NHS England

Ms Ellie Oakley
Assistant Coroner
Inner West London Coroner's Court
33 Tachbrook Street
London
SW1V 2JR

National Director of Patient Safety
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

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6 November 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Samuel Finlay Parkin who died on 16 September 2022.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 16 September 2024 concerning the death of Samuel Finlay Parkin on 16 September 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Samuel's parents and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Samuel's care have been listened to and reflected upon.

Your Report raised concerns over the understanding of limitations in using ultrasound to diagnose or rule out malrotation, and the threshold for additional diagnostic tests, particularly in older children. You also raised that there may have been miscommunication between the surgical, paediatric and paediatric gastroenterology teams. My response to the Coroner focuses only on the relevant national policy or programmes that sit within NHS England's remit. NHS England's National Specialty Adviser for Gastroenterology, Hepatology and Nutrition has been consulted on your Report and has contributed to this response.

Contemporary data suggests that the sensitivity of ultrasound to detect malrotation is around 95%. Standard practice is considered to be a barium study (a type of x-ray / imaging test to examine the oesophagus and stomach), performed to provide further evidence with regards to the diagnosis, although this is also unable to detect malrotation in all cases. As such, it is crucial to ensure that there is joined up working between gastroenterologists and surgical colleagues to ensure that malrotation is ruled out as a diagnosis, through the use of a laparoscope (a type of keyhole surgery where a small instrument / camera is inserted through the abdomen using small incisions) where clinically indicated.

The Royal College of Paediatrics and Child Health have produced guidance and examples of good practice in requesting a second opinion (https://www.rcpch.ac.uk/resources/external-second-opinions/process) and note that this may take many forms - including routine second opinion through inter-hospital multi-disciplinary teams (MDTs) or national advisory panels, or through individual consultants.

NHS England Specialised Commissioning will soon begin work to update the published national service specification on Paediatric Gastroenterology, Hepatology and Nutrition which outlines standards for specialised paediatric gastroenterology services. The updated service specification will reference the guidance produced on the provision of second opinions and will also ensure that the importance of communication between multi-disciplinary teams, including surgical, paediatric and paediatric gastroenterology teams, is highlighted. This will include the need for multi-disciplinary discussion for all patients where the results of investigations are not as anticipated.

Many of the concerns raised in your Report are local to St George's University Hospitals NHS Foundation Trust and their management of Samuel's care, and it is appropriate that they respond to the Coroner on the matters raised. NHS England has been sighted on and has considered the Trust's response. We note and welcome that the Trust have taken a number of learnings and actions from Samuel's care, to include rewriting their local guidance on the management of abdominal pain in children, holding monthly Paediatric Gastroenterology Radiology meetings, and ensuring regular training around the limitations of ultrasound scans in looking for malrotation. We note that they are also leading on a dedicated malrotation session at the British Society of Paediatric Radiology. We refer the Coroner to the Trust for further information.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Samuel, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

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National Director of Patient Safety