

Ms Linda Lee

Area Coroner for Coventry and Warwickshire
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National Medical Director
NHS England
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15th May 2026

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Ethan Michael Hanson who died on 26 April 2025.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 30 March 2026 concerning the death of Ethan Michael Hanson on 26 April 2025. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Ethan's parents and family. NHS England is keen to assure the family and yourself that the concerns raised about Ethan's care have been listened to and reflected upon.

Your Report raised concerns around the following:

1. The absence of computerised mandatory-field safeguards to prevent incorrect or incomplete recording of observations or pain scores.
2. The triage pathway design is not fully aligned with national GIRFT guidance
3. GIRFT guidance lacks practical mechanisms for assessing neurodivergent children and parents
4. Local processes provide no structured support for neurodivergent children or parents
5. Critical GP information is not carried forward into the hospital assessment.

Getting It Right First Time (GIRFT) Guidance

GIRFT clinical leads held a meeting to discuss your Report for Ethan. The GIRFT pathway for acute abdominal pain and appendicectomy (2022) advocates eight quality improvement areas which include consistent approaches to pain assessment, adoption of a defined diagnostic pathway, and consistent identification of the sick child using the National Paediatric Early Warning System (NPEWS) with appropriate early management. This had been developed following a systematic review of evidence and co-developed with clinicians from primary care, emergency care, radiology, anaesthesia, surgery, 111 and paediatrics. GIRFT clinical leads at the meeting discussing your Report agreed that the care delivered in this case did not align with the GIRFT pathway.

In this particular case Ethan arrived without any documented evidence they had been referred which meant that the wrong team saw him. As this was a GP referral it should

have been directed to a specialist, but as it wasn't signposted as a GP referral, this didn't happen.

The GIRFT pathway for acute abdominal pain and appendicectomy is not intended as a replacement for undergraduate and postgraduate medical teaching on the pathophysiology, assessment and treatment of children presenting with acute illness, it is an adjunct adoption of best practice.

As per any pathway dealing with acute illness safety netting advice is critical. The GIRFT Abdominal Pain and Appendicitis best practice pathway clearly states the need to provide families with patient information at discharge. This is further defined in the consensus recommendations document ([Acute-Paeds-Abdominal-Pain-Pathway-literature-review 4.pdf](#)).

Families should receive safety netting advice with who, when and how to contact the appropriate person if they have a concern about their child after discharge.

It was agreed that the GIRFT pathway will be updated to emphasize that the GP should refer specifically to the surgical team, although in this case a referral was not made to any team by the GP.

There is a long-standing requirement to provide reasonable adjustments under the Equality Act 2010 and this forms part of the autism strategy issued under Section 1 of the Autism Act 2009. [The Oliver McGowan Code of Practice on statutory learning disability and autism training 2025](#) and associated Tier 2 training covers provider and healthcare staff duties to assess and support neurodivergent people who may also be parents or carers. Clinical and operational policies should reinforce the key principles of the Oliver McGowan training to support staff in their approach to the assessment, care, treatment and support of neurodivergent people who are patients, parents and/or carers and should be co-produced to ensure they are appropriate and effective. The Health and Care Act 2022 introduced a requirement that registered providers (in this case the GP practice and George Eliot Hospital) must ensure staff receive training on learning disability and autism which is appropriate to the person's role. The training package must meet the standards set out in the code, which the CQC also assesses.

If the Oliver McGowan training principles had been followed in this case, it would likely have resulted in an increased level of concern from the GP, which would have reinforced the need for a letter to accompany the patient and parent to the emergency setting and/or prompted a call to the hospital by the GP to arrange review as recommended in the GIRFT abdominal pain pathway. However, an emergency presentation without the letter should not have negated the need for robust clinical evaluation, examination and investigation within the Emergency Department (including use of NPEWSGIRFT colleagues have advised that adherence to standard processes of care would have identified that Ethan was seriously unwell, irrespective of his diagnosis of neurodivergence).

The Royal College of Paediatrics and Children's Health (RCPH) [standards for emergency care for children and young people](#) also highlights how to appropriately care for autistic children and young people and those with a learning disability, as well

the appropriate standards of support and communication that should be afforded to parents and carers.

Critical GP information is not carried forward into the hospital assessment

NHS England notes the Coroner's concern regarding the potential for important clinical information identified in general practice not to be readily visible during subsequent hospital assessment, particularly where children attend hospital by self-presentation rather than through formal clinician to clinician referral routes.

Having considered this, NHS England does not consider that this case identifies a need for changes to the GP contractual framework. However, we recognise the importance of reinforcing good professional practice at primary–secondary and urgent and emergency care interfaces, particularly for children with suspected serious illness.

General Practitioners are already required to practise in line with the GMC's Good Medical Practice, including the duties to communicate clearly, share relevant information to support continuity and safety of care, and to raise concerns where they believe patients may be at risk. NHS England supports these professional standards and the expectation that clinicians use their judgement to ensure that relevant clinical findings and concerns are communicated appropriately when arranging onward care.

[GMC's Good Medical Practice Guidance](#) at section 21 and 23 which relates to delegation and referral regarding the responsibilities of clinicians states:

21 *You must pass on to the medical, health, or social care professional or service provider involved:*

- a. *relevant information about the patient's condition and history*
- b. *the purpose of transferring care and/or the investigation, care or treatment the patient needs.*

23 *You must record your work in line with paragraphs 69–71 of Good medical practice and use the systems available to you effectively, particularly when you will not see the patient again*

NHS England routinely seeks to support the sharing of learning and best practice across primary care. In response to this Prevention of Future Deaths Report, NHS England will ensure that the learning identified is reflected in system discussions and professional communication, with a particular focus on:

- awareness of how different routes of referral into hospital care may affect triage and assessment pathways; and
- the importance of clear communication of clinical concerns and abnormal findings when children are advised to attend hospital urgently.

NHS England will continue to promote system learning and improvement at the interface, rather than introducing prescriptive new requirements, recognising that safe

care depends on effective professional judgement, communication and joint working across the system.

Frontline Digitisation (FD) Programme

NHS England has developed and led the frontline digitisation (FD) programme, supporting NHS Trusts with adoption of Electronic Patient Record (EPR) systems to support increased consistency in digital maturity and improve information sharing within and between organisations. Beyond facilitating the procurement of EPR systems, the FD programme also provides guidance and support to ensure safe and effective deployments.

At present, George Eliot Hospital NHS Trust continues to operate the DXC Lorenzo Electronic Patient Record (EPR) system. The Trust secured multi-year funding through the FD programme to implement a new EPR, Oracle Health, with a current planned Go-Live date of 15 March 2027.

George Eliot Hospital NHS Trust is working in partnership with South Warwickshire University NHS Foundation Trust on a joint EPR programme and will be joining the existing University Hospitals Coventry and Warwickshire EPR instance, which went live on 17 June 2024. This approach will support the delivery of a unified care record across all three organisations.

Local EPR implementations should have oversight from a Trust Clinical Safety Officer (CSO), a registered healthcare professional responsible for overseeing the clinical safety and risk management of health IT systems, ensuring they are safe for patient use. Digital safety is an important part of patient safety.

Suppliers alongside Trusts are accountable for compliance with two mandatory Clinical Risk Management Standards defined under Section 250 of the Health and Social Care Act 2012:

- [DCB0129](#)
- [DCB0160](#)

DCB0160 relates to deployment of Health IT Systems and is intended to be an ongoing, iterative process rather than a one-time assessment. All modifications to the EPR, including system updates, configuration changes, or incidents, must be proactively evaluated for their potential impact on patient safety throughout the entire lifecycle of the system. Any identified hazards or potential scenarios of patient harm, such as those arising from system functionality, configuration, or user error must be documented in a 'Hazard Log'. This log should be continuously maintained and updated to reflect new incidents, along with the corresponding controls or mitigations implemented. NHS Trusts are required to operate formal incident management systems to support the monitoring, reporting, and investigation of clinical incidents or near misses associated with the use of the EPR system. These systems must facilitate organisations learning, drive process improvements, and ensure that necessary changes to the EPR system are implemented in response to identified issues.

The specific details of the data error in this case will need to be investigated with the George Eliot Hospital NHS Trust. DSB0129 and DCB0160 are mandated standards that should ensure any recorded observations fall within agreed parameters and are designed to reduce entry and transposition errors. The data entry fields should be reviewed and any potential risks (such as incorrect values being entered) picked up on end user testing. Staff should be fully trained in the use of the EPR to ensure they fully understand the importance of correct and complete data entry in the relevant data fields.

It is essential that the FD programme continuously learns and evolves by drawing insights from assurance activities related to local EPR implementations, other digital health technology initiatives, and recognised examples of good practice. The NHS England FD programme team plays a pivotal role in the continuous improvement cycle by actively promoting and disseminating lessons learnt. These insights inform enhancements to the support offer and drive system-wide improvements through collaboration, knowledge sharing, and the application of actionable learning.

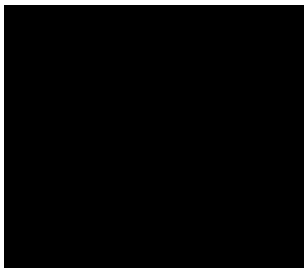
Further investment in digital transformation has been confirmed for the Frontline Productivity (FP) Programme FD programme, a four-year initiative commencing in April 2026. This programme is designed to enable NHS organisations to fully realise the benefits of digitising patient data by advancing the optimisation of EPR capabilities. Building on the experiences and lessons from preceding programme such as FD, the FP programme will also support the analysis of digital health events to uncover root causes and inform the refinement of processes and systems for future resilience and effectiveness.

The newly published [Fit for the Future: 10 Year Plan for England](#), sets out the government's plan for healthcare in England over the next 10 years, which includes a commitment to give patients 'a single patient record (SPR) – to enable more coordinated, personalised and predictive care'. In any given clinical setting healthcare professionals should be able to see all patient contacts prior to arrival in that setting, but this currently doesn't happen. Rather than build a SPR record from scratch, a likely solution may include even better interoperability between the many systems in operation, as NHS England is aware of the challenge in sharing medical records and results within and between all organisation (including social care and commissioned organisations) that use different technologies.

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 Ethan, 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 Director of Patient Safety
NHS England