REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Miss Lorraine HARRIS, Area Coroner for the coroner area of East Riding of Yorkshire and City of Kingston Upon Hull.
2.	**DATE OF REPORT** 30th April 2026
3.	**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.
3.	**THIS REPORT IS BEING SENT TO** 1. NHS Pathways You are under a duty to respond to this report within 56 days of the date of this report, namely by 25th June 2026. I, the coroner, may extend the period if an appropriate application is made.
4.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.

	The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
5.	**SUMMARY OF CORONER'S CONCERN** Missing question on NHS Pathway that would identify where a bleed was controlled or not
6.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
7.	**INVESTIGATION AND INQUEST** On 18th September 2025, I commenced an investigation into the death of Dr Kenneth Wilson CULLY, aged 82 years. **The medical cause of death was** 1a Haemorrhagic shock (exsanguination) 1b Erosion of blood vessel dorsum of left foot **How, when and where** On 17th September 2025 Kenneth Wilson CULLY, aged 82 years, made a call to the ambulance service due to the fact he was unable to stop a catastrophic bleed on his foot, he indicated that he was on blood thinning medication. During the call Dr CULLY ceased responding. Due to high demand, an ambulance was not available to attend for 1 hour and 20 minutes. When the crew arrived at his home Meadow View, 18 Long Street, Rudston, Driffield, East Riding Yorkshire, Dr CULLY had died. Pathology revealed that Dr CULLY's artery and vein had lost their integrity. It would be unsafe to say exactly when Dr CULLY died and whether an ambulance arriving more promptly would have been able to save his life. **Conclusion** Catastrophic bleed following loss of integrity in the dorsal pedal artery and vein.

8.	**CIRCUMSTANCES OF DEATH**
	
	• Dr Kenneth Wilson CULLY led a healthy life and he was able to maintain this until 2022 when his health began to deteriorate.
	• He became unsteady on his feet, in 8-9 months before death had become clumsy.
	• In December 2024 during an admission to hospital, it was noted that he had a non-occlusive thrombus of the left long sapneous vein and was advised by a hospital consultant to commence a 3 month course of Rivaroxaban.
	• This blood thinning medication should have been ceased by the surgery on 10th March 2025. There was a human error regarding how this medication was input on to the system which led to it being given to Dr CULLY as a repeat prescription.
	• Dr CULLY had interactions with the surgery and hospital both before and after the recommended end date for his blood thinning medication, providing multiple opportunities to identify the issue with the prescription being incorrectly recorded as on repeat.
	• On 14th and 23rd January 2025 Dr CULLY had suffered bleeding from foot. On those occasions he had telephoned nearby family first.
	• On 17th September 2025 Dr CULLY telephoned 999 ambulance service and reported that a scab had come off his foot and he was unable to stop the bleeding.
	  ○ It would be unsafe to say exactly how the bleed began, evidence stated it could have happened spontaneously for reasons such as a peak in high blood pressure, or something as minor as knocking the scab off.
	  ○ Pathology found that the bleed was at the dorsum of the foot. There was an ulcer in the location.
	  ○ Both the dorsal pedal artery and the vein had lost their integrity and hence the bleed became catastrophic.
	  ○ The fact Dr CULLY was on blood thinning medication would have impacted his blood's ability to clot.
	  ○ It would also be unsafe to say how long it was after the bleeding commenced that he made the decision to call the ambulance.

	○ The call went through to the Welsh Ambulance Service who were dealing with calls on behalf of the Yorkshire Ambulance Service. ○ The call was categorised at this stage as a category 2. There were no available resources to dispatch at that time due to high demand (staffing levels were regarded as appropriate). ○ Where an ambulance response is delayed and a patient is a high risk of deterioration like an uncontrolled bleed, it is good practice for a healthcare professional to support and try to manage the situation until help can arrive. The Clinician who sought to do this was unable to make contact with Dr CULLY as the line had been left open. ○ I find with all the knowledge that was known (the catastrophic bleed that was uncontained) at the point he stopped responding, the call should have been a category 1. Given the availability of the ambulances and the distance of the nearest available ambulance I do not find that upgrading the call would have prevented Dr CULLY's death.
9.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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 report to you. The **MATTERS OF CONCERN** are as follows: Dr Kenneth Wilson CULLY telephoned the ambulance service to report an uncontrollable bleed from his foot. Calls are taken by control room staff who do not have medical training, they ask a series of questions and on receipt of answers are able to categorise the priority of response required. At the time of the incident the Advanced Medical Priority Dispatch System was utilised. The ambulance service now use the NHS Pathway system. The ambulance service, correctly pre-empting coronial concerns about categorisation especially in light of the duty to prevent future death, sought to check that if provided with similar information, the new NHS Pathway system would recognise the seriousness of an uncontrolled bleed. It appeared that NHS Pathway may have misunderstood the concern raised by the service and

	did not wish to “endorse” what was being stated, which was not the reason for the referral by the ambulance service. In the new NHS Pathway system there appeared to be an insufficiency in the questions to correctly identify the seriousness of an uncontrolled bleed (there is no question regarding whether the bleed is controlled or not). This could lead to the categorisation of the call being incorrect and a delay in treating a catastrophic event needing immediate attention. It is my understanding that the Yorkshire Ambulance Service are willing to work with NHS Pathways to assist them to fully understand the concern raised.
10.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: 1. The Family of Dr Kenneth Wilson CULLY 2. The Yorkshire Ambulance Service 3. Dr CULLY’s GP surgery I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner’s PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
	SIGNATURE *Lorraine Harris*