	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mark Hackett : Chief Executive University Hospital North Midlands Stoke on Trent**
1	**CORONER** I am Mr Andrew Haigh Senior Coroner for the Coroner area of Staffordshire South
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 23rd February 2015 I commenced an investigation into the death of Mary Winifred HYDEN, aged 88 years. The investigation concluded at the end of the inquest on 23rd June 2015. The conclusion of the inquest was **"A naturally occurring intracranial tumour that was not successfully treated" With the cause of her death being 1a Pulmonary Thrombo-embolism 1b Suprasellar meningioma.**
4	**CIRCUMSTANCES OF THE DEATH** Mrs Hyden was referred to a neurologist in 2013 and after a CT scan was found to have a tumour by 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 at least have been better palliation of her symptoms. She died at home on 16th February 2015.
5	**<u>CORONER'S CONCERNS</u>** 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) At the inquest I heard helpful evidence from [redacted] Consultant Neurologist. She was frank about failures in communication in 2013 and 2014 and advised me of significant changes since Cannock Hospital was transferred to the Wolverhampton Trust. However [redacted] 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.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 **26th August 2015.** 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] **(daughter of deceased) and** [redacted] **(sister of deceased)** 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.
9	**1st July 2015** Andrew A Haigh HM Senior Coroner Staffordshire (South)