IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 005042

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner John Olle
Deceased:	Doina Maria Predescu
Date of birth:	10 June 1946
Date of death:	02 September 2022
Cause of death:	1(a) INJURIES SUSTAINED IN A MOTOR VEHICLE COLLISION (PEDESTRIAN)
Place of death:	Purchas Street & Heaths Road, Hoppers Crossing, Victoria, 3029
Keywords:	Motor vehicle collision, pedestrian, poor visibility

INTRODUCTION

1. On 02 September 2022, Doina Maria Predescu (**Doina**) was 76 years old when she died after she was struck by a motor vehicle. At the time of her death, Doina lived at 3/2 Riverbend Crescent, Werribee, Victoria, 3030 with her friend Stefan Gherlagiu (**Stefan**).

Background[1]

2. Born in Romania, Doina emigrated to Australia sometime during the 1990s, after her marriage was dissolved. Her sister, Antoaneta Darrlest, who was already living in Australia at the time, assisted Doina with her relocation to and settlement in Australia.[2] Doina had one son who passed away in 2021.

3. According to her Stefan's son, Gabriel Gherlagiu (**Gabriel**), Doina was an accomplished pianist whose talents in the performing arts were aired on national television in her native Romania. Doina's tertiary studies was in the field of Economics, and after her university years, she was employed in the Forestry Industry for a number of years.

4. After her arrival in Melbourne, Doina took up employment as a cleaner to make ends meet and lived with a couple she had met *en route* to Australia for about six months until she befriended Stefan and moved in with him.

Medical history[3]

5. Other than age-related hypertension for which she was prescribed medication to manage her condition, Doina was in 'good health [for] her entire life'. Gabriel described Doina as a "social butterfly" who enjoyed going to 'play the pokies, as a bit of a social event' at the Italian Social Club (**ISC**) near her home about '3 times a week'.

6. Doina was also known to occupy her time with playing the piano, knitting, cooking and walking her dog, Blackie.

[1] Coronial Brief of Evidence [**CB**], statement of Gabriel Gherlagiu.
[2] CB, statement of Antoaneta Darrlest.
[3] CB, statement of Gabriel Gherlagiu.

THE CORONIAL INVESTIGATION

7. Doina'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.

8. 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.

9. 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.

10. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Doina'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.

11. This finding draws on the totality of the coronial investigation into the death of Doina Maria Predescu 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.[4]

[4] 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

12. On 2 September 2022 at approximately 5.30 pm, Doina told Stefan that she was going to the ISC to 'play the pokies'. According to Gabriel, 'Doina would normally be gone for around 2 hours'. However, when Doina was still not home 'after 7.30 pm', Stefan retired to bed.[5]

13. At approximately 7.25 pm, Amit Kumar (**Mr Kumar**) was driving along Heaths Road, Hopper's Crossing, in the direction of Tarneit, coming from Manor Lakes. Mr Kumar's wife and two children were passengers in the vehicle. According to Mr Kumar, as he followed the vehicle ahead of him, he maintained 'about a 3-metre distance'. Another vehicle was driving immediately behind Mr Kumar.

14. Mr Kumar related that as he was driving along Heaths Road, he 'heard a vehicle toot the horn' but because 'there was a lot of traffic on the road going both ways' he was not sure which vehicle had blown their horn. Immediately after he heard the vehicle's horn but before he 'had time to react', he 'heard a loud bang noise' coming from the left-hand side of his vehicle and then he 'observed someone hit' the windscreen of his vehicle.

15. Mr Kumar stopped his vehicle and alighted to assess the situation and render assistance to the person who had been struck by his vehicle who he described as a 'female laying on the left-hand side of the road'. According to Mr Kumar, as he went to render assistance, he was joined by '2 males (. . .) from the Italian Social Club', one of whom called the emergency services number '000' to report the incident.

16. Steve Stefanides (**Steve**) was one of the road-users driving along Heaths Road at the time of the incident. According to Steve, due to traffic conditions at the time he was driving at 'about 30-40 kmh' when a 'lady caught his eye because she was waddling across Heaths Road'. Steve related further that, after the lady had made her way to the median strip, he was 'beside her' and became worried because 'she kept walking' and he 'could see [that] she wasn't going to stop' and as she 'kept on going to the other side of Heaths Road', the lady did not 'look left and did not stop'.

17. Steve then saw a vehicle approach and estimated that the vehicle was travelling at about '60 km/h'. According to Steve, he just 'knew the car was going to hit' the lady because she 'just

[5] CB, statement of Grabriel Gherlagiu.

kept walking' and although that vehicle had its headlights turned on, it would have been hard to see her' because it 'was dark' and the lady herself 'was wearing dark clothes'.

18. After passers-by went to the lady's aid and were monitoring her while waiting for the ambulance, they described her as one who was 'breathing really heavily and deeply' at the time. According to one passer-by, Joel Marrow, the lady's breathing patterns did not 'sound normal'.[6]

19. Ambulance Victoria (AV) paramedics arrived at the scene at 7.45 pm and started cardiopulmonary resuscitation (**CPR**). However, the AV paramedics' CPR attempts were unsuccessful, and the lady who was struck by the vehicle driven by Mr Kumar was declared deceased at 8.26 pm.[7]

20. A bystander from the neighbourhood who came to the scene after Victoria Police officers had begun their investigation, told a police officer who she believed the deceased may be. According to Senior Constable Natasha Deprez, the bystander informed her that the deceased 'might be her neighbour Doina'. Shortly thereafter, Victoria Police confirmed, by photograph identification, that the deceased was Doina Maria Predescu.

Identity of the deceased

21. On 2 September 2022, Doina Maria Predescu, born 10 June 1946, was visually identified by her friend, Stefan Gherlagiu, who signed a formal Statement of Identification.[8]

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

Medical cause of death

23. Forensic Pathologist Dr Victoria Francis of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 5 September 2022 and provided a written report of her findings dated 24 October 2022.[9]

24. In the execution her duties, Dr Francis considered the Victoria Police Report of death *Form 83*, the post-mortem computed tomography (**CT**) scan and the relevant medical records from the Wyndham Health Centre.

[6] CB, statement of Joel Marrow.
[7] CB, statement of AV paramedic, Victoria Moustos.
[8] CB, Statement of Identification.
[9] CB, Medical Examiner's Report.

25. The post-mortem examination revealed bilateral haemothoraces with multiple buckle anterior rib fractures.

26. Toxicological analysis of post-mortem sample did not identify the presence of any alcohol or any common drugs or poisons.[10]

27. Dr Francis provided an opinion that the medical cause of death was 1 (a) INJURIES SUSTAINED IN A MOTOR VEHICLE COLLISION (PEDESTRIAN).

VICTORIA POLICE INVESTIGATIONS[11]

28. Victoria Police including members of their Forensic Services Department (FSD) conducted a full investigation of incident scene and the circumstances which led to the incident.

29. The ensuing Victoria Police investigation identified that, at the time of the collision, the road surface dry, fair-weather conditions prevailed and that the incident occurred after dusk. Victoria Police investigation confirmed further that the area is poorly lit during times when there is no natural light and that Doina was dressed in dark-coloured clothing and crossed the road where there was no pedestrian crossing.

30. Excessive speed, driver fatigue and driver distraction were not identified as contributing factors in the incident. Similarly, the Victoria Police investigation did not identify that Mr Kumar was affected by alcohol or drugs, illicit or otherwise, at the relevant time.

31. I have reviewed the relevant evidence in this matter, and I am satisfied that the weight of the available evidence does not support a conclusion that Mr Kumar's conduct contributed to Doina's death.

32. I now make apposite findings in this matter.

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 Doina Maria Predescu, born 10 June 1946;

[10] CB, Toxicology Report of Hannah Double, VIFM Forensic Toxicologist, dated 27 October 2022.
[11] CB, statements of Detective Sergeant Dr Janelle Hardiman of the FSD and Senior Constable Matthew Meade, Coroner's Investigator.

b) the death occurred on 02 September 2022 at Purchas Street & Heaths Road, Hoppers Crossing, Victoria, 3029.

c) I accept and adopt the medical cause of death as ascribed by Dr Francis and I find that Doina Maria Predescu died from injuries sustained in a motor vehicle collision in the circumstances where she was the pedestrian.

2. Having considered all the circumstances, I am satisfied that the weight of the available evidence supports a conclusion that there was no reasonable opportunity for Mr Kumar to have avoided the collision. Accordingly, I find that Doina Maria Predescu's death was a tragic accident and further, that her death was not preventable in the circumstances.

3. AND, having considered the factual matrix of this matter, I am satisfied that the circumstances which led to Doina Maroa Predescu's death resulted from her own conduct by failing to assess the traffic conditions and to cross the road only when it was safe for her to do so. Accordingly, I make no adverse comments about or findings against any person or entity.

4. However, given that the incident occurred along a major thoroughfare or arterial road in a residential area and in the vicinity of the Italian Social Club which, as the evidence indicates, attracts a high volume of pedestrians to the area due to the nature of the establishment and further, given the lack of adequate traffic control mechanisms to accommodate a high volume of pedestrians, I am satisfied that coronial comments in this matter are appropriate in the circumstances.

COMMENTS

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

1. There is no pedestrian crossing along Heaths Road in the vicinity of the Italian Social Club, a popular social hub for the many residents who live in the area. In the interests of public health and safety and moreover, in the interests of preventing similar deaths, it may be worthwhile for the appropriate authority to consider the installation of traffic control mechanisms like pedestrian crossing or roundabouts to facilitate pedestrians in the area crossing the road safely.

2. Further, the evidence before me indicates that the speed limit along the section of Heaths Road, Hopper's Crossing, in the vicinity of the Italian Social Club is 60 km/h. Given the volume of pedestrians frequenting the area and the quality of the street lighting in the area,

reducing the speed limit at peak times and a reassessment of the quality of the intensity of the light emitted by lampposts in the area, it may be worthwhile for the appropriate authority to consider reviewing the speed limit and the lighting infrastructure along Heaths Road in the vicinity of the Italian Social Club.

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

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.

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

Gabriel Gherlagiu

Antoaneta Darrlest

Transport Accident Commission

VicRoads

Wyndham City Council

Italian Social Club, Werribee

Senior Constable Matthew Meade, Coroner's Investigator

Signature:

CORONER JOHN OLLE

Date: 29 August 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.