REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

Issued following the Inquest touching the death of Anthony James REEDMAN

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted]**Chief Executive Officer (CEO) of NHS England** [redacted] **Chief Executive Officer (CEO) of North Bristol NHS Trust (NBT)**
1	**CORONER** I am Guy Davies, His Majesty's Assistant Coroner for Cornwall & the Isles of Scilly
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.
3	**INVESTIGATION and INQUEST** On 5 July 2021 I commenced an investigation into the death of Anthony James REEDMAN. The investigation concluded at the end of the inquest on 21 November 2022. The medical cause of death was as follows *1a Cerebrovascular Infarct (Complicated by Post Thrombolysis Bleed)* The statutory questions (who, how, when and where) were answered as follows *Anthony James Reedman died on 30 June 2021 at Royal Cornwall Hospital Truro Cornwall from a stroke contributed to by a recognized complication of thrombolysis which was administered in an unsuccessful attempt to treat the stroke.* The narrative conclusion of the inquest was *Mr Reedman died following a stroke, contributed to by a further brain haemorrhage following the unsuccessful attempt to treat the stroke by way of a thrombolysis. This form of treatment was the only available option for the treating physicians. The thrombolysis was administered at the extremity of the treatment window, namely 4.5 hours after the stroke. This delay in treatment was a direct consequence of an ambulance delay. The possibility of a successful outcome from the thrombolysis was significantly reduced due to the delay in treatment.*
4	**CIRCUMSTANCES OF THE DEATH** Mr Reedman was 54 years old at the date of his death. He had no relevant medical history and was otherwise a fit, healthy and active man with a range of outdoor leisure interests.

	He suffered a basilar artery stroke at approximately 21:45 hours whilst watching television with his wife and friends. His wife, Mrs Reedman, immediately made a 999-call requesting an ambulance. Due to an ambulance delay, it was 4.5 hours before Mr Reedman received treatment by thrombolysis, being administered at approximately 02:25 hours. Thrombolysis is the administration of "clot-busting" medicine. Clinical witnesses stated that they would have referred Mr Reedman for a thrombectomy if that option had been available. Thrombectomy involves using a specially designed clot removal device inserted through a catheter to pull or suck out the clot to restore blood flow. Thrombectomy would have provided better chances of a positive outcome. On average successful outcomes following treatment for a basilar artery stroke are 13% for thrombolysis, and 37% for thrombectomy. Thrombolysis was administered at the extreme edge of the window for that form of treatment. Thrombectomy can be performed over a slightly longer time frame than thrombolysis which is only recommended up to four and a half hours after a stroke. NHS England has approved thrombectomy for use up to six hours after stroke symptoms begin. Thrombectomy is available for limited periods of time for patients at RCHT. The Chief Medical Officer for Royal Cornwall Hospital Trust (RCHT) stated *Derriford (University Hospitals Plymouth NHS Trust (UHP)) is the regional thrombectomy service for Cornwall….. At the time of Mr Reedman's stroke in June 2021, the service operated from 0800 – 1700 Monday to Friday. UHP have recently extended their services from 17 September 2022 to include weekends/public holidays from 0700-1200, and from January 2023 are intending to extend to 1700 on weekend/public holidays. Therefore access to thrombectomy is improving but remains an issue as this is extremely time-critical intervention, but highly effective and indicative in a proportion of patients with acute stroke. Inability to access timely thrombectomy is lost opportunity to reduce the severity of neurological deficit caused by the stroke and thereby reduce the resultant disability.*
5	**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) There is no thrombectomy service available 24/7 for RCHT patients. Thrombectomy is considered by clinicians to be a lifesaving procedure. On average, successful outcomes for treatment for a basilar artery stroke are 13% for thrombolysis, and 37% for thrombectomy. Over the last year it is estimated that 75 stroke patients in Cornwall who would otherwise be suitable for thrombectomy procedures did not receive this procedure because it is not available 24/7 in Cornwall, unlike for example those who live in Bristol. A clinical witness described this situation as a postcode lottery. (2) The nearest 24/7 thrombectomy service is at NHS North Bristol. However, there is no service level agreement between Southmead and RCHT for the treatment of patients from Cornwall when the UHP service is unavailable. This limits the options available to RCHT clinicians in considering treatment for stroke patients.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have 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 January 2023. 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; • Mr Reedman's wife and family • RCHT • SWAST I have also sent it to the UK Stroke Association 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.
9	**22 November 2022** **Guy Davies**