
Monday, 19 April 2021

Sent by email to: [REDACTED]

Dear Assistant Coroner S Hayes

Re: Luke Owen Jackson
Regulation 28 – Action to Prevent Future Deaths

We have read carefully your report regarding the tragic and untimely death of Luke Jackson and have discussed this with senior colleagues within the RCPCH.

The RCPCH supports, educates and develops paediatricians, and the wider child health workforce and services, to deliver high quality safe care for infants, children and young people. Given that we do not have all the details of the tragic death of Luke Jackson, the RCPCH is unable to comment on the specifics of the case.

We have shared this report with the British Paediatric Neurology Association (BPNA) to raise awareness on recognising and managing Hypokalaemia for patients with reduced muscle mass with aim of acting to prevent future deaths.

The RCPCH and BPNA run a variety of courses aimed at the broad spectrum of health professionals caring for children; including primary care professionals, secondary paediatric trainees and doctors, and for specialty professionals. We refer the coroner's attention to this suite of education provision and are committed to reviewing and updating these courses with a view to promoting best practice and raising the standard of medical care provided to children.

- RCPCH - How to Manage: Recognising neuromuscular disorders¹
- BPNA distance Learning Unit 5 - Neuromuscular Disorders²
- BPNA Approaching Children's Tone³

We will be discussing with our British Paediatric Surveillance Unit the suggestion of hosting a webinar to increase awareness of this case and to promote current NICE guidance on replacement fluid therapy in children and young people in hospital. ⁴

¹ <https://www.rcpch.ac.uk/education-careers/courses/rcpch-course/how-manage-recognising-neuromuscular-disorders-free-online-jul-2021>

² <https://www.rcpch.ac.uk/education-careers/courses/specialty-group-course/bpna-distance-learning-unit-5-neuromuscular>

³ <https://courses.bpna.org.uk/index.php?page=tone-management>

We will also be meeting with the Neonatal and Paediatric Pharmacist Group to discuss case-based discussion podcasts and will work through our Medicines Committee to consider the issues from this report in any future planning.

We recognise that medication errors are a significant but preventable cause of harm to children and young people, and we have convened resources via our MedsIQ and Quality Improvement web hubs to improve alerting and information sharing for members and the broader child health profession.⁵ ⁶ Our partnership programme *Medicines for Children* provides practice and reliable advice to parents and families to ensure good quality and reliable information is made available.⁷

Thank you for raising this case with us and reminding us of the importance of this work.

Yours sincerely



Professor [redacted]
President, Royal College of Paediatrics and Child Health

⁴ <https://www.nice.org.uk/guidance/ng29/resources/algorithms-for-iv-fluid-therapy-in-children-and-young-people-in-hospital-set-of-6-pdf-2190274957>

⁵ https://qicentral.rcpch.ac.uk/e-poster_category/medsiq/

⁶ <https://qicentral.rcpch.ac.uk/medsiq/>

⁷ <https://www.medicinesforchildren.org.uk/>