NHS England

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4th March 2026

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Adam Ali Hussain who died on 16th May 2025.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 5th January 2026 concerning the death of Adam Ali Hussain on 16th May 2025. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Adam's family and loved ones. NHS England are keen to assure the family and yourself that the concerns raised about Adam's care have been listened to and reflected upon.

I am grateful for the further time granted to respond to your Report, and I apologise for any anguish this delay may have caused to Adam's family or friends. I realise that responses to Coroners' Reports can form part of the important process of family and friends coming to terms with what has happened to their loved ones, and I appreciate this will have been an incredibly difficult time for them.

Your Report raised the following concerns:

1. The urgent care pathway across Nottinghamshire poorly serves patients with systemic illness that is serious, but not immediately life threatening, and where the clinical assessment disposition reached is for a Category 3 ambulance response.
2. Detailed information in the East Midlands Ambulance Service (EMAS) Computer Aided Dispatch (CAD) transferred from the 111 service is not reliably read or considered by EMAS staff, when cancelling a requested ambulance response and referring a case on to the Clinical Assessment Service provided by Nottingham Emergency Medical Service (NEMS).
3. Families, waiting for an ambulance response, following a clinical assessment by a 111 clinical adviser are not told by EMAS that an ambulance will not be sent.
4. Category 3 calls are viewed by non-clinicians who do not have sufficient skills to safely transfer calls to NEMS, as the inclusion/exclusion criteria are open to interpretation.

5. There is no agreement between EMAS and NEMS as to the criteria for transfer of a Category 3 call, including whether or not a previous clinical validation would preclude transfer to NEMS.

We consider that the third concern listed above falls within NHS England's remit and we have endeavoured to address this concern below. The remaining concerns would be better addressed by EMAS, NEMS and Nottingham and Nottinghamshire Integrated Care Board (ICB), who have also been sent your Report.

Background

The NHS Pathways Clinical Decision Support System (CDSS) is a triage product that is used to support Urgent and Emergency Care (UEC) in England. The product is owned by the Secretary of State for Health and Social Care and is manufactured and managed by the Transformation Directorate of NHS England. It is embedded within host systems in NHS 111 and 999 ambulance providers where it interacts with other technology products to support the assessment, sorting and onward management of calls received by those services.

Calls to services using the NHS Pathways triage product are managed by specially trained clinical and non-clinical health advisors. Their training is specific to the NHS Pathways product, and this enables them to use the information provided by callers to both request ambulance resources, or pass cases to suitable services, based on the patient's health needs at the time of the call.

The NHS Pathways triage product does not provide a diagnosis. It is built to progress through a clinical hierarchy of urgency, enabling symptoms and discriminatory clinical features to be matched to appropriate services or endpoints, meaning 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.

The safety of clinical triage process endpoints from NHS 111 or 999 assessments using NHS Pathways is overseen by the National Clinical Assurance Group (NCAG), an independent intercollegiate group hosted by the Academy of Medical Royal Colleges (AoMRC). Alongside this independent oversight, NHS Pathways ensures its clinical content and assessment protocols are consistent with the latest advice from respected bodies that provide evidence and guidance for clinical practice in the UK. This includes the latest guidelines from organisations including the National Institute for Health and Care Excellence (NICE), Resuscitation Council UK and UK Sepsis Trust, amongst others.

Concern 3: Families, waiting for an ambulance response, following a clinical assessment by a 111 clinical adviser are not told that an ambulance will not be sent

The timelines within which an ambulance response should be provided vary according to the urgency of the call. Ambulance response standards and ambulance quality indicators are the nationally agreed timeframes for ambulances to

arrive at the patient's location following a call passed to the ambulance service; further information can be found at https://www.england.nhs.uk/urgent-emergency-care/arp.

All NHS Pathways ambulance response disposition codes are ratified by the Clinical Coding Review Group (CCRG), the National Ambulance Services Medical Directors (NASMeD) and the Emergency Call Prioritisation Advisory Group (ECPAG). NASMeD is an advisory group consisting of medical director representatives from all ambulance services in England, Wales, Scotland and Northern Ireland who endorse the categorisation of ambulance codes. The purpose of ECPAG is to advise NHS England and the Department of Health & Social Care (DHSC) on issues of ambulance call prioritisation. Its principal remit is to recommend which disposition codes should be mapped to which ambulance responses. The group consists of membership from the Association of Ambulance Chief Executives (AACE), Clinical Coding Review Group, NHS England, NHS Pathways, NASMeD and Ambulance Heads of Control.

The information given to callers about ambulance dispatch is aligned with the ambulance response standards, and NHS Pathways is not designed to take account of operational delays as these can be very variable and do not represent the recommended clinical disposition. In order to support ambulance providers to manage their available resources, NHS England guidance requires Category 3 and 4 calls to be clinically navigated, validated and where appropriate triaged in ambulance control centres, as included in the NHS England » 2025/26 priorities and operational planning guidance, and the NHS England » 2026/27 ambulance emergency and urgent care service specification and the NHS England » Integrated urgent care service specification. This involves validation of the disposition by a clinician (arranged locally), which can result in a different disposition being subsequently reached.

Following transfer of the case to the ambulance service**,** the information captured in NHS Pathways may allow a clinician to re-categorise the call without direct contact with the patient. The Ambulance Trust's Computer Aided Dispatch (CAD) system, rather than NHS Pathways, is used to manage the validation process. It is a requirement that the CAD must be able to provide appropriate exit scripts for Category 3 / Category 4 codes or dispositions. For 999 calls, all ambulance services should have in place call exit scripts and procedures for dealing with response delays when under operational pressure. NHS England supports a position that callers should be provided with sufficient information to make informed decisions, including whether an ambulance has been dispatched to the patient. For incidents that are eligible for clinical validation, the call exit script should outline that patients may receive a call back from a clinician to conduct a further assessment and who may guide them towards an alternative pathway of care, and patients will be asked to keep their phone line free. The wording of the exit scripts is for local determination.

We are unable to comment on the concern that families are not informed that an ambulance is not being sent as it was NHS 111 and the Nottingham Emergency Medical Service (commissioned by NHS Nottingham and Nottinghamshire ICB) who spoke to the patient, rather than the ambulance service. The ICB will therefore be best placed to address any concerns on their exit scripts.

Regional Response

NHS England's Regional Midlands Team have liaised with Nottingham and Nottinghamshire ICB. The ICB has advised that they facilitated a system-wide After Action Review (AAR) with EMAS, NEMS and 111 partners. This was held on 21st January 2026.

The following next steps were agreed:

1. All participant organisations to the review agreed to refer to the fact that a system wide AAR had occurred involving the Derby-Nottingham footprint.
2. As improvement initiatives identified by the review will require collaboration, obtaining agreement to finalise the AAR was an important first step.
3. Those improvement initiatives once established will be taken through and monitored for assurance within the existing governance for the relevant systems.

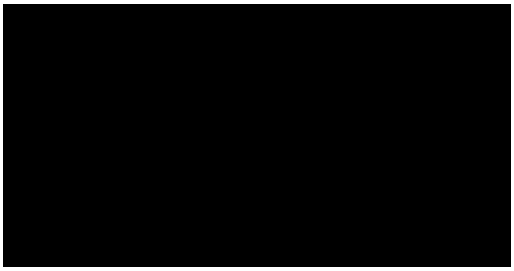
The AAR will be shared with the Regional Quality Board for oversight once it has been finalised and agreed by participating organisations. Should the Coroner require further information regarding the improvement initiatives agreed as part of the AAR, this can be provided in due course.

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 Adam, 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.

I am aware that the Coroner issued another PFD Report on 5 January 2026 which touches upon the same issues which have been raised in this case. NHS England will respond to that Report separately, for completeness, but it may be the case that there is an element of duplication in the information which has been provided. No disrespect is intended to the Coroner in this regard.

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
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