IN THE CORONERS' COURT OF THE NORTHERN TERRITORY

Rel No: D0068/2024

Police No: 24 27684

CORONERS' FINDINGS

Section 34 of the ***Coroners Act 1993***

I, Elisabeth Armitage, Coroner, having investigated the death of **a toddler** and without holding an inquest, find that the identity of the deceased was born on **18 August 2022** and that his **death occurred on 18 March 2024 in the Northern Territory.**

Cause of death:

1(a)	Disease or condition leading directly to death:	**Accidental hanging (entrapment in looped window blind cord)**

Following an autopsy on 18 March 2024, Forensic Pathologist, Dr Marianne Tiemensma commented:

History from initial police report to the coroner. Clinical case record. Communication with detective sergeant Paul Morrissey and scene photos provided by crime scene examiner Jay Collinson

Circumstances surrounding death

The decedent was a 19-month-old male toddler who was reportedly located hanging (fully suspended by the neck from a looped window blind cord) in his parents' bedroom on the morning in March 2024.

The mother was in the kitchen in the unit preparing breakfast while her three young children were playing in the adjacent lounge and bedrooms. At some stage, the mother noticed she hadn't seen her 19-month old toddler for a while and asked her 6-year old son, to check on him in her bedroom. The 6-year old returned to tell his mother to come to have a look as the decedent was "standing funny".

Upon entering the bedroom, the mother noted that the toddler's head was caught in the cord of the vertical blind and he was fully suspended. The cord was approximately a metre above floor level and appeared to be easily accessible from a bedside table and/or a pink suitcase next to the parents' bed. The bedside table and suitcase could have been accessed via the bed and/or a mattress placed on the floor between the bed and the window. The mother reportedly lifted the toddler up and out of the cord and he was found to be unresponsive and limp; she called emergency services and initiated resuscitation until St Johns Ambulance arrived. They continued CPR to no avail and the decedent was declared deceased at the scene.

Summary of main pathological findings

- External examination showed:

- The body of a well-nourished young male toddler, clad in a t-shirt, shorts, and disposable diaper.
- No evidence of neglect or underlying natural disease.
- A deeply indented patterned ligature abrasion (corresponding with the patterning of the beaded window blind cord) on the anterior and lateral aspects of the neck, with the abrasion disappearing into the hairline on the back of the head/neck.
- A vertical linear purple-blue bruise with surrounding soft tissue swelling on the anterior aspect of the forehead
- Frothy fluid in the nostrils.
- No other injuries with careful examination.
- Evidence of medical intervention.

- A post-mortem CT scan was performed that showed:
  - No intracranial injury.
  - No skeletal trauma.
  - No significant underlying natural pathology.
- No internal examination was performed.
- Cardiac blood samples were submitted for post-mortem toxicological analysis.

Comments

- There was no indication at post-mortem examination that the toddler's death resulted from anything other than his unintentional entrapment in the looped window blind cord and resultant hanging. The vertical linear bruise on the forehead could have resulted from impact with the corner of the window frame adjacent to the window blind cord.
- Accidental asphyxia is known to occur in toddlers with their inability to understand dangers and to physically extricate themselves when entrapped (*1*). The danger that the cords of window coverings present for young children has been recognised for some time (*1,2*), and there are mandatory safety standards for corded internal window coverings in the United States of America and New South Wales to prevent these types of accidental hangings/ strangulations (*3*).

References:

1. Byard RW. Curtain cords and accidental childhood hanging. Medical Journal of Australia. 2009;190(7):397-398.
2. Byard RW, Beal S, Bourne AJ. Potentially dangerous sleeping environments and accidental asphyxia in infancy and early childhood. Archives of Disease in Childhood 1994;71 :497-500.
3. Congiu M, Cassell E, Clapperton A. Unintentional asphyxia (choking, suffocation and strangulation) in children aged 0-14 years. Hazard Winter 2005;60. (Victoria Injury Surveillance and Applied Research Unit).
4. htt ps:/ / www.consumer .vic.gov.au/consumers-and-businesses/ products-and-services/ product-safety/ curtain-and- blind-cord-safety (Accessed 19 March 2024).

Review of the Northern Territory electronic clinical case record showed no significant background medical history.

Specimens were taken for toxicological analysis:

Results: No drugs or alcohol listed in the scope of analysis was detected in the preserved cardiac blood.

Police investigation:

A coronial investigation by police found no suspicious circumstances surrounding this death.

Circumstances:

The toddler was born at Darwin. He was only 19 months old at the time of his death. He had two older brothers.

The family owned and lived in a two bedroom unit on top of business premises in the Winnellie Industrial Area. He slept on a mattress on the floor next to his parent's bed. His parents reported that he was a healthy and active young boy. He was known to climb on top of things and he liked to climb onto their bedside table and jump down onto his mattress on the floor. His two brothers slept on bunk beds in the second bedroom.

At 06.00am on 18 March 2024 his father got up and left the house to catch a flight to Alice Springs for work.

Not long afterwards the rest of the family got up and his mother cooked pancakes for breakfast. As she did this the three young boys were playing with each other in the lounge and bedroom areas.

After the boys had finished their breakfast their mother made her own breakfast and sat down to eat it. She noticed that she hadn't heard or seen the toddler for a short time so she asked her eldest son, to go and check on him.

The 6-year old came back a short time later and told his mother to come into the bedroom as his brother "looked funny".

His mother reports she went into her bedroom and found the toddler fully suspended by the neck from the loop in the cord to the window blind. She went over to him and lifted him up but found him to be unresponsive.

In a moment of panic she ran down to her car with him with the intention of driving him to hospital. She then decided it would be better to call 000 for assistance.

The 000 call was received at 09.06am and the call taker then directed his mother to conduct CPR, which she did until St Johns arrived and took over at 9.13am. St John officers recorded his condition as critical (1) on arrival, he was not breathing and they could not find a pulse. St John officers continued to work on the toddler for approximately 45 minutes but were unable to revive him and his death was declared at 09.54am.

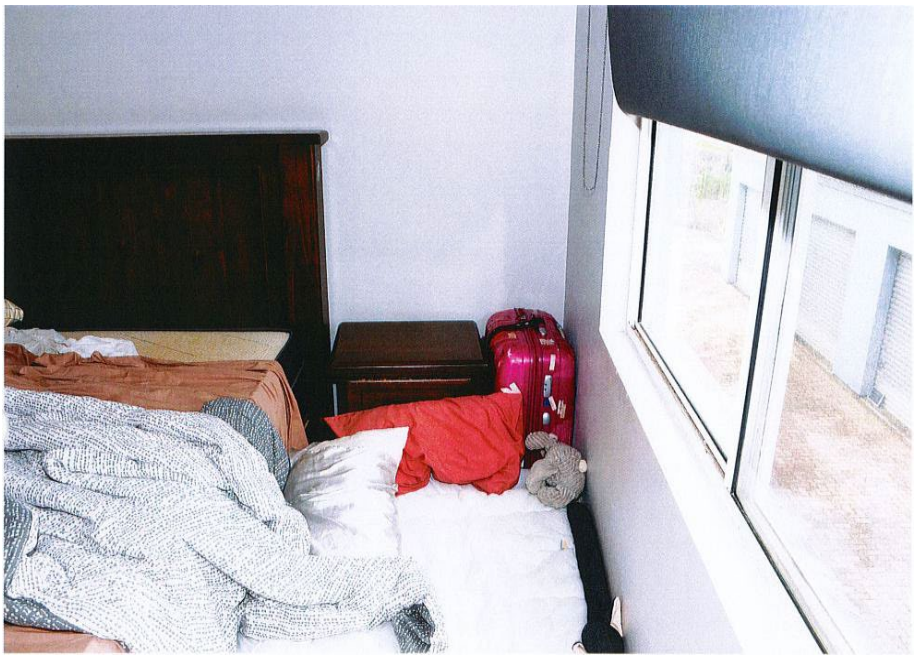
Police, crime scene examiners and forensic pathologists attended the scene and conducted their investigations with nothing noted that was contrary to circumstances as reported.

Crime scene examination confirmed foot marks consistent with the size the toddler on top of the bedside table.

The cord for the blind on the window next to the bedside draw was a silver coloured beaded cord strong enough to support the weight of the child. It was not secured to the wall in any way other than at the top of the blind. The deeply indented patterned ligature abrasion identified by the Forensic Pathologist on his neck was consistent with the beading pattern of the cord. It is not known if he accidently got his head caught in the blind cord as he was jumping or was playing with the cord and got stuck. Both would appear possible.

He had no injuries other than the ligature abrasion and a bruise on his forehead that his mother reported he had received hitting his head on a cupboard several days earlier.

Photographs showing the blind cord and its proximity to the bed and bedside table are produced below.



Legislation concerning the safety of corded blinds is covered by the *Trade Practices Act* with the Safety Standards for blind products specified in the Trade Practices (Consumer Product Safety Standard - Corded Internal Window Coverings) Regulations 2010 and installation specifications are set out in the Competition and Consumer (Corded Internal Window Coverings) Safety Standard 2014. The Trade Practices (Consumer Product Safety Standard – Corded Internal Window Coverings) Regulation 2010 makes it mandatory for Landlords to comply with the Trade Practices Mandatory Safety Standards.

The family purchased the residence approximately 12 months earlier and the blinds were already in place. It is not known when the blinds were installed or by whom. In the circumstances of this case there would not appear to be any legal ramification for the cord not being secured.

Kidsafe Victoria provides advice concerning blind cord safety. That advice includes the requirement that cords must be secured to the wall with cleats or tension devices and that furniture should not be placed near a window where a child can reach a blind or curtain cord.

https://www.kidsafevic.com.au > Home Safety

The ACCC published a warning concerning the dangers of loose blind and curtain cords on 23 June 2016 (release number MR113/16) as follows:

> Tragically, between one and two children die in Australian homes every year as a result of non-compliant corded blinds and curtains. Similar deaths occur regularly across the world and the ACCC is joining international regulators to warn of the hidden dangers associated with corded blinds and curtains.
>
> "Loose cords can be extremely dangerous to young children, as they can quickly tangle or loop around a child's neck. We are urging parents and carers to check each room in their house for blinds or curtains with cords and tie them up with cleats," ACCC Commissioner Sarah Court said.
>
> "It is important to make sure cots, beds, highchairs and playpens are placed away from blind or curtain cords so they remain inaccessible to infants at all times."
>
> "Young children will also climb on furniture, such as chairs and couches that may be near windows with blinds or curtain cords. All cords throughout the house should be secured and out of reach of children," Ms Court said.
>
> The mandatory standard for internal window coverings was declared in July 2010 and a separate regulation relating to installation services of window coverings came into effect in January 2015.
>
> In April, the ACCC conducted a survey of corded blinds and curtains in 131 display homes and found evidence of an alarmingly poor level of compliance with the regulations for both supply and installation of window coverings.
>
> Had the homes been sold with the window coverings as installed, only 10 per cent would have complied with all the requirements of the mandatory standard, including the incorporation of cord guides, cleats to keep the cords out of harm's way, installer details, and mandatory warning labels.
>
> "The ACCC is putting suppliers and installers on notice that they face prosecution and fines of up to $1.1 million if they fail to comply with the regulations," Ms Court said.
>
> The ACCC will continue to educate housing companies, manufacturers, retailers, and installers of corded internal window coverings about the requirements of the mandatory standard. The ACCC will be undertaking further surveillance and enforcement action will be taken where serious breaches of the regulation are found.

Safety at home

When installing new blinds and curtains, make sure you or the installer secure any loose or looped cords—do not leave them hanging down.

- Go through every room in your home and check for any blinds or curtains with long cords that are either loose or looped. Remember, this includes any cords that are within children's reach at floor level or near furniture they can climb on.
- Do not put children's cots, beds, highchairs or playpens near a window where children can reach blind or curtain cords. The cords can become tangled around children's necks and strangle them.
- Do not place sofas, chairs, tables, shelves or bookcases near windows with corded blinds or curtains. As young children like to climb onto furniture to look out the window, they may quickly become entangled in the cords, lose their footing, and suffer strangulation or serious injuries.
- Accidental strangulation can happen very quickly, so never leave children alone in rooms where cords are unsecured if you're visiting someone's home, even for a short while.
- Some blinds can't operate properly without looped cords. To keep them out of children's reach you should secure these cords with either:
    - tie-downs (cleats), or
    - tension devices that enclose cords and chain loops.
- Always fix tie-downs and tension devices firmly to the wall or window-frame so a child is not able to remove them. Never use materials that can't support a significant load, such as double-sided tape or glue.
- Consider replacing corded blinds and curtains with cordless alternatives. There are safer designs of window coverings available for most appliances.

Decision not to hold an inquest:

I make no further findings with respect to the circumstances of this death as, under section 16(1) of the *Coroners Act 1993* ("the *Act*") I decided not to hold an inquest because the investigations into the death disclosed:

- The time, place and cause of death;
- The relevant circumstances concerning the death;
- I do not consider that the holding of an inquest would elicit any information additional to that disclosed in the investigation to date; and
- The circumstances do not require a mandatory inquest because:

- The deceased was not, immediately before death, a person held in care or custody; and
- The death was not caused or contributed to by injuries sustained while the deceased was held in custody; and
- The identity of the deceased is known.

Signature:

_____

Elisabeth Armitage

CORONER

NOTE:

Under section 16(2) of the *Act*, within 14 days after receiving notice of a decision not to hold an inquest, a person may apply to the Supreme Court for an order that an inquest be held.

Under section 16(3) of the *Act*, the Supreme Court may if it thinks fit, make an order that an inquest be held.