Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 NHS England, [redacted]** **2 UKHSA TB Unit, [redacted]** **3 National Institute for Clinical Excellence**
1	**CORONER** I am Miss Laurinda Bower, HM Area Coroner, for the coroner area of Nottingham City and Nottinghamshire
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** Carrianne Franks died on 27 August 2021, at the Bassetlaw District Hospital, Nottinghamshire, as a result of Tuberculosis. She was a Flight Sergeant in the Royal Air Force Nursing Service. A coronial inquest into her death was opened on 21 July 2022. An inquest before a jury concluded on 26 May 2023.
4	**CIRCUMSTANCES OF DEATH** The Jury recorded the following salient conclusions on the Record of Inquest: Carrianne was exposed to, and infected with, tuberculosis from a patient with active TB (smear positive) who was nursed on the Acute Assessment Unit of a London Hospital, where Carrianne was working as a nurse between 23 and 24 November 2020. Carrianne was not an NHS employee, rather she had volunteered through the RAF to undertake a placement at an NHS hospital, to assist throughout the Covid-19 pandemic. Carrianne was not classed by the hospital as a "close contact" of the infected patient, so she did not benefit from contact tracing, a warn and inform letter, or any education on the signs of TB infection to look out in the coming months. By the time Carrianne became unwell with respiratory symptoms in June 2021, neither she, her GP, nor the RAF's Occupational Health Department had been informed that she had been working on a hospital ward where a patient had tested positive for TB (smear positive). It would have been of assistance to the doctors treating Carrianne to have known about her occupational proximity to a patient with active smear positive TB, as they would have conducted tests to seek to rule the condition in or out, and in this case, would have arrived at a diagnosis far sooner and in time to start treatment that would have prevented her death. The lack of knowledge of her heightened risk of TB because of occupational exposure to a smear positive case, significantly delayed her diagnosis and treatment, which in turn contributed to her death.
5	**CORONER'S CONCERNS**

During the course of the investigation my inquiries 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:
(brief summary of matters of concern)

1. **I am concerned that the current clinical and public health guidelines do not identify Healthcare professionals as a group at heightened risk of TB exposure.**
2. **I am concerned that the current definition of 'close contact', thus triggering a contact trace or warn and inform letter, sets the bar too high for notifying NHS staff of the risk of exposure to TB.**
3. **I am concerned that there are insufficient education measures in place to inform NHS staff of the TB symptoms to looks out for, and the need to inform any assessing clinician of their possible exposure to the condition in order to facilitate early diagnostic testing.**

Carrianne was exposed to a very aggressive form of TB from what seemed to be a rather transient exposure to the index patient during her occupation as a Nurse. Of course, not each and every contact with a patient will be logged within the medical records, especially in relation to an ambulatory patient such as the index patient in this case, and so it is possible that Carrianne had greater exposure to the patient while on the ward than interrogation of the medical records would suggest. But at its height, she had only been at work on the unit at the same time as the index patient over 23 and 24 November.

The index patient was cared for in a side room with infection prevention measures in place but Carrianne may well have been unaware that the infectious disease in question was TB as she was not the "named nurse" for this patient and lots of patients had increased infection prevention measures in place during the pandemic. Indeed, Carrianne had denied any known TB exposure when asked by doctors during her respiratory illness.

Carrianne's case highlights the increased transmissibility of smear positive TB in the context of limited exposure to the index patient. I heard evidence from an expert who told me of cases of medical professionals contracting the condition despite no known direct contact with the patient but having spent time in a corridor containing an air vent leading from the infected patient's room.

The warn and inform parameters did not alter (as in broaden) to reflect the fact that the index case was smear positive and highly transmissible, and the patient was known to be ambulatory on the ward. I cannot see a good reason for restricting the warn and inform letter process, rather than applying the same broadly to all staff who worked on the unit at the relevant time.

Carrianne's case highlights the importance of warning all staff of TB cases on their wards, so that if they do become symptomatic in the coming months, and it may be many months later, they will be equipped with the necessary information to share with their treating clinicians.

I heard evidence that the NHS hospital's Occupational Health team will issue contact tracing or warn and inform letters to staff, but this may not include Agency workers, and, in this case, Nurses seconded from the RAF. This is a missed opportunity to ensure that the relevant OH team or GP is aware of the potential exposure to add to the clinical picture should the patient develop atypical respiratory symptoms.

I understand that your agency has input into the UK's TB Action Plan, and I hope that the above concerns can be considered in your drive to reduce the incidence of TB nationally, but also specifically with regard to healthcare professionals to ensure they are given the greatest possible protection from TB related harm and death.

6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 15 February 2023. 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: • The Interested Persons who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner. I may also send a copy of your response to any 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 by the Chief Coroner.
9	**Dated: 21 December 2023** **Miss Laurinda Bower** **HM Area Coroner** **Nottingham City and Nottinghamshire**