REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Jacqueline DEVONISH, Senior Coroner, for the coroner area of Cheshire.
2.	**DATE OF REPORT** 10 June 2026
3.	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
4.	**THIS REPORT IS BEING SENT TO** North West Ambulance Service (NWAS) You are under a duty to respond to this report within 56 days of the date of this report, namely by July 31, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	**YOUR RESPONSE** Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
6.	**SUMMARY OF CORONER'S CONCERN**

	The ambulance service declined to attend a 'welfare call' to the home of an elderly resident which had been raised by an organisation commissioned specifically to confirm daily contact with the resident. The reason provided for declining to accept the call was that it was not known whether the resident was inside the address.
7.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	**INVESTIGATION AND INQUEST** On 27 January 2026 I commenced an investigation into the death of Lesley Katherine HIGGINSON aged 72. The inquest concluded on 4th June 2026.
9.	**CIRCUMSTANCES OF DEATH** Ms Higginson, a medically vulnerable adult, was found deceased at her home address on 18 January 2026 following a concern for welfare raised by neighbours. Due to a desire to remain in her own home and not be attended by carers several times a day, Adult Social care arranged a package of care through SOS Homecare including medication management (epilepsy and other medication) and remote welfare checks. Alertacall, was commissioned to ensure remote contact with her on a daily basis through a call button service known as the Okay Each Day Service. Alertacall had been unable to speak to her over the weekend she died. Mrs Higginson also benefitted from a remote medication delivery service, The Medication Support Company. A new medication safe and computer screen had been installed in her home on 13 January 2026 which was operated remotely at fixed times of the day. She had not answered the calls on Friday 16 January resulting in a team member visit to her home. She was present. On Saturday 17 January there was no contact with her by the medication team, and in accordance with the medication support policy an escalation visit would be due after 24 hours of no contact. A plan was made to visit to check on her welfare on Sunday 18 January but she had died prior to this visit being conducted. In accordance with Alertacall policies and prior agreement with Mrs Higginson, a neighbour was contacted on Saturday 17 January and asked to conduct a welfare check. The neighbour, reported back that contact had not been established. Alertacall then escalated to the emergency services. The police declined attendance for a welfare call. The ambulance service accepted the welfare call initially but later called back rejecting the request to attend stating it was not their policy to accept welfare checks if there is no confirmation someone is in the property. Alertacall recontacted the neighbour who then

	reported having seen Mrs Higginson out riding her scooter with the dog that day. The escalation was closed having established contact with a neighbour. On Sunday 18 January, there was no answer from Mrs Higginson to Alertacall and the neighbour raised concerns confirming that emergency services had been contacted. The ambulance service arrived at 12:34, and entry was forced by the Cheshire Fire and Rescue Service, finding Mrs Higginson deceased on her bed, and confirmed her death at 13:03.
10.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: Mrs Higginson benefitted from a care package designed for her independence and welfare, engaging a remote means of making daily contact with her in the least intrusive manner. Failed contact was followed up by a call to the ambulance service which indicated that they would not attend. It is important to know whether there is an established policy for declining welfare calls, and if so, when it was introduced. It leaves patients in a difficult position when aligned with the constabulary Right Care Right Person (RCRP) policy which was published nationally on 23 June 2023 and implemented in the Cheshire region in January 2024. The RCRP policy states that the police in Cheshire (and in other areas nationally) will not respond to welfare check calls when healthcare are best placed to support those who may be in crisis. It is unclear from the ambulance service response whether a request for a welfare check, in the circumstances of this death, is to be deemed to be healthcare related and whether the ambulance service properly rejected the request, on the grounds stated.
11.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: • **Next of kin** • **Director of Alertacall** • **The Medication Support Company** • **Cheshire East Adult Safeguarding** • **Cheshire Constabulary** I also have a duty to send a copy of the report to the Chief Coroner.

	You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	**SIGNATURE**  **Jacqueline DEVONISH** **Senior Coroner for** **Cheshire**