Lancashire & Blackburn with Darwen Coroners

Regulation 28: REPORT TO PREVENT FUTURE DEATHS (pursuant to Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Chief executive, NHS England
1.	**Coroner** I am Christopher Long, Area Coroner for Lancashire and Blackburn with Darwen.
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3.	**INVESTIGATION and INQUEST** On 10 August 2022 I commenced an investigation into the death of Sarah Elizabeth Read, aged 31. The investigation concluded at the end of the inquest. The conclusion of the inquest was: Sarah Elizabeth READ died on 7 August 2022 at Royal Preston Hospital, Preston in Lancashire. Sarah underwent congenital heart surgery as a child and subsequently required a mechanical mitral valve replacement. As a result of her complex medical history, she was at high risk of thrombus which required intense anticoagulation. Her anticoagulation therapy was adjusted due to pregnancy but despite this she suffered a stroke which led to a decision to terminate the pregnancy which required interruption of anticoagulation to reduce the risk of bleeding. Three days late she suffered another stroke but following an extended stay in hospital she did not recover. Her medical cause of death was found to be:-

	1a Stroke 1b Mitral Valve Replacement 1c Treated infective endocarditis II Pregnancy
4.	**Circumstances of the death** Sarah underwent congenital heart surgery as a child and subsequently required a mechanical mitral valve replacement. As a result of her complex medical history, she was at high risk of thrombus which required intense anticoagulation. Her anticoagulation therapy was adjusted due to pregnancy but despite this she suffered a stroke which led to a decision to terminate the pregnancy which required interruption of anticoagulation to reduce the risk of bleeding. Three days late she suffered another stroke but following an extended stay in hospital she did not recover.
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 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:- (1) Evidence was heard that there is no provision in Lancashire for Thrombectomy Service following a stroke after 5pm and that neighbouring Trusts who provide this service are no longer able to accept patients from Lancashire. Despite efforts made to resolve this, there is nothing in place for coordination of this service regionally to ensure that this urgent lifesaving treatment is available when required after 5pm.
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 15 January 2024. 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: • The Read family • [redacted] (partner) • Lancashire Teaching Hospitals • Manchester University NHS Foundation Trust I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9.	**17.11.2023**  **Christopher Long** **Area Coroner for Lancashire and Blackburn with Darwen**