Derek Winter
Senior Coroner for the City of Sunderland

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Rt Hon Dr Vince Cable MP** **Secretary of State for Business, Innovation and Skills** **1 Victoria Street** **London SW1H 0ET**
1	**CORONER** I am Derek Winter, Senior Coroner for the City of Sunderland
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 1st May 2014 I commenced an investigation into the death of Sophie Allen, aged 2 years. The investigation concluded at the end of the inquest on 4th June 2014. The conclusion of the inquest was an Accident the cause of death having been confirmed as: - 1a Diffuse Profound Hypoxic Ischaemic Injury
4	**CIRCUMSTANCES OF THE DEATH** On 21st April 2014 Sophie was found by her mother at their home address with a blind cord wrapped around her neck. After transfer from Sunderland Royal Hospital to the Royal Victoria Infirmary Newcastle, Sophie was pronounced dead at 03:39 hrs on 26th April 2014.
5	**CORONER'S CONCERNS** Sophie's death was yet another example of the dangers that blind cords pose to the lives of young children. I understand that since 1999 there have been 28 such deaths in the UK due to looped cords (15 of them since 2010). I am aware that following reports from Coroners and other representations the new EN13120 released in February 2014 strengthened the child safety elements of the standard and that your Department continues to actively support safety campaigns which would include the distribution of leaflets and the provision of cleats and cord shorteners. Sadly and despite these efforts public awareness and the need to act promptly to eliminate the risks associated with blind cords not only needs to continue but perhaps should be extended to cover a greater element of the population including parents, grandparents and carers. Although the new standard applies to new installations there will be millions of blind cords already fitted in homes occupied (or visited by children) that pose a very real risk of death as in Sophie's case. It may be that Sophie's family may also write to you.

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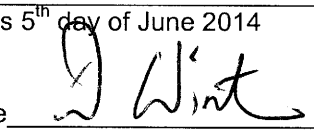
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 4th August 2014. I, the coroner, may 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 the Family. 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 form. 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	Dated this 5th day of June 2014 Signature  Senior Coroner for the City of Sunderland