NHS England

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30 May 2025

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Sandra Ann Millard who died on 20 May 2024

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 7 April 2025 concerning the death of Sandra Ann Millard on 20 May 2024. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Sandra's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Sandra's care have been listened to and reflected upon.

Your Report raises concerns over how the NHS Pathways triage tool works when patients report they are stuck in situ (e.g. unable to move from a chair), as opposed to lying on the floor which prompts further questions.

NHS Pathways triaging progresses through a clinical hierarchy of different urgencies, enabling symptoms and discriminatory clinical features to be matched to appropriate services or endpoints. This means that life-threatening symptoms or problems are assessed first, and less urgent symptoms or problems are assessed sequentially thereafter. The endpoint of an assessment is reached when a clinically significant factor cannot be ruled out and so a "disposition" (outcome) is reached. Dispositions range from an emergency ambulance being called out to self-care.

Between 2017 and 2018, NHS Pathways collaborated with its ambulance service stakeholders to enhance the assessment of patients who may not have fallen but are nonetheless unable to move from their current position. Since 2018, the system has included functionality to assess patients in this situation, regardless of whether their immobility is due to disability, frailty, weakness, pain, or another factor.

If a patient who is unable to move reaches a disposition on the basis of high acuity symptoms (acuity being the measure of severity of the patient's condition and the urgency with which they need to be seen), and if this results in an ambulance being dispatched without any clinical input, a question about whether someone can stay with the patient is included, particularly to support them in case of any delay, or to request additional support if symptoms change.

If a patient who is unable to move does not reach such a disposition, they will progress further into the NHS Pathways triage. Given the wide range of potential causes of immobility and the complexity of individual needs, the system is deliberately designed to trigger a disposition of “speak to a clinician immediately”. This ensures that a clinical professional can assess the specific circumstances and determine the most appropriate response. The possible outcomes following this assessment can include dispatching an emergency ambulance, referring to a community response team, involving social services, or contacting the police if there are any concerns about the individual’s welfare.

In scenarios where the call is transferred immediately to a clinician, the Pathways system does not prompt the question about whether someone can stay with the patient, as this consideration should form a part of the clinician’s overall assessment. In Sandra’s case, the call was not immediately transferred but was instead ended by the call taker, who arranged for a clinician to call her back. The 111 provider would have responsibility for the operational management of this, however the system recommended disposition is for immediate clinical assessment.

It is also expected that local protocols are in place to capture demographic details such as next of kin, as this information falls outside the remit of the NHS Pathways triage tool. Similarly, where a clinician is unable to make contact with the patient (noting that the clinician in this case attempted to call Sandra 4 times before closing the call), it is beyond the scope of NHS Pathways to determine the next steps. This decision lies with the local service provider in accordance with their operational policies and procedures. We understand that South Central Ambulance Service (SCAS) are changing their standard operating procedure as a result of the concerns raised by your Report, and that they will be sharing learnings through national forums.

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 Sandra, 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,

[redacted]
National Medical Director