



## REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

### THIS REPORT IS BEING SENT TO:

**Greg Clark MP**  
**Secretary of State**  
**Department for Business, Energy and Industrial Strategy**  
**1 Victoria Street**  
**London**  
**SW1H 0ET**

#### 1 CORONER

I am Penelope Schofield, Senior Coroner, for the 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 and INQUEST

On 10<sup>th</sup> April 2015 I commenced an investigation into the death of Grace Joy Roseman. The investigation concluded after a three day Inquest held between the 14<sup>th</sup> to 16<sup>th</sup> December 2016. The conclusion of the Inquest was Accidental Death.

#### 4 CIRCUMSTANCES OF THE DEATH

1. Grace Joy Roseman was born on 18<sup>th</sup> February 2015 at 41 weeks and 4 days.
2. A few months before she was born (in late November/Early December 2015) her parents were given a secondhand NCT Bednest crib. The crib did not come with any written instructions and there were no instructions on the crib itself.
3. The crib was manufactured by Bednest but was cobranded with NCT and bore the label NCT Bednest. Before being marketed it had been passed as compliant by the FIFA test house in relation to BS EN 1130 standard.
4. Having been given the crib Mrs Roseman decided that she wanted her own mattress and purchased the "Little Green Sheep" mattress, which met the size specifications stipulated by Bednest, through the NCT website.
5. When Grace was born it became clear that she disliked sleeping on her back so [REDACTED] had to resort to placing Grace in the prone position when she started sleeping in the crib. As a safety measure her husband placed a breathing pad under the mattress.
6. [REDACTED] always used the crib with one of the sides of the crib (the side closest to the bed) in its half lowered position. At no time did she realise that it would be unsafe to do so.
7. On 9<sup>th</sup> April 2015 Grace was put to sleep in her NCT Bednest crib following an early morning feed. Her mother again placed her in the prone position. Sometime after 6.30 am [REDACTED] went downstairs with her other daughter Pearl. At around 8.30 she came back upstairs but Grace was still asleep. Not wanting to disturb her Mrs Roseman went back downstairs.

8. At around 10.00, after having a bath, [REDACTED] went into the room where Grace was sleeping. There she found Grace lying sideways with her head over the half lowered side wall of the Cot. The right side of her head and neck was purple.
9. [REDACTED] immediately took Grace to the hospital (which was very close by) but sadly the Doctors were unable to revive her.
10. Following her death a Post Mortem examination was undertaken by [REDACTED] and the medical cause of death given was postural asphyxia. Following evidence at the Inquest the cause of death was amended to pressure on the carotid sinus leading to positional asphyxia.
11. During the Inquest four experts were called to give evidence and they were all satisfied that, despite her age, it would have been possible for Grace to have got her head over the half lowered side of the crib. They also agreed that once in this position she would not have been able to remove herself from it.
12. Despite the certification that had been provided by FIRA the experts instructed by Trading Standards, who gave evidence at the hearing, took the view that the product was unsafe when being used with the half folded down side, whether or not the infant was being supervised.
13. Since Grace's death Bednest have modified the crib so that the sides can no longer be lowered to a half way position. They have tried to contact as many of their customers as they can and where requested they have sent out modification kits to these customers

#### **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.

- (a) The current BS EN 1130 -1:1997 & 2:1996 Cribs and Cradles for Domestic Use has not kept up with the recent development of infants bedside sleepers. Therefore there has been inadequate and properly informed assessment and consideration of the risks to infants from this new type of bedside sleeper cribs.
- (b) There are currently a number of other products currently being marketed, in addition to the Bednest Crib, with a partially lowered side which in my mind poses a similar risk to that faced by Grace Roseman.
- (c) There is a real reluctance from the industry to accept the possible risk of death of infants (and in particularly those with enhanced development skills) by being able to manoeuvre themselves into a position where their head and neck could become trapped over the edge of the partially lowered side.
- (d) It appears that that the standards which relates to the safety of products for children are being drafted or revised without the authors of those standards adequately consulting with those who have the necessary expertise in paediatric medicine and child development to ensure that the standard properly reflects current scientific knowledge.

I consider that the issues raised in this case should be addressed so that future deaths do not occur in similar circumstances and that action should be taken to reduce the risk of deaths of other infants..

#### **ACTION SHOULD BE TAKEN**

In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action by addressing these issues.

7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 13<sup>th</sup> February 2017. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:</p> <ol style="list-style-type: none"> <li>1. [REDACTED]</li> <li>2. Bednest Ltd</li> <li>3. NCT</li> <li>4. West Sussex Trading Standards</li> </ol> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
<p><b>DATE: 19<sup>th</sup> December 2016      SIGNED: Penelope Schofield, Senior Coroner, West Sussex</b></p>	