

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>Royal College of General Practitioners 30 Euston Square London NW1 2FB ██████████</p> <p>Wes Streeting MP Secretary of State for Health & Social Care C/O Ministerial Correspondence and Public Enquiries Unit Department of Health and Social Care 39 Victoria Street London SW1H 0EU ████████████████████</p>
1	<p>CORONER</p> <p>I am Alan Anthony Wilson Senior Coroner for Blackpool & Fylde</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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</p>
3	<p>INVESTIGATION and INQUEST</p> <p>The death of Mark Simpson on 22nd October 2025 was reported to me and I opened an investigation, which concluded by way of an inquest on 3rd March 2026.</p> <p>I determined the medical cause of death to be:</p> <p>1 a Acute heart failure 1 b Ischaemic heart disease 1 c Coronary artery atheroma</p> <p>2 Renal cell carcinoma</p> <p>In box 3 of the Record of Inquest I recorded as follows:</p>

	<p>Mark Simpson was aged 59 years. During a consultation with a GP (General Practitioner) in May 2025, he complained about some chest pain. Although an ECG (Electrocardiogram) did not raise significant concerns at that time, the GP appropriately made an urgent referral for a cardiology appointment, likely to take place around six to eight weeks later. The way in which the referral was triaged by a Consultant Cardiologist, who had not been fully trained on the correct process, caused confusion which inadvertently led to the referral being incorrectly viewed as one requiring routine rather than urgent response. Over subsequent weeks, there are no reports of worsening chest pain until 19th September 2025 at around 4 pm when Mark contacted the NHS 111 service reporting chest pain for approximately seven hours before being advised to call 999 should the pain become dramatically worse or he feel breathless. He did not inform his Family about this. His GP practice was provided with a record of that consultation, but this information was not relayed to a clinician nor was it added to Mark's medical record at the surgery. On 29th September 2025, and responding to a request to attend a routine appointment to discuss blood test results, Mark reported ongoing chest pain similar to that experienced in May. A further ECG was performed, described as abnormal, and it was recommended a GP review the position. Given his clinical history, it was not felt necessary to contact Mark about the ECG results. There is no report of more chest pain until 20th October 2025 when he attended a further routine appointment to discuss his diabetes and blood pressure during which he told a Practice Nurse he had suffered an episode of chest pain three days prior. The Nurse sought advice from a GP colleague who, informed Mark was awaiting an appointment with a cardiologist, advised Mark be told to seek immediate medical advice or call 999 should the chest pain return. Some two days later, during the early evening his Partner found Mark unresponsive and not breathing in the bathroom. Despite CPR (Cardio-pulmonary resuscitation) he could not be revived and an attending Paramedic confirmed Mark was deceased at 8.45 pm. A subsequent post mortem examination confirmed he had died from the effects of severe heart disease. Since reporting chest pain to a GP in May 2025, there had been missed opportunities to provide more detailed assessment and treatment. By the time he died, Mark had not seen a cardiologist. Had he been provided with an urgent appointment, from the available evidence it is likely he would have been referred for an urgent CT coronary angiogram which may have led to treatment which could have prevented him dying when he did.</p> <p>In box 4 of the Record of Inquest I determined the conclusion to be one of:</p> <p>Natural causes</p>
4	<p><u>CIRCUMSTANCES OF THE DEATH</u></p> <p>In addition to the contents of section 3 above, the following is of note:</p> <ul style="list-style-type: none"> • At a time when Mark Simpson was awaiting an appointment with a cardiologist, he rang the NHS 111 service to report a prolonged period of chest pain. • A detailed summary of that telephone consultation was forwarded to the GP Practice. • The inquest was told that report was considered by a member of staff who was not medically qualified.

	<ul style="list-style-type: none"> • The consultation was not brought to the attention of any GP, including the GP who had initially made an urgent referral to cardiology, a referral which at that time remained outstanding. • Nor was the report of that consultation incorporated into the medical record for Mark Simpson, meaning that in the event any GP at the Practice needed to review his medical record that GP would be unaware Mark had consulted NHS 111 and reported prolonged chest pain of an estimated seven hours in duration. • A GP giving evidence at the inquest acknowledged that should a Patient such as Mark Simpson contact the NHS 111 service in this way, and report chest pain, there is a need for any report the Practice receives about that consultation to be incorporated into the Patient's medical record so that any GPs reviewing that record are aware of the consultation. <p>Having considered all of the above, I have determined that I have a duty to write this report.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>During the course of the inquest, the evidence revealed matters giving rise to concern. In my opinion, there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to send the report:</p> <p>The MATTERS OF CONCERN is as follows. –</p> <p>If a patient contacts the NHS 11 service it is necessary and appropriate for that patient's GP Practice to be informed. Mark Simpson contacted the NHS 111 service reporting chest pain for approximately seven hours before being advised to call 999 should the pain become dramatically worse or he feel breathless. His GP Practice was provided with a record of that consultation, but this information was not relayed to a clinician nor was it added to Mark's medical record at the surgery.</p> <p><u>Concern 1</u></p> <p>The information forwarded to the GP Practice was considered by a member of staff who was not medically qualified, and yet in deciding the consultation did not need to be brought to the attention of a medical professional was making an important decision with potentially significant ramifications for that patient.</p> <p>Notwithstanding that a GP Practice may receive numerous reports about patients of this type, if such potentially significant information is not considered by a member of staff with medical knowledge, important information may be missed and to the later detriment of the patient.</p> <p><u>Concern 2</u></p> <p>If reports of this nature, forwarded to a GP Practice after a consultation with the NHS 111 Service, are not added to a patient's medical record at the Practice, should a subsequent consultation become necessary, the medical professional conducting that consultation in the absence of potentially very relevant information may go on to make inappropriate decisions and place their patient at risk.</p>

	I believe it is necessary for to raise this concern, but it is not for me to be prescriptive about what should / can be done.
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, but I have extended this period to 11th May 2026. I, the coroner, may extend the period further.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:</p> <ul style="list-style-type: none"> • The family of Mark Simpson • Blackpool Teaching Hospitals NHS Foundation Trust • [REDACTED], GP, Newton Drive Health Centre, Blackpool <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	11/03/26