Royal College of
General Practitioners

Dr Jamie Hynes FRCGP
Vice Chair Member Standards

Mrs Linda Lee
Acting Area Coroner for Coventry & Warwickshire

22 May 2026

Dear Mrs Lee

Regulation 28 Report to Prevent Future Deaths - regarding the death of Master Ethan Michael Hanson

Thank you for asking us to comment on the matters of concern following the sad death of Master Ethan Michael Hanson, who died on the 26th of April 2025. Our sincere condolences go to his family and friends given the difficult circumstances and the ongoing questions on how this could have been prevented. We will address the issues raised as requested in the hope that the response can help answer the concerns of the Coroner and Ethan's loved ones.

You have a matter of concern for GPs relating to this tragic death:

> 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.

To give context to the family, The Royal College of General Practitioners works to improve patient care by encouraging the highest possible standards in general medical practice by supporting members, setting standards, providing education and training, promoting research, advocating and representing the College and its 56,000 members.

General Practitioners have a broad curriculum, and the College is responsible for the definitive educational framework for all doctors undertaking GP speciality training. There are 5 areas of capability aligned to the General Medical Council's Generic Professional Capabilities Framework, and these are supported by twenty-two Clinical Topic Guides. Within the Urgent and Unscheduled Care Clinical Topic Guide, areas of a GP's role include aspects relevant to Ethan's care:

> The importance of providing appropriate documentation and records for each patient contact, which must be communicated to the next professional involved with that patient
> Appropriate use of emergency services, including the logistics of communicating with an ambulance or paramedic crew and the response time required

Strategies for ensuring effective and appropriate communication and escalation of concern regarding deteriorating patients to ambulance services, the emergency department (ED) or accident and emergency (A&E) and acute service colleagues

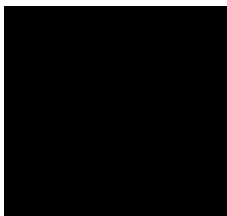
Within NHS England's 2024 'Same Day Emergency Care- service specification' document the flow chart suggests Paediatric SDEC service unless NEWS2 score of over 5, or a score of 3 in a single parameter, in which case referral to Emergency Department is indicated- it is not clear if that threshold applied here. There is no reference in this specification to primary care communication, nor in the 2026 'Model Acute Pathway: standards for care of acutely unwell patients in their first 72 hours in hospital', developed with the Royal College of Physicians, Society for Acute Medicine and British Geriatrics Society, which emphasises availability of senior clinical decision making, usually working at Medical Registrar level.

Work on the interface between primary cand secondary care included a joint statement between RCGP, RCP, SAM and Royal College of Emergency Medicine calling for secondary care to improve primary care access to specialist advice via dedicated telephone lines and urgent expansion of SDEC options for primary care and 111 services. GP Awareness of impact of referral letter and ambulance conveyance on clinical pathways within Emergency care, opportunities to communicate this to GPs.

GP Information Technology Systems record GP Consultations and information such as recorded in Ethan's GP encounter. There is no single GP IT System and suppliers include EMIS, SystmOne and Medicus. There is no single Hospital IT System and given this situation, information sharing between Primary and Secondary care faces challenges. GPs are faced with a choice under time pressures given observations as recorded in Ethan's consultation, to admit via Paediatric colleagues or direct to the Emergency Department. Secondary care pathways will differ between organisations. From a primary care perspective, it may seem that the most direct means of rapid assessment will be through ED. Added awareness that primary care information and method of hospital transfer influences secondary care pathway selection needs to be highlighted to GPs if the existing secondary care pathways remain as described. I intend to communicate this issue to members alongside learning from Prevention of Future Death Reports in a Webinar format for dissemination of learning, ensuring principles being highlighted are generic and not attributable to individual cases, nor impacting ongoing proceedings that follow each coronial review.

Once again, our condolences go to Ethan's family and friends. I hope the comments provide a full picture of where the RCGP can influence the prevention of future deaths within training and continuing professional development.

Yours faithfully



Vice President Member Standards