REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **[redacted], Vice President for Clinical Quality, Royal College of Obstetricians and Gynaecologists, 27 Sussex Place, Regent's Park, London, NW1 4RG, UK**
1	**CORONER** I am Dr Séan Cummings Assistant Coroner for the Coroner Area of London (Western Area)
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 the 31st May 2017 an Inquest was opened into the death of baby Sebastian Clark. The investigation concluded at the end of the inquest on the 16th and 17th January 2019. The conclusion was a narrative one and read: Sebastian Clark died on the 12th March 2017 following his birth on the 8th March 2017 at the Kingston Hospital. He died from 1a Multi-organ failure and hypoxic ischaemic encephalopathy and 1 b acute chorioamnionitis. These are natural causes. His mother had a prolonged rupture of her membranes and developed a chorioamnionitis. The severe effect on Sebastian went unrecognized until he collapsed in utero and whilst he was initially resuscitated he had suffered catastrophic brain injury.
4	**CIRCUMSTANCES OF THE DEATH** Sebastian Clark died from multiorgan failure and hypoxic ischaemic encephalopathy subsequent to an acute chorioamnionitis infection in his mother. No screening for streptococcal infection was undertaken.
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 could 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 heard evidence that suggested that screening for streptococcal infection in women who were in labour would potentially benefit infants in detecting and interrupting ascending chorioamnionitis infections such as the one that arose in Sebastian Clark. I heard evidence that there was no national programme for such screening in England. 2. Kingston Hospital had subsequently developed a guidance note entitled "Pyrexia and suspected Chorioamnionitis" in an effort to reduce the prospect of a further death locally. It seemed to me that a policy such as this should be considered by you in an effort to reduce or prevent future deaths. I attach a copy

	of that document for your information.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, the Vice President for Clinical Quality, Royal College of Obstetricians and Gynaecologists, 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 8th August 2019. 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 (1) [redacted] (2) Kingston Hospital (3) [redacted] Designated Doctor for Child Death, Kingston Hospital 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	**13th June 2019** **Dr Séan Cummings Assistant Coroner**