Ms Melanie Sarah Lee
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National Medical Director
NHS England
Wellington House
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[redacted]

17th August 2026

[redacted]

Dear Ms Lee,

Re: Regulation 28 Report to Prevent Future Deaths – Muluembet Yohanes who died on 25 February 2025.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 17 June 2026 concerning the death of Muluembet 'Mulu' Yohanes on 25 February 2025. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Mulu's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Mulu's care have been listened to and reflected upon.

Your Report raised the following concerns:

1. London Ambulance Service (LAS) informed you that they have advised NHS Pathways of Mulu's case and recommended that neurosurgery be added to the supporting information for 'head injury' and 'vomiting' algorithms. You were unclear if this action had been agreed upon and what the timescales for are.

2. Without a dedicated pathway for 'neurosurgery', it is left to call handlers to choose the most appropriate pathway. 'Head injury' is not reflective of elective, non-trauma surgery.

3. Pathways does not include a question for post-discharge surgery patients about whether they have been given discharge, worsening or red flag advice by their surgical team.

Background on NHS Pathways

NHS Pathways 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. The tool also supports online triage and 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 NCAG. Alongside this external scrutiny, NHS Pathways aligns its content with up-to-date national clinical guidance, including guidance from the National Institute for Health and Care Excellence (NICE), Resuscitation Council UK and UK Sepsis Trust.

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 to identify 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.

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

Principles of Health Advisor Training

In telephone settings (calls made to NHS 111 or 999), assessments are conducted by specially trained non-clinical health advisors and in some cases by a clinician. These advisors complete a comprehensive, structured training programme to ensure they can use the NHS Pathways algorithms safely and effectively. If a case is complex or unclear, health advisors are required to escalate to clinical colleagues. The NHS Pathways licence (which NHS 111 and 999 providers must enter into in order to use the system) states that clinical supervision and escalation support must be available 24/7, and immediately accessible to health advisors during live calls. This clinical availability is a core system control.

Following initial core role training, both health advisors and clinicians are required to undertake mandatory training aligned to each new release of the NHS Pathways system, which typically occurs every 12 weeks. This ensures that staff remain up to date with any changes to clinical content, pathways, and system functionality. In addition, they have access to a comprehensive suite of ongoing learning resources, including ‘Hot Topics’, case studies and e-learning packages, which support continuous professional development and dissemination of learning.

Alongside this, providers are required to undertake regular quality assurance processes, including monthly audit of calls. These audits assess a range of core competencies, including the effective use of probing, and provide structured feedback to support ongoing development and safe practice.

Within NHS Pathways, health advisors are trained and expected to actively probe to clarify and refine the information provided by the caller. This is a fundamental component of the NHS Pathways model and forms an important part of its safety design.

A fundamental component of training is learning how to manage complex calls. The "complex call process" provides a clear protocol for health advisors to seek assistance or transfer a complex call to a clinician. This process should be followed in situations

involving declared medications, medical procedures, or terminology that complicates triage. A complex call is one which isn't straightforward, or where the Health Advisor is working at or beyond the limits of their knowledge or experience. This approach is reinforced by the training motto:

"If in doubt, shout."

1. Adding Neurosurgery to NHS Pathways algorithms at the recommendation of LAS

The NHS England NHS Pathways Team formally received the case on 30th July 2026. This was reviewed by the team on 31st July 2026.

In respect of the request, the algorithms do have 'key points' which help a health advisor know which pathway to use, and which are supported by an extensive training and mentoring package all health advisors must undergo before they are able to use the live system. This includes multiple scenarios to familiarise themselves with the range of different options.

However, a specific situation such as previous neurosurgery would not generally be added as a key point, and so the NHS Pathways team do not consider that this specific change should be made. The triage system uses a symptom-based approach rather than having separate specific routes for every possible medical procedure or medical condition, as it would not be practical or possible to add a question on every single possible scenario. This means that within the triage assessment different questions will be presented to establish symptoms of concern, and as noted above, serious and potentially life-threatening symptoms are assessed first to ensure rapid escalation, such as reaching an ambulance outcome or involving a clinician. The assessment then progresses to less urgent symptoms to identify 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. Therefore, specific situations or conditions are not referenced, as instead there are questions to identify symptoms that indicate onward need for care such as signs of confusion, drowsiness, not responding normally, as well as other symptom markers.

Instead, to address risks that may arise from such situations, and to cover the issue as in this case, where a patient has had recent treatment or been given specific advice in advance, NHS Pathways also has a clear route for callers who have what is referred to as 'Predetermined management plans.' All health advisors must complete training associated with this within their mandatory core module training. This includes scenarios of when this route applies including: 'Recent hospital discharge; Medical devices fitted e.g. pacemaker; chronic, terminal, rare or serious illnesses; Patient with other special needs'.

This route allows a caller to identify any symptoms related to any hospital discharge information (including recent neurosurgery) or instructions and allows onward referrals for an ambulance, Emergency Department attendance or returning to a specific ward for example. It also allows for referral for a further assessment by a doctor or health care professional. In light of this case, the NHS Pathways team will review this training

to ensure that the intended route to check whether patients may have such a predetermined management plan is as clear as possible.

Additionally, even if the predetermined management plan route was not followed and the recent surgery and post operative instructions were not shared, the triage pathway for vomiting and/or nausea with or without abdominal pain, also includes initial questions to ensure there are no 'red flag' symptoms such as, unconsciousness, signs of shock, respiratory distress/severe breathlessness which would lead to an ambulance outcome. The assessment then continues to establish any signs of concern such as confusion, breathlessness, vomiting blood, repeated vomiting and continues to ask symptoms markers until a level of care is reached. As above, recent neurosurgery itself is not a specific marker as the basis for the assessment relies on the symptoms presenting at the time of the call. However the assessment does contain a question asking a wider question relating to whether there has been any operation or surgical procedure within the last 7 days, which without any other symptoms of concern such as those mentioned (which may lead to a higher level of care) would recommend further clinical assessment.

2. 'Head injury' is not reflective of elective, non-trauma surgery

NHS Pathways have advised that **'**head injury' is not an appropriate pathway to assess vomiting unless the vomiting was associated with a head injury. However, as set out above there are a range of triage assessments for vomiting and/or nausea, with or without abdominal pain, and the 'Predetermined management plans' route is designed to pick up whether an individual patient should be assessed differently due to their specific circumstances such as recent surgery, as above.

Health advisors are also trained to probe to establish what is the main problem for the caller to ensure the best triage assessment option is taken.

3. Pathways does not include a question for post-discharge surgery patients of any discharge advice from their surgical team

The **'**Predetermined management plans' route described above does provide a route for those who have been given specific post-operative advice or a plan in the event of certain criteria. In view of this case, this route and the associated training is also being re-examined to ensure that it is considered by call handlers in cases where a caller does not specifically mention their recent surgery, or in case the potential relevance of this is not obvious, to ensure that the call is identified as complex and passed to a clinician for review.

Additionally, as above, if this route was not chosen and instead a caller had a symptomatic assessment there is a question within the relevant symptomatic triage assessments that asks if there has been any surgical procedure or operation within the last 7 days. This question may not be reached in all pathways as the system works on the symptom-based approach as described above and so symptoms detailed may result in an outcome being reached before this question is asked.

The outcome ‘to speak to a clinician in a local service within 2 hours’, as was reached in this case on 31 January at 16:00 hours, is an urgent referral for clinical assessment. We cannot comment on the workings of specific Clinical Assessment Services, but note that medical history should be a key factor in any clinical assessment.

We would also like to reassure the Coroner that the triage system does provide a route for when triage cannot be completed by a health advisor due to the caller being remote from the patient. Any such call flags the need for clinical review and local clinical management by the NHS 111/999 service receiving the call. This needs to be managed on a case-by-case basis as the potential situational factors are infinite and beyond the scope of triage.

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 Mulu, 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