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

North London Coroners Court,
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Barnet EN5 4BE

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01695-2012

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **North London Forensic Service** Barnet Enfield and Haringey Mental Health Trust, Camlet One, Chase Farm Hospital The Ridgeway, Enfield EN2 8JL
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 21st June 2012 I opened an inquest into the death of Adrian Anthony Cowan, aged 48 years old. The investigation concluded at the end of the inquest on the 28th January 2014. The conclusion of the inquest was "Natural causes", the medical case of death was ;1a Pulmonary thromboembolism, 1b Deep vein thrombosis , and under paragraph 2 Epilepsy and diabetes.
4	**CIRCUMSTANCES OF THE DEATH** Adrian Anthony Cowan had been detained under the Mental Health Act 1983 with a diagnosis of treatment resistant paranoid schizophrenia. Mr Cowan had a seizure at 10.45 am on the 14th June 2012, was treated and placed on 15 minute observations. Mr Cowan was last observed at 18.00 hrs when he was seen to be breathing normally. A nurse , calling patients for medicines saw Mr Broard in his room at around 18.15and noted he was breathing. At 18 25 hrs Mr Cowan was seen with a duvet over his head and when checked was found to be unresponsive.
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 the trust policy dealing with the staff response did not include a clear set of guidance to those staff members responding to Mr Cowan's collapse nor did the policy include the need, as part of the emergency response, to request the duty doctor to attend. (2) Some of the nursing staff were not able, when responding to Mr Cowan being found collapsed, act in a calm coordinated manner and were not able to apply the training they had received in basic life support.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 7th April 2014 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 Representative of members of Mr Cowan's 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	**7th February 2014**