

Locally developed guidance (taken through Trust governance) is mandated and is part of NHS England's commissioning documentation as well as professional standards. Locally developed guidance allows guidance to be specific to the Trust's PICU and the population being treated there, as there are different uses for drugs in different PICUs. For example a cardiac PICU will use different doses of drugs.

In response to the Inquest touching the death of Antonio Galisi-Swallow NHS England and the PCCS will take forward the following actions:

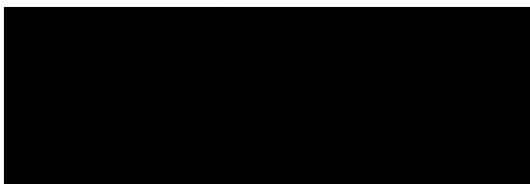
1. The PCCS communications team has shared a "President's message" - an email bulletin to all PCCS members (professionals actively involved in or contributing to paediatric critical care, including doctors, nurses, and allied health professionals) referencing the Regulation 28 Report and the risk of propofol infusion syndrome in PICUs. This has been completed as of February 2026.
2. PCCS will produce a position statement on the use of propofol in Paediatric Intensive Care to formally raise awareness amongst the PICU community. This will be produced in collaboration with the National Paediatric Pharmacy Group (NPPG) and the Association of Paediatric Anaesthetists (APA). This statement will be shared with all PCCS members and hosted on the PCCS website. (Expected completion date: Summer 2026).
3. The next iteration of the [PCCS standards](#) (Version 7 is currently under development) will include a specific requirement that all PCC units must have a local guideline for the use of propofol in PICU. (Expected completion date: end of 2026)

NHS England will support with the development and implementation of the actions to ensure all PICUs have appropriate arrangements in place for the safe use of propofol. Action 2 allows engagement with the relevant professional groups (anaesthetists and pharmacy) and is a formal communication to ensure units take swift action without waiting for the longer-term action of the overall standards re-write (Action 3 listed above).

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 Antonio, 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,





National Medical Director
NHS England