IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 5764

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, PHILLIP BYRNE, Coroner having investigated the death of BRYAN JOSEPH CLOTHIER

without holding an inquest:
find that the identity of the deceased was BRYAN JOSEPH CLOTHIER
born on 8 March 1940
and the death occurred on 14 November 2014
at the Alfred Hospital, Commercial Road, Melbourne, Victoria

from:

1 (a) HEAD INJURY IN MOTOR VEHICLE INCIDENT

Pursuant to section 67(1) of the **Coroners Act 2008** there is a public interest to be served in making findings with respect to **the following circumstances**:

1. Mr Bryan Joseph Clothier, 74 years of age at the time of his death, resided with his wife of 53 years, Mrs Denise Clothier at 12 Pardoner Drive, Rye. Mr Clothier was a former member of the Victorian Magistracy.
2. Although diabetic and suffering problems with a knee Mr Clothier was in reasonably good health, save for suffering from "Acoustic Neuroma" which Mrs Clothier stated was a condition which effected his hearing and balance. As a result of the knee and the balance issues Mr Clothier from time to time utilised a motorised mobility scooter colloquially known as a "gopher".

3. At approximately 3pm on 11 November 2014 Mr Clothier left home on his mobility scooter to go to the Rye Shopping Centre. At approximately 5.30pm Mrs Clothier said she received a phone call from her husband advising her he was on his way home.

4. At approximately 5.45pm Mr Clothier was travelling in a westerly direction on the paved shoulder of Melbourne Road Rye; he was travelling on the northern side of the carriageway as recommended, facing oncoming traffic travelling in an easterly direction on Melbourne Road.

5. At the same time Ms Jennifer Meaby, in her BMW X5 vehicle, was proceeding south in Liesma Street approaching Melbourne Road intending to turn left onto Melbourne Road to travel in an easterly direction towards Rye.

6. Ms Meaby stated she stopped at the stop line on the roadway applicable to the stop sign at the T intersection before proceeding to execute the left hand turn. Ms Meaby advised the coronial investigator, Leading Senior Constable Cameron McNeil, she looked both right and left before proceeding. I add Ms Meaby was given a preliminary breath test which was negative.

7. When formally interviewed on 3 February 2015 the issue of what she did prior to proceeding to turn left was further canvassed. Ms Meaby maintained she looked right, left and right again, being most concerned about traffic from the right as the traffic from her left was on the other side of the carriageway travelling west. Ms Meaby said that when she thought it was safe she commenced to turn. Almost immediately she came into collision with Mr Clothier's mobility scooter, claiming she did not see it until impact. She added she did not expect anything coming from her left as there are no footpaths in the immediate vicinity.

8. Although the collision has been described as "low impact" it was forcible enough that Mr Clothier was thrown from his mobility scooter onto the bitumen surface. At the point of impact Ms Meaby estimated she was travelling at 3-5kph. Leading Senior Constable McNeil advised the weather was fine, clear and sunny, the roadway was dry and traffic was light.

9. Upon the timely attendance of ambulance paramedics it became clear Mr Clothier had suffered a severe head injury. He was intubated at the scene and conveyed by air ambulance to the Alfred Hospital with "life threatening injuries".

10. At the Alfred Hospital Trauma Centre a CT scan demonstrated a large right subdural haemorrhage and a bilateral subarachnoid haemorrhage. In the early hours of 12 November 2014 Mr Clothier was taken to theatre for an emergency right sided decompressive craniotomy, evacuation of subdural haematoma; en route to theatre both pupils had become fixed and dilated.

11. Repeat CT scans the following day showed worsening contusions, a large right posterior cerebral artery territory infarct and extensive oedema. Mr Clothier was reviewed by the neurosurgery team and deemed to have a non-survivable brain injury. The family generously consented to organ donation. Active management was withdrawn and comfort care only provided. Shortly after 2am on 14 November 2014 Mr Clothier passed away.

12. The matter was reported to the Coroner. Having regard to the circumstances and being aware that Mr Clothier had been treated at the Alfred Hospital for some days; the nature and scope of the brain injury known and documented, I ordered an external only post mortem examination and ante mortem toxicology which was undertaken at the Victorian Institute of Forensic Medicine (VIFM) by Senior Forensic Pathologist Doctor Michael Burke. Dr Burke confirmed death was due to:

    1 (a) HEAD INJURY IN MOTOR VEHICLE INCIDENT

    Toxicological analysis of ante mortem samples was unremarkable save for drugs administered as part of hospital procedures; ethanol was <u>not</u> detected.

13. The scene was revisited by Leading Senior Constable McNeil where he made further observations and took additional photographs. This material, included in the Coronial Brief, provides an enhanced understanding of the location.

14. In his statement Leading Senior Constable McNeil made several pertinent observations which I include in this finding; he stated:

    > *"I noted that when stopped at the stop line in the police vehicle and from a driver's perspective when turning left, that the view to the left was severely limited, due to the set back location of the stop line, the curvature of the road, the embankment and foliage covering it. It was further compounded by the 'A' pillar of the vehicle.*
    >
    > *I measured the visible line of sight to the left from the stop line, to the road side reflector, which marks the visible apex as 12.8m.*
    >
    > *I also noted that the driver's attention is drawn to the right as this is where oncoming vehicles are likely to come from and is the immediate danger driver exiting Liesma Street.*
    >
    > *To the right the view is also restricted more from the drivers position to the visible apex was 64.5m.*

Under those circumstances, in my opinion, I believe most people would be concentrating their attention to the right to avoid these oncoming vehicles and it would be unlikely that a driver would look again to the left (after an initial cursory look) before turning".

He made one further important observation:

"I noted that moving the vehicle out past the stop line and coming to a stop at a point approximately 1.5-2 meters further provided a considerably better view in each direction, but still required caution when turning".

15. I accept that the vision to the left of a driver stopped at the stop sign is very restricted to use Leading Senior Constable McNeil's words – "severely limited". However, as Ms Meaby said to the Coronial Investigator she didn't expect anybody coming from the direction Mr Clothier was travelling as she was mainly concentrating on traffic coming the other way, from her right.

16. Having regard to this incident I make the following observations – Section 69(1) of the Coroners Act 2008 provides:

"A coroner must not include in a finding or comment any statement that a person is, on may be, guilty of an offence".

I add that is not for me to make any comment regarding whether a person has, or has not been charged with an offence in relation to the incident that is a matter entirely for the police.

17. I acknowledge and commend Leading Senior Constable McNeil for his comprehensive Coronial Brief of Evidence.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

1. It is noteworthy that those using motorised mobility scooters are deemed to be pedestrians for the purposes of the Victorian Road Safety Act 1986 and Road Safety Road Rules 2009. The rules also provide how and where a "pedestrian" (as defined here) must travel in an area where there is no footpaths, as was the case here.

2. Considerable work has been undertaken by various entities into death and injury involving the use of motorised mobility scooters. In 2003 and 2006 the Victorian Parliamentary Road Safety

Committee examined the issue and made a number of recommendations. In 2010 VicRoads commissioned consultants to review aspects of motorised mobility scooters, (VicRoads 2010 Report). In 2009 the Australian Consumer and Competition Commissioner (ACCC) commissioned Monash University's Department of Forensic Medicine to undertake a study into deaths and injuries associated with the use of motorised mobility scooters, (Monash 2011 Report). The Monash University researchers identified 62 fatalities nationally, between July 2000 and August 2010, involving mobility motorised scooters, 48% which involved collisions with motor vehicles. In short a lot of work has, and is being done, to reduce the risk of motorised mobility scooter related death and injury. The problem is widely recognised, however the potential resolutions vexed.

3. A report published by the Monash University Accident Research Centre relating to research undertaken by the Victorian Injury Surveillance Unit recommended that the Victorian Government:

> *"Investigate the potential benefits of added safety features such as rollover protection, seat belts and personal protective equipment including helmets and gloves".*

4. The Coronial Investigator also suggested consideration should be given to either mandating or promoting the use of protective helmets by those using motorised mobility scooters.

5. The scope of my investigation has not been sufficiently wide to enable me to consider any reasoned formal recommendations on these issues.

6. The Coronial Investigator also made available to the Court a document titled Mornington Peninsula Shire, Motorised Mobility Devices (Scooter), Background Paper, Policy Statement and Action Plan. If I may say so it represents an admirable initiative by the Shire Council in promoting and planning for safer use of motorised mobility scooters.

Having regard to the location of the incident which resulted in the untimely death of Mr Clothier I note objective 1 (one) in the Policy Statement:

> *"To inform Council and Officers about the needs of users and potential users of motorised mobility scooters and motorised mobility devices and consider these in local planning and development of community infrastructure, especially footpath and road networks".* (my emphasis)

Having regard to the size and nature of the municipality that would be a monumental task.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

1. Adopting the suggestion made by the Coronial Investigator, Leading Senior Constable McNeil, I recommend that if it feasible and if it not already been done, that VicRoads and the Mornington Peninsula Shire give consideration to moving the stop line at the intersection of Melbourne Road and Liesma Street, Rye forward 1.5 – 2 metres, thus providing a better vision of approaching traffic, especially from the drivers left.

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

Mrs Denise Clothier

Mrs Sarah Larwill, the Alfred Hospital

Mornington Peninsula Shire

VicRoads

Leading Senior Constable McNeil, Rosebud Police Station

Signature:

Date: 14 April 2015