REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Deborah LAKIN, HM Assistant Coroner, for the coroner area of Worcestershire.
2.	**DATE OF REPORT** 03 June 2026
3.	**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.
4.	**THIS REPORT IS BEING SENT TO** 1. Herefordshire & Worcestershire Health & Care NHS Trust You are under a duty to respond to this report within 56 days of the date of this report, namely by July 26, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
6.	**SUMMARY OF CORONER'S CONCERN**

7.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	**INVESTIGATION AND INQUEST** On 04 February 2026 I commenced an investigation and opened an inquest into the death of Jack Horace BURTON aged 29. The investigation concluded at the end of the inquest on 14 May 2026. The conclusion of the inquest was that: Narrative Conclusion - Jack Horace Burton died on 7 October 2025 at 76 Moorland Road, Scarborough, North Yorkshire of Clozapine toxicity. Mr Burton had been prescribed Clozapine for schizophrenia and he was a smoker, who had been regularly advised that any cessation of smoking would increase Clozapine levels. Mr Burton stopped smoking tobacco on or before 4 October 2025. On the evidence it is likely that this led to a fatal increase in Clozapine blood levels.
9.	**CIRCUMSTANCES OF DEATH** The deceased resided in Worcester and was under primary and secondary healthcare services in that area. He had a diagnosis of paranoid schizophrenia and was prescribed Clozapine by his community psychiatrist. He died while on holiday in North Yorkshire and the results of the post-mortem and toxicology indicate his death was due to Clozapine toxicity. His sister confirmed that Jack was a heavy smoker and was taking 525mg Clozapine nightly as prescribed, which is the correct dose when he is smoking, however whilst they have been on holiday he did not smoke . If he had stopped or reduced his smoking he should have informed his psychiatrist to reduce the amount of Clozapine he was taking , as this could cause seizures.
10.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could 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. There were inconsistent accounts provided to me by two consultant psychiatrists, about the relevance of reduction in smoking, rather than cessation of smoking, attributable to there being no guidance available to doctors on this issue. 2. The evidence revealed that there is no guidance on any standardised practice available to practitioners relating to asking questions and recording

	answers given when discussing possible symptoms of side effects of the medication. Practitioners can therefore make no record if no information is provided, which does not indicate whether questions were asked.
11.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: *[please do not use individual's names, but instead roles/titles]* • [redacted] I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	**SIGNATURE** [redacted] **Deborah LAKIN** **HM Assistant Coroner for Worcestershire**