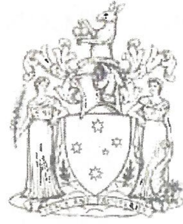


IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 0504

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**CORONER DARREN J BRACKEN**
Deceased:	**SETH JAMES HADDOW**
Date of birth:	20 JUNE 2017
Date of death:	27 JANUARY 2019
Cause of death:	HEAD INJURIES SUSTAINED IN MOTOR VEHICLE INCIDENT (PEDESTRIAN)
Place of death:	12 PETER AVENUE, TATURA, VICTORIA 3616

TABLE OF CONTENTS

Background 1

The Coronial Investigation 1-3

Matters in relation to which a finding must, if possible, be made

- Identity of the deceased, pursuant to section 67(1)(a) of the Act 3
- Cause of death, pursuant to section 67(1)(b) of the Act 3
- Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act 4-6

Findings and conclusion 7

Recommendation 7

HIS HONOUR:

BACKGROUND

1. Seth James Haddow (**Seth**) was nineteen months old when he died on 27 January 2019 from head injuries sustained when he was 'run-over' by a motor car driven by Brendan Haddow. Immediately prior to his death, Seth lived at 12 Peter Avenue, Tatura, with his parents, Jayde Gardner and Brendon Haddow, brother Patrick Haddow (6 months) and half-siblings, Miah Gardner (7) and Layton Gardner (5).

2. Seth's parents described Seth as a healthy, active little boy who enjoyed playing with toy trucks and cars and the family puppy, swimming and playing on the swing. He was a "*Daddy's boy*" who would run to the door with excitement when his father arrived home from work.

THE CORONIAL INVESTIGATION

Coroners Act 2008

3. Seth Haddow's death was a "*reportable death*" pursuant to section 4 of the *Coroners Act 2008* (Vic) (**the Act**) because his death having occurred in Victoria, was unexpected, appears to have resulted from an accident and not from natural causes.[1]

4. The Act requires a coroner to investigate reportable deaths such as Seth Haddow's and, if possible, to find:

   (a) The identity of the deceased;

   (b) The cause of death; and

   (c) The circumstances in which death occurred.[2]

5. For coronial purposes, "*circumstances in which death occurred*",[3] refers to the context and background to the death including the surrounding circumstances. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death relevant circumstances are limited to those which are sufficiently proximate to be considered relevant to the death.

---

[1] *Coroners Act 2008* (Vic) s 4.
[2] *Coroners Act 2008* (Vic) preamble and s 67.
[3] *Coroners Act 2008* (Vic) s 67(1)(c).

6. The Coroner's role is to establish facts, rather than to attribute or apportion blame for the death.[4] It is not the Coroner's role to determine criminal or civil liability,[5] nor to determine disciplinary matters.

7. One of the broader purposes of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through comments made in findings and by making recommendations.

8. Coroners are also empowered to:

   (a) Report to the Attorney-General on a death;[6]

   (b) Comment on any matter connected with the death investigated, including matters of public health or safety and the administration of justice;[7] and

   (c) Make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[8]

Standard of Proof

9. Coronial findings must be underpinned by proof of relevant facts on the balance of probabilities, giving effect to the principles explained by the Chief Justice in *Briginshaw* v *Briginshaw*.[9] The strength of evidence necessary to so prove facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[10] The principles enunciated by the Chief Justice in *Briginshaw* do not create a new standard of proof; there is no such thing as a "*Briginshaw Standard*" or "*Briginshaw Test*" and use of such terms may mislead.[11]

---

[4] *Keown v Khan* [1999] 1 VR 69.
[5] *Coroners Act 2008* (Vic) s 69 (1).
[6] *Coroners Act 2008* (Vic) s 72(1).
[7] *Coroners Act 2008* (Vic) s 67(3).
[8] *Coroners Act 2008* (Vic) s 72(2).
[9] (1938) 60 CLR 336, 362-363. See *Domaszewicz v State Coroner* (2004) 11 VR 237, *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152 [21]; *Anderson v Blashki* [1993] 2 VR 89, 95.
[10] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J but bear in mind His Honour was referring to the correct approach to the standard of proof in a civil proceeding in a federal court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[11] *Qantas Airways Ltd v Gama* (2008) 167 FCR 537, [123]-[132].

10. Facts should not be considered to have been proved on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences,[12] rather such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[13] Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved and the content of the finding based on those facts.[14]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the Deceased - Section 67(1)(a) of the Act

11. On 29 January 2019, Cheryl Haddow identified the deceased as her grandson, Seth James Haddow, born on 20 June 2017.

12. Seth Haddow's identity is not in dispute and requires no further investigation.

Cause of death - Section 67(1)(b) of the Act

13. On 28 January 2019, Dr Matthew Lynch, a Senior Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an external examination upon Seth Haddow's body. Dr Lynch provided a written report, dated 30 January 2019, in which he opined that the cause of Seth Haddow's death was '*Head injuries sustained in motor vehicle incident (pedestrian)*". I accept Dr Lynch's opinion.

14. Toxicological analysis of post-mortem samples was negative for common drugs and poisons.

15. Dr Lynch commented that the findings on examination were consistent with the history given of Seth having been accidentally run over by a reversing motor vehicle. The post-mortem CT scan revealed skull fractures with pneumocranium, subarachnoid and intraventricular haemorrhage.

---

[12] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.
[13] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.; *Cuming Smith & CO Ltd v Western Farmers Co-operative Ltd* [1979] VR 129, at p. 147; *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[14] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336, referring to *Barten v Williams* (1978) 20 ACTR 10; *Cuming Smith & Co Ltd v Western Farmers' Co-operative Ltd* [1979] VR 129; *Mahon v Air New Zealand Ltd* [1984] AC 808 and *Annetts v McCann* (1990) 170 CLR 596.

Circumstances in which the death occurred - Section 67(1)(c) of the Act

16. Brendon Haddow provided a statement to the coroner's investigator explaining that, on 27 January 2019, he went fishing and arrived home at approximately 6.00pm.

17. In a statement to the CI, Ms Gardner, who had remained home with the four children, explained that when Mr Haddow arrived home, she was sitting outside with the children on the front veranda. The children were drawing with chalk on the concrete at the front of the house and at the same time they were washing Ms Gardner's car which was parked on the lawn inside the front fence. Ms Gardner elaborated that, as the weather was sunny and hot, the children were washing the car with sponges and a bucket to get wet and cool off.

18. Mr Haddow was driving a Nissan Navara Utility coupled to a trailer towing his fishing boat. He pulled up and parked on the road outside the house. Having greeted Ms Gardner and the children, he went into the house to get some money with the intention of going to the supermarket. He also collected the keys to a Ford Falcon XR6 Utility **(the Ford)** which was parked on the nature strip outside the house.

19. Mr Haddow decided to drive the Ford to the supermarket rather than uncouple the boat trailer to make the short trip. Ms Gardner stated that, as Mr Haddow came out of the house and went towards the Ford, she told him to uncouple the boat trailer and take the Nissan Navarra. She stated that Mr Haddow ignored her and got into the Ford. In his statement, Mr Haddow said that he got into the Ford, turned it on and sat there for approximately ten seconds to count the money he had collected from the house. He explained that, as there was a tree on the nature strip directly in front of the Ford, it was necessary to reverse from the nature strip onto the road.

20. In his statement Mr Haddow said that prior to reversing the Ford he checked the rear-view mirror and side mirrors and, believing the way was clear, reversed a distance of approximately two metres before he felt the vehicle run over something he described as being "*like I went over a couple of bricks*". He stopped, got out and walked to the rear of the vehicle. Miah pointed to a red bucket under the vehicle. At that point Ms Gardner ran over to the vehicle pointing to Seth who was completely under the vehicle lying face down by the passenger side front wheel. Ms Gardner picked Seth up and carried him to the front lawn where she laid him down. She noted he was limp with obvious head injuries and commenced CPR.

21. Mr Haddow called emergency services and a neighbour assisted by relaying information to the call-taker and also in administering CPR until the arrival of paramedics a short time later. Police arrived shortly after the paramedics.

22. Paramedics' continued attempts to resuscitate Seth were unsuccessful and he was declared deceased at approximately 6.52pm.

23. Mr Haddow stated that, as he came out of the house, he noticed the children washing Ms Gardner's car being watched by Ms Gardner. In particular, he noticed that Seth had a sponge with which he was washing the concrete under the carport and the footpath which runs around the house, just in front of Ms Gardner's car not far from the front of the house.

24. Similarly, Ms Gardner explained that, at the time Mr Haddow got into the Ford she thought Seth was up the driveway next to the house. When she saw Mr Haddow suddenly stop the vehicle, get out and tun towards the back of the vehicle with both hands on his head she ran towards him and realised that Seth was under the Ford.

25. Mr Haddow said that during the course of fishing, between approximately 11.45am and 4 - 4.30pm he drank five cans of Jack Daniels. Following the accident, police escorted Mr Haddow to Goulburn Valley Health in Shepparton where a blood test performed at approximately 8.30pm detected no alcohol or common drugs.

26. Police noted that Mr Haddow had been driving for thirteen years since obtaining his licence and his driving history, consisting of seven penalty notices, did not reflect any history of careless or reckless driving.

27. In her statement, Ms Gardner estimated that, immediately prior to the accident, Seth was out of her sight for perhaps thirty seconds and that any view of him as he ran out towards Mr Haddow's Ford may have been obscured by the position of her car on the lawn.

28. The Ford was inspected by Senior Constable Glenn Fitzgerald of Shepparton Highway Patrol and found to have no obvious faults. SC Fitzgerald noted there were no items in the rear of the vehicle to obscure the view; the rear-view and side mirrors were correctly positioned; the vehicle had good acceleration and brakes; the accelerator and brake pedals had good grip and did not contribute to any slipping of the foot; the tyres had fair tread; the seating position was correctly adjusted for Mr Haddow's height and the vehicle (with an odometer reading of 231,605kms) had been serviced regularly with the next service due at 245,000kms or 17 December 2019.

29. Following an inspection of the accident scene, SC Fitzgerald opined that the following factors contributed to the accident:

(a) Seth was playing in the car port area out of sight of both parents;

(b) Ms Gardner was attending to three other children, including a six-month-old baby and did not see Seth exit the car port area;

(c) Mr Haddow had the vehicle in idle mode for approximately ten seconds whilst counting money, giving Seth time to move from the car port area to the nature strip, which he managed to do without being seen by either of his parents. Once behind the vehicle he was not visible to Mr Haddow and;

(d) The vehicle was not fitted with motion or reversing sensors (nor was it required to be given the date of manufacture).

30. The circumstances of Seth's tragic death once again highlight the less than obvious danger posed by the mixture of driveways, motorcars and young children. The Coroners Prevention Unit (**CPU**) provided me with a report on deaths in such circumstances between January 2015 and January 2019; a period during which eight other 'similar' deaths occurred, three of which occurred in rural settings.

31. Relevant information, including a fact sheet, on the Kidsafe Victoria website incorporates the following advice:

(a) A driveway is a small road. Do not allow children to play in the driveway;

(b) All cars have large blind spaces – some up to 15 metres.

(c) Always watch children when a vehicle is about to be moved. Hold their hand or hold them close to keep them safe;

(d) If you are the only one at home, have children in the car with you when it is to be moved;

(e) Restrict access to the driveway from the house and front yard by using fences and gates; and

(f) Always walk around your car and check before moving it.

32. I propose to provide these findings to the Victorian Department of Human Services and Kidsafe Victoria with a recommendation that they together undertake research into how children might be protected from the inherent dangers driveways pose to them, with a view to raising the public awareness of those dangers and promulgating suggestions to mitigate if not eradicate the dangers. This finding will also be published on the Coroners Court Website.

33. Having considered all of the available evidence, I am satisfied, and find, that Seth's death was an appallingly tragic accident and that no further investigation is required.

34. Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

FINDINGS AND CONCLUSION

35. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) The identity of the deceased was Seth James Haddow, born on 20 June 2017;

    (b) Seth Haddow's death occurred;

        i. on 27 January 2019 at 12 Peter Avenue, Tatura, Victoria;

        ii. from injuries sustained in a motor vehicle incident (pedestrian); and

        iii. in the circumstances described in paragraphs 16-33 above.

RECOMMENDATION

Pursuant to section 72(2) of the Act, I recommend that:

(1) The Victorian Department of Health and Human Services, Kidsafe Victoria, the Transport Accident Commission and the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (the Organisations) together consider the circumstances of Seth Haddow's death and undertake research to identify the factors that contributed to it and to like deaths between 2015 and 2019.

(2) That the Organisations together develop a strategy aimed at reducing, if not eradicating such deaths and increase the public awareness of the identified factors, their associated dangers and developed strategies.

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

(a) Mr Brendon Haddow and Ms Jayde Gardner, senior next of kin;

(b) Ms Melanie Courtney, CEO, Kidsafe Victoria;

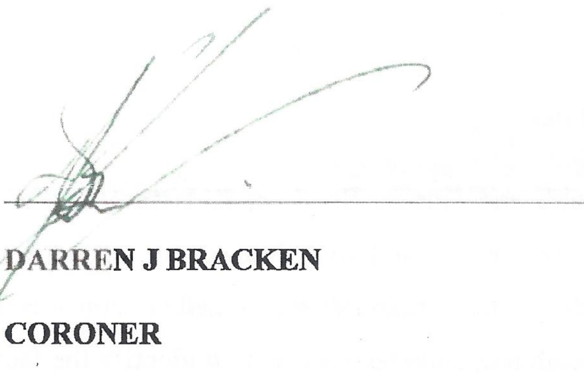
(c) Adjunct Professor Tanya Farrell, Chairperson, Consultative Council on Obstetric and Paediatric Mortality and Morbidity;

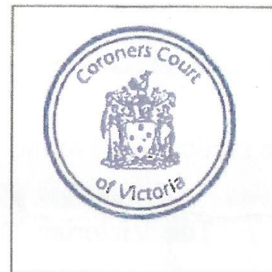
(d) Danielle Wooltorton, Director, Community Services Operation Division;

(e) Mr Joe Calafiore, CEO, the Transport Accident Commission; and

(f) Leading Senior Constable Glenn Fitzgerald, Coroner's Investigator, Victoria Police.

Signature:





DARREN J BRACKEN

CORONER

Date: 28 January 2021.