IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 6378

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Peter White, Coroner
Deceased:	Brooke Smith
Date of birth:	5 February 1973
Date of death:	19 December 2017
Cause of death:	I(a) Injuries sustained in a motor vehicle collision (pedestrian)
Place of death:	Elsternwick

I, PETER WHITE, Coroner,

having investigated the death of BROOKE SMITH

without holding an inquest:

find that the identity of the deceased was BROOKE SMITH

born on 5 May 1973

and that the death occurred 19 December 2017

at 296 Glen Huntly Road, Elsternwick, Victoria, 3185

from:

I (a) INJURIES SUSTAINED IN A MOTOR VEHICLE COLLISION (PEDESTRIAN)

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

1. Brooke Smith was 44 years of age at the time under consideration and had lived in Elsternwick.

2. On 19 December 2017 at approximately 11.12am, Ms Smith attempted to cross to the south side of Glenhuntly Road, Elsternwick and was struck by a Volvo tipper truck driven by Thanh Nguyen.

3. Several witnesses stopped to render assistance and Emergency Services were contacted. Ms Smith appeared to be breathing, but remained unresponsive. Ambulance Victoria paramedics attended the scene shortly after and pronounced Ms Smith deceased.

4. Senior Constable Paul Silberer attended the scene following Ms Smith's death. Senior Constable Silberer came to the conclusion that at 11.12am, Mr Nguyen was driving east on Glen Huntly Road in heavy traffic. Mr Nguyen stopped, at which point Ms Smith walked between cars parked on the northern side of Glen Huntly Road to cross to the southern side of the road. Mr Nguyen began to slowly drive when the front driver's side of his truck collided with Ms Smith. Ms Smith fell, becoming trapped between the tyres on the driver's side of the truck. She was dragged approximately 25 metres along the road before Mr Nguyen stopped the vehicle.

5. Victoria Police conducted a preliminary breath test and a preliminary oral fluid test of Mr Nguyen. Both tests returned a negative result.

6. Forensic pathologist, Dr Joanna Glengarry of the Victorian Institute of Forensic Medicine, reviewed the circumstances of the death as reported by police to the coroner and performed an external examination, having previously reviewed a CT scan of the body. Dr Glengarry advised that Ms Smith had suffered catastrophic injuries that were incompatible with life.
7. Routine post-mortem toxicology detected paracetamol.
8. Dr Glengarry attributed Ms Smith's death to injuries sustained in a motor vehicle collision (pedestrian). I adopt this finding and find that Ms Smith died as a result of injuries sustained when she was struck and later dragged by the Volvo tipper truck driven by Mr Nguyen. I am further satisfied that the design of the vehicle driven by Mr Nguyen caused him to be unaware of these events.
9. I extend my condolences to the family of Ms Smith for their loss.

Previous coronial recommendations and responses

10. In the Finding Without Inquest into the death of James Sawbridgeworth,[1] delivered on 9 June 2016, Coroner Paresa Spanos identified that Mr Sawbridgeworth, who used a walking frame to ambulate, died after walking in front of a moving 1995 Mack prime mover, which had been previously stopped in traffic.

11. Coroner Spanos requested the Coroners Prevention Unit[2] (CPU) assist her with the investigation into Mr Sawbridgeworth's death. The CPU advised that 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. However, Coroner Spanos identified that such systems are not without 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.

12. At the conclusion of the investigation into Mr Sawbridgeworth's death, Coroner Spanos recommended that the Transport Industry Safety Group (TISG) considers the particular

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[1] COR 2014 5064

[2] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

challenges to pedestrian safety – especially those older and more vulnerable pedestrians – posed by trucks and heavy vehicles with limited forward visibility and consider developing a strategy to highlight this road safety issue to the public at large and to truck and heavy vehicle operators and drivers in particular.

13. In response to the recommendation, The Honourable Luke Donnellan, MP, Minister for Roads and Road Safety, wrote a letter to the Court dated 7 October 2016. Mr Donnellan advised that Coroner Spanos' recommendation would be implemented and stated that the Finding would be considered by the TISG at its next meeting in late 2016.

14. By way of letter dated 17 March 2017, Peter Anderson, Chief Executive Officer of the Victorian Transport Association Inc. (VTA), confirmed that the recommendation would be implemented, and that the VTA was in the process of convening a meeting of the TISG's members in late April 2017. Mr Anderson added that the second phase of the VicRoads Travel Happy campaign[3] had commenced in February 2017, and incorporated key messaging in relation to heavy vehicle blind spot awareness. Mr Anderson acknowledged that drivers of heavy vehicles not seeing pedestrians was clearly a major concern.

15. In the Finding Without Inquest into the death of Constantinos Bekiaris,[4] delivered on 5 June 2017, Coroner Audrey Jamieson identified that Mr Bekiaris, a man with impaired hearing and mobility, died after walking in front of a moving prime mover that had previously been stationary in southbound traffic on Burnley Road in Richmond.

16. At the conclusion of the investigation into Mr Bekiaris' death, Coroner Jamieson recommended that the VTA and the TISG continue to investigate previously identified concerns about the lack of forward visibility in trucks and heavy vehicles, and what can be done to improve pedestrian safety.

17. By way of letter dated 5 September 2017, Mr Anderson confirmed that the recommendation would be implemented. Mr Anderson advised that the VTA had consulted with leading heavy vehicle manufacturers and suppliers in relation to 'collision avoidance' technology. The

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[3] Travel Happy – Share the Road is a campaign that encourages all road users to look out for each other to make travelling happier, and safer for everyone.

[4] COR 2016 1102

technology is available and can be retrospectively fitted to a heavy vehicle, however, the costs to deliver this outcome are commercially prohibitive for the majority of heavy vehicle operators.

18. Mr Anderson further advised, the Australian Design Rules (ADRs) do not specify the fitting of forward collision technology to heavy vehicles as a standard. Such equipment is deemed as optional fitment coming at an additional cost. The VTA have specified that the ADRs need to be amended in order that front warning sensors and side sensors are installed at the point of manufacturer for all cab-over heavy vehicles with a Gross Vehicle Mass equal to or greater than 4.5 tonne. This was highlighted in the VTA submission to the *Senate Standing Committee on Rural and Regional Affairs and Transport References Committee Inquiry (March, 2016).*

19. The VTA established a working party with VicRoads to review the heavy vehicle licensing requirement to improve driver skills and safer driving behaviours. In 2017, the VTA, in conjunction with a leading driver education provider, implemented a comprehensive heavy vehicle 'Driver Delivery' program where pedestrian safety and 'blind spot' awareness for drivers is integrated into the program's training approach.

20. Mr Anderson added that the VTA continues to support the VicRoads Travel Happy campaign, and plans to further expand key messaging in relation to heavy vehicle blind spot awareness. The VTA is also working through the Victorian Road Freight Advisory Council to develop a strategy to address this serious issue.

21. Mr Anderson's response to the Court highlights the VTA and the TISG's commitment to continue to investigate concerns about the lack of forward visibility in trucks and heavy vehicles, and what can be done to improve pedestrian safety.

22. In the Finding Without Inquest into the death of Josephine Edden[5] delivered on 20 September 2017, Coroner Paresa Spanos identified that Ms Edden was struck and killed by a garbage truck as she crossed the road at the intersection of Collins Street and Spencer Street. Her Honour asked the CPU to search coronial data and advise as to the frequency of pedestrian fatalities involving a collision with a truck/heavy vehicle that had commenced moving forward from a stationary position, with a driver apparently not seeing the pedestrian.[6]

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[5] COR 2016 0794.

[6] Please note that Ms Edden's death occurred before Mr Bekiaris' death.

23. By reference to Victorian coronial data for the period from 1 January 2000 to 31 October 2016, the CPU identified 80 deaths of pedestrians, who died as a result of injuries sustained in a collision involving a truck or heavy vehicle.[7] Of these deaths, the CPU identified 42 deaths where it appeared the truck or heavy vehicle driver did not see the pedestrian before the collision and 18 deaths, where a truck collided with an unobserved pedestrian after it commenced moving forward from a stationary position.[8]

24. At the conclusion of the investigation into Ms Edden's death, Coroner Spanos recommended that VicRoads convene a working group to examine technological solutions to improve pedestrian visibility to heavy vehicle operators.

25. In the Finding Without Inquest into the death of William Eugene Twinning,[9] delivered on 28 June 2018, Coroner Audrey Jamieson identified that Mr Twinning, died after running in front of a moving Kenworth cab over 9.8 tonne truck, which had previously been stationary at the traffic lights. Her honour made a recommendation that trucks and heavy vehicles be fitted with sensors that alert drivers to objects in their forward blind-spots.

FINDINGS

26. I find that Brooke Smith, late of Elsternwick died at 296 Glen Huntly Road Elsternwick, Victoria, 3185 on 19 December 2017, and that the cause of her death was injuries sustained in a motor vehicle collision as a pedestrian.

RECOMMENDATIONS

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

1. In these circumstances, I repeat Coroner Jamieson's recommendation in the Finding into the Death of William Eugene Twinning with the aim of improving public health and safety and in

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[7] The CPU included light trucks but excluded large four wheel drive vehicles and utilities. Also excluded were intentional deaths and possible suicides, thus focusing upon accidents proper.

[8] In preparing the report pertaining to the death of Josephine Edden the CPU reviewed and updated a data report on heavy vehicle related pedestrian related fatalities prepared previously for Coroner Spanos in the death of James Sawbridgeworth. The data review and update process led to the identification of new deaths that had not been included in the data report relating to the death of Mr Sawbrigeworth. This may occur due to iterative improvements in the CPU database search and death identification strategies, as well as changes in the database contents as deaths are reviewed and recoded upon completion of Coronial investigations. CPU data reports always reflect the CPU's best and most accurate understanding of morality data at the time the report is produced, but are subject to review.

[9] COR 2016 3244

particular pedestrian safety and I recommend that the Australian Design Rules as administered by the Australian Government under the *Motor Vehicle Standards Act 1989* are amended to require that front warning sensors and side sensors are installed during manufacturing for all cab-over heavy vehicles with a Gross Vehicle Mass equal to or greater than 4.5 tonne.

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

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

Maureen Smith, Senior Next of Kin

Donald Smith, Senior Next of Kin

Victorian Transport Association Inc.

Victorian Minister for Roads and Safety

Commonwealth Minister for Infrastructure and Transport

Senator Barry O'Sullivan, Chair of the Senate Standing Committees on Rural and Regional Affairs and Transport

Senior Constable Gary Walter, Coroner's Investigator, Victoria Police.

Signature:

PETER WHITE
CORONER

Date: 12 September, 2015