Newcastle and North Tyneside
Miss Georgina Nolan
HM SENIOR CORONER
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Date: 10 September 2025 [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

CORONER

1 I am Thomas Crookes Assistant Coroner for the Coroner area of Newcastle and North Tyneside.

CORONER'S LEGAL POWERS

2 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

INVESTIGATION and INQUEST

3 On 15 November 2024 I commenced an investigation into the death of Keith REYNOLDS. The investigation concluded at the end of the inquest. The conclusion of the inquest was natural causes and recognised complications of a necessary surgical procedure.

The medical cause of death was

1a Left-Sided Cerebral Infarct

1b Thrombosis of a Left Internal Carotid Artery Stent

II Coronary Artery Bypass Graft and Mitral Valve Repair Operation (11/11/24), Hypertensive Heart Disease, Coronary Artery Atheroma and Mitral Valve Disease

CIRCUMSTANCES OF THE DEATH

4 Keith Reynolds had a history of hypertensive heart disease, coronary artery atheroma and mitral valve disease. He attended hospital on 26 October 2024 with symptoms of unstable angina for which he required an expedited coronary artery bypass and mitral valve repair. Pre-operative assessment indicated that a carotid artery stent was required first to avoid a substantial risk of death during the bypass operation. This procedure occurred on 5

November 2024. The bypass and valve repair surgery took place on 11 November 2024. Mr Reynolds initially appeared well but subsequently became unresponsive, having suffered an ischaemic stroke as a result of the stent becoming blocked with a blood clot. Options were considered in relation to this. Thrombolysis was contraindicated due to his recent surgery. A mechanical thrombectomy was not possible because this service is not available out of hours but would not have been viable in any case due to Mr Reynold's Alberta Stroke Programme Early CT Score (ASPECTS). Mr Reynolds was therefore switched to palliative care and died on 14 November 2024 in the Freeman Hospital, Newcastle upon Tyne as a result of the stroke.

CORONER'S CONCERNS

5 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) A mechanical thrombectomy service is not available in the region outside of 9.00am to 5.00pm due to insufficient neuroradiologists being available to run such a service. I am told that this issue is listed on the Newcastle Upon Tyne Hospitals NHS Foundation Trust's 'Risk Register' and that a business plan has been submitted to NHS England in relation to funding for additional clinicians. However, at the present time, should patients currently require a mechanical thrombectomy outside of the hours of 9.00am to 5.00pm, such a service would not be available to them and this could result in their death despite this potentially being preventable were such a service available.

6 **ACTION SHOULD BE TAKEN**

In my opinion action should be taken to prevent future deaths and I believe you / 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 6 November 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; [redacted] (Mr Reynolds' son). I have also sent it to NHS England 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.

10 September 2025

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Signature 

Thomas Crookes, Assistant Coroner for the Coroner area of Newcastle and North Tyneside.