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

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[redacted]

Coroner ME Hassell
Senior Coroner
Inner North London

[redacted]

Dear Coroner Hassell

Re: RCPCH response to the Inquest Touching the Death of Kazarie T'Calla Kwaku DWAAH-LYDER. A Regulation 28 Report – Action to Prevent Future Deaths.

Thank you for sharing your report with us regarding the tragic and untimely passing of Kazarie Dwaah-Lyder. We were saddened to read the circumstances surrounding Kazarie's death and have discussed with senior colleagues within the RCPCH, including the British Association of Paediatric Surgeons and British Society of Paediatric Gastroenterology, Hepatology and Nutrition, and also with the Royal College of Radiologists.

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

Your report asked whether national guidance could be developed for children suspected of swallowing a non radio opaque object whose symptoms persist. Having gathered views from senior colleagues, I have understood that the circumstances surrounding Kazarie's death are tragic and exceptionally rare.

I understand from the British Association of Paediatric Surgeons that a clinical working group has been set up to look at guidance development for button battery ingestion, and they have advised that they would be happy to receive your report and consider whether guidance could be developed as part of that scope of work. The group includes clinicians working in emergency care, gastroenterology with endoscopy expertise, surgery and other national clinical commissioners. The working group would be pleased to invite a paediatric radiologist to look at this and advise on appropriate outputs as agreed.

I have heard from senior clinicians that in the context of a child who has swallowed a non radio opaque object, there is a balance to be made between arranging for scans (which may likely need a general anaesthetic and could result in a not insignificant dose of ionising radiation), whilst also offering an accessible and timely care pathway for all children suspected of swallowing objects. I understand that these points will be considered by the working group based on the best interests of children and young people.

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 summer, 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 Kazarie's family.

Yours sincerely

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RCPCH President