IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 5023/08

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of LUIZA EFTIMOVA

Delivered On:	23 March 2012
Delivered At:	Coroner's Court of Victoria Level 11, 222 Exhibition Street Melbourne Victoria
Hearing Dates:	29 August 2011
Findings of:	JOHN OLLE, CORONER
Police Coronial Support Unit:	Sergeant Tracy Weir

I, JOHN OLLE, Coroner having investigated the death of LUIZA EFTIMOVA

AND having held an inquest in relation to this death on 29 August 2011
at Melbourne

find that the identity of the deceased was LUIZA EFTIMOVA

born on 29 May 1943

and the death occurred on 9 November 2008

at Royal Melbourne Hospital, Grattan Street, Parkville, Victoria 3052

from:

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

in the following circumstances:

1. Luiza Eftimova was aged 65 years at the time of her death. She lived at 4/7 Boston Place, Fitzroy North.

2. At inquest, I heard an opening from Sergeant Weir and heard evidence from Martin Chelini.[1]

3. At approximately 4.00pm on Sunday, 9 November 2008, Ms Eftimova approached the intersection of Scotchmer and Nicholson Streets, North Fitzroy. The weather was clear and fine.

4. Ms Eftimova lived approximately 700 metres from the intersection, which was well familiar to her. Witnesses observed Ms Eftimova on the footpath on the eastern side of Nicholson Street and the north side of Scotchmer Street. She walked in a westerly direction across Nicholson Street to the pedestrian lights heading towards a southbound tram stop located in the middle of the road.

5. The southbound lanes on Nicholson Street at the time had a green light to proceed through Scotchmer Street intersection.

6. Prior to entering the intersection, Ms Eftimova took only a quick glance to her right. A motor vehicle driven by Brian Preece was travelling south along Nicholson Street in the right hand lane. It appears that half way across the intersection Ms Eftimova first became aware of the oncoming vehicle. Neither Mr Preece nor Ms Eftimova had an opportunity to avoid impact. Tragically Ms Eftimova received injuries from which she subsequently died. No responsibility is attached to the driving of Mr Preece.

Post Mortem Medical Examination

7. On 12 November 2008, Dr Matthew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an external examination on the body of Luiza Eftimova.

[1] Manager Signal Service, VicRoads

8. Dr Lynch found the cause of death to be injuries sustained in a motor vehicle collision (pedestrian).

The Red Pedestrian Lamp was not operating

9. Investigations revealed that the red pedestrian lamp applicable to Ms Eftimova was not working on the day of the incident. At the inquest Mr Chelini explained:

i. VicRoads records reveal that the lamp had blown on the 28 October 2008;
ii. At the time of the incident, it had not been repaired;
iii. It was repaired on the 12 November 2008, during a routine maintenance check;
iv. The current system does not allow the maintenance log to be notified by a fault recorded on the SCAT system;
v. VicRoads are upgrading intersections to ensure there are sufficient "controllers" with the capability of known maintenance of faults;
vi. Further, VicRoads are currently converting lanterns from Incandescent/Quartz Halogen to LED lamps;
vii. With the new system, the maintenance contractor is obliged to repair a blown lamp within one day or less.

The issue is to ensure that one system talks to the other

10. Mr Chelini explained:

"It is just about the programming, identifying the - trying to automate a system so that one system talks to another."

11. In terms of urgency, Mr Chelini considered there is a three-part solution to the current problem.

12. However, he explained the most cost effective:

"Come up with an automated system that can extract the information from SCAT and generate a RAI which is the maintenance job."[2]

13. Mr Chelini explained that the second aspect of the solution would be to:

"Provide funding to swap out the remaining relay-driver controllers, which don't have the lamp-monitoring facility."[3]

[2] Transcript p.14
[3] Transcript p.14

14. And finally Mr Chelini explained:

> *"The third part is we're actually in the process of converting to LED lantern, so that's vehicle and pedestrian."*[4]

15. Mr Chelini explained that significant funds were allocated from government approximately 12 months ago to replace the lanterns, however, a significant number of sites are waiting upgrade.

16. In response to the question as to the length of time required to complete the upgrade if sufficient funds were allocated, Mr Chelini responded:

> *"We started the program last financial year to do the five or six hundred. So there's the contracts to be set up, there's the resources out there. The manufacturers can gear up if they know it is going to happen."*[5]

17. Mr Chelini explained that the first aspect, however, was the most cost effective for the following reasons:

> *"Maybe two-thirds of the network or more than two-thirds of the network already has this capability. It's just about a matter of automating that, so the return is quite good and the second part would be then to move in and, you know, do the next part, with replacing the non-lamp monitoring controllers."* [6]

18. In the interim, Mr Chelini explained that if a member of the public observe a lamp blown, a telephone call to 131170 will be responded to by the Traffic Management Centre which is manned 24/7. Upon provision of the site details an immediate maintenance job will result:

> *"Within the contract, the maintenance contract, there are response times. Now it's not my area of expertise but I know that it is - for pedestrian lanterns it is within a day or so.*
>
> *So certainly you'd say if that happened, if that report was made, there wouldn't be 12 days before it got fixed?*
>
> *--- No.*
> *So that would be a breach of a term of the contract and there would be action taken?*
> *--- Yes, there would be non-conformance."* [7]

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[4] Transcript p.14
[5] Transcript p.14
[6] Transcript p.16
[7] Transcript p.15

A Matter of Speculation

19. It is a matter of speculation to find why Ms Eftimova crossed the intersection in the path of oncoming vehicles with right of way through a green light. However, it remains a possibility that Ms Eftimova, being familiar with the intersection, incorrectly assumed that because there was no red pedestrian light, it was safe for her to proceed. I consider it essential in circumstances in which the technology exists to ensure that the two systems communicate, namely, a fault is communicated to maintenance contractor and repaired within 24 hours.

20. In circumstances in which the blown pedestrian lamp at the intersection occurred on 28 October, it should have been repaired within 24 hours, namely, well before 9 November 2008.

RECOMMENDATIONS

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

1. That VicRoads implement an automated system, which extracts the information from SCAT and generates an RAI (maintenance job) as a matter of urgency;

2. That VicRoads issue a media release informing members of the public to report lamp and signal failures on the 131170 Fault Reporting Number to the Traffic Management Centre.

Finding

I find the cause of death of Luiza Eftimova to be injuries sustained in a motor vehicle collision (pedestrian).

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

- The family of Luiza Eftimova;
- Investigating Member, Victoria Police;
- Mr Preece;
- VicRoads.

Signature:

Coroners Court of Victoria

JOHN OLLE
CORONER

Date: 23 March, 2012