MISS N PERSAUD
HER MAJESTY'S CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

Ref: [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Interim Chief Executive Officer, Public Health England, Wellington House, 133-155 Waterloo Road, London, SE1 8UG** **Email: [redacted]**
1	**CORONER** I am Nadia Persaud, Area Coroner for the coroner area of East London
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 the 8th October 2020 I commenced an investigation into the death of Stacey Camille Alexander-Harriss. The investigation concluded at the end of the Inquest on the 28th April 2021. The conclusion was a narrative conclusion: *Mrs Alexander-Harriss died as a result of an overwhelming bacterial infection caused by a dog bite.*
4.	**CIRCUMSTANCES OF THE DEATH** Mrs Alexander-Harriss was bitten by a dog on the 15 June 2020. In the late afternoon of the 17 June 2020, she began to feel unwell and was taken to hospital by ambulance.

	The dog bite itself appeared, superficially, to be healing. The paramedics suspected sepsis (unknown cause) and placed a pre-alert call to the hospital. Mrs Alexander-Harriss arrived in the emergency department at 1904. The emergency department team noted that she was very unwell, with a metabolic acidosis. IV fluid resuscitation was provided promptly on arrival to hospital. Within the first hour of arrival in hospital, Mrs Alexander-Harris underwent a clinical examination; venous blood gas; laboratory bloods were taken; IV fluids and oxygen administered; painkillers administered; ECG and chest x-ray carried out and her care was escalated to an emergency department consultant. The full blood count led to a primary suspected diagnosis of neutropenic sepsis and she was commenced on IV Tazocin for this. The Tazocin was commenced at 2035. Transfer to the ITU team took place at 2052. Mrs Alexander-Harris received one to one care in ITU. In the early hours of the 18 June 2020, Mrs Alexander-Harris suffered a cardiac arrest, from which she could not be successfully resuscitated. A blood culture received after she had passed away revealed the bacterial growth of Capncytophagia canimorsus. This organism is commonly found in the mouth of dogs. There is a possibility that earlier administration of Tazocin might have made a difference to the outcome.
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 could 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 evidence during the course of the Inquest gave rise to a concern as to a knowledge gap in relation to the organism Capncytophagia canimorsus. The attending doctors were not familiar with this form of bacteria living within the mouths of dogs and cats and how easy it is to infect people with this organism. A severe traumatic injury is not required for infection to develop. This organism can cause an overwhelming infection in susceptible individuals. The Inquest heard that conditions such as type II diabetes and hepatic steatosis render the individual to a higher risk of serious infection. The inquest heard that raising awareness of this organism and the underlying high risk medical conditions within the medical profession, may prevent future deaths. The Inquest also heard that there may be a need for greater public awareness in relation to the need to seek urgent medical attention if a person suffers from a relevant underlying illness and becomes generally unwell following a dog or cat bite.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 **2 July 2021** 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 husband of the deceased. I will also send a copy of the report to the Director of Public Health and to the CQC. I am also under a duty to send a copy of your response to the Chief Coroner and all

	interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
	Date: 7 May 2021 **HMC Signature:**