MR G IRVINE
SENIOR CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
Telephone [redacted] Email [redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Chief Executive Officer, Barts Health NHS Foundation Trust** **Sent via email: [redacted]** **2. [redacted], Secretary of State for Dept. Health & Social Care** **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 30th December 2023 this court commenced an investigation into the death of Dave Yola Anawelo, aged 34 years old. The investigation concluded at the end of the inquest on 20th August 2024 when the court returned a narrative conclusion. *"Dave Yola Onawelo died in hospital on 30th December 2023. Dave suffered from sickle cell anaemia, on the morning of 30th December 2023 he felt unwell and was assessed by paramedics, he was advised to go to hospital but he declined. Later that day, Dave called a second ambulance and was transferred to hospital. Whilst awaiting assessment*

	Dave deteriorated and suffered an acute respiratory failure caused by an untreated sickle cell crisis. Earlier intervention and treatment may have avoided a fatal outcome." Mr Onawelo's medical cause of death was determined as; 1a Acute respiratory failure 1b Acute chest syndrome 1c Sickle cell disease
4	**CIRCUMSTANCES OF THE DEATH** Mr Onawelo was 34 he was diagnosed with sickle cell anaemia. On the morning of 30th December 2023 he felt unwell following a recent sickle cell crisis, he rang 111 an ambulance was sent to his home at 11.56. On assessment at 12.40 Dave had a moderately fast breathing and heart rate and high blood pressure, his pain was assessed as 6/10. Mr Onawelo was observed to have good oxygen saturation levels and no temperature. Dave was advised to attend hospital, but he declined. Later that afternoon Dave called for an ambulance due to a change in presentation, he had developed difficulty in breathing. Clinical observations at 16.38 were unchanged, he agreed to go to hospital. At the local emergency department ("ED") a handover occurred at 17.23, at this time Dave was not examined and no clinical observations or bloods were taken. At 17.27, Dave was assessed, he explained that he believed that he was in a sickle cell crisis, partial observations were taken and he was deemed not to be acutely unwell and therefore suitable for the Initial Assessment ("IA") section of the ED. He and his mother were asked to remain in the waiting area. Whilst waiting, Mrs Onawelo became concerned regarding her son's deterioration and sought attention from hospital staff. A streamer told her that she was being anxious and a senior nurse refused to assist telling Mrs Onawelo that she was "busy with 6 acute patients". It was only at 18.49 when Mrs Onawelo confronted medical and nursing staff within the IA section that a nurse checked upon Dave. Mr Onawelo appeared drowsy and was slouched to one side. Dave was taken into the IA section in a wheelchair and observations were taken which showed values consistent as those observed earlier, his chest was auscultated and found to be clear. Whilst being cannulated a doctor noticed that Dave appeared unwell and so made provision for him to be taken into a resuscitation bay. Dave then began to experience seizures and sustained a cardiac arrest. A venous blood gas test demonstrated that Dave was profoundly anaemic and acidotic, he had raised lactate and potassium levels and a critically low blood sugar level. Resuscitative efforts were commenced but discontinued at 19.48.
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. – A. The Trust failed to adequately identify a critically ill patient with a pre-existing co-morbidity, sickle cell anaemia, that carried with it a high risk of acute

	deterioration. Earlier introduction of fluid resuscitation, blood transfusion and i/v antibiotics is likely to have resulted in a non-fatal outcome. Factors in the emergency department including, patient congestion, over-reliance on the NEWS algorithm and a lack of compassion and clinical curiosity contributed to the outcome.
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 **22nd October 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 Onawelo, 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] 27/08//2024 [SIGNED BY CORONER]**