Mr Graeme Irvine
Senior Coroner for East London
East London Coroner's Court
Queen's Road Walthamstow, E17 8QP

Dear Sir

Inquest into the death of Omar Ahmed – 15 July 2024
Prevention of Future Deaths Report
Ref: [redacted]

We write in response to the Prevention of Future Death Report ('the PFD Report') issued at the conclusion of the inquest hearing in accordance with Regulation 28 of the Coroners (Investigations) Regulations 2013.

We are committed to providing the highest standards of safety and care and wish to ensure that any lessons to be learnt from the circumstances of Mr Ahmed's tragic death are identified and implemented as necessary within our agency. Alongside our engagement with the coroner's investigation, we have conducted our own internal review process, updated our policies, commenced the implementation of a full programme of updated communication, consultation and training, and proactively liaised with the East London Foundation NHS Trust ('the Trust') and the London Borough of Newham ('the Local Authority').

We have provided further details concerning this process below, including the time frames for elements of this process which are in progress.

Our review process

After being informed of Mr Ahmed's death by the Local Authority on 22 December 2023, we conducted a thorough Serious Incident Review ('SI Review Report'), with a focus on the care provided in cases involving a history or risk of self-neglect. This involved a comprehensive review of our policies and procedures and preparation of a detailed report focussing upon protecting and supporting our service users. The SI Review Report sets out the steps we are taking to enhance our safeguarding practices and provides a framework for continuous improvement.

In addition to updating and, where necessary amending our policies, we commenced an eight-week implementation programme on 5 August 2024. A summary of this programme setting out the topics of training, appears in Appendix A.

At the conclusion of the programme, we will hold review meetings to discuss the implementation programme, including challenges and successes, as well as developing further areas of continuous improvement.

The implementation programme of our revised policies and training is being led and overseen by a new internal Governance Team led by our Director of Nursing (Advanced Practitioner / Registered Mental Health Nurse) and including our Director for Quality, Trusted Assessor, Care Champion, Nominated Individual and Registered Manager. We have engaged an independent Registered Mental Health Nurse to provide external governance and accountability. This programme is being properly resourced and supported by the most senior managers and leaders within our service.

Response to the coroner's 'matters of concern'

Our Internal Governance Team has carefully considered the 'matters of concerns' set out in the PFD report relevant to the service provided. With this in mind, we have set out our response with respect to the first and third matters highlighted by the coroner which are relevant to the care we provided.

1. Poor standards of communication

The coroner highlighted the following concern in the PFD Report:

> *"Poor standards of communication between the domiciliary care company, the local authority and NHS trust resulted in a failure to identify the deterioration in Mr Ahmed's living conditions and health."*

Mr Ahmed was under the care of our agency from 31 October 2023 and was admitted to hospital on 15 November 2023 before he sadly passed away on 21 November 2023. We submitted a detailed chronology of our care notes and communications with the Local Authority and GP for the purposes of the inquest hearing. Our Duty Manager contacted the Local Authority on 10 November and again on 12 November 2023 regarding concerns about the lack of basic supplies and issues with financial decision-making. On 13 November 2023, the Local Authority responded, confirming that the duty social worker had made enquiries with Mr Ahmed's next of kin. They also invited follow-up communication in the coming days and weeks.

<u>Our own review</u>

We have scrutinised how we would approach circumstances in the future where a client is making poor decisions with respect to their nutrition, cleaning and personal care, as well as their finances. In circumstances where clients have capacity, to enable appropriate action to

be taken in conjunction with social work and health services, the key issues to be addressed are early notification internally, escalation to the Local Authority and NHS Trust as necessary, and proactive follow up.

This issue was identified and addressed in our SI Review Report in which we have confirmed our revised standard notification and response protocols with the Admissions Policy as follows:

1. Continuing to provide detailed and factual reports of safeguarding concerns to local authorities within 24 hours;
2. Expect a response and action from local authorities within 48 working hours;
3. Actively monitor the situation and follow up to ensure concerns are addressed effectively.

This is supplemented by updated notification and monitoring procedures within our suite of relevant policies:

- Self-Neglect Policy
- Home Environment Safety Policy
- Nutrition and Hydration Policy
- Infection Control Policy
- Admissions Policy
- Handover Policy
- Environmental Safety Policy
- Care Plan Adherence Policy
- Risk Management Policy
- Decision Making and Consent Policy
- Engagement and Participation Policy
- Multi-Disciplinary Team Collaboration Policy
- Medication Management Policy
- Safeguarding Policy
- Admissions Policy
- Handover Policy

<u>Multi-agency liaison and plan</u>

In addition, we attended a multi-agency discussion with the Local Authority and NHS Trust to discuss lessons learnt on 23 July 2024 and arranged a follow up on 4 September 2024. At the second meeting, the following actions were agreed to be undertaken within a twelve week time frame:

- *Communication and Escalation Strategies: The team will implement new strategies to improve communication and timely escalation of safeguarding issues across teams.*

- *Development of Risk Assessment Tool: Newham Council and Sunlight Care will collaborate on the development of a risk assessment tool to identify and protect vulnerable individuals.*

- *Training and Process Improvements: Sunlight Care staff will receive additional training on safeguarding protocols, communication, and the new risk assessment processes.*

A Serious Adults Review Board Meeting has been arranged to take place on 24 September 2024.

In view of the above, we are confident that our revised policies and procedures are robust and staff will proactively escalate similar concerns internally and our managers will proactively monitor concerns raised with the Local Authority.

2. Lack of challenge to poor decision-making

The coroner highlighted the following concern in the PFD Report:

> *"Mr Ahmed's poor decision-making in how he budgeted was never challenged, this led to a lack of nutritious food and cleaning materials in his home.*
>
> *Similarly, Mr Ahmed's unwillingness to turn on his central heating, a contributory factor in the development of his fatal condition -hypothermia, remained unchallenged at the time of his death.*
>
> *Domiciliary carers capitulated to Mr Ahmed's express wishes that they ought not assist him with cleaning, personal care or meals instead, state-funded care hours were utilised to assist Mr Ahmed in attending his local pub and café."*

An element of Mr Ahmed's Care and Support Plan was to facilitate community engagement and social interaction, which was important to Mr Ahmed. In circumstances where there is evidence of self-neglect and a client may not be making appropriate decisions concerning eating, cleaning, hearing and personal care, it is clear that this must be addressed by those involved in the client's care. As the coroner is aware, Mr Ahmed had capacity and was therefore able to make his own decisions. This creates significant challenges for care providers, which are reliant upon working alongside the statutory agencies to make any formal interventions necessary.

Within the existing framework, we have considered what additional steps could be taken in the future. We have reviewed and updated our protocols to ensure that care providers are well-supported in addressing situations where clients with capacity may be making decisions that appear to be against their best interests, such as in cases of self-neglect. Specifically:

1. As set out above, we have revised our own policies and training to reinforce the importance of clearly and swiftly communicating issues of concern internally to enable the concerns to be properly assessed and escalated to the Local Authority and NHS as appropriate;

2. As set out above, we are implementing more robust inter-agency collaboration and clearer guidelines for escalation pathways. This will involve enhanced communication with social workers, GPs, and mental health teams to provide timely and appropriate interventions while respecting the client's autonomy;

3. We are introducing regular multidisciplinary reviews for cases involving self-neglect, allowing for a more holistic approach to care that includes input from a range of professionals. This will help ensure that all aspects of the client's well-being—physical, mental, and social—are considered in decision-making processes;

4. The training programme referred to above includes additional training focused on identifying early signs of self-neglect, understanding legal frameworks such as the Mental Capacity Act, and how to engage effectively with clients who may resist care or intervention. This proactive approach aims to minimize risks while upholding the individual's rights and dignity.

We also highlight the relevance and importance of the 'Liberty Protection Safeguards' ('LPS') framework which was to have been introduced to replace the 'Deprivation of Liberty Safeguards' ('DoLs') framework. One relevant difference would have been the availability of the LPS framework to those living in their own home, as DoLs orders are only available to those in care homes and hospitals. We understand that the LPS framework provides a simpler and clearer framework to seek authorisation for an order to facilitate care and health treatment where needed, including those in their own home.

The Local Authority has informed us that the LPS framework will no longer be implemented. As a result, they will continue to rely on the existing DoLs framework, which does not apply to individuals living at home. We understand that the new LPS framework would have provided those involved in Mr Ahmed's care with the opportunity for assessment of his ability to make appropriate decisions in his own best interests. This is a challenge we trust will be remedied within new legislation.

Finally, we wish to reiterate our deepest sympathies for Mr Ahmed's family. We emphasise our desire to ensure that any changes to our service are identified and implemented to ensure that similar issues with clients in future are dealt with as quickly and effectively as possible.

Yours faithfully

[redacted]

[redacted] (Director)

APPENDIX A: Summary of 8-week implementation programme following SI Review

Week 1: Planning and Communication

- Conduct a meeting with key stakeholders (management, supervisors, training coordinators) to discuss the implementation plan.
- Review and finalize all new policies with input from relevant staff and legal advisors.
- Develop a communication plan to inform all staff about the upcoming changes.
- Allocate necessary resources (training materials, budget, personnel) for the implementation.

Week 2: Staff Communication and Initial Training Preparation

- Communicate the new policies and training schedule to all staff via emails, posters, and meetings.
- Develop a detailed training schedule, including dates, times, and venues.
- Prepare training materials (manuals, presentations, handouts) for each policy and procedure.

Week 3: Training Sessions - Week 1

- **Self-Neglect Policy Training:** Conduct training sessions on recognizing and managing self-neglect.
- **Home Environment Safety Policy Training:** Conduct training sessions on assessing and maintaining home safety and cleanliness.

Week 4: Training Sessions - Week 2

- **Nutrition and Hydration Policy Training:** Conduct training sessions on nutritional assessments, meal planning, and support services.
- **Infection Control Policy Training:** Conduct training sessions on maintaining high standards of infection control.

Week 5: Training Sessions - Week 3

- **Environmental Safety Policy Training:** Conduct training sessions on assessing and maintaining heating and cooking facilities.
- **Care Plan Adherence Policy Training:** Conduct training sessions on reviewing, documenting, and adjusting care plans.

Week 6: Training Sessions - Week 4

- **Risk Management Policy Training:** Conduct training sessions on risk assessments, management plans, and monitoring.
- **Decision Making and Consent Policy Training:** Conduct training sessions on capacity assessments and supporting informed decision-making.

Week 7: Training Sessions - Week 5

- **Engagement and Participation Policy Training:** Conduct training sessions on strategies to promote active engagement and participation.
- **Multi-Disciplinary Team Collaboration Policy Training:** Conduct training sessions on effective multi-disciplinary team collaboration.

Week 8: Training Sessions - Week 6 and Monitoring

- **Medication Management Policy Training:** Conduct training sessions on safe and effective medication management.
- **Monitoring and Evaluation:** Begin monitoring and evaluating the effectiveness of the training and implementation.