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National Medical Director
NHS England
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[redacted]

3 July 2023

[redacted]

Dear Ms Gomersal

Re: Regulation 28 Report to Prevent Future Deaths – Chester Alan Stanley Mossop who died on 3 June 2022.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 20 April 2023 concerning the death of Chester Alan Stanley Mossop who died on 3 June 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Chester's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised have been listened to and reflected upon.

I am grateful for the further time granted to respond to your Report, and I apologise for any anguish this delay may have caused Chester's family. I realise that responses to Coroner Reports can form part of the important process of family coming to terms with what has happened to their loved ones and appreciate this will have been an incredibly difficult time for them.

Your Report raised that the use of bath seats for babies is a concern to the Royal Society for the Prevention of Accidents (RoSPA) and that their use can give parents a false sense of security. You raised the concern that you were not aware if the advice from RoSPA had been distributed on a national level to healthcare professionals and to parents/carers, and whether parents/carers were provided with advice about the safe use of bath seats.

We were very saddened to hear about this case which has been carefully considered by colleagues across the organisation including from Patient Safety, Maternity and Children and Young People teams. In response to the concerns raised, NHS England will be updating its 'Washing and bathing your baby' website page to include guidance on the use of bath seats for babies. This will make clear that bath seats for babies are not recommended for use by RoSPA or by the Child Accident Prevention Trust (CAPT), who we have engaged with on this matter, and that they are not safety devices. The update to the website will also include text to raise awareness with parents/carers that babies can drown within seconds, in just a few centimetres of water and with no noise or struggle and reemphasise that babies of any age should always be kept at arm's reach of an adult whenever they are in the bath. These updates to the website are moving through NHS England's internal approval process and are

expected to be made imminently. We are happy to advise you as soon as these updates have been made.

This advice will also be incorporated into staff bulletins for midwifery and healthcare workers, reminding staff to communicate this important safety message to parents and carers during their interactions. I am also aware that my Maternity colleagues are picking up on the concerns raised with the Royal College of Midwives (RCM) and the British Association of Perinatal Medicine (BAPM), to consider whether any further awareness work can be implemented via their networks.

NHS England will also be sharing the case through Patient Safety bulletins and will discuss at our next national Regulation 28 Working Group meeting in August. Regional colleagues who sit on the Working Group membership will be asked to ensure that the safety message around bath seats is shared to their systems, to help raise further awareness.

We have discussed this case and the concerns raised with colleagues at the Office for Health Improvement and Disparities (OHID) at the Department of Health and Social Care and are advised that they will be raising the case with their networks as a safety alert.

The National Child Mortality Database (NCMD) will also shortly be publishing a thematic report on deaths of children and young people due to traumatic incidents between April 2019 and April 2023, which will include drownings. Many of the drownings considered within the scope of the report did take place when a child or baby had been left unsupervised. As advised above, NHS England are undertaking a communications push to highlight the importance of never leaving babies of any age unsupervised while in the bath. We will also of course consider any additional recommendations made by the NCMD within its report.

NHS England has been sighted on the response to your Report from the Office for Product Safety and Standards (OPSS) and I am pleased to hear that the OPSS will also be assessing the safety and compliance with legal requirements of similar models of baby bath seats to the one used by Chester, and that they will take any relevant action.

I would also like to provide further assurances on national NHSE work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around preventable deaths are shared across the NHS at both a national and regional level and helps us pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

[redacted]
National Medical Director