IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 2535

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**MICHELLE HODGSON, CORONER**
Deceased:	**MARY FILLIPAS**
Date of birth:	4 April 1942
Date of death:	30 May 2017
Cause of death:	1(a) COMPLICATIONS OF MULTIPLE INJURIES SUSTAINED WHEN STRUCK BY A CAR (PEDESTRIAN)
Place of death:	Alfred Hospital, 55 Commercial Road, Melbourne, Victoria

HER HONOUR:

Background

1. Mary Fillipas was born on 4 April 1942. She was 75 years old when she died on 30 May 2017 from complications of the injuries she sustained when hit by a car while crossing Station Street in Burwood, Victoria, on 8 May 2017.

2. Mrs Fillipas lived in Burwood with her husband, Andrew. She had a close relationship with her two adult daughters, Spiridoula and Anna, and her six grandchildren.

3. According to Mrs Fillipas's family, Mrs Fillipas was fit for her age, although she had become noticeably frailer in the two years prior to her death. She was described as fiercely independent, and her family said that she enjoyed taking daily trips by public transport to local shopping centres.

The coronial investigation

4. Mrs Fillipas'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.

5. Coroners independently investigate reportable deaths to find, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[1]

6. The law is clear that coroners establish facts; they do not cast blame, or determine criminal or civil liability.

7. 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

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[1] In the coronial jurisdiction facts must be established on the balance of probabilities 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.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Mrs Fillipas's death. The Coroner's Investigator investigated the matter on my behalf and submitted a coronial brief of evidence.

9. After considering all the material obtained during the coronial investigation I determined that I had sufficient information to complete my task as coroner and that further investigation was not required.

10. 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.

Identity of the deceased

11. Mrs Fillipas was visually identified by her daughter, Anna Skarlatos, on 29 May 2017. Identity was not in issue and required no further investigation.

Medical cause of death

12. On 31 May 2017, Dr Sarah Parsons, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an external examination of the body of Mrs Fillipas and reviewed a post mortem computed tomography (CT) scan.

13. Dr Parsons completed a report, dated 2 June 2017, in which she formulated the cause of death as "*1(a) Complications of multiple injuries sustained when struck by a car (pedestrian)*". I accept Dr Parsons's opinion as to the medical cause of death.

Circumstances in which the death occurred

14. At approximately 5.55pm on 8 May 2017, Mrs Fillipas alighted from a number 767 bus at the stop adjacent to Talbett Street, on the eastern side of Station Street in Burwood.

15. At that location, Station Street is a bitumen road in good condition that runs in a north-south orientation. It has provision for two lanes of traffic in each direction, separated by a solid white line. Station Street slowly climbs to an uphill crest when approaching the intersection

of Talbett Street from the south, and slopes downhill immediately afterwards. The posted speed limit is 60 kilometres per hour.

16. Mrs Fillipas started slowly crossing Station Street from the eastern side of the road, just after the peak of the crest, and was headed to her home on Talbett Street.

17. At the same time, John Stastra drove his vehicle south on Station Street, approaching its intersection with Talbett Street. As Mr Stastra reached the peak of the crest, the headlights of his vehicle lit up Mrs Fillipas, who had reached the middle of the road and was crossing into Mr Stastra's lane. Mr Stastra braked heavily, however he was unable to avoid a collision and the front left-hand side of his vehicle struck Mrs Fillipas. Mr Stastra immediately stopped to render assistance and contacted emergency services.

18. Police and paramedics attended the scene a short time later. Mrs Fillipas, who was initially conscious, was taken to the Alfred Hospital with a visible head injury.

19. Upon arrival at the Alfred, Mrs Fillipas was found to have suffered several serious injuries, including a subarachnoid haemorrhage[2] and fractures to her spine and ribs. She was intubated and transferred to the Intensive Care Unit (**ICU**), where she had multiple surgeries for fixation of fractures over a period of three weeks.

20. Despite receiving maximal treatment, Mrs Fillipas's condition declined during the course of her admission. She developed fluctuating blood pressure, an irregular heartbeat, and intermittent hypoxia (oxygen deficiency). ICU clinicians met with Mrs Fillipas's family who, in light of her poor prognosis, decided that active treatment should be gradually withdrawn.

21. On 27 May 2017, Mrs Fillipas was placed on a palliative care pathway. She was kept comfortable until she passed away at 6.23am on 30 May 2017.

The criminal investigation

22. Mr Stastra was breath tested at the scene and had bloods taken, which were negative for drugs and alcohol. Excessive speed and fatigue were ruled out as contributing factors to the collision. At the time of the collision, the road was dry, weather was fine, visibility was average and it was dark.

[2] Bleeding in the space between the brain and the tissue covering the brain.

23. Mr Stastra told police that Station Street was poorly lit at the time of the collision. Additionally, Mrs Fillipas was wearing dark clothing. He was therefore unable to see Mrs Fillipas until he reached the peak of the crest and his vehicle's headlights illuminated her. Another witness to the collision gave evidence to police that was consistent with Mr Stastra's account.

24. Senior Constable Bastian Gonzalez, Coroner's Investigator, noted that there were two street lights in the vicinity of the collision. The first was on the eastern side of Station Street, approximately 22.8 metres south of the bus stop, however a large tree blocked most of the light. The second was on the northern side of Talbett Street, approximately five metres from Station Street.

25. Senior Constable Gonzalez formed the view that Mr Stastra's ability to see Mrs Fillipas was impaired by the road structure and the poor illumination of the surrounding area. Police investigators determined that Mr Stastra had not committed any criminal or summary offences in relation to the incident, which was, by all accounts, a tragic accident.

FINDINGS

Pursuant to section 67(1) of the *Coroners Act 2008*, I make the following findings connected with the death:

26. I find that:

    (a) the identity of the deceased was Mary Fillipas, born 4 April 1942;

    (b) Mrs Fillipas died on 30 May 2017 at the Alfred Hospital, Melbourne, Victoria, from complications of injuries suffered as a pedestrian hit by a car in Burwood; and

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

COMMENTS

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

27. I received correspondence from Whitehorse City Council, which indicated that street lighting in the relevant area was adequate and it is maintained to appropriate standards. I accept this advice.

28. The Council also informed me that the trees in the area are healthy and maintained in line with required legislation and service standards. The tree outside 40 Station Street had grown over time, so that it's canopy blocked the light from the street lamp for traffic travelling south on Station Street. Council supported my proposed recommendation that the tree be maintained or removed.

29. I was further informed that following Mrs Fillipas's death, Council officers reviewed the collision site with Victoria Police, VicRoads, and Public Transport Victoria. Participants in the meeting formed the belief that a key factor in the collision was the location of the bus stop in relation to the crest on Station Street. They suggested that relocating the bus stop (and the corresponding stop on the western side of Station Street) to the top of the crest would provide greater visibility for pedestrians trying to cross Station Street after alighting from a bus. Having reviewed the available evidence, I agree with the Council's suggestion.

RECOMMENDATIONS

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

1. That Public Transport Victoria consider and investigate relocating the bus stops on the east and west side of Station Street, near Talbett Street, to the top of the crest to improve visibility for pedestrians and drivers.

2. That Whitehorse City Council consider maintaining or removing any tree(s) in the immediate vicinity of the current or relocated bus stop at the intersection of Station Street and Talbett Street in Burwood to ensure drivers have visibility of pedestrians and overhead lighting is not affected.

I convey my sincere condolences to Mrs Fillipas's family.

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

Andrew Fillipas, Senior Next of Kin

Senior Constable Bastian Gonzalez, Coroner's Investigator, Victoria Police

Alfred Hospital

Whitehorse City Council

Public Transport Victoria

Signature:

MICHELLE HODGSON
CORONER
Date: 17.7.2018.