IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 5064

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of JAMES SAWBRIDGEWORTH without holding an inquest:
find that the identity of the deceased was JAMES SAWBRIDGEWORTH
born on 19 December 1927
and that the death occurred on 2 October 2014
at Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria 3052
from:

1 (a) MULTISYSTEM FAILURE COMPLICATING 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 James Sawbridgeworth was an 86 year old retired man who resided alone at 5/11 O'Hea Street Coburg, Victoria. His past medical history included ischaemic heart disease with coronary artery bypass graft surgery, hypertension and hypercholesterolaemia. More recently, Mr Sawbridgeworth had recently developed a stooping gait and started using a walking frame to help him move around safely.

2 On 11 September 2014 at about 11.58am, a single vehicle collision occurred on Bell Street, Coburg, about five metres from its intersection with Waterfield Street. The collision occurred when Mr Sawbridgeworth tried to cross Bell Street from north to south, passing in front of traffic which was stationary at a red traffic control signal.

3 Mr Sawbridgeworth was hit by a blue 1995 Mack 'long nose' prime mover driven by Mr Timothy Cations. The prime mover was towing a semi-trailer and travelling east along Bell Street, Coburg. A witness, Mr Michael Tobin, saw the driver move forward when the traffic control signal applicable to him changed from red to green. Impact was between the front of

the prime mover and Mr Sawbridgeworth who was dragged several metres before the Mr Cations was alerted to the situation by the shouts of several witnesses and stopped the truck.

4 Mr Sawbridgeworth was assisted by bystanders including a medical practitioner, Dr Arul Sivanesan, who happened to be driving past and stopped to offer assistance. Dr Sivanesan and responding ambulance paramedics removed Mr Sawbridgeworth from under the right front wheel of the truck.

5 Mr Sawbridgeworth was taken by ambulance to Royal Melbourne Hospital [RMH] where investigations revealed a broken leg, lacerations to both hands, and to the left side of his head and a broken pelvis. He suffered a complicated clinical course including chest and urinary sepsis, ongoing need for inotropes, gastrointestinal complications and metabolic derangements. On 2 October 2016, following consultation between Mr Sawbridgeworth's family and treating clinicians, the decision was taken to cease active treatment and adopt a palliative approach. Mr Sawbridgeworth was kept comfortable until he passed away later that day.

6 Dr Matthew Lynch, Senior Forensic Pathologist with the Victorian Institute of Forensic Medicine [VIFM] reviewed the circumstances as reported by police to the coroner, the medical deposition and medical records from RMH and performed an autopsy. Dr Lynch advised that it would be reasonable to attribute Mr Sawbridgeworth's death to *multisystem failure complicating injuries sustained in motor vehicle collision (pedestrian).*

7 Routine post-mortem toxicological analysis detected fentanyl, midazolam, olanzapine, metoclopramide, bupivacaine and lignocaine, consistent with therapeutic administration in a palliative setting.

8 Immediately following the collision, police attended the scene to provide traffic control and commence their investigation. One of the attending police officers was Senior Constable Jason Doyle from Fawkner Police who provided the brief of evidence on which this finding is largely based. SC Doyle noted that traffic was (typically) heavy at the time of the collision but found no fault with the road surface or with road infrastructure that may have caused or contributed to the collision.

9 SC Doyle concluded that the collision resulted from Mr Sawbridgeworth mistiming his crossing in that he was directly in front of the large prime mover as the applicable traffic control signal changed to green. Being of relatively small stature (167 cm tall) with a stooping gait, the truck driver would have been unable to see him walk to the front of the nose of the truck and/or would have been unable to see Mr Sawbridgeworth in front of the nose of the prime mover as he took off from a stationary position.

10 SC Doyle made two suggestions for recommendations arising out of this investigation –

a. That prime movers with limited forward visibility be fitted with forward facing cameras, sensors or a mirror system which show the area immediately in front of the truck in a similar way to rear facing cameras on four wheel drive vehicles.

b. That a pedestrian refuge be placed in Bell Street near Waterfield Street, with barriers and signs erected on the southern footpath of Bell Street to encourage pedestrians to use the nearby pedestrian crossing at the intersection of Bell Street and Sydney Road.

11 I find that Mr Sawbridgeworth died as a result of the complications of injuries sustained in the motor vehicle collision on 11 September 2014 and that his cause of death is appropriately formulated as *multisystem failure complicating injuries sustained in motor vehicle collision as a pedestrian.* The available evidence supports a finding that the collision was primarily caused by Mr Sawbridgeworth placing himself in a position where he was not visible to the driver of the prime mover as he took off from a stationary position. There is no suggestion in the available evidence that there was any want of clinical management of care on the part of the staff of RMH that caused or contributed to the death.

COMMENTS

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

1 In light of the circumstances in which the collision occurred, I asked the Coroners Prevention Unit [CPU] to search coronial data and provide advice 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 the driver apparently not seeing the pedestrian. I also asked for advice about any previous coronial comments or recommendations relevant to the circumstances.

2 By reference to coronial data for the period 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.[1] Of these 70 deaths, CPU identified 31 deaths where it appeared the truck or heavy vehicle driver did not see the pedestrian before the collision and 14 (other than the present case)[2] occurring where a stationary truck collided with an unobserved pedestrian after it commenced moving forward from a stationary position, as in the case of Mr Sawbridgeworth.

3 CPU did not identify any coronial findings with recommendations or comments relevant to this death but did advise that crash avoidance systems (including features such as forward

[1] For present purposes CPU included light trucks but excluded large four wheel drive vehicles and utilities. Also excluded were intentional deaths and possible suicides, thus focusing on accidents proper.

[2] For convenience and future reference the relevant coroner's court references are 2002 2953; 2003 2614; 2005 3021; 2007 2514; 2009 6026; 2010 0850; 2010 2820; 2011 0890; 2011 1465; 2011 3325; 2013 3152; 2013 5554; 2015 1076 (not finalised at time of writing); 2016 1102 (not finalised at time of writing);

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.

RECOMMENDATION

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

1. That the Transport Industry Safety Group considers the particular challenges to pedestrian safety – especially those older and more vulnerable pedestrians - posed by trucks 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.

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

Mr Robert Sawbridgeworth

Senior Constable Jason Doyle, Fawkner Highway Patrol

Transport Industry Safety Group

Victorian Transport Association

Minister for Transport

Signature:

PARESA ANTONIADIS SPANOS

Coroner

Date: 9 Jun 2016

Cc Manager, Coroners Prevention Unit