ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Mr M Hackett** **Chief Executive** **University Hospital of North Staffordshire** **Chief Executive's Office** **Trust Headquarters** **City General Site** **Newcastle Road** **Stoke-on-Trent** **ST4 6QG**
1	**CORONER** I am Ian Stewart Smith, senior coroner, for the coroner area of Stoke-on-Trent & North Staffordshire.
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 24th April 2014 I commenced an investigation into the death of Arthur Lindsay Fry aged 60. The investigation concluded at the end of the inquest on 24th November 2014.. The conclusion of the inquest was that Mr Fray died as a result of a recognised complication of surgery with the cause of death being given as:- 1a Brain infarction and thrombosis of left sigmoid venous sinus. 1b Glioblastoma, WHO grade IV (operated).
4	**CIRCUMSTANCES OF THE DEATH** Following symptoms which began in late 2013 the deceased was diagnosed in February 2014 with a brain tumour subsequently typed as a glioblastoma multiforme WHO grade 4. On 14th April 2014 at the University Hospital of North Staffordshire, Stoke-on-Trent he underwent a debulking of the tumour by means of a temporal craniotomy. The procedure was successful initially and he was making a good recovery until the late evening of the 15th April when he developed a markedly elevated high blood pressure and significant neurological deficit. An MRI scan planned for the afternoon of the 15th April had not been carried out because of a breakdown in communication. A CT scan performed at about midnight revealed subdural haematoma, midline shift and features suggestive of infarction of the thalamus. The deceased was taken back to theatre and the haematoma evacuated. No specific bleeding point could be identified rather a generalised bleed from the operative site. Following the procedure his intracranial pressure continued to rise and a CT scan at 6.55am on 16th April showed extensive infarction of the left hemisphere and of the brainstem. His condition did not improve and he died at 10.00am on 17th April 2014.and that earlier diagnosis would not have made any significant outcome.
5	**CORONER'S CONCERNS** During the course of the inquest I heard evidence that an MRI scan had been scheduled for 15th April 2014 because of a down turn in the deceased's condition. He was taken to

	the MRI scanning department but he was declined for scanning by the radiographer because an issue over safety and a further consent form was required by two doctors. This requirement was not made known to the consultant or his team and there was a breakdown in communication. The failure to carry out the MRI scan may have impacted upon the deceased's care. Tighter controls concerning the requisitioning of procedures (in this case MRI and CT scans) need to be designed to avoid confusion and potential failures to carry out the procedures. I am aware that some recommendations have been put forward but I would like to be sure that they are being implemented.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 Friday 4th September 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 following persons:- 1. Chief Coroner, Regulation 28 Reports, Chief Coroner's Office, 11th Floor Thomas More Building, Royal Courts of Justice, The Strand, London, WC2A 2LL 2. [redacted], Healthcare Governance Manager Patient Safety, UHNS Trust Headquarters, City General Hospital, Newcastle Road, Stoke-on-Trent, ST4 6QG 3. [redacted] (widow of the 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	[redacted] 7th July 2015