Regulation 28: Prevention of Future Deaths report

Laura Lesley FARMER (died 26.04.24)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Chief Executive** **UK Health Security Agency (UKHSA)** **Wellington House** **133-155 Waterloo Road** **London SE1 8UG** **2. [redacted]** **Medical Director** **Medicine Board** **University College London Hospitals NHS Trust (UCLH)** **University College Hospital** **2nd Floor Central** **250 Euston Road** **London NW1 2PG**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 9 May 2024, one of my assistant coroners, Melanie Lee, commenced an investigation into the death of Laura Farmer aged 46 years. The investigation concluded at the end of the inquest on 11 September 2024. The jury made a determination at inquest that Laura Farmer died from a stroke caused by an E coli infection.

	Her medical cause of death was: 1a) left middle cerebral artery infarction 1b) thrombotic microangiopathy (TMA) haemolytic uraemic syndrome (HUS) 1c) Shiga toxin-producing Escherichia coli infection
4	**CIRCUMSTANCES OF THE DEATH** Following a diarrhoeal illness about ten days earlier, Ms Farmer was admitted to University College Hospital on 20 April 2024. She was diagnosed with HUS caused by Shiga toxin producing E coli. When she was thought to be in the recovery phase, she suffered an unexpected stroke and, despite best efforts, died as a consequence.
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. Laura Farmer and her family found her diagnosis of an E coli infection difficult to understand. She was a vegan who took great pains with food preparation. As a family, they were extremely hygiene conscious, particularly as [redacted] has a nut allergy. When Ms Farmer became ill, her family members wanted to understand what had happened and to keep themselves as safe as possible. 1. Someone from what was described to me as public health (I assume the UKHSA) spoke to Laura Farmer the day before her death, asking for information. However, she was in intensive care at the time and not able to give a full, detailed picture. There was apparently no exploration of potential contact with animals or water sports and I was told that only scant details of a recent restaurant visit were obtained. 2. The UKHSA did not at any stage ask [redacted] for information to assist in attempting to determine the source of the E coli infection that ultimately killed his wife. If asked, Mr Farmer would have explained that on 6 April 2024, not only did he and his wife visit a local restaurant, they also had drinks at a nearby club, and they had recently eaten and drunk at local military establishments. None of that information appears to have been considered by the UKHSA.

3. After his wife's diagnosis, Mr Farmer was given no advice about how to keep himself and their child safe. He cleaned the bathroom in anticipation of his wife's return home, but did not use any personal protective equipment.

   When he later became unwell, he did not know whether he had put himself at risk. Having heard his description in court, I think it is not an exaggeration to say that he was then terrified that his own actions might leave his child an orphan.

4. The clinicians treating Ms Farmer gave evidence at inquest that they did not know if the source of the infection that killed her had ever been identified.

   Mr Farmer saw in the news that there was a local E coli outbreak in Waverley, Surrey. The clinicians at UCLH knew which strain of E coli had infected Ms Farmer, but not whether that strain had been discovered in Waverley or indeed elsewhere, because after reporting to the UKHSA they received no feedback, no advice on infection control and no information they could give Mr Farmer.

   After a death from E coli, there seems to have been no closing of the loop of safety information that could have assisted those most closely involved.

5. Mr Farmer explained to me that he had spent some considerable time and effort since his wife's death trying to obtain basic information from the public health authorities without success. He struck me as a person of significant drive, and yet he found it incredibly difficult to find the correct person to speak to and then incredibly difficult to gain any meaningful understanding of what had happened.

   This cannot inspire public confidence and seems a very offhand way to treat a grieving relative.

I did not call anyone from the UKHSA to give evidence at inquest, because I had expected that UKHSA would have shared relevant information with both clinicians and family. It may be, therefore, that there are explanations for what seem to be surprising actions and inactions. If that is the case, then of course you will be able to explain as much in your response.

6 **ACTION SHOULD BE TAKEN**

In my opinion, action should be taken to prevent future deaths and I believe that 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 11 November 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 following. • [redacted], husband of Laura Farmer • [redacted], interim chief executive, Care Quality Commission for England • [redacted], chief medical officer for England • [redacted], national medical director, NHS England • HHJ Alexia Durran, chief coroner, England & Wales 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. She may send a copy of this report to any person who she 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.
9	**DATE** **SIGNED BY SENIOR CORONER** 16.09.24 *ME Hassell*