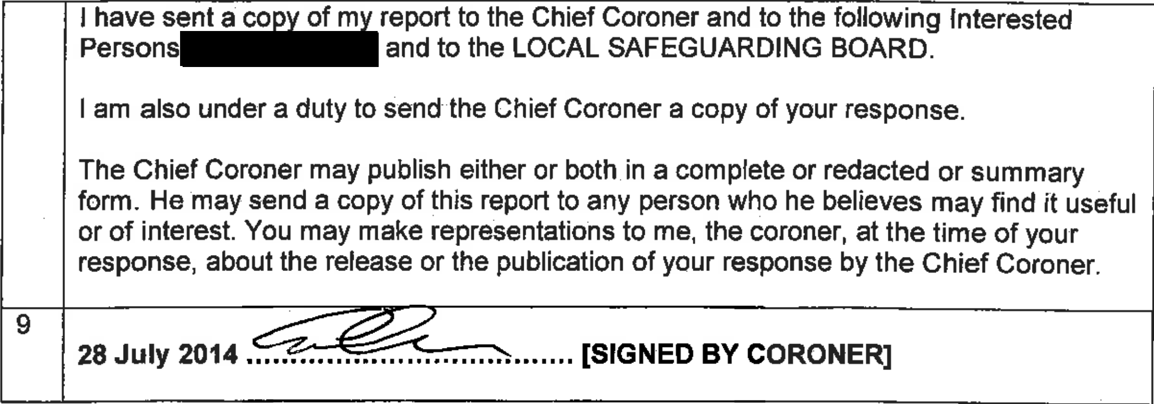
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [REDACTED] (Senior Medical Officer, Maternal and Child Health) Welsh Government.
1	**CORONER** I am **Colin Phillips**, acting Senior Coroner, for the coroner area of SWANSEA NEATH & PORT TALBOT
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. [REDACTED]
3	**INVESTIGATION and INQUEST** On 15 November 2011 I commenced an investigation into the death of Hope Erin Evans. The investigation concluded at the end of the inquest on 16 July 2014. The medical cause of death is 1a Sepsis 1b ESBL E. coli in a premature baby The conclusion of the inquest as how Hope came to her death is a narrative one and is as follows:- Hope died from sepsis contributed to by the ESBL E. coli which was contracted in hospital after being born prematurely at 26 weeks. The source of the ESBL E. coli is likely to have been from another baby but the means of transfer is unknown.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was Hope Erin Evans and she died at 1.00 a.m. on 4 November 2011 at Singleton Hospital Sketty Swansea. Tests confirmed that baby Hope and baby A1 and baby A2 to have had the same strain of the ESBL E.coli. The outbreak management group therefore concluded that the ESBL E.coli was probably transmitted between the babies. Mother A had received private IVF treatment abroad and received a twin pregnancy. Mother A contracted ESB L E. coli although it is unclear how this was contracted. This was reflected as a positive ESB L E. coli result and identified in Mother A's medical notes from abroad which she had in her possession and declared them several days after the outbreak. Mother A was transferred from Prince Charles's Hospital Merthyr to Singleton Hospital Swansea due to premature labour and spontaneous rupture of membranes. Where there are transfers between hospitals the All Wales Inter Hospital Transfer documentation

	should be completed and sent with the women's documentation to the receiving hospital. This documentation has the potential to alert staff to risk factors although there is no specific question relating to women having treatment abroad or having contracted an alert organism. There is no evidence to suggest that this document was completed and sent to Singleton Hospital nor was it requested by anyone at Singleton. All three babies were delivered by Caesarean section on the same day (31st of October 2011) in the same theatre and were transported to the ITU in the Neonatal ward. The babies were placed in cots in close proximity to each other in the ITU unit. At the time the neonatal unit ITU environment was poor with evidence of dated facilities. The number of sinks within the area was inadequate for the number of cots in use at the time of the outbreak. The spacing of cots did not meet current standard The Neonatal ward has undergone substantial refurbishment to ensure more space around the cots and improved hand washing facilities. Screening for ESPN L E. coli is not recommended routinely in UK neonatal units except under outbreak conditions. The ESBL E. coli infection is becoming more frequent worldwide due to injudicious antibiotic use in the community and particularly in India and other countries where antibiotics are freely available over the counter. However recently pockets of infection are arising in this country. It was not until around midday on 3 November that the microbiologist informed the Neo Natal unit of the results of mothers A's cultures (taken on the 29 October while mother A was at Prince Charles Hospital) showing ESBL E. coli.
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. I have concerns that important patient history was not captured by the admitting hospital and passed to the receiving hospital. Mother A had received IVF treatment in India and had there acquired the ESB L E. coli. This important information was recorded in her medical notes which were with her. If the receiving hospital was aware of this then certainly the treatment of the twins would have been different and barrier nursing would have been implemented. 2. The All Wales Inter Hospital Transfer documentation was not completed and revision of the documentation should be considered.
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 22 September 2014. 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 and to the LOCAL SAFEGUARDING BOARD. 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	**28 July 2014 .... [SIGNED BY CORONER]**