OFFICE OF THE
SENIOR CORONER
for the County of West Yorkshire
(Eastern District)

His Majesty's Coroner's Office
The Coroner's Courts
Burgage Square
Wakefield WF1 2TS

[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Chief Executive, National Institute for Health and Clinical Excellence**
1	**CORONER** I am Oliver Robert Longstaff, HM Area Coroner for the Coroner Area of West Yorkshire (East).
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of The Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 28/02/2023 I commenced an investigation into the death of Edward Richard Jones who died in the Leeds General Infirmary ("LGI") on 18th February 2023, 18 days after his 5th birthday. The investigation concluded at the end of the Inquest (which was held with a jury) on 17/12/2025. The medical cause of death was 1a) Bacterial Sepsis; 1b) Invasive Group A Streptococcus. In summary, the jury's narrative conclusion to the inquest reflected that Edward died from the effects of a septic response to Invasive Group A Streptococcus Disease, his death being contributed to by: i) a failure to respond adequately to a continuously high PAWS score that reached 20; ii) a failure to repeat a venous blood gas that had shown a raised lactate and would, if repeated, have shown a worsening lactate; and iii) a delay in giving Edward antibiotics until he had been in the Paediatric Emergency Department ("PED") for between 10 and 11 hours.
4	**CIRCUMSTANCES OF THE DEATH** Edward died from streptococcal sepsis, but this was confirmed only after his death when blood cultures taken before death grew Group A Streptococcus bacteria. Edward had been promptly assessed upon presentation to the LGI PED with abdominal and leg pain, diarrhoea, previous vomiting and dehydration. His diagnosis was unclear, but a differential included malignancy, hepatitis and intra-abdominal surgical pathology. A venous blood gas that had shown a raised lactate was not repeated, and a subsequent failure in communication gave the erroneous impression to the Paediatric Registrar that the venous blood gas had in fact been repeated and was now normal.

	The hospital trust's Sepsis Screening Tool was not used at any time. Shortages in both medical staff and beds on the general paediatric ward compromised Edward's cllinical management, in that shared care between the Paediatric Emergency Medicine and Paediatric General Medicine teams was prolonged while EJ remained for an extended period (up to 13 hours in all) in the PED. The indication for antibiotics was considered several times, but on each occasion prior to Edward's severe clinical deterioration the threshold was not thought to be reached. The hospital trust formally admitted that a decision to administer antibiotics should have been made at each of these occasions. The presence of upper thigh pain and elevated CRP were not given sufficient weight and a lack of pyrexia was falsely reassuring. Despite potential alternative diagnoses, antibiotics should have been administered as direct harm would have been unlikely and it would have been possible to stop them once sepsis had been excluded on blood culture or an alternative diagnosis reached. Antibiotics for suspected cholangitis were eventually prescribed following an ultrasound scan that was suggestive of some gall bladder or liver pathology, but there was a delay of between 60 and 90 minutes in these being administered.
5	**<u>CORONER'S CONCERNS</u>** 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 inquest was told it is acknowledged nationally that there is no Sepsis Screening Tool which is validated for use in Paediatric Emergency Departments or has a sensitivity or specificity which makes it a useful tool for escalation within a Paediatric Emergency Department. LTHT has developed a Sepsis Screening Tool (SST) which is designed to be used by relatively junior nursing staff to improve the likelihood of considering sepsis and therefore requesting a senior medical review. The SST is intended to be completed at admission or if there is a clinical deterioration, such as an increase in PAWS score to 10 or above. The tool contains various checkbox items that if present suggest a high risk of sepsis. These include abnormal respiratory rate, mottling, rash or appearing blue, high heart rate, low blood pressure, altered conscious level and parental or health professional concern. High temperature needs to be 38 degrees C or more and then only in patients less than 4 months old so is less discriminatory. There are secondary checkbox items indicating a moderate risk of sepsis including new leg pain, cold extremities, reduced urine output and temperature at any age greater than 39 degrees C. A single positive score mandates urgent assessment by a senior decision maker defined as a doctor of ST4 grade or higher, or equivalent allied health professional and if sepsis is confirmed to ensure prompt management, including giving IV antibiotics within 60 minutes. The SST tool is not designed to diagnose sepsis directly as this is the task of the senior decision maker but rather to prompt a targeted assessment, which will confirm sepsis or specifically eliminate it. Acknowledging that the trust's SST had not been deployed in any assessment of Edward that was undertaken in the LGI PED, a trust witness told the inquest that work was ongoing to ensure a consistent application of the SST as between the PED and the paediatric in-patient units at the Leeds Children's Hospital. As a coroner making a report of this nature, it is not for me to recommend to any third party that the Sepsis Screening Tool developed by the Leeds Teaching Hospitals Trust, or any document

	like it, should be either more widely disseminated to, or adopted as official guidance for, Paediatric Emergency Departments across England and Wales.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you or your organisation 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 13/02/2026. 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 Chief Coroner and to the following Interested Persons or their legal representatives: Edward's parents; Leeds Teaching Hospitals Trust. I am also under a duty to send the Chief Coroner a copy of your response. 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 by the Chief Coroner.
9	Signed:  OLIVER LONGSTAFF Area Coroner West Yorkshire (E) Date: 18 December 2025