REGULATION 28: CORONER REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **BedNest Ltd** **Unit A** **Drayton Manor Office Buildings** **Drayton Manor Drive** **Stratford Upon Avon** **CV37 9RQ** 2. **National Childbirth Trust** **17 Colquhoun Avenue** **Hillington** **Glasgow** **G52 4BN**
1	**CORONER** I am Penelope SCHOFIELD, senior coroner for the coroner area of WEST SUSSEX.
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** On 10th April 2015 I commenced an investigation into the death of Grace ROSEMAN, a 7 week old baby. The investigation has not yet concluded and the inquest has not yet been heard.
4	**CIRCUMSTANCES OF THE DEATH** Grace was a 7 week old baby. She was asleep at her home address in Haywards Heath with her mother, father and 2 year 11 month old sister. Her mother put her down to sleep in the prone position at approximately 0830 hours in a Bed Nest bed side crib. The crib has a panel on either side one of which can be folded down leaving about 7cm of side with a narrow, hard metal plastic covered edge. Grace was found by her mother at approximately 1000 hours laying with her head over the edge of the crib and her neck resting on the low plastic edge. The cot was in a tilted position, (8cm tilt, maximum recommended by the manufacturer being 5cm but this information was in paper instructions, not on the cot). Grace had a bruise on the left side of her neck. The provisional cause of death is that Grace died from Asphyxia. It appears that Grace had

<table>
<tr><td></td><td>managed to get her head over the edge of the side of the crib. Due to the weight of her head she was prevented from returning it and moving clear. The weight of her head on the side of the cot has restricted her air supply and subsequently led to her death.
The cot in question was a second hand cot that had been passed onto the family from a relative. When the family received the cot there were no instructions on how to use it and it did not have any warning on the cot itself. The family had purchased a new replacement mattress.</td></tr>
<tr><td>5</td><td><u>CORONER'S CONCERNS</u>

During the course of the investigation my inquiries 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. The manufacturer's website clearly shows pictures of babies in these cots with the sides in the incompletely lowered position.
2. The manufacturer's instructions for this cot indicate that a baby should not be left unattended other than when both sides of the bednest are up and secure. In addition any tilt applied to the cot should be restricted to less than 5cm. However this is of little assistance to anyone who has been given a second-hand cot without these instructions being readily available. There are no warnings on the cot itself.
3. Should another baby be placed in the prone position and left with the side incompletely lowered again in one of these cots, another death could occur.
4. If the cot side is not safe to be incompletely lowered or for the cot to be tilted more than 5cm then it should be questioned as to whether these should be options available at all.
5. These cots are currently available to be purchased through the manufacturer, NCT and other leading stores
6. There are a large number of second-hand cots being marketed for sale.</td></tr>
<tr><td>6</td><td>ACTION SHOULD BE TAKEN

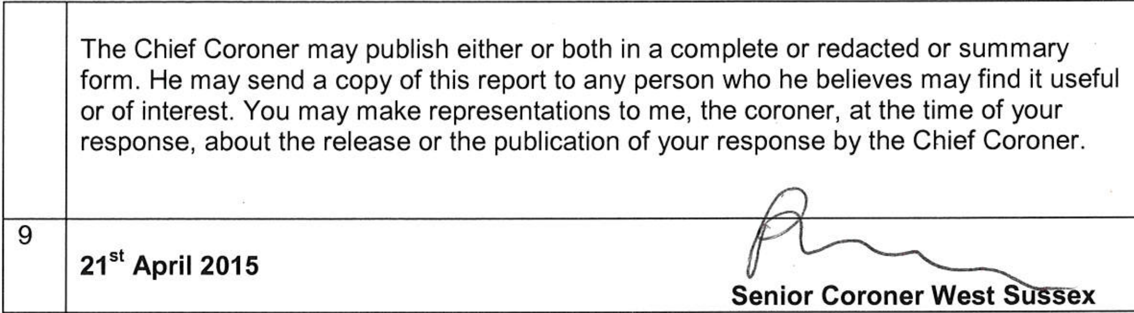
In my opinion urgent action should be taken to prevent future deaths and I believe you and/or your organisation have the power to take such action.</td></tr>
<tr><td>7</td><td>YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 16th June 2015. 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.</td></tr>
<tr><td>8</td><td>COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:-
Gideon and Esther Roseman
Ann Corkery – West Sussex Safeguarding Child Board
I have also sent it to :-
D Sgt Pink – Investigating Officer - Sussex Police
Peter Ashton – Trading Standards WSCC
Dr Ann Wallace – Consultant Paediatrician – Child Development Centre
who may find it useful or of interest.

I am also under a duty to send the Chief Coroner a copy of your response.</td></tr>
</table>



	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	**21st April 2015** **Senior Coroner West Sussex**