Coroner Service
West Sussex, Brighton & Hove

Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1. NHS England, Wellington House** **133-135 Waterloo Road, London, SE1 8UG.** **2. University Hospitals Sussex NHS Foundation Trust, Eastern Road, Brighton**
1	**CORONER** I am **Lisa Milner,** Assistant Coroner, for the coroner area of West Sussex, Brighton and Hove.
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 30 January 2024 I commenced an investigation into the death of Barry MYERS aged 59. The investigation concluded at the end of the inquest on 21 January 2025. The conclusion of the inquest was that: Barry Myers sadly died on the 28 January 2024 at Royal Sussex County Hospital, after suffering an ischaemic cerebral artery stroke. Unfortunately, a mechanical thrombectomy was not undertaken, as Barry had presented at the hospital outside of the hours, when the thrombectomy was able to be performed.
4	**CIRCUMSTANCES OF THE DEATH** Barry Myers sadly died on the 28 January 2024 at Royal Sussex County Hospital, Brighton, after suffering an ischaemic cerebral artery stroke. Whilst it appears that Barry had failed to manage his anticoagulant medication, potentially resulting in his stroke, he could not have a mechanical thrombectomy as there was no service available outside of the operational hours of the department involved at University Hospitals Sussex NHS Foundation Trust. Further, there were missed opportunities to transfer Barry to another centre that were able to provide a mechanical thrombectomy in that time.

5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) The court heard there is insufficient funding in place for patients to be provided with an urgent mechanical thrombectomy between the hours of 4 pm and 8 am at University Hospitals Sussex NHS Foundation Trust.
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 29th May 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:- **The family of Barry Myers** 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 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 by the Chief Coroner.
9	Dated: 12th March 2025  **Lisa Milner** **Assistant Coroner, West Sussex, Brighton and Hove**