NHS England

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[redacted]

5th August 2025

Ms Judith Leach
HM Assistant Coroner
Oxfordshire Coroner's Service
The Oxford Register Office
2nd Floor
1 Tidmarsh Lane
Oxford
OX1 1NS

[redacted]

Dear Ms Leach,

Re: Regulation 28 Report to Prevent Future Deaths – Oscar Keenan who died on 26 June 2024.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 12 June 2025 concerning the death of Oscar Keenan on 26 June 2024. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Oscar's parents and wider family. I was very sorry to be informed of the extremely sad circumstances surrounding Oscar's death. NHS England is keen to assure Oscar's parents and yourself that the concerns raised about Oscar's care have been listened to and reflected upon.

Your report raised concerns about the NHS Pathways algorithm in assessing deteriorating newborns, particularly in the case of altered breathing and sepsis. In particular, you raised the following three concerns:

1. There are apparent inadequacies with the present algorithm in assessing ill newborns/infants, particularly in identifying significant respiratory problems that require early clinical assessment.
2. There is total reliance on the algorithm which does not appear to direct early clinical input.
3. There is/was a delay/lack of direction in obtaining a clinical assessment.

Background of NHS Pathways Clinical Decision Support System

NHS Pathways is the Clinical Decision Support System (CDSS) used for remote clinical assessment (triage) in urgent and emergency care. In use since 2005, it underpins all NHS 111 services and more than half of England's 999 telephony systems. The tool also supports online triage, in-person and enhanced clinical

assessments via modules such as the NHS Pathways Clinical Consultation Support (PaCCS) system.

The safety of NHS Pathways triage outcomes - known as "dispositions" - is overseen by the National Clinical Assurance Group (NCAG), an independent intercollegiate body hosted by the Academy of Medical Royal Colleges. Alongside this external scrutiny, NHS Pathways aligns its content with up-to-date national clinical guidance, including from NICE (National Institute for Health and Care Excellence), the UK Resuscitation Council and the UK Sepsis Trust.

The system supports over 2.5 million triage assessments each month across telephone, digital, and face-to-face settings.

NHS Pathways follows a structured clinical hierarchy. Serious and potentially life-threatening symptoms are assessed first to ensure rapid escalation - such as dispatching an ambulance or involving a clinician. The assessment then progresses to less urgent symptoms, identifying the most appropriate level of care. The tool is not diagnostic. Instead, it works by systematically ruling out more serious causes of symptoms to ensure safe, efficient triage. Relevant history is gathered where clinically necessary to minimise triage time while maintaining safety.

In telephone settings, assessments are conducted by specially trained non-clinical health advisors. These advisors complete a rigorous training programme and are supported at all times by clinicians. If a case is complex or unclear, health advisors are required to escalate to clinical colleagues. It is therefore a condition of the NHS Pathways licence that clinical supervision and escalation support must be available 24/7.

I respond to each of your matters of concern below.

1. **The apparent inadequacies of the present algorithm in assessing ill newborns/infants, particularly in identifying significant respiratory problems that require early clinical assessment.**

NHS England understands how critical early clinical assessment can be in cases such as Oscar’s. As is the usual process, the organisation has carefully reviewed this case.

Having sought further details from South Central Ambulance Service (SCAS) and audited the call and its outcome, whilst Oscar’s symptoms did not meet the criteria for an immediate Category 1 or 2 ambulance response, the system’s safety net was activated due to his father’s report that he was not behaving normally. This led to an outcome of an emergency, expert clinician review – as indicated by the disposition, for GP assessment within an hour.

The NHS Pathways system is designed to identify signs of respiratory distress in infants through a structured set of questions, tailored by age group. These include indicators such as increased work of breathing, reduced consciousness level, changes in muscle tone changes, and signs of fatigue.

We recognize that the remote assessment of very young babies is inherently challenging, and we continuously refine the system based on clinical feedback and real-world cases. In Oscar's case – and in accordance with the investigation at SCAS - the review concluded that the algorithm functioned as intended, and no changes were required. However, every case contributes to our ongoing learning and improvement.

We remain committed to ensuring that NHS Pathways provides the safest possible guidance for infants and their families, and we welcome continued dialogue to strengthen this further. This case is reportable to NCAG and to other oversight groups within NHS England, where opportunities for learning and improvement – whether in the algorithms themselves, or the systems they operate in - are considered.

2. **Total reliance on the algorithm which does not appear to direct early clinical input.**

Calls to NHS 111 or 999 are taken by specially trained health advisors. Though non-clinical, these advisors undergo comprehensive structured training to ensure they can use the NHS Pathways algorithm safely and effectively. This includes classroom learning, assessments and preceptorship (a structured period of support for newly qualified professionals). Once working independently, health advisors must be supervised by clinical staff, to whom they must have access to for guidance and support whenever there is uncertainty or complexity. Requirements relating to this are set out in the NHS Pathways Licence.

A fundamental component of training is learning how to manage complex calls. The "complex call process" provides a clear protocol for health advisors to seek assistance or transfer a complex call to a clinician. This process should be followed in situations involving declared medications, medical procedures, or terminology that complicates triage, or when the advisor feels they have reached the limits of their knowledge or understanding. This approach is reinforced by the training motto:

"If in doubt, shout."

In their audit of the call, SCAS concluded that the health advisor should have initiated the complex call process. This was due to the audible breathing sounds and Oscar's father's description. This assessment is supported by NHS England's NHS Pathways Team following their review of the call. This means that, whilst the health advisor did reach the system safety-net of an emergency call back from a GP, the call should have

entered a process where the immediate assistance of a clinician was sought. This is considered in more detail in SCAS's response to HM Coroner, dated 22 July 2025.

We note the development of additional training and a bespoke breathing package at SCAS, alongside reminders of the processes in place to ensure compliance with training and shared learning.

3. A delay/lack of direction in obtaining clinical assessment

Health advisors using the NHS Pathways system must have access to clinical support and supervision. They are trained to use probing questions to better understand caller responses. If a call is complex, uncertain, or includes three "not sure" answers, advisors are expected to seek clinical input. This support should be available immediately through a 'warm transfer' to a clinician, as required by the system's Licence. To encourage this, NHS Pathways promotes the motto: ***"If in doubt, shout."*** The system generates a recommended outcome (disposition), which is then matched to services commissioned locally. The availability of these services is managed locally.

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 Oscar, 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. Once again, I am very sorry for Oscar's parents' loss and hope that this letter will provide some reassurance around the triage systems used in initial assessment in the urgent & emergency system of care.

Yours sincerely,

[redacted]

[redacted]
National Medical Director
NHS England