FORM 38

Rule 60(2)

FINDING INTO DEATH WITHOUT INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 3829/09

In the Coroners Court of Victoria at Melbourne

I, KIM PARKINSON, Coroner

having investigated the death of:

Details of deceased:

Surname: MCCANN
First name: LACHLAN
Address: 202 Melbourne Road, Williamstown, Victoria 3016

without holding an inquest:

find that the identity of the deceased was LACHLAN DONALD MCCANN
and death occurred on 6th August, 2009

at The Royal Children's Hospital, Flemington Road, Parkville Victoria 3052

from
1a. HYPOXIC ISCHAEMIC BRAIN INJURY
1b. LIGATURE STRANGULATION (BLIND CORD)

Pursuant to Section 67(2) of the **Coroners Act 2008**, an inquest into the death was not held and the deceased was not immediately before the person died, a person placed in custody or care; but there is a public interest to be served in making findings regarding the following circumstances:

1. Lachlan Donald McCann was born on 29 March 2007. He lived with his parents, Ms Samantha Stevenson and Mr Nicholas McCann and his brother, Joshua, at 202 Williamstown Road, Williamstown.

2. The circumstances of Lachlan's death have been the subject of investigation by Victoria Police. Detective Leading Senior Constable Kinna of Keilor Downs Criminal Investigation Unit, provided a brief to the coroner dated 15 December 2009, setting out the investigations undertaken and I have drawn from these investigations in my factual findings.

3. Having regard to recent regulatory changes and information campaigns and taking into account the family preference, I determined that it was not necessary or in the public interest to conduct a public inquest in this case and so have concluded my investigation with this chambers finding.

4. Lachlan was a healthy, happy two year old. He was a much loved and well cared for child. On 6 August 2009, Lachlan and his brother were in the lounge room of the family home waving goodbye through the window to their dad as he left for work. They were standing on the top or back of the couch which was placed directly under the window.

5. The window was a single sash style window measuring 1.0m x 1.5m, fitted with a blind. The blind was a Holland blind with a continuous chain cord mechanism to raise and lower the blind. The cord was located on the right hand side of the window with the bottom of the cord resting on the side of the wooden window architrave, at a height of approximately 300mm from the window sill. The bottom of the cord would have been resting at approximately 1300mm from the floor. This may be established by reference to the location of the fixing mechanism which had been screwed into the architrave to receive the blind cord. Although there was a cord guide mechanism present, it was incomplete in that it no longer had a cover and the cord was not affixed to the mechanism. Ms Stephenson reported that the boys were able to and had removed the covers prior to the incident.

6. At 8.00am Ms Stephenson went to shower and was absent for approximately 5 minutes. When she returned to the lounge-room she located Lachlan unresponsive with the blind cord around his neck. He was in a kneeling position on the couch facing towards the window. It appears that Lachlan had become entangled in the blind cord from his standing position on the couch.

7. Ms Stephenson removed the cord and commenced CPR, which she continued until the ambulance arrived. Ambulance officers continued resuscitation efforts and Lachlan was transported to the Royal Children's Hospital. Lachlan was admitted to ICU, however he was diagnosed with a non survivable hypoxic brain injury. After discussion with clinicians and mother and father, life support measures were ceased and Lachlan died on 6 August, 2009.

8. An examination was undertaken by Dr Linda Isles, Forensic Pathologist with the Victorian Institute of Forensic Medicine and a report made to the Coroner. Dr Isles reported:

> *"About the right side of the neck extending to the midline anteriorly and slightly onto the left side of the neck and up to the left ear, an apparent purple ligature mark that is continuous about the right side of the neck where it is located 5cm below the ear and is associated with some brown discolouration as it heads towards the posterior aspect of the neck where it disappears."*

9. The pathologist commented that these marks were consistent with the circumstances as reported by the police. A skeletal survey and CT examinations did not reveal any unexplained injury or trauma.

10. I am satisfied having regard to the available evidence that no further investigation of the circumstances is required. There were no suspicious circumstances and death occurred as a result of a tragic accident.

11. I find that Lachlan McCann died accidentally on 6 August 2009 and that the cause of his death was Hypoxic Ischaemic Brain Injury in circumstances of Ligature strangulation (Blind Cord)

COMMENT

12. Hazards to young children are not always immediately apparent and in the absence of good information, and appropriate design and safety standards, parental vigilance is not always sufficient to prevent these so very tragic events. All children between ages of 6 months and 6 years are at risk of strangulation injury from blind or curtain cords, with children aged 18 months to three years being the most vulnerable group.

13. Research undertaken for the Coroner by the Coroners Prevention Unit identified that there have been 14 deaths nationally of children associated with blind cords since July 2000.

14. In 2004, a recommendation was made by then State Coroner Johnston in relation to the packaging, labelling and sale of blinds and associated fixtures. The State Coroner also recommended that an extensive public safety campaign be initiated by the Department of Consumer Affairs to educate the public about the dangers to young children associated with such fittings.

15. After Lachlan's death and shortly thereafter that of another child in Victoria, Consumer Affairs Victoria instituted a blind cord safety campaign. The campaign which commenced in January 2010, involves advice to parents and carers as to the dangers of blind cords to young children, safe installation methods and safety fittings available. It was extensively run in print and television media. The warning brochures and safety information kits, including safety devices, have been extensively distributed, including to retailers, manufacturers, child care centres, maternal and child health centres, hospitals, real estate agents and families.

16. Statutory Regulation in Victoria operative since 30 December 2008, requires that all such blinds must be sold with approved attachments for the securing of the cord in a manner which will provide an increased level of safety. The regulations prohibit the sale of new window furnishings with looped cords, looped bead chains or other flexible looped device which do not have specific design and safety criteria including:

- that the cord cannot form a loop in excess of 300mm circumference;
- has a suitable cord release device or tension device;
- that any exposed looped curtain/blind cord, bead chain or other flexible looped device does not extend to lower than 1.6metres beyond the lowest position of the blind;
- contains a warning label and tag on the product as to hazards.

17. These regulations will be overtaken on 30 December 2010, by the application of mandatory National Safety standards adopted and enforced by the Australian Competition and Consumer Commission body, Product Safety Australia.[1] These mandatory requirements impose similar obligations upon manufacturers and suppliers regarding safety standards including safety mechanisms and installation instructions, which are required to contain the following statements:

- All blind cords must be installed in such a way that a loose cord cannot form a loop 220mm or longer at a height of less than 1600mm above floor level.
- A cord guide may be installed lower than 1600mm above floor level if the cord is sufficiently secured or tensioned to prevent a loop 220mm or longer from being formed.
- If a cord is installed lower than 1600mm above floor level it must be designed to prevent a child from being able to remove the cord.
- If a cleat is used to secure the cord it must be at least 1600mm above floor level because a child is capable of unwinding a cord from a cleat.

18. Where items of furniture, including beds, couches or chairs are placed in proximity to the blind cord mechanisms, the specified 1600mm height above floor level will not be sufficient height to protect against entanglement. In such cases cord guides should be fitted to the blind cord mechanism. Cord guides are required to be designed to remain firmly attached to a wall or other structure when subjected to tension force which may be exerted by small children.

[1] Attachment 1 - Product Safety Australia - Mandatory Statement for internal corded window furnishings.

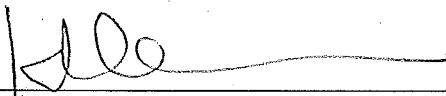
RECOMMENDATION

19. It is apparent that the regulatory mechanisms discussed in this finding apply only to new curtains and blinds. It therefore follows that regulation alone will not be effective where blinds and curtains are already fitted. There is an important role for public safety authorities to provide ongoing information and warning campaigns to inform those who will become parents in the future and their families and friends, of the risks associated with blind and curtain cords to young children and the need for vigilance in relation to installation and maintenance.

20. In this regard I recommend that Consumer Affairs Victoria continue to publicise this risk by way of regular ongoing multi media campaigns and by distributing information regularly to facilities such as those already targeted, including maternal and child health and child care centres and maternity units.

21. I direct that a copy of this finding be provided to the Minister for Consumer Affairs, Consumer Affairs Victoria and to the Royal Children's Hospital Accident Prevention Unit.

Signature:



K.M.W. Parkinson
Coroner
29th October 2010