REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Midlands Partnership Foundation Trust; and** **2. NHS England.**
1	**CORONER** I am Emma Serrano, Area Coroner, for the coroner area of Staffordshire.
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 the 25th April 2025, I commenced an investigation into the death of Mr Turner. The investigation concluded at the end of the inquest on 14 January 2026. The conclusion of the inquest was a narrative conclusion of *"complication following necessary medical treatment"*. The cause of death was: 1a Citalopram toxicity
4	**CIRCUMSTANCES OF THE DEATH** i) Mr Turner was a 63-year-old man, who suffered from paranoid schizophrenia. Amongst other medications, he was prescribed citalopram. He was taking this in accordance with his prescription. The prescription was issues appropriately. On the 18 April 2025, he was found deceased at his home address. ii) He was also prescribed clozapine, which needed be monitored weekly via a blood test and to have a serum text every 6 months. iii) A postmortem revealed that he had passed away from citalopram toxicity. It was agreed in evidence that this was a complication that could result from the use of citalopram, even when used in accordance with the prescriber's instructions.
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 **MATTERS OF CONCERN** are as follows. – 1. That when a high serum level is returned in patients being monitored as they are taking clozapine, there is no guidance, locally or nationally as to what steps should be taken.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 **3 April 2026.** 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: 1. Family of the deceased. 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	**14 January 2026** [redacted] **Miss Emma Serrano** **Area Coroner** **Staffordshire**