REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted]** **Chair of the Joint Committee on Vaccination and Immunisation** **Oxford University** **Children's Unit** **John Ratcliffe Hospital** **Headley Way** **Headington** **Oxford** **OX3 9DU** **2. [redacted]** **Chief Medical Officer** **Department of Health** **Room 114** **Richmond House** **79 Whitehall** **London** **SW1A 2NS**
	CORONER I am Maria Eileen Voisin, Senior Coroner, for the area of Avon.
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** On 24th May 2016 I commenced an investigation into the death of **Isabel Lily GENTRY**, Aged **16**. The investigation concluded at the end of the inquest on 17th March 2017. The conclusion of the inquest was that the medical cause of death should be recorded as Ia) Group B meningococcal meningitis Box 3 read as follows: **Isabel Gentry had meningitis, she became ill on 17th May 2016 her symptoms included: headache all day but worse in the evening; neck pain; a fever, shivering, vomiting, muscular pain, dizziness and she had fainted once, she had loose stools for 3 days. The paramedic that examined her considered that she may have sepsis as part of his differential diagnosis. Isabel was taken to hospital. The doctor did not take an accurate history or a full history and did not reach a differential diagnosis which should have included sepsis and SIRS. The observations and the bloods taken were not normal. The diagnosis of viral gastroenteritis was not accurate. The vital signs were not considered in the light of the fluid and medication she had received. The previous case of meningitis was not acted upon. There was no senior review. Isabel was discharged on the morning of 18th May. During that day she became more unwell Isabel was taken back to the Bristol Royal Infirmary that evening was treated but her condition deteriorated and she died on 20th May 2016.**

	The conclusion as to the death based on all the evidence was recorded as **Natural causes contributed to by neglect**
4	**CIRCUMSTANCES OF THE DEATH** The circumstances were recorded in Box 3 which are reflected above. In summary Isabel Gentry became ill with meningitis on 17th May 2016. She attended the Bristol Royal Infirmary and was discharged on 18th May with a diagnosis of viral gastroenteritis. As the day progressed she became more unwell and was readmitted to the Bristol Royal Infirmary on 18th May that evening. The diagnosis of meningitis was confirmed and sadly despite appropriate care and treatment her condition deteriorated and she died on 20th May 2016.
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. Evidence was provided during the inquest that if Isabel had received the meningitis B vaccination that her death would have been prevented. There is therefore an ongoing risk that future deaths will occur unless action is taken in relation to extending the vaccination program to include the teenage group which is at increased risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 2nd June 2017. 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 – family, [redacted] and South Western Ambulance Service Trust. I have also sent it to Public Health England who may find it useful or of interest and to the CQC. 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	**06 April 2017** **M. E. Voisin**