



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

Royal College of Nursing  
20 Cavendish Square  
London  
W1G 0RN

**General Secretary & Chief Executive**

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Sent by email: [REDACTED] [coroners@camden.gov.uk](mailto:coroners@camden.gov.uk)

31 July 2025

Dear Mr Hassell,

**Re: RCN Response to the Inquest touching the death of Finlay Joshua Roberts  
Regulation 28 - Prevention of Future Deaths Report.**

Thank you for sharing your report with us regarding the tragic and untimely passing of Finlay Joshua Roberts. I was very sorry to hear of Finlay's death. We respond to your Prevention of Future Deaths (PFD) Report dated 20 June 2024.

With a membership of over half a million registered nurses, midwives, health visitors, nursing students, nursing support workers, nursing associates and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world.

RCN members work in various hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on numerous issues by working closely with the Government, the UK parliaments and other national and worldwide political institutions, trade unions, professional bodies, and voluntary organisations.

Not all registered nurses, midwives, health visitors, nursing students, nursing support workers and nurse cadets are members of the RCN. The Nursing and Midwifery Council (NMC) is the independent regulator for nurses and midwives in the UK and nursing associates in England. The NMC's register shows who can practise as a nurse or midwife in the UK or as a nursing associate in England.

We are not the regulator for nurses in the UK, nor do we have any control over individual nursing practice in individual workplaces; therefore, we have no remit to address the concerns you have noted in respect of this death. However, the RCN offers a suite of learning resources to support nurses, students, nursing support workers, midwives, and health care professionals at all stages of their careers. We provide expert-led, quality-assured, evidence-based education for continuing professional development CPD and learning on a range of topics and subjects.

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It is not for the RCN to comment on the performance of any individual nurse or nursing associate.

We note the **Matters of Concern** set out in Prevention of Future Deaths as:

1. A lack of nursing observations may be a much wider issue than is recognised. In my experience there is nothing about the Whittington and the Royal Free that stands out as unusual.
2. The medical staff at the Whittington did not recognise the lack of nursing observations.
  - Observations were thought to be acceptable because they were not reported as otherwise, when in fact they were absent.
  - The discharging doctor decided that, if his final observations were normal Finlay could go home. Those observations were never carried out, but Finlay was nevertheless discharged.

We have considered your report carefully. Of the matters noted, we believe one is of particular note to the Royal College of Nursing.

1. A lack of nursing observations may be a much wider issue than is recognised. In my experience there is nothing about the Whittington and the Royal Free that stands out as unusual.

From the information provided we do not know how many observations (if any) Finlay had during his stay in the Emergency Department. Observations are important as part of a holistic assessment of children. There are many reasons why observations might not be obtainable, however the RCN recognises that challenges are significantly exacerbated by gaps in clinical nursing rotas resulting in understaffed departments. The RCN cannot comment on the specific factors in this emergency department that may have contributed to Finlay's tragic passing.

Beyond calls and actions at the individual level, such as awareness, education and training, broader systemic and cultural considerations are necessary. Staffing levels, skill mix within the team, clinical governance, policy, procedures, escalation plans, raising concerns, management of deteriorating patients, patient safety reviews, and how organisational learning is undertaken following mortality and morbidity reviews must not be overlooked.

The RCN has been collaborating with NHS England and the Royal College of Paediatric and Child Health (RCPCH) to develop a single national paediatric early warning system (PEWS) for England since 2018 and are supportive of equivalent processes across the UK. The RCN has produced supportive educational material to support the roll out of this initiative [System wide Paediatric Observations Tracking Programme](#). This work is aimed for implementation across the four-nations in the UK.

The RCN is also collaborating with the RCPCH in the revision of the emergency care standards for children and young people which will specify that observations are part of holistic care and repetition is dependent on the child's well-being, alongside clarification around frequency of observations.

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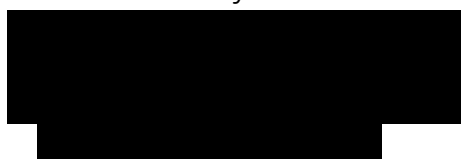
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According to the [NMC annual report](#), 27,168 people left the register in the last year, slightly fewer than the previous year. Of those who left, 20.3% (5,508) were nursing and midwifery professionals who left within the first 10 years of starting their careers. This percentage has increased for the third consecutive year, up from 18.8% in 2020-2021. Additionally, 49% of those who completed the leavers survey indicated leaving their profession earlier than expected. Nursing staffing levels impact patient safety. We can't improve one without improving the other. Our [Nursing Workforce Standards](#) are a roadmap for designing a workforce that can offer patients high-quality care.

Many nurses are caring for unsafe numbers of patients and facing overwhelming pressure and burnout. A [2024 report by the University of Bath](#) identifies psychological stress, workload, staff shortages, and pay as the top reasons for staff leaving the NHS. Rising burnout symptoms, declining job satisfaction, and low confidence in improving working conditions were also observed. Additionally, the proportion of NHS nurses recommending working for the NHS to others has significantly decreased, highlighting significant retention concerns. The right nursing staff with the right skills must be in the right place at the right time to deliver the care children and young people require.

Thank you for seeking our views and reminding us of the importance of this work. Our sincere condolences are with Finlay's family.

Yours sincerely



General Secretary & Chief Executive

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