IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2019 5378**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**MR JOHN OLLE, CORONER**
Deceased:	**INFANT A**
Date of birth:	[redacted]**JULY 2015**
Date of death:	**3 OCTOBER 2019**
Cause of death:	**HYPOXIC ISCHAEMIC ENCEPHALOPATHY IN THE SETTING STRANGULATION BY A ROLLER BLIND CORD (PALLIATED)**
Place of death:	**MONASH MEDICAL CENTRE, 246 CLAYTON ROAD, CLAYTON, VICTORIA 3168**

HIS HONOUR:

BACKGROUND

1. Infant A was born on [redacted] July 2015. She was 4 years old at the time of her death. Infant A lived with her parents and sister, in [redacted], Victoria.

2. Infant A's parents married in 2012 [redacted]. The couple's relationship was described as happy, with the pair being very supportive of each other. There were no issues, domestic abuse or violence in the couple's relationship.

3. In or around December 2014, Infant A's parents purchased their house. It had been owned by two previous owners; the first being a builder owner who designed the house and the second owners had a family. According to Infant A's mother the house was built in late 2009/early 2010, with the original blinds remaining in the house throughout the years. [redacted], Infant A's parents did not make any changes to the property after they moved in.

4. Infant A's mother described her pregnancy and the birth of Infant A as normal; [redacted]. Infant A [redacted] was diagnosed as having a peanut allergy [redacted]. She had her first anaphylaxis reaction in [redacted] 2019, which required her to be hospitalised. Infant A was otherwise well and described as a very active and independent child who loved playing outdoors.

5. In 2018, Infant A's sister was born. After the birth of Infant A's sister, a maternal health care nurse visited the family home on two occasions. Infant A's mother said that the nurse came to the house "purely [to] check up on [redacted]", with there being "no discussion around safety around the home". Infant A's mother did not suffer from postnatal depression or any other mental health issues after the birth of Infant A's sister.

6. At an early age Infant A's parents discovered that Infant A's sister suffered from a range of food allergies; [redacted] As a result, the entire family were diligent about [redacted] cleaning up after themselves, [redacted].

THE PURPOSE OF A CORONIAL INVESTIGATION

7. Infant A's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic), as her death occurred in Victoria, and resulted, directly or indirectly, from an accident or injury.[1]

8. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[2] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

9. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[3] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

10. The "cause of death" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

11. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

12. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the 'prevention' role.

13. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

    (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of

[1] Section 4, definition of 'Reportable death', *Coroners Act 2008.*
[2] Section 89(4) *Coroners Act 2008.*
[3] *Keown v Khan* (1999) 1 VR 69.

justice. These powers are the vehicles by which the prevention role may be advanced.

14. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[4] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

MATTERS IN WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

15. Infant A was visually identified by her father on 3 October 2019. Identity was not in issue and required no further investigation.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

16. On 7 October 2019, Dr Heinrich Bouwer, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an inspection on Infant A's body and provided a written report dated 19 December 2019, concluding a reasonable cause of death to be "I(a) Hypoxic ischaemic encephalopathy in the setting strangulation by a roller blind cord (palliated)". I accept his opinion in relation to the cause of death.

17. Toxicological analysis of ante-mortem and post-mortem specimens detected medications that were administered in the therapeutic setting.

18. Dr Bouwer noted that the external examination was consistent with reported circumstances, and that a ligature abrasion, consistent with being caused by a metal chain from a roller blind was noted about the neck.

19. Dr Bouwer also identified that the post-mortem CT scan and skeletal survey reported at the Royal Children's Hospital showed diffuse brain swelling. There was no unexpected skeletal trauma.

[4] (1938) 60 CLR 336.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

20. On 26 September 2019, Infant A woke up around 6.00am and walked into the bathroom to speak to her father. She engaged in conversation with him for a couple of minutes before getting into bed with her mother; sulking and telling her that her bed was messy. A short time later Infant A had breakfast. While this was occurring, Infant A's mother went into Infant A's bedroom to pull up her blinds. She noticed that the bed was very messy, with the pillow and fitted sheet on the bed, and the blanket and doona, draped over the bed and onto the floor. After breakfast, Infant A was given a book to play with before she, her mother and sister stood by the kitchen window and waved goodbye to Infant's A's father around 7.30am.

21. A short time later, as Infant A's mother ate breakfast, she watched Infant A and her sister play. The children's play moved to the hallway near the front door and then to Infant A's bedroom where the girls first played with some wooden blocks, before Infant A's mother built towers with them and then read them a book in Infant A's bedroom. Infant A's mother left and returned to the room while the children played. She said that she could see Infant A's sister sitting facing the cupboard while she was in the kitchen. Soon after, on noticing that the house sounded quiet Infant A's mother returned to the bedroom to check on Infant A and her sister. On doing so she saw the curtain cord wrapped around Infant A's neck. She immediately lifted and unwound the cord from Infant A's neck and placed her on the bed. Infant A was unresponsive. Infant A's mother then called emergency services, transferred Infant A to the floor and commenced cardiopulmonary resuscitation (**CPR**) as directed by the emergency services operator.

22. At 8.57am, members from Ambulance Victoria arrived at the scene and took over performing CPR on Infant A. Within minutes Infant A's father and members from Victoria Police and the Country Fire Authority arrived at the house. After approximately seven minutes of CPR Infant A had a return of spontaneous circulation. The ambulance paramedics intubated and ventilated Infant A before transferring her to hospital for further treatment. At 9.58am, the ambulance paramedics arrived at the Monash Medical Centre (**MMC**) in Clayton.

23. On arrival at the MMC's Emergency Department, the treating team were advised that Infant A had experienced an out of hospital cardiac arrest after being strangled by a blind cord. They stabilised Infant A's condition before transferring her to the paediatric intensive care

unit (**PICU**). Investigations suggested that Infant A had suffered a severe hypoxic brain injury. After discussions between PICU senior clinicians which included a consultant intensivist, radiologist and neurologist, a consensus was reached that Infant A would suffer from a significant disability. These findings were discussed with Infant A's family, with them being provided with the available options of care.

24. On 2 October 2019, following multiple family consultations, the decision was made to withdraw Infant A's active care and provide supportive and palliative care. Infant A was disconnected from the ventilator later that afternoon and peacefully passed away on 3 October 2019 at 12.19pm.

Further investigation

Examination of Infant A's bedroom

25. On 26 September 2019, Leading Senior Constable Dale Jenkins of Narre Warren Police Crime Scene Services reviewed the scene. [redacted] He noted that there was a single window on the north wall which has a roller blind and pelmet, and that the winder and chain that controls the blind is hung in the west side of the blind. There was a small bedside drawer on the north side of the bed between the bed and the wall [redacted]

26. Detective Senior Constable James Morgan of Casey CIU stated that on examining Infant A's bedroom, it is believed that Infant A had climbed onto the bedside drawers situated next to the curtain cord. She has somehow become entangled with the cord situated to the left of the blind and it has wrapped around her neck. Infant A has slipped from the bedside table with the cord around her neck which left her hanging. Infant A was unable to remove the cord herself which subsequently caused the strangulation.

National Coronial Information System (**NCIS**)

27. On 3 February 2020, on my request, my coroner's solicitor made enquiries with the NCIS regarding the number and details of cases of infants/children who have died as a result of

strangulation on blind/curtain cords since 1 January 2010. Soon after, NCIS provided me with a report identifying that between 1 January 2010 and 31 December 2019 a total of 10 children had died nationally as a result of accidental blind cord strangulation, with 3 of those children dying in 2019. I note that since the NCIS issued their report, a subsequent child died in 2020.

Consumer Affairs Victoria

28. On 16 June 2020, on my request, the court's senior legal counsel, contacted Consumer Affairs Victoria to enquire about what current initiatives are in place around blind cord safety. Specifically, I requested information in relation to:

    (a) Initiatives relating to curtain and blind cord product safety on the part of Consumer Affairs Victoria, including the use of public awareness and safety campaigns, with a focus on 2010-present; and

    (b) A brief outline of the way in which current initiatives continue to implement previous coronial recommendations on this issue.

29. On 10 August 2020, I received correspondence from Susan Zhao, Senior Policy Advisor, Regulation Policy, Regulation, Legal and Integrity Group, Department of Justice and Community Safety (Consumer Affairs Victoria). Ms Zhao provided the following information:[5]

    Background

    Consumer Affairs Victoria (**CAV**) operates within a national, 'multiple regulator model' and engages in joint projects with other agencies and consumer regulators. Curtain and blind cord safety is the subject of national work through Consumer Affairs Australia and New Zealand, Australia's principal national forum for government policy, enforcement cooperation in respect of consumer affairs.

    The *Trade Practices (Consumer Product Safety Standard – Corded Internal Window Coverings) Regulations 2010* contains the mandatory standards for corded internal window coverings and applies to curtains and blinds supplied after 30 December 2010.

[5] Ms Susan Zhao noted in email correspondence dated 10 August 2020 and 10 September 2020, that due to the timeframe in which I requested a response and the COVID-19 restrictions, there were limitations on retrieving documentation concerning Consumer Affairs Victoria's awareness campaign and other materials as this information may be contained in hardcopy form onsite or archived. Subsequently, I acknowledge that Consumer Affairs Victoria's response was provided in lieu of not having full access to hardcopy files.

The Competition and Consumer (Corded Internal Window Coverings) Safety Standard 2014 is the mandatory standard for the installation of corded internal window coverings in domestic dwellings and came into effect on 1 January 2015.

Following the deaths of two small children in separate, tragic events involving blind cords in August and September 2009, CAV commissioned qualitative research to assess levels of consumer awareness and test information materials on curtain and blind cord safety.

CAV initiatives relating to curtain and blind cord product safety, 2010-present

CAV ran an extensive education campaign between January-April 2010, highlighting the risks associated with curtain and blind cords. The education campaign included the potential risk for serious injury or death and encouraged parents to request free safety kits. The kits contained a device that attached looped cords to a window frame, under tension, so they were no longer loose, reducing the likelihood of a child placing the loop over their head or becoming entangled.

The education campaign included:

- a television partnership with Channel Ten (including television commercials);
- direct communication with early childhood industry stakeholders, local councils and national stakeholders including:
    - schools, childcare centres, kindergartens, hospital maternity wards, community and multicultural educators, Members of Parliament, and curtain and blind retailers;
- public relations;
- collateral (including order forms, posters, a website and safety kits);
- online forums ad blogs;
- a radio campaign for Culturally and Linguistically Diverse communities;
- articles through existing internal and external channels (that is, websites, newsletters, Kidsafe Victoria);
- internal communication; and

- information sessions.

As a result of the campaign, 17,000 curtain and blind cord safety kits were ordered from CAV.

In 2010, CAV partnered with Kidsafe, funding their efforts to disseminate messaging through their networks for a number of years. These included speaking opportunities at maternal and child health centres and at baby product stores such as Baby Bunting and Hire for Baby.

In January 2011, a kit order form was included in 55,000 'prep packs' given to parents of children starting school.

In 2014, CAV ran a broader child safety campaign which included curtain and blind cord safety.

In 2017, CAV digitised the safety kit request form on their website, enabling greater access to families.

Current CAV initiatives relating to curtain and blind cord safety and continuing implementation of coronial recommendations

- CAV continues to promote the educational campaign through their website and community engagement sessions with their regional offices.
- Regional offices highlight fact sheets and conduct workshops to promote public awareness. Sessions are targeted at new parents, mothers groups and maternal health care providers.
- The CAV website includes an instructional video and installation steps for the free safety kit, including for rental properties.
- Families can request free safety kits via the website, and schools, hospitals and businesses are able to order the kit in bulk quantities.
- The website also provides a template for schools and businesses to use in their own publications, encouraging readers to request a free safety kit.
- CAV has utilised online platforms such as Twitter, Facebook and YouTube to inform and educate consumers about the importance of curtain and blind safety.

- Overall, CAV has posted 17 tweets and 19 Facebook posts specifically about curtain and blind cord safety and received 11,206 visits to the web page.

- Data from 2018 to present indicates that a further 1,942 kits were ordered from the CAV website.

- Curtain and blind cord safety messaging continues to be a part of general safety campaigns.

FINDINGS

30. Having investigated the death of Infant A and having considered all of the available evidence, I am satisfied that no further investigation is required.

31. On the basis of the available evidence, I am satisfied to the requisite standard that Infant A tragically died as a result of accidental blind cord strangulation.

32. I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) that the identity of the deceased was Infant A, born [redacted] July 2015;

    (b) that Infant A died on 3 October 2019, at Monash Medical Centre, from hypoxic ischaemic encephalopathy in the setting strangulation by a roller blind cord (palliated); and

    (c) that the death occurred in the circumstances described in the paragraphs above.

COMMENT

33. Pursuant to section 67(3) of the *Coroners Act 2008,* I make the following comment:

    (a) In 2010, after the deaths of two young children (Coroners cases: COR 2009 3829 and COR 2009 4704), then Coroner Kim Parkinson reported that Consumer Affairs Victoria instituted a blind cord safety campaign. I acknowledge and commend the work already undertaken by Consumer Affairs Victoria's public awareness campaign and thank them for their assistance in this matter.

RECOMMENDATIONS

34. Pursuant to section 72(2) of the *Coroners Act 2008,* I make the following recommendations:

    (a) Since 2010, it is apparent that the initiation of the Consumer Affairs Victoria blind cord safety campaign has been beneficial. However, in the period 2019-20, following three years of no accidental deaths relating to curtain and blind cords, four infants have died in these tragic circumstances.

    (b) It is paramount that public safety authorities continue to provide ongoing information and warning campaigns to inform those with young children and their family and friends of the risks associated with curtain and blind cords and the need for vigilance in relation to installation and maintenance.

    (c) I acknowledge and commend Consumer Affairs Victoria for the initiatives undertaken in the past decade, and urge that they continue their campaign of curtain and blind cord product safety; publicising this risk on all media platforms by distributing information regularly to the entities already targeted.

    (d) Further, I encourage Consumer Affairs Victoria to increase promotion of their blind cord safety kits.

35. I convey my sincerest sympathy to Infant A's family and friends.

36. Pursuant to section 73(1B) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

37. I direct that a copy of this finding be provided to the following:

    (a) Infant A's family, senior next of kin;

    (b) Commission for Children and Young People;

    (c) Monash Health;

    (d) Consumer Affairs Victoria;

    (e) Investigating Member, Victoria Police; and

    (f) Interested Parties.

Signature:

MR JOHN OLLE

CORONER

Date: 3 December 2020