



Public Health  
England

Protecting and improving the nation's health

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**By post**

Coroner's Service  
County Record Office  
Orchard Street  
Chichester  
West Sussex PO19 1DD

Our ref: 20/08/kl/1073

28 October 2020

Dear Penelope Schofield,

**Re: Inquest into the death of Brenda Elmer on 05 February 2020**

Thank you for sending the attached report for Public Health England's (PHE) consideration.

Under the Coroners and Justice Act 2009, please find below PHE's response in relation to the investigation of the death of Brenda Elmer.

I will address your concerns in the order raised.

***First Concern***

***Establishment and Action of PHE Incident Management Team:***

The Manchester Health Protection Unit within PHE North West, held a meeting after notification of a local cluster of two deceased cases of listeriosis (26 April and 6 May 2020) in Manchester University NHS Foundation Trust on 7 May 2019. These cases were shown to have an identical whole genome sequence profile on 16 May 2019 in PHE Gastrointestinal Bacteria Reference Unit (PHE GBRU). PHE North West then became the incident lead. PHE North West with PHE National Infection Services implemented an Incident Management Team (IMT) with relevant local and national partners on 21 May 2019. On 22 May 2019, the implicated sandwich manufacturer was consequently inspected by the local authority environmental health team (Stafford Borough Council).

Subsequent third, fourth and fifth cases of listeriosis with identical genotype were identified on 23 May 2020, 3 June 2020 and 7 June 2020, respectively. On 24 May 2019, it was reported that a third case had consumed chicken and mayonnaise sandwiches supplied by the implicated sandwich manufacturer, while an inpatient in

a different NHS Trust. The primary hypothesis was developed by the IMT that sandwiches supplied to the hospitals were the source of *L. monocytogenes* infection.

At an IMT meeting on 25 May 2019, the risk assessment surmised that this cluster of cases represented an exposure that occurred between late March and mid-late May 2019, and intelligence on the supply chain indicated that it affected inpatients in 43 National Health Service (NHS) organisations in England, possibly one NHS facility in Wales and one in Scotland, where the sandwich manufacturer had distributed the implicated products. PHE also issued a letter to the supplier of the sandwiches on 25 May 2019 and to all NHS hospitals on 26 May 2020, stating an outbreak of listeriosis on sandwiches served in hospitals by Good Food Chain. The Food Standards Agency (FSA) issued a hazard warning on the implicated food processing facility, Good Food Chain, early in the outbreak. The Good Food Chain voluntarily ceased trading on the 5 June. A chicken sample from the Good Food Chain tested positive for the outbreak strain on 6 June 2019.

Altogether, 28 Incident meetings were held during the outbreak period of 7 May to 19 June 2019. PHE issued public briefing notes and proactive media statements on the outbreak on 28 May, 31 May, 7 June, 14 June and 2 July 2019. Furthermore, PHE and FSA gave public notifications on their website on the outbreak.

#### *Public Notification of Outbreaks:*

PHE agree that communications to the public need to be improved. However, as an executive agency, PHE investigates incidents and outbreaks. Any briefing regarding the incidents is conveyed to NHS England and individual NHS hospitals (which are independent statutory bodies themselves) and the local authorities. They are responsible for communicating, warning and informing their patients, local GPs (via the CCGs) and the public, respectively. PHE can inform the public about national investigations through the gov.uk website. Updates were posted on 7 June, 14 June, 17 June, 26 June and 7 August for this particular incident and high-risk groups were alerted. National and local media were also alerted to these notifications to make the public aware. Advice about medical conditions is provided by NHS England and the public were signposted to NHS website for further medical advice.

PHE has a standard protocol in place to investigate food borne outbreaks and listeria incidents. Due to the severity of listeriosis in vulnerable patient groups (pregnant, immunocompromised, elderly, chronic illness), all clinically compatible patients are screened for listeriosis by bacterial culture, strains are submitted to PHE for whole genome sequencing to be compared by bioinformatic methods to previous patient, food and environmental isolates. Even a single case with matching listeria genotype with a food and/or environmental sample is investigated further and full investigation carried out in the food facility if indicated.

#### *Action taken:*

PHE hosted a multi-agency lessons learnt exercise following the outbreak. This was organised by ERD and chaired by Professor [REDACTED], Medical Director and Director for Health Protection. This included highlighting a need to review hospital food policies.

## **Second concern**

Under EU legislation (2073/2005) there is a legal requirement for food business operators to report adverse results to the FSA. An adverse incident will be when *L. monocytogenes* is detected above the legal limit of 100 colony forming units. Commercial food testing laboratories also test foods for the presence of *L. monocytogenes*, usually for quality control checks for food businesses. There is a voluntary arrangement for them to submit cultures to the reference laboratory. There is no legal obligation for submission of low-level contamination of food or those of the environment.

PHE manages a network of laboratories testing food and water and approximately 25,000 samples at tested each year for the presence of *Listeria*. Similarly, publicly funded laboratories are located in Wales, Scotland and Northern Ireland. Approximately 800 isolates of *Listeria monocytogenes* recovered from food or the environment in England are submitted to the reference laboratory for comparison with isolates from clinical cases. Furthermore, on a voluntarily basis, *Listeria* isolates from the food and the environment are sent to PHE Food, Water and Environmental reference laboratory for sequencing and comparison with human isolates.

During 2019, altogether 821 *Listeria* food or environmental isolates were received, 28 (3 %) of them were from private laboratories. Out of those 28, 8 were from this outbreak and specifically asked for. Currently approximately 900-1,000 cultures of *L. monocytogenes* have been tested by whole genome sequencing to compare isolates from clinical cases of listeriosis with those from food and the environment. Almost all of these isolates come from clinical pathology laboratories and the publicly funded food and water laboratories in PHE. All isolates are tested by whole genome sequencing and the comparison of isolates from unrelated 'routine' testing by PHE food testing laboratories with cultures from clinical cases is the most common way to detect outbreaks of listeriosis. Hospitals do not take food or environmental samples.

There is a legal requirement under the Health Protection Notification Regulations 2010 (UK) to report cases of listeriosis to PHE. We agree that NHS Trusts should send all the *Listeria* isolates to the Reference laboratory for rapid detection of incidents. PHE have written to the national microbiological standards on 20 May 2020. They have taken action and the updated SOP (standard operating manual for identification of *Listeria*) dated June 2020 advises hospital laboratories to refer all isolates from patients to PHE.

Laboratories have been submitting the *Listeria* isolates for further whole genome sequencing typing on a voluntary basis, and almost all isolates are received. During 2019, out of 142 listeriosis cases, 136 *Listeria* strains were received in PHE GBRU. Confirmation of identification of *Listeria* species and *L. monocytogenes* and typing by WGS identification for *L. monocytogenes* isolates and *Listeria* species are undertaken at the GBRU, Colindale.

PHE is an executive agency and is not directly involved with patient care. The role of PHE is to provide guidance on the implementations to be taken, based on best scientific practices in order to retain good health and prevent deaths. PHE has a mandate to investigate the incident but has no legislative power to implement action on NHS or to implement food safety measures. The latter of which is an FSA mandate.

The percentage of listeria isolates from foods sent to PHE FW&E laboratory is small overall. Most isolates are sent by publicly funded laboratories. PHE support submission of strains for further typing and would need a more extensive database of strains to identify vehicles. DHSC has undertaken a review on hospital food, including listeria in sandwiches. Publication of this report is on hold due to the Covid-19 pandemic.

Please do not hesitate to contact PHE should we be of any further assistance in this matter.

Yours sincerely,

FOI Team