CORONERS ACT, 2003

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 11th and 15th days of December 2008, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Nicholas Esposito.

The said Court finds that Nicholas Esposito aged 13 months, died at the Womens and Childrens Hospital, 72 King William Road, North Adelaide, South Australia on the 1st day of March 2007 as a result of hanging. The said Court finds that the circumstances of his death were as follows:

1. Introduction

1.1. Nicholas Esposito, who was 13 months old, shared a bedroom with his 5-year-old brother. Nicholas slept in a wooden cot while his brother slept on the top level of a metal desk/bed arrangement. One end of the cot in which Nicholas slept was situated directly under a window that was covered by a Roman blind. Photographs taken by the police indicate that the bottom of the Roman blind was about level with the top of the end of the cot. The Roman blind had a cord which, when looking at the photographs, could hang down into the cot itself. At that point the cord appears to be constituted by a string that is configured in a loop.

1.2. According to Nicholas' father[1], Nicholas was able to stand and '*toddle about*'. He was able to drink his nightly milk alone in his cot before going to sleep. It appears, therefore, that Nicholas would have been able to pull himself up to his entire height within the cot and that this would have enabled him to gain access to the blind cord that I have described.

[1] Exhibit C2a

1.3. Nicholas and his brother lived with their parents, Mr and Mrs Esposito. On the evening of Thursday 1 March 2007 Nicholas was at home with his father after they had returned to the premises from Nicholas' grandparent's home. Nicholas' mother was not at home that evening.

1.4. Mr Esposito, his two sons and his brother had earlier that evening all been out at the brothers' parent's premises. Mr Esposito and Nicholas returned home separately. Once home, Mr Esposito gave Nicholas his usual bottle at about 7:30pm. Nicholas was in his cot. Mr Esposito left the bottle with Nicholas in the expectation that Nicholas would drink it and then go to sleep. Mr Esposito left Nicholas alone in the room. Not long after, Mr Esposito's brother arrived at the premises with the older boy. Mr Esposito went outside to open a roller door so that his brother could get in. At one point Mr Esposito spoke to a neighbour and he estimates that he would have been talking to her for about 10 to 15 minutes. Mr Esposito then took Nicholas' brother straight to bed. When he did so he turned the light on in the bedroom and discovered Nicholas in the cot, hanging by his neck from the blind cord. Mr Esposito also noticed that the cord was around Nicholas' dummy cord which was clipped to his clothing. Mr Esposito removed the cord from Nicholas' neck and commenced CPR. He also phoned an ambulance.

1.5. According to the South Australian Ambulance Service record in relation to this incident the relevant communication was received at 8:35pm and an ambulance was despatched that same minute. It arrived at the Esposito premises 4 minutes later at 8:39pm. The ambulance crew found Nicholas to be unresponsive, with his pupils already fixed and dilated. There were no respirations or pulse. The ambulance crew did all they could to revive Nicholas at the scene but were unsuccessful. At 8:51pm they departed the scene in the ambulance with Mr Esposito and Nicholas. They continued their resuscitative efforts. The ambulance arrived at the Women's and Children's Hospital at 9:01pm. Further resuscitative efforts took place at the hospital, again to no avail and Nicholas was declared life extinct at 9:11pm.

1.6. Members of South Australia Police investigated this matter. As part of their investigation they attended at the Esposito home and made observations of the cot and in particular of its juxtaposition to the window blind and cord. The investigating officers concluded that there were no suspicious circumstances surrounding Nicholas' death. Based upon the overt compression injury to Nicholas' neck and the thickness

of the cord, police concluded that Nicholas had stood up in his cot and that the cord had then become entangled around his neck. This conclusion was also supported by the post-mortem examination to which I will now turn. I agree with the conclusions that were reached by police in regard to the manner of Nicholas' death.

2. Cause of death

2.1. A post-mortem examination was performed by Professor Roger Byard, Forensic Pathologist, on 5 March 2007. Professor Byard's post-mortem report states:

> 'Death was due to neck compression from hanging with a parchmented ligature mark around the neck being associated with petechiae of the face and conjunctivae. Hanging from curtain cords is a recognised risk when cots are placed next to blinds and the injuries present at autopsy corresponded with the history in the report of death. No other injuries were detected. There were no external or internal injuries other than those described associated with the hanging and a skeletal survey were negative. There were no underlying organic diseases which could have caused or contributed to death. The presence of mild mesenteric lymphadenopathy was in keeping with a mild, co-incidental, viral infection which is very common at Nicholas' age. There was no evidence of any congenital or inherited disease. Toxicology was negative.' [2]

Professor Byard also found no abnormalities upon X-ray.

2.2. Professor Byard has expressed the cause of death as hanging. I find this to be the cause of Nicholas' death.

2.3. The other feature of Professor Byard's report that is important is that Nicholas was well nourished, clean and normal for a male toddler. There is absolutely no suggestion that any neglect was involved in Nicholas' care. Nicholas' death was an accident. Nicholas had clearly been a much-loved child of the family.

2.4. It will also be seen from Professor Byard's report that hanging from curtain cords is a recognised risk when cots are placed next to blinds.

3. Commentary

3.1. Professor Byard gave evidence before me. This was not the first time in which Professor Byard had given evidence to this Court in respect of the death of a toddler by way of hanging that involved a window covering cord. Death by this mechanism was the subject of the Inquest into the death of a male infant, aged 15 months, who

[2] Exhibit C12, page 1

died in November 1999[3]. The Inquest findings were delivered on 20 October 2000. Based on Professor Byard's evidence, the former State Coroner, Mr Chivell, made the following comments at that time:

> 'I believe that the circumstances of this case call for a public warning to be given to the parents of young children about the risks involved in allowing such children to have access to ropes or cords which are long enough to go around the child's neck. Parents should ensure that curtain cords are kept out of the reach of small children. It is recommended that the brochure made available by Kidsafe as part of the Safe Sleeping Campaign should be consulted, as this offers advice and assistance to parents about how to avoid such risks.' [4]

Unfortunately, since 1999 there have been further deaths of infants from this same mechanism. As far as I am aware Nicholas' death is the only such death that has occurred in this State. I am aware of the existence of eight interstate coronial reports between the years 2000 and 2008 involving deaths of children by this mechanism. Two of those deaths, one in Tasmania and the other in Victoria, were the subject of coronial findings and recommendations that are in the public domain. While these statistics might demonstrate that deaths of children by this mechanism are not common, they are nevertheless deaths that should be attended by due and proper scrutiny and this is particularly so because the death of a child in this manner is in my view preventable.

3.2. In his evidence before me, Professor Byard explained that the death of an infant by hanging that involves compression of the major vessels within the neck, possible restriction of the airway, pressure on the vagus nerve or a combination of all of those mechanisms could occur very rapidly. Once the blood supply to the brain is cut off, unconsciousness can occur within a few seconds and death can occur within minutes. Once unconsciousness is established, the infant's body will then be suspended. In those circumstances, its weight against the ligature will not be relieved but, if anything, will be tightened. It is inevitable that the unconscious child will die unless human intervention relieves pressure on the neck. Professor Byard was asked:

> 'Q. Once unconsciousness takes place then there's really no prospect of recovery, is there, unless someone intervenes, is that the position?
>
> A. That's true, and I think it's particularly a problem in toddlers because they don't - they can't work out how they got into the problem in the first place. You or I would actually realise we were in trouble and stand up and move our heads out, they don't

[3] Inquest 42/2000 - Alford
[4] Inquest 42/2000, paragraph 3.2

> do that. And of course, once they lose consciousness then there is no way they could get out.'

Permanent brain damage as a result of the deprivation of oxygen will likely occur within less than 5 minutes of the constriction of the neck. Likewise, death can occur within the same time period. It will be noted in the instant case that Nicholas' father's estimated time of 10 or 15 minutes during which he was speaking to his neighbour would have been sufficient time for Nicholas to have lost consciousness and to have died. It is thus unsurprising that Nicholas was unable to be revived, despite the persistent and highly professional efforts of the paramedics. The fact that a child may quickly lose consciousness and die soon thereafter is very much a matter to be taken into consideration when placing unsupervised infants in situations involving close proximity to curtain cords even for short periods of time. The danger is naturally heightened where the child is put to bed and is for that reason not seen for some hours.

3.3. The principle message here, of course, is that under no circumstances should children's cots be placed in close proximity to windows that have blind and curtain cords hanging from them. Professor Byard had made this point in the 2000 Inquest that I have already referred to. As seen earlier, he again makes the point in his post-mortem report in respect of Nicholas in these terms:

> 'Hanging from curtain cords is a recognised risk when cots are placed next to blinds and the injuries present at autopsy corresponded with the history in the report of death.' [5]

4. Prevention

4.1. Professor Byard, who has a renowned expertise in relation to sudden infant death and its prevention, told me, and I accept his evidence, that public awareness campaigns that have been conducted over a number of years in respect of SIDS and other sudden unexplained deaths of infants, and which have spelt out the risk factors involved in such deaths, have resulted in a very significant reduction of the incidence of both SIDS and sudden deaths of infants from other causes such as suffocation. Professor Byard's estimation was that literally thousands of deaths have been avoided because of the now increased public awareness in relation to this issue. Professor Byard suggests, and again I agree with him on this, that there is no reason to suppose that

[5] Exhibit C12

heightened public awareness of the risks involved in placing children in close proximity to blind and curtain cords would not have the same beneficial effect.

4.2. The importance of providing parents and other caregivers with information about the dangers associated with blind and curtain cords cannot be overstated. As a measure of this, there can be little doubt that had these dangers had prominence in the public consciousness, and as a result Nicholas' parents had been aware of the dangers associated with what appears to be a very straightforward and otherwise benign device such as a blind cord, Nicholas would not have been placed in such close proximity to the device. The possibility of strangulation in these circumstances, while not entirely unforeseeable, has not engaged the public imagination as much as SIDS. The fact that deaths of infants by this mechanism are infrequent would also contribute to this vacuum of unawareness. However, as we have seen, notwithstanding the relative infrequency of these incidents, the dangers are real and present.

4.3. It therefore appears that these dangers need to be kept very much in the public mind, and the dissemination of appropriate information is a matter that must be regarded as having an ongoing necessity. One has to avoid disseminating material that is unnecessarily alarmist, but at the same time there is an obvious need to maintain issues of this nature in the consciousness of the general public.

4.4. To this end a number of publications have already been made available to the public that concern the dangers of hanging by blind and curtain cords. For the most part these publications have consisted of brochures promulgated by such organisations as SIDS and Kids and Kidsafe that are made available at places such as baby expos, doctors surgeries and hospitals. One notes, however, that these outlets are not necessarily frequented by persons other than parents. Some of these brochures and pamphlets were tendered to me during the course of the Inquest. I speak here of Exhibits C12b and C12c. Exhibit C12b consists of a pamphlet and a poster that has been promulgated by the Australian Competition and Consumer Commission. The copyright on these documents appears to have been asserted in 2007. The pamphlet explains the hazards connected with blind and curtain cords and appears to give sound advice in relation to minimising those dangers. Exhibit C12c is an illustrated publication of several pages that has been promulgated by the SIDS and Kids organisation. Initially the SIDS and Kids publications were confined in their scope to the prevention of SIDS and other sudden death in infants. Professor Byard, who has

been the Medical Adviser to SIDS and Kids since 1991 and who has been involved in the production of these publications, told me that the organisation decided to take a holistic approach to the issue of safe sleeping and to incorporate and identify other sleeping hazards in the SIDS and Kids brochure such as dangling cords or string. The brochure now refers to this issue and advises parents and caregivers to keep cots away from any cords hanging from blinds, curtains or electrical appliances.

4.5. Professor Byard told me that it would be highly desirable for these kinds of publications to be more widely made available and distributed. He refers to the fact that there is no national system for distribution. SIDS and Kids, as far as he is aware, does not receive any government funding to educate the public. It seems to me that there is a compelling case for the wider promulgation and dissemination of this kind of material, and in particular by the media, both print and electronic. Such promulgation would naturally require funding and there is little doubt that there is a very real public interest in having this material promulgated by public funding.

4.6. Another aspect of prevention concerns the fixation of warnings to dangerous articles at their point of sale or supply. I have been informed that a number of Australian jurisdictions now regulate the sale and supply of corded internal window coverings so as to minimise the dangers to children presented by those devices. I understand that some States and Territories already have blind cord regulations in place. South Australia does not and I return to the issue insofar as it affects this State in a moment.

4.7. I have examined the regulations that exist in New South Wales. The New South Wales Government Gazette that contains these regulations was tendered to the Inquest[6]. The regulations in question are contained within more general regulations made under the New South Wales Fair Trading Act 1987 that deal with a whole raft of products such as swimming pool outlets, bicycles, protective helmets and floatation devices to name a few. The regulations are entitled the 'Fair Trading Regulation 2007'. The explanatory note to the Fair Trading Regulation suggests that its underlying purpose is to prescribe "safety standards" for various goods including corded internal window coverings. The relevant regulation defines a 'corded internal window covering' to mean:

[6] Exhibit C9

'… any interior drapery hardware or window covering product (for example, a curtain, shade, blind, or traverse rod or track) that incorporates any of the following in its operation (other than solely as a tie-back for the covering):

(a) a looped bead chain (being a series of small beads, equally spaced on a cord or connected by metal shafts, which is curved or doubled, or the ends of which are joined by a device, so as to form a closed loop),

(b) a looped cord (being a form of rope, strap, or string which is curved or doubled, or the ends of which are joined by a device, so as to form a closed loop),

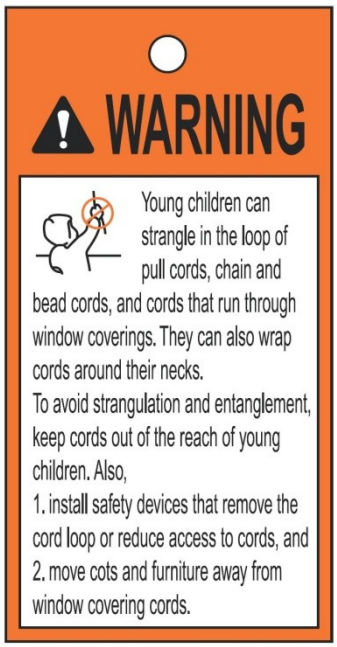
(c) any other type of flexible looped device.' [7]

The regulations insist that a corded internal window covering must be designed so that any exposed looped cord, looped bead chain or other flexible looped device does not extend to within 1600mm above the base of the covering when the covering is in its lowered position. In addition, the regulation calls for the fixation of warning labels and tags to the relevant device. The labels and tags must depict a warning that looped cords, looped bead chains or other flexible looped devices may create a strangulation hazard for children under 5 years and that they should be kept out of the reach of children. There is also another requirement that deals with the juxtaposition of these devices to cots. In addition to all of that, the device must also be accompanied, one assumes at the point of sale, by written documentation that repeats the warnings that I have referred to and provides explanations as to the installation and functions of any safety device that the covering possesses.

4.8. Correspondence from Mr J Betts who is the Senior Standards Officer, Product Safety, Office of Consumer and Business Affairs in South Australia[8], informs that Tasmania, the ACT and Western Australia have blind cord regulations in place. From the material tendered to me, I understand that Queensland also has regulations in operation. The Tasmanian attitude to this problem appears to have been enlivened by a 2002 coronial finding and recommendation in that jurisdiction. A Tasmanian coroner on that occasion referred to the New South Wales legislation as offering a useful precedent in terms of the legislative enforcement of safety standards relating to the supply of window coverings with cords and recommended that mandatory safety standards be implemented in Tasmania. I intend to do the same in respect of this State.

[7] Exhibit C9
[8] Exhibit C11

4.9. The Queensland Government has promulgated a relevant document that was tendered at the Inquest[9]. The document is directed to the attention of suppliers of corded internal window coverings and purports to be a guide providing general information about safety requirements. It points out that from 3 February 2006 all corded internal window coverings supplied in Queensland must comply with certain safety standards. The regulations in force in that State are not dissimilar to those in New South Wales. The document depicts the required warning labels and tags. The generic warning tag appears as follows:



4.10. Consumer Affairs Victoria has promulgated a document that was tendered to the Inquest and which deals with curtain and blind cords[10]. This document appears to be dated January 2004. It purports to be a Product Safety Factsheet and describes the risk involved in curtain and blind cords in respect of child strangulation. It particularly identifies looped cords. It provides the usual advice about the juxtaposition of cots and other furniture in relation to windows. It also sets out useful advice in respect of the modification of existing cords in order to make them safer.

4.11. Mr Betts' letter advises that at present, product safety regulators across Australia are undergoing a process of harmonising all applicable legislation, which will include safety standards and bans. He informs that this process has been agreed to by all State, Territory and Commonwealth Ministers, and is expected to be in place by mid

[9] Exhibit C10
[10] Exhibit C12f

2009. His office is responsible for the administration of Trade Standards in South Australia, including safety and information standards.

4.12. The other aspect of prevention, quite apart from regulating the supply of curtains and blinds at the point of sale, concerns the already existing window coverings in premises. An examination of the material that was tendered to me reveals that there are a number of devices and strategies that can be put in place to modify already existing and fixed dangerous curtain and blind cords so as to minimise or eliminate their inherent dangers. They include the cutting of the loops so that there are single strands left. In addition, devices referred to as tie-downs or tension devices can be secured so that the cord is constantly pulled tight. These devices are useful where cords or chains require a continuous loop to remain operative and for that reason cannot be cut. There is also reference to the usual cleats that can be utilised to secure a cord. There are a number of difficulties involved in the modification of existing curtain and blind cords in premises. Firstly, while looped cords present the most obvious hazard, Professor Byard suggested that even loose, non-looped cords could be dangerous if wrapped around an infant's neck. Secondly, the establishment of safety devices within a home would probably have to remain optional, as the regulations to which I have referred apply at the point of sale or supply. This of course is where public education comes into the picture. There is a need for the public to be made aware of the availability of these potentially life saving measures and devices.

4.13. Indeed, Professor Byard referred to the need for '*a multi-pronged attack*' that involves both the education of the public and the regulation of products to be sold or supplied to the public. Professor Byard placed particular emphasis on the desirability of providing proper information and warnings to families when purchasing products that have intrinsic dangers such as curtains and blinds. He told me in plain terms that people need to know that these devices are dangerous. He adds that the relative infrequency of deaths is really beside the point when it is considered that any death of this nature is preventable and should be prevented. I agree with that assessment of the situation.

4.14. Professor Byard also pointed out, and I agree with him on this as well, that the message not only has to go out to parents but also to the general community, having

regard to the fact that infants are very frequently invigilated over by other family members such as grandparents, and by baby-sitters.

5. Recommendations

5.1. Pursuant to section 25(2) of the Coroner's Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

5.2. I recommend the following:

1) That the public warning that was recommended in the Alford Inquest immediately be repeated with the addition that it be directed to the attention of the general community, not just parents.

2) That the Minister for Health and the Minister for Consumer Affairs conduct public awareness and public education campaigns concerning the dangers to infants presented by curtain and blind cords. The campaigns should have the following features:

   (a) that they be directed to the attention of the general community;

   (b) that they not only be promulgated in pamphlets and brochures relating to the same, but also be promulgated in the print and electronic media;

   (c) that they be maintained on an ongoing basis.

3) That public education should include reference to, but not be limited to:

   (a) the inherent risks and dangers to infants that are associated with and presented by curtain and blind cords, especially looped curtain and blind cords;

   (b) the measures and strategies to be adopted in order to eliminate those risks;

   (c) the rapidity with which an infant can be rendered unconscious by an application of pressure to an infant's neck, and the rapidity at which a permanent cerebral injury or death may be caused in those circumstances; and that this feature of the education campaign should be highlighted.

4) That the Minister for Health and the Minister for Consumer Affairs cause the necessary legislation or subordinate legislation to be enacted that would (a) prescribe mandatory safety standards in respect of the supply and sale of corded internal window coverings and (b) mandate the fixation to those products of warnings concerning the hazards presented by those products.

5) That the Office of Consumer and Business Affairs expedite their consideration of the implementation of regulatory measures that (a) prescribe mandatory safety standards in respect of the supply and sale of corded internal window coverings and (b) mandate the fixation to those products of warnings concerning the hazards presented by those products with a view to the rapid implementation of such regulatory measures in South Australia.

Key Words: Infant Death; Public Warning; Curtain Cord; Hanging

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 15th day of December, 2008.

Deputy State Coroner

Inquest Number 39/2008 (0303/2007)