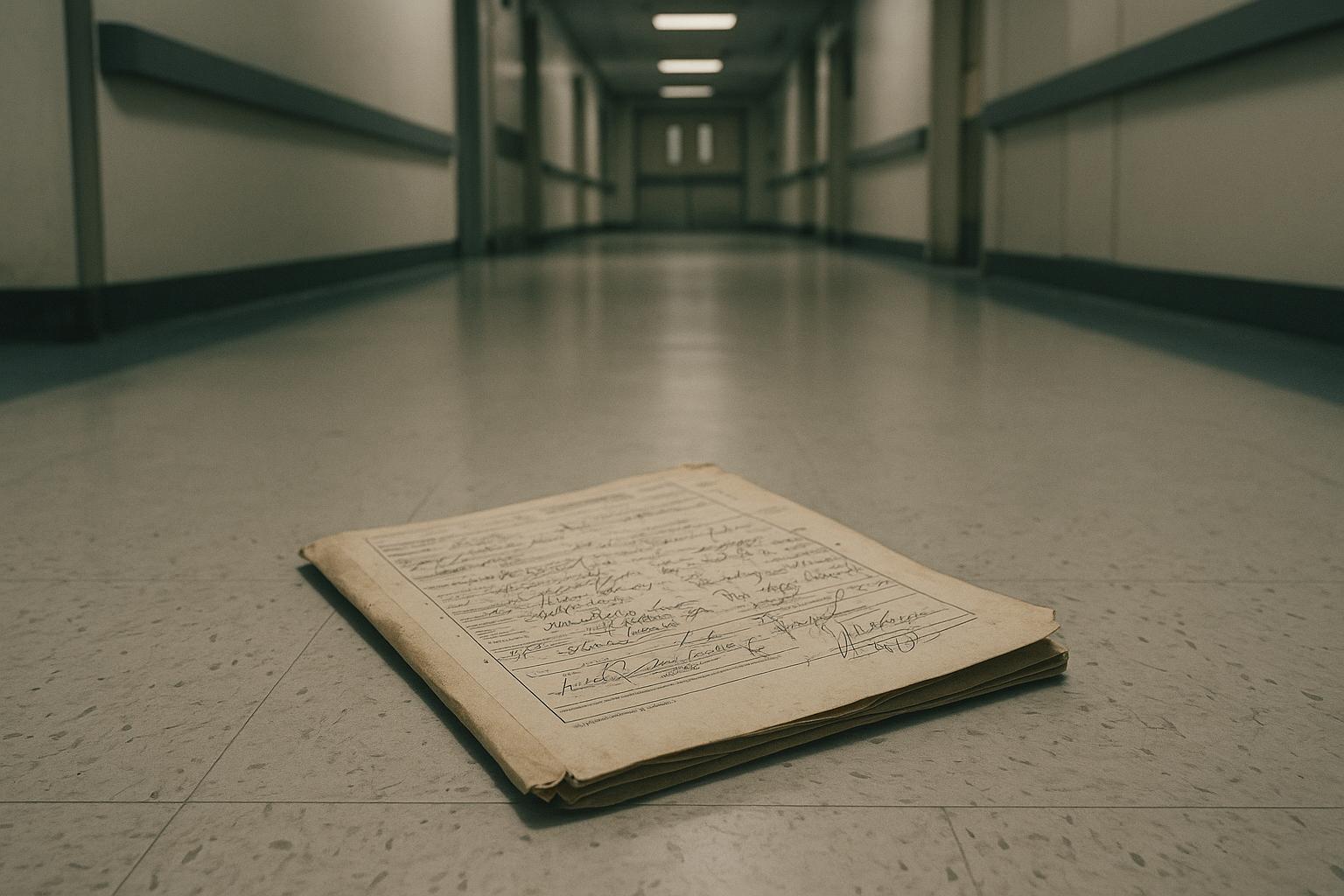
# Lila’s death exposes systemic failings in NHS digital records and paediatric care



The death of five-year-old Lila Marsland, who passed away just hours after being sent home from Tameside General Hospital with an incorrect diagnosis, has cast a stark light on significant failings in patient care and hospital record-keeping systems. Lila had been admitted in late December 2023 showing symptoms including headaches, a sore throat, and vomiting. Despite Lila’s mother, Rachael Mincherton—a nurse herself—expressing concern that her daughter might have meningitis, hospital staff diagnosed her with tonsillitis and discharged her with antibiotics around 2am on December 28. Tragically, Lila was found unresponsive eight hours later.

An inquest held earlier this year concluded that Lila’s death was preventable and "contributed to by neglect." A key finding was that had Lila been admitted and administered broad-spectrum antibiotics within the critical first hour after triage, it is likely her life could have been saved. The hospital’s failure to act on signs indicative of meningitis, as well as lapses in clinical assessment, were central to the verdict. In response to the coroner’s report, Tameside Hospital Trust accepted the findings and issued a public apology for the missed opportunities in Lila’s care, though the family has yet to receive a direct apology from the hospital itself.

Beyond the clinical errors, the case has highlighted systemic issues related to the hospital’s medical records management. Coroner Chris Morris pointed out that the fragmented use of both analogue and digital systems at Tameside General risked "vital clinical information" being lost at critical junctures. For example, medical notes recorded electronically in A&E did not transfer to the paediatric department, where notes were kept on paper. A medical handover document highlighting concerns about potential meningitis was never seen by the doctor responsible for Lila’s care. These failures in communication and documentation were flagged in the coroner’s Prevention of Future Deaths report, which also noted incomplete implementation of national guidelines on meningitis and sepsis screening.

The coroner’s report was sent to the Secretary of State for Health and Social Care and the Trust’s chief executive, expressing deep concerns not only about the hospital but the wider NHS, where "information is stored and shared in a fragmented and disjointed way." In reaction, the Minister of State for Secondary Care, Karin Smyth, outlined that since 2022 the government has invested nearly £2 billion in transforming the NHS from analogue to digital systems, including rolling out Electronic Patient Records (EPR) designed to create unified patient records accessible to all NHS trusts. Nevertheless, Lila’s mother has been critical of the government’s response, branding it as generic and insufficiently addressive of the specific failings at Tameside Hospital. She also voiced worries about the interoperability of different digital systems and the potential for critical patient information to still be lost when patients move between trusts.

The family has channelled their grief into the founding of ‘Lila’s Light’, a charity aimed at supporting bereaved siblings with comfort bags for hospitals in the North West, underscoring the personal and community impact of Lila’s death. Meanwhile, hospital authorities have committed to implementing procedural changes to avert similar tragedies in the future. However, the ongoing absence of a personal apology from the hospital and perceived inadequacies in government measures continue to fuel the family’s distress and calls for deeper reform.

This tragic case underscores not only the urgent need for rigorous clinical vigilance, especially in paediatric emergency care, but also the critical importance of integrated, reliable health record systems. It serves as a powerful reminder that behind the promise of technological upgrades lies a pressing human imperative: ensuring that no vital information, nor a child’s life, is ever overlooked again.

### 📌 Reference Map:

* Paragraph 1 – [[1]](https://www.liverpoolecho.co.uk/news/uk-world-news/schoolgirl-5-died-hours-after-32700578), [[2]](https://www.itv.com/news/granada/2025-06-05/neglect-contributed-to-girls-death-which-could-have-been-prevented), [[3]](https://www.tamesidecorrespondent.co.uk/2025/06/06/hospital-changes-urged-after-tameside-five-year-olds-neglect-inquest-verdict/)
* Paragraph 2 – [[2]](https://www.itv.com/news/granada/2025-06-05/neglect-contributed-to-girls-death-which-could-have-been-prevented), [[5]](https://www.itv.com/news/granada/2025-06-13/parents-of-girl-who-died-after-hospital-fault-yet-to-receive-apology)
* Paragraph 3 – [[1]](https://www.liverpoolecho.co.uk/news/uk-world-news/schoolgirl-5-died-hours-after-32700578), [[4]](https://www.judiciary.uk/prevention-of-future-death-reports/lila-marsland-prevention-of-future-deaths-report/), [[6]](https://www.itv.com/news/granada/2025-10-16/mum-slams-governments-response-to-five-year-old-daughters-preventable-death)
* Paragraph 4 – [[1]](https://www.liverpoolecho.co.uk/news/uk-world-news/schoolgirl-5-died-hours-after-32700578), [[4]](https://www.judiciary.uk/prevention-of-future-death-reports/lila-marsland-prevention-of-future-deaths-report/), [[6]](https://www.itv.com/news/granada/2025-10-16/mum-slams-governments-response-to-five-year-old-daughters-preventable-death)
* Paragraph 5 – [[2]](https://www.itv.com/news/granada/2025-06-05/neglect-contributed-to-girls-death-which-could-have-been-prevented), [[5]](https://www.itv.com/news/granada/2025-06-13/parents-of-girl-who-died-after-hospital-fault-yet-to-receive-apology)
* Paragraph 6 – [[2]](https://www.itv.com/news/granada/2025-06-05/neglect-contributed-to-girls-death-which-could-have-been-prevented), [[3]](https://www.tamesidecorrespondent.co.uk/2025/06/06/hospital-changes-urged-after-tameside-five-year-olds-neglect-inquest-verdict/), [[5]](https://www.itv.com/news/granada/2025-06-13/parents-of-girl-who-died-after-hospital-fault-yet-to-receive-apology), [[6]](https://www.itv.com/news/granada/2025-10-16/mum-slams-governments-response-to-five-year-old-daughters-preventable-death)

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## Bibliography

1. <https://www.liverpoolecho.co.uk/news/uk-world-news/schoolgirl-5-died-hours-after-32700578> - Please view link - unable to able to access data
2. <https://www.itv.com/news/granada/2025-06-05/neglect-contributed-to-girls-death-which-could-have-been-prevented> - An inquest has determined that the death of five-year-old Lila Marsland was 'contributed to by neglect'. Lila was discharged from Tameside Hospital with antibiotics for tonsillitis, despite exhibiting strong signs of meningitis. The jury concluded that had Lila been admitted and given broad-spectrum antibiotics within the first hour of being triaged, her death could have been prevented. Lila's parents, Rachael Mincherton and Darren Marsland, have since founded 'Lila's Light', a charity supporting bereaved siblings by providing comfort bags to hospitals across the North West. The hospital trust has accepted the coroner's findings and apologised unreservedly for the missed opportunities in Lila's care. ([itv.com](https://www.itv.com/news/granada/2025-06-05/neglect-contributed-to-girls-death-which-could-have-been-prevented?utm_source=openai))
3. <https://www.tamesidecorrespondent.co.uk/2025/06/06/hospital-changes-urged-after-tameside-five-year-olds-neglect-inquest-verdict/> - Following the inquest into the death of five-year-old Lila Marsland, which concluded that her death was 'contributed to by neglect', there are calls for changes in hospital procedures. Lila was discharged from Tameside Hospital with antibiotics for tonsillitis, despite showing symptoms indicative of meningitis. The inquest jury found that had Lila been admitted and given broad-spectrum antibiotics within the first hour of being triaged, her death could have been prevented. The hospital trust has acknowledged the coroner's findings and is implementing improvements to ensure such incidents do not recur. ([tamesidecorrespondent.co.uk](https://www.tamesidecorrespondent.co.uk/2025/06/06/hospital-changes-urged-after-tameside-five-year-olds-neglect-inquest-verdict/?utm_source=openai))
4. <https://www.judiciary.uk/prevention-of-future-death-reports/lila-marsland-prevention-of-future-deaths-report/> - The Coroner's Prevention of Future Deaths Report concerning Lila Marsland highlights several concerns, including the incomplete embedding of the Child Sepsis Screening Tool and the Trust's failure to fully implement the latest NICE guidelines on meningitis. The report also points out the lack of a medical record for Lila's examination by the Locum Registrar in Paediatrics and the absence of a comprehensive assessment by the Locum Consultant in Emergency Medicine. The Coroner has sent this report to the Chief Executive of Tameside and Glossop Integrated Care NHS Foundation Trust and the Secretary of State for Health and Social Care. ([judiciary.uk](https://www.judiciary.uk/prevention-of-future-death-reports/lila-marsland-prevention-of-future-deaths-report/?utm_source=openai))
5. <https://www.itv.com/news/granada/2025-06-13/parents-of-girl-who-died-after-hospital-fault-yet-to-receive-apology> - The parents of five-year-old Lila Marsland, who died after being misdiagnosed with tonsillitis and sent home from Tameside Hospital, have yet to receive a personal apology from the hospital. Despite the hospital trust issuing a public apology following the inquest, Lila's family states they have not been contacted directly. Lila's mother, Rachael Mincherton, expressed her disappointment with the response, stating that the government's statement did not address the specific issues at Tameside Hospital or outline how such incidents would be prevented in the future. ([itv.com](https://www.itv.com/news/granada/2025-06-13/parents-of-girl-who-died-after-hospital-fault-yet-to-receive-apology?utm_source=openai))
6. <https://www.itv.com/news/granada/2025-10-16/mum-slams-governments-response-to-five-year-old-daughters-preventable-death> - Rachael Mincherton, mother of five-year-old Lila Marsland, who died after being misdiagnosed with tonsillitis and sent home from Tameside Hospital, has criticised the government's response to her daughter's death. She highlighted concerns about the hospital's use of different systems for recording medical notes, which led to vital information being lost. The government's response, which focused on national improvements since 2022, did not address the specific issues at Tameside Hospital or outline measures to prevent similar incidents in the future. ([itv.com](https://www.itv.com/news/granada/2025-10-16/mum-slams-governments-response-to-five-year-old-daughters-preventable-death?utm_source=openai))