIL ONLY TO: [REDACTED]

Our Ref: [REDACTED]

Your Ref: [REDACTED]

Date: 29 July 2024

Dear Mr Hodson,

**Re: Prevention of Future deaths Shelemiah Peterkin**

Thank you for your Prevention of Future Deaths report dated 20 June 2024 with. May I begin by offering my sincere condolences to Shelemiah's family. I understand that explanations were given during the inquest to offer assurances that lessons have been learned, but further information has been requested through your Prevention of Future Deaths report. I will aim to respond to each of your points in turn.

**Matter 1- Relating to staffing**

Since this time, Lyndon CMHT has successfully recruited into all vacant posts. Additional investment into the team has also taken place as a result of Community Mental Health Transformation, this has increased the workforce capacity within the team, these roles have also been recruited into. With the additional funding and successful recruitment into all vacant posts, it is unlikely that the team will face inadequate levels of staffing in the immediate future. If however this was to occur, there is a clear escalation process in place that would ensure a timely review of any gaps and would support the development of a clear plan to mitigate the identified risks.

**Matter 2- Early Warning Signs**

This was discussed at the Clinical Risk Processes Group on 13th June 2024, with a further meeting chaired by the Deputy Medical Director and Head of Patient Safety on 21st June 2024. It was agreed that Early Warning Signs is a core skill of those who have undertaken clinical training, and that further support for this will be incorporated into the DIALOG+ (care planning and safety planning) training for staff which is currently underway. Additionally, the current CPA Part B Care Plan and the new Dialog+ Safety Plan have been reviewed and there are information and descriptor sentences already built into these forms to indicate the expected standard for the description of an Early Warning Sign. There are processes in place for teams to review the completion and quality of Care Plans through audits and clinical supervision.

Chair: [REDACTED] | Chief Executive: [REDACTED] | Website: [www.bsmhft.nhs.uk](http://www.bsmhft.nhs.uk)  
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I sincerely hope that this has offered you the reassurances that the Trust takes learning very seriously and actions taken are followed up.

Yours sincerely

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**Chief Executive  
BSMHFT**