IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 000754

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Nancy Doreen Hay
Date of birth:	29 August 1923
Date of death:	7 February 2023
Cause of death:	1(a) Chest injuries in the setting of a tram incident (pedestrian)
Place of death:	The Royal Melbourne Hospital, 300 Grattan Street, Victoria

INTRODUCTION

1. On 7 February 2023, Nancy Doreen Hay was 99 years old when she passed away at the Royal Melbourne Hospital (**RMH**) from injuries sustained in a tram incident. At the time of her death, Ms Hay lived at Essendon, Victoria with her grandson.

2. Ms Hay's medical history included dementia, osteoarthritis, osteopenia, and she required the use of a mobility scooter due to reduced mobility. In 2018, she was found to have moderate bilateral sensorineural hearing loss, requiring hearing aids, however she decided not to proceed with hearing aids.

THE CORONIAL INVESTIGATION

3. Ms Hay'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 the circumstances in which the death occurred. The 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 Ms Hay's death. The Coroner's Investigator conducted inquiries on my behalf and submitted a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into the death of Nancy Doreen Hay 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]

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

Circumstances in which the death occurred

8. At about 1:23 pm on 7 February 2023, Ms Hay was riding south on her mobility scooter on the eastern side of Mt Alexander Road in Essendon. She approached the large roundabout at the intersection of Mt Alexander Road, Keilor Road, and Lincoln Road. Pedestrian Patricia Galle was walking in the same direction as Ms Hay and stopped with her at the pedestrian 'zebra' crossing at the single left slip lane on the southbound lanes of Mt Alexander Road.

9. Ms Galle pressed the pedestrian button to cross the road and waited for the light to change. When the pedestrian light turned green, Ms Galle started to cross the pedestrian crossing and observed that Ms Hay immediately "*took off really fast in her motorised wheelchair. She was maybe 6-8 feet in front of [Ms Galle] when [Ms Galle] started walking across the road*". After crossing the 'zebra' crossing in the slip lane, Ms Hay continued across the two southbound lanes of traffic.

10. At the same time, Yarra Trams B-Class tram number 2056 (**'the tram'**) was travelling south on Route 59. The tram was operated by Yarra Trams driver Sia Clarke. As Ms Clarke approached the northern part of the Mt Alexander Road intersection, she slowed down and observed a silver sedan in the right lane, impeding the tram tracks. Ms Clarke was required to apply the brakes and use her bell to move the silver sedan off the tram tracks.

11. Ms Clarke proceeded through the roundabout intersection and checked for traffic and pedestrians. She noted that trams have right of way over all traffic and pedestrians in the Mt Alexander roundabout intersection. She observed several pedestrians to her left, including Ms Hay on her mobility scooter, who "*passed the people walking at a very fast speed…to the left of the people and then moved in front of the people*".

12. Between the pedestrian crossing and the tram tracks, there is a small island where pedestrians can wait before crossing the tram tracks. Ms Clarke perceived that Ms Hay was not going to

[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.

stop at the traffic island, so she immediately applied her brakes and rang her bell several times, to warn Ms Hay and draw her attention to the oncoming tram. Ms Clarke was unable to stop the tram in time and collided with Ms Hay.

13. Ms Clarke immediately notified her radio controller to request an emergency ambulance. She observed Ms Hay lying on the ground, near the front exit door, with her "*mobility scooter on her right hip area*". Members of the public rushed to assist Ms Hay, quickly followed by police who were nearby after an earlier car accident on Mt Alexander Road. Police advised Ms Clarke to remain in the tram while they assisted Ms Hay and waited for paramedics to arrive.

14. When the first ambulance unit arrived on scene, Ms Hay was conscious and relatively alert. By the time the second ambulance arrived only minutes later, Ms Hay had become unresponsive and experienced a cardiac arrest. Paramedics performed cardiopulmonary resuscitation (**CPR**) and achieved a spontaneous return of circulation (**ROSC**). Ms Hay was conveyed by ambulance to the RMH, arriving at about 2:38 pm.

15. On arrival at the RMH, Ms Hay was hypoxic, had reduced air entry to her left lung and was agitated and confused. Clinicians held discussions with Ms Hay's grandson and decided that she was not a suitable candidate for intubation. She was palliated and passed away that evening at about 6:26 pm.

Identity of the deceased

16. On 10 February 2023, Nancy Doreen Hay, born 29 August 1923, was visually identified by her grandson, Brendan Hay.

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

Medical cause of death

18. Forensic Pathologist Dr Joanne Ho from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 9 February 2023 and provided a written report of her findings dated 10 March 2023.

19. The post-mortem examination revealed findings consistent with the reported circumstances.

20. Examination of the post-mortem CT scan showed a right parietal haematoma, right hip/thig haematoma, bilateral pneumothoraces, right haemothorax with slight tension, subcutaneous

emphysema, and numerous rib fractures. There were coronary and aortic calcifications, gallstones, and atrophic kidneys.

21. Toxicological analysis of ante-mortem samples did not identify the presence of alcohol or any commonly encountered drugs or poisons.

22. Dr Ho provided an opinion that the medical cause of death was "*1(a) Chest injuries in the setting of a tram incident (pedestrian)*".

23. I accept Dr Ho's opinion.

FURTHER INVESTIGATIONS

24. Following Ms Hay's passing, Victoria Police, Yarra Trams, and the Office of the National Rail Safety Regulator (**ONRSR**) conducted investigations into the incident. Having regard to section 7(a) of the Act, the coronial investigation was held in abeyance until finalisation of those investigations. The results of those investigations are summarised below.

Yarra Trams

Driver and tram 2056

25. Yarra Trams noted that tram 2056 was serviced five days prior to the incident, which was a 32,000 km service. Between the service on 2 February 2023 and the incident on 7 February 2023, two incidents were logged for that tram, though neither were issues affecting the safe operation of the tram.

26. Following the incident, Ms Clarke underwent drug and alcohol testing, both of which returned negative results. Her recent shifts were analysed, and Yarra Trams confirmed that she was appropriately rested prior to her shift.

27. Yarra Trams staff tested tram 2056 and confirmed that the brakes were activated correctly and were found to have deployed as expected. The Incident Event Recorder (**IER**) fitted to the tram was downloaded and analysed following the incident. The IER demonstrated that Ms Clarke appropriately applied the emergency brakes and rang the bell when she observed Ms Hay. At the time Ms Clarke applied the brakes upon observing Ms Hay, the tram was travelling 18.96 km/h. Yarra Trams found that there was no contribution to the incident from either Ms Clarke's operation of the tram or any mechanical issues with tram 2056.

Environmental factors

28. Yarra Trams completed a Road Safety Audit on 22 February 2023, following the incident. Yarra Trams made several observations regarding Stop 46 on Route 59, near to the location of the incident, including:

    a) the existing 'Give Way to Tram' sign was faded and was no longer legible;

    b) the existing TGSI tactile tiles were in a poor condition and were starting to become a possible tripping hazard;

    c) there was no tram network delineation present at the crossing;

    d) vegetation was blocking visibility for pedestrians using the crossing; and

    e) there was only a small stalling capacity of about two metres at the pedestrian crossing. During busy times, this would provide insufficient space for numerous pedestrians to safely wait.

29. Yarra Trams explained that these matters were not within their control, however they submitted a Safety Case Funding Request to the Department of Transport and Planning (**DTP**).

Victoria Police

30. Victoria Police investigated the collision and cleared Ms Clarke of any wrongdoing in relation to her operation of the tram. The Coroner's Investigator (**CI**)'s observations largely aligned with those made in the Yarra Trams report. The CI further opined that Ms Hay did not give way to the oncoming tram, however noted that the 'give way' signage in the area was faded and was not properly visible.

Department of Transport and Planning (DTP)

31. DTP completed an investigation following the incident, received advice from Victoria Police, and conducted several site visits. DTP explained that the location of the collision is a priority site for an integrated transport study, as it is a complex and busy junction with competing demands for pedestrians, cyclists, motorists and tram and bus services.

32. Whilst the Yarra Trams investigation noted overgrown vegetation, DTP's subject matter expert concluded that the vegetation complied with the Austroads guidelines. Nevertheless,

DTP liaised with the local council, Moonee Valley Council, and organised for the vegetation to be trimmed.

33. As an immediate response to the incident, DTP advised that Yarra Trams installed new line markings and 'Give Way to Tram' signs at the location of the incident on 28 February 2023 and 1 March 2023. Further, DTP noted that it had been investigating the possible removal of Stop 46 on the outbound side of the southern leg of the roundabout, as part of a broader corridor and tram stop redesign strategy.

34. DTP has subsequently provided correspondence to the Court in May 2025, advising that a preferred design for safe pedestrian and vehicle movements (including tram movements) at the junction of Lincoln, Mt Alexander, Keilor and Bulla Roads has been selected for implementation. The design includes the following works:

    a) removal of tram stop 46;

    b) changes to service lane access and alignment with relocated pedestrian-operated signals on Mt Alexander Road;

    c) relocation of the Lincoln Road pedestrian-operated signals to the edge of the junction, to better accommodate pedestrian movements; and

    d) new fenced staggered track crossing at Mt Alexander Road at the southern end of the junction.

Office of the National Rail Safety Regulator (ONRSR)

35. The ONRSR investigated the incident and concluded that the actions of Ms Clarke were in accordance with the procedures and requirements of Yarra Trams' safety management system and were reasonable and appropriate in the circumstances.

36. The ONRSR made similar findings to those made by Yarra Trams. Specifically, the ONRSR noted "*deficiencies in the signage, line marking and vegetation present at the incident location which rendered it non-compliant with [Yarra Trams'] infrastructure standards*". In response to ONRSR's identified deficiencies, Yarra Trams explained that their current infrastructure standards are only applicable to newly constructed network infrastructure.

37. The ONRSR explained that the faded 'Give Way to Tram' signage may not have been seen by Ms Hay, leading Ms Hay to form a mistaken belief that she had right of way. The ONRSR

noted that Ms Hay had utilised this pedestrian crossing on many occasions, and therefore they could not confirm whether she was indeed mistaken on this occasion.

38. Similarly, the ONRSR noted that the faded line markings may have reduced Ms Hay's ability to identify the safe waiting location between the road crossing and the tram corridor. However, based on Ms Clarke's observation of Ms Hay, it appears that Ms Hay accelerated her scooter and committed to crossing the tram tracks without stopping.

Rail Safety National Law Application Act 2013 (Vic) application

39. The ONRSR explained that as a rail transport operator and rail infrastructure manager, Yarra Trams has multiple obligations under the *Rail Safety National Law Application Act 2013* (Vic) (**'RSNL'**). The ONRSR stated that in order to decide whether Yarra Trams contravened any of its duties under the RSNL, the following factors were considered:

    a) the absence of clear delineation markings impaired Ms Hay's ability to attempt to move between the road pedestrian crossing and the tram crossing and to identify the safe position to wait;

    b) the vegetation located near the pedestrian island had grown to a height of 1.8 m, which may have impacted a tram driver's vision of a pedestrian, particularly children or people in mobility scooters and wheelchairs; and

    c) the absence of clear 'Give Way to Tram' signage created the possibility that a pedestrian might incorrectly believe they had right of way over the tram.

40. The ONRSR noted that the above controls are required for all new tram stop installations by Yarra Trams, though they are not required for legacy tram stops. On that basis, the ONRSR stated that it was reasonable to assume that Yarra Trams was aware of the availability of these controls. It further noted that Yarra Trams did not have a process for the management of legacy tram stops on its network; rather, such stops are "*progressively updated 'subject to appropriate approvals/permissions/opportunity*'".

41. The ONRSR further noted potential breaches by Yarra Trams of the RSNL, namely:

    a) failure to comply with Safety Duty – Category 2 – s 59 RSNL – due to the fatality that resulted from the incident;

b) failure to comply with Safety Duty – Category 3 – s 60 RSNL. Regardless of the outcome (fatality or otherwise), ONRSR considered any potential failure by Yarra Trams to comply with their safety duties could be considered a contravention; and

c) Failure to have a sufficient safety management system – s 99 RSNL. The ONRSR noted that despite Yarra Trams implementing infrastructure standards for all new tram stops, these standards do not apply to legacy stops. The ONRSR opined that by not conducting further risk assessments to legacy stops that do not meet the standards and not prioritising works to update these sections may be a contravention of section 99.

42. I sought clarification regarding these comments and further correspondence was received from the ONRSR which indicated that the ONRSR decided not to prosecute Yarra Trams for the potential breaches. The ONRSR did not provide a reason for their decision not to prosecute Yarra Trams.

FINDINGS AND CONCLUSION

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

a) the identity of the deceased was Nancy Doreen Hay, born 29 August 1923;

b) the death occurred on 7 February 2023 at The Royal Melbourne Hospital, 300 Grattan Street, Victoria, from chest injuries in the setting of a tram incident (pedestrian); and

c) the death occurred in the circumstances described above.

44. I am satisfied that Ms Hay proceeded into the path of the oncoming tram as she did not see it, and that her death was accidental.

COMMENTS

45. I note that following the incident there was prompt installation of new line markings, signage and the trimming of vegetation at the tram stop. These were simple risk mitigation strategies which were easy to implement. Whilst it remains unclear why Ms Hay did not see the oncoming tram, I cannot rule out the possibility that unclear line markings, signage and overgrown vegetation contributed to what occurred.

46. According to the ONRSR report, the signage, line markings and vegetation present at the incident location were non-compliant with Yarra Trams current infrastructure standards.

However, these standards do not apply to 'legacy' tram stops, such as at the location of the incident, built before the current infrastructure standards came into force.

47. Having regard to the potential contribution of the vegetation, line markings and signage to what occurred in Ms Hay's case, and the fact that under the current infrastructure standards the tram stop would have been non-compliant, similar potential safety issues may exist at other legacy tram stops.

48. I note that in correspondence to the Court dated 19 May 2025, Yarra Trams and DTP advised that they had together commenced, in November 2024, a network-wide assessment of other legacy tram stops that may require safety modifications, to determine the:

    a) number of locations similar to Lincoln Road and Mt Alexander Road, where pedestrians cross tram tracks that are separated from road vehicles but where a dedicated safe crossing has not been provided;

    b) different types of pedestrian crossings and safety measures currently in place, a risk assessment of the location and whether further safety measures and modifications are required;

    c) types of safety measures and modifications required to improve the safety of each location identified, ranging from simple measures such as improved signage, tactiles and similar infrastructure, to the redesign of tram stops; and

    d) funding required to deliver the modifications.

49. This assessment is expected to be completed by September 2025.

RECOMMENDATIONS

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

(i) That by September 2025, Yarra Trams and the DTP complete the current network-wide assessment of legacy tram stops that may require safety modifications.

I convey my sincere condolences to Ms Hay'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:

Wayne Hay, Senior Next of Kin

Royal Melbourne Hospital

Senior Constable Scott Busuttil, Victoria Police, Coroner's Investigator

Yarra Trams

The Department of Transport and Planning

Signature:

Coroner Catherine Fitzgerald

Date : 26 May 2025

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.