IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2024 000090

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***
*Amended pursuant to section 76 of the **Coroners Act 2008** on 28 April 2026*[1]

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	Ching Ngai Li
Date of birth:	28 April 2014
Date of death:	5 January 2024
Cause of death:	1(a) Cranio-cervical dislocation sustained in a motor vehicle incident (car vs. car, passenger)
Place of death:	736-738 Maroondah Highway, Coldstream, Victoria

[1] This document is an amended version of the Finding into Death Without Inquest regarding Ching Ngai Li dated 20 April 2026. Corrections to paragraphs 21 and 26 have been made pursuant to section 76 of the *Coroners Act 2008* (Vic).

INTRODUCTION

1. On 5 January 2024, Ching Ngai Li was 9 years old when he died in a motor vehicle accident. At the time, Ching lived in Doncaster East with his parents, Wai Kin Li and Sin Lam Lee, and his younger sister.

THE CORONIAL INVESTIGATION

2. Ching'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.

3. 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.

4. 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.

5. The Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Ching'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.

6. This finding draws on the totality of the coronial investigation into Ching'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.[2]

[2] 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.

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

Identity of the deceased

7. On 10 January 2024, Ching Ngai Li, born 28 April 2014, was visually identified by his mother, Sin Lam Lee, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

9. Forensic Pathologist, Dr Hans de Boer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 8 January 2024 and provided a written report of his findings dated 1 February 2024.

10. The post-mortem examination and computed tomography (**CT**) scan revealed a swollen brain with bilateral convexity and basal subarachnoid haemorrhage, right linear skull fracture of the mastoid and occipital bone, atlanto-occipital dislocation, multiple rib fractures, bilateral small pneumothoraces and increased lung markings.

11. Routine toxicological analysis of post-mortem samples did not detect any alcohol or any commonly encountered drugs or poisons.

12. Dr de Boer provided an opinion that the medical cause of death was *"1(a) Cranio-cervical dislocation sustained in a motor vehicle incident (car vs. car, passenger)"*.

13. I accept Dr de Boer's opinion.

Circumstances in which the death occurred

14. On 5 January 2024, Wai Kin Li took his daughter and Ching to the Healesville Sanctuary. Mr Li drove his 2022 Kia Rio Hatchback (**the Kia**). They arrived at the Healesville Sanctuary at around 2.00pm and departed at around 4.00pm. While travelling home, Ching sat in the right rear seat of the Kia, and Mr Li's daughter sat in the left rear seat.

15. At around 4.14pm, The Kia travelled in a south-westerly direction on the Maroondah Highway. This section of the Maroondah Highway is a two-way carriageway, aligned in a north-east and south-west direction. Double solid white painted lines with audio tactile feature divide the opposing lanes of travel. The outer edges of both travel lanes are bordered by solid

white pained lines and abutted by a bitumen shoulder of 1.75 metres. In the vicinity of the incident, the speed limit is 80 kilometres per hour (**km/h**).

16. At the same time, Marlee McMillan-Rule travelled in a work-issued 2020 Toyota Camry Hybrid sedan (**the Toyota**) in a north-easterly direction on the Maroondah Highway. As the Toyota drove along a straight section of road, Ms McMillan-Rule observed the Kia navigating the bend in the road ahead. She observed the Kia travel diagonally across the double white lines and enter her lane. The Kia impacted the Toyota head-on.

17. At the time of the collision, the weather was warm, the road was dry and in good condition, visibility was fine as it was daylight, and traffic was light.

18. Witnesses to the collision contacted emergency services and rushed to the aid of the drivers and passengers. Emergency department nurse, Louisa Ford, was one of the passing motorists who stopped to assist. Ms Ford assessed Mr Li's children and found that Ching had a neck contusion, large epistaxis, he was positioned with his chin to his chest, his lips were dusky, and he had a pulse and was breathing. She observed Ching's condition deteriorate before paramedics arrived.

19. Ambulance Victoria paramedics, Victoria Police members, Country Fire Authority members, and the State Emergency Service arrived at the scene a short time later.

20. One of the AV paramedics declared Ching deceased at the scene.

21. Victoria Police members spoke to Mr Li at the scene who told them that he could not recall what happened and that he had possibly fallen asleep as his head was down.[3]

22. At the scene, Detective Leading Senior Constable Stephen Mottram (**DLSC Mottram**), confirmed that Ching was nine years of age and around 140 centimetres tall, and Mr Li's daughter was seven years of age. Both children were wearing seatbelts at the time of the collision, however neither child was seated in a booster seat or child restraint. DLSC Mottram noted that according to VicRoads guidance on child restraints and booster seats,[4] both children should have been seated in an appropriate booster seat.

[3] The end of this sentence was shortened to remove 'but XXX' from the end, pursuant to section 76 of the *Coroners Act 2008* (Vic).

[4] VicRoads, "Child restraints, booster seats and seatbelt readiness", October 2016, <https://www.vicroads.vic.gov.au/~/media/files/documents/safety-and-road-rules/child-restraints-october-2016.pdf>, accessed 26 March 2026.

23. Detective Sergent Robert Hay (**DS Hay**), with the Collision Reconstruction and Mechanical Investigation Unit (**CRMIU**), reviewed the collision. DS Hay found that the Toyota took evasive action by braking and steering, however, did not observe any evidence of pre-impact emergency response from the Kia to avoid the collision. DS Hay opined that at the time of impact, the Toyota was travelling between 41km/h and 45km/h, and the Kia was travelling between 65km/h and 93km/h.

24. Senior Constable Daniel Pearce (**SC Pearce**), with the CRMIU, conducted a mechanical examination of the Kia. SC Pearce found no faults, failures, or conditions, that could have caused or contributed to the collision.

25. DLSC Mottram obtained expert opinions regarding Mr Li's health and the possibility of a medical or sleep incident preceding the collision. Professor Matthew Naughton, Respiratory and Sleep Disorder Physician, opined that Mr Li demonstrated no sign of sleep pathology, however, he may have had mild chronic sleep deprivation. Professor Naughton considered that if the collision was due to Mr Li falling asleep, it would be an individual episode with no evidence or premonition. Professor Naughton added that he suspected this would have been the first such event for Mr Li and that he would have been likely unaware of the implications of the signs of sleepiness, particularly head nodding and eyelid closure.

26. On 15 May 2024, Mr Li attended Melbourne North Police Station where he was[5] interviewed by police about the collision. He was released without charge. According to the account Mr Li gave during interview, he blacked out while driving and lost control of the Kia just prior to the collision.[6]

CORONERS PREVENTION UNIT REVIEW

27. I asked the Coroners Prevention Unit (**CPU**)[7] to review fatal motor vehicle collisions where the deceased was seven years or older, wearing an adult seat belt and not using a booster seat, and was under 145 centimetres in height.

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[5] A duplicate of the word 'was' was removed from this sentence pursuant to section 76 of the *Coroners Act 2008* (Vic).
[6] Advice from the Office of Pubic Prosecutions to the police was that there was no reasonable prospect of conviction and insufficient evidence to prove that Mr Li drove in a manner that was dangerous to the public considering the totality of the evidence available.
[7] 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.

28. Drawing on coronial data (the CCOV surveillance database), the CPU identified 24 deaths of passengers in motor vehicle collisions between 1 January 2015 and 31 December 2025 who were aged 7 to 14 years. Of these, nine deceased were less than 145cm in height and ranged in age from 7 to 10 years. Of these nine deaths, three children were front seat passengers and six were rear seat passengers. In only three cases was a booster seat mentioned. Of these three, two deceased were in a booster seat and the third, Ching, was not. One of the three children who were front seat passengers in fatal collisions, was not wearing a seatbelt.

29. In Victoria, Rule 266A of the Road Safety Road Rules 2017 states:

> *(5) A passenger who is 7 years old or older, but under 16 years old, must—*
>
> *(a) be restrained in a suitable approved child restraint; or*
>
> *(b) occupy a seating position that is fitted with an approved seatbelt and be restrained in—*
>
> *(i) a suitable lap and sash type approved seatbelt; or*
>
> *(ii) a lap type seatbelt fitted with an approved child safety harness; or*
>
> *(c) be placed on a properly positioned approved booster seat and be restrained by either—*
>
> *(i) a suitable lap and sash type approved seatbelt; or*
>
> *(ii) a suitable approved child safety harness; or*
>
> *(d) occupy a seating position that is fitted with a suitable approved seatbelt.*

30. It is important to note that Rule 266A specifies passenger restraint requirements based on the age of the child not their height which can vary significantly from one child to another.

31. In 2020, Neuroscience Research Australia and Kidsafe Australia updated their *Best Practice Guidelines for the Safe Restraint of Children Travelling in Motor Vehicles*.[8] The *Best Practice Guidelines* noted that the child's minimum standing height (range from 145-150cm) is often recommended as a guide for when to transition the child from a booster seat to an adult seatbelt without requiring a booster seat, due to it being a very simple test to communicate to parents. Relevantly, according to the VicRoads guideline on "Child restraints, booster seats and

[8] Neuroscience Research Australia and Kidsafe Australia, *Best Practice Guidelines for the Safe Restraint of Children Travelling in Motor Vehicles*, 2nd Edition, 2020.

seatbelt readiness" states that adult lap-sash seatbelts are designed for people with a minimum height of 145cms.[9]

32. However, the Best Practice Guidelines recommended the more comprehensive '5 Step Test' to assess whether a child is tall enough to achieve and maintain a good adult seatbelt fit without a booster seat. The five steps are:

1) Whether a child can sit with their back against the seat back,

2) With their knees bent comfortable over the front edge of the seat cushion,

3) With the shoulder belt across the mid-shoulder,

4) The lap belt low across the top of the thighs, and

5) Can stay in this position for the duration of a trip.[10]

33. The Best Practice Guidelines noted (at the time of publication) that the '5 Step Test' has not been formally evaluated but is widely used around the world. Additionally, although the use of a minimum standing height is a simpler test, all rear passenger seats differ in size and shape, and therefore the '5Step Test' may be a better metric for assessing the suitability of seatbelt only restraint for children.

34. The Best Practice Guideline further recommends that: *Once a child has outgrown their forward-facing child restraint, they should use a booster seat … until they can no longer fit within it or can achieve good seat belt fit as assessed by the '5 step test' in the vehicle they are riding in. Most children up to 10-12 years of age will require a booster seat to obtain good belt fit*.[11]

35. The National Transport Commission (**NTC**) is currently reviewing child restraint requirements in the Australian Road Rules (**ARR**).[12] Their Issues Paper, dated 27 October 2025 acknowledges that: *The ARR currently set minimum requirements for using approved child restraints and booster seats based on age. These do not fully align with best practice*

[9] VicRoads, "Child restraints, booster seats and seatbelt readiness", October 2016, accessed 26 March 2026, https://www.vicroads.vic.gov.au/~/media/files/documents/safety-and-road-rules/child-restraints-october-2016.pdf.
[10] Neuroscience Research Australia and Kidsafe Australia, *Best Practice Guidelines for the Safe Restraint of Children Travelling in Motor Vehicles*, 2nd Edition, 2020, p.44.
[11] Neuroscience Research Australia and Kidsafe Australia, *Best Practice Guidelines for the Safe Restraint of Children Travelling in Motor Vehicles*, 2nd Edition, 2020, p.8.
[12] National Transport Commission, "Improving child restraint rules", undated, <https://www.ntc.gov.au/project/improving-child-restraint-rules>, accessed 24 March 2026.

guidance that prioritises a child's size and height. This misalignment can cause confusion and lead to premature transitions to less safe restraints, compromising child safety.[13]

36. In the Issues Paper, the NTC noted that the ARR originally set minimum requirement for using approved child restraints and booster seats at seven years of age because the Australian Standard for booster seats at the time had a maximum weight limit of 26kg (AS/NZS 1754 (2003)). Based on anthropometric data, this limit meant that booster seats did not cater for about one-third of children aged seven years or older.[14]

37. Booster seats have improved and are now available for children up to about 10 years of age, which allows for the minimum age to be increased. Therefore, one of the proposed options in the Issues Paper was to increase the minimum age for adult seatbelt use to either eight years or ten years of age, or to define 'good seatbelt fit' using the '5 step test', which aligns with the *Best Practice Guidelines* recommendations discussed above.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Ching Ngai Li, born 28 April 2014;

    (b) the death occurred on 5 January 2024 at 736-738 Maroondah Highway, Coldstream, Victoria;

    (c) the cause of Ching's death was cranio-cervical dislocation sustained in a motor vehicle incident (car vs. car, passenger); and

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

39. The available evidence supports a finding that Ching sustained fatal injuries in a motor vehicle accident. Ching was seated in the rear seat of the vehicle, without a booster seat or child restraint. Based on available information regarding Ching's height and current guidelines around child restraints, Ching should have been seated in an appropriate booster seat rather than being secured by seat belt alone. This would have enhanced his safety as a passenger and may have prevented his death.

[13] National Transport Commission, *Review of child restraint requirements in the Australian Road Rules: Issues paper*, Melbourne: National Transport Commission, 27 October 2025, p.5.
[14] National Transport Commission, *Review of child restraint requirements in the Australian Road Rules: Issues paper*, Melbourne: National Transport Commission, 27 October 2025, p.25.

40. I convey my sincere condolences to Ching's family and friends for their loss.

COMMENT

Pursuant to section 67(3) of the Act, I make the following comments on a matter connected with the death:

1. As the National Transport Commission is currently reviewing the child restraint requirements in the Australian Road Rules, I do not consider it appropriate to make further comment or recommendations arising out of the death of Ching Li, apart from recommending to the NTC the need for requirements that are easily understood and easily applied by parents and carers of children, that adequately address the differences in the heights and size of children of the same age.

PUBICATION OF FINDING

Pursuant to section 73(1A) of the Act, I order the publication of this finding in accordance with the rules.

DISTRIBUTION OF FINDING

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

Wai Kin Li and Sin Lam Lee, senior next of kin

Transport Accident Commission

National Transport Commission

KidSafe

Leading Senior Constable Stephen Mottram, Victoria Police, Coronial Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date: 20 April 2026

Re-signed: 28 April 2026

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.