

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>[REDACTED] Commissioner of Police of the Metropolis, New Scotland Yard, Victoria Embankment, London. SW1A 2JL [REDACTED]</p> <p>[REDACTED] CEO College of Policing, 10, South Colonnade, Canary Wharf, London. E14 4PU [REDACTED]</p> <p>[REDACTED] Director General, National Crime Agency, Professional Standards Unit, PO Box 58358, London. NW1W 9LA [REDACTED]</p> <p>[REDACTED] CEO Haleon UK Trading Limited, Building 5, First Floor, The Heights, Weybridge, Surrey. KT13 ONY [REDACTED]</p>
1	<p>CORONER</p> <p>I am Professor Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West London</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p>

On the 23rd and 24th February 2026, evidence was heard touching the death of [REDACTED] who died on 15th January 2024 at his home address aged just 8 weeks.

Medical Cause of Death

la Sudden Unexpected Death in Infancy-Unexplained

How, when and where the deceased came by his death.

[REDACTED] was found unresponsive in a bassinet at the home address at approximately 0615 by the night nanny. CPR was given and LAS attended. [REDACTED] was pronounced life extinct at approximately 0700. Chlorpheniramine was present in the [REDACTED]'s blood at the time of death. This was probably administered to [REDACTED] by the night nanny. The cause of [REDACTED]'s death is unexplained.

Conclusion of the coroner as to the death:

Open conclusion

4

Evidence Relevant to the Matters of Concern:

Extensive evidence was taken during the inquest, from his family, the night nanny, police and experts.

The court was satisfied that the night nanny had administered the chlorpheniramine (trade name usually piriton) to [REDACTED]. The baby had been described as unsettled and fussy and a baby who woke frequently in the night. The chlorpheniramine was probably administered to sedate the baby to sleep. Expert opinion accepted by the court was that this drug could possibly have caused or contributed to the baby's death, but it could not be found that it probably did.

The toxicology findings only became apparent when the postmortem report was completed and sent to the court, police and shared with the family.

Evidence was heard that chlorpheniramine causes sedative effects and has been associated with child deaths and should not be administered to a baby of [REDACTED]'s age except on medical advice to treat conditions such as allergy or itch associated with chicken pox infection. It should not be administered to sedate a child.

The night nanny was responsible for care of [REDACTED] including feeding overnight from 9pm to 7am. [REDACTED] slept in a bassinet in a bedroom on the second floor of the family home, and the nanny stayed in the room with the baby. There was a bathroom on the same floor for the use of the nanny and a further small room containing a fridge and sterilising equipment where the baby's bottles were prepared.

On the day of the death the police had attended the scene and made an initial assessment. Child Death teams then took over. The night nanny stated that they had fed [REDACTED] twice that night. [REDACTED] was found to have no signs of injury nor neglect, and the baby's home environment was in order after scene examination. This examination did not appear to consider that [REDACTED] may have been administered a drug. The examination did not include examination of bathroom cabinets for medication (not even the bathroom next to [REDACTED]'s bedroom), seizing feeding bottles

	<p>nor examination of property of the night nanny, nor opening any cupboard doors or drawers in the room in which ■ had been found, nor the room next door.</p> <p>As such, forensic opportunities were missed that may have been able to establish that chlorpheniramine had been administered to ■ by the night nanny to the criminal standard.</p> <p>The night nanny was not arrested and interviewed nor their property searched until October 2024. By then of course all forensic opportunities had been lost.</p> <p>The police accepted that they have responsibility in deaths such as ■s to exclude suspicious circumstances. In this case it appears that they were reassured by the home environment and did not consider matters further, including potential third-party interventions such as inappropriate drug administration which may have led to ■s death. They did not seize feeding bottles despite knowing that toxicology is routinely sent in such cases, and that ■ had been fed by the nanny from bottles. In evidence, the DI repeated that there was nothing of obvious concern.</p> <p>The night nanny stated that she regularly attended training in relation to her role as a nanny and was still working as a nanny and registered with two agencies.</p> <p>The DI who gave evidence stated that they had been in contact with the NCA to enquire whether chlorpheniramine had been a feature of other unexpected child deaths.</p>
5	<p>Matters of Concern</p> <ol style="list-style-type: none"> 1. That child death investigation teams are too easily reassured when they attend deaths and find a well-presented home environment with no overt signs of neglect or injury to the deceased child, such that the scene examination becomes perfunctory and forensic opportunities are lost. 2. That feeding bottles and equipment are not routinely seized pending toxicology results. 3. That insufficient consideration is given the potential role of poisoning in such deaths by the police. 4. That police training and guidelines may need to be updated. 5. That nannies should be specifically trained not to administer piriton or other chlorpheniramine containing substance to a child except on medical advice and with full knowledge and agreement of parents. 6. That there are international reports linking administration of chlorpheniramine and sudden death in children, but this is an area of evolving knowledge, and it may assist understanding if the NCA were to review case files nationally to establish whether in other cases of unexpected child death chlorpheniramine had been administered. 7. That a person whom the court found administered chlorpheniramine illicitly to a child and that administration possibly contributed to that child's death is still working as a nanny. 8. That there is no national regulation system for nannies.

	<p>9. That the warning information on products containing chlorpheniramine, such as piriton may need to be updated to include the association between administration of the substance and sudden unexpected death in children.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. It is for each addressee to respond to matters relevant to them.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:</p> <p>Parents of [REDACTED] Via their legal team</p> <p>Night Nanny: [REDACTED]</p> <p>[REDACTED] Charing Cross Police Station, 2 Agar Street, London. WC2N 4JP</p> <p>Night Nanny Agency [REDACTED]</p> <p>Eden Maternity [REDACTED]</p> <p>The National Nanny Organisation [REDACTED]</p> <p>The Association of Nanny Agencies [REDACTED]</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p>

	<p>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.</p>
9	<p>25th March 2026</p> <p>Professor Fiona J Wilcox</p> <p>HM Senior Coroner Inner West London</p> <p>Westminster Coroner's Court 65, Horseferry Road London SW1P 2ED</p> <p>Inner West London Coroner's Court, 33, Tachbrook Street, London. SW1V 2JR Telephone: [REDACTED]</p>