



DISCUSSION PAPER
UK PUBLIC HEALTH
BLIND CORD/CHAIN SAFETY
WORKING GROUP

August 2014

CONTENTS

UK Chief Medical Officers' Foreword	P 3
Recommendations Summary	P 5
Introduction and Membership	P 6
Extent of the Problem	P 8
Current and Recent Interventions	P 14
Summary	P 19
Recommendations	P 21

Appendices

Appendix A - Terms of Reference

Appendix B – Best Practice Examples

Appendix C – Information for Trade Associations and Professional
Membership Bodies

Appendix D – *Make It Safe* brochure

Appendix E – *Make It Safe* Poster

Appendix F – *Make It Safe* Campaign Timeline

Appendix G - Trading Standards Poster

Appendix H – *Make It Safe* Surveyor and Installer Guide

Appendix I – Window Blind Safety – BBSA and ATSCO Advice

Appendix J – *Make It Safe* Pop-Up Banners

Appendix K – Awareness Raising Examples

Appendix L – Joint Estates and Facilities Alert

THE UK CHIEF MEDICAL OFFICERS'

FOREWORD

In 2013 we, the UK Chief Medical Officers, agreed that work should be done to look at ways in which blind cord injuries and deaths could be reduced.

In the UK, between 1999 and 2013 there were 28 such deaths with 15 of those since 2010. Unfortunately data about this type of accident is limited so we are unaware of how many 'near misses' there may have been.

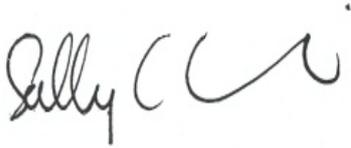
Children under 5, particularly those aged 16-36 months are at most risk from blind cord and chain strangulation, although this can affect older vulnerable children as well. It is estimated that it can take as little as 18 seconds for a toddler to lose their life after becoming entangled in a window blind cord or chain.

This is a particularly distressing type of death for all concerned and one which is preventable through awareness and simple interventions such as securing cords and chains with safety equipment and siting furniture away from windows so that children cannot climb on it.

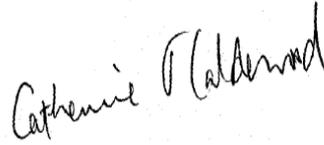
We are impressed by the breadth of work already ongoing to raise awareness of the dangers of blind cords and chains but there is no room for complacency when it comes to our children's safety and we can always do more.

Despite the introduction of new European standards in February 2014 which make it a requirement that new blinds must be safe by design or be supplied with appropriate child safety devices installed, there are still 100-200 million existing blinds across the UK that may not comply with the new European standards. Regrettably, the potential for more deaths and injuries remains and it is important that we get the message out to all those who care for young children.

We would like to acknowledge and thank all those who contributed to this discussion paper and pay tribute to those who continue to raise awareness of the dangers of blind cords and chains whether it be inside or outside the home environment.



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Recommendations Summary

- i. The UK CMOs should write jointly to the Office of National Statistics asking it to consider how to improve the death certification process and coding so that all strangulations associated with blind cords and chains are recorded appropriately.
- ii. The UK CMOs should invite the British Paediatric Surveillance Unit (BPSU) to consider a survey looking at strangulation and near miss strangulation with a view to identifying possible improvements in coding and recording of these deaths and incidents.
- iii. The eight organisations involved in this review should establish a network of contacts for information-sharing and to facilitate links into the various groups currently involved in promoting blind cord/chain safety.
- iv. The UK CMOs should write jointly to the Department of Business, Innovation and Skills asking what monitoring arrangements are in place to ensure compliance with the new standards and to establish whether the new safety systems are working as the standards intended.
- v. Each CMO should write to their health and social care commissioners asking them to include health promotion around blind cord/chain injury/death specifically and home safety in general in their commissioning arrangements with health visiting services.
- vi. CMOs should write a joint letter to the professional bodies asking that home injury prevention is included in competencies for relevant health professionals' training
- vii. Organisations that provide free cleats should be encouraged to advise parents who do not find plastic cleats aesthetically acceptable that alternative designs are available and are encouraged to purchase these for themselves.

Introduction and Membership

1. In September 2013, the four UK Chief Medical Officers (CMOs) agreed that Dr Michael McBride, CMO in Northern Ireland, would lead a group of their respective public health agencies and the Royal Society for the Prevention of Accidents (RoSPA) to look at ways in which to reduce blind cord/chain injuries and deaths. This commitment was reflected in a recommendation in Dame Sally Davies' CMO Annual Report 2012 as follows:

Recommendation 24: The four UK Chief Medical Officers have agreed that the Chief Medical Officer in Northern Ireland, Dr Michael McBride, will lead a group with the four public health agencies and The Royal Society for the Prevention of Accidents (RoSPA) to develop strategies to combat blind cord deaths.

2. The group agreed to present a report and recommendations to the UK CMO group by the end of June 2014. Terms of Reference are included at Annex A.

UK Organisations represented on the group

3. The organisations identified for representation on the group were:
 - Department of Health, Social Services and Public Safety (DHSSPS), Northern Ireland
 - Public Health Agency, Northern Ireland
 - Health and Social Care, Scottish Government
 - Public Health Wales
 - Public Health England
 - Royal Society for the Prevention of Accidents (RoSPA)
 - British Blind and Shutter Association (BBSA)
 - Children In Wales (CIW)

Other Stakeholders

4. The group conducted an exercise to identify other relevant stakeholders. Members of the group were content that views had been represented from European, national, regional and local levels and included the views of

consumers and the public. Further information on partnership working is included on P 14.

5. The Department of Business, Innovation and Skills (BIS) were also invited to nominate a representative to the group. They declined the invitation but were supportive of the work of this group and provided input as required. BIS continues to fund RoSPA and to support RoSPA and the BBSA in their work on the *Make it Safe* campaign.

6. Consumer product safety relating to products and the implementation of EU technical standards and requirements relating to products are not devolved matters. Primary responsibility for enforcement lies with the UK Government and the UK Parliament. In most cases concerning consumer products, BIS takes the lead in preparing any legislation for the whole of the UK, consulting and involving the devolved administrations as appropriate. Generally, the responsibility for enforcing such legislation in relation to consumer products is discharged by local authority trading standards officers in Great Britain and by district council environmental health officers in Northern Ireland

Extent of the Problem

7. The group noted that there was no common definition around blind cord/chain deaths with some coroners recording deaths as strangulation and others as suffocation. Members were of the opinion that there should be an agreed definition for use in the UK and that this would assist with gathering data in the future. The group agreed that a blind cord/chain death should be defined as:
“a fatal accidental strangulation due to entanglement with looped blind cords/chains”.
8. The group noted with concern the findings of the Royal College of Paediatrics and Child Health report *Why Children die; Deaths in infants, children and young people in the UK* (http://www.ncb.org.uk/media/1130496/rcpch_ncb_may_2014_-_why_children_die_part_a.pdf), in which Wolfe et al note that, although infant and child deaths in the UK have declined substantially and continue to fall, the overall UK childhood mortality rate is higher than in some other European countries. They noted also that injuries are the most frequent cause of death in children after their first year of life, with unintentional injuries being the most common. The report observes that many of the causes and determinants of childhood deaths are preventable.
9. The report compares the number of childhood deaths in the UK with those in Sweden which has the lowest number of childhood deaths in Europe. Comparing the number of deaths per 100,000 population, the report demonstrates that, If the UK had the same all-cause mortality rate as Sweden for children under 14 years, we could have nearly 2,000 fewer deaths among children in that age group per year - five fewer children's deaths per day.
10. The report suggests that there are three levels through which we can work together to improve the health and lives of children and young people, and reduce their chances of death:
 - Government and the role of civil society.

- Health systems and organisations.
- Healthcare and public health services.

11. The group felt it essential to implement an appropriate surveillance system in order to establish trends and variations in the number of near misses and deaths due to strangulation by blind cords/chains. Without this it would be impossible to understand which interventions are most effective. The surveillance systems should capture both deaths and near misses and should aim to identify a significant amount of information relating to the accident e.g. how the injury occurred, what the person was doing at the time, where they were, which products were involved etc. One model that was discussed was that of the way healthcare “never events” are treated. They are defined as “serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers”.

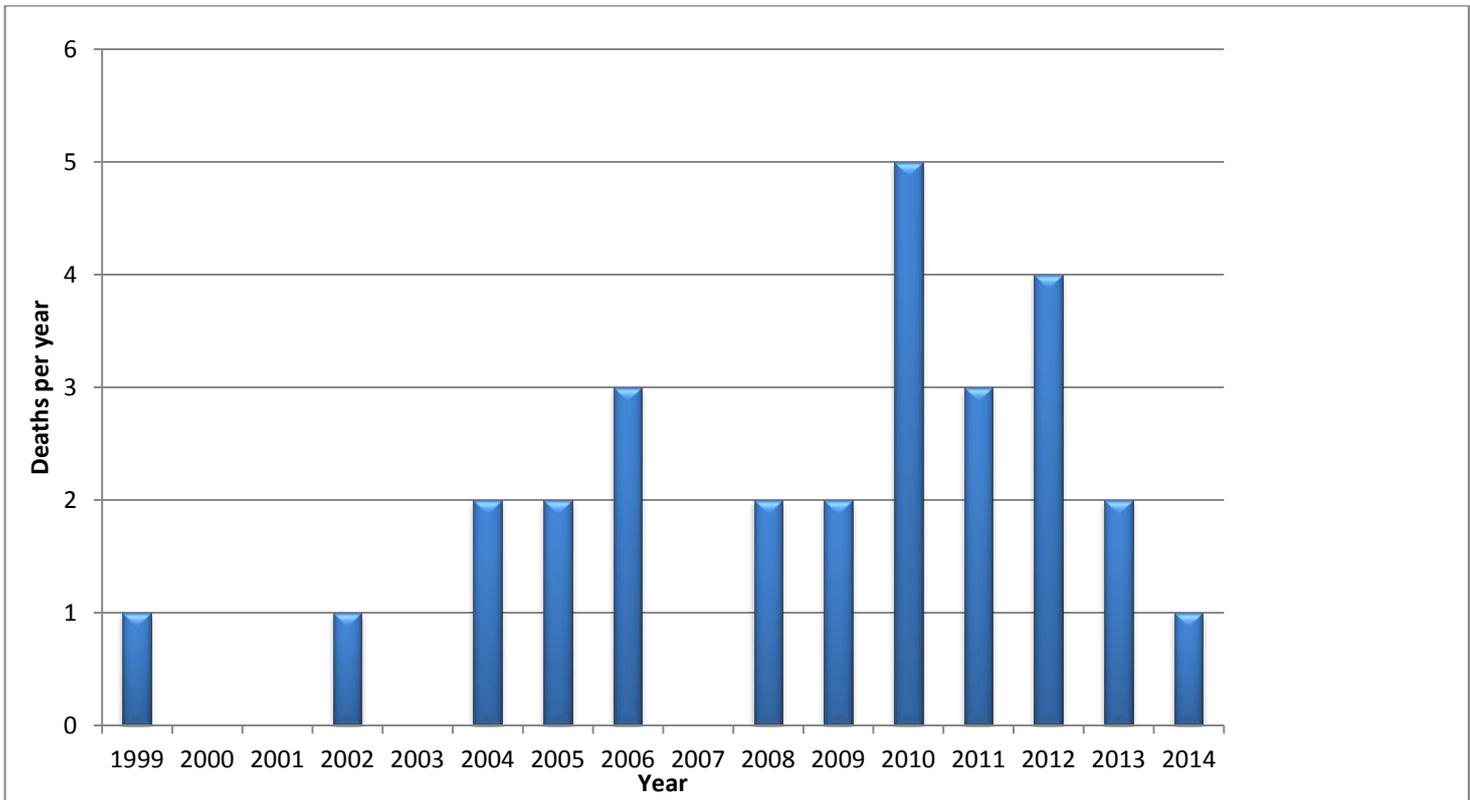
12. The group agreed that greater emphasis should be placed on a whole population approach to blind cord/chain safety. In all other unintentional injury types, those living in areas of deprivation are at greatest risk from fatal and serious injuries however, blind cord/chain injuries do not show this inequity. To date, the majority of awareness-raising and provision of equipment has been targeted at areas of deprivation across the UK and this must be rectified. The recommendations at the end of this report attempt to take a whole population approach.

Existing Data

13. RoSPA works with coroners, local safeguarding boards, child death overview panels, health and wellbeing boards, Directors of Public Health and other key professionals to collate and review available data on deaths due to accidental strangulation by blind cords/chains, but often have to rely on media reports for information. They also attempt to establish common incident causation factors and to conduct comparative studies with other available data sources to attempt to establish a robust data set.

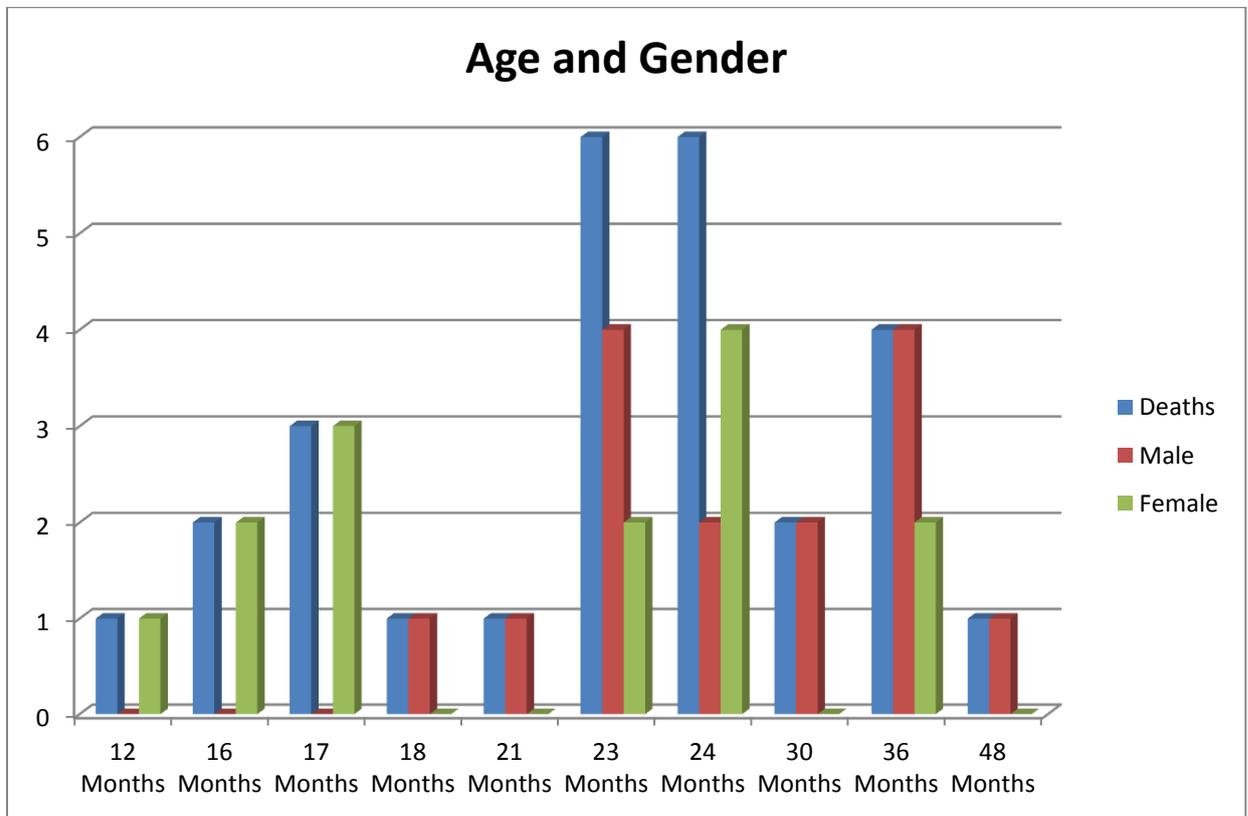
14. RoSPA has recorded a total of 28 deaths in the UK since 1999 with 15 of these occurring since 2010. Deaths were in children aged 16-36 months with the majority (more than half) in children aged 23-24 months. Deaths most commonly occurred in the child's bedroom. The graphs below represent the number of deaths per annum and the age/gender profiles.
15. However, the group acknowledged that there are major gaps in available data as there is currently no mechanism in place to record the relevant information in hospitals. The recorded deaths have therefore been identified by RoSPA through media reports, self reporting and through contact with coroners. There may be more than the 28 deaths that are known about.
16. Near misses are not recorded. RoSPA has confirmed that they are aware of a total of 18 near misses, however they have also noted that in the last five years Hospital Data Episode records in England show that there have been a total of 121 admissions due to accidental hanging and strangulation. It is possible that some of these could have been due to blind cord/chain strangulation.

Figure 1 28 Blind cord/chain deaths recorded by RoSPA since 1999



Source: RoSPA

Figure 2: Age and Gender Profile of Blind Cord/Chain Deaths



Source: RoSPA

17. This data indicates a substantial increase in deaths over the last few years which may be due to an increase in popularity of window blinds – the more window blinds there are, the bigger the risk. While the BBSA do not collect statistics they have accessed published reports¹ on the window covering/home furnishing markets which would suggest a rapid growth in sales of blinds in 2001-2006. For example, in 2007 Mintel noted that “The UK blind market is enjoying a period of significant, sustained growth with retail sales increasing by 62% in the period 2001-2006. The total market is now worth £445m at RSP and has grown at the expense of curtains”

18. Furthermore, the recession in the last few years has driven more sales towards lower cost window treatments which tend to be stock window blinds as opposed to curtains. In 2014 Mintel stated that “Consumers have more choice than ever of low-cost options from a wide range of retailers from discounters to value chains and supermarkets. As a result average spending has been under pressure and more people are placing value and price high on their list of factors to take into account when choosing curtains and blinds.”

19. It is estimated that there are currently 100-200 million window blinds installed across the UK.

Digital Pen Data in Northern Ireland

20. In Northern Ireland some information about blind cords has been collected during routine home safety visits. In the absence of significant data, this information gives an idea of the extent of the problem in a typical home.

21. Between 1 April 2012 and 31 March 2014, at least 5,416 homes with children under 5 were visited and the following data recorded:

- 76% of homes did not keep blind cords/chains out of reach in the living room (3,558/4,657)

¹ Window Furnishings and Accessories – UK, 2007, Mintel
Home Furnishings - Key Note Ltd 2014
Homewares Report January 2014 – Mintel

- 68% did not keep blind cords/chains out of reach in the bedroom (2,860/4,213)
- 64% did not keep blind cords/chains out of reach in other areas (7,2975/4,678)

22. There was little change in the percentage of homes in which blind cords/chains were recognised as a hazard between the years 2012/13 and 2013/14.

23. There have been attempts to gather additional data in Northern Ireland through inclusion of a series of questions about blind cords/chains and awareness of their dangers in the 2014/15 Health Survey. The Health Survey will be issued to approximately 4,000 people and results are expected in autumn 2015.

Current and Recent Interventions

24. An important element of this current exercise has been to attempt to map out the range and extent of work already going on in relation to blind cord/chain safety. The paragraphs below describe the type of work that has been undertaken.
25. There has been much evidence of interventions and good practice already taking place and details of some examples of best practice and pilot programmes are detailed in Appendix B.

Partnership Working

26. Effective partnership working is essential to address the spread of interests and responsibilities and should form an important part of any area's unintentional injury prevention strategy and work plans. It can help to achieve cost-effectiveness and avoid duplication of effort, making sure that all available resources are used in the best possible way
27. The organisations involved in the study have already established links with each other but much work also takes place at national, regional and local level for example with Local Authorities/District Councils.
28. Other organisations that play a major role in blind cord/chain safety include Trading Standards, the British Retail Consortium, the European Committee for Standardisation, the Child Accident Prevention Trust (CAPT), the European Child Safety Alliance, manufacturers, front-line suppliers, users and industry representatives. These organisations, along with RoSPA, BBSA and BIS hold regular stakeholder review meetings. These meetings are used to help ensure safer products are on the market with stronger standards regulating them.
29. RoSPA attempt to forge and maintain good working relationships with families of blind cord/chain victims. These families can then get involved with media

campaigns and highlight the proactive work being done rather than only having reactive media attention post-accident.

30. In Europe, BBSA represents the UK industry at the European Solar Shading Organisation (ES-SO) which is a European federation of national associations like the BBSA. 23 of the EU's member states have not had a child fatality and the BBSA tends to be seen as the leading authority on the revised standards and raising awareness.

New Standards

31. In February 2014 a new European standard was introduced² which addresses child safety, suitability and functionality and which applies to all those involved in the manufacture, supply and installation of internal window blinds operated by cords or chains. The revised standard amends a previous European standard published in 2009. The amendment considerably extends the standard scope so that it covers not only venetian blinds, roller blinds, vertical blinds and pleated blinds, but also honeycomb blinds, Roman shades, Austrian/Festoon blinds, panel blinds, plantation shutters and roll-up blinds.

32. The new standard requires that new blinds must be 'safe by design' or be supplied with the appropriate child safety devices installed. This means that where there is a loop that is present, or could be created, a safety device must be installed at the point of manufacture. These safety devices either break under pressure or tension of the cord/chain or provide the facility to store cords/chains out of reach. Professional installers must fit these devices. Supply-only blinds must include these devices along with appropriate warnings and instructions to the consumer.

33. The standard also imposes a maximum cord/chain length. All blinds must also continue to carry safety warnings. The main standard is supported by two additional standards: EN 16433:2014 and EN 16434:2014 which relate to testing requirements.

² <https://www.cen.eu/news/brief-news/Pages/News-2014-005.aspx>

34. Manufacturers and retailers that do not comply can be prosecuted under the General Product Safety Regulations 2005 as well as the Health & Safety at Work Act if they install the products.

35. The introduction of the new standards was an opportunity for widespread awareness-raising by partner organisations. There was extensive coverage of the standards and blind cord/chain dangers across all local and national media.

Awareness-Raising

36. Significant work to raise awareness of the dangers of blind cords/chains has been and continues to take place across all four jurisdictions. Awareness-raising work has been led primarily by RoSPA and BBSA and includes widespread distribution of *Make It Safe* literature, (see Appendices C-J) press releases, TV and radio programmes and interviews and use of social networking.

37. Parents, grandparents and carers have been particularly targeted through literature and information provided by health visitors and other professionals involved in the care of infants.

38. Examples of the wide range of awareness-raising activities that are currently ongoing are included at Appendix K.

Provision of Equipment

39. Across all four countries, safety equipment has been and continues to be provided free of charge to those who need it through home safety checks and safety equipment schemes aimed particularly at those who live in areas of deprivation. During the life of the *Make It Safe* campaign, RoSPA has distributed more than 500,000 cleats and leaflets through local delivery providers, families and campaign supporters.

40. It should be noted, however, that some concerns were expressed about the type of cleats that would be aesthetically acceptable to parents. In Wales, a

survey carried out by Children In Wales established that, out of 152 parents asked, 81% would not use clear plastic cleats, even if provided free of charge, because of aesthetics. Instead, a preference for brass cleats was stated.

The group agreed that identification of cleat preference and acceptability was vital to effective interventions.

Training

41. RoSPA is the main provider of blind cord/chain safety training in England, Scotland and Northern Ireland. Over the last five years they have trained over 5,000 local delivery providers with a remit for working directly with families. RoSPA in Northern Ireland is working with the Public Health Agency and Home Accident Prevention Northern Ireland. To date ten free training sessions looking at how to reduce the risks posed by blind cords/chains have been delivered. The workshops had an overall attendance of 204 people from a range of backgrounds, including parents, health visitors and retailers.

42. In Wales, the main training providers are Children In Wales who have provided training to over 1,700 members of the children's workforce. The training includes blind cord/chain safety.

43. The Department for Children, Schools and Families (DCSF) (now the Department for Education) committed in the Children's Plan to launch a new £18m National Home Safety Equipment Scheme (to be known as *Safe At Home*) to reduce accidental deaths and injuries among under-fives. Schemes were established in 130 of the 141 local authority areas originally targeted. 4,331 local staff received training, increasing local capacity to promote home safety and leaving a legacy beyond the end of the scheme. Over 1,500 children's centres participated in *Safe At Home*. *Safe At Home* came to an end on 31 March 2011; the final number of families that received equipment was 66,127. This included the supply and fitting of at least two cord winders primarily in children's bedrooms where existing blinds were in place. Education was a critical part of the national scheme, again providing part of the legacy in ensuring that families understood how to keep their children safe beyond the use of equipment which can never be regarded as a substitute for

supervision and safety awareness. Over 300,000 families received safety education either on a one-to-one basis or through group activities provided by schemes. This included raising awareness of safety in relation to blinds with looped cords/chains.

44. A joint estates and facilities alert (Appendix L) was issued on 8 July 2010 raising awareness of the dangers of window blinds with looped cords or chains. The document advised that risk assessments should be carried out on looped blind cords/chains, primarily in healthcare environments where children and vulnerable adults are commonly present.

45. In Glasgow, the Unintentional Injuries Steering Group has prepared an online training module on child injury prevention for all new and existing staff and this includes reference to ways to prevent blind cord/chain injuries. Staff in Glasgow consult with the targeted groups as well as the service providers (i.e. Health Visitors) for both the development and the issue of any programmes.

Summary

46. In carrying out this exercise, the organisations involved were pleased to note the range of work already going on that is serving to raise awareness of the dangers of blind cords/chains while making blinds safer. It was also encouraging to note that many groups already work in partnership with each other and that a range of valuable networks have already been established.
47. The main gap identified was that of appropriate data, in relation to both deaths and near misses. It was recognised that without appropriate data it is difficult to define the scale of the problem or the effectiveness of any interventions but it was also acknowledged that efforts to obtain data would have to be proportionate in order to make best use of limited resources.
48. It was recognised that, although legislation now stipulates that new blinds must be made safe by design or will be installed with safety devices, there are millions of existing blinds installed across the UK that do not meet these stringent requirements.
49. In order to reach those who have unsafe blinds fitted, there is a continuing need to raise public awareness of the potential for accidents and how to prevent them. The focus of this awareness-raising should remain on targeting parents, grandparents and carers.
50. However, the group felt that this type of death should be regarded as a 'never event' and that considerable steps should be taken to prevent deaths occurring in the future.
51. At the outset of this review, members of the group were unaware of the extent of valuable work already being undertaken to try to reduce blind cord/chain injuries and deaths. Meeting to discuss the issue revealed the range of initiatives already being undertaken and this paper has attempted to capture that range.

52. The group acknowledged that each country will continue with their own programme of awareness-raising, training and provision of safety equipment as well as continuing to work collaboratively on a UK basis.
53. The group agreed to share good practice ideas and programmes between the four nations, particularly where these have been evaluated and shown to have made a difference.

Recommendations

54. The following recommendations, which reflect a whole population approach, are for the UK to collaborate on and deliver jointly:

- (i) The UK CMOs should write jointly to the Office of National Statistics asking it to consider how to improve the death certification process and coding so that all strangulations associated with blind cords and chains are recorded appropriately.
- (ii) The UK CMOs should invite the British Paediatric Surveillance Unit (BPSU) to consider a survey looking at strangulation and near miss strangulation with a view to identifying possible improvements in coding and recording of these deaths and incidents.
- (iii) The eight organisations involved in this review should establish a network of contacts for information-sharing and to facilitate links into the various groups currently involved in promoting blind cord/chain safety.
- (iv) The UK CMOs should write jointly to the Department of Business, Innovation and Skills asking what monitoring arrangements are in place to ensure compliance with the new standards and to establish whether the new safety systems are working as the standards intended.
- (v) Each CMO should write to their health and social care commissioners asking them to include health promotion around blind cord/chain injury/death specifically and home safety in general in their commissioning arrangements with health visiting services.
- (vi) CMOs should write a joint letter to the professional bodies asking that home injury prevention is included in competencies for relevant health professionals' training
- (vii) Organisations that provide free cleats should be encouraged to advise parents who do not find plastic cleats aesthetically acceptable that alternative designs are available and are encouraged to purchase these for themselves.

DHSSPS Population Health Directorate

August 2014

Appendix A

TERMS OF REFERENCE

UK PUBLIC HEALTH BLIND CORD/CHAIN SAFETY WORKING GROUP

Membership

The work of the group was commissioned by the four UK Chief Medical Officers and included in a recommendation in Dame Sally Davies' annual report 2012 that "*The four UK Chief Medical Officers have agreed that the Chief Medical Officer in Northern Ireland, Dr Michael McBride, will lead a group with the four public health agencies and The Royal Society for the Prevention of Accidents (RoSPA) to develop strategies to combat blind cord deaths*".

The group will report its findings and recommendations to the UK Chief Medical Officer Group.

The following organisations are represented on the group:

Department of Health, Social Services and Public Safety Northern Ireland

Public Health Agency, Northern Ireland

Health and Social Care, Scottish Government

Public Health Wales

Public Health England

Royal Society for the Prevention of Accidents (RoSPA)

British Blind and Shutter Association (BBSA)

Children in Wales (CIW)

Input will also be obtained from the Department of Business, Innovation and Skills (BIS).

Overall aim:

To work together to consider collaborative actions aimed at preventing deaths and injuries associated with accidents involving blind cords/chains.

Tasks:

The work will comprise the following tasks:

1. Identify relevant stakeholders.
2. Identify statistical evidence and analysis available to assess the extent of the problem.
3. Identify current work taking place.
4. Consider additional strategies required to reduce blind cord/chain accidents and deaths.

Timescale:

To be completed by end of June 2014.

Departmental lead:

The work will be led by the Chief Medical Officer in Northern Ireland with input and support from the other bodies named above. Secretariat duties will be provided by Health Protection Branch, DHSSPS.

Appendix B – Best Practice Examples and Pilot Studies

Registrar NI

In 2013, Dame Sally Davies included a best practice case study of awareness-raising in her annual report. The case study is included at Chapter 2, P7 of the *Annual Report of the Chief Medical Officer 2012, Our Children Deserve Better: Prevention Pays*:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/252675/33571_2901304_CMO_Chapter_2.pdf

The project raises awareness of blind cord risks among parents, grandparents and carers when they present at Council Registration Departments to register a child's birth. During the registration process there is a short wait while birth certificates are being printed. Registrars use these few moments to raise awareness of home safety and draw parent's attention to the *Make It Safe* leaflet. In one year over 3,000 families were provided with this information.

RoSPA is in the process of contacting Registrars in England to encourage them to raise awareness on blind cord safety when parents register a birth issuing a BBSA blind cord safety leaflet and cleats if required

Health Visitors NI

In Northern Ireland a pilot scheme will commence in September 2014 in partnership between the PHA, RoSPA and the Northern Trust. From September Health Visitors will distribute cleats as part of their routine 6-9 month health check. They will have been trained by RoSPA on how to advise on fitting the cleats and will record at their next visit how many of the cleats have been used. Results from this pilot are expected to be available next year.

Unintentional Injuries Steering Group Scotland

NHS Greater Glasgow and Clyde Health Board has an Unintentional Injuries Steering Group as part of child and maternal health and operates to a formal strategy and implementation plan. Local data is secured and acted upon accordingly and a good relationship exists between the Child and Maternal Health team at the Board (who facilitate the meetings) and the local Health Visitors (who are represented at the meetings). This allows for discussion of the key issues and the

best way to tackle the challenges identified and also facilitates across-the-Board-area adoption and support of agreed campaigns. The Group provides an Aide Memoire for use in the Universal Pathway – as part of the National Practice Model - for Health Visitors and includes reference to the dangers of blind cords/chains. This Group has also prepared an online training module on child injury prevention for all new staff and existing staff and this includes reference to ways to prevent blind cord/chain injuries. Staff in Glasgow consult with the targeted groups as well as the service providers (i.e. Health Visitors) for both the development and the issue of any programmes.

Scottish Government Awareness-Raising

The Scottish Government's Community Safety Policy Unit and Child and Maternal Health colleagues jointly funded a specific prevention campaign to reduce blind cord/chain strangulation in young children. The campaign was launched during Child Safety Week 2010 and saw the distribution of 10,000 leaflets across Scotland. A further 2,000 cleats were distributed, initially in North Lanarkshire. Following evaluation, further funding was made available and the campaign has now been rolled out to a total of 10 Local Authorities. To continue the prevention programme RoSPA has also offered the service to all the remaining Local Authorities across Scotland for a small charge.

SHSES

Scotland's Home Safety Equipment Scheme (SHSES) is a pilot project, due to end in June 2014, administered by RoSPA in Scotland and funded by the Scottish Government to provide low income families (target of 800) in 13 local authority areas with appropriate home safety advice and fitted safety equipment. Each family is entitled to up to three blind cord/chain cleats and the blind cord/chain safety leaflet is included in the family resource pack that each family receives. Of the 791 families that have participated in SHSES so far, 334 have been fitted with up to three blind cord/chain cleats with a total of 753 individual cleats having been fitted – this represents the number of windows that are now safer.

Awareness Sessions for Practitioners in Wales, developed by CIW

CIW has developed online awareness sessions for practitioners in Wales. Although this is still being trialed, feedback has been excellent. It has been used by health visitors and in childcare settings during team meetings:

One of the important aspects of the pilot is to ascertain if practitioners will download and deliver it without prior knowledge or support. So far, this has been the case. Practitioners who attended one team meeting have also gone on to download the session and deliver it to other colleagues in other meetings. Two health visitors have also delivered the session to parents as part of their parenting programme. Although not originally designed to be delivered to parents (as it is not sufficiently participative for this), this is encouraging and CIW hopes to explore this further and develop it in line with their *Parent's Pledge* (example of this below).



Parents Pledge
session plan (pilot) srr

Appendix C – Information for Trade Associations and Professional Membership Bodies



Window Blind Safety -
Trade Assoc Info.pdf

Appendix D – *Make It Safe* brochure



BBSA MIS Brochure -
WEB.pdf

Appendix E – *Make It Safe* Poster



2014 MIS Poster
A2.pdf

Appendix F – *Make It Safe* Campaign Timeline



HS1513 - Blind Cords
Poster-2.pdf

Appendix G - Trading Standards Poster



Draft report of UK
blind cord safety group

Appendix H – *Make It Safe* Surveyor and Installer Guide



Surveyor and Installer
guide WEB.pdf

Appendix I – Window Blind Safety – BBSA and ATSCO Advice



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Appendix J – Make It Safe Pop-Up Banners



Make it Safe Pop-Up
Banners.pdf

Appendix K – Awareness Raising

Make It Safe

- BBSA has committed to investing more funds on the *Make It Safe* campaign in 2014 than on any other project in its 95-year history.
- The new *Make It Safe* brochure was produced and has been updated to coincide with the introduction of the new standards. BBSA provide this brochure at cost and, to date, have distributed around 1.6 million leaflets (many through RoSPA).
- The *Make It Safe* video is being re-made in September.
- A *Make It Safe* poster and vehicle and shop window decals are also available. (see Appendix D)
- The *Make It Safe* leaflet has been disseminated to every local authority in Wales and to the main children's organisation (statutory and NGOs).
- *Make It Safe* has been translated into Welsh and is available online.
- RoSPA in England and Scotland plan to re-launch the *Make It Safe* campaign and to roll it out to new areas while still supporting those who have covered the issue already.
- The Child Accident Prevention Trust (CAPT) include blind cord safety on their website and in their printed resources and newsletters.
- RoSPA are disseminating information to registry offices across the England to be given to all parents when registering the birth of their baby. Printed leaflets to be sent to each registry office with a request that one of each is given to the parents of each newly registered baby.

Media

- RoSPA has spearheaded an awareness-raising campaign since 2011 with more than 150 radio and TV broadcasts.
- RoSPA has a dedicated campaign page on its website – www.rospace.com/about/currentcampaigns/blindcords/ - which gives information and advice about the issue, along with the facility to apply for a pack or simply download an electronic copy of the *Make It Safe* leaflet.
- RoSPA has promoted the issue on breakfast television programmes, such as BBC1's "Breakfast" and ITV's "Daybreak", on several occasions and this

year have been involved in the consumer awareness television programmes, “Watch Dog Test House” and “How Safe Is Your Home”. The Make it Safe Campaign has also been featured on BBC1’s The One Show.

- PHA gave an interview on BBC lunchtime news in March which was added to the BBC Facebook page. PHA also gave radio interviews on BBC Talk Back and City Beat
- There has been widespread information promoted across social networking sites including Twitter, Facebook and LinkedIn.
- RoSPA’s press team maintains a wide network of relevant contacts across both broadcast and print media.

Parent/Professional Information

- Children in Wales (CiW) run an accident prevention network for over 500 professionals, policy makers and practitioners. Blind cord/chain risks are included in the bulletins on a regular basis.
- Every health visitor in Wales has also received a copy of the Keep In Mind (KIM) home safety leaflet which includes blind cord/chain safety.
- Information on blind cord safety is included in the Public Health Wales publication *Bump, Baby & Beyond* which is distributed to all new parents. The book is also available as an e-book.
- In Northern Ireland all health visitor contact with families incorporates awareness-raising around accident prevention, including blind cord/chain safety.
- A pilot programme has been established in Northern Ireland whereby Council Registrars raise awareness on blind cord/chain safety when parents register a birth. The Registrar issues a BBSA blind cord/chain safety leaflet and cleats if required (See reference to case study below).
- The PHA in Northern Ireland have placed articles on blind cord/chain safety in various publications including *Birth to Five*, *Parenting NI*, District Council magazines as well as on the PHA website. PHA also plans to have the *Make It Safe* leaflet translated into appropriate languages for Northern Ireland.

- Information on blind cord/chain safety is included in the Health Scotland publication *Ready Steady Baby* which is distributed to all new parents. The *Good Egg Guide to Home Safety* is distributed by Health Visitors at the ten-day visit to new mums and it too contains information on blind cord/chain safety.
- Regular reminders are placed in RoSPA Scotland's weekly newsletter and disseminated to practitioners.
- In Northern Ireland a 10-year strategy for home accident prevention, which includes particular reference to blind cord/chain safety, will be launched for consultation in the coming weeks. It is expected that the strategy will be published before the end of the year

Trade Initiatives

The following are some of the activities already carried out or planned for 2014.

- Advice for trade associations and professional membership bodies has been updated and distributed to over 30 such organisations. (see Appendix B).
- A one day conference and exhibition for the blind trade was held on 24 April, 2014 at the Ricoh Arena in Coventry, with over 700 delegates from the trade, along with representatives from Trading Standards, the British Retail Consortium, RoSPA and BIS.
- A surveyor and installer pocket guide has been produced and over 15,000 copies have been distributed since June.
- Guidance for Trading Standards prepared and has been agreed and is available to Trading Standards via the Association of Chief Trading Standards (ATSCO) website.
- The BBSA has established a Coordinated Partnership under Primary Authority with Surrey Trading Standards to develop further assured advice for the industry
- Life-size pop-up banners to explain the requirements of the cord and chain lengths of the three main blind types (roller, vertical and venetian) have been produced.
- RoSPA has engaged with large chain retailers, all of whom were enthusiastic about improving the safety of corded/chained blinds, sharing safety

information with consumers, and reducing the risks posed to children. This resulted in a commitment from several retailers, including John Lewis, to support the awareness campaign, ensure that all their retail outlets were complying with the standards, and reinforce the messages through their own staff.

- RoSPA are supporting Trading Standards in a national awareness-raising campaign (see Appendix H).

Appendix L – Joint Estates and Facilities Alert



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