ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. NHS England**
1	**CORONER** I am Louise Wiltshire, assistant coroner, for the coroner area of the County of Devon, Plymouth and Torbay
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 12 July 2022 I commenced an investigation into the death of Theo Gordon Tuikubulau. The investigation concluded at the end of the inquest, heard before a jury, on 3 July 2025. The narrative conclusion of the inquest was as follows: Theo died from an invasive Group A streptococcal infection, contributed to by missed opportunities to render earlier care and treatment. The medical cause of death was: 1a Sepsis 1b 1c II
4	**CIRCUMSTANCES OF THE DEATH** Theo was a three-year-old boy who died on 8 July 2022 as a result of sepsis, arising from an invasive strep A infection (i-GAS) .

5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – During the course of the inquest evidence was heard that assessment and resultant ambulance dispositions for breathing complications were likely to be different depending on whether that call was triaged via the MDPS or NHS Pathways systems. Between 5 and 8 July 2022 various calls were made to 999 and 111 by Theo's mother. Breathing complications were described by Theo's mother during those calls as; Theo's lips had turned "a little blue", and that he was fighting for every breath. This information triggered a category 1 ambulance disposition via MPDS and a category 2 disposition via NHS Pathways. The 111 provider used the NHS Pathways system to assess and triage calls. The 999 provider used MPDS to assess and triage calls. The difference in assessment and triage of calls under these two systems appears to create a two-tiered system of assessment and ambulance categorisation in the Devon area (and potentially nationally). It appears that similar breathing complaints requiring urgent medical attention will result in a different ambulance disposition depending on whether the call is triaged via MPDS (used by the 999 provider in Devon) or NHS Pathways (used by the 111 provider in Devon). As a result of the evidence heard at the inquest I considered it likely that my duty to prevent future deaths was engaged in this case. However, I was conscious that I did not hear evidence directly from those responsible for the NHS Pathways or MPDS systems during the inquest. I therefore requested further information from both of the organisations responsible for NHS Pathways and MPDS about why there appears to be a two tier system in Devon (and potentially nationally) which would result in a different ambulance categorisation (category 1 under MPDS and category 2 under NHS Pathways) when a caller describes breathing difficulties such as "fighting for breath", "turning blue", or "gasping". Further I asked that if this two tier system does exist, either in Devon, nationally or both, for further information about what is being done to address those differences in call assessment, triage and ambulance categorisation. On 26 November 2025 I was provided with an independent case review from the International Academies of Emergency Dispatch ("IAED"). They had reviewed the calls triaged via the MPDS system and confirmed that these calls had been properly assigned a category 1 response time. They were unable to comment on the calls triaged by NHS Pathways as it has no association with that algorithm. On 4 September 2025 I was provided with further information from NHS England about

	the Triage systems in place. They confirmed that: *"MPDS is a long-established triage system launched in 1979, published by the Priority Dispatch Corporation (PDC), and its ongoing development is supported by the International Academies of Emergency Dispatch (IAED)… NHS England does not manage or oversee the MPDS and we are therefore unable to provide comment on their system.* *NHS Pathways is a Clinical Decision Support System (CDSS) used for remote clinical assessment in urgent and emergency care. NHS Pathways was launched in 2005 and is developed and maintained by the Transformation Directorate at NHS England, and is overseen by the National Clinical Assurance Group (NCAG), an independent intercollegiate body hosted by the Academy of Medical Royal Colleges. It underpins all NHS 111 services and more than half of England's 999 telephony services…* *…Both triage systems are designed to assess the presenting symptoms/condition and acuity (severity and urgency of the symptoms/condition) of the patient based on the identification of priority symptoms (e.g. unconsciousness, difficulty breathing or chest pain). If, during the call, the patient's condition changed (either improves or worsens), then there is an exception that the call handler will re-triage with the new information which may change the response being arranged."* The response from NHS England further confirmed that: *"Following a review of this case by NHS England's Urgent & Emergency Care (UEC) Teams, it is clear that there is variation between the two triage systems with regards to respiratory distress in children under 5, specifically in relation to the management of declared cyanosis (where the patient's skin or lips have turned blue or grey). If a caller volunteers 'cyanosis', they will be recognised as having ineffective breathing through the MPDS triage. However, the presence of cyanosis is not interrogated within NHS Pathways and as such this symptom / sign is not a specific trigger for generating a Category 1 disposition for ineffective breathing within NHS Pathways, instead resulting in the generation of a Respiratory Distress disposition that is mapped to a Category 2 response."* I was advised within the letter that NHS England will work with the clinical coding groups and NHS Pathways to review this to ensure that the triage and categorisation of ineffective breathing and respiratory distress is consistent across the two triage systems and remains clinically appropriate, for which I am grateful. However, as this has not yet occurred and the two tiered triage system continues to exist, so does my duty to make a report to prevent future deaths in this matter.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.
7	**YOUR RESPONSE**

	You are under a duty to respond to this report within 56 days of the date of this report, namely by 3 March 2026. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons; the family, South West Ambulance Services NHS Trust, Herts Urgent Care and University Hospitals Plymouth NHS Trust. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	[redacted] **Louise Wiltshire** **6 January 2026**