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NHS Trust

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Private and Confidential
HM Coroner ME Hassell
Senior Coroner
Inner North London
St. Pancras Coroner's Court
Camley Street
London N1C 4PP

15th August 2025

RE: Regulation 28 – Response to Prevention of Future Deaths Report – Finlay Joshua Roberts

Dear Senior Coroner Hassell,

Thank you for your Prevention of Future Deaths (PFD) report dated 20 June 2025 concerning the tragic death of Finlay Joshua Roberts. First and foremost, we extend our deepest condolences to Finlay's family. We fully recognise the seriousness of the matters you have raised and are committed to sustained, systemic improvements to ensure that lessons are learned and embedded into our practice.

Below is our response to the concerns raised, along with the actions taken and those in progress to reduce the risk of similar future incidents.

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1. Failure to Carry Out Serial Nursing Observations

We accept the coroner's finding that there was an omission in not conducting serial complete sets of nursing observations. Since Finlay's death, a number of interventions have been implemented.

Actions Taken:

- **Training & Induction Enhancements:**
    - All new nurses now receive training on vital signs monitoring and escalation during induction and in-house triage training. This ensures that all new starters have a foundational understanding of the importance of recording and escalating abnormal observations from the outset. All clinical staff are also required to familiarise themselves with the department's common presentation policies during their induction.

- All adult nurses deployed to work in Paediatric Emergency Department are provided with local induction to the unit as set out in the Trusts induction policy.
- In addition, practice development support has been introduced in Paediatric Emergency Department, with a focused priority on vital signs monitoring and escalation training for the entire Emergency Department team to ensure that they have the same foundation.
- At triage a complete set of vital signs appropriate to their clinical presentation is required for every child presenting to the department with a medical complaint. This standard has been reinforced through the Emergency Department Triage Training Study Day, which all triage nurses attend. These triage observations will be as recommended by the Royal College of Emergency Medicine (RCEM)

- **Monthly and Manual Audits:**
  - Monthly audits of compliance with vital sign observations have been instituted with the support of the Information Requests Team, with outcomes reviewed by the paediatric emergency department senior team. These will be used to identify ongoing training needs and support continuous improvement with feedback to the team.
  - Senior nurses perform random manual audits of observation charts four times per month. The data is feedback to the team through email, message of the month and on an individual basis.
  - The vital signs observations audits will be presented at the division's quality meeting on a quarterly basis. The next Meeting is scheduled August 2025.

- **Simulation Training with PEWS:**
  - Paediatric Early Warning Scores (PEWS) have been embedded into multidisciplinary simulation training. These simulations take place on alternative Thursdays, including the children's and young people department which allows collaborative learning for acute Paediatrics.
- **Clinical Standards Embedded:**
  - A complete set of vital signs appropriate to the clinical presentation is explicitly required at triage for all children presenting with medical complaints, and those with abnormal observations will be escalated according to the score requirement in national guidance as stipulated by the national paediatric early warning score (PEWS).

- The timing of a repeat set of observations follows the PEWS algorithm which supports escalation level including a communication and response framework.
- This requirement is reinforced in training days attended by all nurses involved in triage, handover briefings, and via monthly staff communications.
- Local records are held on staff training/, competences, (PEWS, triage)

- **Electronic Monitoring Enhancements:**
  - Four additional electronic devices have been deployed in the department to facilitate real-time recording and review of vital signs. Each Nursing staff member has access to an electronic device for inputting Vital signs.
  - The Nurse in Charge (NIC) workstation has been upgraded to a dual-screen system, enabling more effective live monitoring of deteriorating patients.
  - The digital medical record in PED has been updated and all current staff who use it have been notified. proforma used for assessment

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2. Medical Staff Not Recognising the Lack of Observations

We acknowledge that staff failed to identify that vital observations were incomplete and not repeated at the time of Finlay's discharge. In response:

- The emergency Paediatric Clerking proforma now requires doctors to specify the frequency that observations should be done.
- The ED paediatric discharge checklist now requires that there is a review of patient's vital signs prior to discharge. This has been implemented since Finlay's death and its use will be audited regularly.
- The discharge checklist will be disseminated at ED and surgical induction in August and paediatric induction in September and at all future medical inductions thereafter.
- Audits will be conducted and will be presented at the division's quality meeting on a quarterly basis.

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3. Systemic Concerns Around Observation Practice

You raised concerns that the issue of missed observations may not be confined to Whittington Health NHS Trust.

Actions Taken and Ongoing:

- **Collaboration and Benchmarking:**
    - We are actively participating in a regional benchmarking initiative led by the North Thames Paediatric Network to examine standards of practice, share learning, and identify system-wide improvement opportunities.
- **Environmental and Staffing Enhancements:**
    - The Paediatric Emergency Department currently has two recent vacancies. The department maintained 100% filled vacancies prior to this.
    - The lead Nurse for PED has focused on retention and recruitment to ensure nursing vacancies are mitigated with support from general ED nurses who have completed the Paediatric ED rotation and RCEM Paediatric competencies.
    - Staffing levels in the Paediatric Emergency department have been reviewed and aligned with SNCT (safer nursing care tool data), and professional judgement based on staff feedback. This review resulted in additional nursing staff. The staffing levels will continue to be reviewed and reported to the Board on a six monthly basis.
    - We have introduced the allocation of cubicles where nurses are assigned responsibility for specific cubicles and key assessments i.e. Triage and patient cohorts to ensure ownership and continuity of care.
    - Triage responsibilities have been restricted to nurses with a minimum of one year of paediatric emergency experience and completion of the RCEM triage competency workbook. All triage nurses undergo Manchester Triage training and competency training before they can autonomously assess children on arrival.
- **Safe Staffing Governance:**
    - The Emergency Department Nurse in Charge checklist has been updated to align with RCEM guidance on paediatric emergency staffing and now explicitly includes paediatric-specific checks.

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4. Timetable for Outstanding and Continuing Actions

There are no outstanding actions.

However, for continuing actions there will be:

- Ongoing monitoring of compliance by the senior nursing and medical team with oversight from the paediatric and emergency department clinical governance committees reporting into the Patient Safety Group on a 3 monthly basis. Patient Safety Group reports to Trust Board via the Quality Governance and Quality Assurance Committees.
- Ongoing training and induction for all staff in regard to the importance of complete observations and their escalation. This training will also be part of all simulation training in PED
- Continued use of the ED paediatric discharge checklist.
- There will also be ongoing participation in the regional benchmarking initiative led by the North Thames Paediatric Network to examine standards of practice, share learning, and identify system-wide improvement opportunities.
- Continued monitoring of staffing levels and equipment to ensure safety is maintained

Conclusion

We remain deeply saddened by Finlay's death and are committed to ensuring this loss leads to lasting change. We are grateful for your findings and for the opportunity to implement and share learning that may help prevent similar deaths in future.

Please let us know if any further information is required or if clarification of any part of this response would be helpful.

Yours sincerely,

[redacted]

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