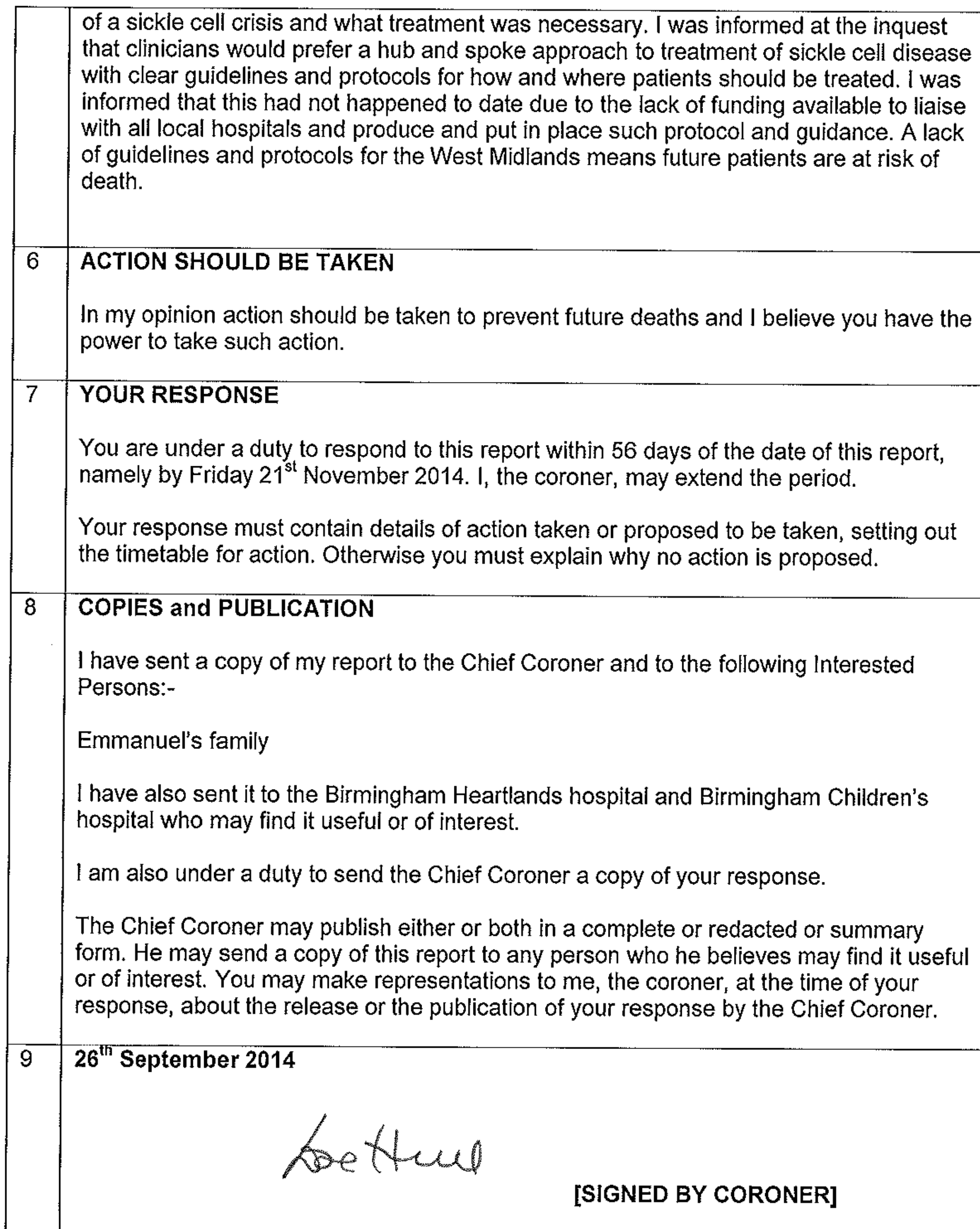
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **NHS England** 2. **Commissioning groups**
1	**CORONER** I am Louise Hunt, Senior Coroner, for the coroner area of Birmingham and Solihull
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 18/02/13 I commenced an investigation into the death of Emmanuel Tobiloba Akinmuyiwa. The investigation concluded at the end of the inquest on 12 September 2014. The conclusion of the inquest was that the deceased died from 1a. Cardiac failure due to 1b. Severe anaemia due to 1c sickle cell disease. I recorded a narrative conclusion as follows: Emmanuel died on the 11th February 2013 as a result of severe anaemia caused by a sickle cell crisis. During his admission there was a gross failure to check his HB on 10/02/13 and a failure to provide an earlier blood transfusion. On balance earlier monitoring of his haemoglobin and an earlier blood transfusion would have avoided his death. His death was contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** Emmaunel was a 7 year old boy who suffered from sickle cell disease. On 08/02/13 he was referred to Birmingham Heartlands Hospital and found to have a HB of 5.7. He was diagnosed as being in sickle cell crisis. On 09/02/14 his HB was 5. Instructions were left that he should have a further blood test taken on 10/02/13. A junior doctor decided not to undertake that test as Emmanuel looked clinically well. On 11/02/13 his HB was checked. The result was available at 4pm and confirmed a level of 2.8. At 20.30 he was given a transfusion. At 21.50 he got up to toilet and collapsed. He could not be resuscitated and died.
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. – Evidence at the inquest confirmed that there needed to be a clear protocol in the West Midlands for the management of patients with Sickle cell disease. Ordinarily they are managed at Birmingham Children's hospital. In this case as Emmanuel was admitted to Heartlands hospital various telephone calls were made to Birmingham Children's hospital. It was acknowledged in an internal investigation by Birmingham Heartlands hospital that staff had a lack of knowledge and appreciation for the signs and symptoms



	of a sickle cell crisis and what treatment was necessary. I was informed at the inquest that clinicians would prefer a hub and spoke approach to treatment of sickle cell disease with clear guidelines and protocols for how and where patients should be treated. I was informed that this had not happened to date due to the lack of funding available to liaise with all local hospitals and produce and put in place such protocol and guidance. A lack of guidelines and protocols for the West Midlands means future patients are at risk of death.
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 Friday 21st November 2014. 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:- Emmanuel's family I have also sent it to the Birmingham Heartlands hospital and Birmingham Children's hospital 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. 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 by the Chief Coroner.
9	**26th September 2014** **[SIGNED BY CORONER]**