Miss K J Gomersal LLB | Senior Coroner | Cumbria

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Case Ref: [redacted]

30 June 2025

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: 1) Chief Executive SSP Health Ltd. 3rd Floor, waterside House, Waterside Drive, WIGAN WN3 5AZ

2) [redacted], Chief Executive Cumbria Health Ltd. 4 Wavell Drive, Rosehill Estate, CARLISLE CA1 2SE

3) [redacted], Chief Executive, Northwest Ambulance Service NHS Trust. Ladybridge Hall, Chorley New Rd, BOLTON BL1 5DD

4) [redacted], Secretary of State for Health and Social Care 39 Victoria Street, LONDON SW1H 0EU

1) CORONER

I am Dr Nicholas Shaw, HM Assistant Coroner for Cumbria

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://www.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 26th November 2024 I commenced an investigation into the death of Thomas Raymond MALLINSON who died in Cumberland Infirmary, Carlisle on 23rd November 2024 aged 79. The investigation concluded at the end of an inquest opened on 11th March 2025 and heard on 19th June 2025.

The Record of Inquest read as follows: "Thomas Raymond Mallinson died in Cumberland

Infirmary, Carlisle on 23rd November 2024. He had developed gastroenteritis which, despite repeated pleas from his wife went without any effective response or treatment from health services for four days. When finally admitted to hospital he was gravely ill and died despite treatment escalation to intensive care. Had he been admitted to hospital in a timely manner it is most likely he would have survived"

The narrative conclusion was that "Death was due to natural disease. Significant delay amounting to neglect was a major causative factor".

The Medical cause of death was given as:

1a Cardiogenic Shock and Acute Kidney Failure

1b Gastroenteritis

II Heart Failure, Atrial Fibrillation

4) CIRCUMSTANCES OF THE DEATH

Thomas Malllinson who had a history including Type 2 diabetes and stage 3 chronic kidney disease became unwell on 17th November with acute vomiting and diarrhoea.

The following day Monday 18th (second day of illness) his wife rang Carlisle Central Practice to request a GP appointment; she was told that no appointments were available and advised to ring NHS 111 for advice after 6pm that evening (not before because her call would be referred back to the practice where there were no appointments!). Thomas remained unwell so his wife called 111 and after an assessment and callback an hour later an ambulance was sent. The emergency medical technician assessed Thomas fully, all his observations were normal and so he was left with advice to try the GP practice again the following day if symptoms persisted

On Tuesday 19th (third day of illness) Thomas was no better, his wife did receive a telephone appointment from the GP practice and was issued a prescription for an anti-diarrhoeal medication.

On Wednesday 20th (fourth day of illness) Thomas was getting weaker and had soiled due to the diarrhoea. 111 was called again at 5.30 pm and she was told that she had secured the last GP telephone appointment of the day at 6.30: that call never came. Getting desperate his wife rang 999 just before midnight, help was not sent but she was told a doctor from Cumbria Health (the out of hours provider) would call back within 2 hours: despite waiting up until 4am that call never came either.

On Thursday 21st (fifth day of illness). "After another terrible night of continuous vomiting and diarrhoea" the GP surgery was again called and an afternoon telephone appointment offered. "Utterly exasperated stressed and traumatized" his wife again tried 999 and this time an ambulance was sent. Thomas collapsed shortly after the crew arrived, they recognized how ill he was and took him to hospital immediately. On arrival in A&E Thomas was found to be hypotensive and hypothermic with acute renal failure and metabolic acidosis. Despite escalation to intensive care he developed refractory cardiogenic shock and died on 23rd November.

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 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) To SSP Health, owners and operators of Carlisle Central Practice, 65 Warwick Road, Carlisle.

I wish to thank [redacted] for his attendance and and assistance at the hearing. It was acknowledged that on 18th the advice "to call back tomorrow" should never have been given and that the telephone appointment the following day really ought to have been a face to face assessment either in surgery or at Thomas's home. I am concerned that no body or organization has taken responsibility for Thomas, an elderly man with significant co-morbidities, during his illness. Should this responsibility ultimately rest with a patients general practitioner, if not where does it rest?

(2) 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?

(3) To Northwest Ambulance Service (NWAS) as providers of both 111 and 999 responses in Cumbria.

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. I am also concerned that (as above) 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. 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.

(4) To [redacted], Secretary of State for Health.

In my summing up after hearing the evidence in this case I explained the legal concept of neglect as a failure to provide basic care and (in this case) medical attention for someone in a dependent condition who can not provide it for himself, and I remarked that I felt Thomas "had fallen through an overcomplex system and was indeed neglected". I am aware that you are hoping to develop a 10 year plan for the NHS and therefore feel it my duty to highlight this case to you as an example of how overcomplexity has lost sight of a man's urgent care needs.

6) ACTION SHOULD BE TAKEN

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.

7) YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 27th August 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 Chief Coroner and to Thomas's widow [redacted] and their daughter [redacted].

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.

30 June 2025

Signature 

Dr Nicholas Shaw HM Assistant Coroner for

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