IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 001102

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sarah Gebert
Deceased:	Master L[1]
Date of birth:	[redacted] 2014
Date of death:	[redacted] 2022
Cause of death:	*Multiple injuries sustained in a motor vehicle incident*
Place of death:	[redacted], Victoria

1. At the direction of Coroner Sarah Gebert, the names of the deceased and his family members have been replaced with pseudonyms to protect their identity, with other identifying details redacted.

INTRODUCTION

1. On [redacted] 2022, [redacted] (**Master L**) was 8 years old at the time of his passing and resided in [redacted] with family members including his grandmother and her partner [redacted] (**Mr K**). Master L was reported to have had a close relationship with Mr K and was known to refer to him as his father.

THE CORONIAL INVESTIGATION

2. Master 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.

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. Victoria Police assigned Detective Senior Constable Alicia Rickard (**DSC Rickard**) to be the Coroner's Investigator for the investigation of Master 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.

6. This finding draws on the totality of the coronial investigation into the death of Master L 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

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

Circumstances in which the death occurred

7. In the week prior to his passing, Master L had been camping at [redacted] with Mr K, his grandmother, and other extended family members.

8. At approximately 2.15pm on [redacted] 2022, Master L and Mr K left the campsite to drive home, making a few stops along the way. They travelled in Mr K's 2012 Renault Koleos and arrived home at approximately 4.00 pm.

9. Mr K initially pulled in perpendicular to the curb, underneath a large tree at the front of the house. He then reversed around to be parallel with the curb and parked across the driveway.

10. Around this time, he received a call from Master L's grandmother which he took while sitting in the parked car. During the phone call, Master L got out of the front passenger seat to pat their pet cat who had come up to the car to greet them.

11. Mr K finished his phone call, and decided to move the car forwards to not block the driveway. CCTV and dashcam footage shows that Master L was crouched down beside the front curb side passenger wheel, not visible to the driver at this time.

12. Mr K drove forward, immediately striking Master L with the front passenger wheel driving over the top of him. He immediately stopped the vehicle as he thought he had driven over the pet cat. Mr K walked around the vehicle and saw Master L's right hand on the ground, coming out from underneath the car.

13. Mr K pulled Master L out by his left arm, laid him on his right side and called 000. Mr K commenced cardiopulmonary resuscitation (**CPR**) and continued until Ambulance Victoria paramedics arrived and took over. Sadly, Master L had been severely injured and was declared deceased at the scene soon after.

14. Victoria Police collected urine and blood samples from Mr K which showed that he had no alcohol or drugs in his system at the time of the collision. After an extensive police investigation which included a collision reconstruction by the Major Collision Investigation

evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

Unit, Victoria Police determined that there were no suspicious circumstances surrounding the death. Mr K was not charged with any criminal offences in relation to the incident.

Identity of the deceased

15. On [redacted] 2022, Master L, born [redacted] 2014, was visually identified by his step-grandfather, Mr K.
16. Identity was not in dispute and required no further investigation.

Medical cause of death

17. Forensic Pathologist Dr David Beer from the Victorian Institute of Forensic Medicine conducted an external examination on [redacted] 2022 and provided a written report of his findings dated [redacted] 2022.

18. The post-mortem examination showed findings in keeping with the clinical history.

19. Dr Beer provided an opinion that the medical cause of death was *multiple injuries sustained in a motor vehicle incident*.

20. I accept Dr Beer's opinion as to medical cause of death.

CORONER'S PREVENTION UNIT REVIEW

21. During the coronial investigation, Master L's mother Ms L wrote to the Court requesting that I consider a number of recommendations focused on preventing similar tragedies from occurring in the future. I am grateful for Ms L's contributions to my investigation.

22. In light of the issues raised, I referred this case to the Coroner's Prevention Unit (**CPU**)[2] for review. The CPU were asked to provide statistics on the number of children aged 0 to 5 years who had died following being struck by a vehicle that had moved off from being stationary, and to seek advice from KidSafe Victoria about current initiatives in the area of low speed run overs of children.

[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.

23. The CPU advised that, during the period 1 January 2010 and 31 August 2023, there were 24 deaths in Victoria of children who were struck in a low speed run over when the vehicle was moving off from a stationary position. An analysis of the fatalities showed that the majority of incidents occurred in summer.

24. KidSafe Victoria provided advice to the CPU that from 1 November 2025, a new standard, *Australian Design Rule 108/00 – Reversing Technologies*, will mandate at least two reversing sensors (motion sensors, reversing cameras or a vibration alerting system) to all types of light, medium and heavy vehicles.[3]

25. The CPU noted that, while this is a positive step forward, it may take many years beyond 2025 for most vehicles to have this standard. Current estimates show that the average age of registered passenger vehicles in Victoria is 10.81 years, and that number is increasing.

26. KidSafe Victoria have also prepared information tools (including a video, fact sheet, poster and brochure) which highlight issues associated with Driveway Safety, also relevant to this investigation, noting the following:

    Driveways are dangerous places for children – they are designed to allow vehicles access to and from a property and therefore present the same hazards as roads. Children's unpredictability, their inquisitive nature and the fact that they are surprisingly quick and mobile, places them at increased risk around driveways.

    On average, every year 7 children aged 0-14 years are killed and 60 are seriously injured due to driveway run over incidents in Australia.

    Most driveway run overs occur in the driveway of the child's own home, or in a friend or relative's driveway. The driver is usually a parent, relative or family friend. In 85% of cases, the driver does not know that a child is close to the vehicle; they think they are being looked after elsewhere.

[3] 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 >, accessed 9 September 2023.

All cars have a blind spot – some up to more than 15 meters behind the vehicle – which can make it difficult to see a child. This means that any car can be involved in a driveway run over, not just larger vehicles such as four wheel drives, vans and trucks.

27. I note that the range of initiatives in place or proposed (some of which are not ready for public release) are consistent with those suggested by Master L's mother in her communications with the Court and will hopefully address the issues identified in this case to help prevent similar tragedies from occurring in the future.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Master L, born [redacted] 2014;

    b) the death occurred on [redacted] 2022 at [redacted], Victoria, from *multiple injuries sustained in a motor vehicle incident*; and

    c) the death occurred in the circumstances described above.

29. Having considered all of the circumstances, I am satisfied that Master L's death was the result of a tragic accident.

30. The loss of a young child is a devastating tragedy for families and the community. I convey my sincere condolences to Master L's family and acknowledge the sudden and traumatic circumstances in which his death occurred.

31. I also recognise the work of the first responders including Victoria Police officers who attended the scene, and I acknowledge their contribution and the difficult and challenging nature of this work.

ORDERS AND DIRECTIONS

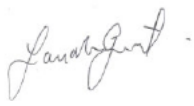
32. Pursuant to section 73(1A) of the Act, I order that this finding be published (in redacted form) on the Coroners Court of Victoria website in accordance with the Rules.

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

    Ms L, Senior Next of Kin

    Detective Senior Constable Alicia Rickard, Coroner's Investigator

Signature:



Coroner Sarah Gebert

Date : 07 December 2023

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.