	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. MHRA 2. NHS England 3. Department of Health 4. Royal College of Psychiatrists 5. Care Quality Commission, Chief Executive
1	**CORONER** I am Andrew Harris, Assistant Coroner, London South jurisdiction
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INQUEST** On 21st January 2022, as Senior Coroner, London Inner South, after a Safeguarding Adults Investigation, I opened an inquest into the death of Mr Luke Alexander Worrell, who had died in hospital aged 39 on 2nd January 2021. The inquest was concluded on 7th September 2023, having called an expert pharmaceutical physician. On 21st September 2023 I took urgent sick leave. I resigned from my position on 31st October 2023, after which I had no jurisdiction. On 21st September 2024, I received a request, in my new role as Assistant Coroner in South London, to determine whether a preventing future death report was needed. I agreed and the case was transferred on 27th November and I was given access to the case file on 27th January 2025. Submissions as to the need for a PFD report were filed, but in view of the passage of time, I do not consider it fair to issue a report to those involved with his care now in 2025, on the basis of evidence 16 months ago about a death 4 years ago. However the issues are potentially generic and so I address my report to national organizations. The medical cause of death was: 1a Ruptured Oesophagus 1b Vomiting from ileus

	1c Gastro-intestinal upset from Clozapine administration II Treatment resistant schizophrenia, urinary tract infection The narrative conclusion was: He died from unintended consequences of necessary medical treatment. There were two significant failures in care, which contributed to his death. The first was a failure to recognize the side effect of Clozapine on his gastro-intestinal tract. The second was the failure to recognize the level of risk Mr Worrell presented to himself after discharge, and in particular the failure to recognise the need for face to face assessment by a psychiatrist in response to his presentation on 7th and 14th December 2020, which amounted to neglect.
4	**CIRCUMSTANCES OF THE DEATH** Mr Worrell suffered from paranoid schizophrenia, dissocial personality disorder and some learning difficulty. He spent most of his life in hospital detention or custodial settings. He had a history of illicit substance misuse, non- compliance with medication and non-engagement with health services. During the Covid pandemic, he was discharged from hospital on 28th October 2020 on oral Clozapine. His mother, the GP and his 24 hour support service had not contributed to discharge planning. He was assessed on the day before discharge as having "less capacity to make informed decisions about his follow up" and he refused the Home Treatment Team's input post discharge. His mother considered he was not ready for discharge; the residential support service wanted him to remain under mental health (MH) section on section 17 leave, as it enabled much easier recall to hospital. This was not considered by the psychiatrist who was his responsible physician as its use had 'fallen out of practice' and he was instead the subject of a community treatment order. On 7th December he declined medication, opened his door naked with a delusion that there was a t-shirt on his mattress touching which would cause death and socks would kill Stevie. It was suspected that he had bought Spice instead of food, and alcohol was found in his room, but neither the care coordinator nor psychiatrist considered that he needed a MH assessment, despite having demonstrated almost all relapse indicators in his contingency and relapse plan, which required one. By 14th December he had persistent vomiting, stopped eating, self-isolated with a barricade and refused medication. 111 was called as

	support staff and CC felt he should be taken to hospital. The GP identified the self neglect but Mr Worrell declined to speak to him on the phone and referred to mental health. Ambulance services were severely stretched by Covid, and the paramedic in the early hours inappropriately accepted that Mr Worrell did not need waking and applied a triage assessment without consultation and made a referral back to mental health services. He took his Clozapine on 16th and was eating, but refused to attend the clinic. By 17th he had failed to attend two review meetings with his psychiatrist, attendances at the clinic and GP consultations, which persisted. On 22nd a GP telephoned and was reassured that he was about to attend the Clozapine clinic and lack of red flags and advised being taken to A&E if he worsened. His mother persuaded him to attend the clinic with her, but he collapsed there and was taken to A&E on a best interests basis. He was grossly dehydrated, partially conscious and confused, with a severe metabolic alkalosis due to persistent loss of gastric acid from vomiting, requiring intensive care. His GI tract was dilated with a significant amount of fluid, due to an ileus from Clozapine administration, which was not recognised and was continued, but probably absorbing little. His care was complicated by postural pneumonitis, confusion preventing reinsertion of NG tube and an arterial line being blocked. He had a coffee ground vomit on 31st December and this caused a rupture of a weakened oesophagus and a deterioration the next day leading to a cardiac arrest, from which resuscitation was inevitably unsuccessful. He died at 11.00 hours on 2nd January in hospital.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows. – 1. The lack of awareness by a series of clinical staff of the potential fatal side effects of Clozapine 2. Inappropriate use of community treatment order, when there was sufficient evidence to keep on a MHA section.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths. I believe that the following organizations would wish to learn of the

	evidence given in the inquest about the circumstances of this death and are in a position to mitigate or prevent future deaths. I attach my judgment to assist them: 1. MHRA 2. NHS England 3. Department of Health 4. Royal College of Psychiatrists 5. Care Quality Commission, Chief Executive
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 17th April 2025. I, the coroner, may extend the period. If you require any further information or assistance about the case, please contact the Inner South case officer, [redacted]: [redacted]
8	**COPIES and PUBLICATION** I have sent a copy of my report to the following Interested Persons: [redacted], mother of the deceased Oxleas NHS Foundation Trust, Medical Director Queen Elizabeth Hospital, Woolwich, A&E Director London Borough of Greenwich, Safeguarding Lead Supported Living Services, Chief Executive I am also sending this report to the Independent Panel on Deaths in Custody, as arguably the deceased should have been in detention. 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	**[DATE]** **[SIGNED BY CORONER]** **21st February 2025** **Andrew Harris, Assistant Coroner, South London**