Department of Health

Rt Hon Alistair Burt MP
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Mr A. Walker
Senior Coroner
North London Coroner's Court
29 Wood Street
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16 JUL 2015

Dear Mr Walker,

Thank you for your letter of 13 May 2015 following the inquest into the death of Hana Elhamid. I was very sorry to hear of Miss Elhamid's death and wish to extend my sincere condolences to her family.

Although the medical cause of Miss Elhamid's death in 2014 was respiratory failure, you consider that if she had been diagnosed as having diabetes in 2012, then none of the other medical events, which ultimately led to her death, would have occurred.

You point out that there was an opportunity to test Miss Elhamid for blood sugar levels while she was in the care of the London Treatment and Rehabilitation Centre (LTRC), which would have revealed the diabetes at a time when it could have been treated and managed.

You raise the following concerns:

- that the patient developed diabetes when on long term Clozapine treatment
- that routine blood tests for sugar in the blood are likely to have prevented events that led directly to Miss Elhamid's death.

I expect any patient in a mental health setting to receive all appropriate care and treatment for mental and physical health conditions.

Barnet, Enfield and Haringey Mental Health Trust (BEHMHT) confirm that it was recommended that Miss Elhamid start a trial of Clozapine in February 2009. In April 2009, Miss Elhamid was transferred to the Ashwood Centre in Croydon , (part of the LTRC) where, I am told, she was not prepared to have blood tests taken and so the trial was not initiated. Miss Elhamid did not begin taking Clozapine until May 2012,

whilst in the care of LTRC. I understand that LTRC could not provide you with records detailing blood glucose tests taken between May 2012 and November 2012 as no such tests had been carried out.

BEHMHT conducted a root cause analysis investigation following the death, which examined whether the clinical care and treatment at BEHMHT was to an acceptable standard and in accordance with policies and procedures. You may wish to contact BEHMHT directly for further background information about this investigation and its outcome.

Clear guidelines, concerning the monitoring of patients who are using antipsychotic medication such as Clozapine, exist and are published by NHS Choices and the National Institute of Health and Care Excellence (NICE). The raised risk of developing diabetes when on Clozapine treatment is known.

In addition, NICE's clinical guideline, *Psychosis and schizophrenia in adults: treatment and management (CG 178)* advises that blood glucose is checked before starting antipsychotic medication; that the secondary care Mental Health service should continue to monitor this for at least 12 months or later if the person has not stabilised; and that GPs should continue to monitor this when responsibility is transferred to them.

Your report has also been shared with NHS England. NHS England is currently working with the Royal College of Psychiatrists and the Prescribing Observatory for Mental Health to investigate patient safety incidents associated with Clozapine. Patient monitoring is included within the scope of this work. Should compelling evidence of system failures be found, then NHS England would support work to improve management and minimise harm.

I hope that you find this reply helpful and I am grateful to you for bringing the circumstances of Miss Elhamid's death to my attention.

Yours sincerely

Alt Burt

ALISTAIR BURT