Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This from is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

Professor [redacted], The Chief Executive, Milton Keynes University Hospital

1 CORONER

I am Tom OSBORNE, Senior Coroner for the area of Milton Keynes

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.

3 INVESTIGATION and INQUEST

On 23/12/2019 I commenced an investigation into the death of Reggie -Jay John PAYNE aged 1 Months. The investigation concluded at the end of the inquest on 07 October 2020. The conclusion of the inquest was:

I a Late onset Group B streptoccocal infection

I b

I c

II

4 CIRCUMSTANCES OF THE DEATH

The deceased was found unresponsive in his cot at [redacted], Springfield, Milton Keynes on 16th December 2020. He was taken to Milton Keynes University Hospital. Despite attempts at resuscitation he was confirmed dead at 09.40 the same day. A Group B streptoccocal infection was identified at post mortem.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:

During the course of the inquest I was referred to the HSIB report relating to Group B strep.
It appears that GBS was never discussed with Miss [redacted] at any time during her pregnancy. She was certainly not made aware of the dangers of this infection to her new baby. It would seem that had Miss [redacted] been screened for GBS infection and the screen had proved positive she would have been offered antibiotics during labour and the death of baby Reggie Jay may have been avoided.
At least 60 countries have a national policy for a form of microbiological screening and antibiotics use during pregnancy to prevent newborn GBS disease. I consider that for the safety of babies born in Milton Keynes, the trust should consider the introduction of a screening program for all pregnant mothers delivering in Milton Keynes. If the screening process proves positive, then antibiotic cover should be offered. This is an area where Milton Keynes could lead the rest of the country and save the lives of many babies.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 22nd December 2020. 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. I have also sent it to

1) The family of Reggie-Jay Payne.
2) The Chief Executive, The Care Quality Commission
3) The Chairman of the House of Commons Health Select Committee, The Rt Hon. Jeremy Hunt MP
5) MP Milton Keynes South
6) MP Milton Keynes North
7) Group B Strep Support Group

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

Tom OSBORNE
Senior Coroner for
Milton Keynes
Dated: 27 October 2020