



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 003812

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Coroner Simon McGregor
Deceased:	Ludmila Sezonenko
Date of birth:	15 October 1957
Date of death:	19 July 2021
Cause of death:	1(a) Multiple injuries sustained in a motor vehicle incident (pedestrian)
Place of death:	Monash Freeway, Doveton, Victoria, 3177
Keywords:	Motor vehicle collision, pedestrian, lighting, Good Samaritan, Heatherton Road, Monash Freeway, VicRoads.

INTRODUCTION

1. On 19 July 2021, Ludmila Sezonenko was 63 years old when she died as a result of injuries sustained in a motor vehicle collision. At the time of her death, Ludmila lived at 22 Jarman Drive, Langwarrin.
2. Ludmila's family had previously cautioned her against getting out of her car at collision scenes however, consistent with her generous nature, Ludmila told them "I'll be fine. If someone needs help you can't ignore them". Her family recalled that Ludmila "always wanted to help".¹

THE CORONIAL INVESTIGATION

3. Ludmila'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.
4. 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.
5. 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.
6. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ludmila'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.

¹ Coronial brief, statement of Phillip Sezonenko dated 12 April 2022, page 11.

7. On 8 February 2022, I confirmed that no criminal charges had been laid against the driver responsible for impacting Ludmila. According to the Victoria Police investigation, and as will be discussed below, at the time of impact the driver was travelling below the posted speed limit and had moved into another lane to avoid a collision with a crashed vehicle.
8. This finding draws on the totality of the coronial investigation into the death of Ludmila Sezonenko 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
9. In considering the issues associated with this finding, I have been mindful of Ludmila's basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006* (Vic), in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

10. On 19 July 2021 at approximately 3.10am, a vehicle (the *Suzuki*) travelling in an easterly direction along Heatherton Road, Endeavour Hills, was involved in a collision which resulted in it landing on the city-bound carriageway of the Monash Freeway, travelling across all five lanes, impacting the concrete median bollards, and coming to rest in the right-hand traffic lane (*the fifth lane*).³
11. At approximately the same time, Ludmila was travelling in a northerly direction in the city-bound carriageway of the Monash Freeway. Upon observing the crashed Suzuki, Ludmila stopped her vehicle in the left-hand lane of the Monash Freeway (*the first lane*) opposite the collision and exited her vehicle, crossing the remaining four lanes of traffic to reach the crashed Suzuki.⁴

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 Coronial brief, statement of Detective Senior Constable (DSC) Lindon Walker dated August 2021, page 19; statement of May Wang dated 1 April 2022, page 92.

⁴ Coronial brief, statement of DSC Lindon Walker dated August 2021, page 19

12. As Ludmila crossed the lanes of traffic, another vehicle (the *Toyota*), travelling in the city-bound carriageway of the Monash Freeway, rounded a slight right-hand bend south of the collision and swerved from the fifth lane to the second right-hand lane (*the fourth lane*) to avoid impacting the crashed Suzuki. In doing so, the Toyota impacted Ludmila as she crossed the freeway to render assistance to the crashed Suzuki.⁵
13. The driver of the Toyota stated that as he manoeuvred to avoid the crashed Suzuki, he observed Ludmila at the last second and braked and swerved in attempt to avoid her but was unable to do so in time to avoid the impact.⁶
14. Emergency services attended the scene at approximately 3.19am and attempted to resuscitate Ludmila however she was verified as deceased shortly after. The driver of the crashed car sustained serious injuries and was transported to hospital.⁷
15. At the time of the collision, it was a cold, clear, and dry morning. The road where the initial collision occurred (and Ludmila's subsequent impact) is a dual carriageway travelling in a northeast-southeast direction, with a bitumen surface in good condition. The city-bound carriageway consists of five lanes with an emergency stopping lane on the western edge and a bitumen shoulder on the eastern edge. It has a posted 100km/hr speed limit. Of note, there is no overhead lighting at this section of the freeway.⁸
16. Based on upon the scene reconstruction and measurements taken by Victoria Police investigators, it was calculated that the vehicle that impacted Ludmila had been travelling between 77km/hr and 94/km/hr at the time of impact.⁹

Identity of the deceased

17. On 23 July 2021, Ludmila Sezonenko, born 15 October 1957, was visually identified by dental record comparison.
18. Identity is not in dispute and requires no further investigation.

⁵ Coronial brief, statement of DSC Lindon Walker dated August 2021, page 19.

⁶ Coronial brief, statement of Haydn Hecton dated 19 July 2021, pages 86-87.

⁷ Coronial brief, statement of DSC Lindon Walker dated August 2021, pages 19-20; statement of May Wang dated 1 April 2022, page 92.

⁸ Coronial brief, statement of DSC Lindon Walker dated August 2021, pages 20-21.

⁹ Coronial brief, statement of DSC Lindon Walker dated August 2021, page 42.

Medical cause of death

19. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 20 July 2021 and provided a written report of her findings dated 22 July 2021.
20. The post-mortem examination revealed multiple and significant traumatic injuries consistent with the history given.
21. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any common drugs or poisons.
22. Dr Archer provided an opinion that the cause of death was from 1 (a) multiple injuries sustained in a motor vehicle incident (pedestrian).
23. I accept Dr Archer's opinion.

FINDINGS AND CONCLUSION

24. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
 - a) the identity of the deceased was Ludmila Sezonenko, born 15 October 1957;
 - b) the death occurred on 19 July 2021 at Monash Freeway, Doveton, Victoria, 3177, from *multiple injuries sustained in a motor vehicle incident (pedestrian)*; and
 - c) the death occurred in the circumstances described above.

RECOMMENDATIONS

25. I note the comments made by the Coroner's Investigator regarding the apparent inadequacy of lighting under the Heatherton Road overpass and the potential that this was a contributing factor in Ludmila's death. Therefore, and pursuant to section 72(2) of the Act, I make the following recommendation:
 - i. I recommend that VicRoads install lighting under the Heatherton Road overpass to improve visibility on this section of the Monash Freeway.

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

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

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

Sabrina Sezonenko, Senior Next of Kin

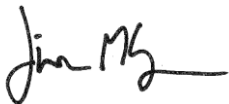
VicRoads

Department of Transport

Traffic Accident Commission

First Constable Tracey Riley, Victoria Police, Coroner's Investigator

Signature:



Coroner Simon McGregor

Date : 20 July 2022

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.
