REGULATION 28: REPORT TO PREVENT FUTURE DEATHS:
MAHAMOUD HUSSAIN ALI (DIED 26 August 2020)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] The Chief Executive Officer East London NHS Foundation Trust Trust Headquarters 9 Alie Street London E1 8DE
1	**CORONER** I am Saba Naqshbandi KC, Assistant Coroner, for the coroner area of Inner North 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 1 September 2020, an investigation was commenced into the death of Mahamoud Hussain Ali, aged 40 years old. The investigation concluded at the end of the inquest on 26 April 2024. The medical cause of death was: 1a. Bronchopneumonia 1b. Ischaemic encephalopathy 1c. Subdural haematoma The conclusion of the jury was accident.
4	**CIRCUMSTANCES OF THE DEATH** On 19 August 2020, Mahamoud Hussain Ali fell in the street. He was taken by ambulance to Homerton University Hospital where he was treated in the Emergency Department. A CT scan of his brain showed no intracranial bleeding and no skull fracture. He discharged himself. The same morning, he fell again in the street and was taken back to the same hospital by ambulance. A second CT brain scan showed no change. Concerns about his behaviour and mental health led to him being admitted overnight. Following a mental health assessment conducted by a psychiatrist on 20 August 2020, Mr Ali was detained under section 2 of the Mental Health Act 1983 and transferred to Lea Ward, Mile End Mental Health Hospital, arriving just before 7pm on 20 August 2020. He was placed in isolation pending a covid test and was assigned to be under observation every 15 minutes. The next day 21 August 2020 at around 1800 he was found unresponsive on the floor of

	his room. LAS were called and he was taken to Royal London Hospital where a CT scan showed evidence of unsurvivable early brain death and where surgery was considered futile. Mahamoud Hussain Ali died on 26 August 2020 at the Royal London Hospital.
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)** Although Mr Ali was meant to be under 15-minute observations, a registered mental health nurse on Lea Ward gave evidence that on 21 August 2020 at around 1740 she saw that the observations board had not been completed for 1700, 1715 and 1730. She then completed it as if she had conducted those observations, recording that Mr Ali was asleep. East London NHS Foundation Trust (the Trust) has acknowledged that the deliberate falsification of observation records is not acceptable. Evidence has been provided by the Trust that since Mr Ali's death on 26 August 2020, there have been 11 fatal incidents where observation records may have been filled in when observations have not been conducted. One of these, in May 2023, was in Lea Ward, the same ward where Mr Ali was detained. Whilst the date and name of the hospital and/or ward connected with each of these deaths have been provided to me, evidence has not been given by the Trust as to the specific circumstances of each death, nor the subsequent individual investigation and findings and any consequential action taken. Nor has this issue been addressed in the Trust's Action Plan as part of its internal investigation. The Trust has stated that the majority of the 11 deaths pre-date the work that it has been doing to improve practice around observations that has been progressing since Autumn 2022. I have been provided with evidence that in October 2023, the Trust wrote to staff about 'Falsification of Observation Records', stating: "*We commenced a Trust wide QI project in September 2022 in response to prevention of future death (PFDs) notices from the coroners. The PFDs highlighted concerns about the quality and consistency of engagement and observation practice. This work has engaged all Directorates in enhancing our appreciation and understanding of the importance and impact of therapeutic engagement and observation. Directorates have been doing work using QI methodology to look at how we can improve standards to ensure consistency and quality in undertaking these*…" Further, that "*Despite this work, we have seen an increase in occasions where observation records have not been completed but records falsified to reflect that they had been done*." Given the above, I am concerned that action undertaken thus far by the Trust has not been sufficient to ensure that observations are being conducted and/or recorded as required which in my opinion gives rise to a concern that future deaths will occur.
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 4 August 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 Mahamoud Hussain Ali [redacted], Chief Executive of the Homerton Healthcare NHS Foundation 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. She may send a copy of this report to any person who she 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	 **10 July 2024**