

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>Secretary of State for Health and Social Care</p>
1	<p>CORONER</p> <p>I am Alison Mutch, Senior Coroner, for the coroner area of Manchester South</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> <p>On 28th October 2024 I commenced an investigation into the death of Madison James Bruce SMITH. The investigation concluded at the end of the inquest on 23rd March 2026. The conclusion of the inquest was narrative: Died in circumstances where his cause of death could not be ascertained whilst asleep in his cot having been placed prone in an unsafe sleeping position. The medical cause of death was unascertained.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Madison James Bruce Smith was born on 1st June 2024. He was a healthy baby who lived with his parents. Due to concerns about his pattern of sleeping during the day his parents engaged a person who described themselves as a maternity nurse. The maternity nurse was listed on a maternity agency platform. Any person can describe themselves as a maternity nurse or a sleep nurse or a post-natal nurse. No qualifications are required and there is no regulation of persons holding themselves out as maternity nurses or the agencies that offer training courses or their services. In this case the maternity nurse and the owner of the agency had no medical qualifications other than a basic first aid qualification. The use of the word nurse gave the impression of a level of knowledge and skills that were not present.</p> <p>The maternity nurse placed Madison in his cot in a prone position to sleep on the night of 17th October. The placing of a baby of his age in such a position is contrary to all national guidance in relation to safe sleeping and is known to be a significant risk factor for the sudden and</p>

unexpected deaths of babies. He should not have been placed in a prone position. Madison stirred several times in the night. He was not checked other than visually via a monitor or once at a distance to ensure he was coping with the unfamiliar sleeping position. The maternity nurse had taken responsibility for checking on him. He should have been checked on closely particularly when he cried. At 7am on 18th October 2024 he was found unresponsive by his father in his cot. He was taken to Wythenshawe Hospital where Doctors confirmed he had died on 18th October. A post-mortem examination was unable to give a cause of death. However, it was identified that prone sleeping created an increased risk of his sudden unexpected death.

5 **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 could 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. The inquest heard evidence that there is a significant demand from families with very young children who would like to get their children into a sleep routine at an early stage. To meet that demand there are now agencies and individuals who seek to meet that demand. However, the inquest was told that there is no statutory regulation of these individuals or of the agencies. Consequently, anyone can set up an agency that purports to offer training and expertise in maternity services. They need not have any formal training or any medical qualification. The courses they offer do not need to be quality assured or meet any minimum standards.

2. Anyone the inquest was told, can attach the term nurse to a word such as night/maternity/ post-natal. The inquest was told that only the term registered nurse is protected and restricted in its use. An individual who has no medical training or formal early years training can offer their services to a family with young children describing themselves as for example a maternity nurse. This can the inquest was told give a misleading impression of their expertise and skill set to a family employing them. A statutory bar on the word nurse being used by anyone other than a registered nurse on the NMC register would avoid this situation from arising.

3. The inquest was told that the promotion of prone sleeping by unqualified individuals describing themselves as maternity nurses and experts in sleeping poses a very significant risk to a young baby. A baby will sleep more deeply in a prone position which is why superficially it can seem to be a solution where a baby sleeps poorly. However, whenever a young baby is placed in such a position it will increase the risk that they

	<p>will die suddenly and unexpectedly. All health professionals need to be vigilant in continuing to emphasise the national guidance on safe sleeping and be vigilant in flagging up to a family that prone sleeping in a child that cannot independently turn over is not a solution to a poor sleep routine but rather is a factor that increases the risk of a sudden and unexpected death.</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.</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, namely by 21st May 2026. 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 namely the Family, Ruthie Maternity Services, [REDACTED], [REDACTED], Child Death Overview Panel who may find it useful or of interest.</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. They may send a copy of this report to any person who they believe 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><u>Alison Mutch OBE</u> <u>Senior Coroner</u></p> <p>[REDACTED]</p> <p><u>26/03/2026</u></p>