


**Private & Confidential**

For the attention of:  
His Majesty's Assistant Coroner Inner  
North London  
St Pancras Coroner's Court  
Camley Street  
London N1C 4PP

  
Senior Service Lead  
Haringey Community Mental Health Services  
Barnet, Enfield and Haringey Mental Health NHS Trust  
St. Ann's Hospital  
St. Ann's Road  
Tottenham  
London  
N15 3TH



18<sup>th</sup> January 2024

Dear Madam,

Regarding: Mr Mohammed Zeeshan Akram (Zee)  
DOB: 22/11/90  
Date of death: 21/03/2023  
Address: Known to the Trust

This letter forms the Barnet Enfield and Haringey Mental Health NHS Trust's ("the Trust") response to the application sections of the Prevention of Future Deaths Report following the hearing regarding the death of Mr Mohammed Zeeshan Akram (Zee), held on 6<sup>th</sup> September 2023 before Assistant Coroner Lee at St Pancras Coroner's Court.

*The MATTERS OF CONCERN are as follows.*

*I heard evidence that there was no routine mechanism to cross reference what people are prescribed and what medication they are actually collecting, and no automatic notification to GPs who are responsible for the medication prescribing. Zee informed BEH that he had not taken his olanzapine and fluoxetine for two weeks. His GP, who was prescribing that medication, was not informed.*

*I am concerned that GPs are not updated, particularly where patients have expressed suicidal ideation, and may not be aware that people are not taking medication and/or that there may be a risk of stockpiling.*

The above matters were considered, and the following response is provided.

The usual procedure within the Early Intervention Psychosis Service ("the service") when the clinical team become aware that a client is not taking their medication as prescribed, is to discuss this with the client, their family, and carers (where appropriate) to understand the reasons behind this and to support the client to continue with the medication as prescribed wherever possible.



In situations where the client is experiencing side-effects, has stopped their medication completely or is requesting a change in medication, a review with the prescribing clinician will be arranged. The timeframe for this review will be informed by the urgency of the issue and associated risks. In the service, one in three of the medical appointments are always available for urgent reviews within five working days.

This medication review by the prescribing clinician will automatically lead to the GP being notified when there are any changes to the client's prescription or treatment plan, including whether the client has stopped taking the medication and any steps the service is taking to provide additional support. The expected standard is the GP would receive this correspondence via email within 48 hours of the medical review. In cases where a rapid medical review is arranged, the service will usually wait until the review before updating the GP, to ensure the GP is provided with the most up to date treatment plan.

Where there are concerns about a use of specific medication, e.g., benzodiazepines or Lithium, clinicians will routinely liaise with GPs to ensure safe prescribing, outside of planned medical reviews.

In this case, the clinician became aware the client had stopped taking his prescribed medication on Thursday 16<sup>th</sup> March 2023, which led to a multidisciplinary team (MDT) discussion at which the agreed plan was for an urgent medical review. This was arranged for Monday 20<sup>th</sup> March 2023, the next available urgent appointment. The MDT discussion also considered whether a referral to a Crisis Resolution & Home Treatment Team was warranted, but felt the threshold was not met.

Since the medical review was arranged for two working days after the service was made aware the client had stopped their medication, we would not have expected additional communication with the GP prior to the medical review.

The Trust is grateful for the opportunity to review procedures following Mr Akram's passing.

Finally, the Trust offers its sincere condolences to the family and friends of Mr Akram. In doing so, the Trust remains committed to the delivery of patient-centred care to its service users.

We hope the above has addressed the matters raised in the Prevention of Future Deaths report.

Yours sincerely,

[Redacted signature]

[Redacted name]

Senior Service Lead  
Haringey Community Mental Health Services  
Barnet, Enfield and Haringey Mental Health NHS Trust



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