NEMS
Community Benefit Services

Confidential

Dr Elizabeth Didcock, Assistant Coroner, for the coroner area of Nottinghamshire

Platform One

Station Street

Nottingham

NG2 3AJ

Thursday 26th February 2026

Dear Dr Didcock

Response to Matters of Concern Regulation 28 Report
Re: Adam Ali Hussain

NEMS acknowledges the coroner's findings and the concerns raised under Regulation 28 following the inquest into the death of Adam Ali Hussain

NEMS wishes at the outset to express our sincere condolences to Adam's family and to acknowledge the gravity of the coroner's findings. We recognise the profound impact of this case and are committed to responding in a way that is open, reflective and proactive. We fully accept the importance of learning from the matters identified and are approaching this response not simply as a statutory requirement, but as an opportunity to strengthen systems, improve clarity across pathways and reduce the risk of future harm. Both before and following the inquest, we have undertaken detailed review of our processes and engaged with system partners to deliver meaningful, sustainable improvements.

This response therefore sets out the immediate mitigation measures already implemented, the ongoing governance actions currently in place, and the further work proposed to reduce risk and strengthen patient safety across the urgent care pathway.

I acknowledge that the coroner issued a further identical Prevention of Future Death Notice on the same day relating to another linked, but different case. The response to both PFD reports are the same as there is considerable overlap but I wanted to assure the Coroner and the families involved, that no disrespect is intended by this.

1. Urgent Care Pathway

Coroner's Concern:
The urgent care pathway across Nottinghamshire, whilst working well for most patients, poorly serves patients with systemic illness that is serious, but not immediately life threatening, (such as is seen in sepsis), and where clinical assessment disposition reached is for a Category 3 ambulance response

Actions Taken

NEMS confirms that it has not continued with manually pushed calls since 3rd December 2026. Prior to 27th June 2025, Category 3 calls assessed by EMAS as potentially suitable for management within the Urgent Care Coordination Hub (UCCH) were at times manually pushed to NEMS. In practice, this

meant that an EMAS Emergency Operations Centre (EOC) colleague would transfer a case directly into the NEMS clinical queue, based on the agreed inclusion and exclusion criteria at that time.

As the evidence unfolded during the inquest, it became clear that the manual push model had the unintended consequence of positioning NEMS in a role more akin to an Emergency Operations Centre (EOC), rather than functioning as an urgent care provider operating within a clearly defined admission avoidance model. This was neither aligned with national GIRFT (Get it Right First Time) guidance nor consistent with the intended purpose of an Urgent Care Coordination Hub. GIRFT describes UCCHs as a single point of access supporting admission avoidance, coordinating community-based responses and enabling ambulance crews to access alternatives to conveyance. Since this time, we have strengthened our governance arrangements to ensure clear operational boundaries, robust clinical oversight, and full alignment with urgent primary care guidelines, thereby preventing a recurrence of this situation.

Since cessation of manual pushes, referrals now occur via Directory of Services (DoS) or automated ITK pathways. These pathways present lower risk because they are generated through NHS Pathways and meet defined criteria, and no further sepsis-related patient safety incidents have been identified since pathway changes in June 2025. Since 27th June 2025, NEMS implemented a pause on manually pushed calls while improvements were agreed with EMAS. Although manual pushes resumed on 21st July following assurance regarding CAD note quality and governance arrangement, NEMS confirms that it has not continued with manually pushed calls since 3rd December 2025.NEMS continues to proactively review cases transferred from EMAS and escalate concerns through joint governance structures, alongside close monitoring of monthly UCCH highlight reports to identify emerging themes

In parallel, NEMS has worked closely with the Integrated Care Board (ICB) to review national GIRFT models for UCCH delivery, ensuring alignment with best practice. It is our clear position that interception or re-triage of EMAS calls should sit within the clinical expertise and statutory responsibility of EMAS. NEMS' role is to provide urgent primary care expertise for appropriate admission avoidance pathways and not seek to replicate ambulance triage functions. Accordingly, our strategic focus has shifted towards preventing avoidable ambulance callouts in defined cohorts such as frail patients, care home residents and those at end of life, where proactive planning, anticipatory care and coordinated community response can safely reduce escalation to 999. This reflects the intended GIRFT model of supporting admission avoidance and coordinated care in the community, rather than intercepting higher-acuity ambulance demand. We will continue to work closely with system partners to ensure the pathway operates safely, with clear accountability and well-understood professional roles.

Further Work

NEMS will continue to share recurring themes and individual cases of concern with EMAS through established governance processes to ensure that identified risks are reviewed and that learning is clearly documented. We have requested that EMAS report back on the outcomes of those reviews and share any learning relevant to NEMS, so that the process operates as a genuinely reciprocal and joint approach rather than a one-directional escalation pathway.

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NEMS will continue to participate in joint After Action Reviews with EMAS where appropriate, maintain focused review of systemic illness presentations within the pathway, and escalate any identified risks to system partners to ensure timely mitigation and shared learning.

2. CAD Information Not Reliably Considered

Coroner's Concern:
There remains detailed information in the EMAS Computer Aided Dispatch (CAD) transferred from the 111 service that 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 NEMS.

NEMS Position

Ideally, CAD notes should mirror the structured format of a DHU 111 report, with clear separation of positive findings, negative findings, outcome rationale, and advice given . At present, this level of clarity is not consistently achieved.

We also acknowledge that the proposed national BARS (Booking and Referral Standard) solution has been identified as a potential mechanism to improve data transfer and prevent Category 3 calls being deprioritised within the system. However, there has been no confirmed implementation timeline, and its formatting and functionality benefits have not yet been fully tested. Notwithstanding the cessation of manually pushed calls, improved data transfer remains essential for safe ITK and DoS referrals, and BARS may form part of that longer-term solution.

Actions Undertaken

NEMS has engaged in ongoing discussions with EMAS and OneAdvanced, the software provider responsible for Adastra (the electronic patient record system used by NEMS) to improve the formatting, structure and clarity of CAD-to-Adastra transfers. This has included identifying the duplication arising from the multiple message structure and formally requesting technical solutions to improve legibility and presentation of narrative information

In relation to role identification, OneAdvanced has updated role types to allow differentiation between Clinical Advisors and Health Advisors within NHS 111. In addition, EMAS' CAD supplier (MIS) is scheduled, in early March 2026, to commence development work to enable transfer of advisor skillset information into the receiving system. This represents a positive step towards improving visibility of prior clinical validation and supporting safer downstream decision-making.

In addition, this process has generated learning and further improvement work between DHU 111 and NEMS in relation to the direct transfer of information from the 111 provider into NEMS systems will improve clinical safety for all patients. NEMS confirms that it has formally agreed with OneAdvanced to implement the Booking and Referral Standard (BaRS) within Adastra and is progressing this work in partnership with DHU. Following system configuration, a formal multi-agency project involving NEMS, DHU, OneAdvanced, NHIS and the ICB Directory of Services team will oversee the migration of CAS and Out of Hours profiles from the legacy ITK framework to BARS, alongside necessary system configuration to ensure structured, complete and clearly displayed clinical information transfer. Although there are national technical dependencies, including firewall configuration and NHS England certification requirements that have affected wider system timelines,

both organisations remain actively engaged and on track to implement BaRS, which will significantly strengthen the quality, reliability and safety of electronic note transfer between DHU 111 and NEMS.

Further Action Proposed

NEMS will continue engagement with EMAS, MIS (CAD Supplier) and OneAdvanced so that reliable identification of prior NHS 111 clinical validation is achieved and narrative transfer is consistently legible and structured.

NEMS will:

- Continue to press for structured CAD formatting aligned to the model outlined in verbal evidence provided at inquest (clear overview, further information, outcome and advice fields).
- Seek clarity on the implementation timeline for BARS and its anticipated impact on formatting and prioritisation.
- Review whether additional internal NEMS risk flags should be applied where duplication or poor formatting obscures clinical clarity.
- Continue to raise concerns formally where transferred information does not allow safe clinical decision-making.

Whilst many of the technical solutions sit outside NEMS' direct control, we remain committed to constructive system engagement to ensure that data transfer supports safe and informed clinical assessment across organisational boundaries.

3. Families Not Told Ambulance Will Not Be Sent

Coroner's Concern:
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

NEMS recognises that patients often believe an ambulance is already en route when referred to our service via EMAS.

Immediate Mitigation Implemented

NEMS has introduced a **standardised opening statement**:

"I am calling on behalf of NEMS, an urgent care provider. The Ambulance Service has passed your call to us to determine whether an ambulance is required or whether we can provide an alternative option."

This is now embedded into clinical introductions to reduce misunderstanding and improve transparency.

Further Action

- Audit of call recordings to ensure compliance.
- Ongoing discussion with EMAS to ensure consistent public messaging across services.

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4. Non-Clinician Review of Category 3 Calls

Coroner's Concern:

Category 3 calls are viewed by non- clinicians at the EMAS Emergency Operations Centre, who do not have sufficient skills to safely transfer calls to NEMS, as the inclusion/exclusion criteria are open to interpretation.

NEMS Position

The manually pushed call model, which relied on interpretation of locally applied inclusion and exclusion criteria, has ceased within Nottingham and Nottinghamshire. Current referrals received by NEMS are either Directory of Services (DoS) driven or generated through automated ITK pathways. These routes follow nationally defined NHS Pathways clinical coding and disposition criteria and therefore do not require additional locally derived screening criteria. They are structured within established national algorithms rather than discretionary interpretation.

5. No Agreed Criteria for Transfer (Including Prior Clinical Validation)

Coroner's Concern:
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

NEMS Position

There is joint agreement in principle that calls which have already undergone clinical validation within NHS 111 should not ordinarily be transferred to NEMS for further validation. Where a clinician within NHS 111 has assessed a patient and determined an appropriate disposition, particularly where ambulance or ED attendance is indicated, this should not routinely result in a further layer of telephone assessment unless there is a clearly defined clinical rationale.

However, NEMS is currently unable to reliably identify whether a call received via EMAS has already been clinically validated within NHS 111. As outlined under Point 2, this relates directly to the transfer of advisor skillset information and the current limitations within CAD-to-Adastra data transfer. Without visibility of whether the original 111 disposition was clinician-led, NEMS cannot consistently differentiate between pathway-generated dispositions and those that have already undergone clinical review.

Further Proposed Action

NEMS proposes continued joint work with EMAS and system partners to formalise clear transfer principles. This should include explicit agreement that clinically validated NHS 111 calls should not be routinely transferred for re-validation, and that where EMAS reassesses a call as requiring ED attendance, it should be conveyed directly to ED without further telephone triage.

Further system-level review may be required to determine whether adjustments to Directory of Services positioning or internal EMAS processes are necessary to prevent avoidable sequential assessments. The shared objective is to minimise fragmentation within the patient journey and reduce the risk of higher-acuity patients being delayed through multiple telephone contacts before definitive care is accessed.

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Update on Internal NEMS Actions

NEMS remains fully committed to learning from the tragic death of Adam and to ensure that the lessons identified translate into meaningful and sustained improvement in clinical practice and system processes. The Organisational Learning Statement previously submitted to the coroner outlined the actions taken to strengthen the Urgent Care Coordination Hub (UCCH) service, enhance telephone consultation standards, improve digital processes, and formalise joint governance with system partners. Those commitments have not only been maintained but continue to be actively progressed and embedded within routine operational and educational practice.

Immediately following the conclusion of the inquests, key learning points were formally shared with the entire NEMS workforce on 14th December. This communication summarised the clinical findings, system themes and professional reflections arising from both cases, with particular emphasis on cumulative contacts, symptom evolution, structured history-taking, recognition of sepsis, and the limitations of transferred documentation. The purpose of this communication was to promote transparency, reflection and collective ownership of learning across all clinical staff.

On 23rd December 2025, the Medical Director met directly with all telephone practitioners involved in delivering the UCCH and Clinical Assessment Service. This session provided a structured opportunity to review the inquest findings, discuss the process changes that have been implemented, and allow clinicians to ask questions, raise concerns and reflect openly on their practice. The discussion was constructive and professionally engaged, reinforcing a culture of psychological safety and shared accountability for improvement.

On 21stJanuary, alongside the Medical Director, I attended a formal system After Action Review alongside the ICB Quality Team, EMAS and DHU. This review considered both cases in detail, identified shared learning themes and examined the collaborative approaches required to strengthen inter-organisational working. Focus was given to information transfer, recognition of clinical deterioration across multiple contacts, and clarity of role boundaries within the urgent care pathway. This system-level discussion reinforced that the risks identified were not isolated to one organisation and require coordinated improvement across providers.

On 23rd January, the Medical Director attended the Learning from Death System Forum and formally requested that the ICB Quality Team undertake a deep dive into other Prevention of Future Death (PFD) reports across Nottingham and Nottinghamshire where communication failures and inter-organisational information transfer were contributory factors. The themes identified in Adam's cases, particularly fragmentation of care and incomplete data transfer across providers, are not unique risks. It is therefore important that system learning extends beyond individual cases to identify wider patterns across the region.

On 3rd February, the Medical Director hosted a dedicated clinical teaching session in collaboration with Mr Chauhan, the consultant general surgeon who provided evidence at inquest. This session focused on the presentation of appendicitis, the variability of clinical features, the evolution of intra-abdominal sepsis, and the importance of considering differential diagnoses when symptoms appear non-classical. The session was well attended by NEMS clinicians and formed part of our strengthened education programme. It provided valuable specialist insight and reinforced the importance of clinical curiosity, escalation when uncertainty persists, and recognition of evolving systemic illness.

These initiatives build upon the strengthened educational processes already described in the Organisational Learning Statement including enhanced sepsis training, structured competency assessments for UCCH clinicians, repeated clinical audits with reflective feedback, digital prompts such as the sepsis screening tool within Adastra, and tighter allocation of appropriately trained staff to high-acuity services.

NEMS recognises that learning from such cases must be ongoing rather than reactive. We remain committed to maintaining enhanced audit cycles, embedding structured reflective practice, strengthening inter-organisational communication processes, and ensuring that clinicians feel supported, trained and equipped to manage complex and evolving presentations safely.

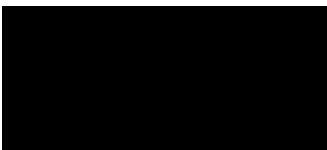
In responding to this Prevention of Future Death report, we remain acutely aware that behind the clinical detail, governance processes and system changes sits the devastating loss of a young life. Adam's death has had a profound impact on his family, and we recognise that no review, response or action plan can undo the pain they continue to experience. We extend our sincere condolences to them and acknowledge the courage and dignity shown throughout the inquest process.

NEMS have taken this inquest, and the learning arising from it, extremely seriously. The work undertaken before, during and after the inquest has involved detailed reflection, engagement with clinicians, system partners and digital teams, and a careful review of both individual practice and organisational processes. This commitment does not end with the submission of this Prevention of Future Death response. The actions described are not reactive measures tied to a statutory deadline; they form part of an ongoing programme of scrutiny, education and improvement that will continue.

These cases have been approached not simply as governance matters, but as deeply human events that require humility, honesty and sustained effort. We remain committed to learning, to strengthening our clinical practice and inter-organisational working, and to ensuring that the lessons identified contribute to safer care for others. Above all, we remain mindful that at the centre of this response is a family living with an irreplaceable loss, and it is with that understanding that we continue this work.

We remain committed to honouring Adam's memory through sustained improvement, transparency and collaboration. Our responsibility is to ensure that the lessons identified lead to safer care for others, and that we never lose sight of the human impact that sits at the heart of our work.

Yours Sincerely



NEMS Chief Executive