UK National Screening Committee

Floor 2, Zone B
Skipton House
80 London Road
London SE1 6LH
T +44 (0)20 3682 0923
www.screening.nhs.uk
@PHE_Screening

[redacted]
Southwark Coroner's Court
1 Tennis Street
Southwark
London
SE1 1YD

11 April 2016

Dear Mr Thompson

Re: Coroner Report and response to preventing future deaths (Edward Paddon- Bramley)

Thank you for forwarding through the coroner report on the death of Edward Paddon-Bramley. I was very sorry to read that [redacted] son, Edward, died from complications of Group B Streptococcus (GBS) at 9 days old. The death of a baby is devastating for parents and their families and I would like to offer [redacted] my sympathy for their tragic loss.

National screening policy is set by an expert Committee, the UK National Screening Committee (UK NSC), which advises Ministers and the NHS about all aspects of screening policy. In November 2012, the UK NSC recommended that antenatal screening for GBS carriage should not be offered. This is because testing women in late pregnancy to see if they carry GBS is not very effective in predicting whether the baby is likely to be affected by early onset GBS disease. This means that thousands of women in labour who carry GBS as a harmless bacterium would be offered antibiotics they didn't need. The balance of benefits and harms from this strategy is uncertain. In December 2015 the UK NSC commissioned an update review into antenatal screening for GBS as per its published process. A public consultation is expected to be held in the autumn for a three month period. Following this the UK NSC will then review the recommendation for screening for GBS in pregnancy.

I hope this addresses your concern about the need to review the current screening policy. More information and how to contribute to the public consultation will be available at the following link; http://legacy.screening.nhs.uk/screening-recommendations.php

In the UK, health professionals are advised to follow the risk-based guidance established by NICE and the RCOG. Though it is not possible to comment on individual cases, it appears that this case is relevant to that guidance. This is because of the prolonged membrane rupture and chorioamnionitis described in your

report. I note that NICE and RCOG have received this report and they are better placed to respond to the issues raised. However, it may be of interest to you to know that research is currently underway to evaluate the value of using rapid tests in labour to detect GBS in women with the kind of risk factors experienced by [redacted] This is sponsored by the NIHR HTA Programme.

Again, I hope this reassures you that the issue of GBS infection in the newborn is taken seriously and is being actively addressed at both policy and research levels.

Yours sincerely

[redacted]

Director of Programmes
UK National Screening Committee
anne.mackie@phe.gov.uk