



Mr Benjamin Myers KC
His Majesty's Assistant Coroner
Greater Manchester South Coroners Court

LADYBRIDGE HALL
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By Email Only

nwas.nhs.uk

21 April 2026

Dear Mr Myers

Regulation 28 Report – Inquest Touching the Death of Yunus Hoque

I write further to your Prevention of Future Deaths Report dated 26th February 2026, which was issued to North West Ambulance Service (“NWAS”) following the conclusion of the inquest touching the death of Yunus Hoque.

I am aware that you will share my response with Yunus’s family, and I firstly wish to express my sincere condolences to them. NWAS’ core purpose is to save lives, prevent harm and provide services which optimise the likelihood of positive patient outcomes.

Through the Regulation 28 report, you have requested that NWAS considers your matters of concern and have suggested that action is taken to prevent future deaths occurring in the future. By this letter I will address those concerns as far as I am able.

The absence of any system for a follow-up call by or on behalf of NWAS in circumstances where an unforeseen delay in ambulance attendance is going to be far in excess of that indicated to the caller, creates a risk that further deaths could occur, given that during this period a patient may deteriorate and their categorisation can move to Category 1 from a lower category.

I can confirm that since Yunus’ death in January 2024, NWAS has implemented a number of steps to ensure more accurate estimated time of arrival information is provided to callers. Previously, estimated times of arrival were provided based on information taken from across the whole geographical area of the Trust. NWAS has since moved to providing estimated times from each of the areas within the Trust: North Cumbria, South Cumbria and Lancashire, Greater Manchester, and Cheshire and Merseyside. This provides the caller with a more accurate estimated time of arrival, as the different regions of the Trust experience different demand challenges throughout the day.

In addition, following consistent monitoring to ensure the most accurate reading is taken to provide this information, it has been concluded that the ‘mean’ time provides the most accurate information which is now used across NWAS.

When patients are waiting for an ambulance, I can confirm that the calls are regularly reviewed by senior clinicians

within our Contact Centres for potential deterioration. All waiting calls are also prioritised by these senior clinicians to ensure our ambulances are sent to our most critical patients as a priority.

Unfortunately, this does not mean that we are able to provide an exact time of arrival for an ambulance, due to constraints on demand and the requirement to dispatch ambulances to the most critical patients in order of need. The reality is, with the finite resources available to the Trust, if NWAS were to carry out call-backs to patients to update them on unexpected changes to their estimated time of arrival, it would reduce our capacity to answer 999 calls for other patients and to provide essential information to callers.

However, prior to the closure of each call, we provide interim care advice which gives the caller advice on how to care for the patient until the ambulance arrives. Full worsening advice is also provided, advising the caller to contact 999 straight away if there are any changes in the condition of the patient, if they are worried about the patient, or if they have any other concerns. This creates the opportunity for the patient's condition to be re-triaged and the appropriate categorisation to be elicited for their symptoms and condition.

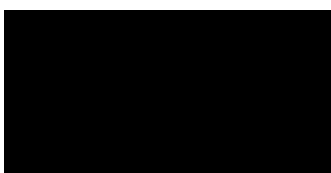
In our experience, the most effective way to minimise waiting times and reduce anxiety for callers is to provide the most accurate estimated time of arrival possible at the time of the call, provide clear worsening advice, maintain clinical oversight of all waiting calls and reprioritise them based on clinical need, and maximise ambulance availability by using the full range of alternative care pathways across the North West.

Nevertheless, I can confirm that NWAS are currently exploring the use of SMS text messaging to patients who are waiting for an ambulance or a further clinical assessment from an NWAS clinician or external provider. This work is in the initial stages but will provide improved information to our callers whilst they await a response.

In addition to the above I would like to highlight that NWAS has made significant improvement in its Category 1 and 2 response times since Yunus' death. This has been achieved by improving the number of responding ambulances available for dispatch by employing more Paramedics and Emergency Medical Technicians. We have also increased the number of clinicians telephoning patients to complete a full clinical triage and referring into alternative pathways of care. This enables our responding ambulances to attend to our most critically unwell patients who require a Category 1 or 2 response.

I am grateful to you for bringing this matter to my attention and I am sorry that you felt it necessary to issue a Prevention of Future Deaths Report to NWAS. If you require any further clarification or information, please do not hesitate to contact me or the Trust's Deputy Director of Corporate Affairs, Emma Shiner.

Yours sincerely

A solid black rectangular box used to redact the signature of the Chief Executive.

Chief Executive