REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Department of Health 2. Royal College of Obstetricians 3. National Institute for Health and Clinical Excellence 4. Royal College of Paediatricians
1	**CORONER** I am Ms L J Hashmi, Area Coroner for the Coroner area of Manchester North.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 6th May 2015 I commenced an investigation into the death of Baby Olsberg.
4	**CIRCUMSTANCES OF DEATH** Baby Olsberg was born at 16:01 on the 23rd December 2013 following spontaneous labour and normal vaginal delivery. The delivery was midwifery-led. His mother had been diagnosed as Group B Streptococcus (GBS) positive during the course of a previous pregnancy in 2011. Screening for GBS was not conducted in the index pregnancy and prophylaxis antibiotic therapy not given, in line with national and local guidance in force at the material time. In the hours following his birth, baby Olsberg showed signs of deterioration in his overall condition. Close midwifery monitoring was conducted of both mother and baby. The midwifery team alerted the paediatric team to the baby's deterioration. Baby was attended by a junior paediatrician at around 19:45 and a care plan was set. The midwifery team called the paediatric team again at around 20:45 and 21:15 alerting them to the need for further review. Baby Olsberg was seen at 22:15 by which point his condition had markedly deteriorated. Baby was admitted to the NICU at around 22:30. His condition and prognosis were guarded. He received aggressive medical management but continued to deteriorate.

	Transfer to tertiary care took place on the morning of the 24th December 2013. Baby suffered three subsequent cardiac arrests and died at 15:20 on the 24th December 2013. Blood cultures confirmed a diagnosis of infection with GBS.
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. That antenatal screening for GBS is not routinely offered by the NHS, to all pregnant women, during the final weeks of pregnancy. 2. That prophylactic intrapartum antibiotics are not routinely offered to all women who test positive for GBS (or have done so in the past). 3. That GBS infection is a very serious illness and in the absence of a national screening and prophylactic treatment programme, babies are potentially being put at risk of harm/death.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 Monday 6th July 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 namely:- - Baby's parents - Pennine Acute Hospitals NHS Trust - Group B Strep Support - [redacted] 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 from. 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	Date: 7th May 2015. [redacted]