OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Thomas John Howell**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Gympie
FILE NO(s):	COR 1846/08(0)
DELIVERED ON:	3 August 2007
DELIVERED AT:	Gympie
HEARING DATE(s):	3 August 2007
FINDINGS OF:	BA Callaghan, Coroner
CATCHWORDS:	CORONERS: Inquest – Motor Vehicle accident, death of a pedestrian
REPRESENTATION:	
Assisting the Coroner	Sergeant Jason Todman

An inquest was held into the death of Thomas John Howell (the deceased) on 3 August 2007. A Queensland Police Service report was submitted to the Court for consideration along with statements from Roy Cotterell Mayfield (bus driver of the vehicle that hit the deceased), Karen Yvonne Roongsang (adult witness to the incident), Anthony Paul Green (bus driver of the second bus travelling behind that driven by Mayfield) and Tracey Louise McPaul and Brendan Charles Ross (2 passengers on the bus driven by Mayfield) and Andrew John King (police officer). The police report contained the autopsy certificate from Dr Springhall that advised the cause of death was due to crush injuries to head and chest due to being run over by a bus. The police report also contained a comprehensive report of the incident location including maps, photographs and diagrams of the area and photographs of the bus and the items that could have impeded the drivers view. Mayfield and Roongsang were called to give oral evidence.

Mayfield is a 73 year old gentleman who was employed part time as a bus driver for Pollys Coaches at the time of the incident. He had extensive experience as a school bus driver. There was nothing in Mayfield's health that contributed to this incident.

On the day of the incident Mayfield picked up the deceased and others at the Gympie High School. Mayfield stopped at the cricket nets on Wises Road to let a student off and continued travelling along Wises Road a short distance to a give way sign where he stopped to give way to traffic. Mayfield moved the bus away from the give way sign when the deceased ran down the aisle calling out for Mayfield to stop the bus. Mayfield stopped the bus and the deceased quickly exited it. Mayfield closed the doors of the bus, checked the side rear view mirror to see if there was any traffic to give way to and proceeded forward. He then saw the deceased in front of the bus. The deceased fell in front of the bus and under the front wheels of the bus. Mayfield steered the bus to the right in an attempt to avoid the rear wheels hitting the deceased. At the point of impact Mayfield estimated the bus was travelling at approximately 10 km per hour. Mayfield's evidence was that by the time he saw the deceased it was impossible to avoid hitting him.

Roongsang's evidence corroborated that of Mayfield as did the statements from those travelling in the bus.

Where Mayfield stopped to let the deceased off the bus was not a designated stop. Mayfield's evidence was that stopping at undesignated stops regularly occurred and this had been the case for the 43 years he had been driving a bus and was done for many and various reasons. The stop was at the request of the passenger and he would stop where requested as long as it was safe and it was not a small child requesting him to make the stop. Where Mayfield let the deceased off was not unsafe. It was approximately 10 metres prior to a slow point in the road, one where pedestrians crossed and the deceased was a 14 year old who had been travelling in Mayfield's bus for some 18 months.

Mayfield gave evidence that each year the Department of Transport visited his employer and gave out a policy document concerning the rights and responsibilities of those involved with student bus travel. This document was presented to the court. This document states that the expected behaviour of students was to use designated stops. It does not specifically refer to drivers using designated stops.

It appears from Mayfield's evidence that the accepted practice is for a driver to accede to a request to stop the bus at an undesignated stop and in regional areas I cannot see how this could be avoided. It seems students use these school buses to get them to sports, shops and other places.

The other aspect that I examined was whether there was anything impeding the sight of Mayfield to be able to see the deceased once he exited the bus. The only items that could have impeded his vision at the front of the bus were the ticketing machine and the route card. These items could have obscured his view of the deceased crossing in front of the bus. Mayfield's evidence is that now the route card is affixed to the top of the windscreen behind the sun visor. The ticketing machine is relatively small and I cannot see how it could be located elsewhere.

I am of the view that where the bus stopped did not cause this accident nor am I of the view that Mayfield is criminally responsible for the death of the deceased. I agree with the police report summary. This death was caused by the deceased attempting an unsafe manoeuvre by running directly in front of the bus at the moment the bus pulled out from the road edge. Mayfield in looking in his rear view side mirror immediately prior to pulling out to look for oncoming traffic was doing what every other driver would do in the circumstances. The fact that he did not see the deceased until the deceased was immediately in front of the bus was not his fault. The first contact between the deceased and the bus was soft but enough to cause the deceased to lose his balance and fall and it appears from the report that at this stage Mayfield was not aware that the deceased was in front of the bus. When Mayfield sighted the deceased he was unable to stop the bus and the deceased fell under the wheels of the bus. Mayfield attempted to take evasive action to try and ensure the back wheels did not run over the deceased to no avail.

Formal Findings

NAME OF THE DECEASED:	THOMAS JOHN HOWELL, a male person born on the 3 June 1992 in Tasmania and late of Gilldora.
PLACE OF DEATH:	Wises Road, Gympie
DATE OF DEATH:	22 June 2006
CAUSE OF DEATH:	The cause of death determined at post-mortem examination was: 1. Crush injuries to the head and chest, due to (or as a consequence of) being run over by a bus.

I am of the view that there is no realistic way of preventing such an accident occurring in the future. The accident occurred due to the actions of the deceased that made the collision unavoidable.

B A Callaghan
Coroner
Gympie