OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the deaths of Elizabeth Joan Cardwell, Isabella Rose Cardwell & Gregory Ryan Sanderson**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2011/4166
DELIVERED ON:	19 November 2012
DELIVERED AT:	Brisbane
HEARING DATE(s):	16 October 2012, 19 November 2012
FINDINGS OF:	John Lock, Brisbane Coroner
CATCHWORDS:	Coroners: Inquest, Motor Vehicle Crash, Triple Fatality, Speeding, Second Hand Baby Capsules

REPRESENTATION:

Counsel Assisting: Ms Emily Cooper, Office of State Coroner

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Introduction

On 6 December 2011, 19 year old Elizabeth Cardwell, her eight week old daughter Isabella, and Elizabeth's partner, 28 year old Gregory Sanderson were all killed in a single motor vehicle crash. The crash occurred on Neurum Road at Winya, which is just to the east of Kilcoy.

Gregory was the driver of the vehicle, Elizabeth was seated in the front passenger seat, Isabella was seated in a baby capsule in the right-hand side rear passenger seat, and Gregory's brother Keith Schloss, was seated in the left-hand side rear passenger seat.

Gregory's brother survived the crash. Isabella was ejected from the vehicle, despite being placed in the baby capsule. Excessive speed was identified as the major factor which caused the crash. Given three people died in this totally preventable crash and there were issues identified in relation to the use of the baby capsule, I decided to hold an inquest into their deaths. The issues identified at the pre-inquest conference to be explored at the inquest were:

- The findings required by section 45(2) of the *Coroners Act 2003*, namely the identity of each of the deceased, when, where and how each of them died and what caused their death;
- the proper use of child car restraint capsules for children from birth to six months of age and issues generally surrounding hand-me-down baby capsules and the safety concerns associated with the same; and
- the contribution of excessive speeding to the deaths, and the necessity for the public to reduce speeding on Queensland roads.

These findings seek to explain how the deaths occurred and consider whether any changes to policies or practices could reduce the likelihood of deaths occurring in similar circumstances in the future.

The scope of the Coroner's inquiry and findings

An inquest is not a trial between opposing parties but an inquiry into the death. The scope of an inquest goes beyond merely establishing the medical cause of death.

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths.

As a result, a coroner can make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future. However, a coroner must not include in the findings or any comments or recommendations, statements that a person is or maybe guilty of an offence or is or maybe civilly liable for something.

The Admissibility of Evidence and the Standard of Proof

Proceedings in a coroner's court are not bound by the rules of evidence but that does not mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its origin or source when determining what weight should be given to the information.

A coroner should apply the civil standard of proof, namely the balance of probabilities. However the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, then the clearer and more persuasive the evidence needs to be for a coroner to be sufficiently satisfied it has been proven to the civil standard.

Family Social Information

Elizabeth's mother provided information to the coroner. Elizabeth was 19 and she is survived by her mother, stepfather, three brothers, an elder sister, grandmother and four stepsisters. The day she turned 19 her father passed away from stomach cancer. Elizabeth was a friend to many, innocent in many ways and easily led but always kind of heart and was growing into a mature young lady.

Isabella was a joy to them all.

The family and Elizabeth's friend's lives changed as a result of the loss of Elizabeth and that of eight week old Isabella Rose. Her mother is particularly concerned that this occurred as a result of what appears to have been excessive speeding after Gregory Sanderson had promised her he would never speed with her daughter and granddaughter in the car.

Gregory Sanderson was aged 28. His stepbrother Keith Schloss survived the crash. Gregory's father said Greg was a happy, loving boy growing up and enjoyed fishing, camping, and bike riding with his father and step mother. He says he then started into drugs and drinking and he accepts his son would get behind the wheel of a car with disregard for the safety of others.

Unfortunately Gregory Sanderson's five page traffic history bears this out. The history included a number of speeding offences and unlicensed driving offences as well as a multitude of other offences. He had received good driving behaviour options and had been disqualified on three occasions.

The Investigation

The crash was investigated by the Moreton Bay Forensic Crash Unit (FCU), with the lead investigator being Senior Constable Barry Griffin. He provided a comprehensive report and gave evidence at the inquest.

On 6 December 2011, Gregory was driving a green Holden Berlina sedan registration number 234RLS. At about 8am Gregory left Kingaroy with Elizabeth in the front passenger seat, Isabella in a baby capsule and his

brother, Keith Schloss in the rear. They collected a friend (who sat in the middle rear seat) and travelled to Brisbane Airport to drop the friend off. They returned from the Airport at about 12.00 and stopped off at a friend's house at Daguilar at about 1pm and stayed for lunch. They left in the direction of Kilcoy at about 1.30pm. Gregory took a short cut back towards the Daguilar Highway via Neurum Road.

The evidence indicates that at about 2.00pm on 6 December 2012, Gregory was driving the Holden sedan in a general westerly direction along Neurum Road, towards Kilcoy and was approaching a sharp left hand bend at the intersection with Winya Road.

It is clear Gregory failed to negotiate this bend in the road and the vehicle began to rotate in an anti-clockwise direction. The front of the vehicle struck an embankment on the left-hand side of the road and began to roll, brushing past some small shrubs before colliding with a large tree. The roof of the vehicle absorbed the full force of the impact with the tree.

The entire length of Neurum Road is 22km. The western section of the road, between the D'Aguilar Highway and Neurum Creek, falls under the jurisdiction of the Somerset Regional Council. That section of road is about 11km in length. The eastern section of road, between Neurum Creek and the Woodford Township, is controlled by the Moreton Bay Regional Council. The relevant section of road for the purposes of the inquest is the western section, controlled by the Somerset Regional Council.

At the time of the crash, the speed limit along this western section of road was 100km/hr as opposed to the eastern side, which was controlled by an 80km/hr speed limit.

About 180m before the sharp left-hand bend at the intersection of Winya Road, there was a 40km/hr advisory sign.

The roadway itself is constructed of chip bitumen formation and is in good condition. A depression was located at the apex of the bend measuring approximately 130mm in depth. SC Griffin considered this depression could be significant enough to possibly unsettle a vehicle travelling through the corner at an excessive speed. However, his investigation of the tyre tracks supports his opinion this depression did not contribute to this crash. No other defects or obstruction were found on the roadway that could have contributed to the cause of the crash.

The vehicle sustained extensive damage to the entire vehicle, and in particular, a crushed roof. The motor vehicle was inspected by a vehicle inspection officer with the Queensland Police Service (QPS) who found it was in a satisfactory mechanical condition and no defects were found, which could have contributed to the crash.

Evidence of the Speed of the Vehicle

There were no direct witnesses to the crash.

A number of witnesses told police that they had observed a green Holden sedan on the morning of the crash in the Blackbutt Range area. A traffic controller at a road work site observed a green or blue Holden sedan drive through a 40km speed limited work site at a speed he thought was about 100km/hr and radioed ahead to the traffic control at the bottom of the range to be careful and to get the registration number. The driver was a Caucasian male in his 20's with a female passenger in the front. He wrote the registration number in the dirt and provided it to the traffic controller further on. He also warned a truck driver who was just ahead on his radio.

A truck driver going through the road work site described a green Holden Commodore also stopped at a red stop light revving its engine very loudly and then come up fast behind him at 100km/hr in the 40km/hr road work zone and pass him.

Senior Constable Fitzpatrick later spoke to the traffic controller and was provided with a registration number of 234RLS and recorded it. This is clearly Gregory's vehicle.

The FCU conducted a speed analysis as part of their investigation. It is not intended to set out the technical aspects of how the tests were performed or the calculations. It is accepted SC Griffin is trained and proficient in conducting such calculations.

The speed at which a vehicle will just begin to side-slip is called critical speed. A critical curve speed of the left-hand bend was calculated at 93km/hr. In other words, the vehicle would be speeding in excess of this speed for the side slip to occur.

Yaw is the action of a vehicle revolving around its centre of mass. Yaw marks are caused by the vehicle tyre rotating and slipping sideways at the same time. A yaw commences at the time the rear tyre starts to side slip and develops as the rear tyres depart from their normal tracking path and cross over the front tyre path. An analysis was also conducted on a tyre mark which had been identified as a yaw mark. This analysis estimated the speed of the vehicle at the commencement of the yaw mark to be 118km/hr.

No alcohol was detected in post mortem toxicology testing of Gregory's blood. There was the presence of a metabolite of cannabis, the significance of which was inconclusive as to whether it was contributory to the driving behaviour.

The totality of the evidence supports a finding that Gregory Sanderson had earlier that day been driving through road work sites at speeds at least twice the posted 40km/hr speed zone. His traffic history indicates he had a propensity for bad driving behaviour.

It is also quite evident that at the time of losing control of his vehicle he was driving at a speed of over 93km/hr and up to 118km/hr through a sharp bend, which had a speed advisory sign of 40km/hr well in advance of the bend.

This crash was totally preventable had he been driving at a lesser speed, which was consistent with the obvious approaching sharp bend.

Evidence of Surviving Passenger

Gregory Sanderson's brother, Keith Schloss was the only survivor of the crash. He had been travelling in the motor vehicle since earlier that morning when they had travelled from Kingaroy to the Brisbane Airport and were in the process of returning, via Kilcoy. He said in a statement to police that he was feeling tired after they left the house of a friend of his brother who lived near Kilcoy. As a result he placed his legs over the centre half of the floor well and he laid his head back and fell asleep. He said the traffic was not heavy and he believed they were travelling at the same speed as other vehicles on the road. He said in evidence Gregory was a good driver.

Given the evidence of earlier speeding of the vehicle I do not accept his evidence that Gregory was travelling at the same speed as other vehicles on the road that day. Gregory’s traffic history would not support his view that Gregory was a good driver.

The next thing he remembers was he woke to the sound of screeching tyres heard a loud bang and then must have been knocked unconscious for a short time. He then looked over and could see his brother in the driver's seat with the roof of the car crushed in over the front seats. He could see Elisabeth Cardwell and knew she was deceased. The baby capsule was in the same position but he could not see Isabella. He was passed a knife by a male person who had stopped and he managed to cut his seatbelt and then was able to release himself and pull himself out of the car through his door window, which was smashed. He tried to kick the roof out to assist his brother and Elisabeth. He couldn't budge the roof and then started looking for Isabella and found her behind a tree near the vehicle. He thought she was alive and just barely breathing and handed her to a female standing nearby who started CPR.

Baby Capsule

Isabella was harnessed within a rear facing baby capsule which appears to have been fitted correctly. However, a small camera located within the vehicle showed a photograph from a previous occasion, showing that Isabella was wrapped in a blanket and seated within the baby capsule with the restraining belts seen on the outside of the blankets.

The baby capsule was given to Elisabeth by her stepsister, however no instruction booklet was provided at the time. It is apparent it was manufactured in 2004.

The instruction booklet for the particular brand of seat provided an instruction advice stating *never wrap baby in a blanket before placing in restraint.* The reason for this is that the blankets substantially reduce the friction levels between the child and the restraints. I should comment that finding that particular instruction in the relevant instruction booklet was not easy and

consideration should be given to consider how better that should be highlighted in the future.

In this case Isabella was thrown from the vehicle and was located approximately 2-3m from the vehicle on the same side as the baby seat. Various witnesses including Mr Schloss agree that Isabella was wrapped in blankets with the restraining belts placed over the top of her, although there is disagreement as to whether it was Ms Cardwell, or Mr Sanderson who placed her in the baby capsule. A resolution of that issue is not necessary as either way Isabella was placed in the capsule in a manner not in accordance with the manufacturer's instructions.

The front passengers in the car were trapped when the vehicle finally came to its resting point. Mr Schloss confirms that the roof of the car was crushed in over the front seats. Being in the backseat, Mr Schloss was able to climb out his passenger window, and the photographs clearly depict the baby capsule still in situ. Mr Schloss survived but did suffer serious injuries. It is remotely possible, that had Isabella been correctly restrained in the capsule, she might have survived.

The issue of second hand and hand-me-down child restraints will be addressed in the evidence of Ms Teerds. It has become evident to me as a result of a number of deaths involving children and various second hand products, that a common factor has been that instruction manuals are not handed down, bringing with it risks of incorrect installation or use.

Australian Standard AS/NZS 1754

A mandatory standard for child restraints for motor vehicles came into effect in 1978 and has since been amended a number of times. The current mandatory standard, which was last amended in May 2011, is now based upon the 2000, 2004 and 2010 versions of AS/NZS1754.[1] The standard applies to anyone in the business of supplying child care restraints including manufacturers, importers, distributors, retailers and hirers.

Clause 6.4.1 of the standard states that for *each child restraint, general information, and information and instructions for installation, use and maintenance shall be provided in a booklet or sheet, which shall be attached to the child restraint by any means that will allow its removal, or provided in a pocket. If a pocket is provided, the cover of the booklet or sheet should state that it is important that the booklet is kept in the place provided on the child restraint.* This part of the standard is mandatory and must be complied with.

The standard notes in a rider to clause 6.4.1 that the provision for the instruction book to remain permanently with the child restraint is a desirable design feature. Some products include a pocket for that purpose. There may be other ways in which a similar purpose can be engineered within the design.

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[1] See AS/NZS 1754:2010 *Child Restraints for use in motor vehicles* published on 24 February 2010

Clause 6.6 provides that each child restraint shall be permanently and legibly marked with the general and appropriate additional warnings given in Table 6.2. Table 6.2 already includes warnings that the restraint is ‘used exactly as shown in the instructions’ and with respect to Type A restraints ‘Fit the harness firmly to the child’.

A draft revision of the Standard has been open for public comment from 14 August 2012 closing on 16 October 2012. There are no changes proposed to clause 6.4.1.

On 16 October 2012 my office wrote to Standards Australia posing the following questions and proposals.

I note from the Standard that all child restraints are required to be supplied with instruction books. I am also aware that the majority of child restraints have a storage location, usually a pouch/pocket. However, I have also noted from the 2012 draft Standard that a storage compartment is not mandated, it is only a recommendation.

The Coroner’s attention has also been drawn to table 6.2 within the Standard, and the general warnings within that table which must be marked on a child restraint.

In light of the above information and issues, please provide any assistance or information possible, in the form of a statement or report, addressing the following questions:

1. *Whether having a storage compartment, such as a pouch or pocket, being included in the Standard 1754 as a mandatory requirement for all manufacturers of child restraints, is plausible; and*
2. *What considerations/information influences the general warnings as contained in table 6.2; and*
3. *Further to question 2 above, has there ever been any consideration given to placing a warning in table 6.2 (with respect to child restraints for infants up to 6 months of age) stating words to the effect of ‘do not wrap baby in blanket when placing in restraint’, or similar?;*
4. *Further to question 3 above, if there has been consideration of such a warning, why was the warning not included in table 6.2?;*
5. *Further to question 4 above, if there has not been consideration of such a warning, would Standards Australia be open to considering such a warning?*

Mr Craig Newland, the Chairperson of the Technical Committee CS-085 *Child restraints for use in motor vehicles,* has kindly responded in the form of a statement. Mr Newland stated that once the draft standard is complete and any revisions from the public comment process have been incorporated, the Technical Committee conducts a formal ballot of its members to determine whether to approve the draft standard.

It is apparent that the Technical Committee has not previously considered the inclusion of a warning in table 6.2 as suggested, nor in relation to making mandatory the inclusion of a pouch or pocket or some other method for the purpose of storing the manufacturer’s manual. Mr Newland said he is not aware of any technical impediments for that to occur. He further advised that any recommendations received by Standards Australia by the coroner in

relation to this inquest, will be submitted to the technical committee for further technical consideration.

I welcome this advice from Mr Newland and I will make some recommendations in that regard later in the decision. I accept it is very much the responsibility for the Technical Committee to consider, which with its expertise is no doubt in the best position to consider the issues raised and if and how they can be addressed.

Kidsafe Queensland

Ms Susan Teerds, Chief Executive Officer, of Kidsafe Queensland kindly provided me with a report detailing the issues of hand-me-down baby capsules and the risks of not having access to the original instruction manual for a baby capsule.

Ms Teerds noted that the use of second-hand or hand-me-down child restraints and baby capsules opens a Pandora's box of problems and safety concerns including the age and condition of the child restraint; instructions on how to use and install the baby restraint; the lack of knowledge by the public on the correct selection; the use and installation of baby capsules and child restraints generally; and the lack of regulation that child restraint installers be certified or required to have completed a recognised installation course.

She noted that it is not recommended that a child restraint be used after 10 years from date of manufacture but it is the case that most people cannot read the imprinted date of manufacture and therefore it is difficult to determine if a capsule is too old to use. In other restraints the date of manufacture may be on a sticker which has already been removed.

She also noted that there is often no way to tell if a restraint has previously been involved in an accident. The Australian Standard provides that the restraint should be destroyed or replaced if it has been involved in a severe crash, even if no damage is obvious.

Ms Teerds highlighted a particular concern was in relation to the attitude of some insurance companies when faced with claims for replacement of child restraints after a severe crash and that insurance companies need to understand the Australian Standard requires the restraint must be destroyed, even if no obvious damage is found.

Ms Teerds also reported that second-hand restraints are often sold or handed down without instruction booklets, leather straps, gated buckles and other components required under the Australian Standard and in the manufacturers instruction booklet.

Kidsafe recommends that an instruction booklet be sourced from the manufacturer or downloaded from the manufacturer’s website.

Ms Teerds noted the Australian Standard does provide for each child restraint to be supplied with a booklet or sheet which shall be attached to the child

restraint by any means that will allow its removal, or provided in a pocket. If a pocket is provided the cover of the booklet should state that the booklet should remain in the pocket.

She stated that the manufacturer's instructions contained within the instruction booklet is critical in the use and installation of all child restraints and it is essential that the instruction booklet be retained with the restraint so that every person using the restraint and installing the restraint is able to use it and install it correctly, and in compliance with the standard and according to the manufacturers instructions.

Under the current Australian Consumer Law where they are sold commercially they must meet the mandatory safety standards in Australia. This includes a legal requirement that an instruction manual be provided for the restraint and that it must be followed. However the vast majority of second-hand restraints and capsules are from a private sale or handed around families or friends and therefore the Australian Consumer Law is not applicable and essentially there is no regulation for hand-me-down or privately sold child restraints.

Ms Teerds recognised that many parents cannot afford to purchase new child restraints and given it is preferable that babies and children are restrained, and a second-hand restraint is better than none at all, it is essential that second-hand restraints have the instruction book available.

Ms Teerds also noted that there is a lack of knowledge by the public on the correct selection, use and installation of baby capsules and child restraints, and the child restraint rules generally. Although funding has been made available from state and federal governments in relation to essential research there is a lack of funding in relation to safety campaigns generally insofar as it relates to injuries to children involving motor vehicles.

Queensland Ambulance Service offers a baby capsule hire service and install baby capsules, whilst Kidsafe Queensland offers a similar service for both baby capsules and child restraints. She stated that given recent reductions in public awareness funding, there is the risk of those services being underutilised.

Ms Teerds stated that a public awareness campaign around the selection and use of second-hand child restraints and baby capsules, whether purchased or handed down would be highly desirable. This campaign should highlight the need for replacement of the baby capsule or restraint which has been involved in a severe accident. The campaign must also include awareness of the need to retain the instruction booklet and all components of the child restraint for future use.

Ms Teerds also believed there should be education of midwives, GPs and other health professionals in relation to the safe transportation of a baby for at least the first 12 months which could be achieved through Web-based activity, provided funding could be provided to develop such education facilities.

Report of Somerset Regional Council

The FCU recommended the Somerset Regional Council carry out a speed review of Neurum Road and a safety review of the left hand bend.

The Somerset Regional Council commenced that review shortly after the crash occurred. This was due to the crash history associated with the road in general as well as this tragic crash.

As a result of the review, recommendations were made that this section on Neurum Road be limited to a maximum speed limit of 80km an hour. The review also was expanded to include a signage review at other higher risk locations identified on the road.

On 27 June 2012 the Council resolved to reduce the speed limit to 80km/h and to improve signage along this section of road. The 80km/hr signs were installed in early July 2012 with the remainder of signage upgraded recently.

The Council was also requested to comment on whether this particular section of road was a 'hotspot' for motor vehicle crashes and whether there had been any decision made regarding the removal of trees from certain roadsides.

The Council advised this particular section of road had not been identified as an eligible project for 'Blackspot' funding.

The Council advised that it did not have any policies on the removal of trees. At risk trees are identified during routine inspections and maintenance but due to the many trees in the region these would need to be identified with an obvious safety issue to be removed.

Trees on Neurum Road have never been considered for removal and the road corridor, including trees, is similar to many other roads within the region.

It is noted the proposed layout for the new signs did provide for the removal of trees to enhance sightlines.

I consider the Council has responded appropriately to the request for a review and has acted quickly in bringing about appropriate changes. I accept it would be impossible and financially impractical for the Council to consider a blanket removal of trees from roadsides and its focus on at risk trees is a proper approach.

Department of Transport and Main Roads

The Department of Transport and Main Roads (DTMR) has a website, which includes useful information over a whole range of safety issues involving motor vehicles. In relation to child restraints, there was a specific section that dealt with the question of 'Can I use a second hand child restraint?' The section did not make reference to the manufacturer's instruction manual.

On 16 October 2012 my office wrote to DTMR asking what its response might be to including in the current website information words to the effect of *the*

manufacturer's instruction booklet should be passed on with the child restraint to the new owner. If the child restraint does not come with the relevant instruction booklet, it is recommended that you obtain a copy of it directly from the manufacturer.

The Department replied on 24 October 2012 to the effect that the Department had no objection to the suggestion and the Department decided to amend its website to include words to this effect and anticipated a version would be published in early November 2012. That has in fact occurred such that the website now includes the following warning:

> *If you are using a second hand child restraint it is recommended that you obtain a copy of the manufacturer's instructions for that device. If the person providing the restraint does not have the instructions, they may be available on the internet, or direct from the manufacturer. The instructions should be referred to before the restraint is used as they contain important information about the safe use of the restraint.*

Autopsy results

Autopsy examinations with respect to each of the deceased persons were performed. It is not intended to describe the findings in any detail. The Autopsy reports confirm that Gregory died from multiple injuries as a result of the car crash. Elizabeth died from neck and abdominal injuries as a result of the car crash. Isabella died from head injuries, as a result of the car crash.

Findings required by s45

Elizabeth Joan Cardwell

Identity of the deceased – Elizabeth Joan Cardwell

How she died – Elizabeth died as a result of injuries sustained in a single vehicle motor vehicle crash. The vehicle was being driven by Gregory Sanderson at a speed in excess of 93km/hr and up to 118km/hr around a sharp bend in the road, which had a 40km/hr advisory speed. As a result of this excessive speed he lost control of the vehicle, causing extensive damage to the vehicle and taking the lives of Elizabeth and her daughter Isabella.

Place of death – Neurum Road Winya Qld 4515

Date of death– 6 December 2011

Cause of death – 1(a) neck and abdominal injuries
1(b) Motor vehicle accident – passenger

Isabella Rose Cardwell

Identity of the deceased –	Isabella Rose Cardwell
How she died –	Isabella died as a result of injuries sustained in a single vehicle motor vehicle crash. The vehicle was being driven by Gregory Sanderson at a speed of in excess of 93km/hr and up to 118km/hr around a sharp bend in the road, which had a 40km/hr advisory speed. As a result of this excessive speed he lost control of the vehicle, causing extensive damage to the vehicle and taking the lives of Isabella and her mother, Elizabeth.
Place of death –	Neurum Road Winya Qld 4515
Date of death–	6 December 2011
Cause of death –	1(a) Head Injuries 1(b) Motor vehicle accident – passenger

Gregory Ryan Sanderson

Identity of the deceased –	Gregory Ryan Sanderson
How he died –	Gregory died as a result of injuries sustained in a single vehicle motor vehicle crash. The vehicle was being driven by Gregory at a speed of in excess of 93 km/hr and up to 118 km/hr around a sharp bend in the road, which had a 40 km/hr advisory speed. As a result of this excessive speed he lost control of the vehicle, causing extensive damage to the vehicle and taking the lives of himself, his girlfriend Elizabeth and her daughter Isabella.
Place of death –	Neurum Road Winya Qld 4515
Date of death–	6 December 2011
Cause of death –	1(a) Multiple injuries 1(b) Motor vehicle accident – driver

Comments and recommendations

The tragic results of speeding impact upon us almost daily, and often involve teenage or younger men drivers. Despite the pleas from police and the media attention given to such tragic events, they still happen.

There is no doubt that driving too fast for the road conditions, which includes other considerations such as the prevailing weather, light and amount of

traffic, is a major factor in serious and fatal traffic crashes. Research, the results of which are readily available on the internet from such organisations as the Centre for Accident Research and Road Safety – Queensland (CARRS-Q), makes it abundantly clear that speeds just 5km/h over the speed limit in urban areas, and 10km/h in rural areas, are sufficient to double the risk of a casualty crash.[2] . It is noted that there is in place a National Road Safety Action Plan 2011-2020 which is focussed on best practice speed management.

Given the research being conducted by such organisations as CARRS-Q with respect to driving behaviours generally and speeding in particular, including the effectiveness of mass media advertising,[3] it is not considered that any formal comment or recommendation by me would be practically useful, other than it is important such research continues for the purpose of delivering effective and best practice management strategies.

It is evident that Standards Australia is open to putting before its technical committee any suggestions for changes to the relevant standard and it is opportune to do so now given the draft standard is being considered.

On that basis I recommend that Standards Australia submit to Technical Committee CS-085 for further technical consideration that AS/NZS 1754 include:

1. Clause 6.4.1 include that the product be engineered such that provision **shall** be made for the instruction booklet to remain permanently with the child restraint;
2. Table 6.2 include with respect to child restraints for infants up to six months old a warning with words to the effect of 'Fit the harness firmly to the child. Do not wrap the child in a blanket when placing in restraint.'

Given the Australian Standard is likely to be upgraded in the near future it may be opportune to consider further public awareness of the issues concerning child restraints. It is therefore recommended that the State Government, through the Department of Transport and Main Roads, consider contributing towards and/or conducting public awareness campaigns on the importance of the correct selection, use or installation of child restraints.

I close the inquest. I offer my condolences to the family and friends of Elizabeth and Isabella Cardwell and Gregory Sanderson.

John Lock
Brisbane Coroner
BRISBANE
19 November 2012

[2] See State of the Road, A Fact sheet of CARRS-Q at www.carrsq.qut.edu.au/publications/corporate/speeding
[3] See State of the Road, A Fact sheet of CARRS-Q at www.carrsq.qut.edu.au/publications/corporate/road_safety_advertising