IN THE CORONERS COURT OF VICTORIA AT MELBOURNE

Court Reference: COR 2011 0598

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: PRABH - DHIYAN

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 PRABH - DHIYAN

AND having held an inquest in relation to this death on 22 January 2013 at MELBOURNE find that the identity of the deceased was PRABH - DHIYAN born on 3 July 2009 and the death occurred on 15 February 2011 at 42 Landscape Drive, Hillside 3037

from:

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

in the following circumstances:

1. Prabh – Dhiyan (known as Dhiyan) was a 16-month-old boy who lived with his mother, father and brothers in the family home. Relatives from India, including his paternal grandmother, were staying with the family at the time of Dhiyan's death.

CIRCUMSTANCES

- 2. On the morning of 15 February 2011, Dhiyan's father was preparing to drive his brother, Nishaan, to school. Dhiyan's mother was sleeping. As father and son departed the house towards the garage, Dhiyan was being held by his grandmother. Dhiyan wanted to go outside to wave to his father and brother. Dhiyan's grandmother carried him outside and placed him on the ground to enable her to assist Dhiyan's brother tie his shoelaces. They were close to the front left hand side of the car.
- 3. Whilst Dhiyan's grandmother was momentarily distracted, Dhiyan crawled into the path of the vehicle and was struck by the front passenger tyre. The vehicle stopped and Dhiyan was carried to the house. Ambulance services attended but, sadly, Dhiyan could not be revived.

Purpose

4. From the outset, I stressed that the purpose of my investigation was not to apportion blame. I note the love and devastating loss suffered by the parents of the three infants subject of my investigations. My purpose is to explore where lessons can be learnt, which might prevent similar deaths in the future. This is one of the central functions of a modern coronial system.

It is hoped that the parents and families of the infants whose deaths were examined can take in a small amount of comfort from the process knowing that the outcome might save other families from the pain of losing an infant.

Catalyst for Change

5. Dhiyan'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

- 6. 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.
- 7. 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

8. 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

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.

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"

9. 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

10. 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 that Dhiyan's death would have caused to those who knew and loved him, particularly his parents and brothers and other family members.

I find that Prabh Dhiyan died on the 15 February 2011 from blunt head trauma (motor vehicle impact – pedestrian).

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

Signature:

JOHN OLLE CORONER

Date: 22 February 2013

