

Mr Crispin Oliver,
Senior Assistant Coroner for
County Durham and Darlington
County Durham and Darlington Coroners Service
Crook Coroners Court
North Terrace
Civic Centre
Crook
DL15 9ES

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

4th September 2026

Dear Mr Oliver,

Re: Regulation 28 Report to Prevent Future Deaths – Andrew Edward Watson who died on 10th October 2019.

Thank you for your Report to Prevent Future Deaths (hereafter “Report”) dated 24th July 2026 concerning the death of Andrew Edward Watson on 10th October 2019. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Andrew’s family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Andrew’s care have been listened to and reflected upon.

Your Report raised the following concerns:

1. There are differences between NHS Pathways ambulance categorisation for choking due to a natural cause as opposed to a foreign object. The latter generates a category 1 response and the former, as happened in Andrew’s case, only a category 2.
2. A call made by the patient themselves as opposed to a third party means a lower categorisation will be reached via NHS Pathways.
3. A life threatening condition which was preventable with critical care intervention, but fatal in Andrew’s case, was assigned to a category 2 ambulance response rather than to category 1.

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 (calls made to NHS 111 or 999), assessments are conducted by specially trained non-clinical health advisors. These advisors complete a comprehensive, structured training programme to ensure they can use the NHS Pathways algorithm 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 and a stipulation of the licencing agreement

Clinical oversight of Ambulance Response Codes

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 [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 principle triage systems.

1. Categorisation of choking due to natural causes as opposed to a foreign object

Without access to the call recording, NHS Pathways is unable to comment further on the specific information provided during the call or the exact route taken through the assessment in this individual case. However, it may be helpful to clarify how NHS Pathways manages presentations described as “choking”, and how this differs between first-party and third-party calls.

Clinically, choking is usually understood as an acute obstruction of the upper airway that impairs or prevents effective breathing. It may present as partial or complete airway obstruction distinguished by symptoms such as ineffective coughing or inability to speak. Within NHS Pathways, the term “choking” generally refers to foreign-body airway obstruction, such as food or another solid object obstructing the airway. This differs from airway compromise caused by other mechanisms, such as severe swelling, abscess formation, anaphylaxis, trauma, or tumour. These presentations may cause significant airway or breathing difficulty, but they are not managed in the same way as foreign-body choking because the mechanism, and therefore appropriate first-aid advice, differ.

In a first-party assessment, after establishing whether there is any immediately life-threatening bleeding, NHS Pathways asks whether the patient is “so breathless that speaking more than a few words is impossible”. This question is intended to identify patients who are struggling severely for breath and are unable to complete sentences because of the degree of breathlessness. If the patient does not have a neck breathing tube apparatus in place and confirms that the breathing problem came on suddenly, the system then asks whether they are choking on a piece of food or a solid object. Where foreign-body choking is identified, this generates a Category 1 ambulance response and presents specific first-aid advice intended to help relieve the obstruction. However, that advice is designed for obstruction caused by a physical object and would not be appropriate or effective where the airway compromise is caused by swelling, infection, abscess, or another non-foreign-body cause.

A patient may describe feeling as though they are choking even where there is no foreign object obstructing the airway. In those circumstances, NHS Pathways focuses on the presenting breathing or airway concern and considers other relevant causes, including asthma and allergic reaction. Without the detail of the call, NHS Pathways cannot confirm which specific questions were presented or how they were answered. However, changes to the system since the time of Andrew’s call include insertion of a question relating to rapid swelling of the tongue or throat in the context of possible allergic reaction. If answered yes, this may generate a Category 1 ambulance

disposition. Where the airway concern is not considered to relate to anaphylaxis or foreign-body obstruction, if the patient is conscious but there is a breathing difficulty, the system will reach a Category 2 ambulance disposition for Respiratory Distress.

The identification of 'abnormal breathing' is challenging over the telephone; therefore Health Advisors are encouraged to listen to the breathing pattern and listen for red flags such as the patient gasping, being described as barely breathing, taking odd gulps of air or turning blue or grey. They are advised that if there is any doubt they should assume the breathing is not normal. If at the start of the assessment the patient has been assessed as conscious and 'breathing normally' and this situation then changes i.e. the patient becomes unconscious or stops responding, the Health Advisor will 'early exit' and further questions will present to ascertain whether a life threatening situation is unfolding which could result in escalation to a Category 1 ambulance disposition for a possible respiratory or cardiac arrest.

The Category 2 disposition for Respiratory Distress reflects the agreed clinical position that an 18 minute response is appropriate. NHS Pathways dispositions reflect this and do not vary to take account of local, operational delays which are managed locally by the individual ambulance services, following their own internal governance and Standard Operating Procedures.

2. Categorisations in calls made by patient opposed to third party

In response to the concern that a patient may receive a lower ambulance response category when making the call themselves, NHS Pathways clinical content does not use a patient's ability to place the call themselves as a factor to reduce the disposition category assigned. NHS Pathways assesses the symptoms and level of compromise identified during the assessment, regardless of whether the patient or a third party is speaking to the Health Advisor. However, the clinical information available during a first-party call may differ from that available when a third party is describing a patient who is unable to speak, unresponsive, or not breathing normally, for example. The ambulance disposition category is therefore determined by the presentation identified during the assessment, rather than by who places the call.

The Category 2 disposition for Respiratory Distress reflects the agreed national clinical position for a patient who is able to communicate to some degree (whether directly with the health advisor or with a third party caller) at the time of assessment, and does not have other symptoms requiring a Category 1 disposition. Category 2 calls are for serious conditions that may require rapid assessment and urgent intervention, but which are not immediately life-threatening cardiac arrest-type presentations (Category 1). Common examples of other Category 2 dispositions include stroke, sepsis, burns, epilepsy and chest pain. The national standard is an average response time of 18 minutes, with 90% of responses within 40 minutes. Of course, there is always a risk of clinical deterioration which is why the delivery of 'worsening advice' is very important and reassessment may result in an upgraded ambulance categorisation.

Safety-netting advice is always provided during such calls, including advice to call back if the patient's condition worsens and a call back in this situation would result in a re triage of presenting symptoms and potential escalation of ambulance disposition. Once the request for an ambulance dispatch has been made i.e. the ambulance disposition has been reached the NHS Pathways system asks if there is someone available to be with the patient until help arrives. This is then recorded in the reporting notes, so if this information is viewed, the ambulance service will more accurately be able to assess risk associated with patients' being on their own, i.e. deteriorating conditions, or if they need to re contact the patient for any reason and the patient does not answer this will of course raise an additional level of concern.

3. Categorisation of a life-threatening condition

We cannot comment in detail on the presenting systems and handling of Andrew's specific call as we do not have access to it, but categorisation of respiratory distress symptoms and response to caller identity are as set out in our responses to matters of concern 1 and 2.

Whilst a peritonsillar abscess may progress and can result in worsening airway compromise, ambulance prioritisation is based on the patient's presentation at the time of assessment. In this case, from the limited information we have received, the patient was reported to be conscious and able to speak, indicating that the airway was not completely obstructed at that point. The presentation therefore met the criteria for a Category 2 emergency ambulance disposition. As with other acute conditions, any subsequent deterioration or emergence of features indicating an immediately life-threatening airway emergency would be expected to prompt reassessment and escalation of the response priority where appropriate.

To allocate a Category 1 disposition solely because deterioration might occur would not be consistent with the principles of clinical triage or national ambulance response standards. Where additional information becomes available, or the patient's condition worsens, the response may be clinically reviewed and upgraded accordingly.

By way of comparison, a conscious patient with severe crushing chest pain suggestive of a myocardial infarction receives a Category 2 ambulance disposition. Whilst such a patient may subsequently deteriorate and suffer a cardiac arrest, requiring a Category 1 disposition, ambulance prioritisation is based on the patient's clinical presentation at the time of assessment rather than the possibility of future deterioration.

In summary, the ambulance response categorisations used within NHS Pathways are subject to external clinical review and sign-off by the relevant national bodies described above. Accordingly, the ambulance response category is determined by the clinical presentation established through the assessment process and the information available at the time of the call, which does not include whether the caller is the patient or a third party, nor allows for local operational service delays.

Ambulance Response Times

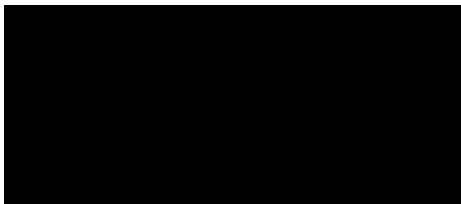
NHS England recognises the ongoing pressures across urgent and emergency care, including ambulance services. Through the [2025/26 Urgent and Emergency Care Plan](#) and the [10 Year Health Plan for England](#), NHS England and the Department of Health and Social Care have set out a programme of improvement focussed on reducing ambulance response times, eliminating handover delays over 45 minutes, ending corridor care, improving hospital flow and discharge, and expanding access to urgent care services across primary, community, and mental health settings. These plans are supported by significant national investment, including national activity growth funding for ambulance services to support increased demand and accelerate delivery of agreed performance improvements.

NHS England remains closely engaged with all ambulance services, including the North East Ambulance Service (NEAS), to support delivery of agreed improvement plans. Since October 2019, NEAS has demonstrated sustained improvement in ambulance performance, with average Category 2 response times improving from 32 minutes 17 seconds to 21 minutes 14 seconds, and 90th centile Category 2 response times improving from 66 minutes 10 seconds to 41 minutes 29 seconds by October 2025. NEAS' 2026/27 year to date mean Category 2 response time is 19 minutes 04 seconds and the 90th centile Category 2 response time is 38 minutes 14 seconds.

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 Andrew, 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