JAMES THOMPSON
Assistant Coroner for Northumberland

County Hall, Morpeth, Northumberland NE61 2EF
Tel 01670 622600
Email [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Chief Executive, NHS England
1	**CORONER** I am James Thompson, Assistant Coroner for the coroner area of Northumberland.
2	**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. http://legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 17th July 2024 I commenced an investigation into the death of Malcolm Morris, 63 years. The investigation concluded at the end of the inquest on 16th August 2025. The conclusion of the inquest was that Malcolm Morris died on 5th January 2024 at [redacted] Northumberland. A narrative conclusion was recorded. The medical cause of death was - 1a Pulmonary Embolism 1b 1c 1d II Lymphoedema complicating right Inguinal Lymph Node Dissection for Squamous Cell Carcinoma plus Obesity
4	**CIRCUMSTANCES OF THE DEATH**

	Mr Morris was diagnosed with penile cancer in May 2023 and underwent necessary surgery to remove it, he suffered with repeated infections which required further treatment & surgery to address this. In July 2023 he had a right inguinal node dissection to arrest the spread of the cancer. He was seen to be infection free by November 2023. He was seen post operatively to develop lymphoedema which is a recognised complication of the surgery. He was referred for treatment of the lymphedema. This amongst other treatments required the wearing of compression garments. At an assessment of his lymphoedema on 3rd January 2024 his right thigh was seen to be swollen. On examination the compression garment was not located in a way that applied pressure to his right thigh. He displayed no symptoms suggestive of a deep vein thrombosis including pain. It is not possible on the evidence to say if a deep vein thrombosis was present at that time. On 5th January 2024 after complaining of pain in his right thigh he collapsed and died. His death was due to a pulmonary embolism which is a naturally occurring disease running its full course and resulting in his death.
5	**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 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. Mr Morris required various periods of hospital admission in Sunderland for elective and also urgent surgery. This was in part to address his cancer and also to treat recurrent wound infections arising from his surgery. Sunderland Royal Hospital is a regional centre for the cancer Mr Morris suffered with. He resided in Northumberland which is outside the usual catchment area for the hospital trust. Upon discharge from hospital in Sunderland, staff were unable to refer him electronically to district nursing services in Northumberland. They had to resort to telephoning the service to make a referral and were unable by this route to pass the necessary information to the service. As a consequence, Mr Morris left hospital requiring catheter care and wound management. He did not initially receive district nursing support. His wound became infected and required readmission to hospital. His catheter bag became full and he, nor his family had any guidance on what action to take. Evidence I heard at inquest described that hospital systems were unable to communicate with healthcare systems outside of the immediate geographical area and as such efficient referrals to district nursing services were not possible.

	This meant detailed information on Mr Morris's discharge arrangements and ongoing treatment could not be passed and ultimately district nurses relied on inadequate brief paper-based discharge documents. In Mr Morris's case he was supported and cared for by his wife and family. They sought advice and made contact with the district nursing services themselves to affect a referral, after the absence of nursing support following his first discharge from hospital. My concern is, had Mr Morris been discharged without any support from his family, lived alone or been vulnerable in some way, he may have not been able to access nursing services. Even with family support, his wound became infected and required readmission to hospital. My concern is other persons may be at risk of death if discharging hospitals cannot efficiently, comprehensively and in a timely fashion refer patients to ongoing care in the community. The evidence I have heard is this is an issue which is not confined to individual hospital trusts and is based on the ability of technology to 'talk to each other' across various NHS services. Given Sunderland Royal Hospital is a regional centre for penile cancer it means patients are treated there who are not living in the usual catchment area for the trust, and as such situations such as this with patients living out of the area must occur regularly.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 16th July 2025. 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the following Interested Persons - The family of Mr Malcolm Morris South Tyneside and Sunderland NHS Foundation Trust Northumbria Healthcare NHS Foundation Trust St.Oswald's Hospice Limited I am also under a duty to send a copy of your response to the Chief Coroner and all Interested Persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.

9	21st May 2025 Signed: James E Thompson HM Assistant Coroner for Northumberland