REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** The Secretary of State for Housing
1	**CORONER** I am Ms J Robertson, Assistant Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 17 January 2019 I commenced an investigation into the death of **Macy May Barbara Fletcher**. I concluded the inquest on 26 June 2019 and my conclusion was that this was an accidental death.
4	**CIRCUMSTANCES OF DEATH** On 9 January 2019 the deceased (a 2 year old child) was found unresponsive in the bedroom of her home address with a blind cord strangulating her neck. Paramedics attended and she was taken to the Royal Oldham Hospital. Efforts to resuscitate her were unsuccessful and she died at 15:08 pm on 9 January 2019 in the Emergency Department at the Royal Oldham Hospital. There is no evidence of suspicious circumstances or third party involvement in her death. The deceased lived in a house that was privately rented from a private landlord. The deceased and her family were the second tenants of this property. Their tenancy agreement commenced on 1 December 2016. The deceased was almost 3 months old at the time that she moved into her property with her family. The deceased's bedroom had blinds. These had supplied and fitted by a local company on behalf of the landlord in or around April 2011. This was prior to European Standard, EN13120:2009+A1:2014, which was published on 28 February 2014 by The British Standards Institution. The blinds were a standard pull cord blind and they did not have any safety features, such as a chain breaker connector, chain tensioner or wand. Prior to the commencement of the tenancy the landlord checked the property and deemed the blinds to be fully operational and in good working order. He did not undertake any further checks after this date – although routine house inspections took place while the deceased and her family were living there. The landlord owns 6 other properties that he privately rents out. Five of those properties have window dressings that were installed after 2014 and the remaining property has curtains.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

	The **MATTERS OF CONCERN** are as follows:- 1. The deceased was strangulated by a blind cord from a blind that had been fitted prior to 2014. This blind did not have any safety features. During the course of the inquest I heard evidence that there is no national body to provide oversight and offer guidance and support to private landlords on their legal obligations and responsibilities and to share best practice – specifically in relation to updates in safety regulations. This would be of benefit to tenants, landlords and would assist in preventing future fatalities In this case, the landlord was unaware that blinds fitted prior to 2014 posed a risk of death or serious injury to young children. I heard evidence that had he had known about those risks he would have replaced the blinds. I also heard evidence that since 1999 there have been at least 40 deaths across the UK due to looped cords. I also heard that there is research that indicates that most accidental deaths involving blind cords happen in the bedroom and occur in children between the ages of 16 and 36 months old. That research shows that most deaths happen when a child is around 23 months old. These toddlers are mobile, their heads still weigh proportionately more than their bodies compared to adults and their muscular control is not yet fully developed. This makes them more prone to be unable to free themselves if they become entangled. In addition, toddlers' windpipes have not yet fully developed and are smaller and less rigid than those of adults and older children. This means that they suffocate far more quickly if their necks are constricted.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively have the power to take such action.**
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 22 August 2019. I, the Coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely:- Family of the deceased, [redacted]g, The Royal Society for the Prevention of Accidents, Child Accident Prevention Trust. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary from. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me the coroner at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	Date: 27.6.2019 Signed: