Ian M Arrow Her Majesty's Senior Coroner
for the County of Devon
Plymouth, Torbay and South Devon Coroner Service

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Chief Executive, University Hospitals Plymouth, NHS Trust, Chief Coroner**
1	**CORONER** I am Ian Arrow, Senior Coroner for Plymouth Torbay and South Devon
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 27 June 2022 I heard an Inquest touching the death of David Anthony Hulme. I recorded a narrative conclusion, namely:- The deceased had a history of chest symptoms. In particular he had a right pulmonary abscess. On 12 June 2020 he underwent a right thoracotomy for pneumonectomy. Histology by a regional hospital pathologist confirmed this as sarcoidosis. It became clear the deceased was deteriorating further. On 25 January 2021 the Histopathologist referred the case to The National Centre of Excellence for lung conditions, a second Hospital Trust. On 1 February 2021 the deceased's wife reported worsening symptoms. On 10 February 2021 the second Trust indicated suspected B Cell Lymphoma. The samples were sent for a third opinion. On 15 February 2021 a supplemental report was issued by the third Trust. On 16 February 2021 a supplemental report was issued by the second trust. All this time the deceased remained on the Intensive Care Unit. The further opinions indicated a condition known as Lymphoma. The deceased was treated for Lymphoma. The deceased's condition deteriorated. A discussion not to resuscitate was had on 3 March 2021. The deceased died on 6 March 2021. His cause of death was Lymphoma a naturally occurring condition. I heard evidence from a Consultant Pathologist that her Pathology Department was under significant pressure of work and in her opinion was understaffed.

	I heard evidence from the Hospital Trusts Pathology Manager that he had prepared a business case for the additional appointments of Consultants.
4	**CIRCUMSTANCES OF THE DEATH** Please see above
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. – I am concerned that the Pathology Department remains significantly under resourced. I ask you please to:- (1) Review the Consultants staffing levels in the Pathology Department particularly those Consultants dealing with Thoracic work so as to ensure timely and accurate diagnosis of conditions at this regional centre.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 22 August 2022. 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. I have also sent it to the family. 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.
9	**Dated 27 June 2022** Signature_____ **I M Arrow, Senior Coroner** **Plymouth, Torbay and South Devon**