



POC1 838141

Richmond House 79 Whitehall London SW1A 2NS

Tel: 020 7210 3000 Mb-sofs@dh.gsi.gov.uk

Mr A Walker Senior Coroner North London Coroners Court 29 Wood Street Barnet EN5 4BE

-5 MAR 2014

De h. Walter,

Thank you for your letter following the inquest into the death of Mone Jahni Karl White. In your report you conclude that the medical cause of death was acute heart failure, asthma/chest infection and dilated cardiomyopathy.

Mone was a three year old boy who suffered with dilated cardiomyopathy and was under the care of the Royal Brompton Hospital. He had repeated episodes of illness requiring hospital treatment.

In 2010 the Royal Brompton Hospital produced a guidance document for those who might come into contact with Mone and sent copies to Northwick Park Hospital, the London Ambulance Service and Mone's parents.

On 5 July 2012 Mone was taken ill and brought by ambulance to Northwick Park Hospital. The doctors treating him did not see the guidance document despite there being a copy in the medical notes.

On the 7 July 2012, Mone's condition deteriorated and although doctors attended and treated him he later became unresponsive and it was not possible to save his life.

You comment that had Mone been referred to the Royal Brompton Hospital on the 5th or 6th July it is likely he would not have died when he did.

You also ask that we consider:

• The development of a flag system for patients, under the care of specialist hospitals, with special clinical requirements to ensure that advice about

clinical care is brought to the attention of all treating clinicians.

I am very grateful that you have brought this important patient safety issue to my attention.

It appears that there was already an effective system in place to ensure that important information was sent to relevant organisations likely to come into contact with Mone, but that this was not seen or acted upon by the clinicians treating Mone at Northwick Park Hospital.

I note that you have sent a copy of this Regulation 28 report to the Northwick Park Hospital. I anticipate that they will be able to comment in more detail on the reasons why the doctors treating Mone had not seen the guidance document prepared by the Royal Brompton Hospital and I would expect them to properly respond to the issues concerning local care procedures and standards, which you have raised.

I can also advise that the General Medical Council (GMC) is the body responsible for setting good medical practise standards for doctors.

Within the GMC code of practise, "Good Medical Practise" there is a section covering the continuity and coordination of patient care which makes clear that all relevant information should be shared with colleagues involved in a patient's care. I've quoted the relevant extract below for your information:

## Continuity and coordination of care

- 44. You must contribute to the safe transfer of patients between healthcare providers and between health and social care providers. This means you must:
- a. share all relevant information with colleagues involved in your patients' care within and outside the team, including when you hand over care as you go off duty, and when you delegate care or refer patients to other health or social care providers
- b. check, where practical, that a named clinician or team has taken over responsibility when your role in providing a patient's care has ended. This may be particularly important for patients with impaired capacity or who are vulnerable for other reasons.
- 45. When you do not provide your patients' care yourself, for example when you are off duty, or you delegate the care of a patient to a colleague, you must be satisfied that the person providing care has the appropriate qualifications, skills and experience to provide safe care for the patient.

With regard to developing a flag system in specialist hospitals to ensure that advice about clinical care is brought to the attention of all treating clinicians, I consider that



this is a matter for attention at local, rather than national level. The NHS Trust concerned needs to ensure they have a system in place whereby all relevant, and available, information is routinely accessed and acted upon.

I would of course be happy to consider any national learning that may come about as a result of this sad case.

I hope that this response is helpful and I am grateful to you for bringing the circumstances of Mone's death to my attention.

Yes showed

**JEREMY HUNT**