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3 August 2026

Dear Ms Andrews,

Re: Regulation 28 Report to Prevent Future Deaths – Daniel Charles Forrest who died on 1 October 2025.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 15 June 2026 concerning the death of Daniel Charles Forrest on 1 October 2025. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Mr Forrest's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Mr Forrest's care have been listened to and reflected upon.

Your Report raised the following concerns:

1. The Southeast Coast Ambulance Service NHS Foundation Trust 'SECAMB' are incorrectly advising callers that an ambulance is being arranged, when any Category 3 or 4 dispositions are required to be validated by clinical staff before they can be added to the ambulance dispatch queue.
2. NHS Pathways does not allow callers to be advised of the estimated time that they may have to wait for ambulance attendance. SECAMB have requested that the wordings provided by NHS Pathways be altered so that there is provision to give further information to callers about how long they may wait for an ambulance to attend but this has previously been declined by NHS England.

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 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. Alongside this external scrutiny, NHS Pathways aligns its 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 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 while maintaining safety.

In telephone settings, 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 case is complex or unclear, health advisors are required to escalate to clinical colleagues. It is therefore a condition of the NHS Pathways licence (entered into by NHS 111 and 999 providers in order to use the NHS Pathways content) that clinical supervision and escalation support must be available 24/7.

Clinical alignment of Ambulance Response Codes between systems

In 2017 NHS England undertook a review of the categorisation of ambulance responses. This programme of work was known as the Ambulance Response Programme (ARP). Further information about this can be found here NHS England » Ambulance Response Programme. As part of this, and ongoing since, activities are managed by NHS England's National Ambulance Team to ensure the alignment of clinical scenarios between the triage systems in use in the sector. These activities are undertaken in partnership with the Ambulance sector.

The NHS Pathways system is developed and maintained by the Transformation Directorate of NHS England. The ambulance responses, or dispositions, are ratified by the National Ambulance Services Medical Directors (NASMeD). This is an advisory group to the Association of Ambulance Chief Executives (AACE), comprising the Medical Directors of ambulance services in England, Wales, Scotland and Northern Ireland. This group endorses the categorisation of ambulance codes across both AMPDS and NHS Pathways, and these codes are further ratified by the Emergency Call Prioritisation Advisory Group (ECPAG).

The purpose of the ECPAG is to advise NHS England, Department of Health & Social Care (DHSC) on issues of ambulance call prioritisation. Its principal remit is to recommend which disposition codes should be mapped to which ambulance responses. The Group membership consists of AACE, NHS England, NASMeD, ambulance Heads of Control and representatives of the principal triage systems.

1. Call handler advice that an ambulance is being arranged

Following review of a case, and categorisation to an ambulance dispatch category, the case is transferred to the ambulance service. The information captured in NHS Pathways may allow a clinician to reassess and re-categorise the call, depending on the clinical context. This can happen either without direct contact with the patient or following further contact. The Ambulance Trust's Computer Aided Dispatch (CAD) system, rather than NHS Pathways, is used to manage the validation process. So, for incidents that are eligible for clinical validation, any delivered call exit script should outline that patients may receive a call back from a clinician to conduct a further assessment and who may guide them towards an alternative pathway of care, and patients will be asked to keep their phone line free. However, if the clinician is unable to contact the caller, as in this case, then the original categorisation would still stand, ie an ambulance would be dispatched in line with that prioritisation.

2. Providing callers with an estimated waiting time

For 999 calls, all ambulance services should have in place call exit scripts and procedures for dealing with response delays when under operational pressure. NHS England has Resource Escalation Action Plan (REAP) levels which are used to manage operational pressures across ambulance services. NHS England supports a position that callers should be provided with sufficient information to make informed decisions, including whether an ambulance has been dispatched to the patient.

NHS England have been approached previously to provide a standard national script for instances where the Ambulance Response Programme (ARP) standards are not going to be met, and has worked with ambulance services to develop these. However, after deployment, due to the complexities of operational delays REAP levels and availability of clinical resource, NHS England were asked by ambulance services to reverse this work, and maintain operational information, such as wait times within emergency operations centres, as outside the remit of NHS Pathways triage. REAP level and rapidly changing operational factors can also impact which calls may be subject to clinical validation and need alternative instructions at different times, and how long an individual ambulance dispatch is likely to take. Therefore, these circumstances are now managed locally, by the individual ambulance services, following their own internal governance and Standard Operating Procedures (SOPs).

NHS England is aware that these situations are complex and difficult to manage. After reviewing the sequence of events described in the inquest, regarding the timing of contacts, we acknowledge the situation would have been deeply worrying for the family.

For the reasons provided above, operation information, such as wait times within emergency operations centres sits outside the remit of triage and is best placed to be dealt with locally by individual Ambulance Trusts.

As above the National Ambulance team have advised that for incidents that are eligible for clinical validation, patients should be advised that they may receive a call back

from a clinician for further assessment, who may direct them to an alternative pathway. Patients should be asked to keep their phone line free.

All ambulance services are required to provide appropriate exit scripts for Category 3/ Category 4 codes or dispositions. For 999 calls, ambulance services should have procedures and call exit scripts in place to manage response delays during periods of operational pressure. While the specific wording of exit scripts is determined locally, the scripts must include safety advice about what action to take if the patient's condition deteriorates.

NHS England supports a position that callers should be given sufficient information to make informed decisions, including whether an ambulance has been immediately dispatched to the patient or if a delay is likely due to demand or other operational pressures.

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 Mr Forrest, 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