IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2023 005592

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Sarah Gebert, Coroner
Deceased:	Miss L[1]
Date of birth:	[redacted] 2020
Date of death:	8 October 2023
Cause of death:	1(a) Head injuries post being struck by a motor vehicle
Place of death:	[redacted], Victoria
Key words:	Child struck by vehicle, driveway, driver unaware, low speed, supervision of children around vehicles

1. *At the direction of Coroner Sarah Gebert, the name of the deceased and her family members have been replaced with pseudonyms to protect their identities. Identifying details have also been redacted.*

INTRODUCTION

1. On 8 October 2023, Miss L was three years old when she died as a result of injuries sustained in a tragic accident at her home.

2. At the time of her death, Miss L lived in [redacted] with her family.

THE CORONIAL INVESTIGATION

3. Miss L'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 Leading Senior Constable Glenn Smith to be the Coroner's Investigator for the investigation of Miss L's death. The Coroner's 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 Miss L's death, 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]

[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.

Background

8. Miss L was born in [redacted], Afghanistan, to her parents, Mr and Mrs L. She is the sister of [redacted] and [redacted]. The family migrated to Australia in late 2021.

9. Miss L was described as a healthy child with no known medical conditions.

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

Circumstances in which the death occurred

10. On the afternoon 8 October 2023, Miss L attended a party with her mother and sister, [redacted] who was eight years old at the time. They were picked up by Mr P, his wife, and his family in a Toyota Fluger Station Wagon. The vehicle was authorised to carry seven passengers including the driver.

11. At about 4.18pm, Miss L, her mother, and sister returned home to [redacted] in [redacted]. Mr P drove the family back home in his station wagon.

12. [redacted] is located in a built-up residential area. The speed limit is 50 kilometres per hour. [redacted] runs north to south from [redacted] into a bowl situated outside [redacted] before a sharp 90-degree bend where it then runs west to east from the bowl. It is a single lane bitumen road for traffic travelling in opposing directions. There are no painted road markings separating the opposing lanes of traffic.

13. The weather was fine that day and visibility was good.

14. The following incidents were captured on closed-circuit television (**CCTV**) located at [redacted].

15. Mr P pulled up and stopped his vehicle across the driveway of [redacted], which was contra flow to traffic.

16. Miss L, her mother, sister, and Mr P's daughter exited the vehicle via the passenger rear door. Without being seen, Miss L subsequently walked to the front of the vehicle and squatted down.

17. Miss L's mother, sister, and Mr P's daughter walked to the rear of the vehicle and proceeded up the driveway toward the house.

18. Shortly thereafter, Mr P began to drive away, turning his vehicle to the left. As his vehicle began moving, Miss L stood up. She was subsequently struck by the vehicle, which caused her to fall to the ground where the front driver's side wheel impacted her.

19. At this time, Miss L's mother turned to look and observed Miss L lying on the roadway. She ran to her.

20. Feeling a jolt, Mr P had stopped his vehicle. He and his wife exited the vehicle.

21. Miss L was moved from the roadway and emergency services were contacted.

22. The first responders to the scene were Victoria Police members at 4.24pm who commenced administering cardiopulmonary resuscitation (**CPR**).

23. Ambulance Victoria paramedics arrived a short time later and continued resuscitation efforts for some time. They subsequently verified Miss L's death at 5.29pm.

24. In an interview with police, Mr P explained that according to Afghani culture it is customary for unrelated females and males to avoid eye contact. For this reason, Mr P had parked his vehicle across the driveway so that he was facing forward and Mrs L could exit the vehicle and walk toward the back without making eye contact with him.

25. Leading Senior Constable Smith noted as part of his investigation that Mr P parked in the manner he did to observe his cultural beliefs. Miss L exited the vehicle and walked to the front unbeknown to Mr P or her mother. Mr P would not have seen Miss L due to her size and the height of his vehicle. When he began to drive away, he unknowingly struck Miss L causing her to fall onto the ground and into the path of one of the vehicle's wheels.

26. Neither the weather nor the road conditions contributed to the collision.

27. Miss L's death was due to a tragic accident.

Identity of the deceased

28. On 8 October 2023, Miss L, born [redacted] 2020, was visually identified by her cousin, [redacted].

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

Medical cause of death

30. Forensic Pathologist, Dr Paul Bedford, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 9 October 2023 and provided a written report of his findings dated 17 October 2023.

31. The post-mortem CT (computed tomography) scan revealed evidence of changes consistent with a basal skull fracture indicating significant injury to the head. There were minor abrasions to the limbs but no significant changes to the chest or abdomen, either externally or internally. No other skeletal injuries were identified.

32. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.

33. Dr Bedford provided an opinion that the medical cause of death was *"1(a) Head injuries post being struck by a motor vehicle".*

34. I accept Dr Bedford's opinion.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Miss L, born [redacted] 2020;

    (b) the death occurred on 8 October 2023 at [redacted], Victoria, from head injuries post being struck by a motor vehicle; and

    (c) the death occurred in the circumstances described above.

COMMENTS

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

36. As part of my investigation, I asked the Coroners Prevention Unit[2] (**CPU**) to provide an analysis of recent statistics on children who were fatally struck by reversing vehicles.

[2] The CPU was established in 2008 to strengthen the coroner's prevention role and to assist in formulating recommendations following a death. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health. The CPU may also review the medical care and treatment in cases referred by the coroner as well as assist with research into public health and safety.

37. The CPU found that since 2014, 18 children have been fatally struck by vehicles in Victorian driveways.

38. Miss L's tragic death highlights the need for constant supervision of children, especially in and around areas where there are vehicles.

39. KidSafe Victoria recommends that parents or caregivers always supervise children around cars, driveways, and carparks and to treat the driveway like a road. They advise that children's unpredictability, their inquisitive nature and the fact that they are surprisingly quick and mobile, places them at increased risk around driveways.

40. In late 2023, KidSafe received funding from the Transport Accident Commission to develop a strategy to prevent low speed run over deaths.[3] KidSafe have advised the court that work is well underway in developing this strategy.

41. I have decided that instead of making a further recommendation, a comment, acknowledging the work currently underway from KidSafe is appropriate.

I convey my sincere condolences to Miss L's family for their loss and acknowledge the profound grief caused by the passing of such a young child.

I further note that the unexpected death of a child in our community is devastating, particularly in circumstances where the death was preventable as in this case and this only adds to the sadness experienced by all those involved.

I also acknowledge the emergency services personnel who responded to the scene and the trauma they experienced that day. The service of each first responder does not go unnoticed.

Pursuant to section 73(1A) of the Act, I order that a de-identified version of 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:

3 Transport Accident Commission, "Approved Projects", <https://www.tac.vic.gov.au/about-the-tac/community/grants/road-safety-grant-program/approved-projects?drop=1>, accessed 3 May 2024.

Mr and Mrs L, senior next of kin

Kid Safe Victoria

Leading Senior Constable Glenn Smith, Victoria Police, Coroner's Investigator

Signature:

Coroner Sarah Gebert

Date: 21 October 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.