CumbnaHealth

[redacted]

20th August 2025

To Or Nicholas Shaw

[redacted]

Dear Dr Shaw

Coroners Regulation 28 Report
Patient: TM
DOB: 05/03/1945
Date of Death: 23/11/2024

I am responding to the Regulation 28 Report to prevent future deaths as outlined in your letter of the 30/6/25

The Regulation 28 relates to the case of the late Thomas Mallinson who died on the 23/11/24.

The summary of matters of concern as documented is below:

To Cumbria Health (CH) - Thomas's case was sent electronically to the service, marked for 2-hour attention. I appreciate why this did not take place as it was impossible for clinicians on night duty to triage a large number of calls waiting while actually visiting and treating their caseload. I note a new "OPEL" system has since been instituted to try to escalate and get extra help as the number of calls waiting increases, but where will these extra resources come from overnight? I am also concerned that the referral from NWAS came as a result of a 999-emergency phone call but there seemed to be no way of telling NWAS that the call had not been dealt with and (presumably) passing responsibility back to them. As referred to above - where does responsibility lie?

I have responded taking each concern separately

1. At inquest and in my statement, I outlined a new updated escalation policy (attached). Within this policy there are steps to be taken to request extra clinical triage assistance The Control Room will send a text out to Clinicians but there is no requirement for any of the receiving Clinicians to respond to the request There are no financial constraints (within reason) to this part of the escalation policy Getting Clinicians to work extra over night shifts is understandably challenging, but we do find that some evening Clinicians are able to extend their shifts into the early hours We therefore do our best to add extra resources where we can at times such as those in November 2024 where we know there was pressure on all system partners (particularly NWAS and the Emergency Departments) due to the high number of respiratory cases in the community It is also important to note that at that time there was no winter pressure

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funding available to support the system which in previous years has come in the form of funding for additional Out of Hours staffing and/or the setting up of community Respiratory Infection hubs to reduce pressure in the daytime for North Cumbria practices and ourselves. These were commenced but not in the period in question.

In terms of the updated policy, we have put in place a clear process for managing calls that we cannot deal with overnight to reduce the risk of simply handing them all back to the daytime GP practices (page 13 in Clinical Operational Policy).
We now provide a welfare call to patients in the overnight period in whom we have breached their response times. If there are concerns of deterioration then the case is escalated to a Clinician as priority. As discussed at inquest we will be adopting an automated text system to do the welfare checks with Adastra (our patient record software provider) when it becomes available which we understand will be by the end of the year.

2. The responsibility for the case of TM lay with CH after it had been passed to our organisation We held a joint case review with NWAS, and they stated that they can get over 200 such calls daily across their area (999 triage that come directly to CH with no allocation of an ambulance) and policing such calls would not be possible Once the case comes into the CH system it sits with us as responsible organisations. As documented in my statement and at inquest I acknowledged that the triage volume made it challenging to manage ail the cases that came into CH that period. CH has no cap on its capacity and if the demand outstrips the capacity our actions are focussed on risk mitigation which the updated policy addresses.

   In other case types we receive from NWAS (those cases that have been allocated a Category 3 or 4 ambulance that requires revalidating to see if the case can be dealt with by primary care and not need an ambulance) there is a robust system for safety netting. The case remains visible to NWAS. If the time response from CH breaches (a Category 3 response from CH is 30 minutes and a Category 4 is 60 mins), then the CH Control Supervisor will automatically hand these cases back to NWAS. There is an additional safety net which involves NWAS checking that the case has also been addressed within those timelines and they will see if CH has not managed the case (which may include handing back to them). NWAS would in such cases contact CH to get an update on the situation.

   Other actions taken so far
   1. CQC have been informed of the receipt of the Regulation 28 and discussions have taken place
   2. The ICB have been informed of the receipt of the Regulation 28. I have had meetings with their quality team looking at how we manage the “shoulder time" at the daytime practice/Out of Hours interface These discussions are ongoing as currently there is no formal agreement on how cases are managed and I have raised the possibility with the ICB about an MOU with all practices that would

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enable both parties to manage the risk of handing over cases to each other. Part of this was a meeting with the Chair of the LMC on the 13/8/25.

3 The ICB have arranged a SUI meeting with the daytime practice in question leading This has not happened as yet but is planned for September 2025.

In summary, the systems involved in dunng the period of time for TM did function in that the case was sent correctly to CH, but our workload outstripped our capacity to deal with the case in the response time required. We did attempt to contact the patient's wife at approximately 6 am but the Clinician was called way to what was deemed a more urgent case.

Our actions have centred on mitigating this risk to prevent such events happening again and we continue to work collaboratively with the ICS on managing the challenges of the winter's clinical pressures.

I would be happy to provide any clarification if needed.

Yours sincerely

[redacted]

[redacted]

Medical Director

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