NHS England

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National Medical Director
NHS England
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21st September 2026

Dear Dr Henderson,

Re: Regulation 28 Report to Prevent Future Deaths – Jesse Samuel Parsons who died on 30th July 2025.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 27th July 2026 concerning the death of Jesse Samuel Parsons on 30th July 2025. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Jesse's parents and family. NHS England is keen to assure the family and yourself that the concerns raised about Jesse's care have been listened to and reflected upon.

Your Report raises concern that placental cord insertion assessment at the routine 20-week anomaly ultrasound scan is not a mandatory requirement.

The NHS Fetal Anomaly Screening Programme (FASP) offers an ultrasound scan between 18^{+0} to 20^{+6} weeks to screen for signs of 11 different conditions.

NHS England implements screening policies, including in FASP, based on UK National Screening Committee's (UK NSC) recommendations. As you are likely to be aware, the UK NSC is a committee formed from each Department of Health across the four UK countries who advise ministers on all aspects of screening and implementation of screening programmes. The recommendations of this expert committee are based on clear principles of screening, detailed evidence review criteria, and a structured evidence review process. The UK NSC applies these principles to ensure that screening programs are justified by evidence that screening provides more benefit than harm at a reasonable cost. The last UK NSC review of screening for Vasa Praevia that occurred in June 2023 indicated that screening is not currently recommended. We discussed Jesse's case with NHS England's antenatal and sonography teams to share learning surrounding Vasa Praevia, and we can confirm that all current screening programmes reflect UK NSC national guidance.

I note that you have addressed your Report to the UK NSC and Royal College of Obstetricians and Gynaecologists. NHS England are guided by the directions given by UK NSC should they wish to undertake a review on screening for Vasa Praevia and recommend any changes.

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 Jesse, 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 Medical Director
NHS England