IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 003498

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Laurence Maxwell Attwood
Date of birth:	27 August 1952
Date of death:	4 July 2021
Cause of death:	1(a) Ischaemic infarction of the right cerebral hemisphere and cerebellum due to thrombosis of the basilar artery and right posterior cerebral artery (operated and palliated) 1(b) Motor vehicle incident (pedestrian vs. car) with head strike and fracture of the distal right tibia
Place of death:	The Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004
Keywords:	Road safety, pedestrian safety, motor vehicle collision, Warrigal Road

INTRODUCTION

1. On 4 July 2021, Laurence Maxwell Attwood was 68 years old when he passed away at the Alfred Hospital after being struck by a motor vehicle on 27 June 2021 when he attempted to cross the road on Warrigal Road, Hughesdale.

2. At the time of his death, Mr Attwood lived with his wife, Kathryn Sutton, at Golf Links Avenue, Oakleigh.

3. Ms Sutton stated she and her husband had lived in the Hughesdale area for 20 years and considered themselves to be very familiar with the area. Ms Sutton also described her husband as "*fairly road savvy. He usually used pedestrian lights to cross intersections*".[1]

4. The available evidence indicates that Mr Attwood was in good health and was not known to be suffering from any impairments.

THE CORONIAL INVESTIGATION

5. Mr Attwood'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.

6. 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.

7. 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.

8. Victoria Police assigned Senior Constable Mallory Inger (**SC Inger**) to be the Coroner's Investigator for the investigation of Mr Attwood's death. SC Inger conducted inquiries on my behalf, including taking statements from witnesses – such as the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

[1] Coronial Brief of Evidence (**CB**), Statement of Kathryn (Kate) Sutton, p17.

9. This finding draws on the totality of the coronial investigation into the death of Laurence Maxwell Attwood, 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.[2]

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

Circumstances in which the death occurred

10. On the Sunday morning of 27 June 2021, at approximately 10.10am, Mr Attwood left home on foot to attend the morning church service at Oakleigh Baptist Church, located at 185 Warrigal Road, Hughesdale. Ms Sutton stated her husband always attended church on Sundays and "*if the weather was fine, he would walk to church and if not, he would drive*".[3] Ms Sutton stated her husband would normally arrive home at approximately 12.00pm after finishing church service.

11. According to Google Maps, the church is located approximately 1.1 kilometres west of Mr Attwood's home. It is about a 15-minute walk via Schoolhall Street, Hughesdale.

12. At approximately 11.52am, Mr Attwood was making his way back to his house, attempting to cross Warrigal Road near the T-intersection of Warrigal Road and Schoolhall Street in a west-to-east direction. There was also a bus stop on the west of the T-intersection, facing Schoolhall Street.

13. At that time, Jimmy Goh was driving a black Audi RS6 ('the vehicle') on the northbound lane of Warrigal Road and saw Mr Attwood step out of the pavement and onto the road in the path of his vehicle. Mr Goh applied brakes but was unable to stop his vehicle in time, and Mr Attwood was struck on the right side of his body as a result.

14. Mr Goh immediately exited his vehicle and assisted Mr Attwood. Road users also stopped and came to the aid of Mr Attwood. Emergency services were contacted.

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[2] 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.

[3] CB, Statement of Kathryn (Kate) Sutton, p17.

15. Ambulance Victoria paramedics arrived shortly after and observed Mr Attwood lying supine on the nature strip as he had already been moved to a safe spot. He was conscious and denied pelvic pain on palpation. Once stabilised, Mr Attwood was conveyed by ambulance to the Alfred Hospital for further treatment and medical investigation. He arrived at 1.34pm and was admitted for further treatment and observation.

16. Around midnight on 28 June 2021, Mr Attwood experienced a sudden neurological deterioration with reduced consciousness. He then experienced left hemiparesis (one-sided muscle weakness), which was determined to be a result of a thrombus at the basilar tip with occlusion of the right posterior cerebral artery. He was later transferred to the Intensive Care Unit once the clot was retrieved.

17. On 30 June 2021, Mr Attwood underwent a magnetic resonance imaging (**MRI**), which revealed extensive brain infarction with a mass effect. Scattered embolic infarcts were also noted. Mr Attwood's treating physicians deemed him unsuitable for neurosurgical intervention.

18. In the following days, Mr Attwood's neurological function did not improve despite the cessation of sedatives. Following a discussion with his family, it was agreed that he be commenced on comfort care.

19. Comfort care was commenced on 3 July 2021 and Mr Attwood passed away on 4 July 2021.

Police investigation

20. Following the incident, members of Victoria Police, including SC Inger, attended and examined the scene as part of their wider investigation.

21. Upon attending the scene, SC Inger noted that at the time of the incident, the weather was clear and sunny, the road was dry, and the traffic was considered heavy.

22. SC Inger noted that Warrigal Road, Hughesdale, is a two-way road with four lanes, running north to south. There are two northbound lanes and two southbound lanes. The opposing lanes are divided by a solid white line. The road was constructed of bitumen and was in good condition, with no damage or faults that would have caused or contributed to the collision. The speed limit of the relevant section of Warrigal Road is set at 60km/h.

23. Police conducted a preliminary breath test on Mr Goh, which returned a negative result. Mr Goh told police that he was driving between 30 to 40 km/h due to the heavy traffic.[4] Police ascertained that Mr Goh held an appropriate Victorian driver's licence without any restrictions on his licence.

24. Following inspection of the vehicle, police ascertained that there were no mechanical faults or failures that caused or contributed to the collision. Throughout their interactions with Mr Goh, police also observed that Mr Goh did not appear fatigued and accordingly ruled out driver fatigue as being a factor in the collision.

Identity of the deceased

25. On 4 July 2021, Laurence Maxwell Attwood, born 27 August 1952, was visually identified by his son, Michael Allan Lawrence.

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

Medical cause of death

27. On 6 July 2021, Forensic Pathologist Dr Hans de Boer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on the body of Mr Attwood. Dr de Boer reviewed the post-mortem tomography (**CT**) scan and the scene photographs taken by Victoria Police and considered the Victoria Police Report of Death (Form 83), E-Medical Deposition Form, VIFM contact log and medical records from Alfred Health. Dr de Boer provided a written report of his findings dated 8 July 2021.

28. The post-mortem CT scan revealed the following:

- Soft tissue swelling on the right back of the head. No skull fracture.
- Cerebral oedema.
- Hypodensity in the territories of the right posterior cerebral artery and basal ganglia on the right.
- Cerebral midlines shift to the left with compression of the right ventricle.
- Transverse fracture of the medial malleolus of the right tibia.

29. Toxicological analysis of ante-mortem samples was not indicated.

[4]CB, Statement of Jimmy Goh, p10.

30. Dr de Boer ascribed the medical cause of death to:

1 (a) ischaemic infarction of the right cerebral hemisphere and cerebellum due to thrombosis of the basilar artery and right posterior cerebral artery (operated and palliated)

1(b) Motor vehicle incident (pedestrian vs. car) with head strike and fracture of the distal right tibia.

COMMENTS

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

1. There are descriptions in the Coronial Brief of road users concerned about the safety of the relevant section of Warrigal Road for pedestrians. One road user, Melanie Alabarella noted, *"I had lived on Warrigal Road for many years and I knew this to be very common occurrence at this section of Warrigal Road as pedestrians often cut through Schoolhall Street"*[5]. A further road user, Tom Boyd noted, *"the traffic at the time was quite busy, and there was no pedestrian crossing in proximity to the bus stop. It appeared as though the elderly man stepped out without looking for traffic"*[6].

2. Discounting the other external factors that may have contributed to the collision, as discussed above, I find that the factor contributing to the collision was Mr Attwood's walking with the flow of the traffic, which meant he may not have been aware of traffic approaching behind him.

3. According to the pedestrian statistics compiled by the Transport Accident Commission (**TAC**), a total of 175 pedestrians lost their lives after being struck by vehicles on Victorian roads in the last five years.[7] This makes up around 15% of the total number of road deaths each year, with 70% of total pedestrian deaths recorded in Metro Melbourne. The statistic also found almost four in ten (38%) pedestrians lost their lives on 60km/h roads.[8]

4. I note the Victorian Road Safety Strategy 2021-2030 ('the Strategy'), which aims to halve the number of road deaths and reduce serious injuries by 2030.[9] Specific aims include ensuring

[5] CB, Statement of Melanie Alabarella, p13.
[6] CB, Statement of Tomy Boyd, p15.
[7] Transport Accident Commission (**TAC**) website, *Pedestrian statistics*. https://www.tac.vic.gov.au/road-safety/statistics/summaries/pedestrian-statistics
[8] Ibid.
[9] Department of Transport, *Victorian Road Safety Strategy 2021-2030*, 2020 ('the Strategy'). Available on the TAC website, https://www.tac.vic.gov.au/road-safety/victorian-road-safety-strategy/victorian-road-safety-strategy-2021-2030.

all Victorians are safe and feel safe on and around Victorian roads and embedding a culture of road safety within the Victoria community. Two of the strategy's action plans are to deliver road safety infrastructure improvement projects, investigate the safety issues associated with people accessing public transport, and then develop a program to address these risks.[10]

5. The Strategy acknowledges that "*road safety is complex, and that it takes a collective response across government agencies…and the Victorian community to deliver safer roads*" and further *"requiring a bold, innovative and future focus approach[11]"* through *inter alia* infrastructure improvement and public information campaigns.[12] To this end, I accept that improving road safety for pedestrians especially requires multifarious efforts across the Victorian government, local government and road users to improve road safety, including pedestrian safety in local infrastructure and educational campaigns tailored to defined sub-groups to ensure maximum effectiveness.

6. I acknowledge and commend Public Transport Victoria[13], TAC[14], and the Pedestrian Council of Australia[15] for their efforts in initiating campaigns that focussed on pedestrian safety. While these efforts are commendable, the infrastructure along the relevant section of Warrigal Road, Hughesdale, appears to be lacking. As evidenced by circumstances surrounding Mr Attwood's tragic death and the statement of witnesses, the relevant section of Warrigal Road has a significant pedestrian desire line. There are three bus stops within the proximity of 500 metres between 135 and 193 Warrigal Road but without a designated pedestrian crossing that allows safe and secure access between the eastern and western sides of Warrigal Road. I find that Mr Attwood placed himself in a dangerous situation as a result of the absence of a pedestrian crossing in the proximity of the collision site. I will make recommendations to this effect.

RECOMMENDATIONS

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

1. With the aim of promoting public health and safety and preventing like deaths, I recommend that the VicRoads review the design of the relevant section of Warrigal Road, Hughesdale, in

[10] Department of Transport, Victorian Road Safety Action Plan
[11] n9, The Strategy, p6.
[12] Ibid, p10.
[13] See Public Transport Victoria website, *Crossing safely*. https://www.ptv.vic.gov.au/more/travelling-on-the-network/travelling-safely/crossing-safely/
[14] See TAC website, *Pedestrians*. https://www.tac.vic.gov.au/road-safety/road-users/pedestrians
[15] See the Pedestrian Council of Australia website, *DON'T TUNE OUT - STOP LOOK LISTEN THINK. https://www.walk.com.au/pedestriancouncil/donttuneout.asp*

light of the circumstances of this collision and consider improving the existing infrastructure with a view to enhancing pedestrian safety and accessibility.

2. With the aim of promoting public health and safety and preventing like deaths, I recommend that the City of Monash consider developing and implementing a local education campaign directed at pedestrians in their catchment areas.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was Laurence Maxwell Attwood, born 27 August 1952;

   b) the death occurred on 4 July 2021 at the Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004;

   c) I accept and adopt the medical cause of death ascribed by Dr Hans de Boer, and I find that Laurence Maxwell Attwood died from ischaemic stroke due to blockage of brain arteries[16] (operated and palliated) following a motor vehicle incident and in the circumstances where Lauren Maxwell Attwood was attempting to cross the relevant section of Warrigal Road without a designated pedestrian crossing; and

   d) I further find that Lauren Maxwell Attwood sustained a head strike and fracture of the distal right tibia as a result of the motor vehicle incident.

I convey my sincere condolences to Mr Attwood's family for their loss.

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

Kathryn Sutton

Senior Constable Mallory Inger, Coroner's Investigator

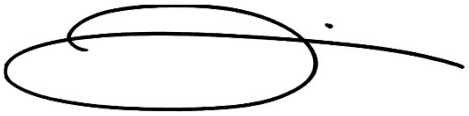
Transport Accident Commission

City of Monash

VicRoads

[16] Specifically the basilar artery and right posterior cerebral artery.

Signature:



AUDREY JAMIESON

CORONER

Date: 23 July 2024

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.