Regulation 28: Prevention of Future Deaths report

Finlay Joshua ROBERTS (died 12.07.24)

	THIS REPORT IS BEING SENT TO: **1. Executive Medical Director** **Whittington Health NHS Trust** **Whittington Hospital** **Magdala Avenue** **London N19 5NF** **2. President** **Royal College of Paediatrics and Child Health** **5-11 Theobalds Road** **London WC1X 8SH** **3. President** **Royal College of Emergency Medicine** **Octavia House** **54 Ayres Street** **London SE1 1EU** **4. Chief Executive** **Royal College of Nursing** **5th Floor** **20 Cavendish Square** **London W1G 0RN**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Poplar Coroner's Court Bow Coroner's Court
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.

3	**INVESTIGATION and INQUEST** On 19 July 2024, one of my assistant coroners, Richard Brittain, commenced an investigation into the death of Finlay Roberts aged 2 years and 11 months. The investigation concluded at the end of the inquest on 9 June 2025. I made a determination at inquest that Finlay died from a rare (in a child) but recognised natural cause, a sigmoid volvulus.
4	**CIRCUMSTANCES OF THE DEATH** Finlay's parents took him to the Whittington Hospital the night before he died, but the paediatric emergency department was understaffed and it was an extremely busy night. There was a failure to conduct serial nursing observations; not all tests were carried out as appropriate; and, though specialist advice was sought from Great Ormond Street Hospital, the late arrival of x-rays, a lack of complete information and a failure to close the loop of communication meant that the advice was not obtained before Finlay was discharged home. It is unclear whether different hospital care that night would have saved Finlay's life. It would have given him a chance.
5	**CORONER'S CONCERNS** During the course of the inquest, the evidence revealed matters giving rise to concern. In my opinion, there is a risk that future deaths will occur unless action is taken. In the circumstances, it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. The lack of serial nursing observations was a fundamental omission from Finlay's care. I heard at inquest that there have been many improvements in the paediatric emergency department at the Whittington since his death, not least of which has been the addition of more nursing staff. However, a lack of paediatric nursing observations is a subject about which I wrote a PFD report on 13 March 2025 to a different hospital (the Royal Free) following the death of Billie Wicks. I remain concerned on two counts:

	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.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 18 August 2025. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the following. • The parents of Finlay Roberts • HHJ Alexia Durran, the Chief Coroner of England & Wales I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.

9	**DATE**	**SIGNED BY SENIOR CORONER**
	20.06.25	*ME Hassell*