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By Email: [staffordshireandstokecoroners@stoke.gov.uk](mailto:staffordshireandstokecoroners@stoke.gov.uk)

Dear Coroner,

**Re: Regulation 28 Report to Prevent Future Deaths – Mark Anthony Turner who died on 18th April 2025.**

Thank you for your Report to Prevent Future Deaths (hereafter “Report”) dated 14<sup>th</sup> January 2026 concerning the death of Mark Anthony Turner, who was found deceased on 18<sup>th</sup> April 2025. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Mr Turner’s family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Mark’s care have been listened to and reflected upon.

Your Report raises a concern that there is no guidance locally or nationally as to what steps should be taken when a high serum level is returned in patients taking clozapine who are being monitored.

In the majority of NHS trusts clozapine treatment will be undertaken though a dedicated clozapine clinic where the overall safe prescribing and associated monitoring will be undertaken.

Information from a number of different sources is currently available to support prescriber’s decisions in relation to Clozapine (or norclozapine) plasma levels, including in cases of high serum levels. These include:

- Information from the manufacturers about plasma level monitoring:
  - [CPMS Factsheet 20 - TDM Update v1](#)
  - [FS CPN metabolism plasma level jun2019.pdf](#)
- [The Maudsley prescribing guidelines](#) (available to all NHS users through their NHS Athens account)
- Specialist Pharmacy Service (SPS), which is commissioned by NHS England to provide advice and guidance on medicines also offer guidance on clozapine monitoring ([Clinical considerations for patients prescribed clozapine – NHS SPS - Specialist Pharmacy Service – The first stop for professional medicines advice](#) )

Most trusts should also have in place their own local guideline(s) on the management of clozapine plasma levels. Some examples from trusts in England include:

- [Microsoft Word - Clozapine Plasma Level monitoring Final 6 with logos.docx](#)
- [Clozapine-role-of-therapeutic-drug-monitoring.pdf](#)
- [Clozapine TDM poster -September 2025.pdf](#)

In Scotland [Therapeutic Drug Monitoring \(Clozapine\) | Right Decisions](#) is another useful resource that could be adopted for use by local Clozapine services.

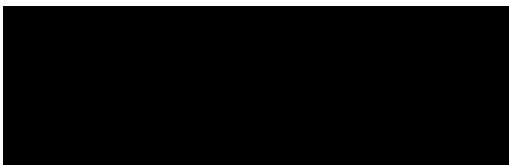
In summary, the interpretation of clozapine plasma levels should be individualised at trust level, based on the general guidance contained in all the above information.

In response to this case, NHS England has written to all Mental Health Chief Pharmacists in England to ask them to work with their local clozapine clinics to review the information and support materials that they use. This is to help ensure the safe and appropriate use of plasma level monitoring within their Trusts, and ensure these are up to date and embedded locally.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Mark, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,



National Medical Director  
NHS England