FORM 38

Rule 60(2)

FINDING INTO DEATH WITHOUT INQUEST

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

Court reference: 4704/09

In the Coroners Court of Victoria at Melbourne

I, KIM PARKINSON, Coroner

having investigated the death of:

Details of deceased:

Surname: SMITH
First name: ROSALIND
Address: 4 Lancaster Avenue, Newtown, Victoria 3220

without holding an inquest:

find that the identity of the deceased was ROSALIND JANE SMITH and death occurred on 30th September, 2009

at 4 Lancaster Avenue, Newtown, Victoria 3220

from
1a. NECK COMPRESSION- (VERTICAL 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. Rosalind ("Rosie") Jane Smith was born on 11 December 2006 at the Geelong Hospital. She lived with her parents, Ms Jennifer Shand and Mr Stephen Smith and her younger brother, Ruben at 4 Lancaster Avenue, Newtown.

2. The circumstances of Rosie's death have been the subject of investigation by Victoria Police. Senior Constable Anthony Sheedy of Geelong Police Station provided a brief to the coroner dated March 2010, setting out the investigations undertaken and I have drawn from these investigations in my factual findings. Having regard to recent regulatory changes and information campaigns and taking into account the family's 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.

3. Rosie was a healthy, happy two year old. She was a much loved and well cared for child. On 30 September 2009, Rosie was having her usual afternoon sleep. She usually had an afternoon sleep lasting for approximately 2 hours. On this day she had gone to bed at approximately 1.30pm and as she had a busy morning her mother was not surprised that she slept for longer than normal.

4. Rosie slept in a free standing toddlers bed beside which was a bedside table directly under the window. The bedroom was approximately 2.5 x 2.5m with a single sash style window measuring 1.0m x 1.5m, fitted with a blind and with separate tie back style curtains. The blind was a Holland blind with a continuous chain cord mechanism to raise and lower the blind. The cord was located to the west side of the window closest to the bed and rested on the wooden window architrave, the bottom of the cord resting at approximately 870mm from the floor. It was not secured to the window frame by any fixing mechanism or enclosed cord guide.

5. Ms Shand reported that upon moving into the house, where window furnishings were already fitted, she and Mr Smith had made an assessment of the safety of the house including the blind cords and had decided that the cords were at such a height that they would not constitute a hazard.

6. Ms Shand went to wake Rosie at 5.10pm and discovered her unresponsive with the blind cord around her neck. Rosie was in a standing position and was out of the bed and at the window side, between the bed and the bedside table. It appears that Rosie had attempted to look out of the window, likely from her bed and her head became entangled in the blind cord, pulling her out of the bed. Ms Shand removed the cord, carried Rosie to the lounge room and commenced CPR, which she continued until the ambulance arrived. Ambulance officers continued intensive resuscitation efforts, however Rosie was unable to be resuscitated.

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

> *"Around the neck there is a pale indented ligature furrow which is up to 6mm in width and situated 50mm below the right ear and 35 mm below the left ear. The ligature mark is irregular with deeper areas approximately 6mm consistent with the nodular elements seen on the cord in scene photographs".*

8. The toxicology report was negative for common drugs or poisons and the forensic pathologist commented that examination did not reveal other injuries or natural disease.

9. 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.

10. I find that Rosalind Jane Smith died on 30 September 2009, and that the cause of her death was compression of the neck as a result of having become entangled in a blind cord.

COMMENT

11. As in this case, 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.

12. Research undertaken on the Coroner's behalf by the Coroner's Prevention Unit identified that there have been 14 deaths nationally of children associated with blind cords since July 2000.

13. 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.

14. After Rosie's death and 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.

15. The Victorian regulations, operative since 30 December 2008, require 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.

16. 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.

17. 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.

RECOMMENDATION

18. 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 to 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.

19. 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.

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

20. 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