West London Coroner Service
25 Bagleys Lane, Fulham, London, SW6 2QA
Tel: [redacted] Email: [redacted]

Date: 12 December 2024
Case: [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1 NHS England

2 Department of Health and Social Care

3 BSI group

4 Office for Product safety and Standards

CORONER

1 I am **Lydia Brown the Senior Coroner** for **West London**

CORONER'S LEGAL POWERS

2 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

INVESTIGATION and INQUEST

On 26 October 2023 I commenced an investigation into the death of James Robert Michael ALDERMAN. The investigation concluded at the end of the inquest on 21 November 2024. The conclusion of the inquest was

3 Baby Jimmy was being breastfed within a baby carrier worn by his mother. After 5 minutes she found that he was collapsed and although immediate resuscitation was commenced he died 3 days later on 11 October 2023 in St George's Hospital. Jimmy died because his airway was occluded as he was not held in a safe position while within the sling. There is insufficient information available from any source to inform parents of safe positioning of young babies within carriers and in particular in relation to breastfeeding.

Accidental death

1a Hypoxic Brain Injury

1b Out of Hospital Cardiac Arrest

1c Accidental Suffocation

II

CIRCUMSTANCES OF THE DEATH

The inquest heard that Jimmy was 6 weeks and 6 days old at the time he died, and apart from a light cold was physically well. He was being breast fed hands free within a baby carrier/sling, being worn by his mother while she moved around the home. It was accepted that the sling was being worn snugly, not tightly, and although she could see his face when she looked down, the TICKS acronym was not met by his position within the sling as Jimmy was too far down.

The TICKS acronym was prepared by the (now disbanded) UK consortium of sling retailers and manufacturers

Tight
In view at all times
Close enough to kiss
4 Keep chin off the chest
Supported back

There appeared to be no advice in the literature regarding the risk of baby slumping and the risk therefore of suffocation, particularly if baby is under the age of 4 months, and no advice that breastfeeding "hands free" a young baby is unsafe, due to the risk of suffocation and not being able to meet every aspect of TICKS.

There appeared to be no helpful visual images of "safe" versus "unsafe" sling/carrier postures.

Evidence was given by the witnesses assisting the inqeust that public information, readily available, not too complex but consistent in message would be welcomed to advise and instruct.

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. –

5

(1) There is very little information available to inform parents of safety and positioning advice of young babies in carriers/slings and in particular nothing in relation to breastfeeding in carriers/slings

(2) This is notwithstanding a significant increase over recent years in the use of such equipment.

(3) The question of whether it is safe to breastfeed "hands free" is not addressed or referred

to in the public domain or manufacturers literature.

(4) The NHS available literature provides no guidance or advice.

(5) The only current "tips" are provided on the National Childbirth Trust (NCT) website but these are in fact unhelpful

(6) Young babies are at risk of suffocation.

(7) Consideration should be given to industry standards to promote the safe use of slings/carriers, to warn users of the risks and whether any such standards should be voluntary or mandatory.

ACTION SHOULD BE TAKEN

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

YOUR RESPONSE

7 You are under a duty to respond to this report within 56 days of the date of this report, but given the Christmas period, this will be extended to 21 February 2025. 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons

- family of Jimmy

- Boba Inc (Beco)

- Madelaine Boot, Sheen Slings

and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18).

I have also sent it to

8 - The Lullaby Trust

- National Childbirth Trust

- ROSPA

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. She 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 13 December 2024

Signature 

Lydia Brown Senior Coroner for