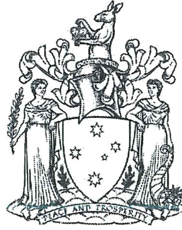

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 000794

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Paresa Antoniadis Spanos, Coroner
Deceased:	Josephine Edden
Date of birth:	9 May 1991
Date of death:	17 February 2015
Cause of death:	Chest injuries in pedestrian incident
Place of death:	Melbourne

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of JOSEPHINE EDDEN without holding an inquest:

find that the identity of the deceased was JOSEPHINE EDDEN

born on 9 May 1991

and that the death occurred on 17 February 2015

at the intersection of Spencer and Collins Streets, Melbourne, Victoria, 3000

from:

I (a) CHEST INJURIES IN PEDESTRIAN INCIDENT

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

1. Ms Edden was a 23-year old Café Manager who lived in Melbourne.

2. At about 6.15am on 17 February 2015, Ms Edden was walking to work south along the eastern footpath of Spencer Street towards its intersection with Collins Street, Melbourne. She was wearing dark coloured clothing and walking quickly.

3. At about the same time, Anthony Walton a self-employed truck driver employed to collect commercial waste throughout the cities of Melbourne and Yarra, was driving an Iveco Ducato Rigid heavy vehicle configured as a garbage truck [truck] south along Spencer Street in the left lane, intending to turn left into Collins Street.

4. At the Spencer-Collins Streets intersection, Spencer Street is a bitumenised road that runs approximately north-south with provision for two lanes of road traffic travelling in each direction and tram tracks in the centre of the carriageway, effectively dividing them. Collins Street is a bitumenised road that runs approximately east-west with provision for two lanes of road traffic travelling west and one east-bound lane and (east and west) tram tracks in the centre of the carriageway. Both Spencer Street and Collins Street have a posted speed limit of 40 kilometres per hour and their intersection is controlled by traffic lights, for vehicles and pedestrians.

5. When Mr Walton approached the Spencer-Collins Streets intersection, the traffic lights applicable to him were green. He gave way to pedestrians using the crossing between the north-east and south-east corners of the intersection and when the pedestrian crossing lights started to flash red, he checked his mirrors and commenced a left turn into Collins Street.

6. Ms Edden approached the Spencer-Collins Streets intersection, apparently intending to cross Collins Street from the north-east corner to the south-east corner. According to witness accounts, the pedestrian crossing signal applicable to her was flashing red or was constant red. As Ms Edden entered the pedestrian crossing she tripped and fell to the ground.

Simultaneously, Mr Walton completed his turn into Collins Street, colliding with Ms Edden,[1] the truck running over her. Mr Walton felt the impact and pulled over. Upon alighting from the truck, he saw Ms Edden on the ground. The emergency services were called and bystanders commenced cardio-pulmonary resuscitation.

7. Responding ambulance paramedics found Ms Edden unresponsive, pulseless and not breathing with injuries to her head, shoulder and chest. She was pronounced deceased at the scene.

8. Senior forensic pathologist, Dr Michael Burke of the Victorian Institute of Forensic Medicine, reviewed the circumstances of the death as reported by police to the coroner, post-mortem computer assisted tomography [PMCT] scans of the whole body and performed a preliminary examination. Among Dr Burke's anatomical findings were multiple lacerations and abrasions involving the head and whole body, and a massive haemopneumothorax (air and blood within the chest cavity) associated with fractured ribs.

9. Routine toxicological analysis of post-mortem samples taken from Ms Edden's body did not detect any alcohol or other commonly encountered drugs or poisons.

10. Dr Burke advised that it was reasonable to attribute Ms Edden's death to *chest injuries in pedestrian incident* without the need for an autopsy.

11. Senior Constable Iqbal Singh of Yarra Highway Patrol commenced an investigation of the collision and Ms Edden's death, later compiling the coronial brief of evidence on which this finding is largely based. The brief establishes that:

    a. Mr Walton, aged 47 years, has held a driver's licence all of his adult life and at the time of this incident, had been endorsed to drive heavy vehicles for 20 years. He had collected commercial waste along the route he took on 17 February 2015 for the previous six years and was well-rested prior to the start of his shift that morning 4.15am.

    b. Mr Walton underwent preliminary breath and oral fluid tests which revealed no evidence of alcohol or illicit drugs.

    c. A mechanical inspection of the truck revealed no mechanical fault that would have caused or contributed to the collision. Indeed, the truck had last been serviced the previous week.

[1] Ms Edden was presumptively identified from her New South Wales-issued driver's licence at the scene and was later formally identified by her father at the Victorian Institute of Forensic Medicine.

d. Ms Edden was wearing black clothing and had earphones in her ears connected to a device.

e. The pedestrian lights on the Spencer-Collins Streets intersection and an audible click, synchronised with the operation of the pedestrian lights were all present and operating on the day of the collision in which Ms Edden sustained her fatal injuries. The pedestrian light cycle consists of a green light for 15 seconds, followed by a flashing red signal for 13 seconds before the red light becomes constant.

f. There were no tyre scuff, yaw or skid marks on the roadway.

g. Mr Walton's account – that he waited until the end of the pedestrian light cycle before commencing his left turn and did not see Ms Edden – accorded with the accounts of other witnesses to the incident who saw Ms Edden fall to the ground in the crossing towards or at the end of the pedestrian light cycle before the truck entered it.

12. On the basis of his investigation, SC Singh formed the view Mr Walton's claim that he had not seen Ms Edden prior to the collision was reasonable given the height and limited visibility afforded him from the driver's seat in the truck and Ms Edden's position on the ground.

13. At my request, the Coroners Prevention Unit [CPU][2] analysed coronial data and provided advice about the frequency of pedestrian deaths involving collisions with heavy vehicles and opportunities for preventing similar death in future. The CPU advised:

    a. Between January 2000 and December 2016 there were 80 fatal incidents involving heavy vehicles colliding with pedestrians in Victoria. Most of these collisions (68 of 80) occurred on a road (as opposed to in a car park or on footpaths) with the heavy vehicle moving forward immediately before impact with the pedestrian.

    b. Of the 68 pedestrian fatalities occurring on roads, more than half (42) occurred when the pedestrian was not seen by the heavy vehicle driver before the collision.

    c. In total, there were 18 deaths arising in circumstances similar to those in which Ms Edden died, that is, when a pedestrian was struck by a heavy vehicle moving forward from a stationary position on a roadway. Seven of those deaths occurred when the vehicle crossed a pedestrian crossing and the remainder occurred on non-crossing

[2] The Coroners Prevention Unit [CPU] was established in 2008 to strengthen the prevention role of the Coroner. CPU comprises of three investigative teams, two medical/clinical units and one staffed by highly skilled researchers and non-medical investigators. The CPU assists the Coroner to formulate prevention recommendations and comments, and monitors and evaluates their effectiveness once published.

roadways (often with the pedestrian crossing in front of the heavy vehicle as it started to move in queuing traffic without seeing the pedestrian).

d. The particular challenges to pedestrian safety presented by heavy vehicles with limited forward visibility have been highlighted in a number of previous coronial investigations, such as those into the deaths of James Sawbridgeworth in 2014, Kathleen Cugley and Ms Edden in 2015 and Constantino Beriaris, Nawgamuwage Perera and Eugene Twining in 2016.

e. Crash avoidance systems (including features such as forward collision warning, pedestrian and bicycle warnings) are now available for retrofitting to trucks to mitigate the incidents of collisions with pedestrians. Such systems are not without their limitations as, although they provide visual and auditory warnings they still require the driver to take evasive action within (in one example) two seconds of the warning being given.

14. I find that Ms Edden, late of 220 Spencer Street, Melbourne, died on 17 February 2015 at the intersection of Spencer and Collins Streets, Melbourne, of the chest injuries she sustained in a pedestrian incident involving a collision with a heavy vehicle. The available evidence does not support a finding that any inattention on the part of the truck's driver, Mr Walton, caused or contributed to Ms Edden's death.

COMMENTS

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

1 Ms Edden's death highlights once again the particular challenges to pedestrian safety posed by trucks and heavy vehicles with limited forward visibility. It is important that pedestrians understand these limitations and are encouraged to be mindful of their own safety in the vicinity of heavy vehicles.

2 I note with approval the advice of the Victorian Transport Association Incorporated [VTA] of its intention to implement the recommendation I made in connection with Mr Sawbridgeworth's death[3].

[3] See finding in relation to the death of James Sawbridgeworth (Court Reference 2014 5064) delivered 9 June 2016.

3 I further note to that as of March 2017, strategies to raise public (and industry) awareness about heavy vehicle 'blind spots' including technological advances that may mitigate them had been discussed at a recent Transport Industry Safety Group meeting and feature in VicRoads' 'Travel Happy' campaign in 2017.

RECOMMENDATION

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

1. That VicRoads convene a working group to examine technological solutions to improve pedestrian visibility to heavy vehicle operators.

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

Drew Ridley

Ms Edden's parents

Victorian Transport Association

Transport Industry Safety Group

VicRoads Corporation

SC Iqbal Singh, Fitzroy Police

Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date: 20 September 2017