MR G IRVINE
SENIOR CORONER
EAST LONDON
East London Coroner's Court, Queens Road Walthamstow, E17 8QP
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REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: 25472916

	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)** **Sent via email: [redacted]** **2. [redacted], Chief Executive Officer and [redacted] Director of Social Care, The London Borough of Newham** **Sent via email: [redacted] and [redacted]** **3. [redacted], Secretary of State for Department of Health & Social Care** **Sent via email: [redacted]** **4. [redacted], Director of Quality and Compliance, Sunlight Care Group** **Sent via email: [redacted]**
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 22/11/2023 this Court commenced an investigation into the death of Omar Abdi

	Ahmed aged 54 years. The investigation concluded at the end of the inquest on 15th July 2024. The court returned a narrative conclusion; *"Omar Abdi Ahmed died on 20th November 2023 in hospital due to hypothermia. Mr Ahmed, an amputee who received domiciliary care three times a day, was found by carers, unresponsive at home on 15th November 2023. Mr Ahmed had developed pneumonia which, along with ischaemic heart disease had contributed to his hypothermia. Mr Ahmed had chosen not to activate his home's heating system.* Mr Ahmed's medical cause of death was determined as; 1a Hypothermia 1b Pneumonia and Ischaemic Heart Disease II Diabetes Mellitus Type II
4	**CIRCUMSTANCES OF THE DEATH** Omar Abdi Ahmed was a 54-year-old man who lived alone in a flat in Forest Gate. Mr Ahmed had significant comorbidity and had undergone a surgical amputation of one leg and the partial amputation of the other. Mr Ahmed received district nursing care to monitor and treat his wounds. Mr Ahmed had a package of domiciliary care, commissioned by the local authority to assist him in undertaking the tasks of daily living such as cleaning, personal hygiene, preparing meals and mobilising. The care was contracted to a private provided who undertook three visits per day, a provision that was topped up with an extra 3 hours per week to assist Mr Ahmed with cleaning and community engagement. Mr Ahmed was admitted to hospital by ambulance on 15th November. On the third domiciliary care visit of the day on the evening of 15th November 2023,Mr Ahmed was found to be unresponsive. The ambulance service found Mr Ahmed hypothermic (28c) with reduced consciousness lying in a foetal position in bed. The patient was assessed to be in septic shock and was noted to have recently developed a pressure ulcer. A safeguarding report was made regarding the condition of the deceased who was found to be wearing a soiled incontinence pad. His right leg was dressed in a dirty bandage that had not been changed for two weeks. The flat was unheated and unsanitary. After transfer to hospital diagnoses of sepsis and hypothermia were confirmed, despite treatment Mr Ahmed died at 2059 on 20th November 2023.
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. 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. 2. Evidence heard in the inquest suggested an under-resourced and demoralised district nursing team lacked the clinical curiosity to predict the harm that would befall Mr Ahmed should he be allowed to disengage from treatment. 3. 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.
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 **14th September 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 Mr Ahmed, the Care Quality Commission and 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 July 2024 [SIGNED BY CORONER]**