NHS England

Mr Andrew Cousins
HM Assistant Coroner for the County of Cumbria
HM Coroner's Office
Fairfield
Station Road
Cockermouth
Cumbria
CA13 9PT

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

6th May 2026

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Jardine Williams who died on 24 March 2025.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 16 March 2026 concerning the death of Jardine Williams on 24 March 202. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Miss Williams' family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Miss Williams' care have been listened to and reflected upon.

Your report raised concerns around the lack of pathway questions seeking to address the immediacy of plans when a patient indicates plans to end their own life, and that the absence of this question from the pathway and thus the absence of such information may not have assisted the call handler in compiling as clear a picture as could have been possible about the case they were receiving.

Background of NHS Pathways Clinical Decision Support System

NHS Pathways is the Clinical Decision Support System (CDSS) used for remote clinical assessment (triage) in urgent and emergency care. In use since 2005, it underpins all NHS 111 services and more than half of England's 999 telephony systems. The tool also supports online triage, in-person and enhanced clinical assessments via modules such as the NHS Pathways Clinical Consultation Support (PaCCS) system.

The safety of the NHS Pathways triage outcomes, known as dispositions,is overseen by the National Clinical Assurance Group (NCAG), an independent intercollegiate body hosted by the Academy of Medical Royal Colleges (AOMRC). Alongside this external scrutiny, NHS Pathways aligns with up-to-date national clinical guidance, including National Institute of Health and Care Excellence (NICE), UK Resuscitation Council and UK Sepsis Trust.

The system supports over 2.5 million triage assessments each month across telephone, digital and face-to-face settings.

NHS Pathways follows a structured clinical hierarchy. Serious and potentially life-threatening symptoms are assessed first to ensure rapid escalation, such as dispatching an ambulance or involving a clinician. The assessment then progresses to less urgent symptoms, identifying the most appropriate level of care. The tool is not diagnostic. Instead, it works by systematically ruling out more serious causes of symptoms to ensure safe, efficient triage. Relevant history is gathered where clinically necessary to minimise triage time whilst maintaining safety.

Telephone assessments are conducted by trained non-clinical health advisors. These advisors complete a rigorous training programme and are supported, at all times, by clinicians. If a patient's presentation is complex or unclear, health advisors are required to escalate to clinical colleagues. It is therefore a condition of the NHS Pathways licence is that clinical supervision and escalation support must be available 24/7.

In the NHS Pathways triage system, where the patient or caller reports either a suicide attempt or active suicidal intent, the lowest endpoint (disposition) that may be reached is a Category 3 emergency ambulance disposition. A higher category of ambulance disposition would be reached where other relevant symptoms/conditions – such as loss of consciousness or difficulty breathing, are present at the time of assessment. This aligns to the ambulance response standards set by the Ambulance Response Programme (ARP).

A new disposition code was developed in the NHS Pathways product in April 2019. 'Dx0124 Emergency Ambulance Response for Risk of Suicide (Category 3)' enables clearer visibility of such cases in the Computer Assisted Dispatch (CAD) system used by staff in ambulance services, supporting them to readily identify the cases requiring prioritised review due to suicide attempt. Furthermore, NHS Pathways provides a code identifying suicidal intent – the means and a plan to complete suicide (SD4244-AMB suicidal means and a plan). The new disposition code was created within the NHS Pathways system in April 2019, following the presentation and ratification of the changes to the former NHS Pathways National Clinical Governance Group (NCGG) in February 2019. This new disposition code was deployed to all service users as part of Release 19 in October 2019 as planned and following sign-off by Emergency Call Prioritisation Advisory Group (ECPAG) on 3 July 2019.

NHS Pathways has additionally provided a significant volume of training materials regarding the assessment of patients with mental health conditions to all provider of NHS 111 and the ambulance services that use NHS Pathways, and has offered to work with and to advise North West Ambulance Service (NWAS) on how best to triage mental health situations. Regional clinical quality colleagues for the North West have also been made aware of your Report for the appropriate assurance purposes.

NHS Pathways does not have oversight of local ambulance queues or their management, and note that it can be the case that waiting times may be longer than the national response times due to local resourcing and demand pressures. Given the

significant consideration nationally of the management of callers at risk of suicide in recent years, and the fact that this has resulted in system changes, national discussions and mandates, NHS England is not considering a further system change to NHS Pathways at this time, but (as with all clinical content). This will remain under review as and when new evidence or guidance emerges.

In this particular case, it appears from your report that the NHS Pathways triage system did elicit the correct information from the patient which triggered the correct nationally approved ambulance response.

NHS Pathways has not been privy to the call recording of this case and is therefore, unable to follow the exact route taken during the call in question. However, from the information provided in your report and following review of the NHS Pathways system, it can be confirmed that there is a question that asks about the immediacy of the potential suicide scenario. The question is worded '*do you feel you are going to do that now?*'. The question rationale is for the health advisor handling the call 'to find out if there is immediate risk of a suicide attempt'. The supporting information available for the health advisor states 'this means the patient is intending to end their own life now'. Please see the screenshot below. This question presents for both first and third party callers and will generate a Category 3 Emergency Ambulance Response for Risk of Suicide, as detailed above.

Do you feel you are going to do that now? PW1687.3400

To find out if there is immediate risk of a suicide attempt.

yes

This means the patient is intending to end their own life now.
Does not mean a patient who:
- Might carry out a plan in the future.
- Has no intention of carrying out their plan.

not sure

no

In April 2021, NHS England issued guidance to ambulance services relating to overdoses taken with suicidal intent. This was further updated in November 2023 to include callers who reach a Category 5 disposition (hear and treat). The guidance highlights the critical importance of clinical oversight and review and sets out that:

- Where a potential threat of suicide is declared, an urgent clinical review should take place within 30 minutes or the case must be automatically upgraded to a Category 2 if this does not occur within 40 minutes.
- The initial clinical review should consider any ongoing suicidal ideation with a specific plan/means.

NHS England's Emergency Call Prioritisation Advisory Group (ECPAG) wrote to all ambulance trusts asking them to confirm compliance with all aspects of the NHS England guidance on '999 overdose and suicidal ideation calls'. NWAS confirmed that appropriate measures were in place as per NHS England guidance. To ensure this remains the case, NHS England will review NWAS' current operational practise in relation to overdose and suicidal ideation incidents to ensure alignment with national guidance.

Regional response

NWAS have advised that colleagues from the Trust attended the Inquest and are currently drafting its own formal response to the Regulation 28 concerns raised by HM Coroner.

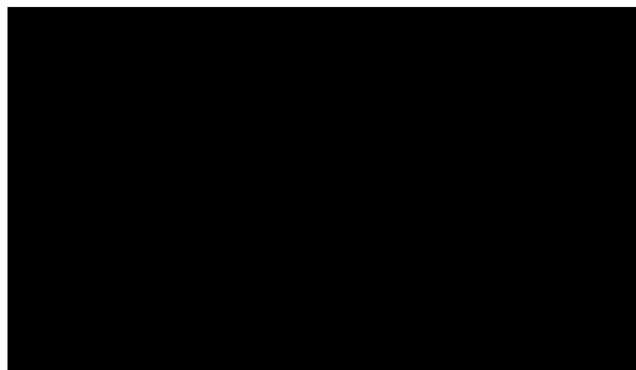
All incidents that are pushed to external Clinical Assessment Service (CAS) providers for validation of ambulance outcomes, including those presenting with overdose or suicidal ideation, are reviewed by senior clinicians who then 'pushes' the incident to the CAS provider. NWAS have advised they are compliant with the requirement for a timely clinical review of such cases. NWAS have advised that in the specific circumstances of this case, the initial transfer of the call to Cumbria Health On Call (CHOC) should not have occurred as suicide related calls fall outside of their CAS criteria. As such, NWAS is reviewing the incident further to ensure that incidents are passed as compliant with the relevant service acceptance criteria. NWAS have made amendments to their CAD systems to allow for automatic upgrade when any clinical review has not taken place, as per the national specification. In addition, NWAS operated a proprietary question for all overdose cases which provides an opportunity for incidents to be upgraded to a Category 2 based on the substance ingested being at high risk. NWAS operates robust clinical oversight within its Contact Centres, the safety of patients with mental health needs remains a priority for the Trust.

For further information on NWAS' system changes and for their review of this incident, please contact them directly or refer to their own response to your report.

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 Miss Williams, 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.

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 Director of Patient Safety
NHS England