Royal College of Paediatrics and Child Health
Leading the way in Children's Health

5-11 Theobalds Road
London
WC1X 8SH
-

Phone: 020 7092 6000
www.rcpch.ac.uk

Assistant Coroner R Brittain
Inner North London

[redacted]

9 September 2025

Dear Assistant Coroner R Brittain,

Re: RCPCH Response to the Inquest Touching the Death of Alfie James Lydon
A Regulation 28 Report – Action to Prevent Future Deaths

Thank you for sharing your report with us regarding the tragic and untimely passing of Alfie James Lydon. I was very sorry to hear of Alfie's death.

Colleagues at the college and I have considered your report carefully and note your concerns regarding a lack of processes in place to document external calls from midwives to hospital teams. We are pleased to note that the Trust involved has taken steps to rectify this. We note your continued concern this is undertaken on paper and is not simply a local issue.

We also note and support your observation and concern that a lack of contemporaneous, accurate and immediately available documentation of discussions between community and hospital teams could result in deaths in future similar circumstances. Our Facing the Future: Together for child health standards state that 'healthcare professionals assessing or treating children with unscheduled care needs in any setting have access to the child's shared electronic record'.

As a membership organisation we have no direct control over the mechanism(s) by which healthcare staff record their clinical communications. Our sphere of influence lies in nudging change at national level. Currently, there is a lack of legislation and guidance on exactly what information, when and how it should be shared between agencies. In practice, our members (paediatricians) have reported difficulties in exchanging information, which may be a result of poor communication between professionals and/or a lack of interoperable information systems available to effectively share information. Use of the NHS number as a single unique identifier for children will overcome these barriers and enable information to be shared more easily between agencies and services. This is something RCPCH have long campaigned for and will continue to do so as we see implementation of the new NHS 10 Year Plan.

We agree with your observation and concern that a lack of record keeping can lead to a lack of continuity and escalation of care, particularly with regards to parental concerns. RCPCH are actively supporting the role out of Martha's Rule, an inpatient safety initiative currently being piloted in England which aims to empower all staff, patients and their families to seek an independent medical review if they feel their concerns about a patient's care are not being adequately addressed. The rule is designed to give families the ability to directly

request an expert review by a senior clinician not within the immediate care team, potentially identifying critical issues before they result in harm.

By establishing this right to an independent review, Martha's Rule improves ability to recognise and respond to deterioration by incorporating parents and families as part of the team. It formalises an escalation route for parents, carers and families to use to ensure their concerns are listened to and acted on and encourages transparency and collaboration. RCPCH contributed to the early working groups for Martha's Rule and we continue to engage with NHS England as data from the pilot sites emerge. Martha's Rule does not extend into the community at present, but learnings from Martha's Rule could in future be applied in the community setting.

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

Yours sincerely

RCPCH President