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20th August 2026

Dear Ms Charbit,

Re: Regulation 28 Report to Prevent Future Deaths – Adam Ankers who died on 4 February 2024.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 14 April 2026 concerning the death of Adam Ankers on 4 February 2024. 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 is 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 raises concerns to NHS England, regarding the following:

1. There are difficulties with lay people (trained or not), including ambulance call handlers, understanding the signs of agonal breathing or cardiac arrest.
2. There is a need for better understanding on the use of defibrillators, particularly by lay people and trained first aiders.
3. Cardiac screening is not available to all young people or young football players despite it reducing the risk of sudden cardiac death in those aged 14 and upwards.
4. Issues with the cascade of communication regarding genetic or hereditary disease means that it does not reach more than half of those within families that need to know about it.

Understanding the signs of agonal breathing or cardiac arrest by lay people

Ambulance Emergency Operation Centres (EOCs) use one of two approved triage tools to code and prioritise 999 emergency calls: MPDS or NHS Pathways. The [international MPDS system](#) is run commercially by Priority Dispatch Corp (PDC). [NHS Pathways](#) is owned by the Department of Health and Social Care and delivered by

NHS England. It is up to individual ambulance services to decide which triage tool to use and to enter into a contractual agreement with the triage provider. The system providers determine and update the protocols, pathways and questions used. Call outcomes (dispositions) are mapped to contractual standards, with the outcomes then mapped to the five national response categories (categories 1-5) which are set out in the NHS Constitution and Ambulance Service 999 contracts.

NHS England oversees how 999 calls are categorised, with decisions made through the Emergency Call Prioritisation Advisory Group (ECPAG). This helps to ensure consistent prioritisation across England and fair access to ambulance responses.

All 999 call handlers are trained to identify breathing difficulties and altered consciousness at the start of the call. EOCs have established processes in place to dispatch quickly for life threatening conditions. Ambulance trusts use predefined 'Nature of Call' (NoC) phrases to rapidly identify presentations that are immediately life-threatening, even before formal triage commences. Training includes recognising cardiac arrest, assessing breathing and development of active listening and probing skills, which are essential throughout the call to gather information that is offered by the caller.

NHS England recognises that identifying signs of agonal breathing or cardiac arrest can be challenging to identify over the phone. However, both MPDS and NHS Pathways use structured, scripted questions designed to prioritise the most serious symptoms first.

Medical Priority Dispatch System (MPDS)

MPDS supports call handlers to recognise ineffective or agonal breathing and possible cardiac arrest in several ways:

- MPDS prompts the call handler to establish if the patient is breathing. If the call handler is unsure, MPDS directs the call handler to treat the patient as not breathing until proven otherwise. This triggers a Category 1 response (the most urgent category of ambulance dispatch). At the same time, the call handler starts cardiopulmonary resuscitation (CPR) instructions and asks the caller to obtain the nearest defibrillator.
- Breathing described as 'very faint' is treated as ineffective breathing. This also triggers a Category 1 response although not CPR. In this case, Adam would have been triaged through 'Protocol 12 Convulsions/Fitting'. A prolonged fit (over 10 minutes) is also recognised as one of the very most serious symptoms and so also results in a Category 1 response. If the fit has stopped, MPDS then uses a breathing verification diagnostic of checking the patient's breathing rate with the caller's assistance. If the interval between breaths is less than four seconds, breathing is deemed effective or normal.
- The call handler provides advice on maintaining the airway and rechecks the breathing regularly. Where breathing is slow (four to eight seconds between breaths), the diagnostic tool is used again with 60 seconds, and the caller is advised to get someone to obtain the nearest defibrillator.

- If the interval between breaths exceeds eight seconds, this is identified as agonal breathing and the call handler initiates CPR instructions and advises obtaining a defibrillator. Both slow and agonal breathing (as well as fitting for over 10 minutes) result in a Category 1 response.

When a patient is identified as having ineffective breathing, agonal breathing, or not breathing at all, the call handler instructs the caller to begin CPR and apply defibrillator pads if available, providing guidance as necessary.

If a patient is reported as unconscious but not fitting, they are triaged under 'Protocol 31 (unconscious/fainting (near))'. The initial question asks if the patient's breathing is completely normal. Unless the answer is an unequivocal yes and the patient remains unconscious, a Category 1 response is again assigned, and CPR and defibrillator instructions are given. If breathing is confirmed as normal, the breathing verification diagnostic is still applied, and actions taken as described above.

MPDS includes rules, guidance and laws to help call handlers recognise agonal breathing and cardiac arrest, including:

- A definition for ineffective and agonal breathing
- A rule recognising that fitting-like activity can be an initial sign of cardiac arrest
- Cardiac arrest is listed as a known cause of seizure
- Brock's Law: The presence of an automated external defibrillators (AED) does not ensure its use; it is the call handler that does
- Aside from Protocol 12, all non-traumatic unconscious patients should be positioned flat on their back with the head tilted back to maintain the airway and avoid additional breathing difficulties
- For unconscious patients due to injury or trauma, they are not moved unless breathing is ineffective, uncertain, or agonal

NHS Pathways

"NHS Pathways" is a Clinical Decision Support System (CDSS) manufactured by NHS England and used for remote clinical assessment (triage). 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 NHS Pathways Clinical Consultation Support (PaCCS).

The safety of 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 England aligns NHS Pathways' clinical content with up-to-date

national clinical guidance, including NICE (National Institute for Health and Care Excellence), 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 triage 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 which would need the most urgent response first, to ensure safe, efficient triage. Relevant history is gathered where clinically necessary to minimise triage time while maintaining safety.

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

NHS England recognises that signs of agonal breathing or cardiac arrest can be challenging to identify in remote assessment settings. To reduce this difficulty as far as is possible the following measures have been taken:

Design Safety Features:

- The NHS Pathways recognition of cardiac arrest, breathing assessment and life support advice has been developed in conjunction with the [Resuscitation Council UK](#) (RCUK) and the National Clinical Assurance Group (NCAG).
- The starting position for every call is an assessment to establish whether the patient is in cardiac arrest. The NHS Pathway is not a diagnostic tool but a system to ensure emergency calls are adequately triaged. NHS Pathways training makes it clear to call handlers that if a caller describes anything other than normal breathing or if there is any doubt, then it must be assumed that the patient is not breathing normally and start telephone CPR.
- The system is designed with a safety feature so that, where a caller is unsure whether a patient is breathing, triage includes a check to confirm whether the patient is breathing in and out normally. This means if a health advisor selects that they or the caller is 'not sure', then the system will take the safest option and, in this instance, manage the patient as if they are not breathing in and out normally.
- If a cardiac arrest is not declared at the onset of call or identified via the Nature of Call (NOC), the NHS Pathways system will subsequently support the health advisor to identify patients who are unconscious. For unconscious patients, breathing assessment is prompted. The breathing assessment aims to identify those who are not breathing or who are not breathing adequately (defined as one breath in every ten seconds). A Category 1 emergency ambulance

disposition will be reached, and life support advice delivered, for those with absent or inadequate breathing.

- For patients who are unconscious, but who have been identified to be breathing with an adequate rate (in and out evenly with a minimum of one breath every ten seconds), a further question presents to identify those whose breathing is noisy due to possible airway compromise. This population also receive a Category 1 emergency ambulance disposition
- If a health advisor receives responses suggesting the patient has stopped breathing in and out regularly, even after the initial assessment, then they are able and are trained to go back and change the answers within the system regarding breathing. If the patient becomes unconscious and was not breathing regularly, then the caller would receive advice as above relating to administering basic life support (BLS) and using an available AED.
- A breathing rate of less than one breath every 10 seconds is used as a measure of inadequate breathing as this is a more identifiable and objective marker in remote telephony triage than clinical descriptions of agonal breathing for assessment between a non-clinical health advisor and a member of the public. NHS Pathways introduced this measure in 2020 to support the identification of agonal breathing which was agreed in conjunction with the Resuscitation Council UK.

NHS Pathways provides a comprehensive CPR training programme to health advisors and clinicians that supports the accurate and timely recognition of cardiac arrest, including cases where callers describe agonal breathing. As part of a CPR Toolkit, call handling staff receive structured cardiac arrest focused training, supported by audio clips of genuine agonal breathing and a range of example caller descriptions. NHS Pathways maintain a Hot Topic on agonal breathing, which is made available to all Providers to reinforce this crucial aspect of recognition. A “Hot Topic” is a short, focused NHS Pathways training resource used to reinforce key areas of triage practice across Providers.

A core feature of our existing training is the “No, No, Go” approach:

- Not conscious
 - Not breathing normally
- Start CPR immediately

Call handling staff are taught that any uncertainty about normal breathing in a collapsed patient should be treated as potential cardiac arrest, and the NHS Pathways system is designed to support that approach by guiding staff rapidly toward CPR instructions including directions on early AED use. In addition, NHS Pathways supplies Providers with CPR call-level data, enabling them to review relevant calls and identify opportunities for focused local improvement.

Additional measures have also been taken following learning from this case. In January 2025, NHS Pathways updated the triage so now anyone who collapses and becomes unconscious during exercise or sport, including those reported to be fitting,

would be presumed to be in cardiac arrest even if they seem to be breathing regularly. This update followed publication in the Resuscitation Council UK (RCUK) new best practice guidelines in December 2023, titled '[Resuscitation on the field of play](#)'. NHS England has informed Priority Dispatch Corporation (PDC) of this best practice guidance, and PDC is reviewing MPDS advice concerning the application of defibrillator pads to all unconscious patients after exercise or exertion.

Following Adam's death, NHS Pathways will enhance and reinforce the existing training by making specific reference to the circumstances and learning from this tragic event in both the next mandatory Release Training, which reaches all existing staff, and the CPR toolkit thus reaching future staff. Including reference to this case within our learning materials will ensure the lessons resonate as strongly as possible. This will be completed by 30th June 2026.

NHS England will work with the MPDS and NHS Pathways coding sub-groups to consider whether further measures should be taken to help members of the public recognise the signs of agonal breathing or cardiac arrest.

Understanding the use of defibrillators, particularly by lay people and trained first aiders

NHS England recognises the importance of rapid access to defibrillation and early bystander intervention in improving survival from out-of-hospital cardiac arrest. Early defibrillation, alongside prompt CPR, is a critical determinant of survival and can significantly increase the likelihood of a positive outcome.

We acknowledge the concern raised regarding the need for improved understanding and confidence in the use of AEDs among both lay persons and those with first aid training.

AEDs are designed to be safe and simple to use, with clear audible and visual instructions guiding users throughout the process. National guidance emphasises that AEDs can be used without prior training; however, lack of confidence or awareness may act as a barrier to their timely use.

NHS England works with system partners, including ambulance services and the [British Heart Foundation](#) (BHF) particularly through support for [The Circuit: the national defibrillator network](#) (which NHS England part-funds in partnership with the BHF). This enables ambulance services to direct bystanders to the nearest registered defibrillator where available.

Ambulance service call handlers also play a key role in supporting bystanders by providing real-time instructions on CPR and directing them to a nearby registered AED.

NHS England does not directly mandate or deliver public first aid training. However, we recognise the importance of ensuring that NHS staff have appropriate resuscitation skills. As part of wider statutory and mandatory training reforms, consideration is being given to strengthening BLS and AED training requirements across NHS staff groups, including those in non-patient facing roles (subject to final policy confirmation).

We will continue to work with partners across the health system and wider community to support awareness, accessibility and appropriate use of defibrillators.

The use of AEDs should be part of the training of all first aid staff and training is widely available through a variety of organisations including [St John's Ambulance](#) and the BHF. In this case, it appears that the first aiders did not recognise cardiac arrest and so did not start CPR. The BHF have campaigned prominently for more of the population to be trained in CPR and have provided online resources around this.

Cardiac screening availability

There has been no clear UK consensus on the benefits of screening of young people for participation in sport.

This topic is governed/decided by the National Screening Committee (NSC) and was last considered in 2019, at which point there was no UK consensus. It is due to be reviewed in 2026/27.

Communication about genetic or hereditary diseases

Evidence shows that not everyone who inherits a gene change associated with arrhythmogenic right ventricular cardiomyopathy (ARVC) will develop ARVC. So, a person can have the gene but never develop the actual condition. This is called “reduced penetrance.” The lifetime penetrance of ARVC is 30% to 50%. There is also variation in the severity of the disease – so some people with the gene will only ever develop a more mild form of ARVC. The age that ARVC starts also varies between people even in a single family with ARVC. However, with some genetic subtypes of ARVC lifetime penetrance is much higher. There are 5 higher risk genetic subtypes, and so there is a lower threshold for using Implantable Cardioverter Defibrillator (ICD) in people with those subtypes. Penetrance is highly related to level of sporting/physical activity.

Cascade communication and discussion about the option of genetic testing for the genetic change identified as causing ARVC in a family starts with close relatives or those considered at risk due to sporting activity and/or symptoms. Given the distant familial relationship between the individual in whom ARVC was initially diagnosed and Adam, it is likely that the Genetic Counsellor in Glasgow may not have known about Adam’s sporting history.

NHS England have reviewed your concern that cascade communication of genetic/hereditary disease “does not reach more than half of those in families that need to know about it” but have been unable to locate the literature or evidence where this originated. Information sharing between family members of a particular genetic risk of a condition will be different for different conditions.

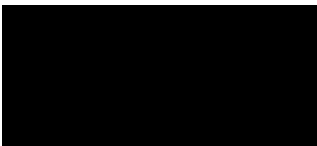
It is standard practice in Europe to cascade information about risk and testing options for genetic/hereditary conditions through family members. In other parts of the world (e.g. parts of Australia) a more proactive approach is taken by clinical services.

Currently, there is insufficient capacity and infrastructure for Clinical Genetics and/or specialist clinical services (e.g. Cardiology/Inherited Cardiac Conditions services) to actively contact family members outside of situations where a particularly high risk has been identified (e.g. individual potentially displaying symptoms and/or athlete undertaking intensive sporting activities at risk of ARVC). The Clinical Genetics service specification is currently being revised, and this will be considered as part of this work. This is an aspect of the clinical service where additional capacity and infrastructure may have the potential to reduce preventable morbidity and mortality. The "Clinical Genetics Transformation Programme", who are the group working on the new service specification and its implementation, will consider the ways in which this may be achieved.

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.

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
NHS England