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Royal College of Obstetricians & Gynaecologists

Ms L J Hashmi
Area Coroner
Greater Manchester North
The Phoenix Centre
L/Cpl Stephen Shaw
MC Way Heywood
OL10 1LR

15 May 2015

Dear Ms Hashmi

Ref: Baby Olsberg, deceased – Regulation 28 PFD

Thank you for your letter dated 8 May 2015 and for raising your concerns about testing for Group B Strep. We have considered your recommendations in light of the findings from the inquest into the death of baby Olsberg and this is our response.

The 2nd edition of the RCOG Green top guideline number 36, Prevention of Early-onset Neonatal Group B Streptococcal Disease was published on 1st July 2012. It gives guidance based on the recommendations of the National Screening Committee.

In response to the specific points in section 5 of your letter:

1. *That antenatal screening for GBS is not routinely offered by the NHS, to all pregnant women, during the final weeks of pregnancy.*
   Point 4.1 in the RCOG guidelines states that **Routine bacteriological screening of all pregnant women for antenatal GBS carriage is not recommended.**
   Until it is clear that antenatal screening for GBS carriage does more good than harm and that the benefits are cost-effective, the National Screening Committee does not recommend routine screening in the UK. Initiating national swab-based screening for antenatal GBS carriage would have a substantial impact on the provision of antenatal care within the UK. Major organisational changes and new funding would be required to ensure an equitable and quality-assured service.

2. *That prophylactic intrapartum antibiotics are not routinely offered to all women that have tested positive for GBS (or have done so in the past).*
   Point 5.1 in the RCOG guidelines states that **Clinicians should offer IAP to women with GBS bacteriuria identified during the current pregnancy.**
   GBS bacteriuria is associated with a higher risk of chorioamnionitis and neonatal disease. It is not possible to accurately quantify these increased risks. These women should be offered IAP.
   IAP should be offered if GBS is detected on a vaginal swab in the current pregnancy.

Current evidence does not support screening for GBS or the administration of IAP to women in whom GBS carriage was detected in a previous pregnancy.

3. *That GBS infection is a very serious illness and in the absence of a national screening programme, babies are potentially being put at risk of harm/death.*
   Group B streptococcus (Streptococcus agalactiae) is recognised as the most frequent cause of severe early- onset (at less than 7 days of age) infection in newborn infants. However, there is still controversy about its prevention. A Cochrane review concluded that, while IAP for colonised mothers reduced the incidence of EOGBS disease, it has not been shown to reduce all causes of mortality or GBS-related mortality. There have been no studies addressing whether routine screening has had any impact on all-cause mortality. In addition, antenatal screening and treatment may carry disadvantages for the mother and baby. These include anaphylaxis, increased medicalisation of labour and the neonatal period, and possible infection with antibiotic-resistant organisms, particularly when broad- spectrum antibiotics such as amoxicillin are used for prophylaxis. The UK National Screening Committee examined the issue of strategies for the prevention of EOGBS disease and recommended that routine screening using bacteriological culture or near-patient testing techniques should not be introduced into UK practice, and the RCOG guidance is in line with their recommendation.

The RCOG has recently published a report of an audit (https://www.rcog.org.uk/globalassets/documents/guidelines/research--audit/gbs-audit-first-report.pdf) which contains the results of a survey of NHS obstetric units in the UK and analyses of routinely collected maternity data, which you may also find useful.

With many thanks for the opportunity to comment on this report.

Yours sincerely

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Vice President, Clinical Quality