IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 006309

FINDING INTO DEATH WITHOUT INQUEST

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

I, ROSEMARY CARLIN, Coroner having investigated the death of FAY DAWN ROGERS without holding an inquest:
find that the identity of the deceased was FAY DAWN ROGERS
born on 7 December 1950
and the death occurred on 12 December 2014
at Alfred Hospital, 55 Commercial Road, Prahran, Victoria

from:

1(a) TRAUMATIC HEAD INJURY SUSTAINED IN A MOTOR VEHICLE INCIDENT (PEDESTRIAN)

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

1. Mrs Rogers was born on 7 December 1950. She was 64 years old at the time of her death. Mrs Rogers lived with her husband in Moe, Victoria and she is survived by her family including her children.

2. Victoria Police provided a brief to the Coroner that included statements from Mrs Roger's husband, witnesses and investigating officers. I have drawn on all this material as to the factual matters in this finding.

3. Mrs Rogers' medical history included hypertension, osteoarthritis and impaired glucose tolerance. She was not a fast walker, however she walked on a daily basis from her home to

the local shops or to the RSL club and Veterans Centre where she volunteered and assisted her husband.

4. On Friday 5 December 2014, at approximately 7.30 a.m., Mrs Rogers had breakfast with her husband. Mr Rogers then left by car for an appointment. At approximately 8.40 a.m., Mrs Rogers left home to walk to Moe Medical Centre, approximately 300 meters away.

5. Along the way Mrs Rogers had to negotiate a large oval roundabout connecting five different roads. The roundabout was elevated with train tracks below it. Mrs Rogers walked from one connecting road, Narracan Drive to an adjacent connecting road, High Street. Mr Rogers drove past her on Narracan Drive and flashed his lights to indicate he would meet her at the medical centre.

6. When Mrs Rogers reached High Street she stopped behind a wooden light pole, intending to cross High Street. The pole was approximately 20 meters south east of the roundabout intersection.

7. At this time, Stephanie Broadbent drove her Honda Jazz along Narracan Drive before entering the roundabout at a low speed. Ms Broadbent veered left to exit onto High Street at the same time as Mrs Rogers stepped out from behind the pole. Mrs Rogers was struck by the front passenger side of Ms Broadbent's car. She became airborne and landed on the road unconscious.

8. Witnesses telephoned emergency services and gathered to help Mrs Rogers. Mr Rogers, who had arrived at the medical centre, walked across and remained with his wife. Mrs Rogers was shaking and her breathing was laboured. Paramedics arrived shortly after and airlifted her to the Alfred Hospital.

9. On arrival, an assessment of Mrs Rogers revealed multiple fractures and injuries including traumatic brain injury. She underwent a procedure to release pressure on her brain and surgery on her right leg. Due to the extent of her injuries and poor neurological recovery, a decision was made to palliate her. Mrs Rogers passed away on 12 December 2014.

10. Dr Yeliena Baber, Forensic Pathologist with the Victorian Institute of Forensic Medicine, performed an autopsy of Mrs Roger's body. The examination revealed injuries consistent with the collision. Dr Baber found 80% narrowing of the left anterior descending coronary artery and the left lung appeared collapsed. Neuropathology revealed grade 3 diffuse axonal injury and multiple haemorrhage. Although there was evidence of Mrs Rogers having natural disease, Dr Baber concluded that her head injury was likely to have been fatal in isolation. Dr Baber reported the cause of death as 1(a) traumatic head injury sustained in a motor vehicle incident (pedestrian).

11. I am satisfied having considered all the evidence that further investigation is not required. I am satisfied the collision was the result of Mrs Rogers stepping onto the road from behind a light pole when it was unsafe to do so. No charges were laid against Ms Broadbent who did not see Mrs Rogers until she was already on the road and it was too late to avoid her. Prior to that Ms Broadbent's vision was obscured by the light pole and possibly the wide 'A pillar' on the passenger side of her vehicle.

12. I find that Mrs Fay Rogers died on 12 December 2014 as a result of traumatic head injury sustained in a motor vehicle incident in which she was a pedestrian.

RECOMMENDATIONS

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

1. The Latrobe Shire Council and VicRoads take a coordinated approach to improving pedestrian safety at the High Street exit from the roundabout by relocating the light pole on High Street so that it no longer obscures the view of pedestrians **and/or** by building a designated pedestrian crossing further away from the roundabout and installing a fence to force pedestrians to cross the road at that point.

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

The family of Mrs Fay Rogers;

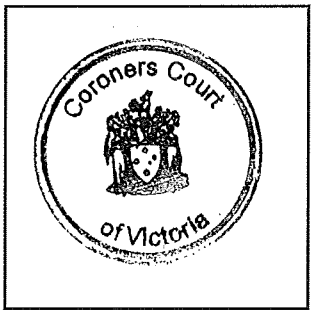
Latrobe Shire Council;

VicRoads;

Coroner's Investigator, Victoria Police; and

Interested Parties.

Signature:



ROSEMARY CARLIN
CORONER
Date: 15 December 2015