Department of Health

From Dr Dan Poulter MP
Parliamentary under Secretary of State for Health

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Mr I Arrow
HM Coroner
Coroner's Court
3 The Crescent
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23rd October 2014

Dear Mr Arrow,

Thank you for your letter following the inquest into the death of Jude Kliem. I was sorry to read of Jude's death and wish to extend my sincere sympathies to his family.

Jude was being treated at Derriford Hospital in Plymouth where various attempts were made by different consultant doctors to arrange for him to be transferred to Bristol and Southampton hospitals. You are concerned that there appears to have been a breakdown in communications between the hospitals involved.

You ask that we:

- review the standardisation of patient retrieval within the NHS
- review the methods of referral of seriously sick patients between hospitals so that lines of communication are clear
- consider standardising documentation to improve communication

At the inquest, you heard that changes have already been made by Derriford hospital for the transfer of paediatric intensive care patients to other hospitals, including the development of a standard pro-forma referral document. This bring them into line with the policy and standard practice of most other paediatric intensive care units (PICUs) in England because of the need to ensure prompt referral and safe transfer of patients who need paediatric intensive care.

I have shared your report with NHS England. I am advised by its clinical experts working in networks covering both PICUs and PICU retrieval services. Most PICUs already use a pro-forma for patient referral and retrieval (similar to the pro-forma you provided from Bristol Royal) to ensure a structured way of communicating the information required. These pro-forma have been developed either by the individual hospitals or by agreement across a region.

There is clearly an opportunity to further improve safety by bringing together the best aspects of the existing formats into a single document. Such a document would contain the key content needed for safe and effective referral and retrieval, to which suitable local or specialist requirements might be added.

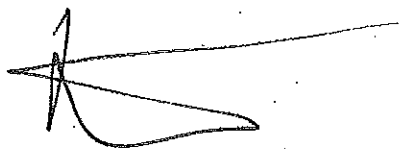
In developing such a national document the PICU networks would build on standards and service specifications already in place, such as *'The acutely or critically sick or injured child in the district general hospital - a team response'* (Department of Health, 2006). There is relevant work currently underway, led by the Paediatric Intensive Care Society's Acute Transport Group, on setting standards for the skills and competencies needed by staff who transfer babies and children in need of PICU.

NHS England intends to take this forward in partnership with the Paediatric Intensive Care Society. Together, they will work to ensure that a national format is not seen as a stand-alone solution, but part of a much wider process that facilitates a senior clinical conversation. The aim is to ensure that both family and clinical concerns are effectively addressed and lead to agreement on appropriate action.

There are several examples of this being already being done successfully in the NHS, and I understand that the organisations that were involved in Jude's care are now working on introducing a similar model. I have asked my officials to keep you up to date with the progress of this work over the coming months.

I hope that this response is helpful and I am grateful to you for bringing the circumstances of Jude's death to my attention.

Best wishes,



DR DAN POULTER