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

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

Sent by email to: [redacted]

14 October 2024

Dear Mr. Hassell,

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

Thank you for sharing your report with us regarding the tragic and untimely passing of Daniel Klosi. I was very sorry to hear of Daniel's death. I have shared your report with other senior paediatric colleagues within RCPCH.

We have read your report carefully. You mention two areas which would benefit from further consideration.

1. *I heard that obtaining no observations should be regarded in the same light as obtaining worrying observations and should be escalated without delay*.

This is an area of uncertainty. There are lots of reasons why observations might not be obtainable. Observations are important but are part of a holistic assessment of children.

As a college we are committed to the introduction, embedding and appropriate standardisation of Paediatric Early Warning Systems (PEWS) within the four nations. PEWS are designed to effectively recognise and respond to the deterioration of children or young people in a healthcare environment. A parental escalation process is essential to any effectively PEWS. We have been collaborating with NHS England and the Royal College of Nursing to develop a single national PEWS for England since 2018 and are supportive of equivalent processes across the UK.

Our Facing the Future standards aim to provide a vision of how paediatric care can be delivered to provide a safe and sustainable, high-quality service that meets the health needs of every child and young person. There are standards covering emergency settings. These standards aim to ensure that urgent and emergency care is fully integrated to ensure children are seen by the right people, at the right place and in the right setting.
We are currently in the process of audit, review and revision and update of our current standards, to be published in 2025.

Two of the Emergency care standards have particular relevance:

- Standard 17 – All children attending emergency care settings are visually assessed by a doctor or nurse immediately upon arrival with clinical assessment undertaken within 15 minutes to determine priority category, supplemented by a pain score and a full record of vital signs.
- Standard 44 – Emergency clinicians with responsibility for the care of children receive training in how to assess risk and immediately manage children's mental health needs and support their family/carers. Training should include risk assessment, current legislation on parental responsibility, consent, confidentiality and mental capacity.'

As mentioned, an update to the standards is currently underway. This update will provide guidance on necessary adjustments for children and young people who are neurodivergent.

2. *The trust emergency department electronic patient records do not show how many times a patient has presented to hospital with the same signs and symptoms during their current illness*

Responsibility for electronic records lies with the NHS. As a college we have called for improved data and digital solutions in our Blueprint for Transforming Child Health Services. Effective data linkage and information sharing within the health system, and between the health system and key partners in education and children's social care is vital to understanding children's health needs, recognising risk of harm, and providing effective care. We will continue to advocate on this as a priority in the development of the new 10 Year Plan for the NHS in England.

Additional to the points you raise, please can we draw your attention to recognition, diagnosis and early management of Sepsis for which we provide links to relevant clinical guidance within our clinical guidance directory. We provide formal support to the NICE quality standard on sepsis; this is currently under review as part of recent updates to the NICE Sepsis Guidance.

The College will be sharing information and suggestions for local improvement from your report with our paediatric members via its patient safety portal. The anonymised information within your report, and anticipated response from NICE, will also be shared for discussion with the RCPCH Clinical Quality in Practice Committee, 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 Daniel's family.

Yours sincerely

[redacted]

[redacted]
RCPCH President