REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Beatson Clark, Greasbrough Road, Rotherham S60 1TZ 1 CORONER Tanyka Rawden, Assistant Coroner for South Yorkshire (West) **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 13th February 2019 an investigation was commenced into the death of Richard Wayne Barraclough aged 51 years. The investigation concluded with an inquest on 7th June 2019. The inquest was assisted with evidence from the brother of the deceased, , general practitioner, Pathologist . The conclusion of the inquest was that Richard Wayne Barraclough died as a result of industrial disease. CIRCUMSTANCES OF THE DEATH Richard Wayne Barraclough was employed by Beatson Clark, Greasbrough Road, Rotherham, S60 1TZ as a Machine Setter. He died on 18th January 2019 at the Northern General Hospital. The medical cause of death is: 1a. Advanced Carcinomatosis 1b. Urothelial Tract Carcinoma 5 **CORONER'S CONCERNS** During the course of the investigation my inquiries 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 MATTER OF CONCERN is as follows. -Evidence was given before the Court that the deceased worked without protective equipment and was therefore regularly and extensively exposed to polycyclic aromatic hydrocarbons. There is an establish link between exposure to polycyclic aromatic hydrocarbon and Urothelial Tract Carcinoma The inquest heard that employees continue to work in the same environment without any protective equipment In my opinion there is a risk that future deaths may occur unless a system is established at Beatson Clark to protect employee being exposed to polycyclic aromatic hvdrocarbons.

6 ACTION SHOULD BE TAKEN

In my opinion urgent 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 7 August 2019. I may extend this period upon your application.

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:

Others sent copies for information:

- 1. Public health England, Wellington House,133-155 Waterloo Road, London, SE1 8UG
- 2. Health and Safety Executive, Foundry House, 3 Millsands, Riverside Exchange, Sheffield, S3 8NH

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.

Mrs Tanyka Rawden 12th June 2019