REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Secretary of State for Health, Secretary of State for Business
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner area of South Manchester
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 23rd April 2018 I commenced an investigation into the death of Savannah-Rose Michelle Owen. The investigation concluded on 7th November 2018 and the conclusion was one of **Natural Causes**. The medical cause of death was **1a) Unascertained**
4	Savannah-Rose Michelle Owen was a healthy baby born on 16th February 2018. On 22nd April 2018 she fell asleep on a nursing pillow on the sofa at her home address. Her parents realised she had become unresponsive and an ambulance was called. Attempts to resuscitate her were unsuccessful. A post-mortem did not find a cause of death but did exclude any third party involvement or suspicious circumstances and on the balance of probabilities would have been due to natural causes.

5	CORONER'S CONCERNS

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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.

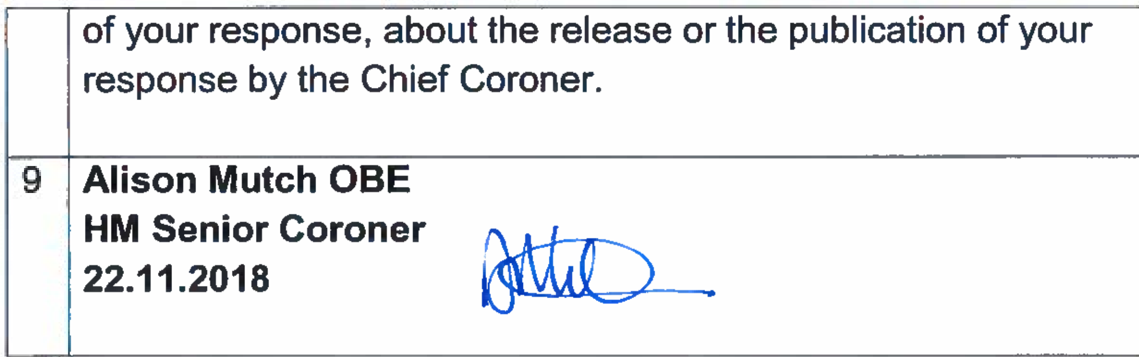
The MATTERS OF CONCERN are as follows. –
The inquest heard that:
Savannah-Rose's mother had purchased the multi-purpose nursing pillow from a well-known supermarket chain. There were warnings about its use on a card that came with the pillow but was not attached to it. On the warning/information leaflet were 5 pictures of a baby positioned on the pillow. In only 2 images was the baby with an adult. On the other 3 the baby was alone.
The inquest heard that sleeping unsupervised on such pillows was not consistent with the safe sleeping advice given to new parents. However:

1. Unlike many items associated with babies/young children such as high chairs/cots there was no specific safety regulation for such items. Instead manufacturers had to interpret the all-embracing safety policy. This risked inconsistent safety warnings/labelling;

2. It was unclear if Health Visitors/ Midwives in the community seeing multi-use pillows being used were flagging up the risks of allowing babies to be propped on them for naps and that their use in such a way was wholly inconsistent with safe sleeping advice;

3. On the warning/information leaflet were 5 pictures of a baby positioned on the pillow. In only 2 images was the baby with an adult. On the other 3 the baby was alone. The inquest was told that this could be misleading as to the importance of never leaving a baby unattended on

	the pillow; and 4. The warning label was not attached to the item therefore; once the package had been opened, there was a high risk that the warning label would be lost. On resale/ recycling of baby items this meant that second hand users/purchasers were unlikely to see the warning.
6	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.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 17th January 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 namely [redacted] and [redacted] the deceased's parents, who may find it useful or of interest. 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	**Alison Mutch OBE** **HM Senior Coroner** **22.11.2018**