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:

Royal College of Obstetricians and Gynaecologists
 Sussex Place
 London
 NW1 4RG

1 CORONER

I am Maria Voisin, Senior Coroner, for the Area of Avon

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 1st May 2014 I commenced an investigation into the death of Elsie Sue PLUMB, aged **1hour**.

The investigation concluded at the end of the inquest on 14th October 2014.

The conclusion of the inquest was Natural causes.

Elsie Plumb died at 08:30 hours on 15th April 2014 at the Royal United hospital, Combe Park, Bath, due to sepsis.

The medical cause of death was recorded as 1a Group B Streptococcal Septicaemia

4 CIRCUMSTANCES OF THE DEATH

Elsie Plumb was born full term. Her mother during the ante-natal period was confirmed as positive for Group B beta haemolytic streptococcus and it was recorded in the notes that she would therefore need antibiotic cover in labour. This did not happen due to the nature of the labour and delivery. Sadly Elsie Plumb died within an hour of delivery due to early onset of early neonatal sepsis due to the Group B streptococcal infection.

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. -

The consultant obstetrician and gynaecologist gave evidence and indicated that changes had taken place at the hospital to clarify guidance in relation to administering antibiotics to the mother, and when this should be done.

He indicated that the Royal College of Obstetricians and Gynaecologists Green-top Guideline No. 36 titled "The Prevention of Early-onset Neonatal Group B Streptococcal Disease" at paragraph 5.4 on page 4 could be more clearly written.

He stated that the sentence currently reads "If GBS colonisation was identified earlier in the pregnancy (by a swab taken for other reasons) immediate induction of labour and IAP should be offered"

| 9 | 21 st October 2014 M. E. Voisin |
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| | 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. |
| | I have sent a copy of my report to the Chief Coroner and to the following Interested Persons – the family and Royal United Hospital, Bath. I am also under a duty to send the Chief Coroner a copy of your response. |
| 8 | COPIES and PUBLICATION |
| | 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. |
| | You are under a duty to respond to this report within 56 days of the date of this report, namely by 17 th December 2014. I, the Coroner, may extend the period. |
| 7 | YOUR RESPONSE |
| | In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. |
| 6 | ACTION SHOULD BE TAKEN |
| | "immediate induction should be offered. IAP should also be offered, whether or not immediate induction is performed." |
| | He suggests that this sentence would be clearer if it were written as follows: |

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