QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Jo-anne Peta Fuller**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Mackay
FILE NO(s):	COR 2016/982
DELIVERED ON:	25th October 2017
DELIVERED AT:	Hervey Bay
HEARING DATE(s):	24th – 25th October 2017
FINDINGS OF:	Magistrate D O'Connell, Coroner
CATCHWORDS:	CORONERS: Inquest – Traffic collision – driver falling asleep – driver SPER suspended – adequacy of existing traffic related charges to reflect severity where death is caused – recommendations for mid-range "reckless" driving offence.
REPRESENTATION:	
Counsel Assisting	Mr J M Aberdeen

Findings

Jo-Anne Peta Fuller

[1]. On 6 March 2016 Jo-Anne Peta Fuller was involved in a fatal traffic accident. She was the driver of a vehicle which was struck head-on by a second vehicle which had crossed over the centreline of a busy main road. Why the accident occurred on a very innocuous section of road was unable to be established by the police, and there were concerns raised about the adequacy of Queensland's driving laws in the circumstances of what transpired in this case.

[2]. This inquest examines the circumstances of the traffic accident to try and establish why it occurred, and whether the applicable driving laws in Queensland are appropriate in such circumstances.

Tasks to be performed

[3]. My primary task under the Coroners Act 2003 is to make findings as to who the deceased person is, how, when, where, and what, caused them to die[1]. In Mrs Fuller's case there is no real contest as to who, when, where, or what caused her to die, the real issue is directed to the 'how' she came to die.

[4]. Accordingly the List of Issues for this Inquest are:-

1. The information required by section 45(2) of the *Coroners Act 2003*, namely, when, where, and how Mrs Fuller died, and what caused her death?

2. Whether either, or both, of the motor vehicles involved in the collision which led to Mrs Fuller's death travelled out of the appropriate traffic lane immediately prior to the collision?

3. What caused either, or both, of the said motor vehicles (as the case may be) to travel out of the appropriate traffic lane immediately prior to the collision?

4. Whether any feature of the roadway, or any attendant signage or other traffic control feature, on Hervey Bay – Maryborough Road, Susan River, should be reviewed in the interest of preventing similar future collisions? and

5. Given the deterrent effect of properly instituted prosecutions to the prevention of similar future road incidents, whether any changes should be considered to the law governing the offences which may be committed by careless drivers, or by disqualified or suspended drivers, which result in death or grievous bodily harm to any person?

[1] Coroners Act 2003 s. 45(2)(a) – (e) inclusive

[5]. The second task in any inquest is for the coroner to make comments on anything connected with the death investigated at an inquest that relate to public health or safety, the administration of justice, or ways to prevent deaths from happening in similar circumstances in the future[2].

[6]. The third task is that if I reasonably suspect a person has committed an offence[3], committed official misconduct[4], or contravened a person's professional or trade, standard or obligation[5], then I may refer that information to the appropriate disciplinary body for them to take any action they deem appropriate.

[7]. In these findings I address these three tasks in their usual order, s.45 Findings, s.46 Coroners Comments, and then s.48 Reporting Offences or Misconduct. I have used headings, for convenience only, for each of these in my findings.

Factual Background & Evidence

[8]. The incident occurred at approximately 3:40 PM on Sunday 6 March 2016. It was a two vehicle fatal traffic crash which occurred on Hervey Bay – Maryborough Road, between Sunnyside Drive and Stockman Way, near Susan River. It was described by police as usually a busy main road with medium to high traffic flow, although this incident occurred on a Sunday afternoon so the traffic volume was lighter. The road is a sealed asphalt surfaced road with one lane of traffic in each direction which at the location of the incident was separated by double white continuous centrelines. The road has a default speed limit of 100 km/h and the incident occurred on a slight bend.

[9]. That day Mrs Fuller had been attending a Legacy Bowls Day at Hervey Bay. She arrived there at about 9:30 AM, leaving about 3:20 PM. She was driving with a passenger in her car (a white, 2000 model, Hyundai Elantra). The passenger, her sister-in-law, described that they were travelling towards Maryborough with no traffic, in their lane of traffic, in front of them. Their vehicle was travelling at approximately 95 km/h when she observed another motor vehicle (a blue, 2013 model, Mazda 3), later found to be driven by Mr McFarlane, suddenly come across the centreline and into their lane of traffic. Mrs Jo-Anne Fuller, as the driver, attempted to take evasive action by braking heavily and steering to her left but a very significant impact occurred. Mrs Fuller died at the scene never regaining consciousness after impact. She was observed to be wearing a seatbelt. Mrs Fuller was considered a good, responsible, and cautious driver. Her traffic history[6] for the period from 2012 showed no traffic infringements at all. The circumstances of the matter certainly confirms her to be a responsible, cautious driver and citizen. She was simply a member of the community who that day was travelling a relatively short distance home from a Sunday bowls club charity event supporting war widows and their families.

---

[2] ibid s.46(1)
[3] Ibid s.48(2)
[4] Ibid s.48(3)
[5] Ibid s.48(4)
[6] Exhibit D.4

[10]. The driver of the second vehicle[7] was Mr McFarlane. His vehicle was observed by a motorist travelling behind him to be driving at the appropriate speed limit, before his vehicle was seen to begin to 'drift' onto the wrong side of the road. There was also a suggestion by another motorist that Mr McFarlane may have been attempting an overtaking manoeuvre when the incident occurred. This is a critical issue to resolve.

Investigations into the incident:

[11]. There was no suggestion that either vehicle involved was speeding, nor engaging in any irresponsible driving behaviour (sometimes called 'hooning'). There was not found any mechanical defect in either vehicle to explain the incident. An examination of the road surface found it to be in good condition, and the weather at the time was fine, and the road surface was dry. The incident occurred in daylight hours and there was no suggestion that the angle of the sun was a factor. There was no suggestion that any native animal, nor wandering livestock, was a factor in the incident.

[12]. The scene examination by the Queensland Police Service Forensic Crash Unit found that Mrs Fuller's car had taken evasive action by braking heavily for approximately 27 metres prior to the point of impact. There was not found at the scene any braking action[8] taken by Mr McFarlane although a later Crash Data Recording from his airbag control module found braking just prior to impact, but no significant throttle input in the five seconds prior to impact. You would certainly expect throttle input if undertaking an overtaking manoeuvre.

[13]. Very significantly, in my view, was that the driver of the vehicle following Mr McFarlane had sufficient time prior to the crash occurring to activate their vehicles' horn to try to get Mr McFarlane to 'pay attention' when they saw him first drift. That driver also gave evidence that they saw no use of his indicator being activated to suggest he was overtaking.

[14]. Of the suggestion that perhaps Mr McFarlane[9] was in the process of overtaking when the incident occurred I consider, after hearing and considering the evidence, that the best evidence came from the vehicle following Mr McFarlane who described Mr McFarlane's vehicle as drifting across the centreline and that he did not use his turn indicator. The action of overtaking usually observed is an action which is quite deliberate, sometimes associated with the vehicle speeding up to undertake the overtaking manoeuvre. None of those things occurred here. One would expect if a person was overtaking, and suddenly recognised a vehicle coming towards them, would take evasive action such as corrective steering. This was not observed

[7] Nothing is to be inferred by my numbering the vehicles 'one' and 'two', they are merely numbered that way based on their sequence, or order, of being mentioned in these Inquest Findings.
[8] It is possible that at high speed in a vehicle with ABS enabled braking no tyre braking friction marks on the road surface would be evident
[9] Mr McFarlane was unable in evidence to recall the specific moments of the collision or his specific actions likely due to the severity of the crash and so observations of other drivers and the investigations by the QPS were crucial

by other motorists which is highly suggestive that the driver was not performing an overtaking manoeuvre. Instead Mr McFarlane's vehicle was observed to drift across the centreline into the path of Mrs Fuller's car. The 'drift' nature of his vehicle crossing the centreline was also confirmed by the vehicle in front of him.

[15]. It is also of note that the place of impact did not occur in the centre of the lane of traffic of Mrs Fuller, but rather was towards[10] the fog line of her lane of traffic. This confirms that she had taken corrective action, steering well to her left. There was simply no corrective steering action taken by Mr McFarlane.

[16]. Further investigation established that Mr McFarlane was approximately 20 years of age at the time of the accident and worked as a manager or crew trainer at a fast food restaurant. There was certainly no suggestion that he suffered a medical incident which led to the crash. The toxicology screen of Mr McFarlane following the accident indicated he was not affected by alcohol, illicit drugs, or prescription medications[11].

[17]. An autopsy found that Mrs Fuller died due to multiple injuries, due to, or as a consequence of, a motor vehicle collision in which she was the driver[12]. There was not found any underlying medical condition which had caused or contributed to the accident occurring. A toxicology screen detected no blood alcohol, no illicit drugs, and just one prescription medication, merely in a therapeutic amount[13]. Accordingly there was no suggestion that she was in any way affected by alcohol, illicit drugs, nor medications.

[18]. In view of her taking corrective steering action, and braking heavily for some distance prior to the point of impact[14], it indicates she was alert and attentive to the task of driving at the time the accident occurred. No blame whatsoever can be attributed to Mrs Fuller for the accident, nor can blame be attributed to her for the emergency actions she took steering well left in an attempt to avoid an impact.

[19]. A review of Mr McFarlane's activities that weekend indicates that he was very social and had slept the night before[15] for less than what is objectively viewed as that required to be adequately rested. His activities on the evening before the incident were that he had travelled to Brisbane on Saturday afternoon after work and socialised, including visiting nightclubs and a casino, consuming his last alcoholic drink at around 2 AM. He stayed overnight at a backpacker hostel before getting to sleep at around 4 AM. He woke at about 10 AM on the

---

[10] in saying this I am referring to the fact that vehicle was not travelling in its usual position in the centre of the lane, rather it had moved well left such that its' passenger side wheels were at, or over, the fogline, and the impact between the two vehicles is what is termed an 'offset collision' where the vehicles corresponding driver's side front ends collided

[11] See exhibit B.13 where only morphine was detected in a blood sample taken about 90 minutes after the incident. Paramedics had administered morphine to him at the scene for his crash injuries.

[12] Exhibit A.4

[13] Exhibit A.5

[14] There were heavy braking marks from her tyres for 27 metres prior to the point of impact, see exhibit B.1

[15] I use the term loosely as he didn't go to sleep until 4am

Sunday, the date the incident occurred. He then travelled to a suburb in Brisbane, Chermside, where he had something to eat, and also slept again for about 10 or 20 minutes, not long. When he woke up he wished he had slept longer. He left Brisbane between midday and 1 PM, stopping to refuel at Caboolture on the way. He was driving alone.

[20]. In the lead up to the accident occurring, just after Maryborough, he said he felt tired. He described it in an interview with police as 'feeling a bit dozy', 'feeling a little bit tired', and 'feeling a bit hazy'[16]. He did not pull over, rather kept driving. It is very evident that the signs of fatigue had set in, yet he continued to drive. He ticked four of the five indicators for fatigued driving as published by the Qld Transport Department[17]. It is evident that he had not had a regular night's sleep, rather he socialised and remained awake until 4 AM, and only slept for about 6 hours. Clearly he was still tired after he woke because in the next two hour period he slept for another 10-20 minutes. Taking this short nap is hardly the actions of a person who is well rested. It is evident to me that he started his journey from Brisbane already tired. He displayed many of the significant fatigue warning signs identified by the Department of Main Roads and Transport in their publications[18].

[21]. There is also the issue of why Mr McFarlane was driving when his licence had been suspended. A summary of the contact with the State Penalties Enforcement Registry (SPER) indicates that Mr McFarlane was sent correspondence on seven occasions, all to the same residential address. No letter was returned unclaimed[19]. I note that the residential address that SPER used for the letters is precisely the same address used by the police when Mr McFarlane was formally charged in relation to the accident. He is not a person who was moving address at any relevant time. Within the period that the correspondence was being sent there was also a telephone call where Mr McFarlane contacted SPER. Accordingly there cannot be any sensible suggestion that he was unaware of his debt with SPER, or that he did not receive the correspondence. The letters make clear that his license was also suspended. Records showed that he only commenced part-payment of his SPER debt very shortly after the incident.

[22]. Clearly his license was suspended at the time the accident occurred. I find it is not credible that Mr McFarlane could realistically believe that he could validly drive at the time the incident occurred. Accordingly he was driving whilst suspended at the time the accident occurred and had been for many months. Clearly he was not a responsible person by continuing to drive whilst his license was suspended. I envisage that Mrs Fuller's next of kin must harbour thoughts that the accident would have never have occurred if Mr McFarlane had abided by the law and not driven on that day. No doubt many consider that a person who drives whilst their license is suspended warrants a higher penalty than a person who holds a valid driver's license at the time that an incident such as this one occurs.

---

[16] Exhibit C.3.1
[17] Exhibit D.5 at the section marked 'The Facts'
[18] Exhibit D.5
[19] Exhibit D.1

[23]. Accordingly on the evidence it is clear, and I find, that Mr McFarlane was the person responsible for the accident and Mrs Fuller's death when he drove whilst fatigued, simply tired, and that he suffered a 'micro-sleep' leading to his car drifting over the centreline whilst he negotiated a slight bend in the road.

List of Inquest Issues Answers

Coroners Act s. 45(2): 'Findings'

[24]. Dealing with the list of issues for this inquest the answers are as follows:-

[25]. **Issue 1.** My primary task is the information required by section 45(2) of the *Coroners Act 2003*, namely:

a. Who the deceased person is – Jo-Anne Peta Fuller[20],
b. How the person died – Mrs Fuller died due to fatal injuries received when whilst driving her vehicle, a second vehicle left their lane of traffic crossing double centrelines and collided with her vehicle. The reason for the second vehicle leaving its' lane was that the driver, Mr McFarlane, likely had a 'micro-sleep' due to fatigue,
c. When the person died – 6 March 2016[21],
d. Where the person died – Hervey Bay – Maryborough Road, near the intersecting road Stockmans Way [22], Susan River and
e. What caused the person to die – Multiple injuries, due to a motor vehicle collision[23]

[26]. **Issue 2**. Whether either, or both, of the motor vehicles involved in the collision which led to Mrs Fuller's death travelled out of the appropriate traffic lane immediately prior to the collision?

[27]. It is clear that only Mr McFarlane's vehicle travelled out of its' lane just before the collision occurred.

[28]. **Issue 3.** What caused either, or both, of the said motor vehicles (as the case may be) to travel out of the appropriate traffic lane immediately prior to the collision?

[29]. Only Mr McFarlane's vehicle travelled out of its' lane, and this was caused by his having a micro-sleep due to fatigue.

[30]. **Issue 4.** Whether any feature of the roadway, or any attendant signage or other traffic control feature, on Hervey Bay – Maryborough Road, Susan

[20] See exhibit A1 QPS Form 1
[21] See exhibit A2 Life Extinct Form
[22] See exhibit A2 Life Extinct Form
[23] See exhibit A3, Form 3 Autopsy Certificate

River, should be reviewed in the interest of preventing similar future collisions?

[31]. There was no feature of the road that contributed to the incident, and no review is necessary as even fatigue warning signs would be ineffective in any meaningful way as nearly every fatigue related trip (originating in Brisbane or Gladstone/Rockhampton districts) have a destination which is only 15-20 minutes away as Hervey Bay is effectively the only significant destination, and is the origin of a journey in the reverse direction of travel in that direction.

[32]. **Issue 5.** Given the deterrent effect of properly instituted prosecutions to the prevention of similar future road incidents, whether any changes should be considered to the law governing the offences which may be committed by careless drivers, or by disqualified or suspended drivers, which result in death or grievous bodily harm to any person?

[33]. In this regard see my Coroner Comments (Recommendations) below.

Coroners Act s. 46: 'Coroners Comments' (Recommendations)

[34]. This inquest touches upon the very same recommendation issues as the inquest conducted in relation to the death of Audrey Ann Dow where findings were delivered by me on 6 March 2015. At that time I envisaged six months was adequate for the government to consider and implement change. In February 2016, nearly one year later, the government declined a separate mid-range offence but still had the circumstance of aggravation for unlicensed or disqualified drivers under review. In the more than two and one-half years since the Dow Recommendations no laws have changed as the recommendations were still "*under consideration*"[24] until very recently, just eight days before the inquest, when an announcement for limited changes on penalties was made through a Media Release issued on 15 October 2017[25].

[35]. Whilst it is pleasing to see that the government has announced an increase in certain penalties[26] it remains that that is only part of the whole issue. Despite the government's response in February 2016 there also needs to be revisited the legislative 'gap' where Queensland is without a mid-range driving offence usually termed 'reckless driving'. I appreciate that the government's position was to reject any change in the law but any such new offence would have been very applicable on the facts of Mrs Fuller's death[27]. The remaining or existing

[24] See exhibit D.3.1 Letter dated 20 June 2017 from the Minister for Main Roads, Road Safety and Ports and Minister for Energy, Biofuels and Water Supply, where it advises changes are proposed but still at the '*government is currently considering*' stage. By Media Release dated 15 October 2017 this has crystallised into a decision to change the law in some respects.
[25] A surprising flurry of activity just days before the inquest took place, but an announcement is not legislated change.
[26] Whether just a doubling of penalties is adequate is also a live issue, as I touch on later
[27] Which occurred nearly one year after my Findings were delivered in DOW

possible offences[28] were certainly not provable to the necessary standard. Mr McFarlane in his police interview readily admitted feeling tired[29] prior to the crash most likely as he only went to bed at 4am that day. In court he was fined $800. Mrs Fuller lost her life. Most would consider such a penalty, $800, even if doubled, as totally inadequate and unjust for the loss of a life, but it is the inadequacy of the options for prosecutors under the present laws with which to charge an offending driver that is the real issue. The QPS investigating officer made this very clear in his evidence, and I agree. Accordingly it remains that I have the same issue with the inadequacy of available laws. No doubt many consider that the current laws are at odds with community expectations as it is an issue continuously, and repeatedly, voiced to me by families affected by such deaths.

[36]. Whether just an increase through a doubling of monetary penalties is adequate for disqualified drivers[30] or license suspended drivers causing death, is an interesting issue. Indeed the four times disqualified driver responsible for the death in the Audrey Dow inquest provided evidence[31] to this inquest that even he was in support of a new mid-range driving offence and he supported much greater penalties for causing death in road accidents. That driver has signed a petition supporting change. Some may find it remarkable that even he believes that he should have received a term of imprisonment for causing a death whilst he was a disqualified driver rather than just receive a fine. He stated in his evidence that when he walked out of court the day he was sentenced, and not imprisoned, his thoughts were that "*he got away with it*" (his own words)[32], and thought he would "*have been better off spending some time in prison'*[33].

[37]. Accordingly I will again make similar recommendations to change[34] the law that I made at the inquest of Dow. It requires a number of aspects of the driving laws to be changed. No doubt watching closely will be the families of the other numerous coronial cases I currently have which raise the very same legislative issues as this inquest.

[38]. I certainly appreciate and acknowledge that there are competing demands on government but, and I do so with the greatest of respect, after more than two and one-half years of families patiently waiting for changes to become law there is clearly an issue of inaction that needs to be resolved if the issue is to be addressed. As the issues have already been with the government for

---

[28] For instance manslaughter or dangerous operation of a vehicle is simply not provable at all on the facts nor supported by the applicable case law. Manslaughter is a very seldom used charge for a motor vehicle related death.

[29] Exhibit C.3.1 where he uses the terms 'feeling a bit dozy', 'felt a bit tired, yep', 'started feeling a bit hazy', and he had socialised until 4am, sleeping until 10am.

[30] These are drivers who have had their licence 'revoked' by a court

[31] See exhibit B.14 where Mr Kite expresses that because he did not go to gaol he thought he had 'got away with it', and had not been punished. This is his thoughts and quite a remarkable mindset on whether he appreciated he received any penalty as he simply 'walked out of court' after sentencing. Even Mr Kite states "I believe I would have been better off spending some time in prison'.

[32] And as I said in the Audrey Dow Inquest Findings I am in no way critical that a fine was imposed, it is simply that it remains (despite community expectations of a higher penalty) the appropriate sentence under the current laws.

[33] ibid

[34] By change I mean legislation passed by parliament, not merely a Media Release of a commitment

significant time, at least now there is announced (thankfully in my view) some initial changes, I consider that only one month is necessary to turn the announced changes on penalties into law. The issue of a new reckless driving offence I recommend also be addressed with the new offence included in the Criminal Code as this will permit its use as an alternate charge in appropriate cases. Two months is adequate for further consideration due to the time that the issue has already been with the government. Further delay only adds to the distress felt by the next of kin.

[39]. Accordingly I remake the following recommendations:-

1. That the present driving laws (s.83 TORUM, "Due Care and Attention") be amended to have a specific circumstance of aggravation:-

   a. For driving without due care and attention where the offending driver causes grievous bodily harm or death[35]; and a further circumstance of aggravation, if:-

      i. the offending driver was then unlicensed; or
      ii. the offending driver was suspended or disqualified,

      at the time the alleged offence occurred, and that the government's announced[36] amendments be passed into law within 1 month.

2. That the issue of a new mid-range driving offence[37] be referred to the Attorney General to consider changing the law to introduce a new mid-range driving offence of Reckless Driving between the existing Criminal Code s.328A Dangerous Driving offence, and the TORUM s.83 Driving without Due Care and Attention offence, and for that review to within two months determine whether it is appropriate:-

   (a) to include a circumstance(s) of aggravation for offending drivers:-
      (i) who cause death or grievous bodily harm, and
      (ii) where they were driving whilst unlicensed or their license was suspended, or
      (iii) where they were driving whilst their license was disqualified; and
   (b) that the recommended new mid-range offence be legislated in the Criminal Code.

[40.] The Queensland Police Service already heavily promotes the '*Fatal Five'* issues for safer driving. One of the issues identified includes fatigue. That

[35] For TORUM s. 83 as it presently stands it is not a circumstance of aggravation, quite unlike Criminal Code s. 328A 'Dangerous Driving' where it may be applicable
[36] Media Release dated 15 October 2017
[37] Whether that is to cover careless, inconsiderate, negligent or reckless, being the various terms (and standards) other States, Territories, and England have adopted. 'Reckless' is a term easily understood by the community, and it is far better than negligent driving.

well publicised campaign should continue. The QPS support[38] appropriate penalties that reflect the loss of life or serious injury and for a new mid-range offence of reckless driving. Adequate options for police charges assists with enforcement on this significant road safety issue particularly as evidence was presented showing fatigue to be a factor in 15-30% of all road crashes[39].

Coroners Act s. 48: 'Reporting Offences or Misconduct'

[41.] The Coroners Act section 48 imposes an obligation to report offences or misconduct.

[42.] The Queensland Police Service prosecuted the responsible driver with the only provable charge available to them on the evidence, that of 'Driving without Due Care' under TORUM. In view of all the circumstances of the matter, particularly the admissions of the driver made at an interview of being tired before the crash occurred and only getting to bed at 4AM, a more serious charge of reckless driving (if that new offence was available) would certainly have been a viable option, and may very well have been proven. The QPS felt that their prosecutorial options were limited due to the absence of a mid-range offence such as Reckless Driving. No doubt a conviction for such an offence would carry a much more serious penalty than just an $800 fine[40].

[43.] It was not suggested, nor recommended, to me by any party at the inquest that any further person or entity should be referred for investigation of an indictable or other offence. Accordingly I make no such referrals under section 48.

Magistrate O'Connell
Central Coroner
Hervey Bay
25 October 2017

[38] See Exhibits D.2 – 2.3 inclusive
[39] Exhibit D.5.1
[40] Exhibit B.4 an $800 fine was the penalty Mr McFarlane received for the Due Care and Attention charge.