QUEENSLAND COURTS

# CORONERS COURT OF QUEENSLAND

# FINDINGS OF INQUEST

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| CITATION: | **Joint Inquest into the deaths of Ian Christoffer Jensen and Timothy Ponde Kepui** |
| TITLE OF COURT: | Coroners Court |
| JURISDICTION: | Bundaberg |
| FILE NO(s): | 2015/2081 and 2014/1586 |
| DELIVERED ON: | **24 March 2017** |
| DELIVERED AT: | **Mackay** |
| HEARING DATE(s): | **25th – 26th October 2016** |
| FINDINGS OF: | Magistrate O'Connell, Central Coroner |
| CATCHWORDS: | Coroners: inquest, collisions between bicycles and motor vehicles, how the collisions occurred, whether Police investigative and prosecutorial responses were adequate in the circumstances. |

REPRESENTATION:

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| Counsel Assisting: | Mr J M Aberdeen |
| Jensen Family: | Mr B Jensen |
| Mr Christopher Tydhof: | Mr D Williams (instructed by Mills Oakley Lawyers) |

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| Queensland Police Service: | Mr C Capper |
| Bundaberg Regional Council: | Mr B McMillan (instructed by Norton Rose Fulbright) |
| Kepui Family: | Ms M Kepui |
| Mr Russell Lyons: | Mr J Benjamin (instructed by Charltons Lawyers) |

[1]. On 3 May 2014 Dr Kepui, and on 1 June 2015 Mr Jensen, were involved in separate fatal traffic accidents. Each were the rider of a bicycle involved in an incident with a motor vehicle. Both cyclists were ordinary[1] members of the public, simply going about their daily activities. Each traffic accident was investigated by the police, charges were laid against the driver of the motor vehicle involved, but the charges were later withdrawn by the police.

[2]. This inquest[2] examines the circumstances of these similar traffic accidents, the adequacy of the police investigation and prosecution, and whether there is a need for further education to raise public awareness of the current laws as they relate to cyclists on the road.

## *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[3]. In these cases there is no real contest as to who, when, where, how or what caused them to die. The real issues are directed to the why they died, that is the circumstances of the accident that occurred.

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

1. The information required by section 45(2) of the *Coroners Act 2003*, namely: who, how, when, where, and what, caused each death,

2. With respect to Mr Jensen:-

   (a) did a collision occur between the bicycle being ridden by Mr Jensen and an Isuzu truck Reg No: 576-KEI on 1st June 2015 on Johnston Street, Bundaberg?
   (b) if so, what were the circumstances giving rise to this collision?
   (c) if not, what were the circumstances causing Mr Jensen to fall from his bicycle?

3. With respect to Mr Kepui, what were the circumstances giving rise to a collision between the bicycle ridden by Mr Kepui and a car (Reg No: QFR-49) and trailer combination at the intersection of Barolin St/Goodwood Road and McCarthy St, Bundaberg on 3rd May 2014?

4. (a) Whether the investigations, and the process of identifying and collecting evidence, carried out in respect of each fatality incident were adequate under all of the circumstances?

[1] They were not lycra clad recreational cyclists, rather were ordinary persons, one dressed in work clothes, a 'hi-viz' workshirt and shorts, and the other simple shirt and shorts presumably on his way to his church.
[2] Approved by the State Coroner to be a joint inquest due to similarity of issues.
[3] Coroners Act 2003 s. 45(2)(a) – (e) inclusive

(b) Whether the prosecutorial processes, including the decision not to proceed further with the prosecutions, were carried out in an appropriate manner?

5. (a) Whether there is a need for further education to raise public awareness of the current laws pertaining to cyclists on the road (including an increased awareness of respective rights-of-way, and of safe clearance?
(b) Whether it is desirable that theoretical testing upon recent changes to traffic laws should be included as part of a driver's licence renewal protocol?

[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[4].

[6]. The third task is that if I reasonably suspect a person has committed an offence[5], committed official misconduct[6], or contravened a person's professional or trade, standard or obligation[7], 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, section 45 Findings, section 46 Coroners Comments, and then section 48 Reporting Offences or Misconduct. I have used headings, for convenience only, for each of these in my findings.

## *Factual background & evidence*

[8]. I can state briefly the broad circumstances involved in each accident. Each accident occurred in daylight hours, on an ordinary road in Bundaberg which had a posted speed limit of 60 km/h. In each instance the cyclist was travelling on the left-hand side[8] of the road, before being struck by a vehicle attempting to pass the cyclist.

[9]. There was no suggestion in either accident of any contributing factor from the road surface, adverse weather conditions such as rain falling or sunlight in the driver's eyes, vehicle defect, use or distraction by a mobile telephone or operation of the vehicles' interior instruments[9], nor the effects of alcohol or drugs on either of the driver's (or the cyclist). I should state clearly that there

[4] ibid s.46(1)
[5] Ibid s.48(2)
[6] Ibid s.48(3)
[7] Ibid s.48(4)
[8] At this time I don't distinguish between being in the 'line of traffic' or to the left of the fogline, as I deal with that aspect later
[9] For example changing the radio, adjusting air-conditioner settings

[10]. was also no suggestion that either driver was undertaking any type of irresponsible driving behaviour, commonly termed 'hooning'.

[11]. Following each accident the police conducted investigations, and made enquiries. They undertook for prosecutorial purposes and coronial investigation purposes what is termed a Forensic Crash Unit (FCU) Investigation Report.

[12]. In each instance the driver of the motor vehicle was charged with the traffic offence commonly termed 'failing to drive with due care and attention'[10]. Each of these is a relatively minor offence, dealt with in the Magistrates Court, and is not the more serious Criminal Code offence of 'dangerous operation of a motor vehicle'. In each instance, after completion of enquiries, the investigating police officer considered there was sufficient evidence to lay the charge, but quite early on in the prosecution of each of the charges they were withdrawn by the police. This occurred after a review of the file on the then known circumstances of the matter. Essentially it appeared to occur due to concerns identified by the police prosecutor, incidentally the same police prosecutor in each instance.

## *Investigations into the incident:*

[13]. The investigation by the police in the events of Mr Jensen's accident commenced immediately the police arrived on the scene. In very short compass the police blocked the road in both directions, preserved the scene and commenced investigations immediately. This was of course entirely appropriate and I have no criticism of the police investigation steps they took that day.

[14]. I appreciate that Mr Jensen's family had concerns over a number of matters which they feel the police did not investigate sufficiently on the day, or after. Mr Jensen's family, who appeared at the inquest through his brother, had a number of concerns about the investigation which may conveniently be covered by issues such as why the police did not examine the scatter pattern of a 30 pack carton of beer cans (which Mr Jensen had been balancing on the top tube of his bicycle at the time the incident occurred), scuff marks on the belt he was wearing, and sufficient examination of the rear view mirror on the passenger side of the truck to determine if it had struck Mr Jensen causing him to fall from his bicycle.

[15]. The police investigation did note these possible issues in their investigation. The 30 pack beer tin scatter pattern has, in my view, precious little utility, I would consider almost none, in assisting to determine how the incident occurred and precisely how Mr Jensen was struck. The scatter pattern is simply consistent with Mr Jensen falling away from the passenger side of the truck towards the grass verge of the road. How those tins then scattered cannot be precisely replicated. They merely show that he was carrying the item at the time. The

[10]s.83 Transport Operations and Road Use Management Act (and for Dr Kepui's incident there was also considered the failure by the car driver to pass on the left of a vehicle turning right)

scuff marks on his belt did not add greatly to the other evidence the police already had.

[16]. The police did make a concerted effort to try and locate any physical evidence of a contact point on the passenger side or front of the truck which may indicate where Mr Jensen was struck, but there was not found any distinctive physical evidence. There was no paint transfer (none would be expected from the person wearing clothing), no fabric fibres, and his helmet did not appear to have left any mark at the front or along the side of the vehicle. There was no panel damage seen. It was of course a possibility that he have been struck by the passenger side rear view mirror, and detailed photographs and examination of it occurred, but there was not found any distinctive evidence on it such as a paint transfer, or damage to it. Of course if it had struck the cyclist and moved it would not take much for a person to move the mirror back into the approximate position it was before the incident occurred (if it had moved at all).

[17]. I reiterate I am not critical of the police investigation of this incident. It was prompt, thorough in the circumstances, and the final report well considered.

[18]. The investigations into Dr Kepui's accident were quite different. As the coroner for Central Queensland my geographical area of the State receives approximately one-third of all road fatalities for Queensland. Accordingly I am very familiar with investigations that the FCU undertake, and also feel qualified to comment on my observations (from a coroner's perspective) of this police investigation into Dr Kepui's accident[11].

[19]. It is appropriate I set out the steps the police took, or perhaps did not take, which then makes self-evident the standard of investigation undertaken by the police.

[20]. The accident occurred at about 8:40 AM on a Saturday morning. The police and ambulance were notified. Police arrived at the scene shortly after with three constables attending. Dr Kepui was then being treated by ambulance officers and the significant issue to note was he had a Glascow Coma Scale[12] (GCS) of just 3[13]. After about 45 minutes of treatment by the roadside Dr Kepui was transported to the Bundaberg hospital. The initial attending police officers remained at the scene until Dr Kepui had been transported away by ambulance. The police left the scene shortly after. They did not do any substantive investigatory work whatsoever at that time. Perhaps it was thought that Dr Kepui would survive and so it would not be considered required that the FCU investigate. Of course FCU investigates all road deaths and accidents involving

[11] in my years undertaking this role I would have received, and reviewed, more than 350 FCU investigation reports

[12] The scale has a range from 1 – 15, with 15 being a total conscious and commutative person, with no evident brain injury. I should add that the assessment is to determine likelihood of a brain injury, which would to my mind make it a serious injury for FCU purposes.

[13] In layman terms he was unconscious, unresponsive, and his condition serious

'serious injury'[14]. A man being treated by ambulance officers with a GCS of just 3 has obviously suffered a very serious injury, particularly where he had significant head injuries and was a man of 61 years of age.

[21]. In any event the police liaised with medical staff at the Bundaberg Hospital and the police were informed at around 11.00 AM that Dr Kepui was unlikely to survive. It was stated in evidence by the police officer who conducted the FCU investigation that he was advised of this fact at the police station around about 11.00 AM that day, so he then knew he would need to investigate. The officer is only a part-time FCU investigator and, very surprisingly to me, he then continued with his rostered duties involving the watch house until the completion of his shift at 3.00 PM. I find this a remarkable managerial decision that the FCU investigator was not immediately relieved of his duties at the watch house to commence investigations at the scene of the accident. Evidence from the FCU officer was that he finished his shift in the watch house and then went by the crash scene on his way home.

[22]. The investigator admitted that on the Saturday afternoon when he visited the crash scene he took no particular measurements, nor marked the road, nor did he meet the initial attending police constables at the scene to have them indicate significant information. He said in evidence that it was probably not necessary as the important information had been washed away from the scene by the Queensland Fire & Rescue Service hosing the road. To me that comment is a little remarkable as the Form 1[15] submitted by the investigating officer does not make any mention whatsoever that the QFRS attended the scene. Perhaps the investigating FCU officer was simply making an assumption, or was confused, but I draw no specific conclusion. More concerning was that the investigating FCU officer then went on rostered leave for two days. On the following Tuesday he then returned to the scene to conduct investigations.

[23]. Perhaps I can highlight very briefly what I see as elementary deficiencies in the investigations by simply noting a few things. These are that:-

a. there was no immediate securing, or investigation, of the scene,
b. there was no marking out, nor scale mapping of the scene whatsoever, rather there was a rough hand sketched diagram done,
c. the motor vehicle involved, and the trailer, were not seized by the police on the day of the incident, and in fact were not even measured by the police until a request was received from the Coroners office for this to be done in the lead up to the inquest, they were merely photographed and then after the vehicle had left the scene.

To me these are basic steps, but they were not done. I note the photographs of the motor vehicle and trailer involved, which showed marks, or impact damage,

[14] This was confirmed in evidence by the FCU investigator.
[15] The initial document reporting the death to the Coroner

on the passenger side of the vehicle, and on the leading edge of the trailer, but apart from simply taking photographs these essential 'actors in the play' were not forensically, or adequately, investigated whatsoever.

[24]. Other investigatory steps did occur including obtaining a dashcam which captured the incident from a vehicle which was approaching the intersection from the side street to the intersection. It was useful in determining how far apart the vehicles were travelling, to confirm that excessive speed was not an issue, but being side on meant that it did not provide critical information on Dr Kepui's position on the road when the incident occurred, and a speed estimate is made difficult because the vehicle in question brakes during the footage. What it does show is that the vehicle involved was travelling about 42 – 51 km/h[16], and not the 20 – 25 km/h that the driver advised the police.

[25]. Fortunately the vehicle involved was driving in a 'line of traffic' and statements were able to be obtained from the lead vehicle. That driver advised that they observed Dr Kepui give a very clear indication, as a hand signal, to turn right. This driver then moved their vehicle to position the driver's side wheels over the centreline so they could simply drive around Dr Kepui. The third vehicle in the line (behind the vehicle involved in the incident), also had a very clear view of the incident. That driver indicated that they saw Dr Kepui clearly indicate to turn right through use of a hand signal and so they decided to slow, and simply pass to the left-hand side of him as there was a small sealed road shoulder at that point. This driver also observed Dr Kepui move to about the centre of the lane, when they then saw the vehicle in front try to drive to the right-hand side of him but struck him. Significantly this driver said that before the impact they could see that a collision between car and cyclist was going to occur. This driver, the third in the line of traffic, said before impact occurred they were already beginning to brake because they could see the accident unfolding in front of them. This is quite suggestive that an observant driver had sufficient time to take appropriate action to avoid a collision.

[26]. What that meant was there were two independent witnesses who observed the incident and could provide evidence to the police for the prosecution of the charge they laid. I should say that these two witnesses when they gave evidence before me were very impressive witnesses. Each lady was solid in the evidence they gave, and never wavered from what they had seen, or could recall. To my mind they would certainly have been very impressive witnesses in the prosecution of the traffic offence. Why I say this is because if there were deficiencies in the investigation process by the FCU officer then there was the ability to obtain further information from these two witnesses to correct the situation, or address concerns.

[16] See exhibit B.3 at page 6 paragraph 17, exhibit A.6 page 2 being a transcript excerpt from an interview with the driver.

[27]. Incidentally my observation of the investigation process of Dr Kepui's accident was that it was very poor, concerningly so to my mind. Evidence given at the inquest was that the Bundaberg district has no dedicated FCU officers, rather they merely use part-time FCU officers. I find this very surprising. Bundaberg is a significant regional city in Queensland, and supports a significant, and important, regional population. It may surprise some but the evidence before the inquest was that the nearest full-time FCU officer is located in Maryborough, a significantly smaller locality than Bundaberg. My observation is, and it is simply my observation, that this issue needs to be addressed by the Queensland Police Service particularly in view of the substandard investigation of Dr Kepui's accident, and the subsequent prosecution process of each accident where the charges did not proceed to court determination.

## *The circumstances of each incident as I find*

[28]. Mr Jensen was seen riding his bicycle balancing a carton of beer on the top tube. He also had some groceries on the rear carry rack and possibly also on the handlebars[17]. What was clear from the witnesses who observed him was that even though he was balancing a carton of beer and groceries, he was riding well and did not appear to be veering at all as he rode. Perhaps he was accustomed to riding carrying groceries, et cetera, as it was suggested he had done this trip on a number of occasions.

[29]. Motorists who were awaiting to exit the shopping centre carpark saw Mr Jensen ride his bicycle across the road quickly. He was observed to ride as far left as practicable on the road, and one witness also described him riding down the slight incline of the road and travelling like "a cut snake". This was not a unit of speed I was familiar with but the witness indicated that it was simply that Mr Jensen was pedalling quickly. Pedalling speed, or cadence, as it is correctly termed, does not directly co-relate to high speed, as it is dependent upon the gear the rider has the selected. In any event, people simply described him as riding quickly, and as an ordinary person on what was a fairly dated mountain bike, he was not travelling at a fast pace[18], or even a speed which had any particular bearing on the accident. What was clear from witnesses was that at all times Mr Jensen kept to the far left-hand side of the bitumen lane. This demonstrated responsible riding.

[30]. The incident occurred where the road widened (presumably[19] to allow passing to the left-hand side of cars stationary and turning right into the supermarket complex), then tapered back into a single lane of traffic. There are no line-

[17] Witnesses were unclear as to whether he had shopping in plastic carry bags draped from the handlebars. In the end it is not necessary that I determine the issue as I find that his riding style, whilst carrying shopping (whatever shopping that was), was skilful.
[18] Such as a recreational cyclist training would ride at.
[19] I say 'presumably' as there was not marked any dedicated left hand passing lane. An oversight arising from the original Development Approval perhaps?

markings defining two lanes heading in the one direction[20]. Mr Jensen did nothing other than to follow the left-hand fogline of his lane. As a cyclist (and a bicycle is defined as a 'vehicle' under the relevant[21] TORUM laws) he was quite entitled to do so.

[31]. The driver of the council truck said that he was merely driving at or below the speed limit. This was confirmed by other motorists and there is no suggestion that his driving was in any way unusual. The truck driver did say that in the period leading up to the collision he did not observe Mr Jensen on his bicycle and explained that this was probably because his attention was directed further up the road where there was another intersection where he saw another car waiting to turn out. The truck driver was not distracted by anything else, merely his attention was directed elsewhere in his field of vision.

[32]. What is clear is that at all times Mr Jensen was clearly visible to a person in the truck's driving compartment. Why I say this is because the passenger seated in the truck stated that he observed Mr Jensen riding on the left-hand side of the road, but noticed that as the passing lane 'merged', or tapered, back into a single lane he became concerned that he thought that the driver had not seen Mr Jensen and that a collision could occur. The passenger had sufficient time to make these observations, anticipate a collision, and then call out to his driver to watch out for the cyclist. The truck driver said that after his passenger gave him this warning he suddenly realised the cyclist was to the left of the truck but by then he was too close to avoid hitting him.

[33]. The police investigation, despite a good and thorough inquiry, could not discern if the truck had struck Mr Jensen. Of course it is possible that a truck passing very close to Mr Jensen had merely caught him by surprise and that caused him to fall off, but that would mean the truck had passed too close to Mr Jensen, and one would think well within the required at least one metre passing rule[22]. The truck driver declined to provide the police with a statement, as he is entitled to.

[34]. At the inquest he was required to give evidence, and chose to decline to give evidence until I directed him to do so. Accordingly his evidence attracts the immunity under section 39 of the Coroners Act. His evidence essentially was that he only saw Mr Jensen just prior to the collision, and as he turned to watch the truck pass Mr Jensen he saw that the passenger side rear view mirror (which on his truck was mounted on a substantial metal bracket) strike Mr Jensen either around on the right shoulder or back of the helmet area, and he saw the mirror move backwards and then spring back into position. He immediately parked his truck when it was safe to do so.

[20] although the pavement widening created different 'darkness' of the paved surface which may give a slight appearance of a differentiation of an overtaking lane, but to make perfectly clear there is none.
[21] TORUM regulation, s.15
[22] TORUM Regulation s.144A

[35]. What is clear is that Mr Jensen was not overrun by the truck, but was struck a glancing blow by the rear view mirror. I appreciate how difficult it was for the truck driver to give this evidence and his providing this evidence honestly is recognised by me, and appreciated by the court[23]. In saying this it does demonstrate that where the passenger was able to observe the rider, and determine that an incident was to occur, with sufficient time to call a warning suggests strongly that there is sufficient available evidence for a successful prosecution of the driver for failing to drive with due care and attention. I comment further about this under my section 48 comments.

[36]. Dr Kepui's accident occurred on a roadway where he was riding on the road shoulder, to the left of the fogline. As I said earlier he was observed by certain motorists in the line of traffic to give a clear hand single indicating that he wished to turn right. As I said he then moved from the road shoulder over the fogline and into the lane of traffic such that the first driver needed to move their driver's side wheels over the centreline to go around Dr Kepui.

[37]. Whilst the driver of the vehicle which struck Dr Kepui stated that they did not see him prior to the incident occurring they did say they followed the first car in moving their vehicle such that the driver's wheels were over the centreline. Dr Kepui first struck the side of the motor vehicle before being struck by the trailer.

[38]. There was some suggestion before me that there was conjecture as to whether Dr Kepui was to the left of the fogline, or in the lane of traffic when he commenced to veer right. I find that he first indicated whilst on the road shoulder and left of the fog line. The evidence before me was that Dr Kepui did not turn sharply, rather he began to slowly veer across the road. He was clearly in the lane of traffic such that the first car needed to move into the opposite lane to safely negotiate around him. Accordingly I find that Dr Kepui was in the lane of traffic prior to the first vehicle commencing to overtake him.

[39]. Under the traffic laws that meant that the vehicles behind Dr Kepui all had to give way to him. It is clear the first vehicle did so and safely negotiated around him to the right. The third vehicle observed Dr Kepui and seeing his intended right hand turn, had actually commenced braking. That driver had planned to pass him to the left where there was slight extended paved road shoulder, because they observed and knew from their observations that Dr Kepui was clearly turning right. Significantly this driver had sufficient time to observe what was unfolding before them, make a decision as to what they should do, and then thought to themselves that an accident involving Dr Kepui and the second vehicle was going to occur, which is what happened.

[23] As a charge may still be laid any media reporting of this evidence will need to be very carefully considered.

[40]. What is clear to me is that the driver of the second vehicle failed to keep any, or any proper, lookout. The timeframe[24] for any prosecution of such an offence has expired, and so no charge of the type that was commenced could be reconsidered. I merely observe that in my view, after hearing the evidence, that I find it perplexing that the charge did not proceed to trial based on the very strong evidence of the two driver witnesses who I found to be thoroughly reliable and credible witnesses.

[41]. Incidentally, and I feel it necessary to make this observation, there was a suggestion in the police material that perhaps because Dr Kepui was Papua-New Guinean that somehow he was unfamiliar with riding bicycles. I do not know what the basis of that remark in the police prosecutor's material was, and perhaps I should point out that Dr Kepui was a man 61 years old and was highly educated, in fact he held a PhD in land agronomy. There was also a suggestion that he was wearing headphones or distracted by listening to music at the time. Even the driver of the second vehicle, the vehicle that struck him and immediately stopped and went to his aid, said he did not observe any earphones nor hear any music, so I am at a loss to understand where that assumption originated from.

## *The prosecution process:*

[42]. The police commenced proceedings against each driver for a charge of failing to drive with due care and attention. That is a relatively minor driving matter under the Transport Operations and Road Use Management Act. Neither charge were preceded with as the police withdrew each charge before it proceeded very far through the court process. Why each charge did not proceed was of concern to me, as in my view there was a clear basis for each charge to continue through the court.

[43]. The coronial investigation had the benefit of the internal correspondence exchange between the prosecutor and the investigating officer. It sheds some light on concerns of the prosecutor. The investigating officer gave evidence in each case, and if I may summarise their evidence, they personally felt frustrated at the charge being withdrawn. It was certainly the opinion of the investigating officer that the charge should proceed. As to why the prosecutor held the views they did I can only glean these from the exchange of correspondence, and documents on the file, because whilst I invited counsel for the Queensland Police Service to have the prosecutor attend and give evidence that invitation was not taken up. Perhaps there are good reasons for that but there was no particular explanation given to me. Accordingly I can only rely upon the information in the exchange of correspondence to determine what factors were operating on the prosecutor's mind. The exchange of correspondence suggests the prosecutor thought the following were particularly relevant:-

[24] Just 12 months from the date of the incident for a standard motor vehicle

a. Mr Jensen:- that the cyclist was travelling at speed, balancing items unsafely whilst riding, and appeared he had ridden towards the truck rather than the truck towards the deceased;
b. Dr Kepui:- the angle at which he veered across the carriageway, the precise point of the collision on the roadway, the familiarity of Dr Kepui in riding bicycles (as he was from PNG originally[25]), the allegation he had headphones on and was listening to music, apparently conflicting Road Rules, that the cyclist may have contributed to the collision by not looking back at the oncoming traffic, the cyclist may not have given enough forewarning, and whether the defendant's interview with the police would be excluded at trial.

[44]. The Queensland Police Service Operations and Procedures Manual provide guidelines in relation to the decision to institute proceedings, sufficiency of evidence, public interest and importantly, in this matter, the withdrawal of charges. In very short compass[26] the decision to institute proceedings rests with the arresting officer. The decision to withdraw a charge requires the authority, or approval, of a commissioned officer or the senior officer supervising that station where the arresting officer is stationed. There are certain other factors to consider including whenever possible consultation with the victim (in this matter one would think that logically that would be the senior next of kin).

[45]. Gleaning what I can[27] from the internal memorandum, and Case Diary Log, the decision to withdraw the charge appeared to be unduly influenced by the prosecutor, without sufficient time, or perhaps more properly, sufficient availability or opportunity for input, from the investigating officer. In addition there certainly did not appear to be any consultation with the senior next of kin before the charges were withdrawn. I am in some respects a little constrained in what I can identify as the principle reason for the withdrawal of the charges, but I remain very concerned that the appropriate steps were not followed in relation to the withdrawal of the charges, particularly when the view of the investigating officer was that they should have proceeded.

[46]. In relation to any matters of concern regarding sufficiency of evidence raised by the prosecutor there was nothing in the material before me that those concerns could not have simply been allayed with appropriate completion of further investigatory steps of the existing evidence. Perhaps the kindest way to put it is that the withdrawal of each charge appeared to be rushed, and included

[25] No one explained to me the relevancy of this in relation to the charge, nor the inference that should be drawn. It must have had some bearing in the mind of the prosecutor otherwise it would not have been included as a consideration for continuing or discontinuing the prosecution. It is of course irrelevant.
[26] I apologise if this information appears simplistic, but it is included for the benefit of the families of the deceased as they both appeared to be 'in the dark' as to how police charges are laid, and withdraw.
[27] As the author was not called as a witness

irrelevant considerations, but the weight given to those irrelevant considerations I cannot determine.

[47]. One aspect which raises my interest is that two charges, in Bundaberg, within a short passage of time, relating to Due Care and Attention involving cyclists were withdrawn without additional further investigation. This is a concern as in each offence a person has lost their life. In my position as Central Coroner I will continue to have the ability to review this situation as further cases are reported to me.

[48]. I am critical of each decision not to proceed with the charge. In relation to the incident involving Mr Jensen as it involved a truck there is time to commence new proceedings, as a two-year time applies if the police consider that it is appropriate to proceed. That is a matter for them[28].

## List of Inquest Issues Answers

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

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

1. The information required by section 45(2) of the *Coroners Act 2003*, namely: who, how, when, where, and what, caused each death,

Answer:
Mr Jensen

a. Who the deceased person is – Ian Christoffer Jensen[29],
b. How the person died – Mr Jensen died due to another driver's inattention, in failing to keep an adequate lookout for another road user, namely Mr Jensen on his bicycle,
c. When the person died – 1 June 2015[30],
d. Where the person died – Johnston Street, Bundaberg[31], and
e. what caused the person to die – cerebral contusions and lacerations, due to fracture of the skull, due to bicycle trauma.[32]

Answer:
Dr Kepui

a. Who the deceased person is – Timothy Ponde Kepui[33],
b. How the person died – Dr Kepui died due to another driver's inattention, in failing to keep an adequate lookout for another road user, namely Dr Kepui on his bicycle,
c. When the person died – 3 May 2014[34],

[28] As the possibility of renewing the charge remains I will not make further comment.
[29] See exhibit A1 QPS Form 1
[30] See exhibit A2 Life Extinct Form
[31] See exhibit A2 Life Extinct Form
[32] See exhibit A3, Form 3 Autopsy Certificate
[33] See exhibit A1 QPS Form 1
[34] See exhibit A2 Life Extinct Form

d. Where the person died – Bundaberg Base Hospital[35], and
e. what caused the person to die – brain stem haemorrhage, due to, traumatic subdural haemorrhage, due to pedal cycle trauma[36].

2. With respect to Mr Jensen:-
(a) did a collision occur between the bicycle being ridden by Mr Jensen and an Isuzu truck Reg No: 576-KEI on 1st June 2015 on Johnston Street, Bundaberg?
Answer: Yes, a collision did occur.

(b) if so, what were the circumstances giving rise to this collision?
Answer: The circumstances were that the driver failed to keep a proper lookout, and drive with appropriate care, such that he failed to see Mr Jensen and his vehicle's passenger side rearview mirror struck the cyclist causing him to fall.

(c) if not, what were the circumstances causing Mr Jensen to fall from his bicycle? This is not necessary to answer.

3. With respect to Dr Kepui, what were the circumstances giving rise to a collision between the bicycle ridden by Dr Kepui and a car (Reg No: QFR-49) and trailer combination at the intersection of Barolin St/Goodwood Road and McCarthy St, Bundaberg on 3rd May 2014?

Answer: The car driver failed to keep a proper lookout and very likely travelled too close to the vehicle ahead, such that the driver failed to observe Dr Kepui's right turn hand signal. Dr Kepui first struck the passenger side, rear half of the vehicle, then was fatally struck by the trailer it was towing.

4. (a) Whether the investigations, and the process of identifying and collecting evidence, carried out in respect of each fatality incident were adequate under all of the circumstances?
Answer: The investigation of Mr Jensen's matter was appropriately investigated. The investigation of Dr Kepui's matter was well below what is considered adequate. Examples of why I consider it inadequate are provided above in these Inquest Findings.

(b) Whether the prosecutorial processes, including the decision not to proceed further with the prosecutions, were carried out in an appropriate manner?

[35] See exhibit A2 Life Extinct Form
[36] See exhibit A3, Form 3 Autopsy Certificate

Answer: I consider the decision not to proceed was flawed. My observations on the decision is set out above in these Inquest findings.

5. (a) Whether there is a need for further education to raise public awareness of the current laws pertaining to cyclists on the road (including an increased awareness of respective rights-of-way, and of safe clearance?
Answer: See below in my Recommendations.
(b) Whether it is desirable that theoretical testing upon recent changes to traffic laws should be included as part of a driver's licence renewal protocol?
Answer: See below in my Recommendations.

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

[50]. This incident does provide the opportunity to recommend improvements aimed at reducing the risk to road users.

[51]. It was touched on at the inquest how little drivers knew of the rules relating to safe overtaking distances of bicycle riders, or safe passing distances as some refer to it. It was demonstrated[37] at the inquest that general knowledge in this area was poor. Drivers quizzed on this issue could not correctly answer what the law was, which is dependent on the posted speed limit of the road.

[52]. There is a need for further education to raise public awareness of the safe passing distances for cyclists on the road. Of course the government department responsible will correctly point out that they already conduct general advertising of these issues to generate increased awareness, but I think it is desirable that when a driver renews, or applies for a drivers license, that some component of that renewal involves theoretical testing, even a simple 'Question & Answer' test for recent changes to traffic laws[38]. This is not a difficult matter, nor involves any significant cost, as I envisage that when a person attends the Department of Transport (or renews online) they simply successfully complete a short quiz of recent rules.

[53]. As licences are renewed every five years all licensed drivers would be captured within this period.

[54]. I raised earlier about the lack of dedicated FCU officers in the Bundaberg district. As it was not specifically included in the List of Issues for the Inquest I do not make it a formal recommendation, although no doubt it will be considered by QPS at a managerial level as any responsible entity would. I shall merely wait to see if anything develops in that regard, and as I remarked earlier Bundaberg is a significant regional Queensland city, and services a significant rural population.

[37] Admittedly only the drivers involved, hardly a wide cross-section of the community
[38] This is not restricted to cyclist overtaking, rather changes generally. No doubt many would also suggest a general refresher on Roundabout entry and exiting rules

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

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

[56]. 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 any new indictable or other offence. Accordingly I make no such referrals under section 48. There does remain the outstanding issue of whether the police again proceed with the charge of Failing to Drive with Due Care and Attention against the truck driver involved in the matter of Mr Jensen. That is a decision for the Queensland Police Service to decide.

**Magistrate O'Connell**
Central Coroner
Mackay
24 March 2017