Daniel KLOSI - determination on 14.08.24

This has been an inquest on behalf of Our Sovereign Lord The King by me, Mary Elizabeth Hassell, Senior Coroner for Inner North London, touching the death of Daniel Klosi who died on 2 April 2023 at the Royal Free Hospital, Pond Street, London. I make a narrative determination as follows.

"Daniel Klosi died shortly after midnight on Sunday, 2 April 2023 from sepsis that developed following a chest infection. In the week preceding his death, Daniel's parents took him to their local hospital accident and emergency department on four occasions:

1. the morning of Sunday, 26 March 2023;
2. the early morning of Friday, 31 March 2023;
3. the morning of Saturday, 1 April 2023;
4. the afternoon of Saturday, 1 April 2023.

On the fourth attendance at approximately 4.45pm on Saturday, 1 April 2023, Daniel's septic process had begun. This was not recognised until after 9pm. Factors contributing to the non recognition were as follows:

- a delay in medical assessment caused by an extremely busy department;
- an inability to obtain observations not being recognised as requiring escalation;
- some presenting features that were very atypical of sepsis;
- a lack of recognition at a profound level of the different in way in which a septic neurodivergent child (in this case, with autism) can present (in this case, appearing to healthcare professionals to be alert when in reality he was agitated) and the consequent need to pay even more attention than usual to parental description.

However, it is unclear whether earlier diagnosis and treatment on the fourth attendance would have changed the outcome.

On the third attendance, the consultant who assessed Daniel:

- failed to read his medical records; and
- failed to elicit a full parental history;

and so did not know that this was his third presentation in a week. She knew about the second presentation but did not read the record of that presentation.

Crucially, this meant that the consultant failed to appreciate that Daniel's current illness had been ongoing for a week (from Saturday, 25 March to Saturday, 1 April). As a consequence, she failed to order blood tests. These would have demonstrated a very elevated C-reactive protein (CRP). Intravenous antibiotics would then have been administered. Daniel's life would have been saved."

I intend to make a prevention of future deaths report.