Regulation 28: Prevention of Future Deaths report

Daniel KLOSI (died 02.04.23)

	THIS REPORT IS BEING SENT TO: **1.** [redacted] **Medical Director** **Royal Free Hospital** **Pond Street** **London NW3 2QG** **2.** [redacted] **President** **Royal College of Paediatrics and Child Health** **5-11 Theobalds Road** **London WC1X 8SH** **3.** [redacted] **President** **Royal College of Emergency Medicine** **Octavia House** **54 Ayres Street** **London SE1 1EU**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 12 April 2023, one of my assistant coroners, Jonathan Stevens, commenced an investigation into the death of Daniel Klosi, aged 4 years.

	The investigation concluded at the end of the inquest on 14 August 2024. I made a narrative determination at inquest, a copy of which I attach.
4	**CIRCUMSTANCES OF THE DEATH** Daniel died on his fourth presentation in a week to the Royal Free Hospital. His medical cause of death was: 1a group A streptococcus sepsis
5	**CORONER'S CONCERNS** During the course of the inquest, the evidence revealed matters giving rise to concern. In my opinion, there is a risk that future deaths will occur unless action is taken. In the circumstances, it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. The Royal Free NHS Trust divisional director of women and children's services gave evidence at inquest of the changes that have been introduced since Daniel's death. • More training has been given and reflection has been undertaken. • A child reattending the emergency department will now be seen by the next available doctor, rather than waiting for a paediatrician to become available. • The trust is trying to gain a more sophisticated understanding of the ways in which neurodiverse patients can present and how best to interpret their presentation. • There is now to be a national change to allow 111 services to contact emergency departments direct. However, it seemed that some areas would benefit from further consideration by the trust. And all of the issues are likely to be just as applicable nationally. 1. It was difficult for the nursing staff to obtain Daniel's observations because he was so distressed. That was understandable, but because of the long wait in a busy department, it meant that on the fourth attendance Daniel did not have a full set of observations for over four hours and shortly afterwards suffered a catastrophic cardiovascular compromise.

	I heard that obtaining no observations should be regarded in the same light as obtaining worrying observations, and should be escalated without delay. It seems that this has not been emphasised explicitly to nursing and medical staff at the trust – and obviously may not have been in other trusts. 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 – and of course this may be the case in other emergency departments.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 14 October 2024. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the following. • [redacted] and [redacted], Daniel's parents • HHJ Alexia Durran, the Chief Coroner of England & Wales I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.

9	**DATE**	**SIGNED BY SENIOR CORONER**
	16.08.24	*ME Hassell*