REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Governing Body Consultant in Public Health, South **Lincolnshire Clinical Commissioning Group** Clinical Leader and Chair of Boston Area Locality, East Lincolnshire Clinical Commissioning Group CORONER 1 I am Alexander R W Forrest, senior coroner, for the coroner area of South Lincolnshire. 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. INVESTIGATION and INQUEST 3 On 20th August 2012 I commenced an investigation into the death of Dimitar SHTARBOV, born on 18th August 1984. The investigation concluded at the end of the inquest on 26th July 2013. The conclusion of the inquest was that the meical cause of death was 1a Bilateral Pneumothoraces due to 1b Acute Asthma and that this was an Accident. CIRCUMSTANCES OF THE DEATH Dimitar was a Bulgarian seasonal Agricultural worker with a long history of asthma treated with bronchodilator inhalers, theophylline and long acting injected corticosteroids in Bulgaria. He did not declare this history when he completed pre-employment questionnaires. He arrived in Lincolnshire for his second year of seasonal work on 6th July 2012. He became ill in early August and attended the A&E department at Pilgrim Hospital 9th & 10th August 2012. Clinical staff at the hospital did not learn of his history of Asthma. He was treated for a wheezy chest infection with antibiotics and a salbutamol inhaler. On the 11th of August, his condition deteriorated and his fellow workers brought him to the A&E department at Pilgrim Hospital. He was in cardiac arrest on his arrival and recuscitation attempts were unsuccessful 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) Evidence was presented to the effect that the majority of seasonal agricultural workers do not know how to access General Practitioner Services and indeed are not aware of the service. They often access primary health care at need via the accident and emergency department (2) They are often not aware of either the 999 service or the 111 service (3) They are often not aware that they are entitled to GP services in the UK, without charge, for the management of chronic medical conditions (4) Dimitar obtained salbutamol inhalers (labelled in both English and Bulgarian - the latter in Cyrillic Script) and injectable long acting beclomethasone (labelled in Cyrillic

script) by post from Bulgaria, with extra supplies being posted to him when he became ill. The evidence as to whether or not these medicines were shown to A&E staff was inconsistent. I was informed in Court that it is very common for seasonal workers with chronic conditions to have what would be prescription only medicines in the UK posted to them from home where such medicines can often be purchased freely without prescription. **ACTION SHOULD BE TAKEN** 6 In my opinion action should be taken to prevent future deaths and I believe your organisations have the power to take such action. YOUR RESPONSE 7 You are under a duty to respond to this report within 56 days of the date of this report. namely by 4th October 2013. 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 Person, Solicitor for the family. I have also sent it to National Review of Asthma Deaths, Royal College of Physicians) and Mr Derek Winter (Coroners Society of England & Wales) who may find it useful or of interest. 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. 8th August 2013 9