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By Email: [redacted]

National Medical Director
NHS England
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2nd April 2026

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Edward Richard Jones who died on 18th February 2023.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 13th February 2026 concerning the death of Edward Richard Jones on 18th February 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Edward's parents and family. NHS England is keen to assure the family and yourself that the concerns raised about Edward's care have been listened to and reflected upon.

Your Report raises concerns that nationally there is no sepsis screening tool which is validated for use in Paediatric Emergency Departments. You highlighted that Leeds Teaching Hospital Trust have developed a local sepsis screening tool.

NHS England rolled out the National Paediatric Early Warning System (NPEWS) in November 2023. The NPEWS is a national standardised approach of tracking the deterioration of children in hospital. The aim of the NPEWS is to allow for consistency in how deterioration in children is recognised. The NPEWS incorporates a sepsis trigger which encompasses the Academy of Medical Royal Colleges guidance. A sepsis trigger is a set of criteria, in this case the NPEWS 'score', which is used to trigger a review of a patient.

The NPEWS has been adopted by NHS England, the Royal College of Paediatrics and Child Health (RCPCH) and the Royal College of Nursing (RCN). Since it's launch it is the preferred model of care, with over 70% of Trusts using it or developing plans to use it.

The RCPH and NHS England are currently trialling an Emergency Department (ED) NPEWS, and this should be published this year. Both RCPCH and Royal College of Emergency Medicine (RCEM) fully support the introduction of ED NPEWS.

As part of the 10 Year Plan, the Government announced that it would create a first wave of 'Modern Service Frameworks' in 2026, to identify interventions, standards and innovations that will support consistent, high quality, and high value care. The first

wave includes a Sepsis Modern Service Framework and publication is anticipated in Summer 2026.

The Sepsis Modern Service Framework will focus on the prevention, identification, escalation and treatment of sepsis and severe infection across all age groups. Many of the challenges in this case are recognised in the Modern Service Framework. It will recommend specific actions such as the need for better tests to identify the presence and type of infection, antimicrobial treatment options, better tools to predict the likelihood of clinical deterioration, and improvement in compliance with evidence-based processes of care, including the timely prescription and administration of antimicrobials. The Modern Service Framework will support the development and implementation of better technologies and treatments, and improved implementation of best practice.

Regional Response

The NHS England North East and Yorkshire Regional Team have liaised with the West Yorkshire Integrated Care Board (ICB) regarding your Report. They advised us that at the inquest, the Trust accepted that they had failed to recognise sepsis in a timely manner, and that this contributed to a delay in the administration of antibiotics which could have prevented Edward's death.

The Trust conducted an investigation which noted, that their 'Paediatric Sepsis Screening Tool' was not used. Several factors contributed to this, but a central concern was that the role of the tool and its interactions with the Paediatric Advanced Warning Score (PAWS) escalation process in the Emergency Department was not clear.

At the time of the inquest, the Trust was able to assure you that their sepsis screening tool was embedded and in regular use in the ED. However, the Trust views this work as an ongoing process, and the use of the tool is regularly audited and sits alongside a rolling education programme. Audit is conducted on a monthly basis and overall compliance with the tool (which covers, screening, re-screening, observation completion, and medical review) is currently between 70-80%. This data is shared with and monitored by the senior ED team.

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 Edward, 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,

[redacted]
National Medical Director
NHS England