NICE National Institute for Health and Care Excellence

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[redacted]

Rachael C Griffin
Senior Coroner
The Coroner's Office for the County of Dorset
Bournemouth Town Hall
Bournemouth, BH2 6DY

Sent via email: [redacted]

26 January 2021

Your ref: [redacted]
Our ref: [redacted]

Dear Ms Griffin,

I write in response to your correspondence, dated 1 December 2020, regarding the very sad death of Brandon-Robert William Collins-Hayward. Our thoughts are with his family.

We have considered the circumstances surrounding Brandon-Robert's death, and the concerns raised in your report – namely, whether there is sufficient guidance relating to the monitoring of mothers and babies in the immediate time following discharge from hospital after birth, and the assessment of babies when the mother is admitted to hospital within 28 days of birth (especially when diagnosed with infection and at high risk of developing sepsis).

We consider that there are 2 NICE guidelines of relevance.

NICE has published a clinical guideline on postnatal care up to 8 weeks after birth (CG37). This guideline covers the routine postnatal care that women and their babies should receive for 6–8 weeks after the birth. It includes advice given on breastfeeding, and the management of common and serious health problems in women and their babies after the birth. This guideline is currently in the process of being updated.

NICE also has a guideline on neonatal infection: antibiotics for prevention and treatment (CG149). This guideline covers preventing infection within 72 hours of birth in healthy babies, treating pregnant women whose baby is at risk, and caring for babies who have a suspected or confirmed infection. This guideline is also currently in the process of being updated, and the guideline's scope has been extended to cover late neonatal infection (>72 hours to 28 days).

Therefore, the concerns you have raised following Brandon-Robert's tragic death will be further considered by the guideline developers as part of this ongoing work. We expect to publish both updated guidelines later this year. The NICE website will be updated with further developments.

Yours sincerely,

[redacted]

Professor [redacted]
Chief Executive

Royal College of General Practitioners

Dr [redacted]
Joint Honorary Secretary

Mrs Rachael Clare Griffin
HM Senior Coroner
For the Coroner Area of Dorset
Sent by email to: [redacted]

9 March 2021

Dear Mrs Griffin,

Regulation 28 Report to Prevent Future Deaths - touching on the death of Brandon-Robert William Collins-Hayward

Thank you for your letter of 23 February 2021. I am responding on behalf of the Royal College of General Practitioners as Joint Honorary Secretary to Council. Firstly, can I convey our condolences to the family and friends of baby Brandon-Robert William Collins-Hayward. I was saddened to read of Brandon's passing.

The report's recommendations for better national guidance regarding the monitoring of mothers and babies following discharge after birth, and that babies are medically assessed when a mother is admitted to hospital, seem sensible but the Royal College of Midwives, the Institute of Health Visitors and the Royal Colleges of Emergency medicine and of Physicians may be in a better position to commend on these. General practitioners (GPs) usually undertake the postnatal check for mothers and babies slightly later at 6-8 weeks. Of course, patients can contact their GP earlier if they have any concerns but in terms of routine checks, earlier checks than 6-8 weeks tend to be undertaken by midwives and health visitors.

I trust that this reply is helpful and if you have any questions, please do not hesitate to contact me.

Yours sincerely,

Dr [redacted]
Joint Honorary Secretary of Council
Royal College of General Practitioners

THE ROYAL COLLEGE OF MIDWIVES

Promoting · Supporting · Influencing

[redacted]
Coroner's Support Officer
The Coroner's Office for the County of Dorset
Bournemouth Town Hall
Bournemouth
BH2 6DY

By Email to: [redacted]

29 January 2021

Dear [redacted]

Re: Regulation 28 report into the death of baby Brandon-Robert William Collins-Hayward.

Thank you for your letter dated the 19th January outlining a request from H.M Coroner Mrs R.C. Griffin, with reference to a Section 28- to prevent further death touching on the death of Brandon-Robert William Collins-Hayward.

The RCM was saddened to read about the tragic death of baby Brandon. We note that the direction of the Section 28 to us was undertaken in good faith by [redacted] Vice President RCOG, however the RCM is a membership organisation and trade union, we have no jurisdiction over the education, employment or registration of maternity staff. The remit for the development and implementation of any new NHS guidance would sit with NHS Improvement.

The RCM hopes that this signposting will support the Coroners actions going forward. Please do not hesitate to make contact if the RCM can be of any further assistance.

Yours sincerely,

[redacted]

Dr [redacted]
Executive Director for Services to Members

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Patron: HRH The Princess Royal. The Royal College of Midwives: A company limited by guarantee. Registered No. 00030157.

Institute of Health Visiting
c/o Royal Society for Public Health,
59 Mansell St, E1 8AN
27th January 2021

Rachael Clare Griffin
HM Senior Coroner
for the Coroner Area of Dorset

Dear Ms Griffin,

Re: Regulation 28 report into the death of baby Brandon-Robert William Collins-Hayward

Thank you for your email dated 19th January 2021 requesting a response to your inquest findings. Your attached Regulation 28 Report contains details of the sad death of baby Brandon-Robert William Collins-Hayward in June 2019, when he was 9 days old, with the medical cause of death recorded as Escherichia coli sepsis.

In England, the midwife will be responsible for the care of the mother and infant in the immediate post-natal period. The midwife would normally discharge the mother and baby dyad from their caseload between the 10th and 14th day following the birth. At this point, the care of the dyad would be transferred to the health visiting service, although midwifery care can be extended up to 28 days after the birth if the baby or mother is unwell or has additional needs which require support from the midwifery team.

As Brandon-Robert William Collins-Hayward sadly died 9 days after his birth, and he became unwell at home, his community care would fall within the remit of the midwifery service and GP; at this point his care would not have transferred to the health visiting service.

However what you ask for is for national learning from this sad case. NICE produce national guidance used by all the relevant professionals. 'Normal Postnatal Care' covers the postnatal period for mother and baby up until 8 weeks post partum. We note that you have already written to NICE. Whilst there is a time lag with their process this would seem the most efficient way of ultimately getting the messaging out to all the relevant professionals who will base their own guidance on that produced by NICE. There is also national guidance produced by Public Health England on identifying sepsis in babies which health visitors will use to inform their practice – you can find details here if you haven't already been alerted to it:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/648381/Sepsis_guidance_for_health_professionals_and_school_nurses.pdf

Paediatricians are the professional group with the greatest expertise in the care of the newborn, again I note you have already written to their Royal College. However it will be GPs and midwives in the community who may make most use from guidance regarding observing the baby's health when admitting a mother with suspected sepsis before the baby is 10-14 days old and I note that the RCOG have advised that you also writing to their colleges.

We share your ambition that any learning from this case should be used to prevent future deaths due to sepsis and appreciate you alerting us. Sepsis is a life-threatening condition in young babies which is difficult to spot and can lead to a rapid deterioration in the baby's condition requiring urgent medical treatment.

We do hope that writing to NICE will ultimately deliver the national change you require, alongside alerting the Royal Colleges of Paediatrics, Midwifery and General Practice - the latter two may have their own guidance on managing sepsis in the mother (something that we don't have) which can be adjusted immediately for future care also of the infant.

If you require any further information, do not hesitate to contact us,

Kind regards

[redacted]

Dr [redacted] CBE Executive Director

Cc [redacted], Chair of the iHV

RCPCH
Royal College of
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Leading the way in Children's Health

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Monday, 01 February 2021

Sent by email to: [redacted]

Dear Coroner Rachel Clare Griffin

Re: Investigation into the death of Brandon-Robert William Collins-Hayward

Regulation 28 – Action to Prevent Future Deaths

I have carefully read your report regarding the tragic and untimely death of Brandon-Robert William Collins-Hayward and would like to first express my sincere condolences to his family. We have been provided with limited details regarding the circumstances of his death and appreciate that many of the details covered in the inquest were omitted for brevity.

I have discussed the findings of the investigation with senior colleagues within the RCPCH. From your report we have specifically noted:

- On Day 3 of life following a normal vaginal delivery, he started to make grumbling noises, developed a shiver and reduced his milk intake.
- On Day 5 of life, he was assessed at home by the midwifery team when a visual check, but no basic observations were performed.
- On Day 8 of life, his mother was admitted to hospital with moderate to severe infection and at high risk of developing sepsis, but he was not referred for medical assessment for possible infection.
- On Day 9 of life, he was yellow in colour, had a yellow discharge in his nappy and started to struggle breathing. Cardiopulmonary resuscitation was commenced, and he arrived at hospital in a peri-arrest condition and received active treatment with continued resuscitation attempts.

It would seem from the report that Brandon-Robert developed overwhelming sepsis in a short period of time. On a clinical level, with the information provided, it seems difficult to directly link the findings on Day 3 and Day 5 of life with the tragic outcomes of this case. In infants under one month of age with sepsis, there could only be hours from the onset of abnormal observations to collapse. Occasionally there are cases of more slowly evolving infection, but with gram negative organisms such as Escherichia Coli, disease progression can be alarmingly fast.

From the information provided, it appears that the potential time for intervention may have been around the hospital admission of Brandon-Robert's mother. However, the cause of sepsis in Brandon-Robert's mother that required her admission on the 6th June 2019 is not clear in the report we received, and it does not state whether the same causative organism was involved in both cases. Post-partum infection is not uncommon, and Escherichia Coli is one of many potential

causes. The Royal College of Obstetricians and Gynaecologists' guideline 64b[1] only recommends treatment for the newborn if either Group A Streptococcus, Group B Streptococcus, some forms of Staphylococci, or Neisseria Meningitides are identified in the mother.

Details were provided on the response from the hospital Trust following this case and I recognise changes have been made to local policies and procedures to ensure observations of babies are taken up to Day 10 following birth, and babies of mothers admitted to hospital within 28 days of birth are medically reviewed either in hospital or at home by the midwifery team.

You have asked the RCPCH, Royal College of Obstetricians and Gynaecologists (RCOG) and National Institute of Clinical Excellence (NICE) to review current national guidance in place for post-natal care following discharge from hospital after birth. It is advised that national guidance should be in place to perform observations on babies at each review within the first 10 days of life and medical assessment of a baby should be required when the mother is admitted to hospital with potential sepsis within 28 days of birth.

National guidance recommendations

Medical Royal Colleges are membership-based professional bodies, which set the standards for training of specialist doctors in some or all parts of the UK and contribute to the further development of professional medical practice. As such, the RCPCH is unable to comment on the specifics of the case relating to the practice of other healthcare professions and specialties beyond paediatrics.

Alongside setting standards for paediatric doctors, RCPCH and affiliated specialty groups provide expert clinical input to the development of service and clinical standards. In England the most widely recognised national guidelines and standards are developed by NICE which has a rigorous and systematic process for topic selection, identifying evidence, evidence synthesis, development, consultation, and final production. Standards are developed in collaboration with expert clinical groups and stakeholders, including Medical Royal Colleges.

The RCOG guideline 64b on bacterial sepsis following pregnancy was last updated in 2012. The NICE clinical guideline CG37[2] was last updated in February 2015 and covers the routine postnatal care women and their babies should receive for 6-8 weeks after birth. The RCPCH provided formal support for NICE quality standard QS37[3] that was last updated in June 2015, which describes high-quality care in priority areas for the routine postnatal care of women and their babies. We support your recommendation to review these national guidelines and advise this includes:

- a review of the current list of organisms found in mothers that should lead to mandatory treatment of the infant.
- a review of current guidance on the type, frequency and formality of observational recording in new mother baby pairs.
- a review of potential trigger points for referral of newborns to other clinical teams.

Of note, there may be significant national resource implications to completing a full set of neonatal and maternal observations on each postnatal visit. This would add around 10 minutes to each postnatal consultation for the 600,000 or so deliveries per year in England.

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[1] https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg64b/
[2] https://www.nice.org.uk/guidance/cg37
[3] https://www.nice.org.uk/guidance/qs37

We would ask that both RCOG and NICE review and update their national guidance to include these considerations. The RCPCH would be pleased to contribute to this work and provide support where appropriate.

NHS bodies and individual clinical departments are also expected to ensure that their operational activities comply with NICE and RCOG guidelines. We would emphasise that there should be in place in all NHS organisations clear systems and processes for clinical governance that monitor and audit practice and outcomes. These arrangements should also ensure that clinicians of all professions practice under the latest national guidance.

RCPCH support for healthcare professionals

I am pleased to set out below additional work that has been undertaken to develop guidance in the relevant areas where RCPCH can make a difference. This includes advocating for adequate training of all healthcare professionals reviewing children and supporting the development of resources to provide appropriate clinical decision support for healthcare professionals.

In 2014, the RCPCH, British Association for Child & Adolescent Public Health and National Children's Bureau released a joint report titled 'Why Children Die'[4]. It examines some of the possible reasons for the relatively high number of avoidable baby and child deaths in the UK and provided recommendations for remedial action, which included all frontline health professionals involved in the acute assessment of children and young people should complete relevant professional development so they are confident and competent to recognise a sick child.

RCPCH resources to support clinical decision

The physiology of infants and their response to sepsis is particularly difficult to identify and a different approach from adults is required. In 2020, the RCPCH supported a complete revision and update of 'Spotting the Sick Child'[5], an interactive tool to support all health professionals in the assessment and recognition of the seriously ill child. The RCPCH also produced free to access paediatric sepsis podcasts[6] designed as educational resources for all health and social care professionals exploring what sepsis is, and the complexities of recognising it.

If basic observations were performed on review of an infant outside the hospital setting within the first 10 days of life, Paediatric Early Warning Systems (PEWS) may help to identify signs outside of normal parameters and raise the level of concern. PEWS are generated by combining the scores from a selection of routine observations such as children's heart rate, respiratory rate, work of breathing, skin perfusion, conscious level etc.

The RCPCH is currently supporting the NHS System-wide Paediatric Observations Tracking Programme[7] (SPOT) led by NHS England, which aims to deliver a consistent PEWS across England in both hospital and community settings. It is hoped that community use of PEWS established by NHS SPOT would provide healthcare professionals with the ability to track observations over time,

[4] https://www.rcpch.ac.uk/resources/why-children-die-research-recommendations#key-messages
[5] https://spottingthesickchild.com/
[6] https://www.rcpch.ac.uk/resources/paediatric-sepsis-podcasts
[7] https://www.rcpch.ac.uk/resources/paediatric-early-warning-system-pewsystem-developing-standardised-tool-england#how-you-can-get-involved

such as in Brandon-Robert on days 3, 5 & 8 of life, so that subtle trends or significant changes can be more easily detectable and lead to early referral and treatment.

RCPCH support for parents and carers

It is also important that safety netting interventions are provided to all parents and carers following discharge from hospital care after birth. In 2020, the RCPCH produced a set of posters for families living in the UK about when and how to get medical help for their child. A specific poster was created for parents/carers of babies less than 3 months old[8] with advice on what to do if their baby is unwell and the signs and symptoms to recognise when urgent medical help is required.

The poster aims to provide timely and accurate advice for parents and families and to empower families to seek help if their baby does not improve. They outline the different levels of concern and the appropriate urgency of medical review in a red, amber, green traffic light format. All healthcare professionals are encouraged to use this guidance and familiarise themselves with the signs highlighted in the red and amber categories. Disinterest in feeding and shivering are both symptoms that it advises for medical review within 24 hours.

The RCPCH has also raised concerns on the redeployment of health visitors during the COVID-19 pandemic[9], and published a recent Insight article[10] on the important role of health visitors in supporting families who have new babies in the community. We will continue to advocate for the provision of adequate resources in child health and support the wider workforce by providing open access guidance on identifying the acutely unwell child in the community.

I trust this provides you with the reassurance that RCPCH is working hard to support the high-quality safe care of babies in the immediate days following birth across a range of areas where we can make a difference. We welcome opportunities to work collaboratively with other organisations and professional bodies and would support the recommendations for a review of current NICE and RCOG guidelines to minimise the likelihood of recurrence of what Brandon-Robert William Collins-Hayward's family has faced.

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

Yours sincerely

Dr [redacted]
Vice President for Health Policy
Royal College of Paediatrics and Child Health

On behalf of

[8] https://www.rcpch.ac.uk/resources/advice-parents-young-people-during-coronavirus-posters
[9] https://www.rcpch.ac.uk/news-events/news/redeployment-health-visitors-has-left-vulnerable-children-risk
[10] https://medium.com/rcpch-insight/what-does-a-health-visitor-do-3a75ac05c0fc

[redacted]
Chair of the Board of Trustees
Royal College of Paediatrics and Child Health