



Newcastle and North Tyneside
Miss Georgina Nolan
HM SENIOR CORONER
Civic Centre , Barras Bridge , Newcastle Upon Tyne , NE1 8QH

Date: 17 November 2025

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: York and Scarborough Teaching Hospitals NHS Foundation Trust
CORONER

1 I am Thomas Crookes, Assistant Coroner for the area of Newcastle and North Tyneside.

CORONER'S LEGAL POWERS

2 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/ukxi/2013/1629/part/7/made>

INVESTIGATION and INQUEST

On 9 December 2024 I commenced an investigation into the death of Thomas Colin MORRELL. The investigation concluded at the end of the inquest.

The conclusion of the inquest was;

3 Thomas Colin Morrell died from recognised complications from a necessary surgical procedure (heart transplantation). There may have been opportunities to intervene at an earlier juncture prior to him reaching end stage heart failure. However, it cannot be said more likely than not that this would have made a difference to the ultimate outcome.

The medical cause of death was;

1a Primary Graft Failure

1b Cardiac Transplantation

1c Hypertrophic Obstructive Cardiomyopathy

II Ischaemic Stroke

4 **CIRCUMSTANCES OF THE DEATH**

Thomas Colin Morrell had a longstanding history of hypertrophic obstructive cardiomyopathy (HOCM) for which he was due to have a re-ablation procedure on 18 October 2024. However, prior to this occurring, he was admitted to Scarborough Hospital's Accident and Emergency department on 08 October 2024 where he was initially treated for abdominal issues but was subsequently found to be in heart failure.

He was transferred to the Freeman Hospital, Newcastle upon Tyne on 15 October 2024 where he was supported with ECMO and then biventricular support before heart transplantation became possible on 23 November 2024. This procedure was complicated by massive bleeding and require a massive blood transfusion. This adversely affected the new heart which arrested and its ability to contract was irreversibly compromised.

Despite ECMO support, his heart function did not improve and Thomas Colin Morrell was found to have sustained neurological injury too. Support was withdrawn and Thomas Colin Morrell died on 3 December 2024 at the Freeman Hospital, Newcastle upon Tyne as a result of the failure of the heart transplant.

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. –

(1) Following Mr Morrell's emergency admission to Scarborough Hospital on 8 October 2024, heart failure (as opposed to abdominal issues) played a greater role in his deterioration than was initially recognised by the treating clinicians. Had this been recognised sooner, Mr Morrell could have been transferred to the Freeman Hospital more quickly. There was not a standard operating process in place for Hypertrophic Obstructive Cardiomyopathy (HOCM) patients covering when to refer patients in such circumstances.

(2) In 2019 an echocardiogram showed no changes to Mr Morrell's heart but by 6 July 2021 a cardiac MRI scan showed focal hypertrophy and patchy scarring within the heart, with functional impairment in the mild to moderate range. On 16 October 2024 an echocardiogram showed severe biventricular failure. There were no scans / echocardiograms undertaken between those dates to check for deterioration. Had the deterioration been detected sooner, I was told in evidence that there may have been an earlier opportunity to intervene prior to deterioration into end stage heart failure, which may have improved the prospects of surgical intervention.

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you / your organisation have the power to take such action.

YOUR RESPONSE

7 You are under a duty to respond to this report within 56 days of the date of this report, namely by 13 January 2026. 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.

COPIES and PUBLICATION

8 I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [REDACTED] (partner of the deceased) and [REDACTED] (mother of the deceased). I have also sent it to the Newcastle Upon Tyne Hospitals NHS Foundation Trust who may find it useful

or of interest.

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.

17 November 2025

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Signature

A solid black rectangular box used to redact the signature of Thomas Crookes.

Thomas Crookes, Assistant Coroner for the area of Newcastle and North Tyneside