	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Jo Churchill MP** **Parliamentary Under Secretary of State** **Minister for Prevention, Public Health & Primary Care** **House of Commons** **London**
1	**CORONER** I am Alan Anthony Wilson Senior Coroner for **Blackpool & Fylde**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** The death of Isaac Jakob NEWTON on 6th September 2019 was reported to me and I opened an investigation, which concluded by way of an inquest held on 10th September 2020. I determined that the medical cause of Isaac's death was **1 a Overlaying.** In box 3 of the Record of Inquest I recorded as follows: A previously healthy child Isaac Newton was fed at approximately 0030 hours on 6th September 2019 and then placed on his back in a double bed. He slept alongside his Father and a half – sibling. He was found deceased later that morning at 05.55 hours. A subsequent post mortem revealed that Isaac died after his airway was obstructed as a result of the weight of an adult body overlying him and inadvertently depriving him of oxygen. The conclusion of the Coroner was that Isaac died due to an **Accidental death.**
4	**CIRCUMSTANCES OF THE DEATH** Isaac Newton was a four-month-old baby boy who had previously been in good health who had been residing in Blackpool with his Father [and Paternal Grandparents] over recent days. Isaac usually lived with his Mother in the Preston area. His Father placed Isaac on his back in a double bed. He proceeded to sleep in that bed with his Father and his Half – Sister, although before retiring to bed his Father smoked some cannabis. Later that morning at approximately 05:55 hours Isaac's Father awoke and saw Isaac was unresponsive. The emergency services attended but the evidence clearly demonstrated that Isaac was already deceased. He had been deceased for some time although it was not possible to say with accuracy when he had died during the night. Over recent nights, Isaac had been co-sleeping in the same double bed as his Father and Half-sibling although his Paternal Grandparents had no knowledge of this and thought Isaac had been sleeping in a cot [one was available in the room where Isaac slept].

	The evidence of a forensic pathologist clearly indicated: • That although placed on his back, at some point after death Isaac had been in a face down position. His Grandmother told the court that Isaac had not yet reached the age at which he could roll over himself; • That no natural disease could be identified which had caused / contributed to Isaac's death; • That overlaying occurs when the weight or indeed part of the weight of an adult or older child overlays the body of the baby thereby compromising respiratory effort and the baby's ability to breathe; • That Isaac died due to acute upper airways obstruction, which the court accepted, had caused a fatal deprivation of oxygen. Although Isaac's Father had admitted using cannabis before retiring to bed, the level of cannabis identified by toxicology analysis was low. When spoken to by police officers at hospital he did not appear to be under the influence although those discussions took place at least six hours after the cannabis use. The court determined that Isaac's Father may have been under the influence / impaired due to his admitted cannabis at some point during the night and whilst he was co-sleeping with Isaac. Cannabis can adversely affect a person's perception of space and time, information processing, attention and coordination. The evidence before the court provided by Isaac's Mother was that when Isaac slept at home with her he would share a bed with his Mother and his Half – sibling. She would try to settle him in a Moses basket but Isaac would generally be in bed with her.
5	**<u>CORONER'S CONCERNS</u>** 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)My concern relates to the risk posed to young infants by unsafe sleeping practices. This inquest involved a young child who was sleeping in a bed with a Parent and a Half – sibling. This was the fourth inquest I have concluded in 2020 that has involved a child that has died whilst sleeping in or on the parental bed. All of these inquests have involved relatively young parents. In three of the four inquests alcohol or drug use was a factor. Although guidance is provided to new parents about the dangers posed by an unsafe sleeping environment, I am concerned that the message is not being appreciated and / or followed. The evidence received from Isaac's Parents was illustrative. His Mother informed the court that she had received advice from health visitors about the potential risks of a child co-sleeping with an adult but had clearly chosen not to follow the advice despite having a suitable cot available for him to sleep in. Isaac's Father by contrast told the court that he could not recall receiving such advice. He gave the impression that he was unware that the child may be at risk were he to use cannabis before co-sleeping, and in preferring to co –sleep rather than place Isaac in the cot he was following the practice he knew Isaac's Mother adopted when Isaac was residing with her. Isaac's Mother gave the impression that Isaac was not in jeopardy when he slept with her and his Half – sibling during the night because there was no risk that she would unknowingly roll over during the night.

	I am concerned that despite efforts to provide guidance to parents about what may amount to an unsafe sleeping environment some parents are continuing to place often very young children at risk. I concluded that it would be remiss of me as Senior Coroner for this coronial area were I not to raise this concern in light of the number of inquests we have concluded during which an unsafe sleeping environment has been adjudged to have played a role in the child's death. I am aware that the Department of Health & Social Care did in July of this year publish details of a major review into improving health outcomes for babies and young children and so I have chosen to forward this letter to the Parliamentary Under Secretary with responsibility for that review as the concern I raise may be of relevance.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you **Jo Churchill MP** **Parliamentary Under Secretary of State, Minister for Prevention, Public Health & Primary Care** 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 11th November 2020. 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: • Parents of Isaac Jakob Newton • Head of Children's' Services, Blackpool Council and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)]. 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	14/09/2020 Signature  Alan Anthony Wilson Senior Coroner **Blackpool & Fylde**