REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], Chief Executive, NHS England 2. [redacted], Chief Executive, Northern Care Alliance NHS Foundation Trust 3. [redacted], Chief Executive, Lancashire Teaching Hospitals
1	**CORONER** I am Christopher Long senior coroner, for the coroner area of 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.
3	**INVESTIGATION and INQUEST** On 19 December 2024 I commenced an investigation into the death of Michelle Julie Marie Michael MASON, 45 years old. The investigation concluded at the end of the inquest on 28 May 2025. The conclusion of the inquest was: Michelle Julie Marie Michaela MASON died on 1 June 2024 at Royal Infirmary, Lancaster in Lancashire. After a sudden onset of lack of vision, vomiting and severe pain an ambulance was called for Michelle, and she was taken to hospital. She was reviewed by a doctor around 6 hours later, by which time it was too late to treat Michelle by thrombolysis. Alternative treatment by thrombectomy was considered which would have required Michelle to have been transferred to another hospital but no thrombectomy service was available locally. Thought was given to transferring Michelle to another hospital in the region, but it was considered to be too late by that stage for treatment. She did not recover. Michelle's medical cause of death was found to be 1a. Ischaemic Stroke 1b Basilar Artery thrombus
4	**CIRCUMSTANCES OF THE DEATH** Michelle Julie Marie Michaela MASON died on 1 June 2024 at Royal Infirmary, Lancaster in Lancashire. After a sudden onset of lack of vision, vomiting and severe pain an ambulance was called for Michelle, and she was taken to hospital. She was reviewed by a doctor around 6 hours later, by which time it was too late to treat Michelle by thrombolysis. Alternative treatment by thrombectomy was considered which would have required Michelle to have been transferred to another hospital but no thrombectomy service was available locally. Thought was given to transferring Michelle to another hospital in the region, but it was considered to be too late by that stage for treatment. 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) NHS England national service specifications provide for a 24/7 thrombectomy service which is not currently being delivered in Lancashire and there is no clear plan to deliver that service (2) There is a lack of understanding from non-stroke specialist clinicians in Lancashire as to when and where thrombectomy services are available for patients in Lancashire (3) There is no mutual aid regionally, even where thrombectomy is available, clinically appropriate, it is known lack the procedure is likely to result in death and it is anticipated resources are available to complete the procedure.
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 31 July 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 and to the following Interested Persons: Family, University of Morecambe Bay NHS Foundation Trust and Northwest Ambulance Service. I have also sent it to the Chief Executive of the Walton Centre NHS Foundation Trust 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	 **DATE 2 June 2025** **Mr Christopher Long** **HM Area Coroner**