IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR1656/10

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: Francesco Vicendese

Delivered On:	17 May 2013
Delivered At:	Level 11, 222 Exhibition Street Melbourne 3000
Hearing Date:	15 May 2013
Findings of:	IAIN TRELOAR WEST, DEPUTY STATE CORONER
Representation:	Mr McLay for family Ms Shilling for Yarra Trams
Police Coronial Support Unit	S/C Kelly Ramsey

I, IAIN TRELOAR WEST, Deputy State Coroner having investigated the death of Francesco Vicendese

AND having held an inquest in relation to this death on 15 May 2013

at MELBOURNE

find that the identity of the deceased was Francesco Armando Vicendese

born on 29th January 1929

and the death occurred on the 4th May 2010

at the Royal Melbourne Hospital, Grattan Street, Parkville

from:

1 (a) Multi-organ failure complicating head, chest and abdominal injuries (operated) sustained due to impact by tram (pedestrian)

in the following circumstances:

1. On the 29th April 2010 at approximately 1.15 pm, Mr Vicendese was struck by a southbound B Class tram in Sydney Road, Brunswick, as he walked into its path from between two parked cars at the eastern kerb. The impact was in the centre of the road, approximately 31 metres south of the Moore Street intersection. Mr Vicendese sustained multiple injuries and was conveyed to the Royal Melbourne Hospital, where he suffered a respiratory arrest shortly after arrival. Despite subsequent resuscitation and surgical intervention, Mr Vicendese suffered a deterioration in his neurological state, renal function and cardiovascular stability. Mr Vicendese succumbed to the injuries he sustained and died on the 4th May, 2010.

2. No autopsy was performed in this case as the coroner, in consultation with Forensic Pathologist, Dr Melisa Baker, determined that a cause of death was evident from the post mortem CT scan findings and the clinical history. The cause of death was determined to be multi-organ failure complicating head, chest and abdominal injuries sustained by impact with a tram.

3. Mr Vicendese was 81 years of age at the time of his death and had a history of diabetes mellitus, hypertension, clubfoot, permanent pacemaker, past cerebrovascular accident, coronary artery bypass graft surgery and chronic renal impairment. It appears Mr Vicendese was cognitively intact, had good eyesight and hearing and despite his medical conditions, was able to live independently following the death of his wife in 2006. Mr Vicendese was familiar with Sydney Road and the Brunswick area, having lived in the vicinity (Coburg) since the 1950s.

4. In the location of the incident, Sydney Road is a two way undivided road running in a north south direction and with retail businesses on its eastern and western sides. There is provision for tram travel in each direction and marked bays for vehicles to park along either kerb. On the eastern side of the roadway the distance from the 1.9 metre wide parking bays to the first tram track is 2.2 metres and to the centre of the roadway is 5.2 metres. The designated speed limit for Sydney Road at the time of the incident was 50 kph.

5. The south bound tram was being driven by Mr Matthew Jessop. Mr Jessop had four years tram driving experience at the time and no history of incidents involving pedestrians.

Nevertheless, he had been involved in a number of incidents with motor vehicles, however, none involved disciplinary action being taken against him. He told the inquest that he was trained to drive defensively and believed he was driving in this manner prior to the incident occurring.

6. Evidence was heard from family members, the tram driver, two independent witnesses and a forensic collision investigator. The primary concern of the family was whether the tram driver could have avoided the impact, by keeping a better lookout and reacting more quickly to the presence of Mr Vicendese. The key to addressing this concern, is assessment of the driver's perception and reaction time.

7. Mr Vicendese's son and daughter both stated that their father was a very slow walker with an unusual gait and that he didn't run, or move quickly. His walking speed was estimated at 2 kph, which meant that it would take 9 to10 seconds for him to cross from the kerb to the centre of the road. They stated that their father had his full faculties and believed he would have been distracted from the presence of the oncoming tram, by looking at medication he had just picked up from a nearby pharmacy . Whilst the son gave evidence that his father's posture was stooped, the daughter stated he was quite erect. Despite their father being 164 cm in height, they believe the tram driver should have been able to see him prior to stepping out from between the parked cars.

8. Mr Jessop stated that when he was 'roughly on Moore Street', he first observed Mr Vicendese when he appeared from between parked cars, looking straight ahead and at no time looking right, or left. He variously described his forward movement as 'running walking very very fast', 'a slow jog' and an 'old man shuffle'. He estimated the tram speed to be approximately 30 kph at this time. (Polling data from the tram recorded the speed at 33 kph). Mr Jessop stated that as soon as he saw Mr Vicendese he sounded the tram gong, applied the brake and on realizing he was not going to stop, applied the emergency brake. This all took approximately one second. Mr Jessop estimated this occurred when the tram was approximately 10 metres away. The emergency braking system automatically engaged the gong to sound continuously, however there was no reaction from Mr Vicendese to the tram's oncoming presence. Mr Jessop stated he could do nothing more and that he was just praying the tram would stop in time. The right front of the tram struck Mr Vicendese, knocking him to the ground, before coming to a stop almost immediately thereafter.

9. Two independent witnesses gave evidence; one a passenger in a north bound vehicle and the other a south bound pedestrian on the eastern footpath. The north bound witness estimated it took "2, maximum 3 seconds" for Mr Vicendese to move to the centre of the road, whilst the other witness estimated it took him "up to 20 seconds", with him then stopping in the middle of the road. Neither saw Mr Vicendese look to his right prior to crossing and they both clearly heard the tram gong continuously sounding and tram brakes leading up to the impact.

10. The inquest also heard from Mr Michael Edgerton, a forensic investigator who was engaged by the tram operator, Yarra Trams, to investigate the incident. In his report dated the 2nd June 2010, Mr Edgerton concluded that Mr Jessop 'acted promptly and prudently to the best of his ability to try and avoid a collision'. He found the main contributing factor to be Mr Vicendese's failure to keep a proper lookout when crossing the road. He conceded in his report that his analysis of the collision and conclusions drawn, was based on information available at the time, and could be subject to change if further information became available. On hearing evidence of Mr Vincendese's walking capacity, he agreed that the assumed walking speed he had used in the perception/reaction analysis was inappropriate. Instead of the standard walking speed he adopted of 1.5 metres per second (mps), he believed 1mps would be more likely. After taking into account additional evidence and varying his

calculations, Mr Edgerton nevertheless remained of opinion that the driver acted promptly upon perceiving the need to react. Mr Edgerton was also of the opinion that Mr Vicendese would not have been visible to Mr Jessop prior to stepping out from between the parked cars, due to the driver's shallow visual angle created by the tram's distance at the time from the cars.

11. The evidence does not support a finding that this tragic incident could have been avoided by Mr Jessop. In order to make such a finding there would need to be clear and compelling evidence, not evidence that is speculative and imprecise. Where the difference of a metre or a fraction of a second can mean the difference between impact or avoidance, calculations to determine perception/reaction time, need to be supported by précis data. Hence, as an example, speculation regarding Mr Vicendese's kilometre per hour walking speed, cannot be of assistance in determining the time it took him to cross the road. In addition, witness observations are unhelpful in trying to determine this issue. Mr Vicendese's walking speed was variously described as, 'very, very slow', 'slowly', 'slow to medium pace', 'fast walk', 'slow jog', 'running very very fast', 'old man shuffle' and 'moving fairly quickly'. These descriptions are imprecise, subjective and of no probative value. Similarly, witness estimates of 3 seconds and 20 seconds to cross the road, are unhelpful in determining the walking speed.

COMMENTS

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

Mr Vicendese's son raised two matters of concern during the course of his evidence. The first related to a significant delay (22 hours) in being notified of his father's death, with the notification not coming from the hospital, but from his aunt. It appears she had been notified after the hospital had been trying to contact Mr Vicendese's wife. Mrs Vicendese died in 2006. I do not have full details of the circumstances giving rise to this error, as the matter is not one that falls within the coroner's jurisdiction. Nevertheless I would hope enquires are made by the hospital as to how the mistake arose, with an explanation then passed on to the family.

The second matter raised was that he had no contact with the police investigator until November 2010. S/C Farley explained that this delay was in part due to him first learning of Mr Vicendese's death, when he received a request to compile an inquest brief from the Coroners Court in June 2010, As delay is critical to any investigation, the circumstances as to why it occurred in this case, should be looked into.

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

Family of the deceased

Yarra Trams

Mr Michael Edgerton

S/C Troy Farley

Royal Melbourne Hospital

Chief Commissioner of Police

Signature:

IAIN WEST
DEPUTY STATE CORONER
Date: **17 May 2013**