KALLY CHEEMA
SENIOR CORONER

County of Cumbria

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[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **CHESTER ALAN STANLEY MOSSOP aged 9 MONTHS** THIS REPORT IS BEING SENT TO**:** **NATIONAL HEALTH SERVICE** **OFFICE OF PRODUCT SAFETY AND STANDARDS**
1	**CORONER** **I am Miss Kirsty Gomersal Area Coroner for County of Cumbria**
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: https://www.legislation.gov.uk/ukpga/2009/25/contents http://www.legislation.gov.uk/uksi/2013/1629/contents
3	**INVESTIGATION and INQUEST** Chester Alan Stanley MOSSOP died on 3 June 2022 following an incident at his home address on 29 May 2022. Baby Chester's death was reported to HM Coroner for Cumbria on 6 June 2022 and his death formally transferred from HM Coroner Newcastle. An investigation into his death (in accordance with Section 1 Coroners and Justice Act) was commenced on the same day. An inquest into Chester's death was opened on 23 February 2023 and his inquest was heard before me on 13 April 2023. The medical cause of Chester's death was: 1a Hypoxic ischaemic brain injury 1b Cardiac arrest (resuscitated) 1c Drowning The determination was: Chester Alan Stanley Mossop was a healthy and well-looked after 9 months' old baby. On 29 May 2022, Chester was placed in a bath seat in a bath of warm water at his home. After approximately 20 minutes of bath time, Chester was left alone in his bath seat. After a few minutes, Chester was found face down in the bath, the bath seat having become unfixed. Chester was given immediate CPR which was continued by attending police, paramedics and clinicians. Chester was conveyed to the Great North Children's' Hospital at the Royal Victoria Infirmary by air ambulance. Everything was done to try to save Chester's life. However, an MRI scan showed that Chester had sustained an unsurvivable

	brain injury due to drowning and he died in his mother's arms on 3 June 2022 at 18:05 at the Royal Victoria Infirmary. The conclusion of the inquest was: Accidental Death I rejected, giving full reasons, a submission that Chester's death was due to neglect and I made no finding in that respect. I rejected, giving full reasons, a submission that Chester's death was due to unlawful killing (by gross negligence manslaughter).
4	**CIRCUMSTANCES OF THE DEATH** Chester was a healthy and well looked after 9 months' old baby. He was usually fit and well. However, on 29 May 2022, he had a mild viral infection (which was confirmed at post-mortem). Chester was placed in a bath seat and given a bath in suitably warm water. The water level was higher than advised - so that Chester did not get chilled. After about 20 minutes of bath time, Chester was left alone in his bath seat whilst a plug-in diffuser (to help his cold) was prepared in his bedroom. It was believed that the bath seat was safe and secure to hold him in place. After a few minutes, Chester was found face down in the bath. The bath seat had become unfixed. There were no sounds that Chester was in distress or difficulty. He was immediately removed from the bath and given immediate CPR by a trained adult. Emergency services were quickly on scene and CPR was continued by police, paramedics and clinicians. Return of spontaneous circulation was achieved. Chester was flown by air ambulance to the Great North Children's Hospital at the Royal Victoria Infirmary in Newcastle. However, an MRI scan undertaken on 2 June 2022 showed that Chester had an extensive severe brain injury consistent with severe global hypoxic ischaemia caused by drowning. It was considered that Chester was unlikely to survive and further intensive care treatment was not in his best interest. Intensive care support was withdrawn on 3 June 2022 and Chester died peacefully in his mother's arms at 18:05. I received a statement from RoSPA (the Royal Society for the Prevention of Accidents) setting out that: • Baby bath seats are unstable and prone to toppling over leaving the baby trapped in the water. • Bath seats may give parents and carers a false sense of security that baby is safer in a bath seat and can be left alone (despite warnings that this should not happen). • There can be a misconception that a baby bath seat is a safety product – this is not the case. • Under no circumstances should parents regard bath seats as a safety aid and leave a child out of arms reach. • RoSPA is aware of incidents where parents have been in the room, but away from the baby, with tragic results. • RoSPA is aware of a number of drownings of young children in the bath where a baby bath seat has been used. • There may be some bath seats that are less stable than others or that have inadequate methods to hold them in place.

	I heard no evidence about any safety concerns with the bath seat in question. The Child Death Overview Panel ("CDOP") advised me that a Bath Safety Alert had been issued in the North-East and North Cumbria. This can be viewed at: www.nenc-healthiertogether.nhs.uk/parentscarers/keeping-your-child-safe/bath-safety-advice I requested an update on several matters but these were not available at the date of Chester's inquest. Given the "ancillary nature" of Reports to Prevent Future Deaths and to avoid the distress of an adjournment to Chester's family, I decided to proceed with the inquest.
5	**CORONER'S CONCERNS** 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: I am aware of similar tragic deaths to Chester's and inquests held by my fellow Coroners. RoSPA is also aware of fatal and non-fatal incidents. The use of bath seats is of concern to RoSPA. Whilst I am aware of the regional Bath Safety Advice (set out above), I am not aware that similar advice has been distributed on a national level to healthcare professionals and to parents / carers. I am not aware whether parents / carers are provided with advice about the safe use of bath seats as part of e.g. health visits. I am concerned that bath seats may given parents a false sense of security that their child is safe. Bath seats are not safety devices.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe the **NATIONAL HEALTH SERVICE** **OFFICE OF PRODUCT SAFETY AND STANDARDS** has 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 **16 June 2023.** 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:

	Chester's family. I have also sent copies to: RoSPA National Child Mortality Database Child Death Overview Panel 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	Dated this 20th day of April 2023  Miss Kirsty J Gomersal HM Area Coroner County of Cumbria