Kally Cheema LLB | Senior Coroner | Cumbria

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Case Ref: [redacted]

8 July 2024

To: [redacted], Chief Executive Cumbria Health [formerly CHOC]

[redacted], Practice Manager Carlisle Healthcare

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I am Dr Nicholas Shaw, HM Assistant Coroner for Cumbria

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.

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http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 8th February 2024 I commenced an investigation into the death of Michael HUGGON who died in Cumberland Infirmary, Carlisle on 7th February 2024 aged 75. The investigation concluded at the end of the inquest on 4th July 2024. The conclusion of the inquest was

3 Death from natural causes. The medical cause being registered as:

1a Cardiac Arrest

1b Hypovolaemia

1c Spontaneous Gastrointestinal Haemorrhage

II Atrial Fibrillation

CIRCUMSTANCES OF THE DEATH

4 **Michael Huggon had been in declining health following a stroke some 9 months before he died, he was found to be in atrial fibrillation at that time and was anticoagulated with Edoxaban to try to prevent a recurrence. He had also been newly diagnosed with interstitial lung disease. On 6th February he was very unwell and his wife rang her GP surgery -Carlisle Healthcare at 14.15 to request a home visit and was told a doctor would ring her back. I was told that after receiving this**

request her call was reviewed by a triaging doctor who then passed it to another doctor to call her back. The call back took place at 18.06 when Mr and Mrs Huggon were told that it was too late to have a visit and that they should call the after hours service -Cumbria Health by way of the 111 service after 18.30.

111 was contacted and an automated voice told the Huggons there would be a 40 minute wait -they took it in turns to hold the telephone awaiting a reply. Eventually 111 spoke and said an ambulance would be sent. Shortly after this Cumbria Health rang to let the couple know there would be yet another call to see if an ambulance was required, this call was prompt and they were told a doctor would visit. The duty doctor arrived at about 21.00 and immediately saw that Michael was extremely anaemic and required emergency admission to hospital -however despite repeated advice he declined and was deemed to have capacity to do so. A nursing call the following day was therefore promised to take a blood count

Sadly Michael collapsed on the toilet shortly after midnight in cardiac arrest, despite prompt and extensive attempts to resuscitate him my his wife, a neighbour, ambulance staff and in the hospital emergency department he was pronounced deceased. A blood test on arrival at hospital indicated a haemoglobin level of just 48 g/L -profound anaemia.

CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

[BRIEF SUMMARY OF MATTERS OF CONCERN]

(1) I was told at the hearing that it is now normal practice for any work unfinished by surgery closing time is left to the after hours service and that GPs no longer "call in on the way home". In this case there was no handover and the Huggons had to start their patient journey all over again -with a long delay to even speak to 111. The process was slow and inefficient with multiple doctors an call handlers involved [by my calculation 4 call handlers/receptionists, 1 nurse and 3 doctors]. I was previously aware that many ambulance calls promised by 111 are sent to Cumbria Health for re-triage to try to prioritize resources. The response from Carlisle Healthcare to a request for urgent help was in my view inadequate, however when Cumbria Health were eventually involved their response was timely. I suspect Michael was exhausted and almost beyond caring when he declined admission in the evening, but feel it is most likely that had he been seen and admitted to hospital earlier he could have received a blood transfusion and would not have died.

(2) Given the above I am concerned that future deaths may occur if urgent requests are not dealt with more promptly, and that if a practice can not deal with its workload a rapid and secure handover process is put in place. I am also concerned that referral to 111 will continue to bring delays and place undue pressure on that service.

(3) It is not within my authority as a coroner to suggest what action might be taken but I would be happy to discuss this matter informally if it might help.

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you and your organizations have the power to take such action.

YOUR RESPONSE

7 You are under a duty to respond to this report within 56 days of the date of this report, namely by 3rd September 2024. I, the coroner, may extend the period.

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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted] and [redacted].

8 I am also under a duty to send the Chief Coroner a copy of your response.

The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

8 July 2024

9 Signature 

Dr Nicholas Shaw HM Assistant Coroner for Cumbria