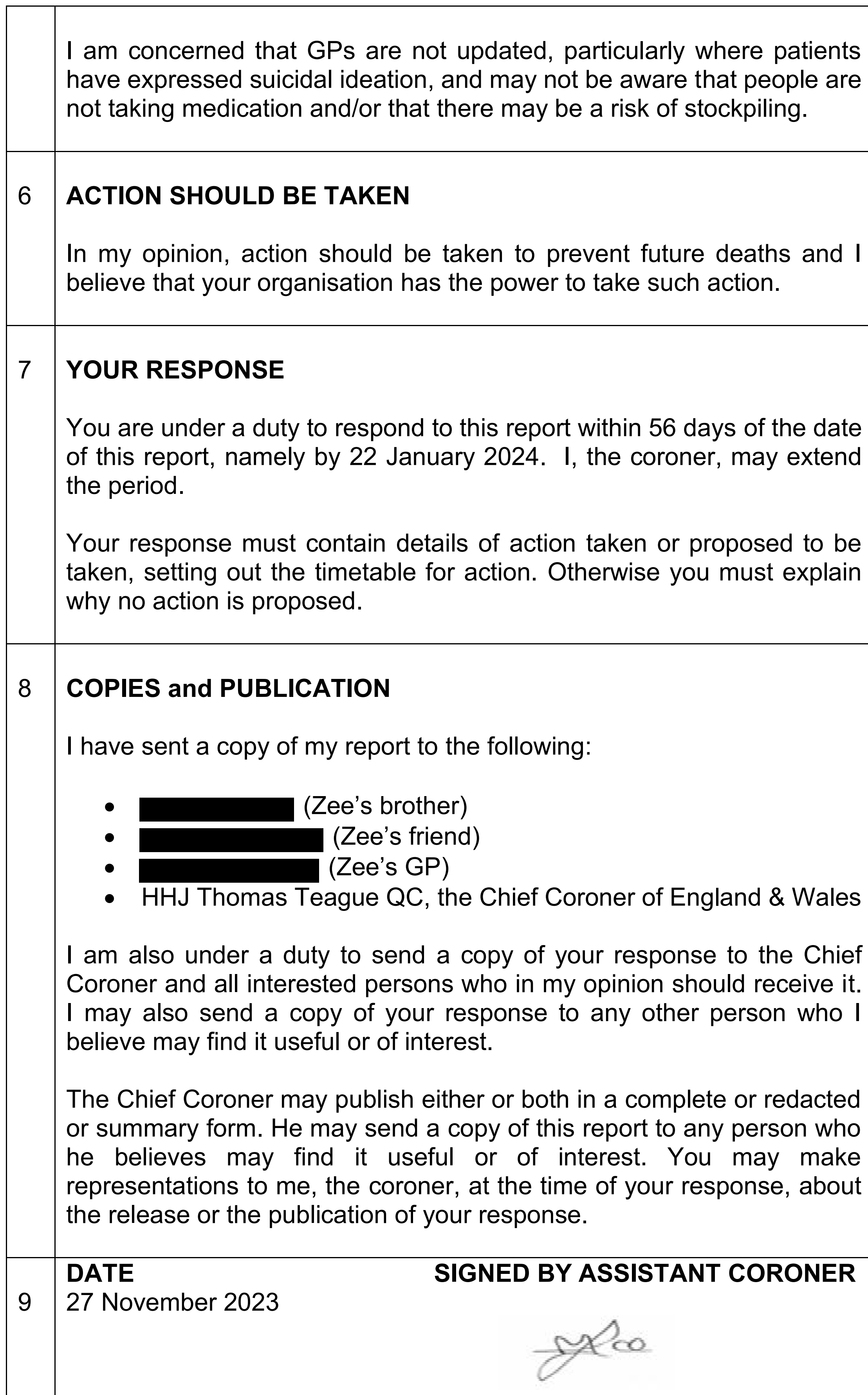
Regulation 28: Prevention of Future Deaths report

Mohammed Zeeshan Akram (Zee) (died 21 March 2023)

	THIS REPORT IS BEING SENT TO: 1. **Barnet Enfield and Haringey Mental Health NHS Trust**
1	**CORONER** I am: Melanie Sarah Lee Assistant Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 27 March 2023 an investigation was commenced into the death of Mohammed Zeeshan Akram, date of birth 22 November 1993. The investigation concluded at the end of the inquest on 6 September 2023. The conclusion was suicide. The medical cause of death was 1a. multiorgan failure; 1b. acute ethylene glycol toxicity; 2. mental health disorder.
4	**CIRCUMSTANCES OF THE DEATH** Zee had a history of suicidal ideation and reported suicide attempts dating back to his childhood. In February 2019 he was diagnosed with a psychotic disorder. He received support for his mental health from the Crisis Team in 2019 and spent two days as a mental health inpatient. In December 2022 Zee reported panic attacks and auditory hallucinations. He was taken on by the Crisis Team who prescribed diazepam, zopiclone, olanzapine and fluoxetine. On 30 December there was a joint review by the Home Treatment Team and Haringey (BEH) Early Intervention Service (EIS) at St Ann's Hospital and Zee was allocated a care coordinator. On 30 December Zee was

	discharged from the Home Treatment Team who wrote asking the GP to continue repeating his medications which were zopiclone [redacted] olanzapine [redacted], fluoxetine [redacted] and diazepam [redacted]. In February 2023 Zee's mental health deteriorated. On 15 February he reported EIS that he was experiencing negative side effects from his medication but that he felt mostly optimistic. He requested a reduction of olanzapine. There was an exchange of text messages between Zee and a dual diagnosis recovery worker between 17 February and 15 March in which Zee appeared upbeat, said that he was attending work and gave no cause for the recovery worker to be concerned. On 16 March Zee attended an appointment and informed his recovery worker that he had stopped taking his olanzapine and fluoxetine 2 weeks previously due to numbness that had led to suicidal ideation. The recovery worker went out of his way to arrange an urgent medical review for Monday 20 March. Zee was given safety netting advice. After this appointment, Zee went to [redacted] where he spent several hours contemplating throwing himself into the Thames. He did not inform his recovery worker of this or contact the crisis team. On Friday 17 March the recovery worker sent Zee a text message with the appointment for a medical review on Monday 20 March. Zee replied that he was unable to make the appointment as he was working on the Monday and so the appointment was rearranged for Tuesday 21 March. On 20 March Zee did not attend work. A friend went to his flat and found Zee unresponsive. Zee was taken to the Whittington Hospital where he died on 21 March 2023.
5	**CORONER'S CONCERNS** 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. 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.

6 **ACTION SHOULD BE TAKEN**

In my opinion, action should be taken to prevent future deaths and I believe that your organisation has 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 22 January 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 following:

- (Zee's brother)
- (Zee's friend)
- (Zee's GP)
- HHJ Thomas Teague QC, the Chief Coroner of England & Wales

I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest.

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.

9 **DATE** — **SIGNED BY ASSISTANT CORONER**

27 November 2023