



Mr Andrew Cousins
His Majesty's Assistant Coroner
Cumbria Coroners Court

LADYBRIDGE HALL
399 Chorley New Road
Bolton
BL1 5DD

By Email Only

nwas.nhs.uk

14 May 2026

Dear Mr Cousins

Regulation 28 Report – Inquest Touching the Death of Jardine Williams

I write further to your Prevention of Future Deaths Report dated 16th March 2026, which was issued to North West Ambulance Service (“NWAS”) following the conclusion of the inquest touching the death of Miss Jardine Williams.

I am aware that you will share my response with Miss Williams’ 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. Within this letter, I will address those concerns raised as far as I am able.

Concern 1: You found that “the flow of information and communication between NWAS and CHOC was unclear and at times appeared to be confused. The information passed to CHOC at the outset, following the 999 call, appeared to be limited and may not have provided the receiving handler with the full picture of the situation”. You were concerned that full and accurate information was therefore not passing between NWAS and CHOC.

As acknowledged by the NWAS Service Delivery Manager during the inquest, and reiterated here for the purposes of this response, the initial transfer of Ms Williams’ call by NWAS to Cumbria Health On Call (CHOC) should not have occurred as the NHS pathways triage indicated a risk of suicide, which is an exclusion to CHOC triaging the call.

The call was made by Ms Williams to NWAS at 17:16hrs on 24th March 2025. The call was passed to CHOC, albeit in error, at 17:40hrs via the Interoperability Toolkit (ITK), which is a method of electronic referral. The transfer of information via ITK relies on the NWAS clinician selecting what they consider relevant for the receiving provider. As a result, it does not enable full transfer of the assessment or all associated information.

It is acknowledged that additional details were recorded during the call which, if shared, would have provided further clarity and context. However, ITK does not support the transmission of complete clinical notes from the 999 call. Booking and Referral Standard (BaRS) is an alternative software solution which offers this functionality and is used between NWAS and the Greater Manchester Clinical Assessment Service (GMCAS).

The BaRS connection between NWS and the GMCAS was implemented as part of a user case and test of change for NHS England, however, BaRS is not yet universally standardised across all providers. ITK remains the current national interoperability standard. BaRS is expected to replace ITK as the national standard; however, this transition is being directed at a national level, and there is no confirmed implementation date at this time. As such, all systems continue to operate under the existing ITK requirements until formal national instruction is issued.

Concern 2: You state “thereafter between 18:14 and 18:54 hours, 4 attempts were made by CHOC to call Miss Williams, but no successful contact was made. At 19:48hrs, NWS called CHOC for an update regarding Miss Williams. I heard evidence that as per the agreed procedure, a third and final attempt at contact would be made. By this stage however four unsuccessful attempts had already been made to contact Miss Williams, and the third attempt to contact her had been made at 18:25hrs”. You considered that the flow of information between CHOC and NWS appeared to have confused the issue.

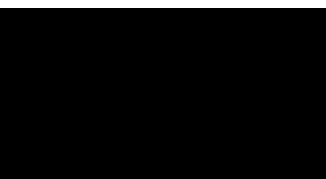
The call from Ms Williams to NWS was correctly categorised as a Category 3 at 17:20 and reviewed by a senior clinician at 17:32, within the 15-minute target time for clinical review. Although erroneously transferred, the agreement in place between NWS and CHOC states that upon receipt of a referral, CHOC are to contact the patient to conduct their own triage. Should the patient not answer the telephone, a further two attempts should be made, following which the call should be passed back to NWS. In line with our respective responsibilities, NWS called CHOC for an update at 19:45 and were informed by the CHOC call handler that only two attempts had been made to contact Miss Williams and a third attempt would be made prior to CHOC passing the incident back to NWS. CHOC confirmed in their evidence, dealt with at inquest under Rule 23 of the Coroners (Inquests) Rules 2013, that between 18:14 and 18:54 hours, they had made four attempts to contact Ms Williams, each without success. The information provided to NWS on this occasion was therefore incorrect. At 20:43, NWS chased CHOC again and were informed a third call had been made with no answer and the CHOC clinician requested a Category 3 ambulance. The ambulance arrived on scene at 20:58, and after obtaining access with the assistance of the fire service, Ms Williams was sadly found to be deceased at 21:25.

Since this inquest, NWS’ Mental Health Liaison Lead contacted CHOC to review the incident collectively. This review was undertaken with CHOC’s Medical Director and Digital Operations/Programme Manager. CHOC have acknowledged the evidence already provided by NWS that the incident should not have been transferred to CHOC due to the identified risk of suicide and that the information provided on this occasion ought to have contained more context. It was also acknowledged by CHOC that, as the incident was categorised as a Category 3 response, it should have been returned by CHOC following the third unsuccessful attempt to make contact, which did not occur.

NWS and CHOC work closely in partnership and place significant emphasis on effective communication between our organisations. Call pathways and incidents are routinely reviewed to maintain a strong governance framework and to support ongoing service improvement. The continued collaborative communication and incident review processes between NWS and CHOC demonstrates our shared commitment to delivering the highest standards of care and to learning from all available opportunities.

I am sorry that you felt it necessary to issue a Prevention of Future Deaths Report to NWS. If you require any further clarification or information, please do not hesitate to contact the Trust’s Deputy Director of Corporate Affairs, Emma Shiner.

Yours sincerely



Chief Executive