Nicola Jane Mundy
Senior Coroner for South Yorkshire (East District)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Department For Health, and NHS England**
1	**CORONER** I am Nicola Jane Mundy, Senior Coroner for South Yorkshire (East District)
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 19/09/2014 I commenced an investigation into the death of Isabella Rosa Drew, 29 days old. The investigation concluded at the end of the inquest on 16 July 2015. The conclusion of the inquest was Narrative conclusion. The cause of death: 1a. Severe acute pneumonia, 1b. Bordetella pertussis
4	**CIRCUMSTANCES OF THE DEATH** [redacted] became pregnant with twin girls in December of 2013. Due to high risk factors in her pregnancy she was referred for consultant led care. Accordingly she received ante-natal input from the GP practice, the community midwifery team and the Doncaster and Bassetlaw Hospital Trust. Guidance from the Department of Health placed a responsibility on all medical health practitioners to discuss with and offer to pregnant women the opportunity to undergo whooping cough vaccination. Despite [redacted] having contact with a number of professionals of all levels throughout her pregnancy the vaccination was not offered to her. Only one of those professionals discussed it with her and advised her to follow up at the hospital where she was told that the hospital did not do vaccinations. As it was, [redacted] never had the vaccination throughout her pregnancy. Twin girls were delivered on the 11th August 2014. In early September Isabella contracting whooping cough. There then followed a rapid and devastating deterioration in her condition with her passing away on the 9th September 2014. Evidence was provided by a number of healthcare professionals who were candid in their evidence, many of them did not appreciate there was a collective responsibility to ensure pregnant women were provided with appropriate and timely advice (with follow up) and all confirmed that following Isabella's death their practices have changed. Furthermore, I heard evidence from both the hospital trust and the GP practice as to how they reviewed and enhanced their procedures for monitoring of pregnant ladies and offering of the whooping cough vaccination with follow up and auditing. Whilst it was clear that Isabella's death triggered a review locally to the extent that the changes made have satisfied me that appropriate measures are now in place, it is clear from the evidence that it is up to local healthcare providers to devise their own systems in an effort to discharge their duties pursuant to the department of Health guidance regarding whooping cough vaccination. In particular, the GP surgery had felt prior to Isabella's death that they had responded to that guidance and it was only following an in depth analysis after Isabella's death that they realised the measures they thought were adequate, were not.

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	Witnesses also alluded to the fact that there might not be quite so robust systems in place in many other parts of the UK. In all these circumstances, I felt it necessary to draw the case of Isabella Rosa Drew to your attention and that there was a feeling that the national guidance provided failed to include sufficient information on the nature and extent of procedures and protocols which should be implemented at local levels to ensure those duties are being met and furthermore to highlight the importance of multi agency communication to ensure that no pregnant ladies fell between two stools.
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. – (1) consideration needs to be given as to whether there needs to be further and more explicit guidance as to how local healthcare providers ensure systems put in place effectively capture their responsibility to advise all pregnant women of the importance of whooping cough vaccination with provision for auditing and follow up procedures. (2) a need further national guidance regarding the importance of effective communication links between the various limbs of ante-natal healthcare providers.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you: i. **The Department For Health**, and ii. **NHS England** 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 10 September 2015. 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: [redacted] Messrs Aston Knight Solicitors, Messrs Browne Jacobson, Messrs Radcliffes Le Brasseur, Messrs Weightmans LLP, [redacted] Sheffield Childrens Trust and to the LOCAL SAFEGUARDING BOARD. 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	Dated 16 July 2015 Signature [redacted] Senior Coroner for South Yorkshire (East District)

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