	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Rt. Hon. Matt Hancock MP - Secretary of State for Health & Social Care** **Department for Health and Social Care** **39 Victoria Street** **London** **SW1H 0EU**
1	**CORONER** I am Mr Andrew Haigh Senior Coroner for the Coroner Area of Staffordshire South
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 6th September 2016, I commenced an investigation into the death of Thomas Paul Arthur JACKSON, aged 24 years. The investigation concluded at the end of the inquest on 1st November 2018. The conclusion of the inquest was a detailed narrative one with the Cause of Death being: Ia) Clozapine Toxicity Ib) Pneumonia II) Treatment Resistant Schizophrenia.
4	**CIRCUMSTANCES OF THE DEATH** Tom was subject to compulsory Mental Health Detention at a secure unit within St George's Hospital, Stafford. In the early hours of 25th August 2016 Tom was found in a poorly state in his room. He was certified dead at 02.25 hours.
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 **MATTER OF CONCERN** is as follows: It is well known that Clozapine is a potentially dangerous drug which needs to be carefully monitored. Monitoring is for both whole blood to look at infection markers and for blood plasma to cheek on Clozapine levels. Since this death the Trust involved has established a policy for the regular checking of blood plasma levels for patients in receipt of Clozapine. However it appears that this is a local policy and that there is no national policy for these checks to be carried out. I wonder if there

	should be a direction for all trusts to carryout blood plasma tests on patients receiving Clozapine on a regular basis perhaps at least six monthly or yearly.
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 8th January 2019. 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 Chief Coroner and to the following Interested Persons: Leigh Day (solicitors representing Tom's mother and sister), [redacted] (Tom's father), Capsticks Solicitors LLP (representing the Midland Partnership NHS Foundation Trust) and Hogan Lovells International LLP (solicitors representing Mylan Product Ltd). 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	**13/11/2018** ..... Andrew A Haigh HM Senior Coroner for Staffordshire (South) Coroner's Office No 1 Staffordshire Place Stafford ST16 2LP Tel No: 01785 276127 sscor@staffordshire.gov.uk