NHS
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NHS Trust

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Dr Nicholas Shaw
His Majesty's Assistant Coroner
Cumbria Coroners Court

By Email Only

8 September 2025

Dear Dr Shaw

Regulation 28 Report – Inquest Touching the Death of Thomas Raymond Mallinson

I write further to your Prevention of Future Deaths Report dated 30 June 2025, which was issued to North West Ambulance Service ("NWAS") following the conclusion of the inquest touching the death of Mr Mallinson.

I am aware that you will share my response with Mr Mallinson's family, and I firstly wish to express my sincere condolences to them. NWAS' core purpose is to save lives, prevent harm and provide services which optimise the likelihood of positive patient outcomes.

Through the Regulation 28 report, you have requested that NWAS considers your matters of concern and have suggested that action is taken to prevent future deaths occurring in the future By this letter I will address those concerns as far as I am able.

1. There were multiple calls to 111 and 999 in this case. I was told that there was no alert to a call handler to Indicate recent contacts for the same patient with the same condition which might highlight a need for more decisive action.

When a call handler receives a call from someone who has been attended by NWAS, either face to face or over the telephone, within the previous 24 hours, an alert is automatically generated on our Computer Aided Dispatch (CAD) system. Once the patient's location is confiimed, a 'pop-up box' appears to inform the call handler that a previous call has been made to that address. If the earlier call remains open in the CAD system, a banner is also displayed to allow the call handler to view the details of that previous call Where a call is no longer active, for example following cancellation, attendance, or onward referral (such as in Mallinson's case), the Emergency Medical Advisors (EMAs) can view the associated records for that location in the 'previous call' tab on their screen. The EMAs are empowered to escalate any concerns regarding a patient to a supervisor and/or a clinician if they have any concerns

I understand this process was described in oral evidence by the NWAS witness, [redacted] (Clinical Delivery Manager) at the inquest hearing, who explained how the system functions in practice. I can further confirm

clinicians also have the ability to review such incidents and can access patient details when this is necessary to support decision making.

It would not, however, be expected that call handlers review all previous calls while managing a new emergency call. The call details remain accessible in the system but, given the time-critical nature of emergency calls and the structured algorithm that must be followed, 999 call handlers would not have the capacity to explore historic records during live calls.

With regards to the 111 service, I can confirm whilst there is no automated alert, our experience is that that the caller will inform the Health Advisor (HA) that they have previously called, and at this point the HA is able to review the previous calls and consider escalation, just as their 999 call handler colleagues are empowered to do.

i can provide assurance that our call handling process follows the nationally recognised algorithm of questions within NHS Pathways, which is a highly regarded safe and reliable system. Where symptoms indicate a greater level of need, this will be appropriately flagged, ensuring that the patient is assessed and managed according to their presenting risk, so any changes in the patient's condition can be captured by the repeated triage that would take place on subsequent calls.

2. **I am also concerned that there is no system that alerts your control to the fact that a 999 (emergency) case you have passed to another agency has not in fact been dealt with.**

In Mr Mallinson's case NWAS handed over the episode of care to Cumbria Health on Call (CHOC) in line with the established clinical pathway. It is not possible for NWAS to follow up on every call once care has been transferred, and the service relies on the contractual arrangements that are in place with partner organisations to ensure appropriate continuity of care.

In this case, Mr Mallinson was referred to community-based care and CHOC accepted responsibility for the referral. I understand this was confirmed by CHOC during the inquest, and there was no dispute regarding the transfer of care. Once a referral has been accepted, the duty of care then rests with the receiving provider, and NWAS' responsibility appropriately ends at that point.

There was no subsequent pass back to NWAS in Mr Mallinson's case, but if there had been NWAS also have established pathways for these circumstances.

3. **A further concern refers specifically to the 111 service. At inquest it was questioned whether for out of hours GP services Cumbria had been better served when calls went to a local control room in Carlisle.**

NWAS 111 operates as an advice service, providing guidance and signposting patients to the most appropriate point of care based on their symptoms and needs. Any calls that are received into the NWAS 111 service, regardless of which of our four contacts centres it is received into, would be managed in the same manner. Therefore, a contact centre in Carlisle would process the calls in the same way we do now and there would be no notable difference.

All calls are handled in the same structured manner, and the outcomes for patients are unaffected by the location of the control centre. Each call is dealt with equitably, ensuring that all patients receive the same standard of assessment and advice.

I am grateful to you for bringing this matter to my attention and I am sorry that you felt it necessary to issue a Prevention of Future Deaths Report to NWAS. If you require any further clarification or information, please do not hesitate to contact me or the Trust's Deputy Director of Corporate Affairs, Emma Shiner.

Yours sincerely

[redacted]

Chief Executive