CORONERS COURT OF QUEENSLAND

Reasons for Decision
(including Findings & Comments)

CITATION:	**Inquest into the death of Casey Lenard Brown**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Mackay
FILE NO(s):	COR 2016/698
DELIVERED ON:	16th December 2021
DELIVERED AT:	Mackay
HEARING DATE(s):	2 March 2021 – 3 March 2021
FINDINGS OF:	Magistrate D J O'Connell, Central Coroner
CATCHWORDS:	Inquest – Road accident – passenger on "route service" bus fatally injured when bus overturned – passenger seatbelts not fitted to bus – Coroner's recommendation that seatbelts be fitted to route service buses within a reasonable time frame

REPRESENTATION:

Counsel Assisting	- Mr J M Aberdeen

Whitsunday Transit aka Campsie Bus Co Pty Ltd	- Mr G Hampson, instr by Piper Alderman Solicitors
Dept of Transport & Main Roads	- Mr B McMillan, instr by in-house Counsel for DTMR

Findings

Casey Lenard Brown

[1] On 16 February 2016 Casey Lenard Brown was involved in a fatal traffic accident. He was a passenger on a bus involved in a single vehicle traffic accident where the bus left the road and then rolled onto its' side before slowing to a stop. There was no second road user involved in the accident. Why the bus left the road and whether it is appropriate for buses to install seatbelts for passengers to prevent or lessen the potential for passenger injuries are issues for the inquest.

Tasks to be performed

[2] My primary task under the *Coroners Act 2003* is to make findings as to who the deceased person is, how, when, where, and what, caused them to die[1]. In Casey's case there is no real contest as to who, when, where, or what caused him to die. The real issues are directed to the 'how' he came to die.

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

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

2. What caused the Bustech XDi Omnibus Reg No 251–TRQ to leave the sealed carriageway on Shute Harbour Road, Cannonvale, and to overturn?

3. Would the nature of the injuries suffered by Casey have been less serious -
   (a) if the bus had been travelling at a slower speed; or
   (b) if Casey had been wearing a properly fitted and worn seatbelt?

4. Should the issue of safety for passengers in "route" buses be reconsidered by the State Government, with particular regard to:-
   (a) requiring route buses to be fitted with compliant lap/sash seatbelts for the driver and all passengers either-
      (i) immediately; or
      (ii) over the course of a fixed phasing-in period?
   (b) limiting the speed of route buses during operations to a specific maximum speed, even if that is lower than that of the relevant applicable speed zone?
   (c) requiring that any new bus, even if it is intended to be used only for "route" services, be fitted with compliant lap/sash seatbelts?

[4] The second task in any inquest is for the coroner to make comments on anything connected with the death investigated at an inquest that relate to

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[1] *Coroners Act 2003* s. 45(2)(a) – (e) inclusive

public health or safety, the administration of justice, or ways to prevent deaths from happening in similar circumstances in the future[2].

[5] The third task is that if I reasonably suspect a person has committed an offence[3], committed official misconduct[4], or contravened a person's professional or trade, standard or obligation[5], then I may refer that information to the appropriate disciplinary body for them to take any action they deem appropriate.

[6] In these findings I address these three tasks in their usual order, s.45 Findings, s.46 Coroners Comments, and then s.48 Reporting Offences or Misconduct. I have used headings, for convenience only, for each of these in my findings.

Factual Background & Evidence

[7] At about 1.00 PM on 16 February 2016, Casey was one of ten passengers, plus the driver, travelling on a fifty-two seat bus. The bus was travelling on Shute Harbour Road, travelling from Airlie Beach and heading towards Proserpine. The road has a 100 km/h posted speed limit, but roadworks then at that location meant an 80 km/h speed limit applied. Where the incident occurred was within the reduced speed limit for the road, and of significance it was a straight section of road for quite some distance.

[8] The police investigated the circumstances of the traffic accident. The police gathered scene evidence, and statements from witnesses, and they had available to them CCTV footage showing the actions of the driver, the movements of the passengers, and of the bus itself as it travelled along the road.

[9] What was reasonably clear was that the bus had drifted off the left-hand shoulder of the road, and that there was not any sudden steering movements nor corrective steering input, and as the bus travelled out of its' lane of traffic and onto the road verge (or road shoulder) it struck a concrete culvert at the entrance to a rural property which caused the front of the bus to launch into the air, and then the bus rolled over onto its' passenger side and slid along a wide grassed table drain before coming to rest.

[10] All of this evidence pointed to it being a single vehicle accident, where the bus has slowly drifted off the left-hand side of the road. What was also clear was that there was no mechanical nor catastrophic defect[6], second road user, defect in the road surface, sudden avoidance of an object on the road, nor wandering livestock or native animal, which has caused or contributed to the accident occurring. The weather was fine and dry, and it was approximately 1.00 PM; so neither adverse weather nor sunlight glare into the driver's eyes were considered possible factors. I can readily exclude all of these as possible causal factors.

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[2] *Ibid* s.46(1)
[3] *Ibid* s.48(2)
[4] *Ibid* s.48(3)
[5] *Ibid* s.48(4)
[6] Such as a tyre blowout at speed

[11] From when the bus left the road surface until it finally came to rest was approximately 95 metres. The bus certainly did not come to a sudden halt, such as occurs in a violent head-on collision, or upon impacting with a native tree, or power pole. The interior area of the bus in fact remained entirely intact, and there was no deformity in the bus's passenger structure, nor seat or seat- back broken loose.

[12] The driver of the bus was Mr Alan Dorman who was then seventy years of age. He declined to be interviewed by the police and he passed away before the inquest. Attempts by the Coroners Court of Queensland to obtain a statement from him as to why the bus left the road were unsuccessful[7]. Accordingly, the only statements by Mr Dorman available to the inquest were those accounts he gave to his health professionals in the months following the accident.

Mr Dorman's medical history:

[13] Mr Dorman's regular general practitioner was Dr Sonya Khatiwala, of Whitsunday Doctors' Service, at Airlie Beach. As part of the police investigation into this incident, Mr Dorman's medical records, from 1 February 2016 (the incident occurred on 16 February) were obtained from Dr Khatiwala[8].

[14] Within this documentation is a statement of Mr Dorman's clinical history[9]:

- 1999 Pericarditis (viral)
- 2004 Hyperlipidaemia
- 2010 Benign Prostatic Hyperplasia (BPH)
- 2015 Thrombocytopenia

[15] Dr Khatiwala saw Mr Dorman on 1 February 2016, for a health check[10]. He advised, on that day, that he had had a cough for about 6 months[11], with a wheeze at night. A chest x-ray was arranged.

[16] On 2 February, Dr Khatiwala advised Mr Dorman that he had a chest infection. The doctor noted that Mr Dorman had a holiday booked in Tasmania for 6 weeks in March. He was prescribed Augmentin™, with a further chest x-ray to be carried out if his "pneumonia" did not resolve[12]. A chest x-ray report under the hand of Dr Nicolson noted that the appearance on x-ray was consistent with severe bronchopneumonia[13].

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[7] Discussions between Counsel Assisting and Mr Dorman's solicitors, as to the possibility of obtaining from him an induced statement for coronial use only, although promising, were unable to be finalised before his untimely passing.
[8] See Exh D.7, 134 folios (unpaginated).
[9] *Ibid*, folio 21.
[10] *Ibid*, f 1.
[11] He was formerly a smoker.
[12] *Ibid*, f 2.
[13] *Ibid*, f 32.

[17] On 18 February, two days after the traffic accident, Mr Dorman again attended Dr Khatiwala. It was noted he sustained a laceration on his forehead as a result of the accident. The doctor recommended that he continue with his plan to go to Tasmania, hopefully to rest and relax; he presented as tearful at times during the consultation, and it was clear that the incident had taken an emotional toll upon him. Mr Dorman was able to advise that his cough had improved, but he still had a little phlegm. A follow-up chest x-ray was advised, to be done upon his return from Tasmania. Dr Khatiwala also arranged blood tests to be done[14].

[18] Dr Khatiwala referred Mr Dorman to the Mackay Base Hospital (Haematology Clinic) in respect of his thrombocytopenia (low platelet count)[15].

[19] Mr Dorman adhered to his plan to holiday in Tasmania, and upon his return, attended again upon Dr Khatiwala[16]. A chest x-ray (presumably taken after his return from holidays) was reviewed and showed "worsening bronchopneumonia". Mr Dorman related that he had been short of breath during his holiday, and that he still suffered from the persistent cough. He also continued to feel distress from the bus accident.

[20] On 8 April, Dr Khatiwala spoke to Mr Dorman, and advised the results of a CT scan of his chest, which showed consolidation of the RM and RL lobes (lung), with emphysematous changes. Mr Dorman advised that his shortness of breath seemed to be improving[17].

[21] During April, May and June, Mr Dorman accessed health assistance concerning the psychological sequelae arising from the bus accident[18].

[22] By letter of 27 May 2016, the Mackay Base Hospital (MBH) advised Dr Khatiwala that Mr Dorman had been placed on the elective surgery list, in respect of a lung biopsy, with an urgency category 4[19]. On 26 May, an urgent chest x-ray had been performed at the MBH which showed increased opacification in the right mid-to-lower lung. A bronchoscopy and biopsy were arranged for early June[20].

[23] By letter of 15 June, Dr Fiona Kermeen, a thoracic physician at the MBH, advised Dr Khatiwala that Mr Dorman was a high risk with respect to an open lung biopsy, and her assessment, based on clinical history and imaging, was organising pneumonia. Her plan was to trial a course of empiric prednisone[21].

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[14] *Ibid*, f 6.
[15] *Ibid*, f 21.
[16] *Ibid*, f 8, 05/04/2016.
[17] *Ibid*, f 9.
[18] See report (26/07/16) of Ms Christine Franklin, psychologist, ff 109-110, first of five consultations on 18 April 2016; report (11/05/16) of Dr Gary Larder, consultant psychiatrist, ff 61 to 67; report (undated) of Professor Jacques Joubert, consultant neurologist, ff 92-101.
[19] Exh D.7, f 81.
[20] *Ibid*, ff 82-83.
[21] *Ibid*, ff 87-88.

[24] On 20 July 2016, Mr Dorman was admitted to the Proserpine Hospital with worsening dyspnoea and a productive cough. Assessment of unresolved pneumonia was proffered, with a note "?? Broncho-alveolar carcinoma"[22].

[25] A Progress Note for 22 July 2016 notes a prescription for a Ventolin inhaler in respect of Chronic Obstructive Pulmonary Disease (COPD)[23].

[26] On 16 August, Mr Dorman was admitted to the Prince Charles Hospital, with a primary diagnosis of right-side adenocarcinoma of the lung[24].

[27] The Registry of the Coroners Court was advised, in September 2017, that Mr Dorman had succumbed to his illness.

Further medical records:

[28] At a Pre-Inquest Conference held on 28 January 2021, Counsel for the Department of Transport and Main Roads, submitted a request that Mr Dorman's medical records prior to 1 February 2016 be obtained, and provided. The Court acceded to that request, and further records were identified, and obtained[25]. No further relevant information was contained within these records.

Mr Dorman's version of the accident:

[29] As previously indicated, Mr Dorman declined to provide a statement to investigating police pertaining to the incident of 16 February 2016.

[30] He did, however, provide two accounts which, to some degree, throw light on his version of events.

[31] Ms Christine Franklin, a psychologist, undertook five sessions with Mr Dorman, commencing in April 2016. Her short report of 26 July 2016 contains the following statement:

> "Mr Dorman was the driver of a bus that allegedly malfunctioned, veered off the road, toppled and came to rest on its side."

The significance which can be placed on this statement is minimal. Mechanical inspection revealed no defects in the bus; and it is unclear whether Ms Franklin, in this part of her report, was purporting to re-state Mr Dorman's explanation, or was simply summarising what she perceived to be the thrust of what he had said to her in the course of his sessions.

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[22] *Ibid*, ff 29-30.
[23] *Ibid*, f 14.
[24] *Ibid*, f 26.
[25] Exhibit D.7A, 98 folios (unpaginated).

[32] Mr Dorman was examined on 24 April 2016 by Dr Gary Larder, a consultant psychiatrist. In his report of 11 May 2016, Dr Larder included the following, in referring to what he was told by Mr Dorman:

> "He said, 'I was driving down the road in the bus, I'd just come off a break, lovely sunny day, going on holidays in four days, had the music playing driving along the road. From that, the next I remember is the bus coming over … in between I don't remember a thing, I have no idea'."
>
> "He added, 'I don't remember a damn thing, that's what's upset me, I don't remember a damn thing'."

[33] A further examination was carried out by Professor Jacques Joubert, a consultant neurologist, on 30 June 2016. This third-person account states:

> "He was driving, his hands on the steering wheel and listening to jazz. He had just had an hour and a half break and was fresh and in good humour. It was a straight road.
>
> He then next remembers the bus veering to the left, going over a culvert, and with an ongoing pole in front of him, he tried to avoid the pole and pull the bus onto the right side and stopped on the embankment. The bus then fell over onto the left side.
>
> He cannot remember between the times when he had his hands on the steering wheel and when he saw the bus fall after going over the culvert."

Diagnoses by Dr Larder and Professor Joubert:

[34] Dr Larder expressed his diagnosis as follows[26]:

> "Mr Dorman suffers from some form of brain condition which has either [1] caused him to lose consciousness for a period of seconds [and which has resulted in his memory for the period up to the bus rolling on its side being absent], or [2] caused him to be unable to remember that period of time [ie, an inability to recall a period of seconds from when the bus was travelling normally until it began to veer off the road and into a ditch and roll on its side].
>
> The elucidation of this brain condition requires investigation. From a clinical perspective the provisional diagnosis is some form of neurological or cardiac condition which altered his consciousness and which prevented him from forming memories for the period of seconds up to the time the bus was rolling over. The working diagnosis is Transient Global Amnesia.
>
> This is because [1] a head injury sustained during the incident could not cause a brief amnesia like the one outlined in his history, [2] a psychiatric disorder is not evident in this case which could cause it [3] he does not

[26] Exhibit D.7, ff 61-67, at f 62.

> present with a past history of amnestic disorder and [4] he does not present now with an amnestic disorder."

[35] Professor Joubert expressed the following opinion[27]:

> "… there were no identifiable neurological disorders that would allow me to commentate within the realms of my expertise as a neurologist. I am aware that this man may be subject to a psychological sequel relating to the accident and this may cause some cognitive deficiency. A psychiatrist and potentially a neuropsychologist may best commentate on this."
>
> "My opinion, taking the history as he has described it, is that the cause of the accident was not an episode of loss of consciousness."

[36] The investigating police officer, Senior Constable Siddall, conferred with Dr Ian Home, from the Clinical Forensic Medical Unit within Queensland Health, in June and August 2016, and had the benefit of viewing some of the video footage which is in evidence in this inquest. At the end of January 2021, Counsel Assisting requested from Dr Home a report setting out his opinions respecting a number of issues[28]. Due to the short period of time involved before the inquest was scheduled to commence, Dr Home was unable to provide a full forensic report. He was, however, able to reprise his advice to Senior Constable Siddall in 2016, as follows:

> " … I could see no overwhelming evidence of driver fatigue. Many of the 10 or so episodes of reported yawning in the 90 min prior to the crash looked like coughs or simply beard rubbing. Whilst I could not be certain regarding his level of consciousness in the ten seconds or so prior to the crash, Mr DORMAN was facing straight ahead just prior to the bus leaving the road. Although a degree of unrecognised fatigue related to the then undiagnosed lung cancer was possible, in my opinion there was insufficient evidence to support or disprove this.

[37] Dr Home then proffered observations upon questions which had been posed in the communication from Counsel Assisting, concerning the matters raised by Issues 3 and 4 in this inquest, which read:

> **3. Would the nature of the injuries suffered by Casey have been less serious if-**
>
> **(a) The bus had been travelling at a slower speed; or**
> **(b) Casey had been wearing a properly-fitted and worn seat belt?**
>
> *A. The Coroner requests your opinion as to Issue 3(a) above.*
> *B. The Coroner also seeks your opinion as to Issue 3(b) above.*

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[27] *Ibid*, ff 92-101, at f 95 and f 97.
[28] Exhibit D.13.

2. What caused the Bustech XDi omnibus to leave the carriageway on Shute Harbour Road, Cannon Valley, and to overturn?

C. Is the driver's upper-body movement – to the right, and down – consistent with the onset of sleep?
D. Is it possible, or likely, that on 16 February 2016, Mr Dorman's cancer would have been in an active, or advanced, state?
E. Is it possible, or likely, that on that date, Mr Dorman may have been suffering, to some degree, from fatigue, caused by the progress of his illness?

[38] Dr Home advised:

"As for the questions posed:

A) Vehicle speed and extent of injury is fairly well established. Reducing speed, regardless of the metrics of the collision, would reduce the kinetic energy involved. Whether the outcome for an unrestrained passenger would have been any different had the bus been travelling at 80km/h or even 60km/h exceeds our level of expertise.

B) Again, the benefits of seatbelts is well established. Had Mr BROWN been adequately restrained, you would have to assume his risk of injury would have been substantially reduced.

C) As per above, at the time of reviewing the video footage in 2016, I felt there was insufficient evidence to conclude Mr DORMAN's movements were consistent with falling asleep.

D) It is likely that Mr DORMAN had undiagnosed lung cancer at the time. On 01/02/2016 he reported a cough that had been present for more than 6 months that was treated as a chest infection and x-rays were reported as showing evidence of pneumonia not cancer. As pointed out, it was not until six months later when his respiratory symptoms failed to resolve that lung cancer was finally diagnosed.

E) There is insufficient evidence to say one way or the other regarding any degree of fatigue due to his undiagnosed lung cancer. There were no concerns whilst hospitalised following the crash and he was discharged home the following day. He subsequently went on a holiday after being medically cleared by his GP. There was no comment regarding fatigue around this time. During the holiday Mr DORMAN was able to ride a motor bike and tow a camper although he did develop a further chest infection that caused shortness of breath, but again no mention of fatigue."

[39]. What appears very clear from the evidence, and I am able to find[29], is that there is no other likely cause for the bus leaving the roadway other than that of the drivers own actions (perhaps better expressed as inactions); but whether this

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[29] No interested party suggested any other causal factor for the bus leaving the road than the driver being the cause of the incident, that is there was no outside influence of weather, defective road, excessive speed, passenger interaction with the driver, etc, and that position of each interested party was certainly sensible and reflected in the available evidence.

was due to momentary inattention, for example whilst looking around at the bus instrument panel, or an episode known as a "microsleep", or from fatigue or tiredness[30], or even a very minor medical episode which left him momentarily incapacitated, I cannot precisely determine as all present very similarly. The possibility of a minor medical episode is raised because of Mr Dorman's senior age, and that he passed away in about September 2017 after being diagnosed with significant and advanced lung cancer first formally diagnosed in approximately August 2016, which was about six months after the accident. At the date of the accident he had no diagnosis of advanced lung cancer, rather was merely feeling episodes of breathlessness which were being investigated[31].

[40]. Counsel Assisting urged me to find that Mr Dorman simply fell asleep as he was driving, and it was said that this was reflected in the CCTV showing his head movements and actions as the bus left the road, including the lack of reaction as the bus left the road[32]. One interested party[33] submitted that the evidence as to falling asleep was insufficient to ground a specific finding to this effect. Dr Home, as previously indicated, stated that the evidence revealed in the CCTV footage was insufficient to conclude, from that footage, that Mr Dorman had fallen asleep. Professor Joubert opined that Mr Dorman did not experience a loss of consciousness, and found no identifiable neurological disorders. Dr Larder proposed a diagnosis for Transient Global Amnesia. Dr Home, while indicating that the evidence was too weak to support a conclusion that Dr Dorman had fallen asleep, also noted that he "could not be certain regarding his level of consciousness in the ten seconds or so prior to the crash".

[41]. I appreciate the points raised by the parties, and they are all valid theories; but I consider that I cannot identify, with the necessary degree of certainty, the "underlying" cause of the lack of attention on the evidence available to me; nor can I completely exclude the various possibilities.[34]. I think the highest I can

[30] And I accept these can be slightly different events, although can appear very similar in outward appearance.

[31] Perhaps not an unusual symptom to be experienced by a 70 year old man who was a little obese based on BMI tables.

[32] Exh C.4 at 3:45.

[33] Parties granted leave to appear as sufficiently interested parties in this inquest were (i) Casey's family, (ii) the proprietor of the bus service which employed Mr Dorman, and (iii) the Department of Transport and Main Roads (TMR).

[34] Counsel for TMR submitted that a further report should be obtained from Dr Home, of the CFMU, by reference to the whole of Mr Dorman's medical history. No indication, by way of a proof, or outline, of the likely content of a further report from Dr Home was placed before me. Submissions were made by TMR, from the Bar table, that this earlier health history might yield some further information which could point towards identification of a precise medical cause for Mr Dorman's absence of driving input. Having read the entirety of Mr Dorman's medical records, there is to my mind nothing specific in that history which could take the matter further. The scope of every inquest is fact-dependent, and it is for the Coroner to set the limits of that inquiry. On the issue of causation, a line must be drawn, at some point, to the retrospective investigation into potentially causal factors – an inquest cannot become "an exercise in endless regression" (*cf Mullaley v State Coroner* [2020] WASC 264 at [111]). The point was made by Sir Thomas Bingham MR in *R v Inner West London Coroner, ex parte Dallaglio* [1994] 4 All ER 139 at 164j: "It is for the Coroner conducting an inquest to decide, on the facts of a given case, at what point the chain of causation becomes too remote to form a proper part of his investigation. That question, potentially a very difficult question, is for him." The Court of Appeal in New South Wales expressed a similar view in *Conway v Jerram* [2011] NSWCA 319 at [48] and [49].

conclude is that the bus left the road due to "momentary driver inattention to the task of driving". Whether that period of momentary driver inattention was the driver falling asleep, an unexplained lapse in awareness[35] or concentration, or an underlying, and undiagnosed, and significantly advanced, detrimental lung condition (which is certainly possible, and is suggested from the medical material as a definite possibility (see Dr Home's email), I cannot precisely determine. Each identified possibility is a fine subset of the broader term "momentary inattention to the task of driving". Very likely each produces the same nett effect, that is the driver is not 'actively' involved or in control of the situation; rather he is driving inattentively, or without input, as is certainly evident on the evidence. I do not think in the circumstances I can find the specific underlying reason for the episode of momentary driver inattention, and I will simply express it as I have. What is very clear is that there is no other persuasive reason for the bus to leave the roadway in the manner it did other than through the absence of driver input.[36]

List of Inquest Issues Answers

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

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

[43] Issue 1. My primary task is the information required by section 45(2) of the *Coroners Act 2003*, namely:

a. Who the deceased person is - **Casey Lenard Brown**[37],
b. How the person died – **Mr Brown died due to injuries received in a single vehicle bus rollover accident, where Mr Brown, as a passenger, was unrestrained**,
c. When the person died – **16 February 2016**[38],
d. Where the person died – **Shute Harbour Road, Cannon Valley, Queensland**[39], and

It is always open to a party to an inquest to place before the Coroner information for the Coroner to consider and possibly receive into evidence. When that is in the nature of expert evidence, "it is for that person (if at all possible) to identify the witness and put the substance of the evidence which the witness may be able to give before the coroner so that the coroner may be able to decide whether or not it is appropriate.*": R (Takoushis) v Inner Nth London Coroner* [2006] 1 WLR 461 at [61] (CA) *per* Sir Anthony Clarke MR delivering the judgment of the Court.

[35] *Query*: a Transient Global Amnesia.

[36] There is no evidence of defect in the bus, second road user, interaction from a passenger, distraction caused by a passenger, a driver using his mobile phone, the bus striking a puddle on the road or water sheeting across the road, the bus suffering a tyre blowout which causes it to leave the road, *etc*. On the evidence, I do not consider that Mr Dorman's work hours were excessive. Whilst he seemed to work quite ordinary hours, which he had successfully done for a number of weeks, he did have a very significant break before commencing his afternoon shift. There was no convincing evidence, nor suggestion, that work hour fatigue was the issue, and he was certainly not driving outside 'logbook' hours if I can use that term, for a bus driver.

[37] See Exhibit A.1 QPS Form 1

[38] See Exhibit A.2 Life Extinct Form

[39] See Exhibit A.2 Life Extinct Form

e. what caused the person to die – **head injury, as a consequence of a bus crash in which he was a passenger**[40]

[44] Issue 2. What caused the Bustech XDi Omnibus Reg No 251–TRQ to leave the sealed carriageway on Shute Harbour Road, Cannonvale, and to overturn? **A period of momentary driver inattention to the task of driving.**

Issue 3. Would the nature of the injuries suffered by Casey have been less serious if–
(a) if the bus had been travelling at a slower speed; or
(b) if Casey had been wearing a properly fitted and worn seatbelt?

Answer (a) **As a general proposition, Yes, but that depends on how much slower the speed.**
Answer (b) **I find there would definitely have been less serious injuries if he had been wearing a properly fitted seatbelt**[41].

[45] Issue 4. Should the issue of safety for passengers in "route" buses be reconsidered by the State Government, with particular regard to:-
(a) requiring route buses to be fitted with compliant lap/sash seatbelts for the driver and all passengers either-
(i) immediately; or
(ii) over the course of a fixed phasing-in period?
(b) limiting the speed of route buses during operations to a specific maximum speed, even if that is lower than that of the relevant applicable speed zone?
(c) requiring that any new bus, even if it is intended to be used only for "route" services, be fitted with compliant lap/sash seatbelts?

[46] It is more convenient that I deal with these more specifically below in Recommendations.

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

[47] This incident does provide the opportunity to recommend important improvements aimed at reducing the injury risk to bus passengers.

[48] The present situation is that coaches, *eg Greyhound*-style buses which operate on a highway over long distances travelling at 100 km/h, all require seatbelts for passengers. Route buses service a local suburban bus route, and may perform

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[40] See Exhibit A.3, Form 3 Autopsy Certificate

[41] I consider that I can make this conclusion after reviewing the CCTV showing the rear interior of the bus and how passengers were violently thrown around whilst unrestrained. There was no damage to seats, nor deformation of the bus structure, so if a person was restrained by a seatbelt the likelihood of injury was significantly reduced. In addition, the serious injuries Mr Brown suffered were head and face fractures from striking hard interior surfaces. After more than 6,000 coronial case investigations I consider that I have sufficient practical experience to make such a conclusion without any specific expert commentary. Indeed, any reasonable person viewing the CCTV would also come to the same conclusion, particularly as the crash deceleration forces occurred over 95 metres.

the function of the local school bus[42]. These buses do not require seatbelts for passengers[43], unless the assigned route includes what has been declared a "designated steep road"[44], *and* is carrying schoolchildren. This is an interesting delineation. In Casey's case, his bus was travelling on a 100 km/h speed limit road[45], even though roadworks that day reduced the speed at the crash location to 80 km/h.

[49] It is necessary, at this point, to briefly digress into the regulation of seatbelts on buses in Queensland. The definition of a "route service omnibus" as contained in the *Vehicle Standard (Australian Design Rule – Definitions and Vehicle Categories) 2005*, is as follows[46]:

> "ROUTE SERVICE OMNIBUS – an omnibus specially designed with spaces for standing passengers."

This category of buses is recognised by Australian Design Rule (ADR) 68/00, which specifies "for certain omnibuses" the requirements to be met in respect of the fitting of seat belts. However, it then goes on to state:

> "This ADR does not apply to '*Route Service Omnibuses*', or omnibuses with less than 17 '*Seats*' including the driver and crew, or vehicles in which all passenger '*Seats*' have a '*Reference Height*' of less than 1.0 metre."

[50] The seatbelt exemption arises from the fact that a bus is "specially designed with spaces for standing passengers"; it bears no relationship to the fact that the particular bus *is* carrying standing passengers. It can, of course, be readily accepted that there is an obvious difficulty with providing a seatbelt for a person who is standing. But the logic behind requiring 51 seated passengers to forgo the protection of seat belts because one or more further passengers may have to stand is somewhat elusive.

[51] The exemption applies by definition to all "route service omnibuses", which in reality includes the fixed-route timetabled busses that commuters use on a daily basis, especially in the cities. Their application, however, is not confined to city routes, where top speeds may be limited, and the distance between stops can be quite short. The route bus "exemption" extends to buses like the bus used in this case by Casey and the other passengers., *ie* which travels at up to 100kph on open roads, carries schoolchildren (and TAFE students) during certain periods

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[42] As did the bus service in which Casey was travelling, from time to time: see Exh D.19A.

[43] Although a seatbelt was provided for the driver in Casey's bus (see Exh B.2 at [3.6]), it was not worn on the occasion of this incident.

[44] An "Environment 3" road. There are a limited number of such roads in Qld; and in reality, they are only steep range descents/ascents: see Exh D.14C at [9]; and <https://www.tmr.qld.gov.au/Travel-and-transport/School-transport/Assistance-schemes/School-Bus-Upgrade-Scheme/Notified-roads>

[45] It could be suggested that the same level of protection as a highway coach affords to passengers (*ie* mandatory seatbelts) should be available to other buses which regularly travel at 100kph on open roads. That is certainly a logical premise.

[46] See also *Transport Operations (Passenger Transport) Standard 2010*, Schedule 4, definition of "route service bus".

of the day, as well as tourists and visitors to the country, and may only infrequently carry standing passengers[47].

[52] No seated passenger on these services presently has the opportunity to utilise a seatbelt, in my view that needs to change.

[53] It is a widely-accepted proposition – one could even a suggest "notorious" fact - that seat belts save lives[48]; and that wearing a seatbelt generally reduces the severity of a person's injuries in a crash. Of course, a precise dividing line between where injury will, or will not, occur, if using speed as the sole yardstick, is a very difficult issue to determine. What can comfortably be stated is that the lower the speed of a vehicle (or vehicles), the lower the severity of injury will be, if a crash occurs[49]. Conversely, the general proposition is that when that same person is wearing a properly fitted three-point[50] seatbelt, the threshold of speed before they suffer significant injury in the same crash dynamics will increase. One can only postulate these propositions in very broad terms; but it is abundantly clear that two of the major causes of road fatality are excessive speed, and the non-wearing of seat belts. These propositions are so well-established as not to require expert evidence.

[54] As was found by the forensic pathologist, Mr Brown died of severe head injuries; in fact, ten of the eleven bus occupants required some hospital treatment as a result of the accident. Essentially, Mr Brown suffered several skull fractures leading to non-survival brain haemorrhage. Others in the accident also suffered very significant and permanent injuries, such as a traumatic amputation of a hand on the part of one passenger, and a major de-gloving of the forearm of another passenger.

[55] I have had the benefit of studying the CCTV footage of the passenger area of the bus as the crash developed[51]. What is readily apparent is that the structure or bodywork of the bus did not deform nor suffer any real impact, rather it remains entirely intact[52]. In fact, the only real[53] impact damage occurred at the very front end of the bus, on the passenger side, well away from where the passengers who received serious injuries were seated[54].

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[47] Once or twice a month: Exh D.19A. The number of standing passengers could not be quantified by the bus proprietor.

[48] A police officer who gave evidence identified it as one of the "Fatal 5"; and the wearing of seatbelts to save lives is the subject of many road safety campaigns.

[49] This was identified by Dr Home as being because less kinetic energy is involved. Where the dividing line falls between fatal and non-fatal injury was beyond his expertise, likely due to the multitude of factors at play in any crash situation.

[50] Another term for a lap/sash seatbelt

[51] Restricted Exh C.1. And I note Justice of Appeal McKenzie's observation (with which Davies and McPherson JJA specifically concurred) that "…if a tape unequivocally shows what has occurred there is no reason why the Court should not act upon what is plainly recorded on it": *R v Smallwood* [1997] QCA 091 at pp 7-8.

[52] And counsel agreed with that observation.

[53] As opposed to cosmetic or minor

[54] I note that no passenger was standing, but this is not surprising as there were 51 seats available, and just ten passengers. The bus's specifications catered to 52 sitting (including the driver), and 42 standing: Exh B.2 at [3.3], and Exh B.2A. The bus company which employed Mr Dorman provided information to the inquest that the 52-seat capacity would be exceeded perhaps only twice a month: see

[56] How the passengers on the bus suffered their injuries is very evident in the CCTV footage. The passengers are violently thrown around within the passenger area of the bus as it rolls onto its' side. They are projected from their seats but are not ejected from the bus itself (nor projected outside, nor even partly outside). What can be drawn from this? What is very evident to me, even without an expert opinion, is that the injury occurs to Mr Brown as he is thrown from his seat and his head strikes the interior roof, interior side, and seats of the bus as it rolls onto its' side. It should be understood that the bus 'rolling' was merely it launching up from the culvert and then turning onto its' passenger side. The bus did not complete an entire 360-degree rollover, rather it only tipped through 90-degrees. This was nevertheless sufficient for the passengers to be violently thrown around within the bus.

[57] What is also evident from the CCTV footage is that all of the seats remain in place, securely affixed to the floor. Despite assertion by counsel for TMR that I needed an expert report into the dynamics of the crash before I could conclude that Mr Brown would have suffered lesser injuries if he had been restrained by a seatbelt, I think my experience as a Coroner,[55] and ordinary common-sense, can be applied. It is clear to me, and I conclude, that if Mr Brown had been restrained in his seat by a properly fitted seatbelt, he would have suffered far less injuries than he did, and certainly would not have suffered those non-survival cranial fractures[56]. Accordingly, and with respect, I do not need an expert to assist me to determine this[57].

Exh D.19A. The bus timetable in evidence (Exh D.3) indicates multiple trips from Proserpine to Shute Harbour, and return, each day.

[55] More than 6,000 coronial cases.

[56] His head would not have struck any hard surfaces; and I note that one fracture was measured as being at least 14cm in length, so very substantial. Of course, he may have suffered some injuries; but, properly restrained, it is very likely all would have been survivable.

[57] The CCTV of the crash sequence showing Mr Brown being thrown around was a restricted exhibit (due to its' graphic nature), and I have reviewed it on a number of occasions. The CCTV footage is in the nature of real evidence (*R v Sitek* [1988] 2 Qd R 284, at 286, 288, 292); it places me in a knowledgeable position to comment on what it shows, more so than someone who has not studied it. It does not involve a re-construction, but rather shows exactly what happened. I appreciate counsel raising this issue, but I am comfortable in view of my knowledge of what occurred, through viewing the CCTV recordings, and the autopsy report findings, that I can reach such a conclusion. Coroners have been drawing such conclusions from available evidence for many years without a specific expert report. It was always open to any interested party to obtain and tender their own expert report on that issue. No party did so. My drawing of such a conclusion cannot be said to be contrary to any other expressed view, and it is clearly available "on the evidence". Counsel for TMR submitted that I should commission a report from the Centre for Accident Research and Road Safety (CARRS) at the Queensland University of Technology, as to the relationship between vehicle speed and the extent of injury in motor vehicle incidents, and as to what would have occurred had Casey been restrained in his seat in this incident. I note that this course of possible further inquiry was mentioned by Dr Home of the CFMU, in his response to Counsel Assisting on 3 February 2021. I have already outlined above my reasons for findings that Casey would almost certainly have not suffered the injuries he did had he been restrained. It is possible to see, with one's own eyes (in Exh C.1) exactly what happened to Casey in this event. The engagement of CARRS, and the commissioning of a report in order to tell the Court what is obvious upon the evidence, in my opinion, would be an unjustifiable dissipation of public funds (as to which note *Davis v Ryan (State Coroner)* [2019] QCA 282 esp at [30]). The drawing of inferences was recently the subject of comment by Justice Wilson in *Masih v Masih* [2021] QSC 207 at [54], where her Honour re-stated the long-recognised principle from *Jones v Dunkel*: *"... As has been said, 'Inferences from actual facts that are proved are just as much part of the evidence as those facts*

[58] In those circumstances, if he had been wearing a seatbelt, I think it is reasonable to conclude that he would have suffered non-fatal injuries, and so survived the crash. The precise degree of injuries he would have suffered is something of which I cannot be certain, but I do know that the crash unfolded whilst the bus travelled approximately 95 metres, and it slid to, rather than impacted upon, any hard object or structure, such as a second vehicle, standing native tree, or a power pole[58]. The sliding, single vehicle, nature of the crash I think is a very relevant factor to consider as to whether Mr Brown would have suffered less injuries if he had been appropriately restrained by a seatbelt.

Seatbelt requirements and Industry position

[59] It was said to me at the inquest that providing seatbelts on route buses would cause issues for drivers being liable to a penalty if passengers failed to wear their seatbelt. While that may have been the position as at the date of the hearing, very helpfully, the Government has now passed legislation which makes clear that bus drivers are not responsible for an offence if a passenger fails to wear their seatbelt. Bus drivers are simply exempt from that requirement.[59]

[60] What is clear is that the position on failure to wear a seatbelt for bus driver/passenger liability is now certain, in that drivers have no personal responsibility for any failure to wear a seatbelt by a passenger. To me that is a sensible approach.

[61] Counsel Assisting advocated that seatbelts should be provided on route buses. The interested party representing a bus company adopted a rather neutral stance on the issue[60], but if required should be phased in over a period of time so that current fleets which do not contain seatbelts can be progressively phased out. The view of TMR was that I should accept that its risk assessment strategy as it

themselves. In a civil cause you need only circumstances raising a more probable inference in favour of what is alleged…where direct proof is not available it is enough if the circumstances appearing in evidence give rise to a reasonable and definite inference; they must do more than give rise to conflicting inferences of equal degree of probability so that the choice between them is mere matter of conjecture. All that is necessary is that according to the course of common experience the more probable inference from the circumstances that sufficiently appear by evidence or admission, left unexplained, should be that the injury arose from the defendant's negligence. By more probable is meant no more than that upon a balance of probabilities such an inference might reasonably be considered to have some greater degree of likelihood' (citations omitted)… " (see (1959) 101 CLR 298, at 309 (*per* Menzies J)).

[58] Coroners are all too familiar with the significant impact and deceleration damage to vehicles when travelling at above urban speed limits when a vehicle collides with a gumtree or power pole.

[59] Section 267A, *Transport Operations (Road Use Management—Road Rules) Regulation 2009*.

[60] The industry representative's submission was not to say seatbelts were too hard, or too expensive to fit, rather that they be implemented after appropriate investigation of practical issues (restraints for wheelchair occupants and motorised scooter users *etc*) and solutions are found. The only issue with this is that a prior Taskforce in 2001 suggested seatbelts for certain circumstances, with implementation by 2017 which was over a 15 year horizon, but that has never occurred. The commercial aviation industry has addressed it (there are seatbelts on all commercial flights), and one would think the bus industry could similarly do so; although, of course, any funding issue for seatbelts would be a State government responsibility, as the Government which would fund such a program (although the inquest did not delve deeply into that issue).

applied to bus transport was the correct approach; and a number of reasons, adverse to the fitting of seatbelts to route buses, were provided[61].

[62] Evidence was given from one experienced bus company owner, who had 41 buses in their fleet. Of all their buses, only one is not fitted with seatbelts. A somewhat interesting piece of evidence from that bus operator was that whenever mining companies or government departments[62] seek to hire one of their company's buses, they *always* specify that seatbelts must be fitted to the bus hired.[63]

[63] There are certainly economic considerations with the fitting of seatbelts to buses; it makes the bus acquisition more expensive[64], and it reduces the number of available seats. Buses fitted with seatbelts are readily available in Queensland, and in fact the particular bus involved in this fatality can be built with a variety of seating layouts, and with or without seatbelts.

[64] One concern is that retro-fitting of seatbelts is very difficult due to their requirement for appropriate structural anchoring within the body of the bus. It is far more cost-effective that they are specified as original fitment. That is certainly a valid point. Issues such as reduced seating (it is about 5 seats out of 52), and whether seatbelts can be used on seats which align along the north-south axis of the bus were raised as issues. There was also the question of how a person with a disability can be appropriately seated in a seatbelt-fitted seat; if one is not provided, it was said to constitute disability discrimination.

[65] There was no evidence at the Inquest of the number of persons in wheelchairs who actually use route buses[65], and one imagines it would be quite a low number, but a very valid point was raised by the next of kin when they addressed me. The aviation industry[66] readily has people who are wheelchair bound ride on commercial planes, and they are always transferred to a seat in the plane where a seatbelt is fitted. Why can't the same occur with buses? I am sure there are many ways to overcome this issue. Manufacturers quite possibly already have a suitable solution. The inquest simply did not explore that issue further as it was not specifically flagged as an issue. The additional cost of seatbelts in

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[61] See Exh D.14C, at pp 5-6. This document was submitted to the inquest on behalf of TMR, an interested party. It was unsigned, and otherwise disclosed no information identifying the author.

[62] Perhaps this is a little uncomfortable a reality for the government, in that departments mandate that any hired bus has fitted seatbelts, but they then oppose that as an overarching legislative position. This is just an observation on the evidence in this case.

[63] Counsel for TMR submitted that evidence of Mr Fox, a local bus proprietor who gave evidence of this fact, should be completely rejected, as being irrelevant to route buses (Transcript 3 Mar, p 1-37 line 42). With respect, it seems to me that whether we speak of route buses, school buses, or highway coaches, the effect of an absence of seatbelts will be the same – *ie* a potential for a higher fatality rate, and a greater severity of injury. I would readily accept that the fitting of seat belts to all but one of BusFox's fleet may have been a decision based upon economic grounds. But of course, the very fact that it was economically-based attests to the well-known, and accepted, positive results of having seatbelts fitted to buses.

[64] The evidence was some $30,000 for a $475,000 BusTech model, so about 6.3%.

[65] Although the Service Contract required at least two such seats on these particular buses be available.

[66] A very valid observation by the family of Mr Brown, and something the more experienced minds appeared to have overlooked.

buses when first purchased represents about 6.3%[67] of the total bus costs, so it is not a cost prohibitive factor. As more buses are required to have seatbelts fitted, that cost will of course reduce[68].

[66] Overall, I am persuaded that seatbelts being fitted on route buses would reduce loss of life, and the severity of injuries, in bus crashes. It is a very valid point made by the bus operator who appeared as an interested party at the hearing, that time is required to phase in such a requirement. There will be a recommendation I make that the relevant authorities review the issue of having mandatory seatbelts on route buses, and this should commence promptly, but be phased into the entire fleet over an appropriate time. Whether that is 10 years or slightly longer, will be up to regulatory bodies and the industry to determine, but I note that a brand-new bus has a serviceable life of around about 20 years. No doubt the forward-thinking bus operators, such as Mr Fox who gave evidence, are already well down the path in having their entire fleet fitted with seatbelts.

[67] What this inquest has highlighted to me is that bus accidents can occur in the most innocuous of circumstances, and here we had a bus travelling along a straight road at 80km/hour which simply left the road and slid to a halt over about 95 metres. It was not a calamitous crash, such as occurs when a bus and truck collide head on; yet still, a young man who was simply travelling home from TAFE lost his life. Mr Brown's death was to my mind an entirely preventable death. I was provided with many statistics showing the relative absence of bus passenger fatalities *per* bus passenger trip. Unfortunately, I was not provided with similar comparative figures for say, passenger vehicle trips. But such figures do not tell the entire story. What needs to be borne in mind is that when a bus is travelling it can theoretically have up to 51 passengers (as in Mr Brown's case) seated on the bus - and for this route bus a further 42 standing passengers[69] - so there is great potential for mass injuries from just a single vehicle bus accident. Some might recall Australia's worst fatality level from a single traffic accident, which was the Kempsey bus crash in 1989, where two buses collided, and 35 people died, with a further 41 persons injured. As I have said, in Casey's case there was a driver and 10 passengers on the bus, and in this case there was one fatality, two cases of very serious injury, and a further eight persons required hospitalisation. To me, that is an alarmingly high ratio of serious injury requiring hospitalisation to passengers actually carried.

[68] I appreciate the situation at the time of this accident; seatbelts were not mandated at that time, and there were various regulatory instruments, including a UNECE Regulation, that did not require them. That may be so, but there is no penalty if Queensland mandates for route buses - indeed any bus operating within the State - that it must have appropriately fitted seatbelts within a set period of time. There is no penalty for *exceeding* the minimum safety regulation. As I have said, bus manufacturers already readily offer seatbelts, it merely appears to be a case of willingness to embrace this.

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[67] See footnote 62 above.
[68] Economies of scale reduces unit costs in time, simply look at anti-lock brakes and airbags, once only fitted to the most expensive modern cars but now readily fitted to budget vehicles.
[69] See footnote 53 above.

[69] No doubt the very same arguments against mandatory seatbelts which were advanced in the 1960's, before seatbelts were mandated for passenger cars in Australia[70], will be resurrected. Apart from the classic cars from prior to 1969/1971, every car sold today has seatbelts. To me it is not a difficult transition to make; it simply requires the regulatory bodies to make the decision that they be mandated[71], provide a starting point, and a timeline for within which all buses shall have seatbelts installed.

Final Recommendation/s:

[70] In my view it is very clear that compliant lap/seat belts for all passengers[72] should be available on route buses. These should be required for each new bus manufactured entering service, and phased-in over an appropriate period of time for existing buses in service (such that there may be a 10 or 12 year horizon for an existing bus to either be made compliant, or retired from service on routes). In my view if appropriate lap/seat belts are fitted then the lowering of speed limits is not required. Accordingly, I make the following recommendation:

Recommendation: *That the State Government implement within one year a requirement that buses on Route Services must have compliant lap/sash seatbelts fitted for each passenger seat for every newly manufactured bus entering service after 1 December 2022, and that within an appropriate horizon timeline (of 10 or 12 years) for any remaining buses to be made lap/sash seatbelt complaint or that bus is retired from Route Services*.

[71] Issue 4(b) raised the possibility that the speed of route buses which were not fitted with seatbelts could be limited to a certain speed, potentially lower than the designated speed for that particular road (or section of road), in an effort to reduce the severity of injuries which could be suffered by unrestrained bus passengers.

[72] In this case, the usual posted speed limit for the section of road involved was 100kph. At the time of this incident, that speed limit was temporarily reduced to 80kph, due to roadworks in progress. Evidence gathered by police investigators indicated the probable speed of the bus at the time of this incident was about 80kph, that is, not in excess of the posted speed limit.

[73] The difficulty involved in trying to establish a meaningful range of speeds for unrestrained bus passengers is well beyond the capacity of this inquest. Certainly, as previously stated, the basic rules of physics dictate that the

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[70] Front seatbelts were mandatory for all cars sold from 1 January 1969, and rear seatbelts from 1 January 1971. Indeed, history shows us that State and Federal Governments were fitting seatbelts to their fleets from the early 1960's, well before they were mandated.

[71] And more recently mandatory three-point seatbelts for the rear seat middle passenger was 'mandated', and so occurred, even though some said it simply was not able to occur. Industry inevitably finds a way.

[72] It is already mandatory for drivers.

slower the speed of a vehicle, the lower will be the extent of the kinetic energy operating upon unrestrained passengers.

[74] Speed, however, is only one factor. The particular movements of the vehicle (as dictated by driver input, and road topography; and road and weather conditions), the layout and design of the bus, and the number of passengers on board (and whether seated or standing) - all must have some part to play in the individual mechanism of injury. It is not something upon which a specific recommendation can be made after one inquest; but it is no doubt taken into account in formulating a policy covering the overall safety conditions of route buses.

[75] It is well-recognised that coroners do not make laws; all we can do is recommend legislative or regulatory change directed at matters such as public health or safety, or a way to prevent deaths from happening in similar circumstances in the future. Coroners shine a spotlight on an issue which, in the Coroner's opinion, may help to prevent future loss of life in similar circumstances. As I said previously, whilst it was highlighted to me at the inquest that various instruments and a convention[73] presently do not specify that seatbelts need be fitted, there is no penalty in mandating for Queensland a higher standard. I noticed at the inquest there was no great reluctance by the industry to follow the path of mandatory passenger seatbelts; they merely need time and, as I said earlier, it seems those more proactive operators have already substantially moved their bus fleets to having compliant passenger seatbelts.

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

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

[77] It was not suggested[74], nor recommended, to me by any party at the inquest that any further person or entity should be referred for investigation of an indictable

[73] See Exh D.14C at [11].

[74] In the course of his closing address, Counsel for TMR submitted that –

> "…there are a range of possibilities that emerge from the evidence your Honour does have, including the prospect that Mr Dorman, himself, knew that he had conditions that might have made him unfit to drive, and that his doctor knew that he had conditions that might have made him unfit to drive."

This submission was made in the context of an application to call further evidence. Aside from the obvious fact that what were referred to were mere possibilities and would not enliven the threshold of "reasonable suspicion" under s.48, I did not take the submission to be advocating referral of either of the mentioned persons. Indeed, there is authority that coroners alone decide referrals and should hear no submissions from any interested party. The cause of Casey's death is clearly indicated by the evidence, and any further exploration of the submitted possibilities would not throw any further light upon that central issue.

or other offence. Accordingly, I make no such referrals under section 48.

Magistrate O'Connell
Central Coroner
Mackay
16 December 2021