REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Department of Health, London 2. Royal College of Physicians, London
1	**CORONER** I am Ms L Hashmi, Area Coroner for the Coroner area of Manchester North.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 6th June 2016 I commenced an investigation into the death of Peter Seale.
4	**CIRCUMSTANCES OF DEATH** Mr Seale had an occupational history of asbestos exposure. In 2011 a chest x-ray showed the presence of pleural plaques. The deceased was not told of this diagnosis at the material time. In 2013 he had further chest x-rays as a result of a persistent cough. Whilst the x-rays did not show any changes in relation to the pleural plaques, no further tests were conducted (e.g. CT) despite his history of occupational exposure (to asbestos) and presenting symptoms. In 2015, the deceased re-presented and was diagnosed with terminal lung cancer. Following post mortem examination the cause of death was: 1a) Bronchopneumonia 1b) Bronchogenic adenocarcinoma 1c) Occupational exposure to asbestos The conclusion at inquest was industrial disease.
5	**CORONER'S CONCERNS** 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. There is no national guidance in relation to the follow-up and monitoring of patients with pleural plaques. Medical opinion is split on the issue leading to inconsistency of approach. There is a risk that patients will be 'lost to follow-up' in cases where action could be taken to afford early/earlier diagnosis/treatment and thus prevent death.

6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 the 3rd August 2016. 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 namely:- • The deceased's family • Pennine Acute Hospitals NHS Trust 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 from. 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	Date: 8th June 2016 Signed: