



Date: 23rd March 2026

Private and Confidential

Mr J Pegg
HM Area Coroner for Hampshire, Portsmouth and Southampton
The Coroner's Court
1 Guildhall Square
Portsmouth
PO1 2GJ

Dear Mr Pegg,

RE Lucy Thornton - Response to Regulation 28 Report to Prevent Future Deaths

I am writing in my capacity as Chief Executive of the Isle of Wight NHS Trust in response to the Prevention of Future Deaths (PFD) report issued following the conclusion of the inquest into the death of Ms Lucy Thornton on 27th January 2026.

On behalf of the Isle of Wight NHS Trust, I would like to express our sincere condolences to Ms Thornton's family and loved ones. We are grateful to the Court for bringing these matters to our attention, and we have carefully considered the concerns raised within your report.

Your report identified concerns regarding the level of training and understanding of call handling procedures in relation to incidents involving potential hanging or suicide. In particular:

1. The procedures direct a Category 1 response (7 minutes) when the person has the means to suspend themselves and has stated that is there present intention. The call handler believes that a Category 1 response is, "When they are going to die now".
2. The procedures direct that when the call handler does not have all relevant information, they should telephone the person and ask questions in relation to the person's present situation. The call handler was on the Isle of Wight. Ms Thornton was in Southsea. The call handler did not call Ms Thornton she felt she was too remote (geographically).

In response to these concerns, a review and audit of the call established that the call handler did not make sufficient efforts, in accordance with Isle of Wight Ambulance Service (IOWAS) processes, to make direct contact with the patient. This has been addressed with the individual concerned.

The call handler did, however, upgrade the incident to a Category 2 ambulance response. This decision was based on information indicating a possible attempt at hanging and a lack of clarity regarding the extent of bleeding.

The call handler reported that the perceived geographical remoteness of the patient, alongside a personal sensitivity to the situation, contributed to the decision not to pursue direct contact with Ms Thornton.

Following receipt of your report, the Ambulance Service has undertaken a comprehensive review of current procedures, training, and guidance provided to call handlers. The Trust has taken the following actions:

1. Review of Call Handling Guidance

Following a letter from Professor Jonathan Benger in April 2021 regarding clinical validation processes, the Association of Ambulance Chief Executives established a clinical validation process in October 2023 for patients threatening suicide, which has been adopted by the Isle of Wight Ambulance Service.

Calls of this nature are triaged as either Category 3 under NHS Pathways or Category 5 “Hear and Treat” calls. The Computer-Aided Dispatch (CAD) system highlights patients who have deliberately or accidentally taken an overdose or where there is a potential threat of suicide. If no clinical validation has taken place within 30 minutes, the system automatically upgrades the incident to a Category 2 response. This functionality has been in place within the Trust since 2023.

At present, there is no NHS Pathways outcome that results in a Category 1 response for a patient threatening to hang themselves, even where means are present. A Category 1 response is only triggered where a patient is actively in the process of hanging.

Patients expressing suicidal ideation and access to means (excluding ingestion or overdose) are escalated to the duty Operational Commander within the control room for further risk assessment, including liaison with the police control room for additional support and intervention.

This incident and your Prevention of Future Deaths report will be formally reported to the national NHS Pathways group. It has also been raised at the National Heads of Emergency Operations Centre meeting, with a request that existing pathways be reviewed to consider whether a Category 1 disposition is appropriate in such circumstances.

Completion date: January 2026

3. Training and Reinforcement of Processes for Suicidal Patients and Remote Callers

Additional training has been introduced for all call handlers to reinforce the appropriate management of calls involving suicidal patients.

This includes:

- Reinforcement of escalation pathways where risk is identified
- Clarification of response categories and associated decision-making
- Emphasis on proactive information gathering and risk assessment

Training is being delivered through mandatory refresher sessions and updated training materials.

Implementation period: February to April 2026

4. Clarification of Procedures for Contacting the Individual at Risk

Guidance has been amended and strengthened to make clear that where relevant information is incomplete, call handlers must make reasonable attempts to contact the individual directly, wherever they are located, in order to obtain information necessary for an accurate risk assessment.

The revised guidance explicitly confirms that:

- The physical location of the call handler is not a barrier to contacting the individual by telephone

- Call handlers are expected to pursue direct contact wherever appropriate

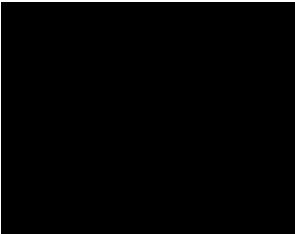
In addition, clear direction has been issued to the call handling team regarding escalation procedures where a call handler feels unable to manage a call due to personal sensitivity or other factors. In such circumstances, the call must be escalated immediately to a senior colleague so that another member of the team can take over and ensure there is no delay in the patient pathway.

Completion date: January 2026

The Trust remains fully committed to learning from this incident and to strengthening its systems and processes to reduce the risk of similar occurrences in the future. We will continue to work with national bodies to ensure that guidance and NHS Pathways appropriately reflect the risks associated with suicidal patients, including those involving potential hanging.

I hope that the contents of this letter provide appropriate assurance that the concerns raised have been carefully considered and addressed.

Yours sincerely,



Chief Executive Officer
IWT & PHU

