IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2625/08

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
*Section 67 of the **Coroners Act 2008***

I, AUDREY JAMIESON, Coroner having investigated the death of WILLIAM TOREY

without holding an inquest:

find that the identity of the deceased was WILLIAM TOREY

born on 9 October 2003

and the death occurred on 19 June 2008

at Royal Children's Hospital, Grattan Street, Parkville, Victoria 3052

from:
1a. COMPLICATIONS OF INJURIES SUSTAINED IN MOTOR VEHICLE COLLISION (PEDESTRIAN)

Pursuant to Section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances:**

1. William Torey was aged 4 years and 9 months at the time of his death. He was the third child of Eric Torey and Maree Batchelor and he had three siblings, Georgina aged 8 years, Sam aged 6 years and Sophia aged 2 years. The family resided at Old Mornington Road, Mount Eliza.

2. On the afternoon of Sunday 8 June 2008, William had been to the beach at Mount Eliza with a large family group, including his grandparents, uncles and aunts, cousins and mother. The family group were returning to the grandparent's house at approximately 4.20pm, exiting the beach by the access steps which led up into the beach carpark at the western end of Williams Road. At the same time Timothy Bracher permitted his son, Andrew Roland Timothy Bracher aged 15 years of age to drive his motor vehicle in the carpark. The car was parked in the north eastern area of the carpark in a parking bay, parked next to a white Subaru Forester. Andrew reversed out of the carpark, before placing the vehicle into drive to move forward. As the vehicle moved forward, Timothy Bracher had to assist Andrew with the steering so it would not collide with the Subaru. After moving past the Subaru, Timothy Bracher instructed Andrew to stop but Andrew applied pressure to the accelerator rather than the brake and the vehicle rapidly accelerated forward. William was struck by the vehicle and pinned

against a pole. He was subsequently freed and treated by Emergency Services personnel and airlifted to the Royal Children's Hospital, where despite their efforts, he died on 19 June 2008.

Investigation

3. William's parents lodged an Objection to Autopsy under section 29 *Coroners Act* 1985 (as it then was). Dr Matthew Lynch, Forensic Pathologist with the Victorian Institute of Forensic Medicine, performed an external examination of the body of William and reported to the Coroner that a reasonable cause of death in the circumstances could be attributed to complications of injuries sustained in a motor vehicle collision (pedestrian). The objection was upheld.

4. Timothy Bracher was originally charged with "Permit Unlicensed Driver" and Andrew with "Unlicensed Driving and Failed to Stop".

5. On 6 August 2009, Andrew pleaded guilty at the Children's Court at Frankston and was disqualified for driving for 4 years and fined $1,000. On the same day at Frankston Magistrate's Court, Timothy Bracher appeared before Magistrate Crisp, who decided to refer the matter to the OPP for consideration. As a result, Timothy Bracher was also charged with "Reckless Conduct Endangering Life and Reckless Conduct Endangering Serious Injury". On 27 April 2010, Timothy Bracher pleaded guilty to "Reckless Conduct Endangering Serious Injury" and on 28 April 2010, he was sentenced to a Community Based Order with conviction to perform 200 hours of community work over 12 months.

COMMENTS:

Pursuant to Section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

1. The death of William is the result of a tragic failure of judgement on behalf of Timothy Bracher, who allowed his unlicensed minor child, Andrew, to operate a motor vehicle in a high risk environment, being a carpark. It is of concern that deaths of this nature do not appear to receive the same level of attention as those which occur "on-road" and are the feature of road safety strategy. Although fatal incidents in carparks are rare, it has been well established that they present an unsafe environment with an unacceptable risk to pedestrians sharing the area with motor vehicles. Education programs are the means by which pre and learner drivers are alerted to the dangers encountered in the process of learning to drive. Learning to drive in appropriate locations such as carparks is recognised as posing one such danger.

2. The Coroners Prevention Unit (CPU)[1], were requested to provide factual information to the Coroner in relation to issues identified about pedestrian safety in carparks. The research identified that the Victorian Parliamentary Roads Safety Committee, constituted under the Parliamentary Committee's Act 2003 had the function to enquire into, consider and report to the Parliament on any proposal, or matter or thing concerned with -

(a) Road trauma and

(b) Safety on roads and related matters.

In May 2010, the Committee issued a report from their inquiry on pedestrian safety in carparks, wherein they identified a range of risks to pedestrians and identified a range of treatments which can be applied to carpark environments to increase their safety factors. Of note it was identified that a carpark should not be considered an environment for training inexperienced learner drivers. The Committee also identified that WorkSafe Victoria as the most appropriate agency to undertake ultimate responsibility for overseeing carpark pedestrian safety in collaboration with VicRoads, Victoria Police, the Department of Planning and Community Development and the Transport Accident Commission. It has not yet been identified whether there has been any further advancement in relation to the Committee's findings.

3. The Victorian Parliamentary Committee also reviewed the incidents of carpark related injuries and deaths between the years 2003 to 2008. During this period 526 injuries were reported, an average of 88 per year, however due to the under reporting and limitations of the data it is likely to be a significant under estimation. Similarly, 7 deaths in the period between July 2000 and November 2009, were reported from the National Coroners Information System (NCIS) for Victoria. The majority of injuries and deaths occurred in pedestrians aged between 40 and 49 years. The Committee report identified that elderly and young children as being particularly at risk of more serious injury and death in carpark environments, due to their inherent frailty, size (in the case of children) and limited or unpredictable mobility.

FURTHER COMMENTS

4. I acknowledge that VicRoads together with a number of other agencies had collaborated to provide traffic safety information for children from pre-school to secondary school to give them skills and knowledge which will enable them to become safer road users.

RECOMMENDATIONS:

Pursuant to Section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

1. In light of the tragic circumstances of William's death and the common practice of using carparks for driving lessons to the young I make the following recommendation:

[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.

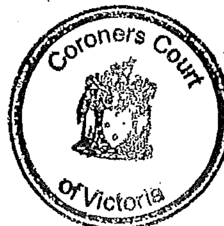
- That VicRoads and other road safety agencies, as part of their process of providing learning programs for young people, ensure that information regarding the risks of operating vehicles in locations such as carparks, be provided to teenagers intending to apply for their learners permit, or undergoing their learner driving period. And that likewise, the same safety messages should provided to those people undertaking a supervising driver role to any learner driver.

Finding

I accept and adopt the medical cause of death as identified by Dr Matthew Lynch and find that William Torey, a pedestrian, died from complications of injuries sustained in a motor vehicle collision in circumstances that were preventable.

I direct that a copy of this finding be provided to the following:

- Mr Eric Torey on behalf of William's family,
- The Honourable Terry Mulder, MP, Minister for Roads
- Mr Gary Liddle, Chief Executive, VicRoads
- Mr Paul Barker, Chairman of Transport Accident Commission
- The Coroners Prevention Unit



Signature:

AUDREY JAMIESON
CORONER

22 February 2012