REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **Sir Simon Stevens** **Chief Executive** **NHS Engalnd** **PO Box 16738** **Redditch** **B97 9PT** **And** **Mr Duncan Selbie** **Chief Executive** **Public Health England** **Wellington House** **133-155 Waterloo Road** **London** **SE1 8UG**
1	**CORONER** I am **PENELOPE SCHOFIELD**, senior coroner, for the coroner area of **WEST SUSSEX**
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 22nd January 2018 I commenced an investigation into the death of Brenda Elmer aged 81 years. The investigation concluded at the end of the inquest on 5th February 2020 The conclusion of the inquest was a Narrative Conclusion which was recorded as:- Brenda Elmer died from complications associated with a Listeria infection that she had contracted from a contaminated sandwich provided by an external supplier whilst an inpatient at St Richard's Hospital, Chichester. This was part of a national outbreak. At the conclusion of the Inquest indicated that I was minded to make a Regulation 28 report. Regretably whilst the indication to make a Regulation 28 report was made at the Inquest the issue of the prevention of duture death report has been delayed due to the additional workload that has ensured due to the current pandemic for which I apologise.

4	**CIRCUMSTANCES OF THE DEATH** Mrs Elmer underwent an operation at St Richards Hospital on 1st May 2019 and was discharged on 3rd May 2019. In preparation for this operation she attended the Hospital on the 5th February, 25th April and 30th April. Unfortunately on one of these occasions she consumed a contaminated sandwich which led to her acquiring a listeria infection. On 2nd June 2019 she became very unwell and was admitted to Tunbridge Wells Hospital, which was her local hospital. She was treated for this infection but despite active treatment, over a prolong period, she sadly did not recover from this infection and she died on 17th July 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. – **First Concern** 1. Mrs Elmer attended St Richards Hospital, Chichester, for elective surgery. She had attended the hosptial for a Pre Operation Assessment on 25th April 2019 and was admitted for her surgery on 30th April 2019. Whilst attending the hospital she acquired a Listeria infection from a chicken sandwich although this was not know at the time. Mr Elmer did not live in Sussex and following her treatment she returned home to Kent on 3rd May 2019. 2. Western Sussex Hosptial Trust, NHS England and Public Health England (PHE) first become aware of a possible outbreak on Listeria on 19th May 2019 when blood cultures from another patient ast the Worthing Hospital site confirmed a listeria infection. On 26th May 2019 NHS England notified all hosptials of a national outbreak of Listeria and a possible link to sandwiches that has been provided by the Good Food Company, a supplier to a number of Trusts. 3. Whilst it was accepted that details of the possible outbreak were shared locally with other medical professionals (and therefore there was a local knowledge of the Listeria outbreak) there did not appear to be any attempt by NHS England or PHE (by way of a Public Health message) to communicate with those patients who were treated within the Trust but who were now out of the area in different parts of the Country. 4. It was unfortunately that when Mrs Elmer fell ill, neither her GP who initially treated her, nor her family had any idea that her illness may be connected to the Listeria outbreak. This meant that she was not prioritised for a blood test and this delayed her being treated appropriately for Listeriosis. This diagnosis was only made when she was admitted to Tunbridge Wells Hospital, her local hospital in Kent following an emergency admission. It is unknown whether earlier treatment would have changed the outcome but it may have eased Mrs Elmer's sufferning. 5. Consideration needs to be given to how communications should be disseminated following such an outbreak so that as many patients as possible, who had been in the hospital at the relevant time, are made aware and can seek medical assistance if they become unwell. **Second Concern.** 1. During the course of the Inquest evidence was given by the representative of Public Health England that there was no legal requirement for Private Laboraties who identifiy Listeria in food to share the Listeria isolate with PHE or indeed keep this isoloate for any period of time. If a problem is subsequentlhy identified

	by PHE then it makes it particulary difficult to check if particular products have been implicated. 2. Similary there is no legal requirement of Hospital Trusts to send in Listeria isolates when Listeria has been identified. This therefore does not allow PHE to match particular strains and identify outbreaks which are connected earlier. 3. In both these circumcumstances this leads to missed opportunities to deal with any outbreak.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 9th October 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:- The family of Brenda Elmer Western Sussex Hosptial Trust 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	**Date 14th August 2020**  **Penelope Schofield, H M Senior Coroner**