QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Natasha Alison Maggs, Tiana Marie Williams, Kody Peter Tugaga Holland-Williams, Allan John Sullivan; and Jordan Guy Hayes-McGuinness**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Southport
FILE NO(s):	2012/4427, 2012/4439, 2012/4444, 2012/4441, 2012/4442
DELIVERED ON:	4th December 2015
DELIVERED AT:	Southport
HEARING DATE(s):	13 August 2015 & 14 August 2015
FINDINGS OF:	Mr James McDougall, Coroner
CATCHWORDS:	Collision, stationary vehicles, Pacific Motorway, emergency phones, breakdown safety, roadside assistance, education campaign.

REPRESENTATION:

Counsel Assisting the Coroner:	Ms Rhiannon Helsen,
Royal Automobile Club Queensland (RACQ):	Mr AC Braithwaite
Department of Transport & Main Roads:	Ms MG Zerner

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Introduction

1. At around 10:00 pm on 7 December 2012, five friends from the Logan area decided to travel to the Gold Coast to 'cruise' and socialise. There were a number of vehicles traveling with the group. The driver, Thomas Bayer, aged 16, was the registered owner of the vehicle, a 1992 blue Holden V8 Statesman sedan. His companions were Natasha Maggs (aged 23), Tiana Williams (aged 17), Kody Holland-Williams (aged 18) and Allan Sullivan (aged 20). Thomas had a learner's driver's license at the time and had asked Natasha to accompany him as the supervising driver.

2. Sometime after 11:00 pm, the Holden experienced mechanical difficulties whilst traveling southbound along the Pacific Motorway and lost power. Thomas drove the vehicle over to the side of the road, parking in the shoulder lane, approximately 1.2km north of exit 54 in the Coomera area. At this location, there are four marked southbound traffic lanes with a shoulder lane on the left hand side, which is 3.7 metres in width and has a metal guard rail. The speed limit on the Pacific Motorway at this location is 110kph and had been so for in excess of 20 kilometres.

3. Thomas, Allan and Kody attempted to repair the Holden, however, were unable to restart it. Others traveling in the group of vehicles also stopped to provide assistance, but were unsuccessful in fixing the car. Thomas, Natasha, Kody, Allan and Tiana remained with the vehicle whilst their friends went to get help, which included calling for roadside assistance.

4. The five young people were sitting inside the Holden when, just after midnight, a 1991 red Nissan Pulsar sedan registered to and being driven by Jordan Guy Hayes-McGuinness, aged 18, entered the shoulder lane on the Pacific Motorway at high speed, and after hitting the guard rail, collided with the rear of the Holden. The impact from the collision caused the Holden to travel close to 30 metres forward.

5. Within minutes of the collision occurring, the Holden caught fire, trapping those still inside.

6. Jordan, the driver of the Nissan, was found deceased in the driver's seat of his vehicle. Thomas, the driver of the Holden, was somehow able to escape his vehicle after the impact and before it caught fire, and subsequently survived the incident. Tragically, Kody, Natasha, Tiana and Allan were found deceased inside the Holden.

Inquest

7. An inquest into the cause and circumstances surrounding the death of Natasha Alison Maggs, Tiana Marie Williams, Kody Peter Tugaga Holland-Williams, Alan John Sullivan and Jordan Guy Hayes-McGuinness was held at the Coroner's Court at Southport over two days from 13th August 2015 to 14th August 2015.

8. Twelve witnesses gave evidence during the course of the inquest. The crash was investigated by Senior Constable A J Cameron from the Queensland Police Service,

Coomera Forensic Crash Unit and a detailed Coronial Report was submitted. Since investigating the collision, Senior Constable Cameron has retired and was not able to give evidence at the inquest. Senior Constable K Hutchinson gave evidence of the findings of the original investigation as well as further investigations of his own carried out at my request.

9. In the course of the inquest, evidence was also heard from Mr Glen Toms, the Chief Executive Officer of Operations from RACQ. Evidence was also heard from Mr Gavin Massingham, Manager of Operations for the South Coast District Department of Transport and Main Roads.

Summary of evidence

Evidence of Thomas Bayer

10. Thomas, the sole survivor of the incident, was interviewed by the Police at hospital shortly after the collision. He had sustained a number of injuries as a result of the incident, including burns to his legs, which required treatment. His recollection of the collision and events that evening are limited due to his severe injuries. During his initial interview with Police, Thomas described the circumstances of the evening as outlined above. In addition, he recalled telling the police that at the time of the collision, the hazard lights on the Holden weren't working, however, the alarm had been activated. He does contradict this latter in the record of interview saying- "I had my hazards on they would have seen that." He was asked about this inconsistency in evidence and said he recalled his hazard lights were on but could not be certain. He said the car alarm was on and this would make the lights flash.

11. He recalled that at some point during the evening Allan and Kody were assisting him trying to get the car started and they pushed the vehicle closer to the guard rail. He told the court that he did not try to call the Traffic Management Centre as he was not aware of its existence. He let his mother, Mrs Elfi Bayer, know of their predicament and as she was a joint owner of the vehicle and was a member of RACQ she called them for assistance late in the evening.

12. At the time of the collision Thomas and his passengers were all seated in the car. He was in the driver's seat. After the collision, Thomas was unable to open the door. He recalls pushing his friends and telling them to get out. He exited the front passenger door by climbing over Natasha. He said "the fire came all up my legs on my hair and face…"

The actions of Jordan Guy Hayes-McGuinness prior to the collision.

Evidence of friends and acquaintances

13. Jordan Guy Hayes-McGuinness was born on 12 April 1994. Jordan moved to Brisbane from the Gold Coast in July 2012 to commence employment as an apprentice carpenter with P & R Lee Builders. He resided in share accommodation with fellow employees, Jack and Billy Walters at Ashgrove. Most weekends, Jordan travelled to the Gold Coast to visit family and friends. He would regularly drive from

Brisbane to the Gold Coast on a Friday night after work to stay at his friend, Aaron Griffiths' house for the duration of the weekend.

14. On 7 December 2012, Jordan attended work at a building site in Coorparoo. His supervisor, Benjamin Eedy, recalls that he was in 'fine spirits' that day, and was looking forward to the work Christmas party at the Alliance Hotel that afternoon.

15. According to Jordan's room mate Jack, Jordan arrived home from work at around 1:30 pm on 7th December. They travelled together to the Alliance Hotel in Jack's car, arriving at around 2:00 pm. Jack left the venue at around 4:00 pm to attend football training, and assumed that Jordan would catch a taxi home later in the evening. He did not return to the venue. During the course of the Christmas Party, Jordan was seen to consume alcohol, including beer and spirits. Around 11:00 pm, at the end of the evening, Benjamin Eedy recalls briefly speaking to Jordan, and describes him as being 'fine and in good spirits'. He remembers seeing Jordan walk away with a couple of his other work colleagues presumably to catch a taxi home.

16. At around 11:00 pm, Jordan called his friend Aaron Griffiths and indicated that he may drive down to the Gold Coast that evening. Aaron knew that Jordan had been planning to attend his work Christmas party. During the call, Aaron thought Jordan sounded like he had been drinking, however, his voice was not slurred, and he sounded excited and energised. He did not worry too much when Jordan did not turn up that evening as he thought Jordan hadn't made his mind up as to whether or not to come.

17. Aaron describes Jordan as a light social drinker. He states that Jordan wasn't good at 'holding his liquor' and would get drunk quickly if he drank too much. During the inquest, Aaron stated that he was aware that Jordan had driven his vehicle whilst intoxicated on a few occasions. He had spoken to Jordan about driving whilst intoxicated in an effort to try and convince him not to do it again. Aaron also described Jordan as a moderate to heavy user of cannabis. He recalls that Jordan would regularly consume cannabis and then drive.

18. At around 11:15 pm that evening, Jack Walters recalls being woken by a noise outside his residence. He then heard the front door open and assumed that it was Jordan arriving home. He was woken again at around 11:25 pm by the noise of a car engine revving loudly. When he looked outside his window, he saw Jordan sitting in his Nissan revving the engine. According to Jack, Jordan appeared to be 'concentrated and angry'. Jordan then reversed his car into Jack's vehicle, which was parked behind him, before speeding off. Jack text messaged Jordan saying 'don't drive mate don't be stupid'. He did not receive a reply. When Jack left his room to inspect the damage to his car, he saw that Jordan had kicked off his shoes in the hallway of the house, which was out of character, and had also dropped his bank keycard on the front steps.

Evidence of other motorway users

19. Just before midnight on 7 December 2012, truck driver, Craig Ross passed a line of eight to ten cars parked very close together in the shoulder lane of the Pacific Motorway near the Coomera exit heading south. He observed that only one of the vehicles had their hazard lights on. He recalls that the area where the cars had stopped had no overhead street lighting, although visibility that evening was good.

20. A vehicle matching the description of Jordan's Nissan was seen by two independent witnesses being driven aggressively and at high speed along the Pacific Motorway southbound shortly prior to and approaching the location of the subsequent incident.

21. At around 11:30 pm, Jack Barton was driving home from a work Christmas Party in Brisbane. He was traveling approximately 90 kph in the middle lane of the Pacific Motorway heading south. Traffic was quite sparse at the time. As he approached Rochedale South, he recalls seeing a Red Nissan Pulsar pass him in the fast lane, before 'aggressively' changing lanes and cutting in front of his car. The Nissan then moved into the left hand lane. After traveling a short distance, Jack saw the Nissan drift off the left hand side of the roadway, scraping and bouncing off the metal safety guard rail. The Nissan then sped off into the distance. Mr Barton exited the Pacific Motorway earlier than he normally would in order to avoid encountering the Nissan again.

22. During the inquest, Mr Barton stated that the manner in which the Nissan was driving was dangerous and erratic and he was concerned that the vehicle may cause an accident. Whilst he thought to call the police, he wasn't sure if he should contact 000 or try and pull into a police station.

23. Sally Paradise was also driving home from Brisbane to the Gold Coast that evening. Just before midnight, she recalls approaching Yatala whilst driving at approximately 110kph in the third southbound lane of the Pacific Motorway. There were no vehicles around her at the time. She describes a small red car suddenly 'flying past' her in the second lane, which seemingly came out of nowhere. She saw the red car swerving in and out of lanes without indicating, and passing other cars ahead of her without slowing down. She estimated, given her years of driving experience, that the red car would have been travelling at least 150kph. At the inquest, Ms Paradise agreed that the driving behaviour of the red car was dangerous, and left her feeling quite shocked and concerned for her welfare and the welfare of her fellow motorists.

24. She considered calling the police to report the behaviour of the red car. A short while later, Ms Paradise saw the aftermath of the crash between the Nissan driven by Jordan and the stationary Holden. She describes the scene of the incident as very dark, with no street lighting or lights on either of the two vehicles involved. She saw the same red car that she had witnessed driving dangerously only moments ago, smashed up against the metal guard rail in the shoulder lane of the Pacific Motorway. She also saw a blue car, which was stationary in the first lane. As she drove past, Ms Paradise recalls seeing a large amount of liquid coming from

underneath the blue car. She also observed a male person standing in front of the blue car, looking dazed. Another motorist had stopped a few hundred metres up the road, and was running back towards the crash site.

25. Ms Paradise subsequently called 000 to report the crash, before turning around, via the Hope Island exit, in order to return to the incident location to try and render assistance. As she approached the crash site, she recalls seeing that the blue car had burst into flames, which she describes as a 'huge fireball' that could be seen over the trees separating the northbound and southbound lanes of the Pacific Motorway.

26. Interstate truck driver, Bernard Vincent was driving a semi-trailer that evening from Browns Plain to Casino. While driving in the second lane of the Pacific Motorway southbound approaching the Coomera exit, he came across the collision, which appeared to have just occurred. He describes the area as 'very dark' with no overhead street lighting, and no lights on either of the vehicles involved in the collision. Mr Vincent recalls seeing a male person (Thomas) standing between the two vehicles waving his hands for help. He quickly pulled up his semi-trailer a couple of hundred metres past the crash site, and ran back towards the vehicles. As he approached the vehicles, he saw that there were flames coming from underneath the blue car. Mr Vincent recalls yelling out to Thomas to stand back from the car. He describes a sudden 'loud bang' before the blue vehicle exploded into a fireball. Due to the ferocity of the fire, Mr Vincent was unable to get within 20 metres of the vehicle. He helped another motorist render assistance to Thomas who had sustained burns to his legs.

27. Police were contacted shortly after midnight and advised of the collision by passing motorists. Sergeant David Sampson from the Coomera District Dog Squad, who was the first officer to arrive on the scene, was advised whilst in transit to the location that one of the vehicles had ignited and was on fire. Upon arriving at the scene, Sergeant Sampson observed that the vehicle was engulfed in flames, with flames 'coming a number of metres above the vehicle and out of every window'. Accordingly, he was only able to get within 3 metres of the vehicle.

28. A short time later, the Queensland Fire Service attended the scene and extinguished the blaze. The Pacific Motorway was closed, and an investigation into the incident was commenced by investigators from the Coomera Forensic Crash Unit.

Post-mortem findings

29. External and full internal post-mortem examinations were subsequently conducted on each of the deceased, with detailed reports of the findings prepared by Pathologists Dr. Beng Ong and Dr. Nadine Forde. A number of toxicology and histology tests were also conducted.

30. Natasha Maggs, Kody Holland-Williams and Allan Sullivan were all found to have died as a result of head injuries, with Allan also suffering significant neck injuries.

Tiana Williams was found to have died as a result of the effects of fire, with head injuries also listed as a significant condition. It is likely Tiana Williams was unconscious when the fire commenced.

31. Jordan Hayes-McGuinness was found to have died as a result of head injuries. Toxicology results showed a significant level of alcohol in Jordan's blood (0.132%), more than twice the legal limit for driving (0.05% in Queensland), as well as high levels of tetrahydrocannabinol (THC), a derivative of marijuana or cannabis.

Report by Forensic Medical Officer, Dr Sally Jacobs

32. Forensic Medical Officer, Dr Sally Jacobs was asked to provide an opinion regarding the likely effects of the drugs that were detected in Jordan's toxicological samples.

33. Dr Jacobs noted that whilst levels of alcohol and THC detected in post-mortem blood samples can be affected by post-mortem changes, this was less likely in Jordan's case given the blood sample was taken from his femoral vein, reducing the likelihood of contamination from body cavities and organs. Dr Jacobs advised that it was safe to assume that the levels detected were a reasonably accurate reflection of Jordan's blood alcohol content at the time of his death.

34. By way of summary, Dr Jacob's opinion was as follows: - The blood alcohol content (0.132%) detected in Jordan's post-mortem blood sample would have significantly impaired his ability to safely control and operate a motor vehicle. Alcohol can affect a person's level of restraint and reaction time. It may be the case that someone who is intoxicated would take more risks with their driving, and may not drive safely. As alcohol affects a person's judgment and information processing, they are unable to divide their attention and do two things at the one time, such as take note of their surroundings and make adjustments to their driving. The level of impairment experienced generally increases with the level of alcohol concentration.

35. In relation to crash risk, a person with a blood alcohol content of 0.1% would have seven times the crash risk of a person with a zero blood alcohol content.

36. The level of THC (0.012mg/kg) detected in Jordan's post-mortem blood sample, if reflective of the level at the time of the accident, is well above the range that is known to impair driving skills and be associated with an increased crash risk (0.0035 to 0.005mg/kg).

37. Both alcohol and THC are central nervous depressants and have the potential to interfere with the skills required to safely control a motor vehicle. When present together the effect is likely to be additive, thereby increasing the degree of driving impairment.

38. For completeness it should be noted that a blood sample was also taken from Thomas Bayer shortly after the incident. Analysis of this sample showed no evidence of alcohol or other drugs.

Police investigation

39. A thorough police investigation was subsequently conducted by Senior Constable ('SC') AJ Cameron from the Queensland Police Service ('QPS'), Coomera Forensic Crash Unit. At the conclusion of the investigation, a detailed Coronial Report was submitted. The relevant portions of the Coronial Report are summarised below.

Road and weather conditions

40. In the area of the Pacific Motorway where the incident occurred there were four marked southbound traffic lanes with a shoulder lane on the left-hand side. The stopping lane was 3.7 metres in width with a metal guard rail to the left side. The four southbound lanes were approximately 4 metres in width separated by painted broken white lines and white reflective delineators. The section of the road was straight and level with unobstructed views. The concrete road surface at the incident location was in a good condition with no obvious potholes or foreign debris on the road. The weather at the time of the incident was fine and dry, with the road surface also being dry. Visibility at the collision site was said to be poor due to it being night time and the lack of overhead street lighting in the area. However, the reflection from the white delineator markings in each of the lanes were clearly visible.

Condition of the vehicles

41. Mechanical inspections were subsequently conducted on each of the vehicles following the incident. Jordan Hayes-McGuinness's vehicle, the Nissan, was found to be in a satisfactory mechanical condition, with no defects that could have contributed to the cause of the incident. In relation to Thomas' vehicle, the Holden, Vehicle Inspection Officer, Simon Major was unable to make a full assessment of the condition of the vehicle due to the extensive fire damage sustained. However, he noted that there were no obvious or evident mechanical defects found. According to Thomas, the vehicle had recently undergone some mechanical repairs.

Jordan Hayes-McGuinness's driving history

42. Jordan held a Queensland P1 driver's license at the time of the incident, and was on a 'Good Driving Behaviour Option' (from 19 April 2012 until 19 April 2013). He was also restricted from late night driving between the hours of 11:00 pm and 5:00 am. He was in contravention of the imposed curfew when the collision occurred.

43. On 3 December 2012, he was convicted by a Court Enforcement Order, and was to have his driver's license suspended for an extended period.

Telephone records

44. Vodafone telephone records were obtained by Police in relation to Jordan's mobile telephone number. These records suggest that there was no activity on Jordan's mobile telephone at or near the time of the incident.

Conclusions reached by the initial investigators

45. Following completion of the initial QPS coronial investigation, SC Cameron reached a number of conclusions about the incident, notably -Whilst the Holden was stationary in the shoulder lane of the Pacific Motorway heading south, the Nissan,

driven by Jordan Hayes-McGuinness, drove off the left side of the motorway first colliding with the metal guard rail and then colliding at high speed into the rear of the parked Holden.

46. The minimum speed at which the Nissan was travelling prior to impact was calculated as being 141.42kph (more than 30 km above the legal speed limit).

47. The impact at high speed caused the fuel tank of the Holden to rupture and a short time later the leaking fuel ignited causing the Holden to erupt into flames.

48. Whilst the area in which the incident occurred has no overhead street lighting, there was no evidence to suggest any features of the road layout or design, or any road or prevailing weather conditions, in anyway contributed to the incident.

Further investigations conducted by QPS

49. In May 2015, QPS were tasked with conducting a video of the drive along the Pacific Motorway southbound between Stapylton and Nerang. The purpose of the recording was to identify, in real-time, the information signage relating to emergency telephones, breakdown information, recovery service advisory signage, and any other relevant road features. This trip was recorded in daytime and night-time hours.

50. The video footage taken indicates that there are no clear fixed signage along the Pacific Motorway between Stapylton and Nerang in relation to any motorway breakdown service or the contact number for the Traffic Management Centre. This number being **13 19 40.**

51. Furthermore, at night-time, the visibility of the roadway and the surrounding signage, including those for emergency telephones, was substantially reduced. The fog-edge lines on the roadway, however, were clearly visible.

52. A video recording and photographs depicting the conditions at the incident location on the Pacific Motorway for a stranded motorist, who attempted to walk towards the nearest emergency telephone near the Coomera exit, was also obtained. This video shows the terrain of the surrounding area if a motorist was to walk along the Pacific Motorway behind the metal guard rail. It demonstrates that there are a number of tripping hazards present, which would be hard to see at night-time, as well as a steep slope, which is difficult to safely navigate. The video also highlights the safety risk posed to anyone should they be in such a position next to traffic traveling at least 110kph.

When to call 000

53. During the inquest, Inspector Dennis Fitzpatrick, who is the manager of the Brisbane Police Communication Centre, was called to give evidence, primarily in relation to when the public should contact 000 for assistance. Inspector Fitzpatrick stated that 000 is to be called when there is a life endangering emergency. He was of the view that in this case it would have been appropriate to report Jordan's dangerous driving behaviour prior to the collision by way of 000. When 000 is called, the reported

incident is entered in the communications network, and triaged with the other calls being received at the time. Emergency services can then be instantly dispatched if the circumstances of the incident require it. He reiterated that 000 is the most appropriate form of contact for an immediate response should a member of the public feel as though their safety, or the safety of others, is in danger.

Information from the Department of Transport and Main Roads

54. Given the circumstances of this incident and the concerns about the safety of motorists who breakdown near a high-speed roadway, various information was sought and provided by the Department of Transport and Main Roads ('DTMR') during the course of the coronial investigation. The material provided included information about the scope and visibility of the Traffic Management Centre contact number and services offered, particularly the Motorway Breakdown Response Service, as well as the use of emergency telephones along the Pacific Motorway, and the broader Roadway management system.

55. During the inquest, Manager of Operations for the South Coast District of DTMR, Mr Gavin Massingham, gave evidence. I have summarized the relevant portions of the information and Mr Massignham's evidence.

Traffic Management Centre and Motorway Breakdown Response Service

56. The role of the Traffic Management Centre ('the Centre') is primarily to provide information to the public about roadway conditions. When callers initially contact the Centre via 13 19 40 they are firstly provided with the present road conditions for their area. They can then be connected to a Centre operator by simply staying on the line.

57. The Centre co-ordinates the Motorway Breakdown Response Service, which only operates in the Brisbane metropolitan area. The Motorway Breakdown Response Service was created to ensure vehicles were swiftly removed from a high speed environment, like the Pacific Motorway. If a car is broken down on a motorway in this area, then - free of charge - the car is quickly removed to an agreed safe drop off point. This service is available to all family vehicles and operates 24 hours a day, 7 days a week on all state controlled motorways in the Brisbane Metropolitan area. In peak periods, vehicles in a breakdown priority zone will be cleared within 30 minutes. The Pacific Motorway is a priority clearance zone.

Visibility of the Traffic Management Centre number and services

58. In material provided during the coronial investigation, DTMR stated that the Centre telephone number was well-publicised through the phone book, the DTMR website, on static and variable message signs, as well as occasionally through the media. Along the Pacific Motorway from Tugun there are two static signs, which advertise the contact number. One sign is located below the lower right corner of the large 'Exit 71 Exit 500m Left Lane' sign heading southbound. The second sign is a stand-alone sign located just before the Exit 80 off-ramp heading northbound. These signs

do not specifically provide information about the Motorway Breakdown Response Service, however, they do direct the public to call the general contact number.

59. When asked for suggestions to improve the visibility of the Centre number and services offered, DTMR submitted that the primary purpose of the Centre telephone number is to provide timely and relevant traffic and road condition information. Whilst motorists in regional areas can contact this telephone number for breakdown service information, they will be directed to emergency services or a roadside assistance provider. DTMR is mindful of not representing itself as the primary breakdown support number across Queensland.

60. DTMR did suggest, however, that the Centre contact number and the range of services available could be publicised further by greater utilisation of variable message boards, the development of marketing material to be placed in DTMR customer service centres and working with insurance companies to add information about this service to their own motor assistance material.

61. In evidence during the inquest, Mr Massingham agreed that the permanent signage on the Pacific Motorway displaying the Centre contact number was minimal. Whilst he referenced the dilemma of trying to avoid sign proliferation, Mr Massingham agreed that DTMR would consider increasing the visibility of the Centre contact number and the Motorway Breakdown Response Service through the use of permanent signage on the Pacific Motorway. One possibility for publication of this number accepted by Mr Massingham was along the metal guard rail down the side of the Pacific Motorway.

Emergency telephones on the Pacific Motorway

62. The nearest emergency telephone (number 524) to the incident site is approximately 1 kilometre north, near the Coomera exit. When a motorist picks up the emergency telephone they are automatically connected to the Centre. In order to access the telephone, a motorist would need to walk down the side of the Pacific Motorway and across the Motorway exit at Coomera. Clearly, this would be a dangerous journey and one not likely to be attempted by most motorists.

63. The last 12 months of data for the emergency telephones near the site of the collision on the Pacific Motorway were also provided by DTMR. This data demonstrates that the emergency telephones on the Motorway are not used regularly by commuters, particularly given the amount of traffic on the roadway. This is most likely because of the increase in the use of the mobile telephones by motorists.

64. Mr Massingham stated during his evidence that the purpose of the emergency telephones, which had been in place in Queensland for a number of years, was to connect a motorist immediately with an operator in the Centre. He acknowledged that given the prevalence of mobile telephones, the emergency telephones are now ‘much more limited’ in their use. As such, Mr Massingham agreed that it was even more important for the Centre contact telephone number, and the services that are

offered to road users that are in a dangerous situation, to be more visible to motorists, not only on the motorway, but also in the public domain.

Roadway lighting

65. DTMR confirmed that there have been no modifications to the roadway, including lighting, since 2012. The design standard of the roadway where this incident occurred is of a similar high standard to the entire approximate 50 kilometres of the Pacific Motorway. As per the DTMR Road Planning and Design Manual, 'generally, route lighting is not provided on urban and rural motorways. However, in urban areas where background lighting levels and night-time vehicle volumes are high, route lighting is common practice.' DTMR are of the view that given the high standard of the road design at the incident location, additional road lighting would not be of a significant benefit. Furthermore, the cost associated with installing additional lighting would be quite prohibitive given the limited value.

CCTV network

66. Footage of the fatal collision and Jordan's driving behaviour prior to the incident were not captured by CCTV cameras. DTMR's CCTV network is used to verify and assist with the management of the road network around incidents. The CCTV is monitored by two or three operators 24 hours a day, however, no specific camera is monitored continuously. In addition to the CCTV footage, the Centre relies upon system notifications and calls from the public, as well as other trusted sources. The Centre operators are responsible for managing the road network, not for identifying and stopping certain criminal behaviour. However, if an operator does watch an incident in real time, the Police are notified.

Further actions regarding breakdown safety

67. DTMR's Traffic Systems and Road Use unit are in the process of developing a draft Breakdown Safety Action Plan ('the Plan'), which identifies and discusses a number of opportunities and challenges in relation to breakdown safety. It recognises the risks posed to motorists, who find themselves in a stationary vehicle, generally due to breakdowns, on a roadway. The Plan is intended to improve breakdown safety by examining the various components, including incident response and monitoring, traffic management and road user awareness. Presently, this discussion paper is in a draft form, and is yet to be subjected to stakeholder and expert input. The Plan has not been endorsed and does not form DTMR policy. DTMR have also expedited the development of the Queensland Breakdown Safety Initiative ('the Initiative'), which summarises key opportunities for improving breakdown safety in Queensland. This initiative is also in the draft stage and is yet to be formally endorsed by DTMR.

68. In its draft form, the Initiative recognizes that stationary vehicles are one of the most frequent types of traffic incidents on the state-controlled road network. Stationary vehicles on a high speed roadway pose a significant safety risk not only to the occupants of the stationary vehicle, but also to passing motorists, who may become involved in a collision. The Initiative recognizes the benefits of having a cooperative, coordinated and safe response to traffic incident management. Educating road users in relation to what can be done to ensure their safety, and the safety of other

motorists, when they break down is also recognized as crucial to effectively managing the high risk posed to motorists in these situations.

69. The draft Initiative suggests a number of actions aimed to address various issues, which impact on motorist's safety following a vehicle breakdown. Given these specific proposals are in a very preliminary stage, and are not endorsed DTMR policy, I will not outline each proposal specifically.

Information from RACQ

Roadside Assistance call and operating procedures

70. Information as to the timing of the roadside assistance call made in relation to Thomas' broken down vehicle was sought from the Royal Automobile Club of Queensland ('RACQ') during the course of the coronial investigation. Records held by RACQ confirm that the request for roadside assistance in relation to Thomas' vehicle was made by his Mother, Mrs Elfi Bayer, at 12:22 am on 8 December 2012, by which time the collision had already occurred. The Traffic Management Centre in Brisbane was immediately notified of the request for assistance, given the location of the vehicle, and a tow truck through Nationwide Towing was deployed.

71. According to RACQ Operating Processes, the expected response time for a request of roadside assistance is within 60 minutes from the time the request is made. This does not vary depending on the time of day the request is made. The request made by Mrs Bayer, however, was given high priority, as the vehicle was classified as being in a 'dangerous location', that is, on a motorway. Accordingly, the request for roadside assistance was prioritized within the queue and attended to as quickly as possible. On the evening in question, a towing vehicle arrived at the incident site within 14 minutes of the roadside assistance call being made.

72. RACQ Operating Processes for Contact Centre Service Delivery stipulate that when a call for roadside assistance is made to RACQ, an automated message ('IVR') firstly asks the caller if they are in a dangerous situation. If the caller indicates that they are in a dangerous situation, the call is automatically placed to the front of the queue and put through to a consultant. These Operating Processes also provide that non-members, who are in a dangerous location or situation and contact RACQ for roadside assistance, will be provided with help, whether it's having their vehicle towed to a designated safe location or aiding to free a child locked in a vehicle. This service is provided at no cost to the non-member. This policy applies even in locations which are not covered by the Department of Transport and Main Roads ('DTMR') Motorway Breakdown Response Service.

73. Since 2012, RACQ have also introduced a further safety measure, whereby at the conclusion of each call for roadside assistance, a message is played, which urges motorists to be mindful of their surroundings and safety by activating their hazard lights, exiting their vehicle if it is safe to do so, and if not, to remain in the vehicle with their seatbelt on.This safety message is then sent to the motorist via text message.

74. Mr Glen Toms, the Chief Executive Officer of Operations for RACQ, gave evidence during the inquest. He clarified the relationship between RACQ and DTMR, and how this affects the response to roadside breakdowns. Whilst RACQ is a large mutual owned by its members, of which it has 1.2 million roadside members, it has also tendered for and been awarded the contract for incident management, traffic response and freeway clearance services for DTMR. As such, RACQ, as part of this commercial relationship, can also be tasked by DTMR to perform certain roadside assistance and recovery services.

Comment in relation to roadside safety of motorists with disabled vehicles

75. As a peak professional body for the motoring industry in Queensland, RACQ were also invited to comment on concerns raised by the circumstances of this tragic incident in relation to the safety of motorists, who have broken down on the side of the Pacific Motorway or other high-speed road environments. In response, Mr Steve Spalding, the Executive Manager, Technical and Safety Policy of RACQ provided the following advice and suggestions to improve the safety of motorists in such a situation:

    a. Education is a key aspect of improving the safety of motorists in such a situation. RACQ, in conjunction with DTMR, have previously produced and distributed the Breakdown Safety Glovebox Guide, which provides motorists with information about what to do in the event they breakdown. This guide began distribution in May 2014 and was provided to RACQ members via The Road Ahead magazine, with registration renewals, and to a number of businesses and groups at various road safety meetings.

    b. RACQ are of the view that there are further opportunities to improve awareness levels of safety at the roadside. RACQ encourages the development of a DTMR campaign focusing on this issue.

    c. RACQ supports messaging that mirrors the advice and information contained in the Breakdown Safety Glovebox Guide.

    d. Whilst DTMR's 13 19 40 Traffic Management contact telephone number is a good source of information for motorists for road closures, incidents and related traffic information, the initial recorded message could be improved. At present, a motorist is required to listen to the initial message about all current incidents before they are able to report their own.

    e. From an engineering perspective, RACQ indicated support for the following improvements:

        i. Wider shoulders that provide more of a gap between a disabled vehicle and traffic in running lanes (at least 2.5 metres).

ii. Traffic monitoring cameras, variable message signs and variable speed limits/lane control technology that may help in locating broken down/disabled vehicles, slowing other traffic and providing more of a buffer between disabled vehicles and other traffic.

iii. Steps to ensure that any installation of safety barriers does not reduce shoulder width or emergency breakdown lanes.

iv. Audio Tactile Lane Markings on the edge as well as centre line of dual carriageways to provide drivers a warning that their vehicle is drifting out of the lane and onto the shoulder/breakdown lane.

76. During his evidence at the inquest, Mr Toms reiterated his support for each of these safety recommendations. He acknowledged that the shoulder lane in this particular case was fit for purpose as it was 3.7 metres in width. Mr Toms agreed that the services provided by DTMR through the Motorway Breakdown Response Service and the RACQ Operating Processes provided to non-members are quintessentially intended to serve the same purpose, that is, to meet a community need and provide assistance to a motorist who is in distress in a dangerous location or situation.

77. Mr Toms was asked to respond to the suggestion of merging the services provided by DTMR and RACQ into a singular roadside assistance service that is well known to the public, highly publicized and services all major roadways in Queensland. Mr Toms acknowledged that it would be worth considering and that a singular contact number would be beneficial. He expressed concern about the current message set up for the Traffic Management Centre number (13 19 40), which requires the caller to listen to all of the traffic incident reports that are current before being able to speak to a consultant.

78. Mr Toms expressed the view that the service provided by DTMR through the Motorway Breakdown Response Service needed to be publicized, so that there was greater public awareness of this government funded resource and the contact number to access the service. He suggested that a visible presence on the Motorway of the contact number through signage would bring a greater awareness of the service. Mr Toms was also supportive of a public awareness campaign, aimed at motorists who breakdown, particularly in a high speed environment.

DTMR's response to safety improvement suggestions

79. During the inquest, Mr Massingham was asked to respond to some of the suggestions made by RACQ in relation to improving the safety of motorists who had broken down near a high speed roadway.

80. Mr Massingham acknowledged the suggestion by RACQ for a DTMR fronted public awareness campaign centred on breakdown safety for motorists, as well as greater advertising of the contact telephone number and services provided by DTMR through the Traffic Management Centre. Mr Massingham stated that DTMR would

consider such a campaign, and further publication of the Centre contact number through various means.

81. In response to Mr Spalding's suggestion about improving the effectiveness and efficiency of the Centre's initial message when a motorist calls 13 19 40, Mr Massingham indicated that DTMR were happy to consider amendments to the current set up, which enabled a motorist to immediately speak to an operator in the event they were in a dangerous situation.

82. Mr Massingham also indicated his support for the engineering suggestions made by Mr Spalding, confirming that DTMR's road planning and design guides support wide shoulders on high-speed roads, subject to budgetary and engineering restraints. He also noted that audio tactile lines were generally used by DTMR to prevent fatigue related crashes, and have been installed in areas where there are a history of such events occurring.

83. During the inquest, Mr Massingham was also asked to respond to the suggestion of merging the services provided by DTMR and RACQ into a singular roadside assistance service that is well known to the public, highly publicized and services all major roadways in Queensland. Mr Massingham acknowledged that this was certainly something that DTMR would consider. He noted that the recent move to contracting only one service provider for the Motorway Breakdown Response Service, that being RACQ, was a move to make the service more efficient and which could possibly be expanded further.

Submissions invited as to recommendations under s. 46

Submission by Bill, Donna and Melissa Williams

84. Tiana Williams was the daughter of Bill and Donna Williams and Melissa's only sibling. I offer my condolences to them and to all of the families who lost loved ones in this tragic accident.

85. The Williams submit, quite reasonably and sensibly, that there should be in place strict requirements for driver education relating to drugs, alcohol and driving. They also submit there should be in place compulsory defensive driving courses for young drivers. They also submit that the public should be educated in and made aware of, emergency assistance numbers such as **13 19 40,** and the public should be encouraged to report dangerous driving behaviour by road users using the **000** number. These submissions are very sensible and they have my full support.

Submissions by DTMR

Traffic Management Centre contact number and service

86. DTMR agrees to consider ways in which the Traffic Management Centre telephone number and services provided can be better publicised and made more visible to motorists. DTMR submits this be limited to key State Controlled roads in Metropolitan Brisbane and South East Queensland where the Motorway Breakdown

Service applies. They submit that the proposal needs to be balanced against budgetary constraints, the ongoing maintenance costs of maintaining any new signage, along with avoiding sign proliferation, which will potentially limit the effectiveness of the signage. DTMR is already investigating and implementing improvements to the efficiency and effectiveness of the messaging system for incoming calls to the 13 19 40 number.

Roadside Assistance

87. DTMR submits motorists can elect to obtain private breakdown service insurance with RACQ or another provider for a modest annual fee. Whilst many motorists have this insurance, some do not. As a consequence, uninsured motorists face the possibility of finding themselves in a high-risk situation without the comfort of having a breakdown service they can rely. DTMR has attempted to mitigate this risk for key State Controlled roads in Metropolitan Brisbane and South East Queensland, they say it is not practical, nor feasible, to expand the Motorway Breakdown Service across the State for all dangerous situations and breakdowns on major roadways. Currently any motorist who contacts the 13 19 40 number reporting a breakdown anywhere in the State will be assisted. If the breakdown fits the criteria for the Motorway Breakdown Service, a recovery vehicle will be despatched. If not, the motorist will be directed to emergency services or a roadside assistance provider.

88. DTMR advised that it is open to engaging further with private insurers to consider additional processes to assist motorists who are in distress in dangerous situations or located on major roadways. However, this exercise would have to be finely balanced, as DTMR does not want to create an environment which discourages motorists from taking out roadside assistance insurance. Likewise, it is unlikely private providers of roadside assistance insurance will want to promote a 'free' service for cars broken down in dangerous situations and on major roadways.

89. DTMR is hesitant to utilise the 13 19 40 number as a universal breakdown number across the State. This is because many breakdowns across Queensland do not fit the criteria for Motorway Breakdown Service and many motorists have private insurance. If the 13 19 40 number was to be utilised as a universal number, Traffic Management Centre operators would need to refer the majority of breakdown calls to emergency services or private providers which would have a significant impact and overwhelm current Traffic Management Centre resources (RACQ attend close to 1 million call-outs every year). If this course was to be adopted, there would need to be significant collaboration between DTMR and private roadside assistance insurers to determine how a universal breakdown number could be implemented both practically and commercially. It may well increase the cost of roadside assistance insurance to motorists.

90. In summary, DTMR submits the implementation of a universal number for breakdowns across the State for all motorists irrespective of whether they have insurance or who they are insured with would present numerous challenges and may be financially prohibitive. Further, within budgetary constraints and against other competing demands, DTMR is committed to expediting the finalisation of its

Breakdown Safety Plan and Initiative. However, within budgetary constraints and balanced against other public awareness campaigns, DTMR is committed to continue to prioritise the promotion of motorist safety in a breakdown situation.

RACQ submissions

91. The RACQ submits that the minimum width of breakdown lanes be 2.5 metres. That would not have affected the outcome of this tragedy however as the width of the breakdown lane at the accident location was 3.7metres and there was evidence that the Holden had been pushed close to the side barrier. It is a matter of observation though that there are many sections of the Pacific Motorway where there are no breakdown lanes or lanes less than 2.5 metres in width and motorists don't choose where they break down. RACQ also submits there should be built in breaks in safety barriers (over-lapping safety barriers). I agree these would offer some protection for stranded motorists.

92. RACQ submits that Managed Motorways (e.g. Lane Use Management Systems (**LUMS**) and Variable Speed limits (**VSL**) also provide breakdown safety benefits on high-speed, high traffic networks.

93. RACQ says it strongly advocates for improved breakdown safety awareness and related education campaigns in Queensland. Since 2013, RACQ has supported and has been involved in the Safer Australian Roads And Highways (**SARAH**) Group's Yellow Ribbon Road Safety Campaign and RACQ strongly encourages others to also support it. RACQ submits that there should be more widespread education and awareness campaigns about what motorists should do when their vehicle breaks down, and these should be based on the messages within the Breakdown Safety Glovebox Guide produced by RACQ and the Queensland Government in 2014. A guide such as this could be, subject to funding limitations, distributed annually or bi-annually with registration renewal notices in order to maximise exposure of the message and therefore familiarisation of the best practice safety protocols in the event of a breakdown.

94. Breakdown safety education could be enhanced for young or learner drivers. The TMR "Your Keys to Driving" document for learner drivers has one reference to motorway breakdown safety which advises drivers to use the emergency lane and put hazard lights on. Additional information could include calling 13 19 40, where appropriate moving to a safe location behind the safety barrier or remaining in the passenger side of the vehicle with a seatbelt on if there is no alternative. In addition, motorists should also be made aware of the risks to those working around the road and the steps that they can take to improve safety.

95. RACQ supports messaging that educates motorists on the risks of striking a vehicle stopped on the side of a high-speed road and to 'slow down and move over' when they see a broken down vehicle or roadside assistance vehicles.

96. RACQ submits that there is a need for improvements to both the 'front end' usability of the 13 19 40 service, and the promotion of the service as an option for accessing breakdown clearance assistance.

Analysis of the coronial issues

The findings required by s. 45 of the Coroners Act 2003

97. In accordance with section 45 of the Coroners Act 2003 ('the Act'), a coroner who is investigating a suspected death must, if possible, make certain findings.

98. On the basis of the evidence presented at the inquest, I make the following findings:-

    a. the identity of the deceased persons are Natasha Alison Maggs, Tiana Marie Williams, Kody Peter Tugaga Holland-Williams, Allan John Sullivan and Jordan Guy Hayes-McGuinness;

    b. I find that Natasha Alison Maggs, Tiana Marie Williams, Kody Peter Tugaga Holland-Williams and Allan John Sullivan and Jordan Guy Hayes-McGuinness died after the Nissan Pulsar sedan driven by Jordan Guy Hayes-McGuinness entered the shoulder lane of the Pacific Motorway southbound near Coomera at high speed, and after hitting the guard rail, collided with the rear of the broken down Holden in which Natasha, Tiana, Kody, Allan and Thomas Bayer were seated. The impact from the collision caused the Holden to catch fire shortly after impact, trapping Natasha, Kody, Allan and Tiana inside.

    c. Jordan died as a result of injuries sustained from the impact of the collision. I find that at the time of the collision Jordan Guy Hayes-McGuinness had a blood alcohol concentration of approximately 0.132% and was heavily affected by THC (0.012mg/kg). I find that Jordan Guy Hayes-McGuinness' ability to safely drive a motor vehicle was grossly affected. I find that he was driving at a speed in excess of 140kph. I am unable to determine on the available evidence whether or not he intended to drive into the rear of the Holden sedan.

    d. I find that the condition of the Pacific Motorway at the location of the collision did not contribute to the accident. The width of the stopping lane at 3.7 metres was adequate in the circumstances and afforded reasonable protection to the stationary vehicle from ordinary law abiding motorists. Although it is generally unsafe to remain in the vehicle on the side of a high speed motorway, it was understandable and not unreasonable for the passengers of the Holden to remain in the vehicle, given the time of night and the terrain behind the safety barrier.

    e. The date of death of all of the deceased persons was 8 December 2012.

The scope, visibility and sufficiency of services provided by the Department of Transport and Main Roads Traffic Management Centre, including the Motorway Breakdown Response Service, in relation to stationary vehicles on the side of the Pacific Motorway.

99. The circumstances of this tragic incident raise concern about the safety of motorists who have broken down on the side of a major roadway such as the Pacific Motorway. The video footage taken by QPS in recent times and played at the inquest highlights the safety risk posed to motorists who find themselves stationary next to a high speed roadway.

100. DTMR and RACQ both recognise this high safety risk. It is this risk which brought about the Motorway Breakdown Response Service provided by DTMR. Whilst this service is of great value to the community, its existence is not well known, nor is the mechanism by which it can be accessed by the public. The Traffic Management Centre contact number – **13 19 40** - and the services which can be accessed through this Centre, are not well publicised on the Pacific Motorway or generally in the wider community. While there are two static signs with the number exhibited on the Pacific Motorway, this is clearly insufficient and needs to be rectified.

101. The declining use of the emergency telephones on the Pacific Motorway by broken down motorists, makes it essential that the Traffic Management Centre contact number, by which the Motorway Breakdown Response Service is accessed, be well publicised and public awareness of the service be widely known.

102. The Motorway Breakdown Response Service funded by DTMR, for which RACQ has the commercial contract, is clearly a vital service which assists to reduce the risk posed to motorists who find themselves broken down next to a high speed motorway. Unfortunately, the Motorway Breakdown Response Service only operates in the Brisbane metropolitan area. While motorists in regional areas are able to contact the Traffic Management Centre, they will be directed to emergency services or a roadside assistance provider. Commendably, RACQ has a community policy to provide assistance to non-members, who are in a dangerous situation.

103. A single emergency community roadside assistance service for Queensland, which helps motorists who are in distress in a dangerous situation or location on a major roadway, would be of great benefit to the community. This would ensure that the service was coordinated centrally with a single contact number and operated more widely.

Recommendations in accordance with s. 46

104. Section 46 of the Act provides that a coroner may comment on anything connected with a death that relates to:
    a. public health and safety,
    b. the administration of justice, or
    c. ways to prevent deaths from happening in similar circumstances in the future.

Traffic Management Centre contact number and services

105. DTMR conceded that the contact telephone number for the Traffic Management Centre was not well signed on the Pacific Motorway. Given the importance of this telephone number, particularly in coordinating the Motorway Breakdown Response Service and the declining use in emergency telephones, consideration should be given to increasing the permanent and temporary signage displaying the Traffic Management Centre contact number on the Pacific Motorway, including the possibility of having the number printed on the metal guard rail. DTMR should also consider increasing the public awareness of the Traffic Management Centre telephone contact number and services provided, particularly the Motorway Breakdown Response Service, through the use of marketing material and other such means.

106. The DTMR should consider reviewing ways of improving the efficiency and effectiveness of the Traffic Management Centre messaging system, so when motorists first contact the service, they can immediately speak to an operator in the event they are in a dangerous situation, rather than first listening to recorded information about road and traffic conditions.

Roadside assistance

107. Whilst DTMR's Motorway Breakdown Response Service is certainly vital in reducing the risk posed to motorists who breakdown on a major roadway, it only operates in a very limited area. I would recommend that DTMR engage in further consultation with RACQ and motor vehicle insurers in Queensland with the aim of creating an efficient, viable roadside emergency assistance service for all of Queensland. In making this recommendation I am very mindful of the tyranny of distance in such a large State and of the expense such a service would entail.

Education campaign

108. Although DTMR's Initiative and Breakdown Action Safety Plan are yet to be endorsed as formal policy, it is clear that addressing the safety risks posed to motorists who breakdown, is a definite priority for DTMR. Both documents appear to acknowledge the need for greater public awareness of what a motorist should do to ensure their safety and the safety of others in the event of a breakdown, and to reduce the high safety risks posed to motorists in such a situation. Examining and improving the manner in which breakdown response is managed by DTMR and other external roadside assistance providers, also appears to be central to DTMR's future strategy. Both DTMR and RACQ are to be commended for their joint endeavours in this regard.

109. I recommend that DTMR continue to prioritise this issue by way of a public awareness campaign directed at breakdown safety for motorists, and to continue to expedite finalisation of the aforementioned Breakdown Action Safety Plan and Initiative.

Driver training and education

110. I recommend that there be an emphasis placed on defensive driving and the dangers of driving under the influence of drugs and alcohol in the driver training of learner drivers.

I close the inquest.

James McDougall
Southeastern Coroner
4th December, 2015