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

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From the President:
[redacted]

Dr Karen Henderson
HM Coroner's Court
Station Approach
Woking, Surrey GU22 7AP

20th May 2014

Dear Dr Henderson

Jackson CHADD (deceased)
Regulation 28 – Action to Prevent Future Deaths

I have read carefully your notification above, and discussed this with senior colleagues within the RCPCH in order to respond to your request for details and timescale for action to be taken.

The matters of concern listed are as follows:

1. Lack of effective supervision of a NCG Paediatrician
2. Lack of consultant supervision of out of hours on-call paediatric trainees
3. Lack of independent consultant assessment of paediatrics admissions into FPH outside normal working hours
4. Lack of effective application of national guidelines for assessment and investigation of fever in children less than 1
5. Failure to acknowledge or act on the concerns of a parent

Given that we do not have all the details of the case presented the RCPCH is unable to comment on the specifics of the case. We have presumed that the hospital Trust will be responding on local policies and procedures and their implementation relating to the above, and will be reviewing and addressing any issues pertaining to the personal practice and competence of the staff involved.

I am pleased to set out below the standards of care that we would expect and the work that is in progress to develop further guidance in the areas where RCPCH can make a difference.

Medical Royal Colleges – background

Medical Royal College are membership-based professional bodies which set the standards for training of specialist doctors in some or all parts of the UK and also contribute to development of professional practice and service standards. All medical consultants in the UK are required to pass professional examinations in their chosen specialty to maintain competence on a specialist register including revalidation and continuous professional development, subject to approval by the General Medical Council (GMC) which regulates the professions.

Alongside setting standards for doctors, Medical Royal Colleges, and their affiliated specialty groups, provide expert clinical input to development of service and clinical standards. In England

the most widely recognised guidelines and standards are developed by the National Institute for Health and Care Excellence (NICE) which has a rigorous and systematic process for topic selection, identifying evidence, evidence synthesis, development, consultation, and final production. Standards are developed in collaboration with expert clinical groups and stakeholders such as medical Royal Colleges and, as could be expected, demand for new guidelines greatly exceeds the capacity of NICE to develop them.

NHS bodies and individual clinical departments are expected to ensure that their operational activities comply with NICE guidelines alongside service standards developed by professional bodies such as RCPCH. There should be in place in all NHS organisations clear systems and processes for clinical governance which monitor and audit practice and outcomes and design programmes of on-going clinical training for staff. These arrangements should ensure that clinicians remain familiar with the guidance relevant to the cases with which they are presented.

Paediatric service and supervision standards.

This case is one of four recent coroners' cases which have come to my attention, three of which have been referred to me under Regulation 28, and two of which have been referred also to the Secretary of State. Whilst there were different factors relevant to each of the cases, there are also common themes, and I believe it is important to consider the cross cutting issues in order to respond to best effect.

The points which, to a greater or lesser degree, cross all cases are as follows:

- Adequate training of all healthcare professionals dealing with children
- Appropriate clinical decision support for healthcare professionals dealing with children
- Adequate consultant supervision of junior doctors dealing with children.

In this tragic case, we have linked your matters of concern to relevant standards and guidance in order to set out our action.

- Items 1-3 relate to clinical supervision and availability of senior advice, for which the 'Facing the Future' standards (RCPCH 2011) apply as well as the 'Standards for CYP in Emergency Care Settings (RCPCH Intercollegiate 2012).
- Item 4 relates to the NICE 'Fever guidance', CG160 which replaced CG47 in May 2013.
- Item 5 is, in our opinion, a local matter for response by the Trust.

Facing the Future and emergency care standards (Items 1-3)

This document sets out ten standards for paediatric services, mostly based around acute settings. It can be found on www.rcpch.ac.uk/facingthefuture and a summary of the standards is attached below. The pertinent standards for Jackson's case would be

Standard 1 – children admitted are seen by a middle grade or above within 4 hours.
Standard 2 – children admitted are seen by a consultant or equivalent within 24 hours
Standard 3 - children referred are seen by a consultant, middle grade or suitably experienced nurse.

In Jackson's case it appeared to take seven hours for him to be seen by a middle grade doctor from arrival at the emergency department, but since Jackson was discharged and not admitted standard 2 did not come into play.

Standard 8 on page 19 of the Emergency Care standards states that 'systems are in place to ensure safe discharge of children or young people including advice to families on when and where

to access further care if necessary'. The definition of 'safe discharge is not provided but many units have local policies in place that require consultant-led discharge of babies under 12 months of age.

The 'Facing the Future' standards were audited in 2012 by RCPCH for compliance by units across the UK. We found standard 1 was met by 77.4% of units and standard 2 by 87.7%. 99.2% met standard 3. Although this case may have been compliant with our existing standards, our audit report indicated that we were proposing to reconsider standard 2 amongst others with a view to increasing the frequency of consultant review to twice rather than once in 24 hours. This review has now commenced and will take around three months during which we will be collating any evidence available to support the recommendations made. In parallel I have discussed this matter with Professor Reid at Health Education England, and as a result our workforce team is working with HEE to model the implications for medical staffing across the country were we to recommend twice daily consultant review. Although it is clear that some children would still slip through the net, even with twice daily consultant review, some parts of the country and some other specialties have already set this as an expected standard of care. In the current environment where there is an increasing emphasis on consultant-delivered care, I believe we have to say first and foremost what we consider to be safest practice, albeit recognising that implementation may require considerable changes to staffing and / or models of care.

NICE fever guidance

At the time of Jackson's death, the NICE fever guidelines were in place as CG47, but have since been updated to CG160 to provide greater clarity on warning signs and actions required to identify serious illness in children. NICE has produced a number of implementation tools and trusts are encouraged to ensure that these guidelines are followed and adherence audited through clinical governance processes. It s not clear from your summary the extent to which this was done by the Trust in Jackson's case.

Why Children Die

Earlier this month RCPCH and NCB launched a joint report 'Why children die' http://www.rcpch.ac.uk/index.php?q=child-health/standards-care/health-policy/child-mortality/child-mortality

This examines some of the possible reasons for the relatively high number of avoidable baby and child deaths in the UK and provides in Part B a policy response of recommendations for remedial action which include the following.

Better training for healthcare staff

- All frontline health professionals involved in the acute assessment of children and young people should utilise resources such as the 'Spotting the sick child' web resource and complete relevant professional development so they are confident and competent to recognise a sick child
- Clinical teams looking after children and young people with known medical conditions make maximum use of tools to support improved communication and clarity around on-going management, for example: introduction of epilepsy passports or asthma management plans where appropriate; cooperating with schools to meet their duty to support pupils with medical conditions.

Whilst recognising that some children will still fall through the net, we are of the view that a higher level of consultant supervision should be encouraged and are reviewing our standards accordingly.

This is also in line with the various 7-day consultant working documents[1] and our own report on consultant-delivered care[2].

RCPCH has a policy priority to focus on reducing child death and we will continue to work with NCB and other partners to press for continued action in this important area.

I trust this provides you with the reassurance that RCPCH is working hard to minimise the likelihood of recurrence of what Jackson's family has faced; thank you for raising this important case and reminding us of the importance of this work.

Yours sincerely

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President

[1] http://www.england.nhs.uk/tag/seven-day-services/
[2] http://www.rcpch.ac.uk/what-we-do/workforce-planning/consultant-delivered-care/consultant-delivered-care