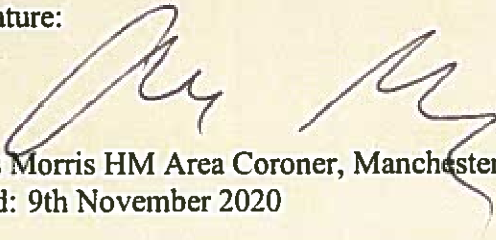
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Rt. Hon. Robert Jenrick MP, Secretary of State for Housing, Communities and Local Government.
1	CORONER I am Chris Morris, Area Coroner for Greater Manchester South.
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 2020, Alison Mutch OBE, Senior Coroner for Manchester (South), opened an inquest into the death of Joey Jenson Walker who died at the Royal Manchester Children's Hospital on 23rd April 2020. The investigation concluded at the end of the inquest, which I heard on 29th October 2020. The court heard evidence that Master Walker died as a consequence of: - **1) a) Hypoxic brain injury;** **b) Out of hospital cardiac arrest;** **c) Accidental strangulation.** The inquest concluded that Master Walker died as a consequence of an **accident.**

4	CIRCUMSTANCES OF THE DEATH On 5th April 2020, Master Walker was found unresponsive in an upstairs bedroom of the private rented house he shared with his mother, having become entangled by the neck in a roller-blind cord. Master Walker was freed and resuscitation efforts commenced before he was taken to the local hospital by ambulance. From there he was transferred to the Paediatric Intensive Care Unit at Royal Manchester Children's Hospital where he tragically died 18 days later. A police investigation concluded there were no suspicious circumstances surrounding Master Walker's death. The investigation established the blind cord (which had probably been installed by a previous tenant) was not a functioning safety cord which would break if undue pressure was put on it.
5	CORONER'S CONCERNS The MATTER OF CONCERN is as follows. – It is a matter of concern that residential landlords are not currently subject to any obligation to inspect window coverings such as roller blinds installed at private rental properties, or to otherwise ensure that only safety cords are used on blinds in use in properties let out to residential tenants.
6	ACTION SHOULD BE TAKEN In my opinion, action should be taken to prevent future deaths and I believe you and your organisation 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 January 2021. 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 Master Walker's mother and father. I have also sent a copy of my report to Tameside Metropolitan Borough Council and the British Blind and Shutter

	Association, who may find it useful or of interest. 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	Signature:  Chris Morris HM Area Coroner, Manchester South. Dated: 9th November 2020