IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 004475

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	MN[1]
Date of birth:	
Age:	17 Months
Date of death:	15 August 2020
Cause of death:	1(a) Head injuries sustained in a motor vehicle incident (pedestrian)
Place of death:	Peninsula Health, Frankston Hospital, 2 Hastings Road, Frankston, Victoria, 3199

[1] This Finding has been de-identified to replace the names of the deceased and their family members with pseudonyms to protect their identity. Other identifying information, including the deceased's date of birth, and family address have been omitted.

INTRODUCTION

1. On 15 August 2020, MN was 1 year old when she unexpectedly crawled into the driveway of her family home in and was accidentally run over when her father began shuffling the family cars in the driveway.

THE CORONIAL INVESTIGATION

2. MN'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 an officer to be the Coroner's Investigator for the investigation of MN'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 MN 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

Circumstances in which the death occurred

7. MN was the youngest of four children born to DE and FG. As at Saturday, 15 August 2020, she was a feisty but happy 17 month old baby.[3]

8. DE explained to my investigators that around 11 am, he finished setting up a chalk table in the backyard for his children, who were playing nearby. He then realised he had to drive to the shops in Karingal so he walked from the backyard through the back gate and headed towards his work van in the front driveway. His plan was to move the work van to the nature strip and take the family car behind it to the shops, because his van was full of rubbish. In his rush, he must have left the back gate open.[4]

9. Meanwhile, FG had been in and out of the house during the morning. She recalls DE coming into the house to get the keys for the van. She then went to the back yard to check the children. Her oldest child told her that MN was now out the front, which she assumed meant DE had taken her with him in the car, and so took no further action. [5]

10. When DE got into his van, started the engine and drove forward. He said he heard two "bangs", both were pretty big. After the first bang, he assumed his van was now clear of whatever minor obstacle it had just hit, and so continued to drive forward. [6]

11. Then he felt a second bang and saw his daughter on the driveway on his side of the vehicle. He rushed out of the car, picked her up in his arms and yelled hysterically for FG to call 000.[7] She did so, but was hysterical herself.[8]

12. A neighbour heard the screaming and came to help, and then drove them to hospital.[9] MN could not be resuscitated at hospital and was declared deceased at 1.36 pm.[10]

13. My investigators at the scene recorded blood splatters on the driver's side front wheel arch, and the corresponding part of the cement driveway.[11]

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[3] Statement of FG, Coronial Brief.
[4] Statement of DE, Coronial Brief.
[5] Statement of FG, Coronial Brief.
[6] Statement of DE, Coronial Brief.
[7] Ibid.
[8] Statement of FG, Coronial Brief.
[9] Statement of Mr Jones, Coronial Brief.
[10] Report of Dr Choo Leong Goh, Coronial Brief.
[11] Statement of DSC Wayne Reynolds, MCIU, Coronial Brief.

14. There were no witnesses to the actual mechanism of this accident, but such as there is any prevention opportunity in this case, it lies therein. Proper supervision of young children requires direct line of sight contact, without any assumptions, because of their innate enthusiasm, spontaneity and inventiveness.

Identity of the deceased

15. On 15 August 2020, MN, born , was visually identified by both her parents.

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

Medical cause of death

17. Senior Forensic Pathologist Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 17 August 2020 and provided a written report of her findings dated 21 August 2020.

18. The post-mortem examination confirmed the presence of fatal skull, jaw, rib and arm factures, together with a large right facial abrasion, consistent with the history given.

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

20. Dr Glengarry provided an opinion that the medical cause of death was *1 (a) Head injuries sustained in a motor vehicle incident (pedestrian).*

21. I accept Dr Glengarry's opinion.

OTHER INVESTIGATIONS

22. On 15 October 2020, my investigator confirmed that no criminal charges will be laid in relation to this accident.

COMMENTS

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

23. Proper active supervision of young children requires direct line of sight contact, without any assumptions, because of their innate enthusiasm, spontaneity and inventiveness.

24. Data from 2001 – 2010 found that on average in Australia, each year seven children aged 0 – 14 years die and 60 are seriously injured, after being hit by a four-wheeled motor vehicle moving around a home.[12]

25. Investigations for a prior coronial investigation identified that between 2015 and 2020, eight children aged 0 - 5 years died in Victoria in similar circumstances, after being struck by a motor vehicle at their home or the road immediately adjoining the driveway.

26. Accordingly, I commend Kidsafe Victoria and the Transport Accident Commission for launching a new driveway safety campaign. [13]

FINDINGS AND CONCLUSION

27. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications. [14] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

28. Having considered all of the evidence, I am satisfied that in this case, both parents made understandable but incorrect assumptions about the whereabouts of their child, and in doing so, each contributed to the death of MN. In saying that, I am satisfied that MN's death was a tragic accident in circumstances that are sadly too common, and requires no further investigation.

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

    a) the identity of the deceased was MN, born ;

[12] National statistics for 2001-2010: https://www.bitre.gov.au/sites/default/files/is_043a.pdf
[13] Coronial Investigation into the death of Seth Haddow COR 2019 0504.
[14] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

b) the death occurred on 15 August 2020 at Peninsula Health, Frankston Hospital, 2 Hastings Road, Frankston, Victoria, 3199, from head injuries sustained in a motor vehicle incident (pedestrian); and

c) the death occurred in the circumstances described above.

I convey my sincere condolences to MN's family for their loss.

Pursuant to section 73(1B) 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:

DE & FG, Senior Next of Kin

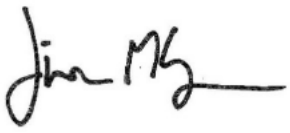
Amber Salter, Peninsula Health

Liana Buchanan, Commissioner for Children & Young People

Melanie Courtney, KidSafe Victoria

Senior Constable Brian Smith, Coroner's Investigator

Signature:



CORONER SIMON McGREGOR

CORONER

Date: 25 March 2022

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.