MISS N PERSAUD
HIS MAJESTY'S CORONER
EAST LONDON
EAST LONDON CORONERS, 124 Queens Road, Walthamstow, London E17 8QP
Telephone 020 8496 5000 Email [redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

Ref: [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Chief Executive Officer, Barts Health NHS Foundation Trust **Sent via email:** [redacted] **Cc:** [redacted]
1	**CORONER** I am Nadia Persaud, Area 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 the 13 June 2024 I commenced an investigation into the death of Abdirahman Abdirizaq Afrah, aged 17 at the time of his death. The investigation concluded at the end of the inquest on 15 May 2025 with a conclusion of natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Abdirahman Afrah began to suffer from chest pain, associated with a cough, from the very early hours of the 3 June 2024. At around 2330 on the 3 June 2024 he attended Newham University Hospital A&E, on the direction of a NHS 111 clinical adviser. He notified the triage nurse of severe chest pain including pain radiating to the left arm and

	shoulder. He had a tachycardia of 130 beats per minute, but other vital signs were normal. An ECG was carried out which showed a sinus tachycardia and P pulmonale. Venous blood gases showed an abnormal base excess, indicating a compensated metabolic acidosis. Abdirahman was given two lots of painkillers whilst in the A&E department, but his pain continued to be severe. After around 3 hours of waiting, Abdirahman asked to lie down due to his level of pain. He was told that there were no beds available and that he would have to wait a further 4 hours or so. He notified the nurse that he would have to leave, to be able to lie down to relieve the pain. The nurse advised him that he could leave. He was not seen by a doctor before leaving the department. A doctor from A&E called him the following afternoon to tell him to return to the A&E department for a doctor to explain the results of the tests. He raised concerns about the waiting times and said that he was seeing his GP later the same afternoon. The importance of returning to hospital was not explained clearly to him. Abdirahman did attend his GP practice at around 1630 on 4 June 2024. He was seen by a physician's associate who did not have the hospital results available to her. Abdirahman was clinically stable at the consultation. He was advised by the physician's associate to return to the emergency department to discuss his results. It is unlikely that he was advised to return with any sense of urgency. At around 8pm on the 4 June 2024, Abdirahman suffered a collapse in his home address. Emergency services were called and he was urgently conveyed back to Newham University Hospital. Sadly, all life-saving efforts at this time were unsuccessful. Abdirahman's life was pronounced extinct at Newham University Hospital at 2145 on 4 June 2024. Abdirahman died as a result of bleeding caused by a pulmonary vascular malformation. There was a missed opportunity to provide further investigations and treatment to him when he attended hospital on the late evening of the 3 June 2024. The evidence did not however reveal that such investigation and treatment would, on the balance of probabilities, have prevented his death
5	**<u>CORONER'S CONCERNS</u>** 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. The inquest heard that waiting times to be seen in Majors A&E at Newham University 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. 2. There was no timely triage of Majors 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. 3. When the doctor called Abdirahman the following afternoon, she did not have all of 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 left, should be fully informed about the clinical condition and risks. The risk of not returning should be made very clear. 4. 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. 5. 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 appointment. The inquest heard that the A&E doctor did not know how to share such information with the GP.

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 **22 July 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 am sending a copy of my report to the Chief Coroner, to the family of Mr Afrah, to the CQC, to the local Director for Public Health and to NHS England. NHS England are receiving a copy of the report, as the inquest heard that excessive waiting times are a problem throughout hospitals nationally. 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	**27 May 2025**