REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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, West Suffolk NHS Foundation Trust** **2 [redacted], Chief Executive, Suffolk and North East Essex Integrated Care Board**
1	**CORONER** I am Darren STEWART OBE, HM Area Coroner for the coroner area of Suffolk
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 17 January 2024 I commenced an investigation into the death of **Lauren Rae MORET-DELL** aged **32.** The investigation concluded at the end of the inquest on 21 November 2025. The conclusion of the inquest was: **Narrative Conclusion - Lauren Rae MORET-DELL was a much loved and desperately missed member of her Family. A person who during her relatively short life, cut so tragically short, had a significant, positive impact on the lives of those around her.** **Mrs. Moret-Dell presented to West Suffolk Hospital Emergency Department on 23rd December 2023 after she developed symptoms of nausea with incoordination and slurred speech. She had a background history of type 1 diabetes mellitus with proliferative retinopathy for which she had undergone laser treatment. Neurological examination was unremarkable. A Computed Tomography (CT) head scan showed no abnormalities. Her symptoms were considered likely to be due to poor glucose control. A Transient Ischaemic Attack (TIA) was considered an unlikely but possible cause of her symptoms. She was commenced on aspirin. A plan was made for Mrs. Moret-Dell to be referred to the TIA clinic which subsequently was not made through the correct pathway.** **On 3rd January 2024 Mrs Moret-Dell's GP surgery contacted West Suffolk Hospital asking them to confirm whether she had a TIA clinic appointment booked. The TIA clinic team received a request to review Mrs Moret-Dell on 4th January 2024 contacting her in turn on 5th January 2024 offering her an appointment that day, which Mrs Moret-Dell was unable to attend. An appointment was arranged for 11th January 2024.** **In the early hours of 8th January 2024 Mrs Moret-Dell collapsed at home when getting out of bed. She was attended by ambulance paramedics who found her to be alert, have left sided weakness and slurred speech. She was admitted by ambulance to the West Suffolk Hospital emergency department. A CT head scan showed no abnormalities. She then developed bilateral arm and leg weakness,**

	was unable to speak and had a progressive deterioration in her consciousness level requiring intubation and admission to the intensive therapy unit. **A CT angiogram (CTA) was obtained which showed occlusion of the left internal carotid artery (ICA). Mrs Moret-Dell was discussed with the Addenbrookes Hospital stroke team and transferred on the afternoon 8th January 2024 for further assessment for possible thrombectomy in a late (6-24 hour) time window. A repeat CT angiography at Addenbrookes Hospital showed right anterior circulation artery and distal right middle cerebral artery occlusions as well as the left ICA occlusion. A CT perfusion scan showed bilateral hemispheric ischaemic strokes with no salvageable tissue and a thrombectomy was therefore not undertaken.** **Mrs Moret-Dell was transferred to the neurocritical care unit where she sadly died on 10th January 2024.** **A postmortem examination of Mrs. MORET-DELL's body established that her medical cause of death was due to a Bilateral Embolic Stroke.** **Lauren Rae MORET-DELL died due to the effects of a Bilateral Embolic Stroke, a naturally occurring condition.** The medical cause of death was confirmed as: **1a Bilateral Embolic Stroke** **2 Type 1 Diabetes Mellitus**
4	**CIRCUMSTANCES OF THE DEATH** **Narrative Conclusion see part 4**
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: **West Suffolk Hospital NHS Foundation Trust** During the course of the Inquest evidence was heard that neither the treating consultant, nor specialist doctors working in the team that treated Mrs. Moret-Dell on the 23rd December 2023 were proficient in the process to make referrals to the Transient Ischaemic Attack (TIA) Clinic. Evidence was also heard as to the importance of timely referrals to the TIA clinic in line with National Institute of Clinical Excellence (NICE) Guidance. Although the failure to refer Mrs. Moret-Dell to the TIA Clinic in a timely manner was not causative of her death, I am concerned that in another case the failure to correctly understand and implement TIA Clinic referrals in a timely manner gives rise to a risk of death. **Suffolk and North East Essex Integrated Care Board** Evidence was heard at the Inquest that the out of hour provision for stroke care did not include West Suffolk Hospital based stroke consultant input, this being obtained either through an approach to Addenbrookes Hospital, Cambridge, or other specialist hospitals in London. Due to the distances and time involved to

	subsequently transport patients to specialist centres, the lack of access to stroke consultant input adversely impacts on the treatment of stroke patients during out of hours. I am concerned that the lack of commissioned stroke consultant input during out of periods at west Suffolk Hospital gives rise to a risk of death.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 April 1st, 2026. 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 of Lauren Rae MORET-DELL** I have also sent it to **Care Quality Commission** who may find it useful or of interest. 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	**Dated: 04/02/2026** [redacted] **Darren STEWART OBE** **HM Area Coroner for** **Suffolk**