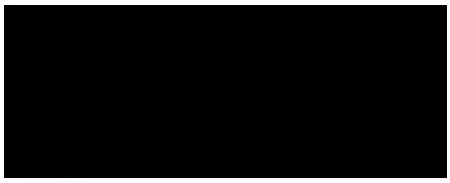
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **CHIEF EXECUTIVE OF BIRMINGHAM AND SOLIHULL MENTAL HEALTH FOUNDATION TRUST**
1	**CORONER** I am Mr Adam Hodson, HM Assistant Coroner for Birmingham and Solihull
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 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 8 February 2024 I commenced an investigation into the death of Shelemiah Pedaiah PETERKIN. The investigation concluded at the end of the inquest. The conclusion of the inquest was: Suicide
4	**CIRCUMSTANCES OF THE DEATH** **On 02/10/2023, Shelley was reported missing by a friend. Following concerns for Shelley's welfare, police forced entry to her home at 23:45 where she was sadly found deceased, and she had clearly been deceased for some time. Post mortem and toxicological analysis confirmed that she died as a result of intentional consumption of [redacted], which she had purchased off the internet. Shelley had been spoken to by police on 03/09/2023 about the reasons for the purchase and she had reassured them as to its use. She had a history of poor mental health and was under the care of the community mental health team at the time of her death. Shelley had missed her planned monthly depot injection on 18/09/23 and the mental health team were trying to locate her. There was a missed opportunity by the police to force entry to her home on 27/09/2023, but it is not possible to say whether she would have been found alive at that time.** Following a post mortem, the medical cause of death was determined to be: **1a [redacted] poisoning** **1b** **1c** **II**
5	**<u>CORONER'S CONCERNS</u>** 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. – **<u>Matter 1</u>**

	1. I heard evidence that there was a 6-day delay in the Community Mental Health Team team making a referral to the Home Treatment Team which was put down "clinical pressures". Upon discussion, these "clinical pressures" related to staffing levels and the evidence was that at the time the team was meant to have 7 clinical members of staff but only had 3. I was told that matters have improved somewhat and that now there is sufficient staffing levels. 2. However, it was confirmed that gaps in staffing levels do occur which can have a knock-on effect of causing issues with service delivery and care for patients. 3. It is not difficult to foresee that inadequate staffing levels will give rise to missed opportunities for patients to be assessed; for interventions to take place; and for treatments to be given - particularly where patients may choose to disengage with services but who do not demonstrate any "red flags" or early warnings, as was the case with Shelley. 4. As such, I am concerned about the risk of future deaths occurring if staffing issues arise in the future. **<u>Matter 2</u>** 1. I heard evidence from the Structured Judgment Review that a learning point was identified that early warning signs were not completed to the required expectation or standard. 2. As such, an Action Plan was prepared and a task was agreed that this would be discussed at the Trust Risk and Task Finishing Group to establish clear clinical standards, with the same then being disseminated within the Trust. This was allocated to the Clinical Service Manager for ICCR and was due to be completed by May 2024. 3. In evidence, it was confirmed that target had been missed due to a meeting being cancelled, but assurance was offered that it would take place in July - after the inquest has concluded. 4. I am concerned that if this target is pushed back and/or is not met, for whatever reason, there is a risk that future deaths will occur. Upon conclusion of the inquest, I am *Functus Officio*, with no power to request updates from the Trust to check and ensure that targets have been met and changes have been made. Whilst I am grateful for the efforts of reassurance provided by representatives of the Trust at the inquest, I am reluctant to dismiss my concerns, particularly where actions remain outstanding, and I have opportunity to take action now to ensure that the risk of future deaths is reduced. It is for you and your organisation to take the action that is required to resolve the issues and to prevent future patients from dying avoidable deaths. It is not for me as Coroner to make recommendations on how you do that, therefore I leave matters in your hands.
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 15 August 2024. 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] (Next of Kin) I have also sent it to the ICS and NHS England who may find it useful or of interest. 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	**20 June 2024** Signature:  **Adam Hodson** **Assistant Coroner for Birmingham and Solihull**