




**Mark Andrew Beresford**  
**Assistant Coroner for South Yorkshire (East District)**

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO: The Chief Executive</b> Doncaster Royal Infirmary Armthorpe Road Doncaster DN2 5LT</p>
1	<p><b>CORONER</b></p> <p>I am Mark Andrew Beresford, Assistant Coroner for South Yorkshire (East District)</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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. <a href="http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7">http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7</a> <a href="http://www.legislation.gov.uk/uksi/2013/1629/part/7/made">http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</a></p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 16/02/2016 I commenced an investigation into the death of Thomas William Pearson, 64 . The investigation concluded at the end of the inquest on 24 June 2016. I recorded a narrative conclusion that Mr Thomas William Pearson died at Doncaster Royal Infirmary on 11th February 2016 from a combination of a lung disease, which was attributable to his work as an underground coal miner and to his cigarette smoking, and of rheumatoid arthritis. I recorded the medical cause of Mr Pearson's death as 1(a) Chronic obstructive pulmonary disease (chronic bronchitis) and rheumatoid arthritis</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>Mr Pearson was a retired coal miner who had been a heavy smoker. He suffered from, inter alia, chronic obstructive pulmonary disease and rheumatoid arthritis.</p> <p>In 2015/2016 he suffered a number of bouts of pneumonia and, on a number of occasions, was admitted to Doncaster Royal Infirmary.</p> <p>On 22<sup>nd</sup> January 2016 Mr Pearson was admitted with debilitating breathlessness. He received treatment but died, at Doncaster Royal Infirmary, on 11<sup>th</sup> February 2016.</p>
5	<p><b>CORONER'S CONCERNS</b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. --</p> <p>(1) Mr Pearson suffered from chronic obstructive pulmonary disease and rheumatoid arthritis. He had worked underground as a coal miner for approximately 26 years and had been a heavy smoker.</p> <p>(2) For approximately 4 years (up to January 2016) Mr Pearson was using an inhaler containing seretide, one of the component elements of which is fluticasone.</p> <p>(3) In the latter months of his life Mr Pearson suffered a number of bouts of pneumonia.</p> <p>(4) Dr T Rogers (Consultant Respiratory Physician), who gave evidence at the inquest, confirmed that fluticasone causes a reduction in the body's defence mechanisms and, as a</p>

	<p>result, carries with it an increased risk (estimated at 1.7 fold) increase in the risk of the patient developing pneumonia.</p> <p>(5) For a proportion of patients, the increased risk of developing pneumonia may be justified by the benefits that the use of fluticasone brings. However, Dr Rogers also stated that, for the majority of patients, namely those without a raised eosinophil count (a group which included Mr Pearson), fluticasone, whilst still carrying an increased risk of the development of pneumonia, would bring no benefits.</p> <p>(6) In response to an enquiry put to him, Dr Rogers agreed that it would be helpful for the use of inhaled steroids (in particular fluticasone) to be reviewed.</p>
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6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe you The Chief Executive have the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 18 August 2016. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons. [REDACTED]  [REDACTED] I have also sent it to NHS England who may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>Dated 04 July 2016</p> <p>Signature   Assistant Coroner for South Yorkshire (East District)</p>