

REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's [PFD Publication Policy \(2026\)](#).

1. CORONER

I am Ms. Catherine Wood, Area Coroner for Kent and Medway

2. DATE OF REPORT

10 June 2026

3. 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. THIS REPORT IS BEING SENT TO

1. The Kent and Medway Integrated Care Board
2. The Secretary of State for Health and Social Care
- 3.

You are under a duty to respond to this report within 56 days of the date of this report, namely by 5 August 2026. I, the coroner, may extend the period if an appropriate application is made.

4. YOUR RESPONSE

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.

I have a duty to send a copy of your response to the Chief Coroner.

In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision.

Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.

The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages [Non-responses to Prevention of Future Death \(PFD\) reports - Courts and Tribunals Judiciary](#)

5. SUMMARY OF CORONER'S CONCERN

The Trust does not have an electronic medical records system and staff treating the deceased were unable to access his clinical records from other organisations.

6. ACTION SHOULD BE TAKEN

In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.

7. INVESTIGATION and INQUEST

On 19 April 2024 I commenced an investigation into the death of Adegboye Prince Azeez Mukaila, aged 35 Years.

The investigation concluded at the end of the inquest on 30 March 2026. The conclusion of the inquest was Narrative " He died as a consequence of an acute and rapid deterioration whilst being treated in hospital for a sickle cell crisis. His death was due to multiple organ failure due to his acute sickle cell crisis on a background of sub clinical organ damage due to his underlying sickle cell disease, some of which, was only diagnosed post mortem."

1a Multi-Organ Failure

1b Sickle Cell Crisis

1c Sickle Cell Disease

1d

II

8. CIRCUMSTANCES OF THE DEATH

Adegboye Azeez Mukaila was a 35 year old man with known Sickle cell disease with previous complications of his disease including retinopathy and splenic haemorrhage. He suffered from intermittent pain, likely as a consequence of his underlying disease, which he mainly managed with analgesia at home and he had not previously required any blood transfusion and did not have a care plan in place for dealing with any possible sickle cell crisis.

In mid March 2024 he had been unwell but this was attributed to him being run down following a recent bout of flu. On 20 March 2024 he felt more unwell than normal and by the early hours of 21 March 2024 he was taken to Darent Valley hospital by his wife arriving at 05.46am. He was seen promptly by nursing and medical staff, blood samples were sent and a chest x-ray ordered and he was treated with analgesics, intravenous fluids, antibiotics and oxygen was prescribed to maintain oxygen saturations as required. Of note the blood tests taken did not include a Group and Save despite the hospital policy indicating this was required and he was not admitted to the haematology ward but to a surgical ward under the care of the medical team with a working diagnosis of sickle cell crisis and hypophosphataemia. An electronic referral was made to Haematology at around 3.30pm that day with a plan to request his notes from Lewisham and Greenwich NHS Trust.

On the ward round the following morning he was seen around 10am and the looked unwell and it was noted that he had reduced air entry in his lungs and was now requiring oxygen. The plan remained for haematology review but for some unexplained reason the haematology referral was not picked up by the haematology registrar until around 4pm that afternoon over 24 hours since the referral was made and some 34 hours after he had attended the hospital. The haematology registrar referred him to the critical care team and discussed him with the consultant haematologist on call and a decision was made to transfuse him with blood as his haemoglobin had fallen from 110 on 21 March to 76 g/L from a sample taken on 22 March at 11.10 but only reported at 17.05.

Discussions were held with the haematology team at Lewisham to confirm his previous

treatment and the Intensive care team reviewed him and a decision was made for him to be transferred to Laurel Ward, a high dependency unit for respiratory support as his arterial blood gas revealed type 1 respiratory failure. He was reviewed by the intensive care consultant at 21.00 whilst still awaiting transfer to the high dependency unit and whilst his oxygen requirement had now increased to 60% he was stable, had no signs of respiratory distress and no longer desaturated when he fell asleep. Further blood samples were required for crossmatching which were taken by the intensive care registrar and he was transferred to the Laurel ward shortly afterwards. He was reviewed by a different intensive care registrar around 22.00 and plans were now being made to consider transfer to Guys and St Thomas's for an automated exchange transfusion and liaison occurred between the two hospitals with further tests being requested by the tertiary centre.

He deteriorated further at around 05.15 and by now was requiring 95% oxygen and CPAP was commenced but was not tolerated by the patient and he was transferred to intensive care and intubated shortly after his arrival. The medical team noted that he had some ECG changes indicating ST elevation and he then became profoundly bradycardic and suffered from a cardiac arrest. Despite all possible treatment and a lengthy resuscitation period including a number of returns of circulation he deteriorated and died as at 11.46 on 23 March 2024. A post mortem revealed pulmonary oedema, a congested liver, marked splenomegaly and congestion along with clear evidence of sickle cell disease including pulmonary arteriolar obstruction by sickled red cells, bone marrow necrosis, pulmonary artery thrombosis and emboli, acute splenic sequestration with Gamna-Gandy bodies and myocardial scarring. A cause of death was provided as multi-organ failure due to sickle cell crisis in turn due to sickle cell disease.

9. CORONER'S CONCERNS

During the course of the inquest I heard evidence 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:

During the course of the hearing it became apparent that the Trust do not have an electronic record keeping system. The evidence indicated that electronic notes enhance the ability of clinicians to document and provide care and aid communication between different clinical teams and departments. Here this impacted on the care provided to the deceased as a referral to the haematology team needed to be printed out and placed in a tray in the secretaries office and the haematology registrar on call had to check the tray intermittently (usually morning, lunchtime and at the end of the afternoon). The referral took over 34 hours to be acted upon and it was likely that the reliance on paper based notes led to delays in the referral being acted upon and appropriate advice and management provided.

There were also issues in being able to access records held by other organisations as the staff at Darent Valley hospital did not have access to any previous clinical notes from other organisations to confirm his diagnosis. Staff had to ring the Trust where the deceased had been previously seen for his Sickle cell disease and ask them to forward relevant information. This led to a lack of clarity in the notes regarding Mr. Mukaila's sickle cell status. It was not clear whether he was on a Sickle Cell Registry and had undergone annual reviews. Had there been accessible notes between different NHS organisations his medical history would have been clear and may have assisted with clinical decision making which in turn may have had an impact on his care and treatment.

Access to electronic notes at the earliest opportunity would make it far easier for clinical staff to provide appropriate care and treatment. Whilst I found at the hearing that these issues did not more than minimally or trivially contribute to the death it would undoubtedly lead to a risk of future deaths for others.

10. COPIES AND PUBLICATION OF THIS REPORT

I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it.

I also may send a copy of the report to any other person who I believe may find it useful or of interest.

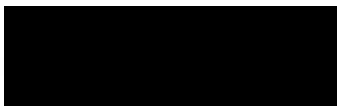
I can confirm I have sent the report to:

1. His family
2. Dartford and Gravesham NHS Trust

I also have a duty to send a copy of the report to the Chief Coroner.

You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's [PFD Publication Policy \(2026\)](#) Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.

Signature



**Chief
Coroner**

RESPONSE TO A REPORT TO PREVENT FUTURE DEATHS

REGULATION 29 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

When a coroner sends a prevention of future deaths (PFD) report to a person or organisation, they must respond within 56 days. Recipients of a PFD report can apply to the coroner for an extension. A response to a PFD report must detail the action taken or to be taken, whether in response to the report or otherwise, or it must explain why no action is proposed.

The purpose of the response template below is to promote clarity, ensure that responses address the coroner's concerns directly and transparently, and support consistency and good practice across organisations and sectors.

It does not restrict how a person or organisation formulates their response; recipients remain responsible for determining what action is appropriate and for ensuring that their response accurately reflects the steps taken or planned.