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RCPCH

Royal College of
Paediatrics and Child Health

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10 AUG 2016

Ms L J Hashmi
Area Coroner
Greater Manchester North
The Phoenix Centre
L/Cpl Stephen Shaw
MC Way Heywood
OL 10 1LR

2nd August 2016

Dear Ms Hashmi

Re: Baby Smith, deceased – Regulation 28 Report 30th June 2016

I have read carefully your report and discussed this again with senior colleagues at the RCPCH.

Given that we do not have all the details of the tragic death of Baby Smith, the RCPCH is unable to comment on the specifics of the case and the Pennine Acute Hospitals NHS Trust has been asked to respond directly on local communication, record keeping and policies and procedures.

Following your report from May 2015, you raise again concerns around neonatal Group B Streptococcus (GBS). We are not aware of any new evidence or guidance on GBS and hence the RCPCH's response remains as in May 2015. I have set this out again below in response to each of your matters of concern:

1. That antenatal screening for GBS was not being routinely offered by the NHS, to all pregnant women, during the final weeks of pregnancy

The UK National Screening Committee does not recommend routine screening of all pregnant women for GBS carriage. We note that the National Screening Committee is due to review this recommendation again in 2015/16.

The Royal College of Obstetricians and Gynaecologists (RCOG) has produced a guideline (no. 36) for the prevention of early-onset neonatal group B streptococcal disease. The most recent edition was published in July 2012 and is based on the recommendations of the National Screening Committee. Point 4.1 in the guideline states that routine bacteriological screening of all pregnant women for antenatal GBS carriage is not recommended. The RCOG has also stated that initiating national swab-based screening for antenatal GBS would have a substantial impact on the provision of antenatal care within the UK and that major organisational changes and new funding would be required to ensure an equitable and quality-assured service.

2. That prophylactic intrapartum antibiotics were not routinely offered to all women who test positive for GBS (or have done so in the past).

The RCOG guideline states that clinicians should offer intrapartum antibiotic prophylaxis (IAP) to women with GBS identified during the current pregnancy, if detected on a vaginal swab.

The National Institute of Health and Clinical Excellence (NICE) published a guideline on antibiotics for the prevention and treatment of early-onset neonatal infection (CG 149) in 2012. Section 1.3 of the guideline states that women should be offered IAP using intravenous benzylpenicillin to prevent EOGBS if they have:

- had a previous baby with an invasive GBS infection or
- GBS colonisation, bacteriuria or infection in the current pregnancy

3. That given the seriousness of the illness, in the absence of a national screening and prophylactic treatment programme, babies were potentially being put at risk of harm/death.

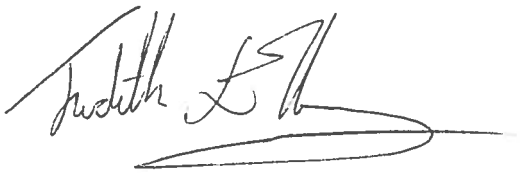
GBS is recognised as the most frequent cause of severe early-onset (at less than 7 days of age) infection in newborn infants. A Cochrane review in 2014, however, concluded that, while IAP for colonised mothers reduced the incidence of early onset neonatal GBS (EOGBS), it has not been shown to reduce all causes of mortality or GBS-related mortality.

There have been no studies addressing whether routine screening has had any impact on all-cause mortality. In addition, antenatal screening and treatment may carry disadvantages for the mother and baby. These include anaphylaxis, increased medicalisation of labour and the neonatal period, and possible infection with antibiotic-resistant organisms, particularly when broad- spectrum antibiotics such as amoxicillin are used for prophylaxis.

The NICE guideline on antibiotics for the prevention and treatment of early-onset neonatal infection (CG 149) sets out how to monitor risk factors for EOGBS during labour. It states that a clinical assessment should be carried out without delay if there are any clinical indicators for EOGBS including a review of the maternal and neonatal history and a physical examination of the baby including an assessment of the vital signs. The guideline also states that if clinical concern increases, consideration should be given to performing necessary investigations and starting antibiotic treatment, adding that if a baby needs antibiotic treatment it should be given as soon as possible and always within one hour of the decision to treat.

Thank you for raising this important case and reminding us of the importance of this work.

Yours sincerely,



Professor Judith Ellis MBE
RCPCH Chief Executive