Providing NHS services

Regulation 28 Response

Carlisle Central Practice
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Date: 27/07/2024

To Dr Nicholas Shaw
HM Assistant Coroner for Cumbria
Fairfield Station Road
Cockermouth
Cumbria CA13 9PT

Re: Regulation 28 Report - Prevention of Future Deaths - Mr Thomas Raymond Mallonson (Deceased)
[redacted]

Dear Dr Shaw,

Please find below our response to the Regulation 28 report dated 20 June 2025 following the inquest into the death of Mr Thomas Raymond Mallinson.

Firstly, on behalf of Carlisle Central Practice, I would like to extend our sincere condolences to Mr Mallinson's family.

We recognise the concerns raised as we are fully committed to delivering high-quality, safe, and compassionate care to all our patients. As discussed during the inquest, while this tragic case involved multiple services including 111, 999 and the Out-of-Hours, we would like to assure you that our systems and staff are operating to the highest standards and clearly demonstrate below that they effective.

As part of the inquest, we conducted a full investigation detailed as follows:

- Monday 18 November 2024: Mr Mallinson's wife called the surgery in the afternoon requesting an appointment for diarrhoea. This started the previous day (Sunday 17 November 2024). Reception advised that we had no available appointments and to call 111 should the symptoms worsen.

- Monday 18 November 2023: According to EMIS records, Mr Mallinson's wife called 111 in the evening Mr Mallinson was eventually seen by the paramedics who deduced he was not clinically dehydrated His observations including his blood pressure, pulse, temperature and oxygen saturations were all normal. Mr Mallmson's wife was advised to contact the GP if he was no better.

- Tuesday 19 November 2024: Mr Mattison's wife called the GP surgery and was put through to the doctor on the same day. She spoke to [redacted] (GP). At this point Mr Mallinson had been suffering with a two-day history of diarrhoea, and the GP was advised by Mr Madison's wife that his vomiting and abdominal pain were settling. During the inquest it was suggested that [redacted] should have carried out a home visit It would not be conventional to perform a home visit on a patient with such a short history of and improving symptoms. This is unless there were major concerns about sepsis or hydration, which there were not. Considering the information to hand, I believe [redacted] followed the correct protocol.

- Wednesday 20 November 2024: Call to 111 was made by Mr Mallinson's wife, this was booked on the self-booking system for a GP call back. 111 booked this into a 17:45 telephone slot at 17:42. The incoming 111 callback requests are manually monitored by the GP practice throughout the day. Due to the short timeframe of three minutes between booking and slot time the practice actioned the query as quickly as practically possible. Unfortunately, no follow up call was received from 111 to alert the practice to the short notice booking and, from a practice perspective, 111 should have not booked a slot on such short notice

- Thursday 21 November 2024: Reception staff arranged an outbound triage call with the GP as per 111*s request. The GP spoke to Mr Mallinson's wife at 15:36 and was advised that he had been admitted to hospital.

- Saturday 23 November 2024: Mr Mallinson sadly passed away on the Intensive Care Unit at Cumberland Infirmary Carlisle.

Actions taken by me:

- I reviewed the care navigation process of this case. Considering the symptoms and their duration, the call handler and GP acted appropriately.
- I conducted an audit of all cases of diarrhoea, vomiting and gastroenteritis in the months of May and June 2025. It was ascertained that no missed opportunities were identified, and every case concluded with the best possible outcome.

The GP practice have taken the following actions as part of our continuous training:

- **Continue to reinforce training for reception and call navigation teams.**
- **Continue to do monthly significant event analysis review meetings to team reflection and learning.**

Additionally, as is usual, their formal training is recorded as part of our ongoing competence framework, with refresher sessions delivered regularly. Our regular telephone audit confirms our staff handle calls in an appropriate manner and direct patients to alternative services where necessary. For example, the telephone audit was carried out on calls taken between 1 May 2025 and 1 July 2025. The results show that 96% of calls taken were appropriately triaged with only 1 call failing to refer to other services.

For further support, *a* structured mentorship system exists within the team to help less experienced reception staff. Doctors are accessible for same-day clinical triage where concerns are raised by reception.

[redacted] (GP) spoke to Mr Mallinson's wife on the third day of his illness. At the time he was reported to be eating and drinking, with settled abdominal symptoms. You felt that there may be an element of wellness bias and that a face-to-face appointment or a home visit would have been more appropriate. [redacted] has reflected in detail on the case, participated in a formal Significant Event Analysis, engaged in one-to-one clinical supervision with me and undertaken additional learning in the assessment for gastroenteritis, dehydration and frailty. Considering the indication from Mr Madison's wife that they symptoms were improving and the number of patients that would present with similar symptoms, respectfully, our views differ from yours and we feel that [redacted] acted appropriately in this case.

To evaluate current standards of care, I conducted a focused audit on patients with Gastroenteritis, diarrhoea and vomiting at Carlisle Central Practice between 1 May 2025 and 1 July 2025. Fifty-five patients were reviewed to see whether appropriate clinical decisions, safety-netting, and escalation pathways were followed. Of the patients reviewed, 73% were seen face-to-face, with the remainder assessed remotely based on clinical appropriateness. Notably, high risk patients including those aged over 75, immunocompromised individuals and children under 5 were managed safely in every case. The audit clearly demonstrates that the practice has robust and safe systems in place for managing patients presenting with gastroenteritis. The tragic circumstances of Mr Matlinson's case are not due to any actions or in-actions of the surgery and there is no evidence of a wider pattern of unsafe care at the surgery. We have committed to repeating this audit annually to ensure continued assurance.

We also recognise your wider concerns about fragmented care across the NHS services. During the inquest, we noted that Mr Mallinson's case involved repeated transfers between 111, 999, Out-of-Hours and the GP surgery. In our view, this case exemplifies the complexity and lack of clarity that can occur when multiple providers share responsibility without a single clear point of accountability. We therefore support your decision to address this Regulation 28 to national stakeholders and would welcome further national guidance and structural changes to reduce these risks for vulnerable patients in future.

In summary, when Mr Mallinson's wife spoke to [redacted], he had diarrhoea for two days, his vomiting and abdominal pain had settled and he was eating and drinking. Considering his symptoms, it would be common practice to manage this case as [redacted] did.

My Mallinson's family asked for medical help from the Northwest Ambulance Service who did not arrive, they re-directed the call to 111 instead. The call then sat in the third party Out-of-Hours GP system for seven hours without any action. At this point if an ambulance had gone out to Mr Mallinson, it would have significantly increased his chances of survival.

We are deeply saddened by Mr Mallinson's death and take this case as a serious opportunity for reflection and improvement where necessary.

Should you require any additional documentation or evidence please let us know.

Yours sincerely.

[redacted]
Director of Clinical Operations
SSP Health