Essex Partnership University
NHS Foundation Trust

06 October 2025

Chief Executive Office
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Wickford
Essex
SS11 7XX

[redacted]

Private and Confidential
Ms Sonia Hayes
HM Area Coroner for Essex
Coroner's Office
Seax House
Victoria Road South
Chelmsford
CM1 1QH

Dear Ms Hayes,

Resmije Ahmetaj otherwise known as Merita Brahimi (RIP)

I write to set out the Trust's formal response to the report made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, dated 12 August 2025 in respect of the above, which was issued to the Trust and Basildon Car Park Management following the inquest into the death of Ms Brahimi.

I would like to begin by extending my deepest condolences to Ms Brahimi's family. The Trust sympathises with their very sad loss.

The matters of concern as noted within the Regulation 28 Report have been carefully reviewed and noted. I will now respond in full to these concerns in respect of those concerning the Trust, in the hope that this provides both yourself and Ms Brahimi's family with comprehensive assurance of changes that have been made and already underway to address the concerns you have raised.

Concern 1) EPUT mental health team were relying on the clozapine clinic staff to monitor Ms Ahmetaj's mental health, but this was not the purpose of the clinic. Staff took blood samples and vital signs with a quick chat that took about 5 minutes and were not undertaking a mental state examination.

Response:

It is important to appreciate that the Clozapine clinic is not a standalone service but part of the wider mental health team. Personnel who run the clinic are Care Coordinators, who hold their own caseload and are part of the service Multi-Disciplinary Team (MDT).

Where possible patients seen through the Clozapine clinic are assigned a Care Coordinator who forms part of the Clozapine clinic staff in order to ensure continuity of care. As such, Ms Brahimi's Care Coordinator was part of the Clozapine clinic and provided support both in the Clozapine Clinic and in her role as Care Coordinator outside of the clinic.

A protocol for clozapine clinics forms part of the Trust's Formulary and Prescribing Guidelines which sets out the responsibilities of the various parties to this support pathway and provides the practicalities of running these clinics. The purpose of these clinics is

primarily to enable the undertaking of the mandatory blood testing required for continued supply of clozapine.

The Trust ethos is to make every contact count and each contact is therefore an opportunity to interact with a patient and for staff to monitor a patient's mental state, which is also undertaken by the care co-ordinators as part of their role within this clinic.

Patients attend clozapine clinic for the duration they are prescribed the medication which may be many years; during which staff are able to build relationships with the patients over time. Formal mental health assessment is only one method for assessing a patient's mental state and staff are cognisant that patients can prepare answers when they become familiar with an assessment tool. There is considerable value in the informal discussions used at the clinic to gain insight into a patient's mental health. If there are any indicators of concern these are escalated to the Consultant and / or the assigned Care Coordinator for onward clinical management.

We would like to assure the Court and the family that this concern has been shared with the mental health team manager and team in order that review and reflection can be carried out in respect of this PFD and the Court findings in this case.

Concern 2) There was confusion about the mental health Trust prescribing dose for Ms Brahimi's antidepressant medication and an overreliance on discussions with her rather than checking the prescription dose and communication with the GP was delayed.

Response:

In mental health practice, medication non-adherence and patient-led dose adjustments are common. Patients may alter their prescribed regime for example, by taking half a tablet instead of the full dose depending on how they feel. This can result in discrepancies between what is prescribed, what is dispensed, and what the patient reports. Such challenges are well recognised in the wider clinical literature, and clinicians are often required to navigate uncertainty between prescribed and actual medication use.

In this case, during the consultation with the doctor on the 22nd May 2024 the patient reported that she was taking sertraline [redacted] and this was documented in the clinical notes on the day by the doctor. A brief letter was sent to the GP on the same day requesting an increase in dose of Sertraline (t[redacted]). The GP responded on the 24th May 2024 advising that the patient was in fact prescribed and reporting use of sertraline 200 mg. This is the maximum licensed dose. This meant there was no role for recommending a further increase, and the appropriate course of action was to review the patient at her next planned appointment which would be on 1st July 2024 to consider alternative treatment options. At this time there were no indications to suggest a need to bring the appointment forward.

On reflection, the discrepancy between the dosage understood by the doctor, based on the patient's account, and the dosage confirmed by the GP was not recorded in the clinical notes. In addition, the actions required following receipt of the GP's response were not documented.

Whilst this discrepancy was not causative of the sad outcome in this matter, reliance on the patient's report was made in good faith as part of the therapeutic process. I can assure the Court that, moving forward, the importance of clearly recording and communicating any inconsistencies between a patient's reported medication dosage and the dosage prescribed by the GP will be reinforced with the medical team, in order to ensure safe and effective prescribing and to minimise the risk of confusion.

Concern 3) There were issues around communication and escalation within the Trust mental health team. A routine 6-month blood anti-psychotic to check clozapine levels assay was taken on 3 June and the results reported on 7 June were sent to the psychiatrist and showed markedly sub therapeutic blood levels of antipsychotic medication. This subtherapeutic level was not acted upon and was contrary to:

a. Ms Ahmetaj insisting she was compliant with her medication
b. Ms Ahmetaj did not have any noted risks that would cause interference with her medication.
c. Ms Ahmetaj informed EPUT clinicians that:

i. On 24 June she thought her medication Clozapine was not working
ii. On 27 June she no longer wished to take her prescribed antipsychotic medication, and
iii. Did not agree she had Schizophrenia, and
iv. wanted to revert to a previous medication Quetiapine.

These matters were not escalated to the psychiatrist and Ms Ahmetaj was informed to continue her clozapine and wait for her appointment on 1 July and there was no consideration of the risk of relapse of psychosis.

Response:

The plasma Clozapine assay undertaken on 3rd June 2024 and reported on 7th June demonstrated a markedly low levels of clozapine in the plasma. The result were reviewed by the clinical team. It is important to emphasise that this did not reflect sub-therapeutic prescribing, as the patient's Clozapine dose had remained unchanged since discharge. A previous Clozapine assay undertaken in 2023, at the same dosage, confirmed a therapeutic plasma level of 0.53.

National and local guidelines emphasise that Clozapine plasma levels are an adjunct to clinical decision-making and should not be used in isolation to guide practice. Clinical assessment of the patient remains the primary determinant of treatment intervention.

The most likely cause of unexpectedly low plasma levels is non-adherence. Accordingly, the first step in clinical management should be to review the patient's report of compliance. Other factors may also influence assay results, particularly the timing of blood sampling in relation to dosing, an important consideration for patients prescribed Clozapine twice daily. These aspects should be explored with the patient before any treatment changes or dose adjustments are recommended, which was put in place for this patient (see further below)

In this case, the patient had been maintained on the same Clozapine dose for over one year, with previously documented therapeutic levels. Between 7th June (when the assay result became available) and 27th June, the patient was reviewed on five occasions by the community mental health team. No evidence of rebound psychosis or acute relapse was identified during these reviews. An appointment with the consultant psychiatrist was already scheduled for 1 July and there was no indication of a need to bring forward appointment based on the community contacts.

As set out in evidence at this hearing, Ms Brahimi engaged well with the community team and was seen both at home and at clinic. She presented well and very consistent and this was documented in her medical record. We acknowledge that the documentation was lacking in explicitly linking the low clozapine levels and monitoring of mental state through

community contacts. As stated above, in the event that a patient displays deterioration in mental health state the community staff would escalate this to the consultant.

It is recognised that urgent escalation is generally indicated where Clozapine plasma levels are found to be *elevated* due to the risk of toxicity. In contrast, guidance for low levels suggests the following pathways:

- Consider repeating the assay if results are unexpected, particularly where they differ markedly from previous assays on a stable dose and no external factors are evident.

- Assess whether the laboratory finding is consistent with the patient's clinical presentation before initiating treatment changes.

On reflection, while the management of this case was consistent with current guidance, there are learning points regarding communication and escalation. Specifically, inconsistencies between assay findings, patient-reported adherence, and clinical stability should have been explicitly documented and escalated to the consultant psychiatrist at an earlier stage. Doing so would have provided additional assurance around risk management and strengthened the therapeutic dialogue with the patient. This learning is being taken forward by the MDT.

Concern 4) The mental health Trust record-keeping did not contain all relevant information relating to the care and treatment there were omissions relating to symptoms and potential signs of deterioration and compliance with medication.

Response:

The Trust recognises that quality record keeping is a challenge for NHS organisations and as such there is continuous focused improvement work undertaken across the Trust. We were grateful for your acknowledgment of the improvements in clinical documentation in respect of cases coming before your Court.

We offer our assurences to the Court and the family in respect of the robust monitoring methodologies for record keeping including an annual audit, regular local audits using the Trust Tendable system and record keeping reviews as part of 1:1 supervision with staff. Staff hold a professional responsibility for good practice in their record keeping and all staff are regularly reminded of this.

Additionally we can confirm that discussions have been undertaken with service leads with regards to record keeping in respect of this particular case and highlighting importance of timely and detailed record keeping. Service Managers were tasked to emphasise the importance of this service staff.

The Trust has continued with a Record Keeping Safety Improvement Programme (SIP). This SIP program is focusing on improving patient safety in respect of documentation specifically. The approach will be to support continuous learning and improvement and regular review.

To further support staff the Trust has developed a new Clinical record keeping guidance to help guide staff on what is a good clinical record.

Concern 5) Clozapine constipation was raised as a serious side effect such that there is a Trust policy to manage this matter. This was not dealt with within the Trust for Ms Ahmetaj, and it took two weeks to raise this for the GP to manage. This did not cause or contribute to Ms Ahmetaj's death however there is a concern for the long delay for other patients.

Response:

The importance of bowel habits is covered in the clozapine clinic protocol and in section 2 of the Formulary and Prescribing Guidelines. This includes a template letter (Appendix 3 of Section 2) for use when patients are initiated on clozapine to inform the patient's GP practice that there are side effects, including constipation and interactions that they need to be alert for. The clozapine clinic protocol includes a proforma for monitoring side effects and specifically highlights the need to ask patients about bowel habits.

Ms Brahimi was reviewed in the outpatient clinic on 22 May 2024, and a letter was sent to the GP on 7 June 2024 flagging concerns about constipation. Whilst the GP was of course able to obtain any further detail from the clinic as required, it is acknowledged that the letter did not provide sufficient clinical detail, such as current severity, frequency of bowel movements, or associated symptoms. The patient's presentation at this time did not however indicate a deterioration or any other serious complication at this stage. The lack of sufficient detail within the letter, whilst regrettable, (and as acknowledged in the PFD report) did not contribute or directly cause the patient's sad death.

We can assure the court that the Trust provides staff with clear guidance in the Clozapine policy last issued in January 2025 on the assessment, monitoring, and documentation of Clozapine-related constipation. The updated policy from January 2025 has been disseminated widely across the medical teams, and a dedicated teaching session took place on 2nd of October 2025 to reinforce best practice in the monitoring and documentation of Clozapine side effects.

I hope that I have provided some reassurances around the steps that we have taken to address the issues of concern contained within your report. We know there is an acute need to embed and effect change, hence we will monitor the above provisions to ensure these are contributing to our overall aim of keeping patents safe and delivering therapeutic care.

Please do let me know if you require any further information at this stage.

We understand that a copy of this reply will be shared with the family.

Yours sincerely,

Chief Executive