IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2018 2386

# FINDING INTO DEATH WITHOUT INQUEST

*Form 38 Rule 60(2)*

*Section 67 of the **Coroners Act 2008***

**Amended pursuant to section 76 of the Coroners Act 2008 as at 19 August 2020 as indicated by the asterisks in paragraphs 1, 4 and 37(d).*

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| Findings of: | Paresa Antoniadis Spanos, Coroner |
| Deceased: | Marek Koziol |
| Date of birth: | 20 November 1956 |
| Date of death: | 20 May 2018 |
| Cause of death: | Injuries sustained in motor vehicle collision (pedestrian) |
| Place of death: | Parkville, Victoria |

INTRODUCTION

1. Marek Koziol was a retired 61-year old man who resided with his wife and daughter and his Guide Dog Penny.*

2. In 1992, Mr Koziol sustained chemical burns at work that resulted in severe corneal scarring, rendering him 'legally blind'. Mr Koziol began to receive mobility services from Guide Dogs Victoria in 2000 and at the time of his death, Penny was his primary mobility aid.

3. Mr Koziol was seen periodically at the Eye and Ear Hospital as well as specialist ophthalmologist Professor Grant Snibson.

CIRCUMSTANCES IMMEDIATELY PROXIMATE TO DEATH

4. On 6 May 2018, in the company of Penny, Mr Koziol attempted to walk across the Old Calder Highway, Keilor East, near the Coles Express service station, about 60 metres east of the intersection of Hunter Street. Mr Koziol was struck by a vehicle and sustained multiple injuries to which he ultimately succumbed despite the ministrations of an off-duty paramedic who happened to be in the vicinity, Ambulance Victoria (AV) paramedics who responded to a call to 000 and clinical staff at the Royal Melbourne Hospital (RMH) where he was treated between 6 and 20 May 2018.*

PURPOSE OF A CORONIAL INVESTIGATION

5. The purpose of a coronial investigation of a *reportable death*[1] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[2] For coronial purposes, *death* includes suspected death.[3]

[1] The term is exhaustively defined in section 4 of the ***Coroners Act 2008*** [the Act]. Apart from a jurisdictional nexus with the State of Victoria a reportable death includes deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; and, deaths that occur during or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death (section 4(2)(a) and (b) of the Act).

[2] Section 67(1).

[3] See the definition of "death" in section 3 of the Act.

6. The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[4]

7. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[5]

8. Coroners are empowered to report to the Attorney-General in relation to a death; 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 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.[6] These are effectively the vehicles by which the coroner's prevention role can be advanced.[7]

9. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[8]

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[4] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[5] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

[6] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[7] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[8] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1).

IDENTIFICATION

10. Mr Koziol was suitable for visual identification and his brother in law Andrew Sulewski signed a Statement of Identification dated 20 May 2018 before clinical staff at RMH. As his identity was not contentious, this matter required no further coronial investigation.

MEDICAL CAUSE OF DEATH

11. Mr Koziol's body was brought to the Coronial Services Centre. Senior forensic pathologist Dr Matthew Lynch, from the Victorian Institute of Forensic Medicine (VIFM), conducted an external examination of Mr Koziol's body in the mortuary and reviewed the circumstances of death as reported by police to the coroner, Mr Koziol's medical records and the eMedical deposition from RMH and post-mortem computed tomography scanning of the whole body undertaken at VIFM (PMCT).

12. On external examination, Dr Lynch observed injuries consistent with the reported history of a closed head injury with rib and limb fractures. Additionally, the PMCT revealed calcific coronary artery disease, cerebral oedema and increased lung markings.

13. Dr Lynch advised that it would be reasonable to attribute Mr Koziol's death to *injuries sustained in a motor vehicle collision (pedestrian)*, without the need for an autopsy.

14. Routine toxicological analysis of post-mortem samples taken from Mr Koziol detected morphine, midazolam and levetiracetam, consistent with their therapeutic use in a comfort care setting.

CORONIAL INVESTIGATION

15. One of the Victoria Police members who attended the scene was Senior Constable Megan Fisher who investigated Mr Koziol's death and compiled the coronial brief on which this finding is largely based. The brief includes statements from several eye witnesses to the collision, attending members of Victoria Police, a paramedic and a representative from Guide Dogs Australia, the account of the driver involved, Mr Mazziol in the form of a Record of Interview, Ambulance Victoria

patient care records, a Victoria Police Incident Report, articles pertaining to neuroplasticity and noise levels and a series of photographs depicting the scene.

16. One of the eyewitnesses was Janet Dowling who saw Mr Koziol standing at the kerb with Penny and then heard a loud 'thud'. Simultaneously, Michael Dowling saw and heard a red car hit Mr Koziol, who became airborne and landed heavily on the ground, sustaining head injuries. Kylie Cecchini was about one and a half car lengths behind the red car, which she estimated was travelling at about 50 kilometres per hour and had begun to slow as it negotiated a round-about. Ms Cecchini saw brake lights activate on the red car just prior to the collision.

17. Several bystanders rushed to Mr Koziol's aid, including an off-duty paramedic. Emergency services were contacted.

CLINICAL MANAGEMENT AND CARE

18. Ambulance Victoria paramedics responded a short time later and found Mr Koziol with a Glasgow Coma Score of 5. He was intubated and transported to the Royal Melbourne Hospital (RMH) and admitted to the Emergency Department. Mr Koziol had extensive head injuries included a subarachnoid haemorrhage, subdural haemorrhage, left thalamic haemorrhage, right scalp haematoma, left rib fractures and a right tibial plateau fracture.

19. After multiple investigations, Mr Koziol was admitted to the Intensive Care Unit (ICU) for treatment with input from the Trauma, Orthopaedic, Neurosurgical and Plastics teams during his admission. Mr Koziol underwent surgical debridement of wounds on 10 May 2018.

20. Throughout his ICU admission, Mr Koziol showed no neurological recovery and on 17 May 2018 an MRI showed diffuse axonal injury. On 20 May 2018 a family meeting with held and it was determined that supportive care should be withdrawn. Mr Koziol was extubated and kept comfortable until he passed away at 11.00pm.

THE COLLISION – THE DRIVER

21. David Mazziol, the driver of the red vehicle, a 2014 Toyota Corolla which collided with Mr Koziol, was formally interviewed by police. Mr Mazziol explained that he was travelling along the Old Calder Highway in the centre of the

road towards Keilor and as he passed the second roundabout on the road, he heard a bang and saw that his windscreen had caved in. Mr Mazziol stated he did not see anyone (or a dog) prior to the collision and estimated that he was travelling at about 50 kilometres per hour. Shortly before the collision, he had checked his rear vision mirror on the passenger side and found the road was clear.

22. Mr Mazziol was asked whether he suffered from any health condition and he confirmed that he had a defibrillator installed in 2013. The defibrillator records any irregularities, but it did not do so on 6 May 2018. He also explained that he was prescribed Epilem as a precaution for seizures and was under the care of a neurologist. Mr Mazziol held a full and current driver's license. He confirmed that he was not using his mobile telephone at the time of the collision. Police checked the phone and ascertained that he made a telephone call to his father about four minutes after the collision.

THE COLLISION – THE SCENE

23. Directly outside the service station where Mr Koziol attempted to cross is a bus stop that includes a designated concrete curved parking bay for buses to stop in, out of the traffic flowing in a southeast direction.

24. Old Calder Highway at this location has provision for two lanes of traffic in either direction. The northwest lanes are divided by a single broken white line. The southwest lanes are also divided by a single broken white line until the eastern end of the bus stop, where the lane closest to the kerb abruptly ends and diverges to the right, creating a single lane to continue east.

25. At the centre of the roadway directly opposite the service station, the double lines spread apart, forming a painted traffic island. At the far south/eastern end of the traffic island, about two metres southeast of where Mr Koziol came to rest, there is a concrete traffic island in the middle of the road. The raised concrete island runs for about 11 metres, ending back to two solid white lines. These two lines then join to become double lines and continue away from the collision scene.

26. The weather was fine, and visibility was good at the time of the collision.

MR MAZZIOL'S CAR

27. The red 2014 Toyota Corolla sedan was in a roadworthy condition aside from the damage sustained in the collision. It had moderate damage to the front driver's corner and windscreen area, consistent with the collision. There were minor scratch marks on the lower front bumper area below the driver's side headlight. Above the headlight area, the bonnet directly in front of the driver had a large dent and scratches.

28. The windscreen in front of the driver's area had sustained major damage including severe cracking and there appeared to have been a major impact on the lower driver's side corner. The upper driver's side corner had also sustained major impact damage with the glass in the cabin area.

29. Mr Mazziol's car was a E170 variant with the 2ZR-FE petrol engine variant fitted. Enquiries made with Toyota Australia established that the decibel (dB) level of his vehicle when idle was approximately 39dB. At about 55 kilometres per hour, the sound emitted from Mr Mazziol's car would have been about 33 dB, which is about the same as the noise level one might expect to hear in a library.

30. Research into neuroplasticity has shown that when one sense is dulled or absent such as when a person is vision impaired, other senses such as hearing are heightened.

GUIDE DOGS VICTORIA

31. Aaron Horsington, Acting Team Leader at Guide Dogs Victoria provided a statement that explained the guide dog assistance program. As part of the extensive training that guide dogs receive, they learn tasks such as stopping at kerbs, avoiding obstacles or people, locating property and straight-line travel.

32. Traffic awareness is a key component of the Guide Dogs training program for handlers. Mr Horsington explained that this is an awareness exercise and teaches the handler how to manage different traffic flows and actions they may take in case of a misjudgement in their timing. The responsibility of choosing a safe place and time to cross the road lies with the handler of the Guide Dog.

33. However, a Guide Dog may refuse to move if a car is moving across the path of the handler or pulls up very close to where they are standing. In these

circumstances the dog's own self-preservation may take over. Ultimately, the handler instructs the Guide Dog to go in a particular direction and as to the intended destination, and the place and timing of road crossings.

34. Mr Koziol attended three Guide Dog training programs. Each program provided instruction on safe practices for working with a Guide Dog, reinforcing the dog's trained behaviour and he worked successfully with a Guide Dog[9] for 17 years. Along the way, Mr Koziol received regular follow-up, including aftercare and additional orientation programs to support his work with his Guide Dog.

FINDINGS/CONCLUSIONS AS TO CIRCUMSTANCES

35. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications. [10]

36. Adverse findings or comments against individuals or institutions are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and in so doing caused or contributed to the death under investigation.

37. Applying the standard of proof to the available evidence my conclusions are that:

    (a) Mr Koziol's identity was Marek Koziol, born 20 November 1956, late of a Kings Park address;

    (b) Mr Koziol died at the Royal Melbourne Hospital, Parkville, on 20 May 2018 and the medical cause of his death is injuries sustained in a motor vehicle collision as a pedestrian;

    (c) Mr Koziol was legally blind and had been trained in the use of a guide dog, including training in traffic awareness;

    (d) Penny had been Mr Koziol's guide dog for less than a year;*

[9] Mr Koziol had three Guide Dogs over the years, Khan, Tolley and Penny.

[10] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 esp at 362-363. "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…"*

(e) Penny was trained to be obedient to Mr Koziol, who was the decision maker about the direction in which they would travel;

(f) Even with the assistance of Penny, Mr Koziol needed to rely on his senses to make the decision to cross the Old Calder Freeway;

(g) Mr Mazziol's car emitted about the same level of noise as one would hear in a library and it is unlikely that Mr Koziol heard the car before he decided to alight onto the road;

(h) No drugs or alcohol were involved on the part of Mr Mazziol, nor was the speed or manner of driving such that it could be said to have caused the collision; and

(i) Mr Koziol died as a result of a tragic "accident" in the real sense of the word.

## RECOMMENDATION

Pursuant to section 72(2) of the ***Coroners Act 2008***, I make the following recommendation on a matter connected with the death, including recommendations relating to public health and safety or the administration of justice:

1. That Guide Dogs Victoria consider incorporating into their training programs strategies to address the challenges associated by some modern motor vehicles that emit lower noise levels and to visually impaired people as they move around in public, whether assisted by guide dogs or otherwise.

## PUBLICATION OF FINDING

Pursuant to section 73(1A) of the ***Coroners Act 2008***, I order that this finding and recommendation made following investigation of Mr Koziol's death be published on the Internet in accordance with the rules.

## DISTRIBUTION OF FINDING

I direct that a copy of this finding is provided to the following for their information:

The family of Mr Koziol

Kellie Gumm, Royal Melbourne Hospital

The Proper Officer, Guide Dogs Victoria

Disability Services Commissioner

Vision Australia

Senior Constable Megan Fisher (#36554) c/o O.I.C Brimbank Highway Patrol

Signature:


PARESA ANTONIADIS SPANOS

Coroner

Date: 7 July 2020