
**SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT ALLOA**

**DETERMINATION**

**by**

**Sheriff David N Mackie**

**Inquiry into the circumstances of the death of**

**Muireann Caitlin McLaughlin**

## SUMMARY

**29 May 2009**

Muireann Caitlin McLaughlin was just 2 ½ years old when she died on Tuesday 5th February 2008. She was at home with her two elder siblings Eoife, aged 6 at the time and Cian who was aged 4. Their mother, Katherine McLaughlin, a teacher, was attending a hospital appointment and the children's grandmother, Beryl Searle, was baby sitting. Their father, Angus McLaughlin arrived home from his work as a Radiographer Manager unexpectedly early just after 4.20 p.m. and relieved Beryl Searle who went home.

As his mother-in-law was leaving and having bade her farewell, Mr McLaughlin made his way upstairs intending to change out of his work clothes. On the stairs he had a brief exchange with his eldest daughter Eoife. He had some recollection of Cian brushing past him on the stairs on his way up. He ascended the stairs and at the top made for the master bedroom at the far end of the landing. Cian called to his father from his bedroom, "Why isn't Muireann talking to me?" Mr McLaughlin was unable to see Muireann from where he was, his view obscured by a wardrobe but he made his way immediately into the room. He was met with the sight of his daughter hanging by the neck from the looped blind cord at the right hand side of the window in Clan's bedroom and facing into the room. Her feet were a few centimetres off the floor and she was absolutely still. It is almost certain that she was already dead.

He carefully released and lowered her. Trained in CPR Mr McLaughlin commenced chest compressions and intermittent breaths. He would sustain this for some 45 minutes until the paramedics took over. Mrs McLaughlin arrived home from the hospital. She opened the door to find her two other children there and Eoife screaming, "Muireann's dead". She rushed upstairs to find her husband administering CPR to their lifeless daughter. She immediately dialled '999'. She remained on the line with the Operator relaying information about Muireann. The ambulance arrived a highly creditable 8 minutes later. The paramedics did not want Mr McLaughlin to stop his attempts at resuscitation by CPR. On arrival at the Accident and Emergency

Department of Stirling Royal Infirmary at approximately 1715 hours Muireann was in cardiac arrest. Chest compressions were continued with oxygen ventilation. There was no response to prolonged attempts at resuscitation and Muireann was pronounced life extinct at 1745 hours.

It seems that Muireann climbed to a height sufficient to allow her head to be placed through the blind cord, that she slipped or fell sustaining an impact against the window ledge on the right side of her lower jaw so severe that she was either rendered unconscious or was badly dazed and thereby incapacitated. She became suspended by the loop of the blind cord around her neck and rapidly succumbed to the consequence of compression of her windpipe and possibly compression of the blood vessels and nerves in the neck. It was the pathologist's chilling evidence that death in such circumstances can occur in a matter of 15 to 20 seconds or a little longer.

There is a simple but deadly risk of strangulation associated with looped blind cords especially for children aged 4 and under. Since 1990 the incidence of deaths of children mainly under 4 years of age by strangulation associated with blind cords has been one per year.

At the date of the accident leading to Muireann's untimely death the strangulation risk associated with free hanging looped blind cords was well known and well understood in the USA, Canada and Australia. Knowledge and awareness of the danger could be traced to at least the early 1990's and before. The hazard was equally known and understood in the UK by those engaged in ensuring product safety, such as the DTI / Department for Business Enterprise and Regulatory Reform (BERR), a significant portion of those whose commercial business it was to manufacture, supply and install window blinds namely those who were members of the BBSA, the relevant trade association, and by those in the voluntary sector having a concern regarding product safety or the prevention of accidents such as RoSPA and CAPT.

The paradox of the situation in the UK is that the strangulation hazard from looped blind cords and the means of minimising that hazard have been known of for nearly 20 years. The shortcomings of the only official safety standard in relation to these products were clear as soon as they were published in 2004. Public awareness is recognised as an important means of minimising the danger to children and yet far from receiving publication of the danger with publicity campaigns, as in the US and Canada, this country has seen no such campaigns and, as a result of bureaucratic delays at the European level, publication of the revised safety standard has been slow.

Those engaged in the manufacture, supply and fitting of window blinds fall into two categories; those who are members of the BBSA and those who are not. The Alloa Blind Company which manufactured, supplied and fitted the blind associated with Muireann's accident, was not a member. There is a large number of small businesses comparable to the Alloa Blind Company throughout the UK which operate independently and without regulation. In 20 years the Alloa Blind Company had never been visited by Trading Standards or had any other contact with that office.

The means of avoiding or minimising the risk associated with free hanging looped blind cords were known and understood. They are, in the main, simple and cheap.

There were certain reasonable precautions whereby the death and any accident resulting in the death might have been avoided.

The accident might have been avoided if the cord were placed out of Muireann's reach by the use of a cleat or for it to have been shorter than it was so that the bottom end of the loop was placed out of Muireann's easy reach.

A cord tidy or cord tensioning device would have retained the cord against the wall adjacent to the window, prevented the cord from hanging free and thereby reduced the hazard.

In the hitherto unregulated world of internal window blinds the precautions outlined above would have been unlikely to have been utilised without an adequate awareness in both the supplier and the householders, Muireann's parents. This might have been achieved by publicity campaigns being mounted by any or all of the DTI / BERR, BBSA, RoSPA or CAPT. Repeated campaigns would have been required to maintain awareness in the public consciousness. On an objective view this knowledge and understanding was available before the date of Muireann's accident and the precaution of such campaigns might have heightened the awareness necessary to promote use of safety measures. It appears that the inertia since the publication in 2006 of the proposed revisals to the European safety standard exemplified by the failure of member states to respond at all to the BERR initiative for change has placed a brake on other non regulatory measures such as publicity campaigns.

The proposed revisals to the European Standard (EN 13120:2004) go a long way to redressing the balance but will remain ineffective unless accompanied by purposeful publicity, adherence by all concerned with the window blind industry whether members of the BBSA or not and supervision by BERR through Trading Standards Officers.

Public safety and especially the safety of young children most at risk from this strangulation hazard will be best served by a system of direct regulation rather than a dependency upon the indirect regulation of a safety standard alone.

**The following recommendations are made:**

- that consideration be given to the promulgation of regulations to govern the design, manufacture, supply and installation of window blinds so as to minimise if not eliminate the strangulation hazard presented by free hanging looped blind cords. It would be fitting for the UK and Europe to lead advances in product safety relating to internal blinds rather than to continue to lag behind developments in the USA, Canada and Australia.

- that in the formulation of appropriate regulations consideration be given to banning the use of looped blind cords at all but not so as to create other, different hazards or to render blinds effectively inoperative

- where the operational viability of window coverings necessitates the use of looped cords that safety measures should contain the following elements, *viz.*:

    - Safety warnings on the outer packaging of blinds and blind components;

- Safety warnings permanently attached to cords along with conspicuous warnings for the purchaser / supplier / fitter;

- The use of minimum cord lengths commensurate with operational viability;

- The use of safety devices such as plastic connectors designed to give way, separating the two ends of the blind cord forming the loop, in the event of a sudden load such as that of a small child becoming suspended;

- The use of a cord tidy or tension device to hold the bottom of the loop fixed to the adjacent wall or frame and eliminating the free hanging characteristic of looped blind cords;

These are the safety precautions which are already known, recommended and applied to varying degrees in the USA, Canada, Australia, Europe and the UK. They are incorporated in the proposed revision of the European Safety Standard EN 13120:2004.

These precautions will be to no avail, however, if manufacturers, suppliers, fitters and most of all the general public are unaware of the strangulation hazard posed by free hanging looped blind cords. Many homes have blind cords already fitted and in place for many years. Homes where there were no young children and no obvious danger can become the homes of such children. Homes occupied by senior adults not at risk from blind cords can become the playground for visiting grandchildren. The replacement of many thousands of existing blinds and blind cords will take decades. The need for public awareness is, therefore, paramount.

The strongest recommendation is that BERR, BSI, BBSA, RoSPA and CAPT give consideration to promoting a co-ordinated, repeated publicity campaign in order to raise public awareness of this hazard. It strikes mercifully rarely but it does so randomly and indiscriminately with potentially lethal consequences. While actual deaths have been at the rate of one per year since 1990, recorded near deaths have numbered at least 20 times that number. It is reasonable to suppose that other near deaths go unreported where they do not result in the need for medical attention.

If even some of the foregoing recommendations are followed, if public awareness is raised not least by the publicity which will be attendant upon publication of this Determination and the loss of a young life can be avoided in this and future years then the family of little Muireann will have the slight consolation that her untimely and tragic passing will not have been entirely in vain.

**Abbreviations used**

**BBSA** - British Blind & Shutter Association

**RoSPA** - The Royal Society for the Prevention of Accidents

**CAPT** – Child Accident Prevention Trust

**BERR** – Department for Business Enterprise and Regulatory Reform

**BSI** - British Standards