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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. Secretary of State for Health & Social Care Rt Hon. [redacted]**<br>**2. South London & Maudsley NHS Foundation Trust**<br>**3. Croydon University Hospital**<br>**4. Medicines and Healthcare Products Regulatory Agency**<br>**5. Royal College of Psychiatrists**<br>**6. Royal College of Emergency Medicine** |
| 1 | **CORONER**<br><br>I am Professor Andrew Harris, Assistant Coroner, South London. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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 | **INVESTIGATION and INQUEST**<br><br>The inquest was opened on the 22 December 2023, into the death of Mr Luke John Chatterton on 11 December 2023 and concluded on 22 August 2025.<br><br>The medical cause of death was:<br><br>1a Aspiration of gastric contents<br>1b Vomiting, exacerbated by the use of medications (Clozapine, laxatives, Hyoscine, Amlodipine and Omeprazole)<br><br>Under II was entered Constipation exacerbated by use of medications (Clozapine, Hyoscine, Omeprazole, Amlodipine) and some chronic diseases.<br><br>The jury concluded that Mr Chatterton died in part from the necessary treatments for his schizoaffective disorder and that prescribing Clozapine and Hyoscine followed a balancing of risks and benefits. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Mr Chatterton had a long history of Clozapine related constipation. He was under mental health section at Bethlem Hospital with treatment resistant psychotic disorder. On 11 December, he began vomiting in the morning and was in great pain. Bowels sounds were infrequent and faint and he was referred to Croydon University Hospital with suspected intestinal obstruction most likely caused by constipation related to Clozapine induced gut hypomotility. In A&E an Xray was conducted and reviewed (at less resolution than in the radiology department) but no escalation for professional advice nor CT scan were sought and he was discharged, arriving back round 2pm. Surgical review of the Xray subsequently identified that it showed signs of impending obstruction and risk of perforation.<br><br>His pain worsened and the hospital was rung at 5pm for advice. His blood pressure dropped a little, his abdomen distended and became diffusely tender. He vomited standing and collapsed unconscious. An ambulance was called. CPR was begun. After 27 minutes Adrenaline was drawn up but there was no IV line. There was a 32-minute delay in the emergency resuscitation team arriving (but "equivalent" staff |

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| | were continuing resuscitation) and a 37-minute delay in London Ambulance team arriving, when fluids and Adrenaline were finally given after 25 minutes of asystole.<br><br>Restoration of spontaneous circulation was achieved, and he was returned to A&E at 19.45 and died after further resuscitation at 20.51. Autopsy found a distended small and large bowel, impacted and constipated distal large bowel, but the absence of perforation or peritonism and the clinical presence of bowel sounds were judged to exclude complete obstruction. |
| 5 | **MATTERS OF CONCERN**<br><br>1. The safety of the resuscitation process where detained under MH section.<br><br>2. The lack of identification of the risks of deterioration and death of a patient chronically on Clozapine with query obstruction, who may benefit from escalation or further investigation, in the emergency department of the acute hospital.<br><br>**CORONER'S MATTERS OF CONCERN** are described as follows:<br><br>1. The delays in accessing advanced life support (ALS) resuscitation in the MH hospital were worse than expected in the community. London Ambulance Service target for Category 1 calls is 7 minutes and yet it took 37 minutes before the paramedics arrived. Despite concerns that resuscitation skills were hard to maintain in a MH Trust, Adrenaline and IV lines were part of the system at the time. Initially no IV line could be found, then none could be inserted. 25 minutes of asystole elapsed before Adrenaline was administered. Evidence was heard that MH Trusts cannot safely provide advanced life support resuscitation unless they are co-located with an acute hospital site. The National Quality Standards in mental health in patient care requires calling 999 immediately and strongly *recommends* provision of IV-line insertion and drug administration and a team leader with ALS skills, but the Resuscitation Council has apparently approved the Trust policy. Thus, the safety of a patient detained by the State, who has a cardio-respiratory arrest, would seem to vary according to post code, some sites not being close to acute hospital standards, and might even be worse than in the community. Given that those who suffer psychosis have increased risks of premature death, including suicide and cardiovascular deaths, in part related to treatment, the State would seem to have a responsibility to mitigate these risks, when compulsorily detaining them. It raises the question as to whether patients with high risk should have the right to choose a site where there is co-location of acute services and whether units with high concentration of detained psychotics should and can be safely equipped to provide Advanced Life Support.<br><br>2. The acute Trust has taken a number of steps to facilitate identifying the risks of a patient who is referred with suspected obstruction. Outstanding is the development with the mental health Trust of an educational package and guidelines for managing suspected acute obstruction, including pseudo-obstruction (a complication of Clozapine) and recognizing the rare but potentially fatal risks of anti-psychotics. There is currently no national formal guideline on management of bowel obstruction. Given the rarity of antipsychotic induced acute obstruction, there seems to be merit in alerting national professional bodies to enable consideration to be given to the development of a guideline, which might identify the use of red flags to escalate and investigate those at most risk. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths. I believe that the organisations listed are in a position to mitigate or prevent future deaths. |

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| | **CONCERN 1** is brought to the attention of the Secretary of State for Health and Social Care, and the South London & Maudsley NHS Trust.<br><br>**CONCERN 2** is brought to the attention of the Croydon University Hospital Trust, the Medicines and Healthcare Products Regulatory Agency, the Royal College of Psychiatrists and the Royal College of Emergency Medicine. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 14 November 2025. I, the coroner, may extend the period.<br><br>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 was proposed. |
| 8 | **COPIES and PUBLICATION**<br><br>I have sent a copy of my report to the following Interested Persons:<br><br>• [redacted]<br>• North East London Foundation Trust<br>• Croydon University Hospital<br>• London and South Maudsley NHS Trust<br><br>I am also copying it to Resuscitation Council UK and [redacted], expert witness, for information as they each have an interest in a matter.<br><br>I am also under a duty to send the Chief Coroner a copy of your response. She may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person whom she 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 | **19 September 2025** **Andrew Harris** |