



Our vision is to EXCEL at patient care



George Eliot Hospital
NHS Trust

George Eliot Hospital NHS Trust
College Street
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Warwickshire
CV10 7DJ



21 May 2026

PRIVATE & CONFIDENTIAL

Ms L Lee
HM Assistant Coroner
Warwickshire Justice Centre
Newbold Terrace
Leamington Spa
CV32 4EL

Dear Ms Lee

RE: REGULATION 28 REPORT – ETHAN HANSON

Further to your report which the Trust received on the 30 March 2026, in accordance with paragraph 7, Schedule 5 of the Coroner's and Justice Act 2009 and the regulations 28 and 29 of the Coroner's (investigations) Regulations 2013, I offer the following response:-

Following the Coroner's inquest on Monday 16 April 2026, regarding the death of Ethan Hanson (EH). The Trust would like to formally acknowledge the findings of the coroner and recognises its responsibilities in conjunction with the actions as detailed in the Regulation 28, Prevention of Future Deaths notice.

In response to the Regulation 28 notice, the Trust took immediate action by convening a multidisciplinary meeting on Wednesday 29 April 2026. The meeting was chaired by the Chief Nursing Officer and attended by both internal and external partners, including representation from General Practitioners and the Integrated Care Board (ICB).

The purpose of the meeting was to undertake a collective, multidisciplinary review to understand how future care delivery could be strengthened. The discussion focused on ensuring that all opportunities are consistently identified and acted upon, with the aim of developing a more robust and integrated care pathway that mitigates the risk of similar incidents occurring in the future.

The actions and outcomes of the meeting form part of the Trust's response below.





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1. Absence Of Computerised Mandatory Field Safeguards

There is no electronic system with mandatory fields or hard-stops to prevent incorrect or incomplete recording of observations or pain scores. A transposition error between oxygen saturation and temperature occurred. The absence of automated safeguards requiring complete and accurate observations before pathway selection or discharge creates a risk that clinically significant information may be overlooked. Although there is an intention to develop such a system, it is not currently in place.

Trusts Response

The Trust recognises the concerns raised regarding the absence of an electronic observation system incorporating mandatory fields and automated safeguards to prevent incomplete or inaccurate documentation. The identified transposition error between oxygen saturation and temperature illustrates the inherent risks associated with reliance on manual processes and underscores the need to strengthen digital controls to better support clinical decision-making and patient safety.

An immediate mitigating action was implemented shortly after Ethan's death to reduce the risk of transcription errors while observations remain paper-based. This requires all paediatric observations to be repeated prior to discharge from the department, with compliance monitored through routine audit processes.

In addition, all children triaged as 'yellow' or above under the Manchester Triage System are reviewed with a Registrar or Consultant. The 'yellow' category denotes patients with significant conditions that are not immediately life-threatening but have the potential to deteriorate; as such, the target is for these patients to be clinically assessed within 60 minutes

In terms of the future electronic system, the Chief Digital Officer has offered the following response:

The Trust is currently in the implementation phase of its Electronic Patient Record (EPR) programme. As part of this work, the Trust is reviewing the critical delivery timeline to reflect issues identified within the programme to date and is therefore unable to confirm a specific go-live date at this stage, although implementation is currently anticipated in August 2027. The programme is well underway, with funding clearly identified within the Trust's financial plans, and the Trust remains fully committed to successful delivery across both George Eliot Hospital NHS Trust and South Warwickshire University NHS Foundation Trust.

The Trust recognises that the implementation of the new EPR system presents a significant opportunity to improve the reliability and safety of clinical documentation and workflow processes. Although the detailed system design remains under development, the intention is that the EPR will include enhanced validation processes, structured documentation, and clinical safety functionality to reduce the risk of incomplete or incorrect observations being recorded or overlooked. This includes



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consideration of mechanisms such as mandatory fields, automated prompts, escalation triggers, and decision-support safeguards to support clinicians prior to pathway selection or discharge decisions. We can confirm that the new EPR system will flag any critical or unusual observations and will not allow transcriptions of observations that could not be possible such as oxygen saturations of 140.

Until the EPR system is fully implemented, the Trust will continue to reinforce existing governance arrangements, staff training, and clinical oversight processes to minimise the risk of similar errors occurring and to ensure that observations and clinical assessments are reviewed appropriately as part of safe patient care. Additionally, the Trust will seek to implement PEWS documentation within the current electronic Patient Track for use in the Children's Assessment Unit (CAU) as an interim measure to strengthen the recording, visibility, and escalation of paediatric observations

2. Pathway Design Not Fully Aligned With National GIRFT Guidance

The Trust is developing a triage model for paediatric abdominal pain. Evidence heard at inquest showed that the pathway options do not mirror the structure or escalation principles contained in the national GIRFT guidance for paediatric abdominal pain and appendicitis. This carries a risk that children with time-critical surgical conditions may not be escalated promptly or placed on an appropriate pathway.

Trust Response

The Trust recognises that the current triage model for paediatric abdominal pain does not fully align with national GIRFT guidance, creating a potential risk to timely escalation of children with serious surgical conditions. In response, immediate actions have been taken to embed the GIRFT pathway into practice, alongside targeted education, simulation training, and a formal review to update the Trust's Standard Operating Procedure and ensure full compliance. These actions include:

- The Trust is ensuring that all staff are following the GIRFT Paediatric Acute Abdominal Pain & Appendicectomy Best Practice Pathway Guidance (June 2022).
- The pathway has been shared with all the clinical staff within the Emergency and Paediatric Department to ensure all staff are aware of the expected approach and to support a more consistent practice.
- The Paediatric Lead delivered a teaching session on the 13 March 2026 to the Paediatric Team focusing on acute abdominal pain, using this case to highlight key learning points. The importance of following the pathway was reinforced again in the clinical huddle afterwards. This teaching session is being repeated on the 22 May 2026.
- The learning from this case is being built into a simulation programme. The upcoming CAU simulation sessions will involve a wider multi-disciplinary group and will include scenarios around abdominal pain, including neurodivergent children, to support better recognition, communication, and escalation. These sessions are held monthly.
- The GIRFT guidance (paediatric acute abdominal pain) along with the current Trust process, is going to be reviewed to identify any gaps and actions needed



to ensure compliance and then a new Standard Operating Procedure (SOP) will be compiled to align with GIRFT. This will be completed by the end of June 2026.

3. GIRFT Guidance Lacks Practical Mechanisms For Assessing Neurodivergent Children And Parents

The GIRFT guidance recognises that neurodivergent children may be more difficult to assess or diagnose, but it does not provide practical mechanisms for clinicians to adapt history-taking, pain assessment or communication. The guidance does not consider the risk that a neurodivergent parent may struggle to convey concern, may appear reassured when they are frightened, or may find questions and instructions confusing or intimidating. The absence of such mechanisms risks misunderstanding children's symptoms and misinterpreting parental reassurance

Trusts Response

The Trust acknowledges the concerns raised regarding the absence of practical mechanisms within the GIRFT guidance to support assessment and communication with neurodivergent children and their families. However, this matter falls outside the Trust's direct remit. GIRFT has been made aware of these considerations through receipt of the Coroner's Regulation 28 Report to Prevent Future Deaths. The Trust will, however, ensure full compliance with any enhanced or updated guidance issued by GIRFT in response to these findings.

4. Local Processes Provide No Structured Support for Neurodivergent Children Or Parents

Local assessment processes do not contain structured prompts or guidance for recognising how neurodivergence may affect symptom expression or parental communication. Without a structured approach there is a risk that important clinical information will not be elicited or understood, and that apparent agreement with a discharge plan may be misinterpreted.

Trusts Response

The Trust recognises the risk that the absence of structured prompts within local assessment processes may lead to challenges in identifying how neurodivergence can influence symptom presentation and communication. In response, the paediatric team at GEH has undertaken a review of current processes, guidelines, and training, with actions in place to strengthen support for children with neurodiverse conditions and learning difficulties, ensuring care is delivered in line with best practice and supports improved clinical outcomes

Actions taken:

- The paediatric casualty card is currently being amended to include whether the parent/carer has any potential neurodiverse implications which may affect communication. This has been discussed with the Paediatric Neurodiversity & Learning Disability Lead for South Warwickshire NHS University Foundation Trust (SWFT), and it was identified that the question to be placed on the casualty card should be "does this child have any communication, sensory or



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behavioural needs”. Work is now being undertaken to have this included on the casualty card and will be completed by the end of May 2026.

- Compliance with the Oliver McGowan Mandatory Training is required for all staff. Current compliance within the Clinical Assessment Unit (CAU) stands at 81%, with full compliance expected by the end of June 2026.
- A formal escalation pathway has been developed to support staff in managing neurodivergent patients, promoting increased clinical curiosity and consideration of atypical presentations. Supporting materials, including a flowchart and handbook were approved on 21 May 2026 and implementation will commence.
- Accessible, easy-to-understand patient and family information leaflets are being developed to support families in recognising and escalating concerns. These materials will be co-produced with Young Inspectors, established through partnership with IMPACT (Warwickshire County Council’s Young People’s Forum for SEND), Healthwatch Warwickshire, and Warwick Hospital, and will be shared across GEH and SWFT.
- The Trust has a Play Specialist in post, providing specialist support to reduce anxiety and enhance communication for neurodivergent children through appropriate tools and techniques.
- The Trust supports the safe prioritisation and expedited flow of neurodivergent children through the Emergency Department and Clinical Assessment Unit, where clinically appropriate
- The Trust is undertaking an evaluation of a pager system to enable families to temporarily leave the department while awaiting assessment where the Clinical Assessment Unit (CAU) environment may be causing distress. A formal demonstration of the system is scheduled for 21 May 2026 to inform feasibility and next steps.
- The FLACC (Face, Legs, Activity, Cry, Consolability) behavioural pain assessment tool is being implemented within CAU to support more consistent and appropriate pain assessment, with full implementation anticipated by the end of June 2026.
- The Trust’s Communications Team is developing a formal communications plan, in partnership with the Paediatric Neurodiversity & Learning Disability Lead, to increase awareness and utilisation of Hospital Passports and “All About Me” tools. This will include a public-facing campaign, commencing in July 2026 and continuing thereafter.
- A neurodivergent champion role is being established across GEH and SWFT, supported by a dedicated training programme. These roles will act as advocates for neurodivergent patients and their families, with implementation scheduled from July 2026.
- The professional development portfolios for Advanced Care Practitioners are being reviewed and updated to incorporate competencies relating to the care of neurodivergent patients, with completion expected by October 2026.
- The Trust is scoping the development of a dedicated desensitisation environment within the Emergency Department. As part of this work, the Operational and Emergency Department Managers are undertaking a visit to St George’s Hospital, Stafford, to review a Cubbie Sensory Pod—an evidence-



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based sensory environment designed to reduce anxiety and sensory overload. This will inform future planning to enhance the assessment environment and support improved communication for neurodivergent patients and families

- The Trust acknowledges the need for a digital solution to flagging neurodivergence. Our approach within our new EPR system is still under final discussion, however our overall intention is to apply a reasonable adjustments flag to the child's digital record with the consent of the parent, with documentation focused on the need for tailored communication support with parents, rather than recording any parental diagnosis itself. This would align better with data minimisation principles while still addressing and fulfilling the required clinical and safety intent.

5. Critical GP Information Not Carried Forward Into The Hospital Assessment

The GP identified the possibility of appendicitis or another serious underlying cause and recorded abnormal observations. The absence of an ambulance conveyance or written referral letter meant this information was not transferred to the hospital. As a result, Ethan entered a different clinical pathway, and the assessing clinician was unaware of the GP's concerns. There is a wider risk that GPs may not be aware of the implications of referral route on triage and assessment in local hospitals, and that critical deterioration indicators can be lost at the point of transfer.

Trust Response

The Trust, alongside GP and ICB representatives, acknowledged that the absence of access to GP patient records represented a significant gap in the care provided to EH.

Following a multidisciplinary meeting held on 29 April 2026, it was agreed that all nursing and medical staff within the Emergency Department and Clinical Assessment Unit would be granted access to the Integrated Care Record System. This enables clinicians to review GP records, including the referring clinician's working diagnosis and clinical considerations, prior to hospital assessment.

All parties recognised the critical importance of timely access to comprehensive patient information, and this action was endorsed as a key improvement to support safer, more informed clinical decision-making. The system is now fully operational and accessible to all Emergency Department staff

The Trust is undertaking a review of the Directory of Services with system partners to ensure an awareness of services delivered across all local hospitals for both adults and paediatrics. It is envisaged that this will be completed by the end of July 2026.

Actions taken:

- The Trust will undertake an evaluation of an electronic interface with the Directory of Services for General Practice, with the aim of ensuring that the most current and accurate information is consistently accessible to all GPs. This work is scheduled for completion by the end of July 2026.
- The Trust is developing a coordinated communications programme to clearly articulate the range of services provided across GEH and SWFT. This will be



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disseminated through multiple channels, including the Trust websites, NHS 111, West Midlands Ambulance Service (WMAS), and primary care, to support informed referral decisions and promote service awareness.

- The Trust intranet is currently undergoing review and update to ensure accuracy and accessibility of information. In parallel, the Directory of Services for NHS 111 and WMAS has been reviewed and is confirmed to be current and up to date.

6. General Learning

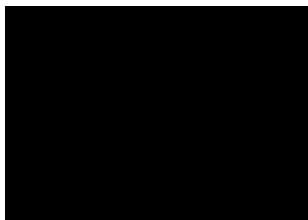
Learning from this case has been shared with the whole multidisciplinary team in GEH emergency department and beyond. Further multi-disciplinary team simulation sessions (completed monthly), led by the Paediatric Practice Educator, will involve a presentation of a neurodivergent patient with abdominal pain. This case has also been discussed at length with the Paediatric Crisis Neurodiversity & Learning Disability Lead Nurse from SWFT.

A Patient Forum survey is going to be conducted to look at patient and family satisfaction with regard to communication. This is currently under construction and is expected to be finished by the end of June 2026.

The Trusts would like to thank the coroner's office again for the opportunity to review and strengthen the pathways of care for our patients and hope this answers your outstanding concerns. As a Trust we strive for excellence in patient care and put the patient at the heart of all we do. The Trust uses incidents as an opportunity to learn and grow.

Please do not hesitate to contact me if you require any clarification.

Yours sincerely



Chief Nursing Officer

