IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 3779

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Jacqui Hawkins, Coroner
Deceased:	Walentyna Huczyk
Date of birth:	11 August 1923
Date of death:	19 July 2019
Cause of death:	1(a) Complications post scooter versus car incident
Place of death:	Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004

INTRODUCTION

1. On 19 July 2019, Walentyna Huczyk was 95 years old when she died from complications of injuries sustained when she was struck by a car whilst crossing the road on her motorised mobility scooter. At the time of her death, Ms Huczyk lived alone in Sale.

THE CORONIAL INVESTIGATION

2. Ms Huczyk's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

4. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

5. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Huczyk's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into the death of Ms Huczyk, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities. [1]

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

7. On 16 July 2019, Ms Huczyk travelled home from the local shops using her powered mobility scooter. She travelled north along Raymond Street, Sale, towards the pedestrian crossing area near the intersection with Stawell Street.

8. Near this intersection, Raymond Street is a two-way road running north to south. The north and south bound lanes are divided by centre road car parking with concrete edging containing space for pedestrians to cross at Stawell Street. The sign posted speed limit is 50km/h.

9. At the same time, six friends in three cars travelled in convoy heading south on Raymond Street. They were passing through Sale intending to buy some food. Brayden McConnell was driving the middle car of the convoy, his 2001 White Toyota Hilux.

10. As they approached Stawell Street, Mr McConnell saw a woman on a mobility scooter on the far side of the road. There was also a car coming from the opposite direction, stationary on Raymond Street, waiting to turn right onto Stawell Street. The lead car moved past the stationary car and as Mr McConnell moved closer to the intersection, Ms Huczyk appeared from behind the stationary car, crossing Raymond Street on her scooter.

11. Mr McConnell applied his brakes and swerved. However, his brakes locked up limiting his ability to steer. As the car skidded, it impacted Ms Huczyk's scooter and she was thrown from it. When his car came to a stop, Mr McConnell and his friends immediately went to assist Ms Huczyk, she was conscious but complained of pain to her shoulder.

12. Victoria Police members attended the scene of the incident and commenced an investigation into the cause of the collision. They took scene photographs and measurements and observed skid marks on the road.

13. Ambulance Victoria Paramedics attended and conveyed Ms Huczyk to Sale Hospital. At hospital, she was identified to have fractured ribs with flail chest, small right hemopneumothorax, T6-T7 spinal process fracture, and right scapular fracture.

14. On 17 July 2019, Ms Huczyk was transported to the Alfred Hospital and admitted to the Intensive Care Unit (**ICU**). Her condition deteriorated the following night, with delirium and agitation. Ms Huczyk was provided palliative care and she passed away on 19 July 2019.

15. Victoria Police subsequently conducted a collision reconstructed and calculated that the Toyota Hilux was travelling at 54km/h when it commenced skidding. Police did not identify any problems with the design, structure or maintenance of the relevant section of Raymond Street.

Identity of the deceased

16. On 23 July 2019, Walentyna Huczyk, born 11 August 1923, was visually identified by her daughter, Helena Anderson.

17. Identity is not in dispute and requires no further investigation.

Medical cause of death

18. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 22 July 2019 and provided a written report of his findings dated 29 July 2019.

19. The post-mortem examination revealed significant injuries to Ms Huczyk's chest which had led to respiratory failure.

20. Toxicological analysis of ante-mortem samples identified the presence of morphine,[2] prazosin,[3] ondansetron,[4] and paracetamol.[5]

21. Dr Bedford provided an opinion that the medical cause of death was '1(a) Complications post scooter versus car incident'.

22. I accept Dr Bedford's opinion.

FINDINGS AND CONCLUSION

23. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    (a) the identity of the deceased was Walentyna Huczyk, born 11 August 1923;

    (b) the death occurred on 19 July 2019 at the Alfred Hospital, 50 Commercial Road, Melbourne, Victoria from 1(a) complications post scooter versus car incident; and

[2] Morphine is a narcotic analgesic used for the treatment of moderate to severe pain.
[3] Prazosin is used for the treatment of high blood pressure.
[4] Ondansetron is used clinically to control nausea and vomiting in post-operative patients and in those receiving cytotoxic chemotherapy and radiotherapy.
[5] Paracetamol is an analgesic drug.

(c) the death occurred in the circumstances described above.

24. I am satisfied that Mr McConnell drove reasonably and his driving did not cause the collision.

25. I convey my sincere condolences to Ms Huczyk's family for their loss.

COMMENTS

26. Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

27. Deaths of mobility scooter-users are sadly not uncommon in the coronial jurisdiction. This is one of three I have recently investigated.[6]

28. The Australian Institute of Health and Welfare (**AIHW**) conducted a review of mobility scooter related injuries and published an overview in May 2019.[7] They found that in Australia, 69 people aged 60 and over died from a mobility scooter-related incident between 1 July 2006 and 30 June 2016. Sixty-four percent of these individuals died following a collision incident between their mobility scooter and another transport vehicle, such as a car, truck, or train. The most common activity at the time of the fatal mobility scooter incident was crossing a road (45%).

29. In November 2020, VicRoads released a guide for choosing and using mobility scooters and powered wheelchairs and a fact sheet for general practitioners about motorised mobility scooters.[8] These are useful resources to prepare new mobility scooter users for safe use of their device. I commend VicRoads for producing this resource.

30. Noting similar trends to the AIHW, the Coronial Investigator, Senior Constable Lachlan Adams proposed a recommendation for a public safety campaign to increase awareness and safety of mobility scooter users. I agree with SC Adams that there is an opportunity to promote public awareness of mobility scooter users as a potential traffic hazard distinct from pedestrians on foot and cyclists. With the aim of improving the safety of mobility scooter users (and all road users), I have made a recommendation in line with these comments.

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[6] Coronial investigation into the death of Donald Johnston COR 2018 1109; Coronial investigation into the death of Lambertus Embregts COR 2020 1453

[7] AIHW: McKenna K, Tovell A & Pointer S 2019. Mobility scooter-related injuries and deaths. Injury research and statistics series no. 121. Cat. no. INJCAT 201. Canberra: AIHW. Accessed at <https://www.aihw.gov.au/getmedia/61abe614-d7b8-41c3-ba9a-0215f77a7c89/aihw-injcat-201.pdf.aspx?inline=true>

[8] Accessed at https://www.vicroads.vic.gov.au/safety-and-road-rules/pedestrian-safety/motorised-mobility-devices

RECOMMENDATION

31. Pursuant to section 72(2) of the Act, I make the following recommendations:

    I recommend that the Victorian Department of Transport implement a targeted public awareness campaign to highlight the risks associated with motorised mobility scooters as a potential traffic hazard.

32. Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

    Helena Anderson, Senior Next of Kin

    Mr Paul Younis, Secretary of Department of Transport

    Alfred Health

    Dr William Truong

    Senior Constables Lachlan Adams, Coroner's Investigator

Signature:

JACQUI HAWKINS

CORONER

Date: 29 March 2021

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.