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 0208 447 7680
Fax 0208 447 7689

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Edgware Community Hospital, Burnt Oak Broadway, Edgware HA8 0AD
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 25th Day of July 2015 I opened an investigation touching the death of Benjamin Thomas Brown 35 years old. The inquest concluded on the 10th March 2016. The conclusion of the inquest was Natural Causes, the medical case of death was 1a Sudden Cardiac Death due to Cardiac Arrhythmia and under paragraph 11 Schizophrenia, Fatty Liver Disease
4	**CIRCUMSTANCES OF THE DEATH** Benjamin Thomas Brown was a patient on Avon Ward at the Dennis Scott Unit at Edgware Community Psychiatric Hospital detained under section 2 of the Mental Health Act. Mr. Brown had a sixteen-year history of treatment resistant Schizophrenia. Mr. Brown was admitted to Edgware Community Hospital on the 18th July 2015. Mr. Brown was on 15-minute observations the last of which was recorded 8.15. A Registered Mental Health Nurse from an agency was not told about the need for 15 minute observations and having taken hourly observations was pressured into making entries in the Patient Observation Records for times when Mr. Brown was not observed. There were other entries on the Patient Observation Records that having been checked with CCTV evidence confirmed that entries had been made into the Patient Observation Records when no observation had been made.

	An entry at 8.30 was entered after Mr. Brown was found to be unresponsive at 8.45am The time that Mr. Brown suffered a cardiac arrest is likely to have been between 5am and 8.45am . Resuscitation was initially provided with nursing staff and the duty doctor and then by the London Ambulance Service who arrived at the Dennis Scott Unit at 9.15 am. Mr. Brown was recognized as having died at 10.06 It is likely that the identification of the cardiac arrest was identified outside the time window for successful resuscitation.
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, The auditing of those persons carrying out 15 minute observations. 2. Training of staff for resuscitation in the event that a patient collapses. 3, The auditing for the prescription and management of clozapine.
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 Monday 1st November 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 and the Mental Health Trust.

	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	**5th September 2016**