

Your Ref: AAH/EAW 359-2015

Our Ref: INQ/091/15

Date: 24 August 2015

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Mr A Haigh
Coroner's Office
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Email: 

Dear Mr Haigh

Mary Winifred HYDEN

Further to my letter dated 10 July 2015, I am pleased to provide a response to your report under paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, addressing your concerns surrounding the death of Mrs Mary Hyden.


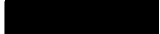
Background

Mrs Hyden was referred to a neurologist in 2013 and after a CT scan was found to have a tumour on her brain. She saw the neurologist again in 2014 but still no information about the tumour was given to her or her GP. It may be that at no time was curative surgery possible in any event but there could have at least been better palliation of her symptoms. She died at home on 16 February 2015.

The Conclusion of the inquest was a naturally occurring intracranial tumour that was not successfully treated.

Concerns

During the course of the inquest H M Coroner, Mr Haigh, felt that evidence revealed matters giving rise for concern. In his opinion, matters for concern are as follows:

1. At the inquest Mr Haigh heard helpful evidence from  Consultant Neurologist. She was frank about the failures in communication in 2013 and 2014 and advised Mr Haigh of significant changes since Cannock Hospital was transferred to the Royal Wolverhampton Trust. However,  also indicated in evidence that she is working regularly 7 days a week and the day before the inquest worked 14 hours (and again this was not unusual). These do appear to be excessive hours with an increased potential for fatal errors. I should be grateful if you could look at this.

Action Taken

The EC Directive on Working Time for Consultants was introduced in October 1998 and from this time onwards, all consultants are covered by the entitlements afforded by the Directive. In 1998, the Central Consultants and Specialists Committee (CCSC) of the British Medical Association and the NHS Executive negotiated a collective agreement regarding the application of the Directive for senior hospital doctors, which applied derogations to inflexible hourly, daily and weekly limits under regulation 21 and in their place established the right of senior hospital doctors to take compensatory rest where the limits were exceeded. These derogations were applied to ensure that continuing responsibility to patients was maintained and the necessary protection for senior hospital doctors under the directive was retained.

This essentially means that the regulations relating to night working, daily rest, weekly rest and breaks at work do not apply to career grade hospital doctor, such as Dr Summers. However, under regulation 21, they are able to accrue compensatory rest for hours worked during rest breaks; this enables career grade doctors to continue to carry on their duties flexibly and professionally ensuring that they are able to maintain continuity of service. Dr Summers worked under this regime and her job plan reflected the above required criteria. Essentially, she was not working outside of the regulations.

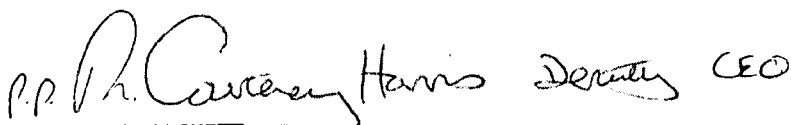
Nevertheless, I understand that the Medical Director and the Clinical Director for Neurosciences have reviewed [REDACTED] job plan (July 2015) and a new job plan will be effective from 1 October 2015. In her new job plan, [REDACTED] clinical sessions will be reduced to allow her to have a better work life balance and since November 2014, Dr Summers does not travel to Cannock Hospital to undertake clinics and ward referrals and this has significantly reduced her travel requirements.

In addition to this, [REDACTED] is not currently working in isolation at the County Hospital and has the support of a second Consultant. She has also been encouraged to utilise the administrative support that is available to her. As a Neurosciences Directorate we are keen to provide the right working environment for [REDACTED] and patient safety is very high on our priorities.

I sincerely hope that this report provides H M Coroner, Mrs Haigh, with assurance that the University Hospitals of North Midlands NHS Trust has taken the matters arising from the inquest touching upon the death of Mary Hyden seriously. Whilst it is understood that this failure in communication occurred prior to the merger of the University Hospital of North Staffordshire and Mid Staffordshire NHS Foundation Trust, the Trust strives to provide a high standard of care to all patients and I am grateful to you for raising these matters on this occasion so that we were able to review our processes post-merger.

Should you wish to discuss any aspect of this report further, please do not hesitate to contact me directly.

Yours sincerely


MARK HACKETT
CHIEF EXECUTIVE