

**REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS
2013**

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's [PFD Publication Policy \(2026\)](#).

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| 1. | CORONER
I am Mr Zafar Siddique, Senior Coroner, for the coroner area of Black Country. |
| 2. | DATE OF REPORT
4 August 2026 |
| 3. | 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. | THIS REPORT IS BEING SENT TO

1.The Royal Wolverhampton Trust / Walsall Healthcare NHS Trust.

You are under a duty to respond to this report within 56 days of the date of this report, namely by 29 September 2026. I, the coroner, may extend the period if an appropriate application is made. |
| 4. | YOUR RESPONSE
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.

I have a duty to send a copy of your response to the Chief Coroner.

In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision.

Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. |

	The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
5.	SUMMARY OF CORONER'S CONCERN I have concerns about the Trusts referral process between Hospitals when an urgent referral is made by telephone only. There is a risk of no formal recording of the request including documentation and subsequent audit trails.
6.	ACTION SHOULD BE TAKEN In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
7.	INVESTIGATION AND INQUEST On 26 January 2026, I commenced an investigation into the death of Martin Alan Poole, aged 69 years and the inquest was concluded on the 30 July 2026. The medical cause of death was 1a) Metastatic Sarcoma of the Prostate Conclusion: Narrative Conclusion The deceased died after developing an aggressive and fast developing Sarcomatoid Carcinoma of the prostate which on balance would have had limited response to conventional treatments..
8.	CIRCUMSTANCES OF DEATH The deceased, Mr Poole was a 69-Year-old gentleman with previous medical history of retention of urine, penile mass and enlarged prostate. He was admitted into Manor Hospital in Walsall with a Hernia on 11/08/2025, where a CT scan found that he had an enlarged prostate and notes reflected that he would be referred for urgent follow-up by Urology at New Cross Hospital. This referral was made by telephone but then subsequently downgraded to non-urgent. Mr Poole then presented to his GP who also made a referral to Urology.

	However, in November of the same year he was admitted to New Cross Hospital and was experiencing problems with this catheter and urinary retention. Further examination diagnosed widespread metastatic disease. His condition declined and by the 16th of January 2026 he was placed into Goscote Hospice for end-of-life care and sadly passed away on 24th January 2026.
9.	CORONER'S CONCERNS During the course of the inquest I heard evidence 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: I have concerns about the Trusts referral process between Hospitals when an urgent referral is made by telephone only. There is a risk of no formal recording of the request including documentation and subsequent audit trails.
10.	COPIES AND PUBLICATION OF THIS REPORT I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: 1.Family of Mr Poole I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
	SIGNATURE 

