REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) [redacted] - University College London Hospitals NHS Foundation Trust**
1	**CORONER** I am R Brittain, Assistant Coroner for Inner North London
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** The investigation into the death of Eric Laser Matthews, aged 1 month, was commenced on 9 January 2014 and concluded at the end of the inquest on 2 April 2014. The conclusion of the inquest was narrative (Copy attached).
4	**CIRCUMSTANCES OF THE DEATH** Eric Matthews was born on 26 November 2013. He was discharged home after a course of antibiotics, which was required for presumed sepsis. Over the next month he was well and no further issues of concern arose. On 24 December 2013 his parents placed him in a 'sling' baby carrier in order to comfort him during a period of crying. He appeared to settle during a short walk, however, on their return home it was clear that Eric was not breathing. Resuscitation was started and the ambulance service called. After a period of approximately 39 minutes, sufficient circulation returned so that resuscitation could be stopped. Eric was ultimately transferred to Great Ormond Street Hospital where, despite further treatment, he was found to have suffered a significant hypoxic injury to his brain. Treatment was discontinued and he died on 1 January 2014. Evidence was provided by Paediatric Pathologist, [redacted] that, on the balance of probabilities, the cause of the cardiac arrest was positional asphyxia. There was no evidence that the use of the sling was inappropriate or incorrect. In her evidence [redacted] stated that there have been reported cases of infant deaths in similar circumstances, notably in the United States and Australia. She noted that [redacted], Perinatal Pathologist at UCLH, is currently collating reports of such cases in the UK, with a view to understanding this risk more thoroughly. Eric's parents set out that they had no knowledge of the risk of positional asphyxia through use of a baby sling. Eric's mother noted the valuable work undertaken by the

	Lullaby Trust, with regard to the provision of information to parents relating to sleep positioning. She proposed that the Trust might be well placed to distribute similar information regarding sling use.
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) There appears to be a body of evidence that positional asphyxia can occur through use of baby slings. However, knowledge of this risk appears to be limited at present to academic circles and has not been widely researched. (2) If there is currently sufficient evidence to raise this risk to parents, I am concerned that this information has not been publicised more widely.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the above information may be helpful to you, [redacted] as it relates to the research you are undertaking on the risks posed by baby slings. It may be that you would wish to send details of your research to Eric's family and to organisations such as the Lullaby Trust, who may be able to publicise the risks posed, should this be appropriate now, or at any future point.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 30 May 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 Eric's family. 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	**4 April 2014** **Assistant Coroner R Brittain**