

MISS K J GOMERSAL
HM SENIOR CORONER

County of Cumbria



Fairfield
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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS MARK RYAN FOSTER THIS REPORT IS BEING SENT TO: Castlegate & Derwent Surgery Isel Road Cockermouth CA13 9HT
1	CORONER I am Miss Kirsty Gomersal HM Senior Coroner for County of 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: https://www.legislation.gov.uk/ukpga/2009/25/contents http://www.legislation.gov.uk/uksi/2013/1629/contents
3	INVESTIGATION and INQUEST Dr Mark Ryan FOSTER, who was known as Ryan, died on 17 February 2024 at his home address. Following post-mortem examination, the medical cause of Dr Foster's death was found to be: 1(a) Pulmonary Embolism An investigation into Dr Foster's death was commenced on 29 May 2024. An Inquest into Dr Foster's death was opened on 15 August 2024 by HM Assistant Coroner Dr N A Shaw. Dr Foster's Inquest was heard before me on 12 and 13 August 2025 and was concluded on 20 October 2025 when I delivered my findings and conclusions. The determination was: <i>Dr Mark Ryan Foster was usually fit and well. He had been experiencing shortness of breath since December 2023. On 11 January 2024, he consulted with his GP. A chest x-ray was carried out and this was unremarkable. Dr Foster's symptoms of breathlessness persisted and he attended his GP on 12 February 2024. Dr Foster was examined and a ddimer was ordered. For reasons that cannot be determined, the ddimer was not carried out that day. Dr Foster re-attended the Practice on 14 February 2024 for the ddimer test. A re-examination, including ECG, was carried out by a nurse who ordered blood tests. This</i>

	<i>did not include a ddimer. The results of the blood test were received in the late afternoon of 15 February 2024. The most significant finding was a markedly elevated pro-BNP of 1981. A telephone consultation with a GP took place at 09:43 on 16 February 2024. Dr Foster was not referred to secondary care. On 17 February 2024, Dr Foster was witnessed to collapse at home at approximately 13:10. Despite resuscitation efforts, Dr Foster's death was confirmed at 14:12. The cause of Dr Foster's death was a pulmonary embolism. On the balance of probabilities, the pulmonary embolism onset was around 1 February 2024. Dr Foster required admission to hospital on 16 February 2024. On the balance of probabilities, Dr Foster would have survived if admitted to hospital and treated.</i> The conclusion of the inquest was: <i>Natural causes contributed to by neglect</i>
4	CIRCUMSTANCES OF THE DEATH Dr Foster was 53 years old. He was usually fit and well. He had been experiencing breathlessness since December 2023. Following a telephone consultation with a GP on 11 January 2024, a chest xray was carried out which was unremarkable. The symptoms of breathlessness persisted. Dr Foster attended a face-to-face consultation at the Castlegate & Derwent Practice with a trainee GP on 12 February 2024. The Wells Score was utilised and a ddimer (and ECG) ordered to rule out a pulmonary embolism. For reasons that could not be ascertained, the ddimer was not carried out that same day; it was booked for the afternoon of 14 February 2024 with a Practice Nurse. The Practice Nurse recognised the urgency of a ddimer test. The Practice Nurse also recognised that because of the time of the appointment on 14 February, bloods would not be sent to the laboratory until the following day. The Practice Nurse sought advice from a GP, carried out an examination (including an ECG) and requested blood tests, but not a ddimer. There was a missed opportunity for Ryan to be seen by a GP on 14 February 2024. It was accepted that the Practice Nurse, although experienced, was acting outside her normal practice. However, it could not be determined that this missed opportunity met the legal threshold for causation. The blood test results were received on the late afternoon of 15 February 2024. The results were broadly unremarkable save the pro-BNP which was markedly raised at 1981. The expected level for a patient such as Ryan is 50. A level about 400-500 is elevated. A level above 1000 is very rare. A raised BNP is a sign of heart failure. A telephone consultation with a GP took place at 09:43 on 16 February 2024 to discuss the results. The GP was not aware that a pulmonary embolism could cause heart failure. Ryan was referred for an outpatient ECHO, the waiting time for which was around 4-6 weeks. On 17 February 2024, Ryan called for help. At about 13:10, he was witnessed to collapse in the hallway of his home address. Despite resuscitation by paramedics, Ryan was confirmed deceased at 14:12. Post-mortem showed an occlusive thromboembolus in the right pulmonary artery which extensively branched into the distal segmental pulmonary vessels. Expert opinion was that the onset of the pulmonary embolism was around 1 February 2024. I found that there were missed opportunities to see Ryan in person and to refer him to hospital on 16 February 2024. I heard evidence from two expert witnesses which included: • The chest xray and blood tests had excluded most causes of breathlessness.

	• The pro-BNP of 1981 was significantly elevated and consequently worrying. • A telephone consultation was neither safe nor appropriate; Ryan should have been seen in person. • Referral to secondary care was definitely required such that it was mandatory. • The referral for an outpatient ECHO was not appropriate. • Had Ryan been admitted to hospital, on the balance of probabilities, he would have survived. I found that: • Had Ryan been admitted to hospital on 16 February 2024, on the balance of probabilities, he would have survived. • Not admitting Ryan to hospital on 16 February, more than minimally, negligibly or trivially contributed to his death on the balance of probabilities. • Ryan was in a dependent position because of his illness. • By not admitting Ryan to hospital, there was a failure to provide or procure basic medical care. • This failure fell far below what could reasonably be expected and was therefore a “gross” failing. • This gross failure more than minimally, negligibly or trivially contributed to Ryan’s death on the balance of probabilities. • Therefore, Ryan’s death was contributed to by neglect. I heard evidence of the difficulties that the practice faced at the time and the difficulties faced by the GP who spoke to Ryan on 16 February 2024. During the inquest, I heard evidence of the steps that had been taken by the Practice since Ryan’s death. Those steps included training on pulmonary embolism, reduction in the number of trainees, increased face-to-face consultations and clarification of the processes for requesting blood tests However, I also heard evidence that the Practice is not well governed and is in a “state of turmoil” such that leadership and safety is undermined. The Practice has not been able to address certain matters. Further, the Practice’s investigation into Ryan’s death has not been fully completed. Whilst the Practice has made improvements to the significant event process, it does not yet have a cogent smethod of investigating incidents.
5	<u>CORONER’S CONCERNS</u> 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: 1. Castlegate & Derwent Practice does not have unified leadership and governance. 2. Castlegate & Derwent Practice does not yet have a robust method of investigating incidents.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe the Castlegate & Derwent Practice has 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 19 December 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 the following Interested Persons:  and Ryan's family  (via his Solicitors Clyde & Co) Care Quality Commission I have also sent a copy to  National Institute for Health and Care Excellence ("NICE") NHS North East and North Cumbria Integrated Care Board. 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.
9	Dated this 23 day of October 2025  Miss Kirsty J Gomersal LLB HM Senior Coroner County of Cumbria