IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 0658

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: PIO

Delivered On:	22 February 2013
Delivered At:	Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	22 January 2013
Findings of:	JOHN OLLE, CORONER
Police Coronial Support Unit	Sergeant Sharon Wade, assisting the Coroner

I, JOHN OLLE, Coroner having investigated the death of PIO

AND having held an inquest in relation to this death on 22 January 2013
at MELBOURNE
find that the identity of the deceased was PIO
born on 17 September 2009
and the death occurred on 18 February 2011
at 345 Edward Road, Chirnside Park 3116
from:

1 (a) HEAD AND NECK INJURIES AND MOTOR VEHICLE INCIDENT (PEDESTRIAN)

in the following circumstances:

1. Pio was aged 17 months at the time of his death. He lived with his parents and siblings on a 110 acre property in Chirnside Park.

2. Pio's family occupied one of three residences, which shared a common driveway. Pio's family had owned the property for many years and operated a market garden.

3. The driveway passed directly alongside Pio's house leading to farming sheds, parking areas, paddocks and a residence where tenants, Tamara and Evan lived.

Circumstances

4. On the 18 February 2011, Pio's family dined outside at a barbeque. The children were playing on the trampoline and play equipment at the southern end of the front yard. Pio's mother was observing the children from the table at the north end of the front yard. Pio's father was operating a machine in the paddock out of view of the house. The sandbox was located on the other side of the driveway from the play equipment.

5. At approximately 8.00pm, Tamara and Evan left their house driving a four-wheel drive at a slow pace down the driveway. They noted the children playing and Pio's mother sitting at the table. They noted Pio's brother crossing the driveway ahead of them from left to right. When they were approximately parallel to the play equipment, Tamara stopped the car as Pio's brother was then standing at the driver side of the car. Following a brief conversation, the

vehicle moved forward. A bump was immediately felt at the rear of the vehicle, and Pio's body was observed through the side mirror, lying on the driveway behind the car.

6. Emergency Services were contacted and police and ambulance officers attended the scene but, tragically, Pio was unable to be resuscitated.

7. The driver was subsequently found to have consumed cannabis, however, I am satisfied on the basis of expert evidence of Dr Morris Odell, the ingestion of cannabis was not causative of the tragic event.

Purpose

8. From the outset, I stressed that the purpose of my investigation was not to apportion blame. I note the love and devastating loss suffered by the parents of the three infants subject of my investigations. My purpose is to explore where lessons can be learnt, which might prevent similar deaths in the future. This is one of the central functions of a modern coronial system. It is hoped that the parents and families of the infants whose deaths were examined can take in a small amount of comfort from the process knowing that the outcome might save other families from the pain of losing an infant.

Catalyst for Change

9. Pio's death was one of three investigations into infant driveway deaths. These tragic events have been a catalyst for change, and have provided the impetus for the formation of a cross agency committee to examine ways in which the incidents of these type of deaths can be reduced in Victoria. In August 2012, a public awareness campaign was developed and launched. In September 2012, the Commonwealth Government identified driveway safety as a priority road safety issue, and expressed a willingness to work with all States and territories towards a shared approach to driveway safety.

Coroners Prevention Unit (CPU)[1]

10. At my request, the CPU has assisted my investigation. Between January 2000 and September 2012, CPU identified fourteen children who suffered fatal injuries when struck by a vehicle in

[1] The Coroners Prevention Unit is a specialist service for coroners created to strengthen their prevention role and provide them with professional assistance on issues pertaining to public heath and safety.

a driveway. Seven children died since October 2010. In the same period, the Royal Children's Hospital Trauma Service identified seventy three non-fatal injury admissions of children involved in vehicle driveway incidents. On average, seven per year.

11. The Commonwealth Department of Infrastructure and Transport recently published a review of child pedestrian deaths in the vicinity of their home. The statistics are alarming. For the ten-year period, 2001 to 2010, sixty-six children died. A further our hundred and eighty-three children were seriously injured. On average, fifty children per year.

Driveway Safety Campaign

12. The outcome of the Victorian Driveway Safety Committee was the driveway safety campaign which was launched by the Minister for Community Services, the Honourable Mary Wooldridge at the Royal Children's Hospital in July 2010. The campaign seeks to raise awareness of parents and caregivers of small children regarding driveway safety, particularly regarding supervision and exercising caution at all times in driveways. The campaign features a radio advertisement, posters promoting driveway safety:

    "Just because you can't see me doesn't mean I'm not here"

13. Further, the campaign will be incorporated into the existing VicRoads safety strategy focussing on early childhood settings. In a media release following our investigations, Child Safety Commissioner, Bernie Geary stressed, in particular for parents or carers of children under six years of age:

    "Always make sure you know where your children are before you reverse out of a driveway."

Conclusion

14. More than 90% of all incidents occurred in a driveway of a child's home. The remainder occurred in the driveway of a relative or friend. The vehicles were driven by a parent, a family member or a friend. Most of the children were under the age of six. Incidents most often occurred between 4 and 6.00pm and 8 and 10.00am. Most of the vehicles involved were four-wheel drives, vans and utes. 85% of drivers were unaware a child was near their vehicle.

Finding

I acknowledge the immense anguish that Pio's death would have caused to those who knew and loved him, particularly his parents and siblings and other family members.

I find that Pio died on the 18 February 2011 at 345 Edward Road, Chirnside Park from head and neck injuries and motor vehicle incident (pedestrian).

I direct that a copy of this finding be provided to the following:
Pio's family
Child Safety Commission Victoria
Interested Parties

Signature:

JOHN OLLE
CORONER
Date: 22 February 2013