IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 005452

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the ***Coroners Act 2008***

Findings of:	AUDREY JAMIESON, CORONER
Deceased:	Joseph Thang Khat Siam Hatzaw
Date of birth:	19 October 2020
Date of death:	30 September 2023
Cause of death:	1a : INJURIES SUSTAINED IN MOTOR VEHICLE COLLISION (PEDESTRIAN)
Place of death:	3 Springfield Road Blackburn North Victoria 3130
Keywords:	Child death, low speed runover, vehicle runover

INTRODUCTION

1. On 30 September 2023, Joseph Thang Khat Siam Hatzaw (**Joseph**) was 2 years and 11 months old when he died after being struck by a car. The incident occurred at low speed, in the carpark of the New Hope Community Centre in Blackburn North.

2. At the time of his death, Joseph lived in Ringwood with his family.

THE CORONIAL INVESTIGATION

3. Joseph Thang Khat Siam's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

6. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Joseph Thang Khat Siam Hatzaw's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into the death of Joseph Thang Khat Siam Hatzaw including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary

for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

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

Circumstances in which the death occurred

8. On 30 September 2023, the Burmese festival, 'Khuado Pawi', was held at the New Hope Community Centre in Blackburn North (**the Centre**). The event was scheduled to commence at 6:30pm and had approximately 250 to 300 attendees. The Centre's carpark has a capacity of approximately 100 vehicles and is located approximately 5 metres from the Centre's entrance.

9. With his family, Joseph attended the Centre and entered the main event hall. At 6:42pm, closed circuit television (**CCTV**) footage captured Joseph and his younger brother exiting the main event room.

10. At 6:42pm, the two boys walked through the automatic sliding doors at the Centre's entrance and exited the building. CCTV footage demonstrated that within 10 seconds of the boys walking through the sliding doors, their mother, Cing Nuam (**Ms Nuam**) exited the main event room to look for her children. Ms Nuam could not see her children, returned to the main event room before exiting and searching again one minute later.

11. As the boys climbed down the stairs at the Centre's entrance, a Toyota Tarago (**the Tarago**) entered the carpark and stopped approximately six metres from the entrance. Joseph and his brother walked to the rear of the Tarago, then up its left-hand side as its passengers disembarked.

12. Joseph and his brother stopped immediately in front of the Tarago, at the front left-hand corner, and the vehicle began *'rolling slowly'* forwards. At 6:43pm, the vehicle rolled over Joseph. Timestamps on the CCTV footage indicate this occurred one minute and five seconds after Joseph exited the main event hall.

13. Witnesses to the incident came to Joseph's aid and contacted emergency services. At 6:51pm, Fire Rescue Victoria arrived at the scene and commenced cardiopulmonary resuscitation

[1] Subject to the principles enunciated in Briginshaw v Briginshaw (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

(**CPR**). At 6:53pm, Ambulance Victoria paramedics arrived and continued resuscitation efforts. Unfortunately, at 7:33pm, Joseph was declared deceased.

Identity of the deceased

14. On 2 October 2023, Joseph Thang Khat Siam Hatzaw, born 19 October 2020, was visually identified by his father, Pau Khan Thang, who completed a formal Statement of Identification.

15. Identity is not in dispute and requires no further investigation.

Medical cause of death

16. Forensic Pathologist Dr Matthew Lynch (**Dr Lynch**) of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on the body of Joseph Thang Khat Siam Hatzaw. Dr Lynch considered materials including the Victorian Police Report of Death for the Coroner (**Form 83**) and post-mortem computed tomography (**CT**) scan and provided a written report of his findings dated 4 October 2023.

17. The post-mortem CT scan revealed extensive injuries including a fractured cranial vault and bilateral pneumothoraces.

18. Dr Lynch provided an opinion that the medical cause of death was 1(a) INJURIES SUSTAINED IN MOTOR VEHICLE COLLISION (PEDESTRIAN).

THE PREVALENCE OF LOW SPEED RUNOVER INCIDENTS

19. The circumstances of Joseph's death are unfortunately not uncommon. To better understand the frequency, and to identify corresponding prevention opportunities, I sought the assistance of the Coroners Prevention Unit (**CPU**)[2] to provide me with data on fatalities of children aged 0 to 14 years who died as a result of being struck by vehicles in low speed runovers.[3]

Coroners Prevention Unit

[2] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[3] Low speed runovers that occurred in other areas such as carparks and caravan parks were included in this analysis as these spaces present the same safety risks as driveways, and therefore were considered relevant for prevention purposes.

20. The CPU identified 25 fatalities between the years of 2012 and 2023, including Joseph. The highest number of deaths occurred in children aged between 1 and 5 years, with the majority of these being children aged 1. The CPU identified a range of vehicles including sedans, utilities, SUVs and vans were involved, with larger vehicles (e.g. SUV's and large utility vehicles) being overrepresented. Unfortunately, in 2023 there was a spike in low speed runover deaths in Victoria, with 6 children tragically losing their lives, including Joseph.

21. The CPU further advised that from 1 November 2025, a new standard, entitled *'Australian Design Rule 108/00'*, will mandate at least two reversing sensors[4] on all varieties of light, medium and heavy vehicles, whether they be for domestic or commercial use.[5] While I acknowledge this to be a promising initiative, the standard will apply only to new vehicles and will not require for pre-existing vehicles to be retrofitted with such technologies. Current estimates demonstrate that the average age of registered passenger vehicles within Victoria is 10.98 years, and that this number is increasing.[6] Whilst this is slightly lower than the national average of 11.2 years, it indicates that it may be some time before all Victorian vehicles have such safety measures.

22. Given that the majority of identified fatalities of this kind occurred amongst young children, their short stature must be considered. The evidence indicates that Joseph was standing immediately in front of the Tarago's left-hand corner – it was unlikely that Joseph was visible to the driver. It remains uncertain whether the technologies required under the new standard would be able to detect a small child's presence in all positions around a vehicle, such as in this instance.

The work of Kidsafe Victoria

23. The CPU also alerted me to the work of Kidsafe Victoria, who have produced a multitude of resources on driveway safety including *'A Parent's Guide to Kidsafe Roads'* (**the Guide**). While Joseph's death did not occur in a driveway, I consider that the risks present in a carpark are substantially similar. The Guide recommends that parents or caregivers always supervise children around cars, driveways and carparks, treat the driveway like a road and create a safe

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[4] Reversing sensors are to include motion sensors, reversing cameras or a vibration alerting system.

[5] Assistant Minister for Infrastructure and Transport, "Mandating reversing vehicle aids to save lives on and around Australian roads", https://minister.infrastructure.gov.au/brown/media-release/mandating-reversing-vehicle-aids-save-lives-and-around-australian-roads#:~:text=The%20new%20standard%2C%20called%20Australian,models%20from%201%20November%202025.

[6] Bureau of Infrastructure, Transport, Regional Development, Communication of the Arts, "Road Vehicles, Australia, January 2024", https://www.bitre.gov.au/publications/2024/road-vehicles-australia-january-2024.

play area for children away from garages and driveways. It recognises that while reversing sensors and cameras can assist, they should never be relied upon on their own. Parents or caregivers should always walk around the vehicle before getting into the vehicle to check there are no children around and wave goodbye from a safe place away from the driveway.

24. Additionally, following a coronial recommendation,[7] Kidsafe Victoria is preparing to release Victoria's first ever *'Low Speed Vehicle Runover Prevention Strategy'* (**the Strategy**).[8] The Strategy provides a background into low speed incidents, identifies key risk factors, and establishes a framework for the development and implementation of vehicle safety initiatives including advocacy, awareness raising and education. The development of the strategy was supported by the Transport Accident Commission Road Safety Grant Program.

25. The Strategy, which the Court understands is to be released on 5 December 2024, emphasises key data points including the alarming statistic that there are 41 children killed or injured in Victoria annually from low speed runover incidents. The majority of these incidents occur while the driver is returning home, repositioning their vehicle, or leaving the home.

26. The Strategy adopts a three-pronged approach and identifies vehicle design, property design and human factors as *'focus areas'* to curtail low speed runover incidents. With respect to vehicle safety, Kidsafe Victoria seeks to develop a 'safe family car' category with the Australasian New Car Assessment Program (**ANCAP**) and Used Care Safety Ratings (**USCR**). This category would assist families when evaluating the safety features of a family vehicles and considers factors including Autonomous Emergency Braking (**AEB**), forward and reversing technologies and 360° visibility.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

1. The circumstances of Joseph's tragic death, bring into focus the importance of road safety and awareness particularly in young children, who often possess a curious and inquisitive nature. The risks of children and roadways is not unknown to the general public, however, their small size can often prevent drivers from knowing of their presence until it is too late.

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[7] See the recommendation made by then-Coroner Bracken contained in the Finding without Inquest into the Death of Set Haddow (COR 2019 000504) signed 28 January 2021. Accessible at: https://www.coronerscourt.vic.gov.au/sites/default/files/2021-04/SethJamesHaddow_050419.pdf.

[8] Kidsafe Victoria, '*Low Speed Runover Prevention Strategy*' accessible at: https://www.kidsafevic.com.au/wp-content/uploads/2024/12/Low-Speed-Vehicle-Runover-Prevention-Strategy-2024_FINAL-1.pdf.

2. The short period of time which elapsed between Joseph exiting the Centre's main event hall and being struck by a vehicle – approximately 65 seconds – demonstrates the need for drivers to exercise vigilance at all times when operating a vehicle.

3. The forthcoming requirement for new vehicles to be fitted with sensors and/or cameras will hopefully aid to reduce the frequency of these deaths. However, I also acknowledge the risk that drivers may become blasé and become excessively reliant on these technologies. It is therefore imperative that these standards are combined, so as to magnify their effect, with public education on the danger of low speed runovers.

4. It is encouraging that public awareness is being piqued by the joint and concerted efforts of multiple organisations including the Transport Accident Commission and Kidsafe Victoria. I sincerely hope that Kidsafe Victoria's new campaign, *'Low Speed Runover Prevention Strategy'* and their continued efforts to educate on and mitigate these incidents will contribute towards a reduction of these tragic deaths.

FINDINGS AND CONCLUSION

1. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

   a. the identity of the deceased was Joseph Thang Khat Siam Hatzaw, born 19 October 2020;

   b. the death occurred on 30 September 2023 at 3 Springfield Road Blackburn North Victoria 3130; and

   c. I accept and adopt the cause of death ascribed by Dr Matthew Lynch and find that Joseph Thang Khat Siam Hatzaw died from injuries that he sustained when struck by a motor vehicle.

2. AND I find that Joseph Thang Khat Siam Hatzaw's death occurred as the result of a tragic accident during a brief moment of suspended supervision.

I convey my sincere condolences to Joseph Thang Khat Siam's family for their loss.

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.

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

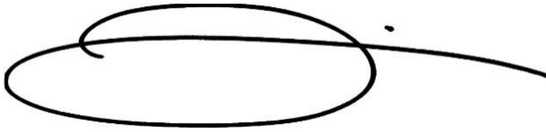
Pau Khan Thang and Cing Khan Nuam, Senior Next of Kin

Transport Accident Commission

Kidsafe Victoria

Sergeant Samuel Howie, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 4 December 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.