Royal College of Paediatrics and Child Health
Leading the way in Children's Health

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Christopher Morris
HM Area Coroner
Manchester South

[redacted]

Dear Mr Morris

Re: RCPCH Response to the Inquest Touching the Death of Luca Yates
A Regulation 28 Report – Action to Prevent Future Deaths

Thank you for sharing your Report with us regarding the tragic and untimely passing of Luca Yates. We were saddened to read the circumstances surrounding Luca's death and have discussed with senior colleagues within the RCPCH.

Whilst we cannot comment on the specific details around Luca's passing, we have read your report carefully and would like to offer a response to both of your concerns, and other areas where the Royal College of Paediatrics and Child Health will bear most impact.

The paediatric curriculum

The Progress+ curriculum has been developed in the context of 'excellence by design' and is a high level, outcomes-based curriculum. The outcomes are developed to describe key capabilities to deliver safe care at the end of ST4 (for core training) and at CCT (for specialty level training) in the context of rota design, service configuration and expected levels of team and consultant support.

I note the concern raised by yourself regarding changes to the paediatric curriculum following introduction of Progress+ and that these might lead to less experience of managing neonates born in poor condition and requiring resuscitation.

There are three issues which might have caused concern:

1. The removal of specific mandated blocks of training during core training.
2. The wording and expectation of key capabilities and in particular the change in airway capabilities to remove compulsory intubation DOPS (direct observation of procedural skills) from early years training.
3. Equipping general paediatricians to manage neonatal resuscitation (pertaining to specialty level training).

A. Neonatal training placements during core training

It is true that there are no specific mandatory placements during core training. This is because the curricular learning outcomes and key capabilities are generic in nature and can be acquired in most settings. However, in order to meet the key capabilities related to neonatal care (see below) and to prepare trainees to be on tier 2 rotas at ST4 covering neonatal units, all trainees will spend time during their core training in a neonatal setting. Full

neonatal resuscitation to the point of chest compressions and central drugs is rare and many trainees (even in the previous curriculum/training pathway) do not lead many such events during their training. These happen in all delivery settings, including local neonatal units and Special Care Baby Units as well as tertiary neonatal units. Many trainees will spend time in a tertiary neonatal setting but as indicated, core neonatal capabilities can be acquired in a local neonatal setting as well.

The capabilities to lead neonatal resuscitation will be largely acquired and maintained through training and simulation, augmented by clinical experience. The key capabilities needed are outlined in the core syllabus document and are clearly aligned to the need for neonatal resuscitation skills. It is our view that these key capabilities, combined with our new 'readiness for tier 2 working' assessment form, and the much more specific (and safe) airway capabilities in the core curriculum do provide safe training to manage neonatal resuscitation as the first senior responder – always with consultant support available to come in from home. In addition, there continues to be a requirement to be a current Newborn Life Support (NLS) provider in order to work on the tier 2 rota.

B. Key Capabilities in Core Syllabus

The specific key capabilities pertaining to neonatal resuscitation in the Core Syllabus are outlined below. All key capabilities are mandatory to evidence.

Learning Outcome 3

- Demonstrates achievement of both basic and advanced life support
- demonstrates neonatal airway maintenance: airway opening manoeuvres and the use of airway adjuncts (including supraglottic airway) to maintain the airway of a term or preterm baby to the point of intubation.

Learning Outcome 4

- Recognises the potential life-threatening events in babies, children and young people and leads resuscitation and emergency situations

C. Airway Capabilities

Previously in training, Level 1 (ST1-3) needed to have a successful DOPS for neonatal intubation. However, there are fewer neonates being intubated as part of routine neonatal care and opportunities to learn and maintain skills are increasingly limited. It is recognised that neonatal intubation in unskilled hands can be damaging, particularly if there are repeated attempts. A single successful DOPS for intubation does not make someone safe and it takes the emphasis away from developing safe, non-invasive neonatal airway management skills.

The Resuscitation Council UK Newborn Life Support (NLS) guidelines include use of a supraglottic airway to manage the neonatal airway. The RCPCH core curriculum now mandates safe non-invasive neonatal airway management skills. This is a much safer way of manging the airway in a baby born in poor condition. This is also in line with the draft BAPM Neonatal Airway Safety Standard.[1]

D. Readiness for Tier 2

At core level (ST1-4) it is expected that trainees will be supported to develop decision making skills and to be working independently on a tier 2 rota by the start of ST4. Therefore, trainees will be on the tier 2 rota before completion of the core curriculum.

[1] https://www.bapm.org/resources/BAPM-Neonatal-Airway-Safety-Standard

Alongside the curriculum we have introduced a formal supervisor assessment that the trainee is ready to be on the tier 2 rota with remote supervision (i.e., a consultant on call from home). To agree that a trainee is ready for this step there needs to be agreement that there is evidence of:

- Neonatal capabilities.
- General paediatric capabilities.
- Neonatal Life Support & Advanced Paediatric Life Support course, or equivalent.
- Mandatory procedures (including airway maintenance as above).

This is a new assessment, as previously trainees stepped up to a tier 2 rota in a more ad hoc and unregulated manner, sometimes before completion of level 1 training. The 'readiness for tier 2 working' assessment now gives more assurance of capability to manage emergency resuscitation situations as the first senior responder. However, it is recognised that a tier 2 ('middle grade') at ST4 will require consultant support and supervision.

E. General paediatric consultants experience of neonatal resuscitation

70% of paediatric trainees will train as general paediatricians, of which a significant proportion will go on to work in a DGH covering a local neonatal unit or SCBU where there may be a need for neonatal resuscitation. In recognition of this, the general paediatric specialty level syllabus has mandatory key capabilities relating to neonatal resuscitation and airway management. To evidence these, trainees at specialty level following the general paediatric pathway will need to spend time in a neonatal setting again.

The specific key capabilities are:

Specialty Learning outcome 1:

- Leads a team in the resuscitation of extremely unwell babies, children or young people.
- Maintains the airway of term and preterm neonates up to and including safe intubation attempt under optimal conditions. Recognises the risks of repeated intubation attempts and if intubation is unsuccessful maintains the airway with adjuncts including supraglottic airway. Can follow a difficult airway pathway with the support of other professionals.

The airway capabilities have been carefully developed to maintain a focus on safe management, including non-invasive management and working in teams to manage a difficult airway. Trainees at this level are expected to learn to intubate but to recognise how to manage the airway should intubating not be possible. In addition, general paediatric trainees at this level must maintain NLS provider status (or equivalent) and consultants who cover neonatal units generally have a trust requirement to have up to date NLS provider status.

<u>Sharing information for quality improvements</u>

The College will be sharing information and suggestions for local improvement from your report with our paediatric members via its patient safety portal. The information within your report will also be shared for discussion with the RCPCH Clinical Quality in Practice group in early Spring, where further actions may be identified.

Thank you for seeking our views and reminding us of the importance of this work. Our sincere condolences are with Luca's family.

Yours sincerely

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RCPCH President