Barts Health
NHS Trust

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PRIVATE & CONFIDENTIAL

Ms Caroline Beasley-Murray
HM Senior Coroner

Dear Ms Beasley-Murray

RE: Regulation 28: Report to Prevent Future Deaths

I write in response to the recent Regulation 28: Report to Prevent Future Deaths notice regarding the care of Clara Moniatis.

Clara, a 5 month old child, was bought to the Whipps Cross Hospital (WCH) Emergency Department (ED) by her parents with worsening symptoms of possible tonsillitis. Having been clinically stable, Clara deteriorated rapidly after 5 hours in the department and arrested, resuscitation was unsuccessful. Post mortem examination identified previously undiagnosed dilated cardiomyopathy.

The matters of concern raised in the Regulation 28 notice were:

1. The matter of waiting times from chest x-ray to the review of the imaging
2. The matter of the need for a system whereby a PEWS alert leads to a prompt clinical review

We have previously noted that the documented timings of x-ray review represent a maximum time, as notes are often made in retrospect within a busy emergency department.

Following a thorough review of our own investigation findings and the views of the Coroner's expert witness, and taking into account that Clara was seen by a senior specialist doctor within 20 minutes of her PEWS increase, we believe we could have done nothing which would have prevented Clara's sad outcome. However, this has reaffirmed the critical importance of early senior review of deteriorating patients, following national guidelines on the escalation protocol for PEWS, and we have shared the learning widely among our clinical staff.

Yours sincerely

[redacted]

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