ANNEX A

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. Secretary of State, Department of Health** **2. Chief Executive, National Screening Committee** **3. Chief Executive, National Institute for Clinical Excellence** **4. Chief Executive, The Royal College of Obstetricians and Gynaecologists**
1	**CORONER** I am Dr Julian Morris, assistant coroner, for the coroner area of Inner London South
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 12 June 2014 an investigation was commenced into the death of Edward Paddon-Bramley, aged 9 days. The investigation concluded at the end of the inquest on 2 November 2015. The medical cause of death was: 1a Hypoxic Ischaemic Encephalopathy 1b Chorion-amnionitis with fetal involvement 1c Group B streptococcus ascending infection. The conclusion of the inquest was natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Edward was born at 41+6 following spontaneous rupture of membranes – he was delivered at 34 hours after rupture – with severe infection affecting his chorion and all 3 umbilical vessels. He was born by emergency lower segment caesarean section. Subsequent cultures confirmed the presence of Group B Streptococcus (GBS) which had, on the balance or probabilities, given rise to the infection, the rupture of membranes and the placental abruption. Despite neonatal care Edward sadly did not survive. GBS normally live in the intestine and can also live in the vagina of women where it causes no issues unless the woman is pregnant and going into labour. Those who test positive are treated with anti-biotics. There is no national policy to test all pregnant women for GBS. Differing Trusts provide anti-biotics, following rupture of membranes, at varying times following the initial rupture.
5	**CORONER'S CONCERNS** Evidence was provided to the Court by way of National guidelines (NICE 2008, Induction of labour), Trust guidelines (more than one Trust), The Royal College (Green-top

	guideline no 36) and by Consultants. Trust guidelines as to the treatment of prolonged rupture of membranes (PROM) differed from those provided by NICE and the use of anti-biotics, after varying times of rupture, irrespective of the clinical picture. Consultants' views as to the best practice for treating PROM and whether women should be screened for GBS during pregnancy differed from those provided by NICE. In conclusion, evidence was given at the inquest that there is a difference of opinion and practice in the treatment of mothers (and their babies) who suffer from ROM of a prolonged period. Both clinicians and Trusts appear to be at odds with NICE. There also appears to be arguable opinion that GBS screening in pregnant women together with the use of intra-partum anti-biotics ought to re-viewed.
6	**ACTION SHOULD BE TAKEN** There is a risk to both mothers and their unborn babies following rupture of membranes. It is not clear that the available medical evidence and guidelines in the monitoring, to include pregnancy screening for infection of GBS, together with the points at which anti-biotic cover and delivery are effected, of pregnant women who have pre-labour rupture of membranes has been reviewed recently as Trusts and doctors are following differing regimes. The parties are asked to consider these.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 3 May 2016. 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. If you require any further information about the case, please contact the case officer, [redacted] If you require further information about the process of responding to this report the Court's clerk, [redacted] can be contacted. Your report should be sent to [redacted]
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 Lewisham and Greenwich NHS Trust (delivering Trust) and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18). 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	**6 March 2016** **Dr Julian Morris**