REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: NHS England
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South
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 26th January 2023 I commenced an investigation into the death of Elizabeth Jane Brown .The investigation concluded on the 18th May 2023 and the conclusion was one of **Narrative: Died from mesothelioma caused on the balance of probabilities by exposure to asbestos the precise source of which cannot be ascertained.** The medical cause of death was **1a) Mesothelioma ; 2) Chronic Obstructive Pulmonary Disease**
4	CIRCUMSTANCES OF THE DEATH Elizabeth Jane Brown had significant respiratory health issues including severe Chronic Obstructive Pulmonary Disease. In November 2022 a CT scan raised a suspicion of mesothelioma. Further tests and discussion confirmed that on the balance of probabilities she had mesothelioma caused by asbestos exposure. The source of the asbestos exposure could not be established. She deteriorated rapidly and died at Stepping Hill Hospital on 23rd January 2023 from mesothelioma.
5	<u>CORONER'S CONCERNS</u> 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. – The inquest heard evidence that Elizabeth Jane Brown had been referred to immunology services in 2018 due to low antibody levels and concerns about the overall impact on her health. A treatment plan was developed. She had an appointment on 4th February 2021 when the plan was that she should be followed up in 12 months' time. She had not been seen again at the date of her death on 23rd January. Such long waits and delays to see immunologists in specialist clinics were the inquest was told not unusual notwithstanding the role they could play in treating those in need of immunology services. The evidence before the inquest was that the reason for those delays was a significant shortage of qualified /trained staff nationally which had led to services across the country being run with a high level of vacancies. The position was not improving in terms of recruiting to vacant posts the inquest was told
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.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 7th May 2024. 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 namely 1) [redacted] on behalf of the Family and; 2) Manchester University NHS Foundation Trust, 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.
9	**Alison Mutch** **HM Senior Coroner**  **12.03.2024**