	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Chief Executive Ms Paula Clark SaTH 2. Chief Executive Ms Tracy Bullock UNMH
1	**CORONER** I am Mr John Penhale Ellery, Senior Coroner, for the coroner area of Shropshire, Telford & Wrekin.
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.
3	**INVESTIGATION and INQUEST** On 4th March 2019 I commenced an investigation into the death of Peter Edward SMITH. The investigation concluded at the end of an inquest on the 29th day of January 2020. The inquest concluded with a narrative conclusion as follows: Natural cause contributed to by delay in diagnosis and treatment of his adenocarcinoma.
4	**CIRCUMSTANCES OF THE DEATH** On the 29th September 2018 a chest x-ray indicated a potential left upper zone abnormality resulting in a CT scan being performed on the 22nd November 2018 and a PET scan on the 27th December 2018. Subsequent tests and investigations lead to a date for surgery on the 26th February 2019. Time was of the essence but by then surgery was no longer possible. The deceased relapsed on 20th February and died on the 4th March 2019.
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 was significant delay in the diagnosis and treatment of Mr Smith's adenocarcinoma which contributed to his death on the 4th March 2019. 2. Time was of the essence, but tests, reports, appointments and discussions took place consecutively to the extent that by the time a final date for surgery was fixed it was no longer possible. 3. Had tests been conducted expeditiously and concurrently with predictable tests organised in advance it is likely that the surgery would have been able to take place significantly earlier than it did. 4. Although separate Trusts they were effectively treating Mr Smith's adenocarcinoma as one.

	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe your organisations 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 1st April 2020. 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 1. Lanyon Bowdler Solicitors for Mrs Christine Smith, widow 2. [redacted] for SaTH 3. [redacted] for UHNM 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.
	 Mr John Penhale Ellery Senior Coroner Shropshire, Telford & Wrekin 5th February 2020