Her Majesty's Coroner for the
Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court,
29 Wood Street,
Barnet EN5 4BE

Telephone
Fax

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO North Middlesex Hospital, Sterling Way , Edmonton, London N18 1QX
1	**CORONER** I am Andrew Walker, senior coroner, for the coroner area of Northern District of Greater London
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 2nd June 2015 I opened an investigation touching the death of Carole Rita Lovett , aged 63 years old. The inquest concluded on the 22nd February 2016 The conclusion of the inquest was " Narrative ", the medical case of death was 1a Bronchopneumonia 1(b) Hypoxic brain injury complicating hypoxic cardiac arrest, 1(c) Clozapine associated myocarditis and Schizophrenia under paragraph 2.
4	**CIRCUMSTANCES OF THE DEATH** Having become unwell Carole Rita Lovett, a patient under Section 3 of the Mental Health Act 1983 at St Ann's Hospital , was transferred to Northwick Park Hospital on the 16th May 2016. Mrs Lovett had developed a myocarditis as a consequence of the use of Clozapine medication. Mrs Lovett was placed in the Acute Assessment Unit of the hospital where the deterioration of her condition continued until she was found un-responsive in her bed at 14.35 in the early afternoon. Mrs Lovett was resuscitated and transferred to the Critical Care Unit where she died on the 31st May 2015.
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.

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	The **MATTERS OF CONCERN** are as follows. – The level of competence and training of staff working in the Acute Assessment Unit with regard to the use of NEW Score system and communication between all levels of staff. That when the monitoring equipment alarmed this did not result in senior staff attending. No consideration was given, when the alarms were continuously sounding, for alternate forms of monitoring.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 Thursday 30th June 2016. I, the coroner, may extend the period. 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;- Representatives of the family 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	**6th May 2016.**