IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2016 1102

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

I, AUDREY JAMIESON, Coroner having investigated the death of CONSTANTINOS BEKIARIS without holding an inquest:
find that the identity of the deceased was CONSTANTINOS BEKIARIS
born 18 June 1934
and the death occurred on 10 March 2016
at Burnley Street, Richmond Victoria 3121
from:

1 (a) INJURIES SUSTAINED IN MOTOR VEHICLE COLLISION (PEDESTRIAN)

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

1. Constantinos Bekiaris was 81 years of age at the time of his death. He was retired and lived in Burnley Street, Richmond with his wife Urania and one of their three children. Mr Bekiaris' medical history included arthritis and impaired hearing; he used a walking stick to assist with mobility.

2. During the afternoon of Thursday 10 March 2016, Mr Bekiaris left his home to run errands. He was not wearing his hearing aid, as the battery was flat. At approximately 4.36pm, Mr Bekiaris returned to the Richmond area and parked his car on Burnley Street. Mr Bekiaris was observed

crossing Burnley Street from east to west, between Farmer and Bliss Streets, prior to the intersection with Swan Street. A 2010 Mercedes Actros flat nose prime mover, driven by Mark Longley was stationary in southbound traffic on Burnley Street, approaching Swan Street. Mr Bekiaris proceeded to cross the road; he was less than one metre in front of the Mr Longley's vehicle, and behind another vehicle, when the traffic began to move. The prime mover accelerated and Mr Bekiaris lost his balance; he fell onto the road, in the path of the vehicle.

3. A bystander ran up to the prime mover and knocked on the window, to alert Mr Longley that Mr Bekiaris was trapped under the vehicle. The prime mover came to a stop approximately 2.5 metres north of Swan Street. Emergency services were contacted, and bystanders ventured onto the road to clear space and direct traffic away from the prime mover. Ambulance paramedics and police arrived shortly afterwards; it was apparent upon their arrival that Mr Bekiaris was deceased. Police performed a preliminary breath test upon Mr Longley, which returned a negative result. Toxicological analysis of Mr Longley's blood, sampled at 7.10pm on 10 March 2016, did not detect any alcohol, common drugs or poisons.

Forensic pathology investigation

4. Dr Matthew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an external examination upon the body of Mr Bekiaris, reviewed a post mortem computed tomography (CT) scan and referred to the Victoria Police Report of Death, Form 83. Anatomical findings were consistent with the known mechanism of injury. Toxicological analysis of Mr Bekiaris' post mortem blood did not identify any alcohol, but did detect a trace of paracetamol.[1] On the evidence available to him, Dr Lynch ascribed the cause of Mr Bekiaris' death to injuries sustained in a motor vehicle collision as a pedestrian.

Police investigation

5. Senior Constable (SC) Heather Obuch, the nominated coroner's investigator,[2] conducted an investigation of the circumstances surrounding Mr Bekiaris' death, at my direction, including the preparation of the coronial brief. The coronial brief contained, inter alia, a transcript of a police interview with the driver of the prime mover Mark Longley, and statements made by Mr

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[1] Paracetamol is an analgesic drug available in many proprietary products.

[2] 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 takes instructions direction from a coroner and carries out the role subject to the direction of a corner.

Bekiaris' daughter Violeta Bekiaris, a number of witnesses, and attending emergency services personnel.

6. Violeta Bekiaris stated that her father was a fairly independent man, who knew how to look after himself without assistance on a day to day basis. He was retired for approximately five years prior to his death. Ms Bekiaris stated that her father's health had always been pretty good until recently. Arthritis affected his legs, and he used a cane to assist with walking. Mr Bekiaris generally wore a hearing aid, but his daughter added that he was still able to hear without it.

7. Police identified that Burnley Street runs in a north-south direction, and is a sealed bitumen road in good repair. There are two lanes of traffic in each direction, or one lane for vehicles to park adjacent to the footpath and one for travel. The posted speed limit is 60km/h. On 10 March 2016, there was intermittent rain and the road was generally wet; there were vehicles parked in the vicinity of the collision, on both east and west sides of the road. The traffic was heavy.

8. Detective Senior Constable (DSC) Caitlin Ryan of the Major Collision Investigation Group in Brunswick stated that following the collision, she entered the prime mover cabin from the driver's side, and sat in the driver's seat. DSC Ryan observed that the height of the prime mover limited the ability of a driver in a seated position to observe a person directly in front of the vehicle. Leading Senior Constable (LSC) Robert Long from the Heavy Vehicle Unit stated that there was a two metre blind spot in front of the prime mover. LSC Long held a 220 centimetre stick in front of the prime mover. It was identified that anything less than 220 centimetres in height, would not be visible by the driver.

9. LSC Long stated that upon visual examination, the prime mover was in good condition and appeared well maintained. Documentation was located in the prime mover which indicated that the vehicle was only used in the Melbourne metropolitan area. LSC Long added that this documentation also indicated that Mr Longley had not exceeded his permitted hours of work in a fatigue regulated heavy vehicle for 10 March 2016. Mr Longley had a current and full heavy vehicle driver's licence. The vehicle's windscreen wipers, demister and headlights were operating automatically at the time of the collision.

10. SC Obuch identified that the area in front of the prime mover was not a pedestrian crossing, and there was no reason for Mr Longley to have foreseen that a pedestrian would step in front

of his vehicle, outside of his possible vision. Mr Longley was not considered by police to be at fault.

Previous coronial recommendations and responses

11. In the Finding Without Inquest into the death of James Sawbridgeworth,[3] 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 1995 Mack prime mover, which had been stopped in traffic. Her Honour asked the Coroners Prevention Unit[4] 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.

12. By reference to Victorian coronial data for the period from 1 January 2000 to 31 March 2016, the CPU identified 70 deaths of pedestrians, who died as a result of injuries sustained in a collision involving a truck or heavy vehicle.[5] Of these deaths, the CPU identified 31 deaths where it appeared the truck or heavy vehicle driver did not see the pedestrian before the collision and 15, including Mr Sawbridgeworth's death, where a stationary truck collided with an unobserved pedestrian after it commenced moving forward from a stationary position. The CPU also 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, Her Honour 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.

13. At the conclusion of the investigation into Mr Sawbridgeworth's death, Coroner Spanos recommended that the Transport Industry Safety Group considers the particular challenges to pedestrian safety – especially those older and more vulnerable pedestrians – posed by trucks

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[3] COR 2014 5064

[4] 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.

[5] 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.

and heavy vehicles with limited forward visibility and considers 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.

14. In response to the recommendation, The Honourable Luke Donnellan, MP, the 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 Transport Industry Safety Group at its next meeting in late 2016.

15. 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. Mr Anderson advised that due to a range of reasons, the Transport Industry Safety Group did not meet in the second half of 2016. However, the VTA was in the process of convening a meeting of the Group's members in late April 2017. Mr Anderson added that the second phase of the VicRoads Travel Happy campaign had commenced in February 2017, and incorporated key messaging in relation to heavy vehicle blind spot awareness. Mr Anderson acknowledged that the issue whereby the driver of a heavy vehicle has not seen a pedestrian was clearly a major concern.

FINDINGS

The investigation has identified that on 10 March 2016, Mr Bekiaris, a man with impaired hearing and mobility walked in front of a prime mover that was stationary in southbound traffic on Burnley Road in Richmond. The driver of the prime mover, Mr Longley, was unable to see Mr Bekiaris and I make no adverse finding against him. I find that Mr Bekiaris contributed to his own death, by crossing the road in between the prime mover and another vehicle, in an area that was not a designated pedestrian crossing.

I accept and adopt the medical cause of death as identified by Dr Matthew Lynch and find that Constantinos Bekiaris died from 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. The Court does not appear to have received further correspondence from the Victorian Transport Association Inc. that would indicate further progress has been made in this area. In these circumstances, I repeat Coroner Spanos' recommendation in the Finding into the Death without Inquest of James Sawbridgeworth, and **I recommend that** the Victorian Transport Association Inc. and the Transport Industry Safety Group 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.

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:

Mrs Urania Bekiaris

Transport Industry Safety Group

Victorian Transport Association Inc.

Victorian Minister for Roads and Safety

Senior Constable Heather Obuch

Signature:

AUDREY JAMIESON
CORONER
Date: **5 June 2017**