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PRIVATE AND CONFIDENTIAL
Mrs Judith Leach
HM Assistant Coroner for Oxfordshire
Via email only ([redacted])

22nd July 2025

Dear Mrs Leach,

I am writing to you in response to the concerns that you highlighted to the Trust following the inquest hearing into the very sad death of baby Oscar Michael Thomas Keenan that concluded on 3rd May 2025. Thank you for allowing us the time to review and respond to your concerns.

At the outset I would like to offer my personal condolences to baby Oscar's parents.

To confirm, your Regulation 28 report relates to concerns regarding the adequacy of the algorithm built into the NHS Pathways clinical decision software support system when assessing ill newborns or infants. Your report was also issued to NHS England because they design and manage the NHS Pathways system and will be able to consider whether a change to the algorithm itself is required.

It is disappointing that the Trust were not provided with the opportunity to participate in the inquest hearing. I understand that the court were aware of concerns that had been raised by baby Oscar's parents regarding the outcome of the 111 call in advance of the hearing. It is regretful that evidence was not requested from the Trust in response to these concerns as would usually be the case.

Actions taken by the Trust shortly after baby Oscar's death.

At the Joint Agency Response meeting held on 28th June 2024, the Chair of the meeting, D[redacted], questioned whether the response reached at the end of the 111 call was appropriate. This prompted the Trust to review the call to see whether it was managed appropriately. The call was audited on the same day and regrettably it was identified that there were missed opportunities for a higher disposition (call outcome) to have been reached. The audit identified that the Health Advisor should have probed further using supportive information contained within the NHS Pathways system in relation to Oscar's breathing. The auditor determined that if after probing a clear answer had not been received, the Health Advisor should have requested advice from a clinician.

Due to the comments made on the call by Oscar's parents and their description of his breathing, it was determined that a Category 2 ambulance response disposition should have been reached at the end of the 111 call. On behalf of the Trust, I am very sorry that a lower outcome was reached.

On 1st July 2024, the case was discussed at the Trust's Daily Critical Review meeting. This meeting is led by our Patient Safety Team who determine whether any wider review is required

under the Patient Safety Incident Response Framework when a concern is identified. The outcome of this meeting was that the Patient Safety Team were satisfied a wider review by the Trust was not required.

A meeting was held with the Health Advisor on 2nd July 2024 to feedback the results of the call audit and a call review plan was initiated to ensure that individual learning took place, and any support required was implemented. A call review plan details any specific support / learning / development actions required to address the area(s) of development highlighted within the non-compliant audit. The plan is accompanied by any relevant support materials, for example, NHS Pathways Hot Topics, extracts from NHS Pathways training materials, shared learning documents, local policies / procedures. At the audit feedback meeting, the call recording was played to the Health Advisor and the issues highlighted within the non-compliant audit were discussed with him in detail. The Health Advisor has continued to have regular random audits performed in line with the requirements of the NHS Pathways licence and their performance is in line with expected standards.

Review undertaken after receipt of the Regulation 29 report.

Following receipt of your report, the case was reviewed at the Trust's Safety Review Panel which comprises of Assistant Directors from the clinical and medical teams, our Consultant Pre Hospital Care Practitioner, clinical governance leads, members of our safeguarding and quality improvement teams and our Patient Safety Specialist. The panel noted the speed at which the Trust ensured that feedback was provided to the Health Advisor following the call taking place and determined that the error made is not an issue that is occurring Trust wide, so a learning response was not required under the Patient Safety Incident Response Framework.

In addition to the above, our Clinical Coordination Centre (CCC) Quality Improvement Team have considered points 2 and 3 of the concerns raised and they are satisfied that there is not an inherent or recurrent issue of staff not seeking clinical advice when appropriate to do so within our call centres.

As indicated at the beginning of this letter, the Trust is a user of the NHS Pathways system, and we are consequently not able to alter the algorithms contained within it, only NHS England can do this. We have therefore focused our review and response on the training that is provided to Emergency Call Takers and Health Advisors who use the NHS Pathways system and the process in place for identifying any themes or that indicate additional wider training may be required.

Core NHS Pathways training is set by NHS England, and it is a condition of the NHS Pathways licence that their training programme is followed. This training is delivered within SCAS by local trainers who have attended national 'train the trainer' sessions to ensure consistency across all providers. In addition to the core training, the Trust has a dedicated CCC Quality Improvement team who are responsible for sharing learning with call centre staff as new and emerging themes and trends are identified from a wide range of sources including, but not exclusively, case reviews in preparation for Coronial proceedings (See *SCAS Shared Learning Processes_CCC* document enclosed with this letter). Generic common themes are reviewed monthly by the Quality Improvement team and associated shared learning material is issued at least once a month. Factsheets, posters, and anonymised case studies are issued as their main media for this because these methods have been identified through staff feedback as being an effective way of disseminating learning. The team also use podcasts and share links to other associated reference materials where relevant.

Shared learning is issued via email with an embedded MS Forms acknowledgement link that is mandatory for colleagues to click on to acknowledge that they have read and understood

the content. Compliance with shared learning acknowledgement is monitored and managed by operational line managers. All acknowledgement forms have the option for individuals to flag that they require further information to aid their understanding, and the CCC Quality Improvement team will then follow up with those individuals to ensure that they have a good understanding of the relevant topic, and they are safe to continue working in their role.

To further gauge understanding and comprehension of the content within any shared learning materials issued, there is a monthly Quick Quiz for both service lines (111 and 999) comprising of 10 true / false and / or multiple-choice questions. The questions are drawn from any recent Standard Operating Procedure (SOP) Change Notices, shared learning materials, existing SOPs, and general triage principles for the NHS Pathways system. The quiz is facilitated via MS Forms which allows staff who submit incorrect answers to see explanations of the correct answer with sign posting to the source reference materials. Quick Quizzes have included questions regarding assessing a patient's breathing in July 2024, August 2024, September 2024 and April 2025 and regarding when and how to pass a call to a clinician every month since December 2024.

The Quality Improvement team have confirmed to me that because assessing the adequacy of breathing can be difficult over the telephone, a bespoke 'breathing' package was developed to aid the education of staff. In this package, staff select a sound recording to play which demonstrates a type of breathing pattern and they then have to confirm which type of breathing they have heard. This package is provided to all new starters and is available for all staff to access on an ongoing basis. All shared learning material is available for staff to access on a dedicated page on the staff intranet along with Hot Topics issued by NHS Pathways. It is the intention of the Quality Improvement team to include questions specifically related to assessing breathing in children (including neonates) over the coming months.

Having considered the robust processes and additional training that the Trust currently has in place, I am satisfied that these measures are sufficient to mitigate the chance of a similar error occurring when a call is taken by a member of our call centre team. This does not take away from how truly tragic baby Oscar's death was. Should NHS England decide to update the algorithm contained within NHS Pathways, this will of course mean that SCAS staff will have access to this updated version upon its release.

I hope that this letter has adequately addressed the concerns that you have raised. Should you wish to discuss these matters further, please contact [redacted], Head of Legal Services at the Trust who will be able to facilitate this.

Yours sincerely,

[redacted]

[redacted]
Chief Executive

SCAS Shared Learning Processes CCC

NHS
South Central
Ambulance Service
NHS Foundation Trust

CCC SHARED LEARNING PROCESSES

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Dissemination

CCC Shared Learning is currently issued using one (or more) of the following mediums:

- **CCC SOP Change Notices**
  These are issued via CCC Operations aimed at specific service lines, e.g., 111, 999, or the whole CCC.

- **CCC Memos**
  These are issued via CCC Operations aimed at specific service lines, e.g., 111, 999, or the whole CCC.

- **Take Note!**
  A brief key point memo highlighting a new or revised process based on a simple *'Experience? Reflection? Action?'* model.

- **CCC SCAScade**
  An anonymised case study providing detailed analysis of a topic.

- **Did You Know?**
  Poster format with headline facts and/or informational statements about a topic, typically issued alongside a more detailed Factsheet.

- **CCC Factsheet**
  Detailed information about a topic linking in with system use and providing references for further reading.

- **CCC Quick Quiz**
  End-of-the-month 10 question quiz for any learning issued during that month. Content covers recent SOP Change Notices and Shared Learning materials along with existing SOPs and Pathways triage principles. Quiz answers with embedded links to source reference materials are posted on the HUB.

- **CCC Quick Quiz Spotlight**
  Detailed explanation and analysis of Quick Quiz questions that have failed to receive responses of 80% or higher on more than 1 occasion (after potential re-phrasing and correct response explanation).

Shared Learning materials issued for Datix learning are uploaded to the relevant Datix record.

Specific Shared Learning actions arising from Datix reviews are logged and tracked on Datix.

CCC Quick Quiz results are tracked, and questions receiving responses of less than 80% are reviewed and re-quizzed to monitor for improvements. Questions and training materials are reviewed as appropriate to support better understanding.

There are several streams of information that feed into potential CCC Shared Learning:

Routine Quality Assurance Audit Process

All NHS Pathways trained staff taking 111/999 calls from the public receive monthly routine audits for quality assurance purposes. The audits are conducted according to the NHS Pathways Licence requirements which has two audit tiers: those staff taking more than 200 calls per month receive a minimum of 3 random audits per month; those staff taking less than 200 calls per month (or who have been employed for less than 6 months) receive a minimum of 5 random audits per month. Side-by-side audits are considered the gold standard as they facilitate immediate feedback post-call, and potentially in-call support. Calls are audited against defined NHS Pathways Audit Competencies and correct adherence to local Standard Operating Procedures (SOPs).

All audits include constructive feedback which is passed to the individual via email. Feedback from non-compliant audits is provided face-to-face by the auditor wherever possible. Where different working patterns prevent this, feedback is provided by colleagues (other auditors, 111 Team Leaders or 999 Senior Emergency Call Takers). Clinicians may receive initial feedback via email until a face-to-face review can be arranged.

Routine audit feedback typically involves information about skilled questioning, effective probing, active listening, and correct system navigation as the most common audit competencies where individual development areas are highlighted.

Themes and trends identified through routine audit are communicated with CCC colleagues via a monthly email sent with an MS Forms acknowledgment link embedded within.

Datix Review Findings

Feedback is received via Datix enquiries logged by internal colleagues and external routes reported by the Clinical Governance and Patient Experience teams from concerns, complaints, and HCP feedback. As part of the case review process any associated calls are audited, and individual feedback is provided as outlined above. Identified themes and trends from case reviews and complaints are reported to commissioners by the Trust Clinical Governance Leads, and this information is also shared with the Education Team so that Educators and Coaches can use real-case examples to support their training scenarios. When the Datix are completed, feedback is emailed to the reporter before it’s closed.

Learning from Deaths Review

Cases are examined by a Mortality and Morbidity Review Group and any concerns about CCC involvement are fed back via the Learning from Experience forum and shared with the Quality Improvement team.

Learning from Experience Forum

This is a SCAS-wide bi-monthly meeting to share learning across all areas of the Trust.

Clinical Governance Reviews

The Clinical Governance teams review potential cases of concern and present them as emerging incidents to a Safety Review Panel for multi-disciplinary discussion. Cases are benchmarked against the NHS Patient Safety Incident Response Framework (PSIRF) criteria to determine the level of further review and action. Following a robust case review process, draft reports are reviewed by the specific service line Clinical Governance meetings for further discussion and any identified learning is fed back to the Quality Improvement team. Completed reports are returned to the Incident Review Panel for final approval before being submitted to the Integrated Care Board (ICB) commissioners.

Patient Surveys

These are sent out regularly by the Patient Experience Team, and a process is being developed to share the collated results with the Education Team, again to identify potential themes and trends which might be used to inform and update training materials.

Coroner Cases

As part of our coroner case review process any associated calls are audited. Individual feedback is provided as outlined above. If a case identifies a gap in internal processes these are reviewed, most commonly via consultation with the CCC Senior Management Team and recommendations shared with the service line SOPs Working Group for collective feedback.

The Trust endeavours to internally identify any needs through its Datix reporting processes and Safety Review Panel meetings so that measures are already in place before a coroner's case inquest is held to demonstrate to the coroner that internal case review has identified learning and mitigation actions have already been taken. This hopefully avoids receiving a Prevention of Future Deaths Order (PFD – Regulation 28 report).

Approved amendments to existing processes usually take the form of an interim EOC/111 SOP Change Notice which is then adopted into the next full version release of local SOPs. All such Notices are issued via email to relevant CCC skillset groups with an MS Forms acknowledgment link embedded in the email. Colleagues click on the link to acknowledge they have read the material; the links are shared with CCC Operational Management to monitor their teams' compliance.

Any shared learning identified from such cases is disseminated throughout the CCC in a similar way, via email with embedded MS Forms acknowledgement link. A brief consolidation question set can be added to the acknowledgment link to demonstrate understanding of the material content. Again, links are shared with CCC Operations to monitor their teams' compliance.

Once issued to CCC staff, all shared learning materials are uploaded to a the SCAS HUB SharePoint page for the EOC Education and Development Team where they can be freely accessed at any time by all Trust colleagues, and the link to that page is provided as a reminder within any subsequent new issue.

NHS Pathways System Issues

During the day-to-day use of the NHS Pathways telephone triage tool colleagues regularly highlight potential issues with the system, for example inconsistencies with how two related Pathways deal with the same symptoms. We also receive regular feedback from external partners and HCPs raising concerns about the Pathways system. Case details are first internally reviewed to ensure the issue is not a result of 'operator error' or a wider health system issue.

Details of concerns are logged with NHS England for review by the national NHS Pathways clinical authoring and training teams. We raise requests for information, requests for change, and share cases of potential interest. All Patient Safety cases where there is a potential contention about how the Pathways system was used are anonymously shared with NHS England in this way.

NHS Pathways System Updates

New Pathways software releases are issued approximately every 8 weeks; if NHS England uphold a logged issued and make system changes these are added to a forthcoming release and details of those changes are shared with colleagues along with the pre-release notes for the version training update materials (which are issued via email with embedded MS Forms acknowledgement link and knowledge review document). These must be completed prior to any new release go-live date.

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111 End to End Review Meetings

These meetings are held monthly and are used to review a case from point of call to 111 throughout the complete patient journey, with input from GP, OOH, ambulance, and ED/Ward. The aim of this end-to-end process is to identify any areas of learning from the cases under review, and to implement process/system changes if required. Any issues involving the NHS Pathways system are reviewed and referred to NHS England as above.

Examples of CCC Shared Learning

- an End to End Review meeting highlighted a case of a 30-year-old female 8-weeks post-delivery complaining of sore breasts and feeling very unwell. The case was triaged to a 6-hour GP timeframe, but the GP felt this was too long as they were concerned about potential sepsis markers.

  There was one question within the assessment algorithm used (Breast Problems) that asked about breast feeding, but because the patient was expressing her breast milk and not actively feeding from her breast, the Health Advisor said 'no' to this question. If they had said 'yes', the resulting disposition would have been to speak with a GP within 1 hour.

  This case was shared with NHS Pathways with a request that they review their supporting information for this breast-feeding question to include 'this also means expressing breast milk' and NHS Pathways acknowledged that they would improve the supporting information to make it clearer.

- A coroner's case highlighted the unfortunate death of a patient with breathing difficulties where grey lips were declared during the call. The system did not consider the abnormal lip colour. The non-clinical Emergency Call Taker did not understand the potential significance of grey lips with associated breathlessness, and as a result a lower category ambulance response was dispatched.

  Following this event, a "Take Note!" memo was issued to all CCC call taking staff to highlight the importance of declared abnormal lip colour in the context of breathing difficulties, and this was followed up with a more detailed interactive anonymised case study (CCC SCASCade).

  The case study author received subsequent emailed confirmation from an in-house clinician who had taken over a call passed by a non-clinical colleague specifically because abnormal lip colour had been declared during their call.

  Additionally, this the case was shared nationally with NHS Pathways who have acknowledged that this case will form part of their ongoing review of their system.

- A coroner issued a PFD highlighting a national concern that 999 services were not aware of appropriate DNACPR exceptions. This linked in with a locally identified audit trend where 999 Emergency Call Takers did not always exclude the DNACPR exemptions listed in current local SOPs before accepting reports of a valid DNACPR form as being appropriate. We also had a recent case where CPR advice was withheld from a patient with a valid DNACPR form who required intervention because of an issue with their mechanical ventilator.

  A "Take Note!" memo has been issued together with a detailed CCC SCAScade case study to share this learning, which has also identified a potential gap in our existing SOP relating to DNACPR exceptions – recommendations have been submitted to the EOC SOPs Working Group to address this.

- A national case review was issued by NHSE relating to the assessment of sub-arachnoid haemorrhage, arising from a tragic case of a young adult male who had multiple contacts with multiple healthcare services with headache symptoms. This national case study was shared with CCC colleagues along with a Factsheet highlighting signs and symptoms.

- A coroner's inquest highlighted a case where an available defibrillator (AED) was not offered to a family calling 999 for a cardiac arrest. The resulting case review identified significant learning around the 999 AED process, including national review and amendment of the NHS Pathways cardiac arrest algorithms.

- A coroner's inquest highlighted concerns over the toxicity risks associated with deliberate overdose of sodium nitrate/nitrite. Details were shared with all CCC Clinicians within a "Toxicity Dirty Dozen" Factsheet, providing guidance and links to the National Poisons Information Service (NPIS) Toxbase reference website.

Wider Trust Communications

All CCC staff complete and maintain statutory and mandatory e-learning and attend yearly face-to-face update training. The agenda for F2F training is primarily set by the regular rotation of the UK Core Skills Training Framework (CSTF) 11 statutory training elements, e.g., Basic Life Support updates. Added to this are mandatory elements set by the Trust's subject matter experts, e.g., safeguarding, sexual safety at work, learning difficulties/disabilities. Any extra time in the allowed F2F training provision time (usually 7.5 hours) focuses on Shared Learning topics.

There are a variety of communication methods available to share learning across the wider Trust including within the CCC. Examples are:

- SOPs / policies / procedures
- Clinical and Operational Directives
- Clinical and Operational Memos
- SCAScades (anonymised case reviews)
- E-learning
- Face-to-face Education sessions
- Statutory and Mandatory training sessions
- Hot News emails
- Staff Matters newsletters
- Podcasts
- Twitter / Yammer feeds
- Apps
- JRCALC (Operations)
- Team days (Operations)

Not all of these are applicable to CCC staff, however via Hot News, Staff Matters and approved social media feeds CCC colleagues are kept abreast of wider Trust initiatives and new schemes.