



IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

**COR 2021 005404**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

*Section 67 of the Coroners Act 2008*

Findings of:	Coroner Simon McGregor
Deceased:	YBT <sup>1</sup>
Date of birth:	November 2013
Date of death:	10 October 2021
Cause of death:	1(a) Head injury in motor vehicle incident (pedestrian)
Place of death:	Tidal River Campground Main Road, Tidal River, Victoria, 3960
Key words:	Wilsons Promontory, Tidal River, caravan, motor vehicle incident.

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<sup>1</sup> This finding has been de-identified by order of Coroner Simon McGregor to replace the names of the deceased and their family members with pseudonyms of randomly generated three letter sequences to protect their identity and redact identifying information.

## INTRODUCTION

1. On 10 October 2021, YBT was 7 years old when she died due to injuries sustained in a motor vehicle incident. At the time of her death, YBT lived in Douin with her parents BZJ and ZCS.
2. YBT was an outgoing child who enjoyed going to Wilsons Promontory to see and feed the birds. She loved nature and called ZCS her “Eco Warrior” for volunteering with the “Friends of the Wilsons Prom” group. YBT enjoyed school and had many friends.<sup>2</sup>

## THE CORONIAL INVESTIGATION

3. YBT’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 an officer to be the Coroner’s Investigator for the investigation of YBT’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.

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<sup>2</sup> Coronial brief, statement of ZCS dated 15 October 2021, page 12.

7. This finding draws on the totality of the coronial investigation into the death of YBT 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.<sup>3</sup>
8. In considering the issues associated with this finding, I have been mindful of YBT's basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006* (Vic), in particular sections 8, 9 and 10.

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

### **Circumstances in which the death occurred**

9. On 8 October 2021, YBT, BZJ, and ZCS drove to Wilsons Promontory in their Nissan Navara and caravan. The family arrived at approximately 6.30pm and planned to stay for two nights whilst ZCS assisted with the "Friends of the Prom" volunteer group. The group chose a camp site in a sandy grassed area where they parked their vehicle.<sup>4</sup>
10. On 9 October 2021, YBT's soccer ball was kicked underneath the caravan. ZCS stated that they would normally use a broom to get it however they had forgotten to pack the broom. They decided to wait until the following day to move the caravan forward to collect the ball.<sup>5</sup>
11. On 10 October 2021, YBT went for a bike ride before returning to pack up the campsite. At approximately 10.00am, the family finished packing and got into the Navara, with BZJ in the driver's seat, ZCS in the front passenger seat, and YBT in the rear seat behind ZCS.<sup>6</sup>

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<sup>3</sup> 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.

<sup>4</sup> Coronial brief, statement of ZCS dated 15 October 2021, page 12.

<sup>5</sup> Coronial brief, statement of ZCS dated 15 October 2021, page 12.

<sup>6</sup> Coronial brief, statement of ZCS dated 15 October 2021, page 12.

12. After BZJ told YBT that he was going to drive forward so she could retrieve her soccer ball, YBT replied that she would “jump out” and get the ball. She then exited the vehicle.<sup>7</sup> YBT’s parents told investigators that they believed YBT would wait for the Navara to move forward prior to getting her ball from underneath the caravan.<sup>8</sup>
13. As BZJ began to move the Navara forward slowly, ZCS checked the side mirror and observed YBT on the ground underneath the caravan. ZCS jumped out and yelled for BZJ to stop the vehicle. ZCS found YBT underneath the caravan’s axle and yelled for BZJ to “go back”. BZJ then immediately reversed the Navara.<sup>9</sup>
14. BZJ and ZCS discovered YBT in an unresponsive state with a head injury and, with the assistance of other campers and park staff, began resuscitation attempts.<sup>10</sup> Emergency services attended the scene however YBT was unable to be revived and was verified as deceased.<sup>11</sup>

### **Identity of the deceased**

15. On 10 October 2021, YBT, born November 2013, was visually identified by her father.
16. Identity is not in dispute and requires no further investigation.

### **Medical cause of death**

17. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (VIFM) conducted an examination on 11 October 2021 and provided a written report of his findings dated 12 October 2021.
18. The post-mortem examination revealed significant traumatic injuries consistent with the history given.
19. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any common drugs or poisons.

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<sup>7</sup> Coronial brief, statement of Charles Tomlinson dated 23 October 2021, page 17; statement of ZCS dated 15 October 2021, pages 12-13.

<sup>8</sup> Coronial brief, statement of Leading Senior Constable Damian Young dated 5 May 2022, page 51.

<sup>9</sup> Coronial brief, statement of Leading Senior Constable Damian Young dated 5 May 2022, page 51.

<sup>10</sup> Coronial brief, statement of ZCS dated 15 October 2021, page 13; statement of Scott Griggs dated 11 November 2021, page 32.

<sup>11</sup> Coronial brief, statement of ZCS dated 15 October 2021, page 13.

20. Dr Burke provided an opinion that the cause of death was from a 1 (a) head injury in motor vehicle incident (pedestrian).
21. I accept Dr Burke's opinion.

## **FINDINGS AND CONCLUSION**

22. Whilst the death of YBT was a tragic accident and does not represent any intent or criminality on the part of her parents, it is important to consider that children are inherently spontaneous, unpredictable, and do not make the same assumptions about safety, especially around vehicles, that adults commonly make. Constant line of sight supervision is always vital to prevent accidents such as this.
23. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
  - a) the identity of the deceased was YBT, born November 2013;
  - b) the death occurred on 10 October 2021 at Tidal River Campground Main Road, Tidal River, Victoria, 3960, from a *head injury in motor vehicle incident (pedestrian)*; and
  - c) the death occurred in the circumstances described above.

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

Pursuant to section 73(1A) 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:

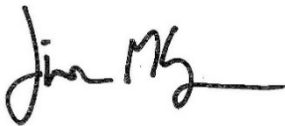
BZJ And ZCS, Senior Next of Kin

Erica Edmands, President, Kidsafe Victoria

Liana Buchanan, Principal Commissioner, Commission for Children and Young People

Leading Senior Constable Damian Young, Victoria Police, Coroner's Investigator

Signature:



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**CORONER SIMON McGREGOR**

**CORONER**

Date: 15 August 2022

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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.

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