REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
THIS REPORT IS BEING SENT TO:

1. NHS England
2. Department of Health and Social Care
3. Home Office
4. Foreign, Commonwealth and Development Office

1 **CORONER**

I am Ellie Oakley, Assistant Coroner for Inner West 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 24 August 2024 the Coroner commenced an investigation into the death of Abdulrahman ALAJMI. The investigation concluded at the end of the inquest on 15 April 2025. The conclusion of the inquest was: Natural Causes exacerbated by travel for treatment

4 **CIRCUMSTANCES OF THE DEATH**

The Medical Certificate of the Cause stated the following:

1a) Multiorgan Failure

b) septic shock (Acinetobacter baumennii)

c) infected left leg wound and ischaemic left leg

2 ischaemic heart disease, peripheral vascular disease

On 7 August 2024 at the London Clinic, 20 Devonshire Place, London, Abdulrahman AlAjmi died from multiorgan failure (as set out in the medical cause of death). He had arrived in the UK for medical treatment on 24 July 2024 in a much poorer medical condition than had been outlined by the referring hospital, as he had deteriorated three days before he flew without the receiving hospital being notified of that. He was on a ventilator and bleeding, neither of which had been indicated to the receiving hospital or ambulance which transferred him from the plane to the hospital. Despite appropriate medical treatment being given in the UK, he did not recover. I found that it is probable that the flight contributed to his death by exacerbating his very serious pre-existing medical conditions. The evidence also indicated that patients who come to the UK for treatment from overseas often arrive in a worse condition than anticipated, which means that receiving hospitals and ambulances may not always be equipped to treat the patient appropriately (as they have accepted the referral on the basis of a different medical condition).

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 will 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. In the course of the evidence it was confirmed that there is no set procedure regarding the acceptance by hospitals in the UK of patients for treatment from other countries.
2. It was stated in evidence that patients often arrive in a substantially different (often worse) condition to that described to the receiving clinicians when they

accepted the referral and agreed that they were able to provide treatment. This means that UK health providers may receive for treatment individuals who are more unwell than anticipated, potentially requiring expertise that is not held by the receiving treatment providers (albeit in this case they had an ICU team who were able to provide the necessary treatment).

3. The evidence provided showed that it is up to each individual hospital to determine whether they are willing and able to accept a referral and agree the process for transfer of the patient. The evidence indicated that that process is not uniform and relies heavily on the accuracy of the information received from the referring medical staff, as well as it being appropriately updated should circumstances change.
4. The evidence indicated that it is the decision of the medical staff in the country that the patient is coming from whether, and with what medical support, a patient can travel to come to the UK. That is not within the control of the UK. However, the process by which hospitals in the UK accept referrals from other countries and the provision of visas (and any conditions attached to them) for those individuals to enter the UK for that treatment is within the control of the UK.
5. The evidence showed an absence of systems or structures to ensure that patients arriving in the UK for medical treatment are able to be received (by the ambulance transferring them and the hospital treating them) safely and be properly treated: with a full understanding of the accurate and up to date medical position.
6. The evidence leads to a concern that patients are being put at risk, leading to the possibility of future deaths occurring, and that the UK's health services are put under unnecessary strain by receiving patients who are more unwell than anticipated when a referral is accepted.
7. I consider action should be taken to investigate this issue and consider what, if any, systems can and should be implemented, or steps can and should be taken, to protect patients, and mitigate the risks to and impact on both patients and the UK's health services.

6 **ACTION SHOULD BE TAKEN**

In my opinion action should be taken to prevent future deaths and I believe 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 this report, namely by 11 June 2025. 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:

[redacted] son of Mr Abdulrahman AlAjmi
The London Clinic

I have also sent it to The Independent Healthcare Provider Network, the Faculty of Intensive Care Medicine and the Intensive Care Society, who may find it useful or of interest.

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 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 by the Chief Coroner.

9 16 April 2025

Signature:

Ellie Oakley
Assistant Coroner for Inner West London