IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 2172

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: WILLIAM

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 WILLIAM

AND having held an inquest in relation to this death on 22 January 2013
at 56 Prossors Lane, Red Hill 3937
find that the identity of the deceased was WILLIAM
born on 12 February 2010
and the death occurred on 14 June 2011
at Royal Children's Hospital, 50 Flemington Road, Parkville 3052

from:

1 (a) BLUNT HEAD TRAUMA (MOTOR VEHICLE IMPACT)

in the following circumstances:

1. William lived in Red Hill with his parents and siblings. William was aged 16 months at the time of his death.

Circumstances

2. On the 14 June 2011, William's father left the family home through the main door with the intention of driving to a friend's home. William's mother was washing up and the children were playing in the adjacent playroom which was visible from the kitchen.

3. William's father adopted the drive position of his four-wheel drive. Without his knowledge, William followed him outside. Having checked his mirrors, he reversed the vehicle. Feeling a bump at the front left wheel, he looked forward to see William lying on the ground. He immediately stopped the vehicle and alerted his wife to call '000' and began CPR. Ambulance paramedics attended the scene approximately six minutes later. William was airlifted to Royal Children's Hospital and tragically succumbed to his injuries later that evening.

Catalyst for Change

4. William'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]

5. 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 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.

6. 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

7. 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"

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[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.

8. 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

9. 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 William's death has caused those who knew and loved him. In particular, William's parents and siblings, and extended family members.

I find that William died on the 15 February 2011 at the Royal Children's Hospital from blunt head trauma (motor vehicle impact).

I direct that a copy of this finding be provided to the following:
William's family
Child Safety Commissioner
Interested Parties
Signature:

JOHN OLLE
CORONER
Date: 22 February 2013