Eastern Area of Greater London Coroners
MISS N PERSAUD
SENIOR CORONER
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REF:4847

25th June 2018

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: [redacted] Senior Clinical Immunisation Manager, Public Health England (NHS England-London region)**
1	**CORONER** I am Miss N Persaud Senior Coroner for **Eastern Area of Greater 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 03/10/2017, I commenced an investigation into the death of Lauren Amelia Rose SANDELL. The investigation concluded at the end of the inquest on 25th June 2018. The conclusion of the inquest was a narrative conclusion: *Lauren Sandell died as a result of meningococcal sepsis (serogroup W135). She fell within the cohort of patients requiring the MenACWY vaccination. Guidance available to the GP practice indicated that the vaccination should have been given before the start of the new academic year. Her GP practice had signed up to an Enhanced Service Specification to provide the vaccination to patients of Lauren's age. This was signed between March to June 2016. The Enhanced Service Specification required an active call and re-call system to be in place for patients of Lauren's age. Lauren received no call or re-call from the practice. There was no alert placed on Lauren's notes to ensure that she was notified of the vaccination if and when she attended surgery. The Practice Nurse raised the need for the vaccination opportunistically with Lauren's mother, on 13 September 2016 (5 days before Lauren left for university). The risks of not having the vaccination were not adequately explained to her mother. There was insufficient stock of the vaccine within the practice, for Lauren to be vaccinated prior to her departure to university. The Practice was not fully informed about the availability of the two different types of ACWY vaccination (one of which had an unrestricted supply). Had Lauren received the vaccination prior to attending university, it is likely that her death on 2 October 2016 would have been avoided.*
4	**CIRCUMSTANCES OF THE DEATH** Lauren Sandell turned 18 years old on the 23 January 2016. She should have received contact from her GP surgery to be vaccinated against the MenACWY vaccine prior to the beginning of the academic year (2016/7). The family first discovered the need for the vaccine when it was mentioned opportunistically

	to her mother on the 13 September 2016 (5 days before she was leaving for University). The risks of Lauren not having the vaccine were not made clear to her. There were insufficient amounts of the vaccine within the surgery for Lauren to be vaccinated before leaving for university. An appointment was booked for the 28 October 2016. Lauren began to feel unwell on the 29 September 2016. She suffered from headaches/vomiting and aches and pains. On the 2 October 2016 she became unresponsive at her home address and her life was pronounced extinct by paramedics on scene. (Further detail can be seen in the narrative conclusion).
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) There would appear to be on-going confusion about who is responsible for ensuring that those children who are not (for whatever reason), vaccinated at school, should be vaccinated before attending university. The evidence indicated that 70% to 80% of children receive the vaccination at school. This would leave 20% to 30% of children unvaccinated. The evidence indicated that GPs should primarily provide the safety net for unvaccinated children. (2)The provision of the vaccination against MenW appears to fall under an enhanced service for GPs. As this is an optional addition to the GMS contract, it is unclear whether all GP surgeries have a responsibility to capture unvaccinated children. (3) It does not appear that there is any form of audit to ensure that GP practices have in place systems to identify those children who are not captured by the school programme and to put in place measures to protect children, particularly before commencing university.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that NHS London and ultimately 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 **24th August 2018**. 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] parents), the Broadway Surgery and legal representatives for the Practice Nurse. I have also sent it to Matthew Cole (Director of Public Health) and the CQC, who may find it useful or of interest. 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	25/06/2018 Signature Miss N Persaud Senior Coroner **Eastern Area of Greater London**