MR G IRVINE
SENIOR CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]k

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Interim Chief Executive Officer, The East London Foundation NHS Trust (ELFT)** [redacted]et **2. [redacted], Chief Executive Officer and Jason Strelitz Director of Social Care, The London Borough of Newham** [redacted]k
1	**CORONER** I am Graeme Irvine, senior coroner, for the coroner area of East 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 17th April 2023 this court commenced an investigation into the death of Regina Olufunmilola Ademiluyi, aged 83 years. The investigation concluded at the end of the inquest on 21st March 2024. The conclusion of the inquest was a short-form conclusion of "Natural causes" Mrs Ademiluyi's medical cause of death was determined as;

	1a Aspiration Pneumonia II Malnutrition, fractured left femur (previously operated on), sacral pressure sore
4	**CIRCUMSTANCES OF THE DEATH** Regina Olufunmilola Ademiluyi was a frail 83 yr old woman who had a number of co-morbidities including; osteoarthritis, vascular dementia, hypertension and a previous post-surgical CVA. In the months leading to Mrs Ademiluyi's death she was bed-bound due to complications arising from the surgical repair of a broken hip. From the time of that surgery the local authority had assessed Regina as requiring double-handed domiciliary care 4 times per day. From October 2023 state-funded domiciliary care was not provided to Regina as her daughter (Regina's primary carer) was dissatisfied with the quality of care being provided and asked for it to cease. Regina's daughter was thereafter given control of the state-allocated care budget to deploy as she saw fit. At the time of Regina's death in March 2024, no carers had been engaged by the family using the state-allocated care budget. To be clear, Regina's daughter did not take any state funding for herself, she simply did not deploy it to instruct domiciliary carers. From October 2023 until her death Regina's cognition and physical health declined. Regina's dysphagia and loss of appetite led to malnutrition and a corresponding decrease in physical reserve evidenced at autopsy by atrophy of the liver and virtually no abdominal fat. Regina developed a grade 4 pressure ulcer on her sacrum and suffered an aspiration incident that led to her fatal illness.
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 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. From October 2023 until her death in March 2024, Regina Ademiluyi was deprived of the state-funded domiciliary care to which she was entitled. The NHS Trust and local authority responsible for her care during this period failed to ensure effective care was provided in the following ways; a. A safeguarding report submitted by NHS district nurses was insufficiently detailed to reflect the concerns that had developed regarding the deceased. The content of the safeguarding report did not trigger the threshold to investigate the matter further. b. When faced with the limited information withing the safeguarding report the local authority did not seek further information or clarification from the Trust on the basis of the report. c. The Trust failed to formally assess Mrs Ademiluyi's mental capacity, had they done so it is possible that an IMCA would have been appointed to act as her voice, over-ruling her daughter's views which may have resulted in effective care being put in place. d. Despite the concerns raised regarding the behaviour of Mrs Ademiluyi's daughter no effort was made to offer a carer assessment to address whether she was overwhelmed by the task in hand. 2. Despite the death of Mrs Ademiluyi's occurring in the spring of 2023 no meaningful reflection or remediation had been undertaken by the Local Authority into the failings in care by the time of the inquest almost a year later. It was

	suggested by the legal representative of local authority that the inquest hearing itself was the extent of the significant event analysis undertaken by their professional client.
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 **17th May 2024**. 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 the family of Mrs Ademiluyi and to the Care Quality Commission. I have also sent it to the local Director of Public Health who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**[DATE] 22/03/2024** **[SIGNED BY CORONER]**