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Dr Julian Morris Southwark Coroners Court 1 Tennis Street London SE1 1YD

Sent by email to:

23 December 2024

Dear Dr Morris,

Re: RCPCH Response to the Inquest Touching the Death of Lacey May Brookman A Regulation 28 Report – Action to Prevent Future Deaths

Thank you for sharing your report with us regarding the tragic and untimely passing of Lacey May Brookman. I was very sorry to hear of Lacey's death. I have shared your report with other senior paediatric colleagues within RCPCH, namely our Officers for Clinical Standards and Quality Improvement.

We have read your report carefully. Of the four matters of concern noted, one is of particular note to the RCPCH given our role postgraduate medical education:

The training of doctors in considering the diagnosis [of retrocaecal appendicitis] as a possible differential to generalised abdominal pain.

An important learning outcome in our core syllabus for paediatric training is the ability to conduct a clinical assessment of babies, children and young people, formulating an appropriate differential diagnosis; plans appropriate investigations and initiates a treatment plan in accordance with national and local guidelines, tailoring the management plan to meet the needs of the individual. This includes the capability to recognise the potential life-threatening events in babies, children and young people and lead resuscitation and emergency situations. Diagnosis of acute abdominal pain is an important part of this syllabus.

We also support the training resource, <u>Spotting the Sick Child</u>, which includes abdominal pain as one of seven common symptoms.

You have additionally noted the <u>Best Practice Pathway Resource</u> for paediatric acute abdominal pain and appendicectomy, which was published in June 2022 by Getting It Right First Time (GIRFT), which was developed with several College members. We will ensure we signpost to this accordingly.

The College will be sharing information and suggestions for local improvement from your report with our paediatric members via its <u>patient safety portal</u>. The anonymised information

within your report 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 Lacey's family.

Yours sincerely



RCPCH President