The Royal College of Radiologists

Coroner ME Hassell
Senior Coroner
Inner North London
St Pancras Coroner's Court
Camley Street
London
N1C 4PP

4 April 2024

[redacted]

Dear Coroner Hassell,

RCR Response to Regulation 28: Prevention of Future Deaths report issued on 9 February 2024 in relation to the death of Kazarie T'Calla Kwaku Dwaah-Lyder

I was very sorry to read about the death of Kazarie and I would firstly like to express my sincerest condolences to Kazarie's family for the very sad and tragic loss of their child. We take the matters raised in your report very seriously and are committed to learning from cases where there have been bad outcomes.

We have been specifically asked to consider whether national guidance could be developed for children suspected of swallowing a non-radio opaque object whose symptoms persist. This question was discussed in detail with senior colleagues at the Royal College of Paediatrics and Child Health, British Association of Paediatric Surgeons and the British Society of Paediatric Radiology. I note the response from the Royal College of Paediatrics and Child Health to your report which details the conclusions of these discussions and the RCR would endorse this response.

As noted in the RCPCH response, there is an existing multi-professional clinical working group, currently chaired by the British Association of Paediatric Surgeons, looking to develop guidance to prevent fatalities caused by children swallowing button batteries. This multi-professional group has agreed to consider whether guidance on swallowing non-radio opaque objects could also be developed as part of that scope of work and I can now confirm that a paediatric radiologist has been appointed to this group to contribute to this important work.

The RCR cannot comment on individual cases, however, my understanding is that the circumstances surrounding Kazarie's death are tragic and extremely rare. The development of national guidance in this area is complex. Any potential guidance in light of this case will also need to carefully consider the significant risks and potential harm posed to a large proportion of young children from (potentially unnecessary) investigations which involve general anaesthesia and exposing children to significant ionising radiation. Decisions about

63 Lincoln's Inn Fields, London, WC2A 3JW, UK
+44 (0)20 7405 1282
enquiries@rcr.ac.uk
rcr.ac.uk

paediatric imaging need to take into account the increased risk from ionising radiation in children from factors such as cumulative radiation risk over a lifetime, longer lifetime to express relative risk, and that a growing child has more radiosensitive tissues. I note these points will be considered by the clinical working group based on the best interests of children and young people.

The RCR has also highlighted your report with the British Society of Paediatric Radiology, a special interest group for radiologists in the UK and Republic of Ireland who practise paediatric radiology, to raise awareness of the circumstances surrounding Kazarie's death for future learning amongst the paediatric radiology community.

I am grateful to you for bringing these matters of concern to our attention and for giving us the opportunity to respond.

Yours sincerely,

[redacted]
RCR President