FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the Coroners Act 2008

Court Reference: 1105/08

In the Coroners Court of Victoria at Morwell

I E.C.Batt, Coroner having investigated the death of:

Details of deceased:

Surname:	Patray
First name:	Jeannie Anne
*Address:	19 Dinwoodie Dve NEWBOROUGH VICTORIA 3825

AND having held an inquest in relation to this death on 2nd October 2009

at Latrobe Valley Law Courts

find that the identity of the deceased was Jeannie Anne Patray

and death occurred on the 15th March 2008/ at Morwell

from

1a Intracerebral haemorrhage secondary to fracture base of skull.

1b Rupture of descending thoracic aorta.

in the following circumstances:

On the date of death the deceased aged, 52, was walking towards Morwell along the Princes Highway. She was in company with a female friend. It was dark and the time was approximately 8.20pm when she came to a point on the Morwell-Traralgon Road or Princes Highway about 200 metres west of the Princes Freeway entrance. Here the road is a two-way four lane road with a centre medium strip with vegetation separating traffic in opposite directions. There is no street lighting and it is not an area generally used by pedestrians. The deceased was walking in the right-hand lane of the west bound carriageway perhaps as much as 1 metre from the northern edge of this carriageway as it is bounded by a white line. The speed zone applicable to vehicle traffic at this point is 100 kph. The deceased was observed attempting to flag down cars by a passing motorist. This motorist reported his observation to D24 at Moe in a mobile telephone call concluding at 8.16 pm. He expressed the view it was likely the pedestrian would be struck by a car. The Deceased's companion at this time similarly warned her that her carefree attitude was putting her own life at risk.

Some three or four minutes later a vehicle, lawfully driven by

Mark Leslie Watson, struck the deceased while it travelled in this right-hand lane of the west-bound carriageway of Princes Highway. This vehicle was travelling at

100 kph and due to the darkness its driver had no opportunity to observe the deceased and take evasive action. Injuries sustained by the deceased in this impact were instantly fatal. Paramedics who were shortly on the scene found her unresponsive.

The call from the concerned motorist to D24 was taken by a Constable of Police who was manning the D24 phone that night. It was a busy night and many calls were being attended to. It is reasonably likely the Constable did not appreciate the urgency of the situation created by the deceased's dangerous behaviour on the roadway. He attended to other calls and did not obtain a prompt despatch of this call. This failure did not contribute to the death as the accident was too close in time to the receipt by D24 of the 000 call. Nevertheless it is evident that some procedural matters need attention at D24 Moe for the incident not to be repeated. In particular D24 operators should give a priority 1,2 or 3 to jobs to assist the police being dispatched in deciding what level of urgency is required. When calls are received by a concerned member of the public about a perceived risk to life and/or public safety it ought to be assumed that an urgent situation of danger exists and those jobs accordingly be allocated high priority.

Training of officers manning D24 needs to be reviewed to ensure that officers working there can properly evaluate calls and appropriately allocate them. Standing Operating Procedures at Moe D24 expressly require that "any incident or job involving a freeway, major highway or railway should be despatched immediately." It is imperative that this direction be well understood by D24 operators. However at the time of this tragedy those Standing Operating Procedures were not precise. The Orders in one sentence direct the Member "to use their own initiative and judgment" and in another, one sentence later, direct the operator to 'not prioritise the dispatch of jobs on their own authority."

RECOMMENDATIONS:

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

Recommendations are made though to some extent they may be overtaken by work already underway by Victoria Police consequent upon this accident.

It is recommended:

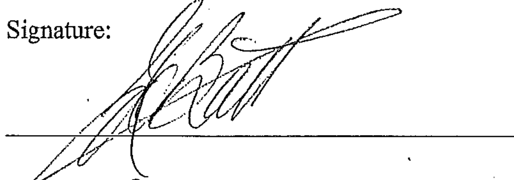
1. that D24 operators be trained generally, and specifically at their local regional level, to be able to identify and prioritise the urgency of 000 calls.

2. that a Sergeant be on duty for each shift of D24 (or be easily accessible to members on duty there) to supervise Local D24 operations.

3. that the Standard Operating Procedures be reviewed to clarify and simplify the steps and obligations upon operators at D24 Moe.

4. that Standard Operating Procedures as reviewed at Moe, be taken to a recommended review at State level to standardise the procedures of D24 centres across Victoria.

Signature:



Date: 23 / 11 / 09.