OFFICE OF THE STATE CORONER

FINDING OF INQUEST

CITATION: Inquest into the death of **Croft, Penelope Ann** [2005] OSC

TITLE OF COURT: Coroner's Court

JURISDICTION: Brisbane

FILE NO(s): COR 612/04

DELIVERED ON: 18 November 2005

DELIVERED AT: Brisbane

HEARING DATE(s): 5 and 6 July 2005

FINDINGS OF: O Rinaudo, Acting Deputy State Coroner

CATCHWORDS: **CORONERS: Inquest, Motor Vehicle Accident; Engine compartment door of bus open; Cyclist struck by open engine compartment door of bus.**

REPRESENTATION:

Assisting:	Sergeant R A Rochfort
Croft Family:	Mr P V Carter Solicitor and Mr Croft

Judgment Category Classification:
Judgment ID Number:
Number of Paragraphs:
Number of Pages:

CORONERS FINDING

PLACE INQUEST HELD: Brisbane

DATE: 18 November 2005

This is the inquest into the death and circumstances of death of **Croft, Penelope Ann.**

1. I must deliver my findings pursuant to the provisions of the *Coroners Act 2003*. I do so, reserving the right to revise these reasons should the need arise.

2. The purpose of this inquest, as of any inquest, is to establish, as far as practicable:-

   - Whether or not a death happened;
   - The identity of the deceased person;
   - How the person died;
   - When the person died;
   - Where the person died; and
   - What caused the person to die. [Section 45 (1) and (2)]

3. It should be kept firmly in mind that an inquest is a fact finding exercise and not a method of apportioning guilt. A Coroner must not include in the findings any statement that a person is, or may be guilty of an offence or civilly liable for something. [Section 45(5)]

4. The procedure and rules of evidence suitable for a criminal trial are not suitable for an inquest. The Coroners Court is not bound by the rules of evidence and may inform itself in any way it considers appropriate. [Section 37]

5. In an inquest there are no parties; there is no charge; there is no prosecution; there is no defence; there is no trial. An inquest is simply an attempt to establish facts. It is an inquisitorial process, a process of investigation. These observations were confirmed by Justice Toohey in *Annetts v McCann* ALJR at 175.

6. A Coroner's inquest is an investigation by inquisition. It is not inclusive of adversary litigation. Nevertheless, the rules of natural justice and procedural fairness are applicable. Application of these rules will depend on the particular circumstances of the case in question.

7. A Coroner may, whenever appropriate, comment on anything connected with the death that relates to:-

a) Public health or safety; or
b) The administration of justice; or
c) Ways to prevent deaths from happening in similar circumstances in the future. [Section 46 (1)]

8. If, from information obtained while investigating a death, a coroner reasonably suspects a person has committed an offence, the coroner must give the information to:-

a) for an indictable offence – the Director of Public Prosecutions; or

b) for any other offence – the chief executive of the department in which the legislation creating the offence is administered.

9. A Coroner may give information about a person's conduct in a profession or trade, obtained while investigating a death, to a disciplinary body for the person's profession or trade if the coroner reasonably believes the information might cause the body to inquire into, or take steps in relation to, the conduct.

10. All proceedings before this Court are sad proceedings. At this stage I express my sympathy and condolences, and that of the court, to the family of the deceased for their sad loss, in the tragic death of Penelope Ann Croft.

Summary of evidence

Events leading to the incident and death.

11. The deceased was an experienced bike rider and tri-athlete. The deceased had ridden bikes since she was a child and had been riding racing bikes for the last 10 to 12 years.

12. The deceased was an extremely fit person and was not suffering from any medical conditions, was not taking any medication and did not suffer from fits or blackouts. The deceased rode and ran many kilometres per week including to and from work, a distance of 15.5km.

13. The deceased had been riding home from work for several months. After assessing the possible routes to ascertain the safest, Mr Croft and the deceased had settled on a route which meant that the

deceased would travel along Wellington Street into Panorama Drive, onto Woodlands Drive and left onto Mt Cotton Road.[1]

14. Mt Cotton Road is a two lane asphalt road running in a north/south direction with an 80km/h speed zone. There is one lane in each direction separated by double centre lines. There is an asphalt shoulder on each side of the road.[2]

15. The incident is alleged to have occurred in the following way. A white Austral bus Queensland registration number 335 GBD with 'UBS' & 'Underwood Bus Service' written across the front, sides and rear was travelling in a southerly direction on Mt Cotton Road when about 100 metres before the turn off to Sirromet Winery, it passed the deceased riding her racing bike. The time was approximately 4.50pm. The right rear engine compartment door was open. In the open position the door was approximately 2.2 metres high and at right angles to the bus protruding from the bus by some 1.16 metres.[3] This was approximately the same hight as the deceased in the riding position.[4] As the bus passed the deceased the open door struck the rider in the back of the head inflicting injuries which were the cause of death.

16. There are no witnesses who saw the impact. There is conflicting evidence about whether the compartment door was open or not. The following evidence was given at the inquest.

17. Witness Clinton Drew Tschirpig, *"And as I was travelling I looked like that and I just saw her going over the handlebars and I just thought the wind blew her off the bike from the bus and I didn't know that she'd been hit by the bus…it was – seemed pretty close to me like, where the truck had to move apart and the bus type thing and the – I just sort of happened to see the cyclist and I thought, that was pretty close."*[5]

18. Witness Karl Heinz Adam, *"I was very near the entrance of the winery and in that S-bend section, which enabled me to see the door – the flap open of that bus and my engineering and technical background immediately alarmed me to the fact of how dangerous this could be. No sooner had I passed the bus that I saw a person laying on the ground. I pulled over immediately to see what help I could render"*[6] *…No sooner that had crossed my mind of how dangerous this could be, that I saw a person lying there and*

[1] Taken from the statement given by Mr Croft to Police, contained in exhibit 6 on page 3.
[2] For scale map of the accident scene see exhibit 39.
[3] See exhibit 34 photo number 17 and the evidence of Sergeant Nicole Lisa Fox, transcript page 9 at line 54.
[4] See transcript at page 12 line 10.
[5] See transcript at page 26 line 9.
[6] See transcript at page 38 line 20.

automatically I – I thought this must be the unfortunate result of – of this door being up."[7]

19. Witness Stephen William Davies said that he had seen the bus shortly before the incident. He recognised it as his daughter's school bus. He said that he got a clear and uninterrupted view of the left hand side of the bus and that no door was open. He said that he saw the incident but was some 300 metres behind the bus when he saw what he described as *"It seemed like it was moving off in my respect and I thought it was a young kid fallen down, you know, jumping out."*[8]

20. Witness Jillian Louise Bizon, *"The bus was coming down – down the hill, and I was travelling up – you know, up and around the hill. I saw the back section of the bus had a hatch open. I had my children in the car, and I said to them, the hatch – I thought it was the luggage hatch was open on the bus. So I beeped my horn and flashed my lights, and sort of, was waving out the window. And the – I don't know that the bus driver saw me, or if he did, he ignored me and just kept driving through. I just proceeded a short distance past there and I saw a lady on the ground."*[9]

21. Witness Damien John Cornel said that he was stationary at the entrance to the winery waiting to turn right into Mt Cotton Road. He saw the rider on his right coming towards him. He saw the bus approaching the rider from behind. When asked if he saw the door open he replied, *"No I didn't see a thing…I didn't pay any attention to that…it was clear for me still to go so I went round.*[10]

22. Witness Craig Andrew Williams said that he saw the compartment door open and hailed down the driver. He said, *"Well, basically, when the bus driver came down to meet me at the back of the bus, it was – we just shut the small black door, it – yeah – it was just a little bit out of alignment. So, just pulled it forward and then slammed it shut. And then it just secured properly"*[11]

23. There is sufficient eyewitness evidence to establish that the compartment door opened and was at right angles to the bus when the bus passed the rider. The open compartment door came into contact with the back of the rider's head inflicting wounds which were fatal.

[7] See transcript at page 39 line 18.
[8] See transcript page 30 generally.
[9] See transcript at page 43 line 50.
[10] See transcript at page 34 line 20.
[11] See transcript at page 47 line 11.

How did the left passenger side engine compartment door open

24. Evidence presented at the inquest in this death failed to identify one single factor that caused the passenger side engine bay door to open.

25. What is clear from the evidence is that the door did open and was the cause of the death.

26. A number of possible reasons emerged during the inquest. Each of these will be explored and possible solutions to prevent such a possibility reoccurring will be made.

Possibility 1- School children[12]

That the door was opened by a school child travelling on the bus that day.

27. It is unlikely that this occurred however it is possible. The children were dropped off at 2.30 and the incident occurred at 4.30 approximately. However the door is designed to stay down even when open unless it is lifted to about 45 degrees. At that point gas lifters assist with the lifting of the door.

28. It is possible that if the door had been opened by a child it could have stayed down until the bus travelled over a portion on Mt Cotton Road which is bumpy which could have caused the door to open.

Proposed Solution

29. Although at the time it did not have one, the closing mechanism on the door in question has since been fitted with a key locking device.

30. Any bus with a similar closing mechanism which is readily accessible to the public should similarly be fitted with a key lock.

Possibility 2 – lack of or poor maintenance[13]

31. Poor maintenance caused the closing mechanism to be working at less than optimum efficiency and a sudden jolt or bump had caused the door to open.

[12] There is a reference to the possibility that a child could have opened the door as they were waiting to get on but this is discounted and unlikely. See the evidence of Mr Wilton on page 103/104 of the transcript and the evidence of the driver Mr Featherstone on page 110 of the transcript. The only issue for consideration is that the company fitted locks to the compartment door after the incident thereby removing this possibility.

[13] A number of witnesses gave evidence about this issue. They were Mr David Tanner and Mr Shane Michael Lynch of the Department of Transport. See also particularly exhibit 29.

32. There is some evidence that the rear right lock was defective. It was unclear if the damage was pre or post event. However, a spring was missing from this locking device. Evidence was given that the locking device was still operative without the spring. In addition, the release arm to this lock was bent. Evidence was that this could have contributed to the failure of the lock although this was discounted by other evidence.

Proposed Solution

33. All doors should be regularly maintained. The operator's manual requires regular maintenance. It is possible that latches and locks are overlooked during maintenance because they fail so rarely.

34. At least each time the bus is serviced and preferably every month, all latches and door locking mechanisms should be thoroughly checked and overhauled as required.

35. In addition a fail safe system should be installed to all doors. This could be a simple locking device that has to be released by a special key such as an allen key. This safety device should work in such a way that it will not lock into place unless the door is closed properly.

Possibility 3 – the inner door[14]

36. The engine bay has an inner door and an outer door[15]. The outer door is the one that is being considered here. However, the inner door of this bus was not properly closed and locked. A locking device on the bottom of the door was missing and the one at the top of the door was not working properly or was defective.

37. There was clear evidence that the inner door was banging against the outer door. Whilst there was evidence to suggest that this would not have caused the outer door to come open by itself, it is possible that the swinging inner door was a contributing factor. Particularly if the outer door was not securely fastened for whatever reason.

Possible Solution

38. Inner door must at all times be securely fastened. A device should be fitted to all such buses so that this inner door even if it is not securely fastened and is swinging loose, cannot hit the outer door.

[14] Evidence about the possibility of the inner door being the cause of the accident varied. One witness said that it was possible but others said that it was unlikely. See for example the evidence of Mr David Tanner on page 63 line 22 of the transcript.
[15] See exhibit 34 photo 18 being the inner door and 16 being the outer door.

This could take the form of a safety latch or a welded piece of steel that stops the door before it can hit the outer door.

Possibility 4 – driver awareness and training[16]

39. The driver of the bus says that he always checks the bus over before starting his run and again after the students have left the bus.

40. There is however no clear driver's instruction or check list procedure to be followed.

41. The driver said in evidence that if the door was open it could not be seen via the left side bus rear vision mirrors.

42. There is no formal method of reporting and recording defects detected by the driver during routine inspections of the bus before departure.

Possible Solution

42. Formal and proper training should be given to all drivers about the need to check all exterior doors to ensure they are securely fastened. This should not be a simple cursory look but a physical inspection of each door to ensure it is properly closed and fastened.

43. A driver's check list setting out the elements of the inspection should be followed by the driver and signed off at the start of the day and after dropping off children. For non school buses this inspection should occur at least twice per day.

44. If it is not possible to see an open door using rear vision mirrors then alarms should be fitted to the doors to ensure that the driver is alerted to the potential danger at the earliest time.

45. Any defect in the bus detected by the driver during routine inspections should be entered into a special log kept solely for this purpose and reported to the officer responsible for the maintenance of the bus who will be responsible for ensuring that the log is properly completed. This log must be available for the inspection of service mechanics and the department of transport.

[16] Much was made during the inquest of the practices and procedures of the manufacturer and the bus company about what procedures were in place and what training drivers were given about inspection of the bus to ensure that doors were properly and securely shut. See particularly the evidence of Mr Wilton and Mr Featherstone on this point.

I make the following findings :–

(a) The identity of the deceased was Croft, Penelope Ann.

(b) Her date of birth was 4 August 1949.

(c) Her last known address was 66 Mill Street Redland Bay 4165.

(d) At the time of death her occupation was Public Servant.

(e) The date of death was 2 March 2004.

(f) The place of death was Mt Cotton Road, Mt Cotton.

(g) The formal cause of death was head injuries, due to, or as a consequence of a motor vehicle accident.

RECOMMENDATIONS:

Pursuant to section 43 of the Act, the following recommendations are made by way of rider to the formal findings.

I recommend:

1 All exterior doors on buses should be fitted with key locks.

2 All exterior doors on buses should be fitted with a safety locking system with a special key. This system should only lock when the door is properly secure.

3 All exterior doors on buses should be fitted with alarms to alert the driver that a door is semi-open or open. This alarm system should be both visual and audible.

4 All exterior doors on buses should be regularly maintained and inspected at the time of regular maintenance and at least each month. Bus maintenance personnel should give the owner a written report that the doors have been inspected and are in good working order.

5 Drivers should be properly instructed to undertake a physical inspection of all outer doors including physically pulling on the door to ensure it is locked and secure.

6 Drivers should be given a list of things to check on the bus at least twice per day. This check list should be checked off and signed by the driver.

7 Inner doors on engine compartments should be locked by an adequate locking device and a safety system should be installed to ensure that the inner door cannot come into contact with the outer door should the inner door become loose.

8 A maintenance log must be kept by the company/owner of the bus in which is to be listed any and all defects detected by the driver of the bus during routine inspections before departure each day. This log must be available for service mechanics and the Department of Transport for inspection.

I extend my condolences to Mrs Croft's family and friends in their sad loss.

Thank you to Sergeant Rochfort and Mr Carter for assisting in this inquest. The inquest is now closed.

Orazio Rinaudo
Acting Deputy State Coroner