Prevention of Future Deaths Report

Kashim ALI (date of death: 21 May 2024)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Chief Executive Officer** **East London NHS Foundation Trust** **Robert Dolan House** **Trust Headquarters** **9 Alie Street** **London** **E1 8DE**
1	**CORONER** I am Ian Potter, 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 28 May 2024, an investigation was commenced into the death of Kashim Ali, then aged 56 years. The investigation concluded at the end of an inquest heard by me on 21 October 2024 at Poplar Coroner's Court. The inquest concluded that Mr Ali died from natural causes. The medical cause of death was: 1a cardiac arrest 1b hypertensive heart disease II schizophrenia, hyperkalaemia, type 2 diabetes mellitus
4	**CIRCUMSTANCES OF DEATH** Mr Ali was detained under section 3 of the Mental Health Act 1983, on Millharbour Ward at Mile End Hospital. His detention was for the purposes of providing treatment in relation to his longstanding diagnosis of 'treatment resistant schizophrenia. On 21 May 2024, shortly after 09:00, Mr Ali was noted to be asleep in his bed. A few minutes later, he was noted to be totally unresponsive. Emergency

	procedures were followed, but attempts at resuscitation were not successful. Mr Ali died as a result of cardiac arrest.
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) Any National Early Warning Score ('NEWS2') should always be escalated. However, during Mr Ali's time on Millharbour Ward he achieved a NEWS2 score on more than one occasion, which was not escalated to the nurse in charge for review. While this was not a causative factor in Mr Ali's death, I consider that it creates significant risk for other patients in future, if not addressed. 2) During part of his on Millharbour Ward, Mr Ali was on one-to-one observations, requiring him to always be within the sight of a dedicated member of staff. Following Mr Ali's death, it transpired that during this period of observations, designated members of staff were noted to preoccupied with the use of their personal mobile telephones at times, and on one occasion, the designated member of staff was sat on a chair with their back to Mr Ali's door. While this was not a causative factor in Mr Ali's death, I consider that such practices undermine patient safety and would place future patients at considerable risk. 3) The Trust noted, during its own serious incident investigation, that the quality of record keeping in relation to Mr Ali's observations was not always accurate. Given the key role that accurate record-keeping plays in patient care within any healthcare setting, I formed the view that this also creates significant risk. I heard evidence that the Trust is taking the above matters seriously and that they are going to be addressed at Board level. However, it was acknowledged that there was still work to do to address the risks identified.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 the report, namely 9 December 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 the following: 1. [redacted] – Mr Ali's next of kin 2. Care Quality Commission 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	**Ian Potter** **HM Assistant Coroner, Inner North London** **28 October 2024**