REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

1. THIS REPORT IS BEING SENT TO:

• NHS England

• George Eliot Hospital NHS Trust

• Getting It Right First Time (GIRFT), NHS England

• Royal College of General Practitioners

2. CORONER

I am Linda Lee, Acting Area Coroner for Coventry and Warwickshire.

3. CORONER'S LEGAL POWERS

This report is being made under paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

4. CORONIAL INVESTIGATION AND INQUEST

The investigation into the death of Ethan Michael Hanson, aged 8, who died on 26 April 2025, was transferred into the jurisdiction on 2 December 2025 and concluded on 16 March 2026.

The inquest was conducted without a jury.

The conclusion was medical misadventure.

Medical cause of death

1a) Septic shock

1b) Peritonitis

1c) Perforated appendicitis

5. CIRCUMSTANCES OF THE DEATH

Ethan was autistic and was awaiting an ADHD diagnostic assessment. On the morning of 23 April 2025, he was seen by his GP because of abdominal pain, vomiting and concern about a serious underlying cause, including appendicitis. The GP accurately recorded a raised temperature and tachycardia. No ambulance was summoned and no written referral letter was provided. The GP advised that Ethan should go directly to hospital with his mother, apparently without appreciating that self-presentation would place him on a different pathway at George Eliot Hospital than if he had arrived by ambulance or with written referral details.

On arrival at George Eliot Hospital, Ethan was triaged “yellow” and assessed by an Advanced Nurse Practitioner. As no referral letter accompanied him, the GP’s findings and concerns were not available to the assessing clinician. No urine dipstick or blood tests were undertaken. Ethan reported severe pain, scoring 10/10, but no clinician-assessed pain score or repeat observations were performed. A transposition error occurred in the recording of oxygen saturation and temperature. A phosphate enema was given for presumed constipation. A senior medical review did not take place prior to discharge.

Evidence was given that, had the correct temperature reading been recorded, Ethan would have been escalated for registrar or consultant review. Evidence was also given that, by a consultant surgeon that had he reviewed Ethan at the time, appendicitis would likely have been diagnosed, though in his opinion not every clinician would have necessarily done so.

Hospital staff perceived Ethan and his mother to be content with the plan and comfortable with discharge. Ethan’s mother explained that she is neurodivergent, was frightened and remained concerned, but was unable to articulate disagreement or challenge the decision at the time.

After discharge, Ethan deteriorated. On 25 April 2025 he collapsed at home and suffered cardiac arrest. He was resuscitated and taken to University Hospitals

Coventry and Warwickshire, where imaging confirmed perforated appendicitis, generalised peritonitis and sepsis. He was transferred to Birmingham Children's Hospital but died on 26 April 2025.

George Eliot Hospital does not undertake operative management for paediatric appendicitis, and children requiring surgery are transferred to Leicester or to University Hospitals Coventry and Warwickshire. This configuration increases the importance of early recognition and escalation at initial presentation, and means the Trust has less exposure to operative cases than a centre providing surgical treatment.

The Trust carried out a review following Ethan's death and made several recommendations. Evidence heard at the inquest indicated that the steps taken did not fully address the issues identified in this case.

5. CORONER'S CONCERNS

During the course of the investigation and inquest I became aware of matters giving rise to concern. In my opinion, there is a risk that future deaths could occur unless action is taken.

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.

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.

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.

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.

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.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe your organization has the power to act.

7. YOUR RESPONSE

You are under a duty to respond within 56 days of the date of this report, that is by 25th May 2026.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

8. COPIES AND PUBLICATION

A copy of this report has been sent to the Chief Coroner and to the Interested Persons. It may be published on the Judiciary website.

Copies have also been sent to:

- The family of the deceased
- University Hospitals Coventry and Warwickshire NHS Trust
- Birmingham Women's and Children's NHS Foundation Trust
- Deceased's GP Practice

Signed:

Linda Lee

Acting Area Coroner for Coventry and Warwickshire

Date: 30 March 2026