QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

NON-INQUEST FINDINGS

CITATION:	**Investigation into the death of P, aged 9**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2014/2465
DELIVERED ON:	26 September 2014
DELIVERED AT:	Brisbane
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	Coroners: investigation, children, rural property, mobility scooter, head injuries, helmets, supervision

Introduction

P was aged nine.

On 10 July 2014 she suffered fatal head injuries as a result of a crash occurring while she was riding as a passenger on a mobility scooter.

Autopsy results

An external autopsy examination was ordered together with a post-mortem CT scan. This revealed the cause of death was a result of severe head injuries as a result of a mobility scooter accident.

The investigation

P was visiting a rural property owned by Mr M. Mr M was the employer of P's mother and P would often visit the property and play with Mr M's son, O. Among other activities, the children would often ride a Pride Ultimate mobility scooter. It is apparent they had driven the scooter many times.

P's mother was not at the property at the time. She had been present previously when the children were on the scooter but had put in place strict boundaries especially not allowing her daughter to ride down to the hideout area because of the ridge line leading down to the creek. She had told P to park at the end of the driveway where it was flat and walk the rest of the way.

The scooter itself has a maximum speed of up to 15 kilometres an hour when set to the high speed and 7.5 kilometres an hour when set to low speed. After the crash, the scooter was found in situ set to high speed.

It is apparent that around lunchtime O and P were playing outside. During that time, and apparently without Mr M's knowledge, P and O began riding the scooter. In the lead up to the crash, O had been sitting on P's lap and they were intending to go to a hideout they had made in a creek bed nearby. O had full control of the mobility scooter.

As they were travelling towards the creek O lost control of the scooter, which then fell approximately 2.3 metres over the ridge. O received only minor injuries but P fell and hit the rocks below. Neither child was wearing a helmet at the time.

Mr M finished making lunch and tried to find the children. When they were not near the house he drove his motor vehicle down towards the hideout. From the hideout location he looked back up the creek bed and saw his son. He made his way to where P was slumped over the rocks but she did not respond.

He brought P back to the house and called for assistance. He was assisted by someone trained in first aid who was visiting the premises and conducted CPR. Queensland Ambulance Services attended but P was declared deceased.

The police investigation concluded that as O was only four years old, he would not have had the proper control or appreciation of the outcome of losing control of the scooter. The road surface was particularly rough gravel, which included larger size rocks and the handling capability of the mobility scooter would be severely compromised in that terrain.

Issues of supervision also were considered. It was noted the children were in little danger of encountering traffic as the road was rarely used by motorists other than actual residents.

The investigator concluded that even if an adult had been in the general vicinity of where the children were riding on the scooter, the actual crash could still have occurred. Given the scooter did not have an ability to reach greater speed than 15 kilometres an hour, it was regarded as a relatively safe option. The user manual did have instructions concerning riding on outdoor surfaces with advice to reduce speed on uneven terrain. The manual also provided it was not for carrying passengers, although this may have been with a view that the operator was adult sized.

Conclusions

P has died as a result of a tragic accident. Rural properties are associated with higher rates of injuries to children and many are attributed to motor bikes or quad bikes. Accepting this mobility scooter is not the same type of vehicle, it is still important to recognise that children have a limited capacity to evaluate danger. This sad case is a reminder of the inherent dangers facing children when they are allowed to undertake tasks for which they are completely unsuited, particularly when unsupervised.

The wearing of a helmet may have prevented the serious consequences of this crash.

Further, notwithstanding the road may not have been regularly utilised by anyone other than local residents, it does not lessen the responsibility of supervising adults to ensure as safe a play environment as is possible. This clearly was not such an environment.

This tragic case occurred during the course of my considering my findings in relation to three children who had died when riding quad bikes. There are many similarities to those cases raising issues of overestimating the capacity of children to ride such vehicles safely and to make appropriate decisions when problems occur, the wearing of helmets, carrying of passengers when the vehicle is unsuited for this purpose, and supervision.

P's mother was anxious that her child's death was not in vain and she hoped awareness could be raised to reinforce to Australians, especially those in rural communities, the inherent dangers that surround children everyday and to prompt adults to consistently evaluate their environment and take responsible steps to keep children safe.

For those public interest reasons, P's mother consented to these investigation findings being published pursuant to s. 46A of the *Coroners Act 2003.*

John Lock
Deputy State Coroner
Brisbane
26 September 2014