Barts Health
NHS Trust

Group Executive Office
Ground Floor
Pathology and Pharmacy Building
The Royal London Hospital
80 Newark Street
E1 2ES
Group Chief Medical Officer
[redacted]

Date:18th July 2025

Dear Miss Persaud

Prevention of Future Death Report – Abdirahman Afrah
Your Reference – 2025-0245

Thank you for your Regulation 28 Report concerning the tragic death of Abdirahman Abdirizaq Afrah. We extend our deepest condolences to his family and recognise the importance of learning from this case to prevent future deaths.

We take the matters of concern you have raised with the utmost seriousness. Below we set out actions already taken and those planned by Barts Health NHS Trust to address each point.

The responses will be delivered in an updated 'Left Without Treatment' (LWOT) policy (drafted and waiting formal review and stakeholder approval) and an immediate safety bulletin which will be actively shared to all staff groups in the Emergency Department. This will be shared electronically, and daily at in-person handovers to reach as many staff as possible to effect immediate change in practice. More detail is included in each section.

The inquest heard that waiting times to be seen in Majors A&E at Newham Hospital could sometimes be between 9 to 14 hours. Many patients are unable to tolerate such long waits and leave the department before being seen.

And

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Emergency Medicine Journal 2022;**39:**168-173.

There was no timely triage of major's patients by the medical team, to ensure that those with the greatest potential of clinical decline are picked up quickly and appropriate investigations commenced at an early stage. Without such frontloading of care, patients like Abdirahman who might compensate right up to the point of collapse might be missed again.

We have grouped these together as prompt triage and 'queue management' go together with managing clinical safety in the emergency department.

Long waits for any part of the patient journey are harmful and a poor experience. The Royal College of Emergency Medicine describes the harm this causes in emergency departments* across the country. We recognise this pressure in our department and that the underlying causes are multifactorial. Tackling long waits in the emergency department must have a whole-hospital response.

The underlying issues are multifactorial, and we appreciate that long waits in the Emergency Department (ED) are the responsibility of the whole hospital to fix.

Front Door and Triage

We acknowledge the importance of early investigations in the patient journey. We undertake Rapid Assessment and Treatment (RAT) for patients presenting to the emergency department. This involves oversight and review by a resident doctor trained in the rapid assessment process. At the time Abdirahman attended ED there would have been a single resident doctor working at the front door, so it is not possible to see every patient, but focus on cases raised by the triage nurse and targeting high risk patients on the screening assessment; RAT would have been the opportunity for Abdirahman's first contact with a doctor . A chest X-ray would likely have been requested at this stage.

Since August 2024, enhanced RAT training has been added to the induction of all resident doctors above foundation level and there is an active program to train all regular locum doctors in this process. This has increased our capacity to front-load tests and investigations throughout the day and night.

There is an active quality improvement project ongoing which is aimed at improving processes for initial assessment of patients self-presenting to the emergency department. The aim of this project is to decrease initial assessment waiting times. In addition, there is a focused area for high-risk patients where there is increased availability of the RAT Dr to respond to queries, review patients, request imaging and start treatments. The project includes introducing easy to follow assessment

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pathways and an education package for all nursing staff involved in initial assessment.

Appropriate Place of Care

Since October 2024 we have introduced a new ‘Fast Lane’ for assessment and treatment of walk-in emergency patients. The provision of an area with consultation rooms and dedicated ED doctors has resulted in decreased waiting times for this group of patients and improved performance against the 4-hour target for non-admitted emergency patients from 50 to 65%.

Over the past 12 months we have expanded our physical space in the Same Day Emergency Care (SDEC) area. We have also merged our ambulatory medical and emergency medical clinical teams working in this area, with additional increase in clinical staffing numbers. This has allowed suitable patients to be directed to the most suitable clinical area and as a result this has reduced waiting times in the emergency department and improved patient experience. For example, patients presenting with chest pain follow one of the key pathways that can be assessed on SDEC, as well as easing the pressure on emergency patients in the main department.

ED Workforce Review & Expansion

We have successfully recruited to all of our consultant vacancies in the last 6 months and will have a significant increase in senior residents managing the department from August 2025. This increase in senior decision makers will enhance the safety in the department overall, with senior oversight over the queue and earlier definitive decision making in the patient journey with a resultant reduction in waiting times.

Care Beyond the Emergency Department & Flow

We frequently experience patients waiting a long time in the emergency department for an inpatient bed. There are several improvement projects ongoing within the hospital to improve flow which have resulted in a significant improvement in the number of patients being discharged before 5pm to enable greater flow from ED to the ward which in turn reduces congestion in ED prior to the evening which is a very busy period

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Recognising that a functioning ED and manageable waiting times depend on a whole hospital response, 'action cards' have been created which give actions to ED nursing and medical teams, hospital site management and speciality teams to manage long waits in ED. Actions include direct referral to speciality teams to see patients, accessing escalation areas, triggering contact with Trust managers and directors to manage workload across the Group.

Oversight & Queue Management

In the last 12 months we have implemented several electronic tools that provide at a glance prompts to senior medical and nursing staff. These are designed to draw attention to patients who need immediate action or should be seen sooner.

Automatic vital sign frequency and 'red heart' alert flag. This provides a visual cue to medical and nursing staff if a patient's observations are outside normal range and need repeating.

Notification of VBG and ECG requiring review. This gives a visual flag that an ECG has been taken and requires review and signing by a doctor. The VBG flag has been implemented in the past two months and mitigates many of the risks of the old paper system. When results are available electronically, they are flagged with a red sign in the patient's location and must be signed when acknowledged.

Acuity flags and concerns. We have introduced a customised acuity rating system for patients falling into different risk groups to draw attention and give priority. These are those who have infectious diseases, those who are vulnerable (through physical or other disability, hearing or communication issues), mental health presentations and those who have clinical concerns requiring prompt response (sickle cell, crisis cancer with immunosuppression, sepsis).

When the doctor called Abdirahman the following afternoon, she did not have all the relevant clinical information to hand. She was not aware of the compensated metabolic acidosis. It is unlikely that she advised Abdirahman of the importance of returning to the hospital. It is foreseeable that patients may be reticent to return to A&E, because of the lengthy waits, so doctors making the call to patients who have

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left, should be fully informed about the clinical condition and risks. The risk of not returning should be made very clear.

Whilst we acknowledge that we are already doing more than many emergency departments by calling patients who have not waited, we are keen to do more.

The doctor who called Abdirahman was aware the blood test was abnormal and, on this basis, advised that he should return for an assessment.

The new LWOT policy will be clear on how to advise patients regarding their options for assessment and treatment including advice on the risks of not receiving care to enable patients to make an informed choice.

Abdirahman was 17 years old. He declined to return to A&E. There was no direct discussion with a responsible parent about the need to return to A&E.

In Abdirhaman's case, his parent was on the call with him when the attendance at his GP practice was discussed. However, we must consider the actions needed when dealing with adolescents.

We recognise that those under the age of 18 are children by law and, where appropriate, a responsible adult or person with parental responsibility is likely to need to be contacted. However, adolescents are special group that deserve due consideration. It would not be appropriate to make a blanket rule to disclose information about attendance to a parent or guardian when in some cases this may not be in the best interests of the adolescent.

In view of this case, we are urgently reviewing our left without treatment (LWOT) policy to include a section around the special consideration for under 18s that have LWOT where a senior decision maker must be involved when making a management plan.

We have included a section in our current staff safety bulletin that any patients under 18 who have left without treatment must be escalated to a senior clinician in real time so that the appropriate response can be decided upon and implemented.

When Abdirahman stated that he would be seeing his GP later that afternoon, he asked for the relevant results to be sent to the GP. Neither the results, nor the discharge summary were sent to the GP in time for the

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appointment. The inquest heard that the A&E doctor did not know how to share such information with the GP.

On this occasion no discharge letter was completed. Even with advances in electronic patient records, discharge letters are not shared rapidly as they are not intended to share very urgent clinical information.

Discharge letters for patients within the East London Patient Record footprint are received after around six hours of leaving emergency department. This is to avoid serial letters being generated after any changes are made (with results or prescribed medicines).

Patients out-of-area (e.g. those visiting London, registered to a GP practice elsewhere), have discharge letters printed and posted manually by administrative staff in daily batches.

More urgent electronic messages can be sent to GPs via Accurx (an NHS messaging platform) which works for most practices both in and out of area.

Since August 2024 we introduced specific administration time for junior doctors in ED to check results. During this process all resident doctors have been using Accurx to contact patients and GP practices and thus the use of this form of communication has increased significantly.

Discharge letters should still contain useful clinical tests and investigations, especially if action may be needed from the recipient. Direct phone calls may be needed where written messages are not fast enough

We have emphasised the importance of including sufficient clinical information via the most appropriate means when managing patients who have left without treatment in our current staff safety bulletin and will formalise instructions in the LWOT policy, so this is accessible to all current and future staff.

Yours faithfully,

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Chief Medical Officer

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