IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 4615

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**JUDGE SARA HINCHEY, STATE CORONER**
Deceased:	**JULIA FOLCIK**
Date of birth:	4 June 1927
Date of death:	27 September 2016
Cause of death:	Injuries sustained in motor vehicle collision (pedestrian)
Place of death:	The Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3050

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HER HONOUR:

BACKGROUND

1. Mrs Folcik was an 89-year-old woman who lived with her son in St Albans at the time of her death.[1] She had been a St Albans resident for approximately 50 years.[2]

2. Mrs Folcik never held a driver licence and walked everywhere. She was known to deliver eggs in her local area.[3]

3. Mrs Folcik's medical history included osteoporosis, osteoarthritis and chronic back pain.[4] She was reported to otherwise be in excellent health, although her family observed that she was becoming forgetful.[5]

THE PURPOSE OF A CORONIAL INVESTIGATION

4. Mrs Folcik's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and was violent, unexpected and not from natural causes.[6]

5. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[7] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

6. It is not the role of the Coroner to lay or apportion blame, but to establish the facts.[8] It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

7. The expression '*cause of death*' refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

8. For coronial purposes, the phrase '*circumstances in which death occurred*' refers to the context or background and surrounding circumstances of the death. Rather than being a

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[1] Western Health medical record
[2] Coronial brief, 39
[3] Coronial brief, pages **(pp)**15 and 39
[4] Coronial brief, page **(p)** 59
[5] Coronial brief, p 39
[6] *Coroners Act 2008* (Vic) section 4
[7] *Coroners Act 2008* (Vic) section 89(4)
[8] *Keown v Khan* (1999) 1 VR 69

consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

9. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's '*prevention*' role.

10. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

    (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.

11. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[9] 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 that they caused or contributed to the death.

12. In conducting this investigation, I have made a thorough forensic examination of the evidence including reading and considering the witness statements and other documents in the coronial brief.

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

Identity of the Deceased, pursuant to section 67(1)(a) of the Act

13. On 27 September 2016, Mrs Folcik's son, Mr Stan Folcik, visually identified his mother.

14. Identity is not in dispute in this matter and requires no further investigation.

[9] (1938) 60 CLR 336

Medical cause of death, pursuant to section 67(1)(b) of the Act

15. On 29 September 2016, Dr Matthew Lynch, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an external examination of Mrs Folcik's body. Dr Lynch provided a written report, dated 5 October 2016, which concluded that Ms Folcik died from injuries sustained in a motor vehicle collision (pedestrian).[10]

16. Toxicological analysis results of ante mortem specimens taken from Mrs Folcik were indicative of hospital treatment. No alcohol was detected.[11]

17. After a review of Dr Lynch's report dated 5 October 2016 and the E-Medical Deposition dated 27 September 2016, I accept the cause of death proposed by Dr Lynch.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

18. On 26 September 2016, Mrs Folcik was walking on Main Road East, St Albans. The exact nature and destination of her trip are unknown. It is however assumed that she was travelling to sell or deliver eggs, as she had with her a wheeled shopping buggy containing eggs.[12] Mrs Folcik was wearing a black coat at the time of the incident.[13]

19. At approximately 9.40am, east of the intersection of Main Road East and Percy Street,[14] Mrs Folcik was crossing Main Road East from south to north at an undesignated pedestrian crossing, when she was struck by a yellow taxi cab. The taxi was turning right out of Percy Street, to travel east on Main Road East. The taxi cab was reported to have collided with Mrs Folcik's shopping buggy, causing her to fall to the ground. The collision occurred in the eastbound lane of Main Road East, approximately in the centre of the road.

20. The taxi driver stopped, and together with another member of the public, moved Mrs Folcik from the road to the footpath.[15] The taxi driver then telephoned emergency services and requested that an ambulance attend.[16]

21. Members of Victoria Police arrived at the scene at approximately 9.47am.[17]

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[10] Coronial brief, pp 60 at 63
[11] Coronial brief, p 54
[12] Coronial brief, summary and p 3
[13] Coronial brief, p 3
[14] Coroner's Investigator, Leading Senior Constable Matthew Moohan, describes that the location as running generally north and south, terminating at Main Road East in a T intersection. The precise point at which Mrs Folcik commenced crossing the road is unknown; coronial brief, summary
[15] Coronial brief, pp 1, 3, 8 and 34
[16] Coronial brief, pp 3 and 34-35

22. Paramedics arrived at the scene at approximately 9.50am. Mrs Folcik was conscious and able to speak, however her description of the incident was not obtained at the time. The paramedics assessed Mr Folcik, who was complaining of abdominal, lower back and right foot pain.

23. At approximately 10.00am, the taxi driver returned a negative result for a preliminary breath test performed at the scene.[18]

24. At approximately 10.40am, Mrs Folcik was transported *via* ambulance to the Footscray Hospital where she received two units of packed red blood cells and fluid resuscitation to treat hypotension. She remained conscious and spoke with her son.[19] Medical imaging determined that she had sustained multiple rib and pelvic fractures, and a possible bladder injury.[20]

25. At approximately 5.50pm, Mrs Folcik was transferred from the Footscray Hospital to the Royal Melbourne Hospital, to be managed by the trauma team.[21] Imaging determined that she had also sustained a scapular fracture and bladder perforation. She experienced rapid atrial fibrillation and continued to have intraperitoneal haemorrhage with associated dropping haemoglobin levels. After discussion, it was determined that Mrs Folcik was not a candidate for surgical intervention. A decision was made not to intubate Mrs Folcik, or to perform cardiopulmonary resuscitation. She received palliative care and died at 8.00am on 27 September 2016.[22]

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

Witness and driver accounts

26. On 6 July 2017, a police member re-interviewed two witnesses and reviewed the evidence that had been gathered at the scene, including photographs.[23]

27. On 25 July 2017, Coroner's Investigator Leading Senior Constable Matthew Moohan interviewed the taxi cab driver at the Keilor Downs Police Station. The driver was described

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[17] Coronial brief, p 14
[18] Coronial brief, p 15
[19] Coronial brief, p 39
[20] Western Health medical record
[21] Western Health medical record
[22] Melbourne Health medical record
[23] I note that the Coroner's Investigator considered the witnesses to be unreliable, in that their evidence and recollections were described as 'vague'; coronial brief, summary

as co-operative with police, forthcoming with his account of the event and provided police members with details that had not previously been available.[24]

28. The taxi driver stated that he had good local knowledge, having worked as a taxi driver in the St Albans area for approximately seven years.[25] The driver held a current Victorian driver licence at the time of the incident.[26] He stated that he:

(a) did see other pedestrians at the intersection who appeared to be intending to cross Percy Street around the time of the collision;[27]

(b) had not previously seen a pedestrian crossing Main Road East at the location of the incident;[28]

(c) looked left and right prior to commencing his turn;[29]

(d) recalls that there were no cars parked to his right on Percy Street at the time;[30]

(e) did not see Mrs Folcik step onto the road, that '…[i]t happened in the blink of an eye';[31] and

(f) did not see Mrs Folcik due to a blind spot created by the 'A' (front corner) pillar of his vehicle.[32]

29. The taxi driver stated he was travelling at a speed of less than 10 kilometres per hour at the time of the incident.[33] Two eyewitness stated that they did not consider that the taxi cab was speeding at the time of the collision.[34] One witness stated that he observed the taxi driver waiting at the intersection for approximately 10 to 15 seconds, looking both ways prior to turning right.[35] The witness also reportedly told a police member that he had a clear view of the taxi cab and saw the taxi's indicator operating prior to the right turn.[36] The witness stated

[24] Coronial brief, summary
[25] Coronial brief, p 37
[26] Coronial brief, p 51. I note that the taxi driver had no recorded traffic offences under the *Road Safety Act 1986* (Vic) at the time of the incident; coronial brief, p 52
[27] Coronial brief, p 37
[28] Coronial brief, p 37
[29] Coronial brief, pp 35-36
[30] Coronial brief, p 36
[31] Coronial brief, pp 3 and 35
[32] Coronial brief, summary, and pp 27 and 31. I note that the Coroner's Investigator used a Victoria Police Toyota Camry (the same vehicle as the relevant taxi cab) to establish that the 'A' pillar *did* in fact create a significant blind spot; coronial brief, p 27
[33] Coronial brief, p 3
[34] Coronial brief, pp 8 and 26
[35] Coronial brief, pp 11-12
[36] Coronial brief, p 26

that the taxi started to move first, and that Mrs Folcik was struck at approximately the centre of the eastbound lane.[37] A witness described Mrs Folcik as walking slowly across the road.[38]

30. The taxi driver had commenced his shift at 6.30am on 26 September 2016 and was due to finish at 3.00pm.[39]

31. Examination of the taxi cab did not permit police members to determine which part of the vehicle struck Mrs Folcik.[40] The taxi driver stated that his vehicle only hit Mrs Folcik's shopping buggy, and not Mrs Folcik.[41]

32. A witness described the conditions at the time of the incident as sunny, with no rain or wind. The witness also described the road surface as dry.[42]

33. On 9 September 2017, the taxi driver appeared at the Sunshine Magistrates' Court, where he pleaded guilty to a charge of failing to give way. He was fined $317.00 without conviction.[43]

The safety of the road

34. Main Road East is the main thoroughfare through St Albans. It generally runs east-west from Sunshine Avenue in the east to Kororoit Creek in the west. Percy Street generally runs north-south from St Albans Road and terminates in a T-intersection at Main Road East. At the intersection, Main Road East is approximately 11 metres wide, measured from kerb to kerb. There is one east and one west-bound marked lane, although, due to the street's width, there are two lines of traffic in each direction. The two marked lanes are divided by a broken white dividing line.[44]

35. Main Road East is bordered by raised concrete kerbs and a nature strip approximately three metres wide, with mostly residential properties along the road. Visibility for drivers travelling north on Percy Street intending to turn onto Main Road East is excellent, particularly in respect of a driver's view of the opposing nature strip on either side of the intersection, although visibility to the west might be slightly impeded by parked vehicles.[45]

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[37] Coronial brief, p 26
[38] Coronial brief, p 12
[39] Coronial brief, p 30
[40] Coronial brief, pp 26 and 34
[41] Coronial brief, p 31
[42] Coronial brief, p 11
[43] Coronial brief, summary
[44] Coronial brief, p 25
[45] Coronial brief, p 25

36. Traffic control at the intersection of Main Road East and Percy Street (approaching from the south on Percy Street) is by way of a 'Give Way' sign, which is clearly visible.[46]

37. I note that a witness stated, 'I see elderly people cross at that intersection in front of Percy Street all the time. It's a very dangerous spot to cross.'[47] Another witness stated 'I have seen a lot of people cross at the intersection, it is very dangerous. It is too far to walk for the next lights. A lot of older people cross there.'[48]

38. In this respect, I note the presence of a shopping strip, supermarket and medical centre in the general vicinity of the Main Road East and Percy Street intersection.

39. The Coroner's Investigator informed me that the Brimbank Highway Patrol has been in discussions with the Brimbank City Council in relation to alterations to Main Road East. The changes largely relate to lane markings, creating dedicated right turn lanes and painted traffic islands. This would reduce Main Road East from two traffic lines in each direction to one clearly marked lane.[49]

40. Due to the volume of pedestrian traffic in the surrounding area, the Coroner's Investigator suggested the installation of a pedestrian crossing (with or without traffic lights) directly outside Errington Reserve, which borders the western side of Percy Street and the southern side of Main Road East.[50]

41. I note that the nearest pedestrian crossings are 239 metres to the west and 217 metres to the east. For seniors and those with a disability, this could present a significant distance.[51]

42. On 8 February 2018, VicRoads were asked to provide the Court with Road Crash Information System data for the intersection of Main Road East and Percy Street for the last five years.

43. On 28 February 2018, VicRoads provided the requested information.

44. The Road Crash Information System indicates that aside from this incident, there has been one other reported incident in the last five years. This other incident involved a motor vehicle, and an injury, albeit not one classified as a '*serious injury*'.

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[46] Coronial brief, pp 25 and 31
[47] Coronial brief, p 9
[48] Coronial brief, p 12
[49] Coronial brief, p 27
[50] Coronial brief, p 27
[51] Coronial brief, p 27

RECOMMENDATIONS PURSUANT TO SECTION 72(2) OF THE ACT

45. Having regard to:

(a) the death of Ms Folcik;

(b) the reported heavy pedestrian traffic around the intersection of Main Road East and Percy Street, St Albans;

(c) the proximity of the intersection of Main Road East and Percy Street to local amenities;

(d) the statements obtained from local residents regarding the frequency of pedestrians (particularly senior pedestrians) observed crossing at the intersection of Main Road East and Percy Street, St Albans; and

(e) the distance from the intersection of Main Road East and Percy Street, St Albans, to designated pedestrian crossing,

I **recommend** that the Brimbank City Council conduct an assessment of the intersection of Main Road East and Percy Street, St Albans, with a view to modifying the intersection to increase pedestrian safety.

FINDINGS AND CONCLUSION

46. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

(a) the identity of the deceased was Julia Folcik, born 4 June 1927;

(b) the death occurred on 27 September 2016 at the Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, from injuries sustained in a motor vehicle collision (pedestrian); and

(c) the death occurred in the circumstances described above.

47. I convey my sincerest sympathy to Mrs Folcik's family.

48. I direct that this Finding be published on the Coroners Court of Victoria's website.

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

(a) Mr Stan Folcik, senior next of kin;

(b) Miss Kellie Gumm, Trauma Project Manager, the Royal Melbourne Hospital;

(c) VicRoads;

(d) Brimbank City Council; and

(e) Leading Senior Constable Matthew Moohan, Victoria Police, Coroner's Investigator.

Signature:

JUDGE SARA HINCHEY

STATE CORONER

Date: 1 August 2018