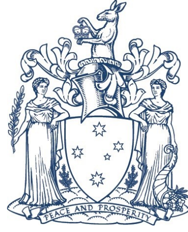

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 3524

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the ***Coroners Act 2008***

Findings of:	Coroner Jacqui Hawkins
Deceased:	Julie-Ann Margaret Johnston
Date of birth:	13 August 1956
Date of death:	20 July 2018
Cause of death:	I(a) Injuries sustained in a motor vehicle collision (pedestrian)
Place of death:	Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3050

BACKGROUND

1. Julie-Ann Margaret Johnston was 61 years old at the time of her death. She lived in Kilsyth with her husband, Ronald Johnston.

2. On 20 July 2018, Mrs Johnston was struck by a bus at the Croydon Railway Station Bus Terminal. She sustained significant injuries and was transported to the Royal Melbourne Hospital. On arrival to hospital, Mrs Johnston suffered a cardiac arrest and passed away that day.

3. Mrs Johnston's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008.*

4. The role of a coroner is to independently investigate reportable deaths to establish, 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. The law is clear that coroners establish facts; they do not lay blame or determine criminal or civil liability.[1]

5. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Mrs Johnston's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence/actions.

6. In writing this Finding, I do not purport to summarise all the evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

IDENTITY OF THE DECEASED

7. Julie-Ann Margaret Johnston was visually identified by her husband, Ronald Johnston, on 20 July 2018. Identity was not in issue and required no further investigation.

MEDICAL CAUSE OF DEATH

8. On 23 July 2018, Dr Joanna Glengarry, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an external examination on the body of Mrs Johnston and

[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.

reviewed the Form 83 Victoria Police Report of Death, medical deposition, and the post mortem computed tomography (CT) scan.

9. Toxicological analysis of post mortem blood detected the presence of lignocaine, a local anaesthetic often administered prior to surgery or during resuscitation attempts.

10. The external examination showed severe injuries to Mrs Johnston's right leg, and abrasions, bruises and lacerations to her face, torso, and limbs. There was no post mortem evidence of significant natural disease.

11. Dr Glengarry provided an opinion that the medical cause of death was 1(a) *Injuries sustained in a motor vehicle collision (pedestrian)*. I accept and adopt this cause of death.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

12. At about 6.10am on 20 July 2018, Mrs Johnston parked her car at Croydon Railway Station and walked towards the train platform. She walked along a pedestrian 'zebra' crossing that runs along Pierson Drive and traverses three bus only lanes where the bus terminus joins Pierson Drive. As Mrs Johnston passed the terminus' northern bus exit point, she was struck by a bus attempting to turn right onto Pierson Drive. She was pulled under the bus behind the drivers' side front wheel and was trapped under the bus.

13. Witnesses outside of the bus terminal contacted emergency services.

14. The bus driver stopped immediately and rushed to see what had happened. There were two passengers on the bus, they both heard or felt something impact the bus and exited the bus with the driver. They found Mrs Johnston conscious, but clearly injured and trapped under the bus.

15. The driver ensured the bus was lifted off the ground to its raised position where the weight was taken off the axles, before returning to comfort and speak to Mrs Johnston.

16. Victoria Police were the first to arrive at the scene and they observed Mrs Johnston laying on her back completely under the bus, between the rear wheels, and the bus driver was holding her hand. They ensured no part of the bus was physically touching Mrs Johnston. Mrs Johnston was still conscious and complained of leg and abdominal pain.

17. Firefighters from the Metropolitan Fire Brigade (**MFB**) and the Country Fire Authority (**CFA**) and Ambulance Victoria paramedics arrived a short time later. It took approximately 40 minutes for the MFB and CFA to successfully lift the bus to safely extract Mrs Johnston. The paramedics' capacity to monitor and assist Mrs Johnston during this time was limited.

18. Mrs Johnston was conscious and speaking to the paramedics when she was placed in the ambulance for transport to the Royal Melbourne Hospital, and continued to complain of leg and abdominal pain. However, her conscious state decreased during the journey and she went into cardiac arrest on arrival to hospital.

19. Mrs Johnston was moved into the hospital and despite resuscitation attempts, she was pronounced deceased at 7.40am.

CRIMINAL INVESTIGATION

20. Victoria Police attended the scene of the incident and immediately commenced an investigation into the cause of the collision. They observed that it was before daylight, but the area was lit with street and station lighting. It had rained earlier in the morning, but was not raining at the time of the collision.

21. The driver of the bus, Gary Dickinson, underwent a preliminary breath test and provided a blood sample for toxicological analysis which were negative for alcohol or other drugs. Police confirmed that Mr Dickinson held a full current Victorian driver's licence with heavy rigid endorsement, suitable for driving commercial passenger buses.

22. Mr Dickinson was subsequently conveyed to the Croydon Police Station for interview.

23. During the interview, Mr Dickinson explained that he had nearly 10 years' experience driving buses. He stated he had commenced work that day at about 5.25am and was well rested. He confirmed he was familiar with driving buses through the terminal, including the pedestrian crossings.

24. Mr Dickinson stated that prior to making the turn, he had been watching a pedestrian to his left on the roadway, but they moved back onto the footpath and he made the turn. He could provide no explanation as to why he did not see Mrs Johnston.

25. Victoria Police members obtained CCTV footage from the area and confirmed the sequence of events as described by witnesses to the collision.

26. Detective Leading Senior Constable (**DLSC**) Michael Hardiman, of the Victoria Police Collision Reconstruction and Mechanical Investigation Unit attended the scene of the collision to process the scene. From the material gathered for the investigation he concluded that the bus travelled at an average speed of approximately 12km/h as it passed through the terminus. He noted that it was not possible to determine the precise speed at the time of the collision as there was no measurable 'throw distance' to use for calculations, rather Mrs Johnston had been knocked to the ground and rolled or tumbled underneath the bus.

27. DLSC Hardiman was unable to identify why Mr Dickinson failed to give way to Mrs Johnston. He noted that there was no obvious obstructions to the visibility of the driver, other than the driver's side rear vision mirror which is always protruding from the side of the bus. The windscreen was clean, and the sun visors were pulled down slightly, but did not impede vision in either a forward direction or to the right hand side of the bus.

28. On 24 July 2018, Victoria Police mechanic, Senior Constable Nick Brickley performed a mechanical inspection of the bus. He concluded that there were no mechanical faults with the bus that would have caused or contributed to the collision.

29. Detective Sergeant (**D/Sgt**) Stephen Hill inspected the bus involved in the collision and with assistance from a Ventura Bus Driver, re-enacted the events of 20 July 2018, with a Go Pro camera positioned at the driver's eye level. On reviewing the footage, D/Sgt Hill concluded there was no flare visible to the driver, and there was ample opportunity for the driver to observe a person walking across the pedestrian crossing.

30. Mr Dickinson was charged with four offences in relation to the collision;

    a. Dangerous drive causing death;

    b. Drive in a manner dangerous;

    c. Careless driving; and

    d. Fail to give was to pedestrian on a pedestrian crossing.

31. Mr Dickinson appeared before the Melbourne County Court on 30 May 2019 and pleaded guilty to dangerous driving causing death. On 14 June 2019, he was sentenced to a three-year community corrections order. His licence was cancelled, and he was disqualified from driving for three years from the date of his sentencing.

CORONIAL INVESTIGATION

32. During his attendances at the scene for this investigation D/Sgt Hill observed the speed at which buses were travelling through the bus terminus and estimated it to be approximately 25km/h. Whilst not obviously fast, he considered this was fast given the close proximity in which they operate to pedestrians moving about both on the walkway and on the roadway.

33. D/Sgt Hill noted that the exit to the terminus was not governed by any signage, however there was clearly an obligation on bus drivers to give way to vehicles travelling on Pierson Drive.

34. D/Sgt Hill suggested that bus drivers were likely susceptible to complacency in this setting as they drive through the terminus several times daily.

35. In light of these observations D/Sgt Hill suggested two means by which safety might be improved at the Croydon Railway Station Bus Terminal;

    a. Installation of devices to force buses to slow down (e.g. speed humps); and

    b. Signage reinforcing the need to give way to passing cars, or that otherwise would force them to stop.

36. D/Sgt Hill communicated his observations and suggestions outlined in the paragraphs 32-35 above to local police members, the Maroondah City Council and Metro Trains. In doing so, D/Sgt Hill identified that the land the bus terminal is on, is land leased by Metro Trains from the Department of Transport, whilst the adjoining roads are managed by the Maroondah City Council. I consider these suggestions are reasonable and worthy of consideration and I have made a recommendation to this effect.

37. Having considered the evidence I am satisfied that no further investigation is required.

FINDINGS

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

    (a) the identity of the deceased was Julie-Ann Margaret Johnston born 13 August 1956; and

    (b) Mrs Johnston died on 20 July 2018 from 1(a) *Injuries sustained in a motor vehicle collision (pedestrian)*;

    (c) in the circumstances described above.

39. I wish to express my sincere condolences to Mrs Johnston's family. I acknowledge the grief and devastation that you have endured as a result of your loss.

RECOMENDATIONS

40. Pursuant to section 72(2) of the Coroners Act, I make the following recommendations connected with the death.

    I recommend that the Secretary of the Department of Transport, work with the Executive Director of Metro Trains Melbourne and the Co-ordinator of Engineering Services and Strategy at Maroondah City Council to conduct a safety audit of the bus terminus at Croydon Railway Station to determine whether there are any additional safety measures, such as speed humps or give way signage, that are suitable to improve and ensure the safety of pedestrians at Croydon Railway Station.

41. Pursuant to section 73(1) of the Coroners Act, I order that this finding be published on the internet.

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

The family of Mrs Johnston;

Mr Paul Younis, Secretary of the Department of Transport

Mr Steven O'Brien, Co-ordinator of Engineering Services and Strategy, Maroondah City Council;

Mr Robert Duvel, Executive Director, Metro Trains Melbourne;

Ventura Bus Lines;

Information recipients; and

Detective Sergeant Stephen Hill, Coroner's Investigator, Victoria Police

Signature:

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JACQUI HAWKINS
Coroner
Date: 31 July 2020