REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], CEO, Essex Partnership NHS Foundation Trust** **2. Basildon Car Park Management**
1	**CORONER** I am Sonia Hayes, Area Coroner, for the coroner area of Essex
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 16 July 2024 an investigation was commenced into the death of Resmije Ahmetaj otherwise known as Merita Brahimi, aged 53 years who died on the 30 June 2024. The investigation concluded at the inquest on 18 June 2025. The conclusion of the inquest was a Narrative: Resmije Ahmetaj otherwise known as Merita Brahimi fell from a height at the car park whilst suffering from an exacerbation of psychosis contributed to by subtherapeutic antipsychotic medication with a medical cause of death of '1a Traumatic head injury, 1b Fall from height.
4	**CIRCUMSTANCES OF THE DEATH** Resmije Ahmetaj otherwise known as Merita Brahimi died on 30 June 2024 from Traumatic Head Injury as a consequence of fall from a height from the Multi Storey Car Park, Great Oaks, Basildon and did not have capacity to formulate an intention to take her own life. Ms Ahmetaj had a history of delusional disorder and had been suffering with psychosis and was diagnosed with Schizophrenia in 2023 and was on medication. Antipsychotic medication assay blood test results on 7 June 2024 indicated that this medication was not at a therapeutic level for treatment resistant schizophrenia. This was not escalated. Ms Ahmetaj was suffering from an exacerbation of her psychosis as a consequence. Ms Ahmetaj had informed the mental health team on 24 June she did not need her medication and the assay results available in the records were not noted. On 27

	June Ms Ahmetaj informed mental health that she did not think her medication was working, that she did not want to take it and did not agree she had schizophrenia. Ms Ahmetaj had requested alternative medication that had been previously prescribed. This was not escalated. Ms Ahmetaj went to see family and it was noted her mental health had deteriorated with evidence of relapse of her psychosis.
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. – Essex Partnership University NHS Foundation Trust (EPUT) (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. (2) There was confusion about the mental health Trust prescribing dose for Ms Ahmetaj antidepressant medication and an overreliance on discussions with her rather than checking the prescription dose and communication with the GP was delayed. (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 subtherapeutic 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. (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. (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. **Basildon Car Park Management** (6) The car park has a link walkway to residential housing on the penultimate floor from where Resmije Ahmetaj fell. The top floor has mitigation that would prevent a person from jumping/falling but the penultimate floor that has a pedestrian link walkway does not. There is likely to be more pedestrian footfall on the penultimate floor as a consequence and any fall from this height would inevitably be fatal.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 7 October 2025. 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.
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	COPIES and PUBLICATION I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: • Family (Brother and Sister) • Care Quality Commission 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	 **12 August 2025** **HM Area Coroner for Essex Sonia Hayes**