IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

**COR 2020 005032**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

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

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| Findings of: | Coroner Sarah Gebert |
| Deceased: | Master J |
| Date of birth: | [redacted] 2017 |
| Date of death: | 10 September 2020 |
| Cause of death: | *Neck compression due to entanglement in the cord of a blind* |
| Place of death: | [redacted], Doncaster, Victoria |

This finding has been de-identified by order of Coroner Sarah Gebert to replace the names of the deceased and their family members with pseudonyms to protect their identity and to remove identifying information,

## INTRODUCTION

1. Master J[1] was 3 years old at the time of his passing. He is survived by his parents Mr J and Ms G, young sister Miss J and older half-sister Miss G. Other extended family included his grandmothers Ms R and Ms W as well as his uncle Mr G.

2. Master J's mother is of Maori and Tongan descent and described Master J as *a strong boy.* She said he was *a very happy boy full of positive energy and was all about love.* Master J was described by his family as being *quirky, full of life* and a *very happy child.*

3. His half-sister Miss G described him as a *mini interior designer.* She said he would get anything that he could and push it into a corner of the room and go, *Tada* and that when he said sorry, *he would run up and kiss you.*

4. On 10 September 2020, Master J was found by his mother with his neck entangled in the cord of a blind at their home in Doncaster. Sadly, he was later pronounced deceased.

## THE CORONIAL INVESTIGATION

5. Master J's passing was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. Victoria Police assigned Detective Senior Constable Benjamin Hales (**DSC Hales**) to be the Coroner's Investigator for the investigation of Master J's passing. The Coroner's Investigator

[1] Referred to in this finding as "Master J", unless more formality is required.

conducted inquiries on my behalf, including taking statements from witnesses and compiling a coronial brief of evidence. The comprehensive brief contains a range of statements including from Master J's family, a VARE interview with Master J's sister Miss G, ambulance paramedics, the forensic pathologist who examined him and investigating officers, as well as other relevant materials.

9. The Court also obtained Master J's records from Eastern Health, the Boronia Mall Clinic, Department of Health and Human Services (**DHHS**), Ringwood Magistrates' Court, the Ringwood Family Relationship Centre, Knox Maternal Health and Goodstart Early Learning [redacted].

10. Following receipt of the brief, I also explored possible prevention opportunities which are outlined in my finding.

11. This finding draws on the totality of the coronial investigation into Master J's passing including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

**Background**

12. Master J was born at William Angliss Hospital in Ferntree Gully. He spent the first 2 ½ years of his life being raised by both his mother and father. Ms G recalled that he started walking at 8 months old but he struggled with speech. Mr J said that Master J had *learning difficulties and delayed speech,* for which he was seeing the Early Language Group in Ringwood and a paediatric speech pathologist with Eastern Health in about 2020. Master J also attended Good Start [redacted] day care from when he was 1 year old but ceased attending in February 2020.

13. Ms G said that Master J liked keeping things *neat and tidy*, that he was *very particular* and *really liked watching PJ Masks.* Her brother's partner Ms O said *Master J was full of life, he was such an energetic little boy and was always on the move. He was forever climbing and jumping off furniture.*

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[2] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. 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 as to those matters taking into account the consequences of such findings or comments.

14. In February 2020, Master J's parents separated. They shared custody of their children with Mr J as the primary carer. Ms G would see Master J and Miss J *Sunday to Tuesday nights* and Mr J would have the children every other night. In May 2020, they attended mediation with the Eastern Access Community Health to discuss child custody arrangements and these arrangements were agreed to. Mr J had the children *80% of the time* and Ms G 20% of the time.[3]

15. On 25 February 2020, Master J was taken to hospital while staying with his mother and was given pain relief and an antihistamine.

16. At the end of July 2020, Ms G moved into rental accommodation at [redacted], Doncaster with her brother Mr G and his partner. Master J, Miss J and Miss G would stay with their mother at this location on her custody days. The property was managed by Jellis Craig in Doncaster.

17. On 31 August 2020, Ms G applied for an Intervention Order and a Family Violence Interim Intervention Order (**FVIO**) was granted and served on Mr J on 1 September 2020. The return date for the order was 21 June 2021.[4] Mr J's children were protected persons under the FVIO and, whilst it allowed Mr J to *do anything permitted* by a *written agreement about child arrangements* (including a Family Law Act order), it appears that their arrangement with respect to the children had not yet been formalised.[5] The FVIO therefore had the practical effect of suspending their agreement regarding the children, unless the order was varied or Ms G agreed. Mr J subsequently made an application to vary the FVIO on 8 September 2020 to *remove the kids from it* which was returnable on 15 September 2020. Mr J disputed the allegations which formed the basis of Ms G's FVIO.

18. Ms G told her brother that *the order would assist in custody of Master J and Miss J and…it suspended custody arrangements.*

19. I note that the DHHS received two reports in relation to young Master J, dated 25 February and 5 September 2020. No orders were made in relation to the first report and the second report

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[3] *Children will have time with Mother between 4-5pm Sunday until 4-5pm on a Tuesday on a weekly basis.*

[4] The Ringwood Magistrates' Court advised that the return date was due to the backlog created by the pandemic.

[5] There appears to have been a written parenting plan, which was negotiated at Family Dispute Resolution. These are not binding documents unless converted into court orders. If the parenting plan wasn't converted into a parenting order/consent orders, at any point either party could revoke the plan by simply indicating that they no longer wanted to comply with the arrangements. A party can attempt to negotiate to see the children whilst the FVIO was on foot, and if agreed by the other party in writing, a person would be permitted to see the children in accordance to the terms agreed.

remained at the intake phase at the time of Master J's passing, noting that there was insufficient information to suggest any immediate risk.

20. With respect to the new premises at Doncaster, Ms G said that they were waiting on a delivery of furniture so there was minimal furniture in the lounge room, describing it as *a big space for the kids to play.* She said,

> *Master J never really played on the lounge room window that looked onto the front door. When he did get up there, he would push his kid chair or bean bag to help him get up. His feet would just fit on the window sill. He didn't go up there often, in the lounge room because it was too hard for him. It was too tricky and it would take him too long to get up there.*
>
> *Master J would love to do the same in my room. I would let him get on the window sills in my room because it was easier as he would climb up on bedside table, onto the window sill and then jump on the bed. He liked the adrenalin.*
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> *...After Master J had learnt to jump from the window sill to my bed, he then started to jump from the lounge room window sill onto the bean bag.*

## MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

### Circumstances in which the death occurred

21. On 10 September 2020, Master J got up around 7.00am and Ms G set him up in the loungeroom with a TV show, seat and table as well as something to eat while she showered. Ms G recalled she got in the shower before about 10.00am. She recalled that when she was almost finished, Miss G, who was 10 years old, came in saying that there was a postman at the door with a parcel. Miss G then brought the parcel in herself. Miss G told her that Master J was on the window sill but refused to get down when she requested him to do so.

22. When Ms G got out of the shower, she recalled she could hear Master J jumping around the lounge room. She proceeded to open her parcel and try on the garment she had received. She said this was for a very short amount of time. Ms G then *walked into the lounge room* but *didn't see Master J straight away.* She then scanned the room and noticed him *hanging on the curtain cord* in front of the window that looks straight out onto the front door.

23. Ms G ran towards him and *unhooked him from the beaded cord.* She commenced Cardiopulmonary Resuscitation (**CPR**) and called to her brother Mr G for help. Mr G

came running shortly after and *knew straight away that he was gone.* Mr G proceeded to contact an ambulance from Ms G's phone at about 10.37am.

24. At approximately 10.47am, paramedics attended the scene and were joined by firemen and police members including the Coroner's Investigator DSC Hales. Mr G ontacted Mr J and informed him that *there had been an incident and that the ambulance was there.*

25. Paramedics observed Master J to be in cardiac arrest and undertook resuscitation. However, tragically, Master J was unable to be assisted and was pronounced deceased at 11.16am.

26. Police commenced an investigation and collected photographs and the curtain blinds and rods which Master J had been entangled in. They observed various household pieces of furniture in the lounge room, including children's furniture, as well as some storage boxes, toys and clothing.

27. Following investigation, police found no evidence of suspicious circumstances surrounding Master J's passing.

**Identity of the deceased**

28. On 10 September 2020, Master J, born [redacted] 2017, was visually identified by his uncle, Mr G.

29. Identity is not in dispute and requires no further investigation.

**Medical cause of death**

30. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 17 September 2020 and provided a written report of her findings dated 9 November 2020.

31. The post-mortem examination revealed *findings in keeping with the clinical history.* Examination of a post-mortem CT and skeletal survey revealed *No evidence of unexpected skeletal trauma. Diffuse brain swelling may be a combination of expected post-mortem changes and pre-mortem hypoxia.*

32. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.

33. Dr Baber formulated the cause of death as *Neck compression due to entanglement in the cord of a blind.*

34. I accept Dr Baber's opinion.

## CPU REVIEW AND FURTHER INVESTIGATIONS

35. As part of this investigation, I requested advice from the Coroner's Prevention Unit (**CPU**) as to whether there were any prevention opportunities in this matter.[6] The CPU's central purpose is to identify opportunities to reduce preventable deaths investigated by coroners.

36. The review noted that the loungeroom of the premises where the incident occurred were a set of vertical blinds installed at the windows. These blinds were operated by two chains (one white metal beaded chain and one nylon rope) that were attached to the left-hand side of the device. These chains were free standing and not secured to any wall. Enquiries by Victoria Police established that the blinds were installed around July 2008.

37. The CPU identified two Victorian deaths of young children involving blind cords in the past decade; they were Master J and Infant A[7]. While this is a low absolute number, the CPU was concerned that there might be a substantial burden of non-fatal injury associated with blind cords. Consequently, the CPU contacted the Victorian Injury Surveillance Unit (**VISU**) to find out how many hospital emergency department presentations occurred relating to blind cord injuries.

38. On 11 June 2021, the VISU advised the CPU that between July 2010 and June 2020, there were 26 cases of children presenting to Victorian emergency departments due to cords from blinds or curtains getting caught around their neck (these were also described as hanging or strangulation incidents). Most of these 26 children were aged between one and three years. They included six children aged one year, seven children aged two years, and six children aged three years. Fifty percent of the children were admitted for further treatment and there were no deaths in hospital during this time.

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[6] The CPU assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations.

[7] COR 2019 5378, investigated by Coroner John Olle delivered on 3 December 2020.

## Mandatory standards for corded internal window coverings

39. Mandatory standards for corded internal window coverings apply to curtains and blinds supplied after 30 December 2010 (**mandatory standards**). These mandatory standards are encoded in the *Trade Practices (Consumer Product Safety Standard – Corded Internal Window Coverings) Regulations 2010*, and in the *Competition and Consumer (Corded Internal Window Coverings) Safety Standard 2014*.

40. Correspondence with Consumer Affairs Victoria (**CAV**) confirms that there was *no specific legislation in July 2008 governing the installation of curtains or blinds,* however in December 2008, the Minister for Consumer Affairs issued a fixed-term ban order prohibiting the supply of corded internal window coverings unless they complied with the terms of the ban order. This was in effect until 30 August 2012.

## Coronial investigation into the death of Infant A and Safety Kits

41. In Coroner Olle's finding in the death of Infant A, he noted the application of the mandatory standards post 30 December 2010. Coroner Olle commended the extensive work undertaken by CAV before and after these standards were introduced, to educate people about the risks to children associated with curtain and blind cords. The CAV campaign encouraged parents to request free safety kits containing a device to attach looped cords to the window frame under tension, so they are not loose and present less of an entanglement risk to children.

42. Coroner Olle made the following recommendation in four parts:

    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.*[8]

    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.*

[8] This reference to four infant deaths is national, not only Victoria. As noted above, there have been two child blind/curtain cord related deaths in Victoria in the past decade, in 2019 and 2020.

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.*

43. In response to the recommendations, CAV advised: *The next batch of safety kits is currently being prepared for distribution from April 2021. These kits will be available directly from CAV as well as KidSafe (Vic) and distribution will be accompanied by public promotion.*

**Further Opportunity for Prevention**

44. As it was recognised that the mandatory standards were not retrospective, there are potentially thousands of Victorian homes - including rental homes, such as where Master J resided – which do not have blind cords affixed to the wall because the blinds were installed before 30 December 2010.

45. Accordingly, the Court wrote to the responsible minister with an invitation to comment on potential prevention opportunities, specifically mandating blind safety kits in residential rental properties.

46. On 23 November 2021, the Hon Melissa Horne MP advised that safety in rental properties is a key priority for the Victorian Government, as reflected by recent reforms to the Residential Tenancies Act 1997 which came into effect on 29March 2021. She indicated that the reforms prescribed a range of rental minimum standards critical to ensuring the amenity, safety and privacy of renters within a rental property and as part of the reforms, renters are no longer required to seek permission from their rental provider before attaching child safety devices such as blind or curtain cord anchors.

47. The Minister indicated that the rental reforms work in conjunction with mandatory safety standards as prescribed under the Australian Consumer Law and confirmed that the mandatory safety standard for corded internal window coverings do not operate retrospectively and therefore only apply to coverings supplied from 30 December 2010. The Minister noted that since the introduction of the standard, CAV has taken significant steps to encourage the uptake of blind safety for all properties through highlighting the risk associated with curtain and blind cords for young children and promoting awareness and supplying free blind cord safety kits.

48. And further that despite initial difficulties encountered by CAV in preparing new batches of blind cord safety kits, they were now available and could be ordered online via the Consumer Affairs government website.[9]

49. The Minister further advised that she would consider any recommendations concerning mandating blind safety kits in residential rental properties to ensure the safety of Victorian children residing in those properties. She suggested this could be implemented as a new minimum standard via amendment regulations made under the *Residential Tenancies Act 1997* and that she would seek further advice on this from the Department of Justice and Community Safety after the findings are handed down.

**KidSafe (Vic)**

50. KidSafe (Vic) were consulted as part of this investigation and supported the proposal for the mandating of blind safety kits in residential rental properties and expressed their support to the relevant minister.

**Other Concerns**

51. During the course of the investigation concerns were raised by Master J's grandmother, Ms R, regarding the basis upon which the FVIO was obtained by Master J's mother as well as the duration of the interim order (around ten months). She noted that the order was made six months after they were separated and that it had the effect of suspending the child sharing arrangements which in turn removed Master J from his familiar surroundings.

52. Inquiries were made regarding the return date of the order and the Ringwood Magistrates' Court advised that the listing of the return date was due to the backlog created by the pandemic. As noted above, Mr J did make an application to vary the FVIO on 8 September 2020 which was returnable on 15 September 2020.

53. I acknowledge Ms R's deep concerns regarding this matter however, having made this inquiry, I consider any further examination of this issue falls outside the scope of the coronial investigation.

**FINDINGS AND CONCLUSION**

54. Pursuant to section 67(1) of the Act I make the following findings:

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[9] Consumer Affairs Victoria, "Order a curtain and blind cord safety kit", <https://www.consumer.vic.gov.au/ products-and-services/product-safety/curtain-and-blind-cord-safety>, accessed 7 March 2022.

a) the identity of the deceased was Master J, born [redacted] 2017;

b) the death occurred on 10 September 2020 at [redacted], Doncaster, Victoria from *Neck compression due to entanglement in the cord of a blind*; and

c) the death occurred in the circumstances described above.

**COMMENTS**

55. Pursuant to section 67(3) of the Act, I make the following comments connected with Master J's passing.

a) I reiterate Coroner Olle's view that it remains 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.

**RECOMMENDATIONS**

56. Pursuant to section 72(2) of the Act, I make the following recommendations:

a) With the aim of improving Victoria's uptake of blind cord safety kits and preventing like deaths, I recommend that the Minister for Consumer Affairs, Gaming and Liquor considers mandating that blind cords in current residential rental properties are affixed to the wall.

b) With the aim of emphasizing and enhancing the role of real estate agency staff in detecting broken blind cord safety devices, I recommend that the Minister for Consumer Affairs, Gaming and Liquor incorporates reference to 'blind cord affixed to the wall' in its condition report for residential rental properties.

57. The passing of such a young child is devastating for his loved ones as well as for the community. I convey my sincere condolences to Master J's family for their loss and acknowledge the tragic circumstances in which his death occurred.

58. I also acknowledge the work of the first responders who came upon such a tragic scene as part of the work they undertake on a daily basis.

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

Mr J, Senior Next of Kin

Ms G, Senior Next of Kin

Ms R, Other Applicant

Liana Buchanan, Commission for Children and Young People, Other Applicant

Yvette Kozielski, Eastern Health, Other Applicant

Consumer Affairs Victoria

KidSafe (Vic)

Detective Senior Constable Benjamin Hales, Victoria Police, Coroner's Investigator

Signature:

**SARAH GEBERT**

**CORONER**

Date: 27 June 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.