

Ms Tanyka Rawden
Senior Coroner for South Yorkshire (West)
South Yorkshire (West) Coroner's Service
Medico-Legal Centre
Watery Street
Sheffield
S3 7ES

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

By Email: [REDACTED]

[REDACTED]
27th March 2026

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Mia Maisie Lucas who died on 30th January 2024.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 5th February 2026 concerning the death of Mia Maisie Lucas on 30th January 2024. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Mia's parents and family. NHS England is keen to assure the family and yourself that the concerns raised about Mia's care have been listened to and reflected upon.

Your Report raised concern that there is no national guidance for clinicians on when to consider, and how to diagnose, Autoimmune Encephalitis.

There are [National Guidelines for the management of Encephalitis](#). They are also available on the [Encephalitis International website](#) to download. Whilst the guidance is not specifically for Autoimmune Encephalitis they include a section on it. These guidelines are currently being updated and the update has a much larger section on the management of Autoimmune Encephalitis. They are in the final draft stage and are due to be submitted in April 2026.

Due to Autoimmune Encephalitis being rare, it likely that there is a lack of awareness by Emergency Department staff and Children and Adult Mental Health Service (CAMHS) staff as to when to consider Encephalitis as a diagnosis and when to consult the guidelines.

[Encephalitis International](#) is an international non-profit organisation which does a lot of work regarding awareness for medical staff through resources on its website and through a conference it runs every year for health care professionals. The website has accessible [guidance](#) which includes clear indications for when clinicians should perform a lumbar puncture for any child with suspected encephalitis.

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 Mia,

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