IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 0895

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**AUDREY JAMIESON, CORONER**
Deceased:	**JOAN CHRISTINE HARRISON**
Date of birth:	**13 October 1948**
Date of death:	**22 February 2018**
Cause of death:	**Injuries sustained in a motor vehicle collision (pedestrian)**
Place of death:	**Alfred Hospital, 55 Commercial Road, Melbourne, Victoria**

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

1. Joan Christine Harrison was 69 years of age and residing alone in Richmond at the time of her death. Ms Harrison is survived by her older sister, Anne, and her sons, Matthew and Mark. She was independent and enjoyed bird watching, theatre, films, reading and U3A classes.

2. Ms Harrison's medical history included myelodysplasia, gastro-oesophageal reflux disease, and previous cataract surgery. Following a suspected transient ischemic attack in November 2017, she underwent neurological tests, however, full investigation found no abnormalities. Ms Harrison's regular medication included aspirin and pantoprazole.

3. At approximately 4.00pm on 22 February 2018, Ms Harrison walked north on the eastern footpath of Church Street, Richmond, and approached the intersection with Highett Street. At that time, Darcy Fox drove her silver Mitsubishi sedan west on Highett Street and into the slip lane, intending to turn left on to Church Street. A striped pedestrian 'zebra' crossing spanned the slip lane and Ms Fox positioned her vehicle just behind the give way line, which meant her vehicle covered the zebra crossing. Whilst she looked to her right monitoring the traffic, Ms Fox accelerated slightly and struck Ms Harrison who had commenced crossing the slip lane in front of Ms Fox's vehicle. Ms Harrison fell backwards and hit her head. Ms Fox stopped immediately and telephoned for emergency services. Multiple witnesses nearby also rushed to assist. Ambulance Victoria paramedics subsequently attended and transferred Ms Harrison to the Alfred Hospital.

4. At hospital Ms Harrison underwent scans which showed a skull fracture with intracranial haemorrhage and traumatic brain injury. Following these scans, her condition deteriorated. Ms Harrison had recorded an Advance Care Directive which indicated her preference against surgical procedures in the event she was incapacitated. Accordingly, she was extubated and provided with comfort care. Ms Harrison was declared deceased at 9.10pm on 22 February 2018.

INVESTIGATIONS

Forensic pathology investigation

5. Dr Matthew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**), performed an external examination upon the body of Ms Harrison, reviewed a post mortem computed tomography (**CT**) scan and referred to Alfred Hospital Medical records and the Victoria Police Report of Death, Form 83. The post mortem CT scan confirmed occipital skull fracture with intracranial haemorrhage and examination showed occipital laceration.

6. Dr Lynch formulated the medical cause of Ms Harrison's death as injuries sustained in a motor vehicle collision (pedestrian).

Police investigation

7. Upon attending the scene of the accident, Victoria Police members observed that the road surface was dry and in good repair, the weather was fine, visibility was good, and the traffic was moderate. They noted that the pedestrian zebra crossing spanning the slip lane was positioned less than one metre from the give way line where the slip lane met Church Street. There were no indications of pre-collision braking, and no skid or yaw marks, which was expected due to the very low speed of Ms Fox's vehicle at the time of the collision.

8. Ms Fox underwent a preliminary breath test which did not detect alcohol and police observed that she did not appear drug affected.

9. Police examined Ms Fox's car and did not observe any damage to the car caused by the collision. They assessed the car to be in good roadworthy condition and noted that it had recently been serviced.

10. Senior Constable (SC) Sonia Cameron was the nominated Coroner's investigator.[1] At my direction, SC Cameron investigated the circumstances surrounding Ms Harrision's

[1] A Coroner's Investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the Coroner to assist the coroner with his/her investigation into a reportable death. The Coroner's Investigator receives directions from a Coroner and carries out the role subject to those directions.

death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by Darcy Fox, witnesses Cameron Johnstone, Warren Smythe, Tom Bergin, Jeremy Bloom, Metropolitan Fire Brigade members Luke Romanin, Simon Ryan, Phil Cuthburt, Phil Edwards, Ambulance Victoria paramedics Alan Eade, Chris Jenson, Ashleigh Dwyer, General Practitioner Dr Jeannie Knapp, Constable Alexander Urano, First Constable Ngon Le, and Detective Senior Constable Ben Ansell.

11. During the investigation, police took statements from multiple witnesses who confirmed that prior to the collision, Ms Fox's car had been stationary behind the give way line, covering the pedestrian zebra crossing. One witness explained he had been walking and crossed the slip lane behind Ms Fox's vehicle. Witnesses also confirmed that the collision had happened at low speed, and saw Ms Harrison stumble and fall backwards striking her head.

12. SC Cameron concluded that the actions of both Ms Harrison and Ms Fox contributed to the collision. SC Cameron opined that whilst it was reasonable for Ms Fox not to expect a pedestrian to cross in front of her vehicle at the intersection, she should have conducted appropriate checks to ensure it was safe to turn. However, at the same time, in order to continue walking north and cross the slip lane, Ms Harrison stepped onto Church Street and walked along the roadway in front of Ms Fox's car, rather than waiting for the designated pedestrian crossing to clear, or crossing at the rear of Ms Fox's vehicle.

13. Ms Fox was later charged and found guilty of the summary offence of careless driving under the *Road Safety Act 1986* (Vic).

14. SC Cameron also considered that the positioning of the pedestrian zebra crossing directly behind the give way line as the slip lane meets Church Street contributed to the collision and opined that public safety would be improved by the installation of pedestrian lights.

Further investigation

15. Considering SC Cameron's comments regarding the safety of the pedestrian crossing where Ms Harrison was struck, I requested information from VicRoads about other incidents at the intersection and the possibility of installing pedestrian lights.

16. In a letter dated 4 June 2019, Fatima Mohamed, Acting Regional Director VicRoads Metropolitan North-West Region, provided information indicating that between 1 July 2012 and 30 June 2017, VicRoads recorded five crashes at this intersection, none of which involved pedestrians crossing the Highett Street slip lane.

17. Ms Mohamed noted that the installation of traffic lights at this crossing would introduce further safety challenges. She said that pedestrians would likely be required to wait longer to commence crossing. She also described concerns that the existing island separating the slip lane and through traffic is narrow, with limited space for pedestrians, and pedestrian lights may cause overcrowding causing spillage onto the roadways. Ms Mohamed noted that there is currently very limited opportunity to widen the island to mitigate this risk.

18. Ms Mohamed outlined that VicRoads had undertaken an investigation into the collision that caused Ms Harrison's death and VicRoads's preferred safety treatment for this intersection involves:

    a. Relocating the existing pedestrian zebra crossing approximately 6 meters (i.e. a car length) away from the existing give way line where the slip lane meets Church Street.

    b. Installing pedestrian fencing at the south-eastern corner of the intersection to direct pedestrians to the relocated pedestrian crossing.

    c. Relocating the traffic pole to allow enough movement space for pedestrians within the island.

19. The perceived benefits of this treatment include that pedestrians will retain their level of priority in crossing the road, whilst allowing drivers waiting to turn left into Church Street and giving way to on-coming vehicles to do so clear of the path of pedestrians. Further, relocating the crossing would allow greater parts of the median traffic island to be used and pedestrians would be facing oncoming vehicles when approaching the crossing, giving them more awareness of oncoming vehicles.

20. Ms Mohamed advised that this treatment will be considered for funding in a future funding program and is considered a short-term solution whilst ongoing consultation might achieve an enhanced long-term solution.

RECOMMENDATIONS

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

1. Considering the comprehensive advice and consideration provided by VicRoads, and in the interests of furthering public safety and preventing like deaths, I recommend that VicRoads pursue funding and implementation of the safety treatment they have identified. Principally, by relocating the existing pedestrian zebra crossing approximately 6 metres away from the give way line where the Highett Street left turn lane meets Church Street, installing pedestrian fencing to direct pedestrians to the newly located zebra crossing, and relocating the median traffic pole to allow safe foot traffic through the island.

FINDINGS

This investigation has identified that Ms Harrison was a local to the area where she was struck by a car. The pedestrian zebra crossing she intended to use was blocked by a car waiting for a break in traffic to turn left from a slip lane. Ms Harrison attempted to cross in front of the vehicle and was struck when it commenced turning. She was struck at low speed, however, the impact caused her to fall backwards resulting in head injury and her death.

I accept the medical cause of death formulated by Dr Lynch and I find that Joan Harrison died from injuries sustained as a pedestrian in a motor vehicle collision.

Pursuant to section 73(1A) of the *Coroners Act 2008* (Vic), I order that this Finding be published on the internet.

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

Mark Harrison, Senior Next of Kin
Matthew Harrison, Senior Next of Kin
VicRoads
Alfred Health
Senior Constable Sonia Cameron, Coroner's Investigator

Signature:

AUDREY JAMIESON
CORONER
Date: **4 October 2019**