REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT DATED 17 JUNE 2025 IS BEING SENT TO:** **NHS England.** For information: **Family of Greta Mary Ann Lewis** **Chief Coroner.**
1	**CORONER** I am Philip SPINNEY, HM Senior Coroner, for the coroner area of The County of Devon, Plymouth and Torbay.
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 16 July 2021 an investigation was commenced into the death of Greta Mary Ann Lewis. The investigation concluded at the end of the inquest held on 10-11 June 2025. The conclusion of the inquest was that Greta Ann Lewis died as a consequence of complications of a stroke. The short form conclusion of *natural causes* was recorded.
4	**CIRCUMSTANCES OF THE DEATH** In March 2020 Greta Mary Ann Lewis suffered a stroke which left her with right sided weakness. She was cared for at home by her husband with support from a care package. In March 2021 she became unwell and after initial treatment at home by her GP, on 12 March 2021 she was admitted to North Devon District Hospital. Over the next weeks she was treated in North Devon District Hospital and South Molton Community Hospital. Despite treatment she became more unwell and frail. Her final hospital admission was in South Molton Community Hospital where she sadly died on 12 July 2021 due to complications caused by her stroke. The evidence revealed that on 31 March 2020 Mrs Lewis was triaged in the emergency department North Devon District Hospital (NDDH) at 1402hrs; it was noted that she attended following a stroke, describing the onset of right sided facial droop and right sided arm and leg weakness at 1300hrs.

	The hospital had been pre-alerted as this was a potentially time critical episode. Mrs Lewis was assessed by the duty consultant and a junior Dr. Her symptoms and signs were noted and it was recognised that she was not eligible for thrombolysis (clot busting medication) as she was taking rivaroxaban. She also had a stroke severity assessment score calculated as less than 5, this is a national score based on the symptoms and is used to guide immediate treatment options. This score meant that she would not benefit from a thrombectomy (the removal of clots by mechanical retrieval). This is a procedure only performed in Derriford in Plymouth or Bristol Hospital by an interventional neuroradiologist, this is a specialist and highly skilled procedure. Following a CT scan Mrs Lewis deteriorated further with worsening weakness and the addition of speech problems. This deterioration meant that she was now eligible for thrombectomy, however this was not available at NDDH at that time and she had missed the window of opportunity for a referral to Derriford which was 1500hrs. The inquest heard evidence that at the time there was no further possibility of referral. Evidence was also heard that the current situation is that the cut off time for referral is now 16.30hrs. A thrombectomy can reduce the risk of severe disability or permanent damage caused by blood clots, restore blood flow to vital organs and can potentially prevent limb loss or death in acute cases.
5	**<u>CORONER'S CONCERNS</u>** The concerns relate to the provision of the thrombectomy procedure to patients suffering with a stroke in the South West. 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) The evidence revealed that there is a gap in the availability of the time critical and potentially lifesaving thrombectomy emergency procedure to patients that have suffered a severe stroke in the South West.
6	**ACTION SHOULD BE TAKEN** **(1) Consideration should be given to reviewing the availability of thrombectomy procedures in the south west and consider the**

	viability of a 24/7 service. In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 11th August 2025 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 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. She may send a copy of this report to any person who she 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	**SIGNED:** **Mr Philip C Spinney** **HM Senior Coroner**