

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 259

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

Inquest into the Death of: STEVEN JOHNSTONE

Delivered On:	21 December 2012
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street, Melbourne 3000
Hearing Dates:	13 November 2012
Findings of:	HEATHER SPOONER, CORONER
Representation:	Ms Rachel Walsh on behalf of VicRoads Mr John Bolitho on behalf of the Transport Accident Commission
Police Coronial Support Unit	Sergeant David Dimsey

I, HEATHER SPOONER, Coroner having investigated the death of STEVEN JOHNSTONE
AND having held an inquest in relation to this death on 13 November 2012
at MELBOURNE

find that the identity of the deceased was STEVEN MICHAEL JOHNSTONE
born on 8 March 1990
and the death occurred on 17 January 2010
at Plenty Road, Mill Park

from:

- 1 (a) MULTIPLE INJURIES
- 1 (b) MOTOR VEHICLE COLLISION (DRIVER)

in the following circumstances:

1. Mr Steven Johnstone was aged 19 when he died. He previously worked as a roof tiler and a baker although he was unemployed at the time of his demise. He lived at Belmont Road, Ivanhoe with his brothers and another young male, Ben Hall who also died in the crash. Mr Johnstone had a loving relationship with his family. There was no relevant past medical history.
2. At approximately 1.50 am on Sunday 17 January 2010 a single vehicle collision occurred on Plenty Road in Mill Park, when a Ford XR6 sedan owned and driven by Mr Johnstone struck a tree at excessive speed, resulting in the deaths of five of the six young occupants:
 - Steven Johnstone, aged 19 years;
 - William Te-Whare, aged 15 years;
 - Ben Hall, aged 19 years;
 - Mathew Lister, aged 17 years; and
 - Anthony Iannetta, aged 18 years.
3. 15-year-old Elissa Iannetta, a rear seat passenger and sister to Anthony, was the sole survivor.
4. A comprehensive investigation into the crash was conducted by Leading Senior Constable (LSC) Shane Miles from the Victoria Police Major Collision Investigation Unit (MCIU). It was apparent that Mr Johnstone had engaged in several high-risk driving behaviours over a period of time prior to the collision. This included drink driving, excessive speeding, using a mobile telephone while driving, running red lights, exceeding a passenger restriction and driving a vehicle that was overloaded with passengers (carrying six occupants when it was

designed to carry only five). Additionally, the evidence suggests that Mr Johnstone was quite enraged in the lead up to the crash.

Events Leading to Death

The Circumstances

5. LSC Miles compiled the inquest brief and also provided me with a detailed and fulsome summary, part of which is set out below:
6. On the evening of Saturday 16 January 2010, Steven Johnstone, his girlfriend and her friend attended an 18th birthday party at a house in South Morang. Steven was driving that night. During the course of the evening, between 9.00pm and midnight, the three shared a slab of Black Ice Vodka Cruisers (24 bottles). Mr Johnstone's girlfriend stated: "*Steven drank the most of the three of us. I estimate I had about six drinks and Sarah had about six as well.*"¹
7. At midnight the party began to close down and people moved out into the street. The two female companions had to be home by midnight so Mr Johnstone drove them home to nearby Mill Park. The friend stated, "*I was a little concerned that Steven was a P plater and had been drinking but I knew Steven would not do anything to put our lives in danger.*"² Another male at the party however did attempt to prevent Steven from drink driving: "*I didn't try to take his car keys off him to stop him from driving but I told him he shouldn't drive because he had been drinking. I told him that twice. ... Steven also said that he does it all the time and that he would be alright. By that I took it to mean that he drinks and drives all the time.*"³
8. After Mr Johnstone dropped them home, the girls 'snuck out' of the house and the three headed back to the party, arriving there at around 1.00am. Mr Johnstone parked his sedan outside the front of the house.
9. A group of males subsequently approached Mr Johnstone and surrounded his vehicle where a physical altercation occurred over a debt. Mr Johnstone then drove off under heavy acceleration alone, and angry, towards his home address in Ivanhoe.

¹ Refer to p.105 of inquest brief

² Refer to p.110 of inquest brief

³ Refer to p.117 of inquest brief

10. Mr Johnstone travelled onto Plenty Road at high speed. A witness who was also travelling on Plenty Road observed Mr Johnstone's vehicle: *"..It was doing approximately 180km/hr or faster. The engine was revving flat out. I think he was going as fast as he possibly could."* Mr Johnstone continued on to Ivanhoe.
11. On the same evening, a group of friends including Ben Hall, Mathew Lister and Anthony and Elissa Iannetta 'hung out' together in the Mill Park and Bundoora areas. Late that evening the group attended the address in Belmont Road Ivanhoe where Ben Hall and Steven Johnstone resided. William Te-Whare, the younger brother of Steven Johnstone, was staying at the house overnight and was woken by the group when they arrived.
12. Mr Lister and the Iannetta siblings were hoping to get a lift with their other group of friends to Preston so they could make their way home however there was no room in their vehicles. The three were keen to get home and did not want to stay overnight at the Ivanhoe house. Elissa stated: *"As soon as the others left we decided that we would have to just stay at the house overnight and sleep there until morning. Neither Ben or Will had a car and we had no way of getting home or to the station anymore."*⁴
13. The group had just seen off their friends and were about to go to a local convenience store when Mr Johnstone arrived at the Ivanhoe address. Standing in the street outside the residence at this time were Ben Hall, William Te-Whare, Mathew Lister and Anthony and Elissa Iannetta. Mr Johnstone asked Mr Hall and Mr Te-Whare to go with him to return to South Morang. The two were easily coerced. Anthony Iannetta and Mathew Lister asked Mr Johnstone for a lift to Preston to which Mr Johnstone agreed, telling them to get in. With respect to Mr Johnstone at this point, Elissa stated: *"He got out of the car and he seemed OK to be driving and he was just saying for us to get into the car. He was saying it hurriedly and was just trying to get us all in the car quickly. He didn't say why he was just in a real hurry."*⁵
14. The group of five then got into the car with Mr Johnstone, which was now overloaded. Mr Johnstone left the address and headed back towards South Morang. He had no intention of dropping the others off first.

⁴ Refer to p.95 of inquest brief

⁵ Refer to p.95 of inquest brief

15. Mr Johnstone's younger brother William Te-Whare was in the front passenger seat. Ben Hall was seated behind William Te-Whare, with Mathew Lister to his immediate right. Elissa was the other centre rear seat passenger, seated beside her brother, Anthony, who was seated against the rear driver side door.
16. Mr Johnstone left the address and travelled to nearby Waterdale Road where he then travelled north. The group of friends who had just left the Ivanhoe address before Mr Johnstone arrived were also heading north on Waterdale Road and not far from the Ivanhoe address when Mr Johnstone passed them at high speed. A number of those persons describe the blue Ford sedan overtaking their vehicle at speeds up to 150km/h on the wrong side of the road. They further describe Ben Hall hanging out the rear passenger side window of the vehicle, calling for them to follow and indicating that there was a 'fight'.
17. The Ford sedan continued at speed towards Latrobe University before turning left into Kingsbury Drive towards Plenty Road. A witness was standing in Haig Street, near Waterdale Road, and saw the Ford sedan pass. That witness stated: *"I hadn't quite got to the intersection when a car went 'whoosh' past me. I got a maximum of about 2 seconds to see the front of it. I would estimate the speed above 150 kilometres hour"* Waterdale Road and the other roads travelled by the Ford sedan are significant feeder roads through residential and light industrial areas with varying speed limits up to but not exceeding 80km/h.⁶
18. Mr Johnstone turned right from Kingsbury Road onto Plenty Road and headed northeast or outbound towards Bundoora. He continued to drive at speed and travelled through a number of red lights. It is believed that around this time Mr Johnstone contacted another brother on Anthony Iannetta's mobile phone whilst driving.⁷ The conversation lasted approximately four minutes whilst Mr Johnstone was driving at these high speeds. Mr Johnstone was trying to 'recruit' his brother and some of his friends to also join them and travel to South Morang. His brother was at a party further along Plenty Road and an arrangement was made to meet up with his brother and the others at University Hill Shopping Centre. His brother indicates Mr Johnstone was angry and seeking revenge for the earlier incident.⁸

⁶ Refer Exhibit 17

⁷ Refer Exhibit 24.

⁸ Refer to p.147 of inquest brief

19. Two witnesses travelling together were also heading outbound on Plenty Road, near the Mount Cooper Estate, when the Ford sedan passed them. One stated: *".... I was travelling at about 80 at the time in the 80 zone and this car passed me extremely fast. In relation to my car, I suggest they would have been doing 120 or more.... It was that fast that they were gone very quickly..."*. That witness continued to say: *"After they passed me I saw that they then moved into my lane and were still heading towards the intersection, which was still showing a red light. They travelled up to the light and braked and slowed down a bit, which I think was because there was a car crossing through the intersection which they waited for before they then drove through the red light and continued along Plenty road. To me they then accelerated away again and were travelling at high speed once more."* That witness then goes on to state: *"I then watched as the car approached a road I know as Settlement Road, which was showing a red light also. ...The car then drove up to the intersection, still travelling in the middle lane and as they did at the intersection at Officeworks, they braked before driving through the red light again."*
20. According to Elissa: *"We had been driving up the main road for a while and were still speeding and running red lights when we then stopped at Bundoora Square."*
21. For reasons unknown, there appears to have been a breakdown in communication between the two brothers and Mr Johnstone stopped at the Bundoora Square Shopping Centre. Here he pulled into the car park where the group waited for the brother and his friends to arrive. Instead, that group had stopped further up the road at University Hill.
22. Although there was now an opportunity for Mathew Lister and the two Iannetta siblings to get out of the car, they remained with the others in the vehicle. According to Elissa, *"I'm not sure why we got back in the car, maybe because no one was scared at that time. But after we left, Steven started driving faster and that is when some of us became scared."*⁹
23. With all persons still seated in their original positions, it is believed Mr Johnstone became more enraged or hurried due to his brother's 'no-show' and left the shopping centre car park and continued on towards South Morang, now travelling at even greater speeds.
24. A witness and his wife were also travelling outbound on Plenty Road and were passing under the Metropolitan Ring Road overpass about to turn right onto the Ring Road. The Ford sedan

⁹ Refer to p.96 of inquest brief

passed them at high speed and was all over the roadway. The witness stated in part: *"...Suddenly I saw a blue BF Falcon XR6 sedan pass me on the inside ... It passed me as if I was not moving at all. The Falcon was in the left hand lane ... The Falcon had to cross all three lanes to make it around the bend. ... The engine was screaming. It was revving right out, it was full throttle. I estimate his speed to be approximately 200km/h."*

25. A further witness was in a taxi, also travelling north on Plenty Road, just north of McKimmies Road. That witness stated: *"... a car went past us with noise and a speed of nothing I have ever seen on a legal road in my life... The noise was phenomenal, it was something that you would hear and see at a race track."*
26. Elissa's recollection of the moments before impact tells of a frightening situation: *"I remember that we had just overtaken a car and then gone through another red light when I looked over Steven's shoulder and saw the speedo was reading between 140 and 150. I was getting scared at this time as was Anthony and I could also see that Matt was scared by the look on his face. Nothing was being said to Steven at this time, probably because they didn't want to be whimps or they were scared of Steven, I don't know. But we were definitely scared, I was more scared that if we did crash we all get really badly hurt and I was starting to think more and more that we might crash."*¹⁰
27. The Ford sedan continued north at high speed and approached the intersection with Childs Road to the left and Blossom Park Drive to the right, approximately 500 metres north of McKimmies Road. There was a group of cars at the intersection which had just started to move away after the lights turned green. There was a single vehicle on the inside or left lane and three vehicles in the outside or right lane.
28. As the last of the three vehicles in the right lane entered the intersection, Mr Johnstone drove into the right turn lane for Blossom Park Drive and attempted to overtake all three cars in the outside lane, travelling to their outside. The front two cars had already crossed the intersection, forcing Mr Johnstone to drive up onto the centre median strip as he continued his attempt to overtake the vehicles. The Ford travelled along the edge of the grassed centre median for a short distance before Mr Johnstone lost control of the vehicle and it began to yaw back across the roadway to the left in front of the other vehicles. The vehicle was still

¹⁰ Refer to p.96 of inquest brief

travelling at high speed and at a relative constant velocity. The sedan rotated in a slow anti-clockwise rotation and yawed across the roadway to the left, with the vehicle almost side on when it left the bitumen surface on the far side of the road. The vehicle continued to slide sideways when it got onto the grassed surface on the left side of the road before slamming driver side first into large tree. Such was the speed and ferocity of the impact it uprooted the large tree completely from the ground and was able to spin clockwise around the base of the tree before the tree returned to the ground. The vehicle suffered massive impact damage with the tree coming to rest on top of the vehicle facing with the foliage to the north and trunk to the south.

29. As a result of the massive impact Steven Johnstone, William Te-Whare, Benjamin Hall, Mathew Lister and Anthony Iannetta were killed instantly. The investigation determined that Anthony and Elissa had been wearing a seatbelt at the time of impact while Mathew Lister and Ben Hall were not. Due to the extent of the damage, police were unable to determine whether the two front seat passengers were wearing a restraint.¹¹

Collision Reconstruction

30. Leading Senior Constable Jenelle Mehegan of the MCIU, a qualified Collision Reconstructionist, attended and inspected the scene. LSC Mehegan determined that the vehicle was travelling at a minimum of 150kph when it first commenced to yaw to the left and was travelling at 106kph when it impacted the tree.

Mr Johnstone's licensing and offending history

31. Mr Johnstone first obtained a probationary "P1" licence on 8 January 2009 and he held a current licence at the time of the incident. The P1 period was set to end on 7 August 2010. A number of restrictions were imposed on Mr Johnstone as a P1 driver under Victoria's graduated licensing system, including a zero blood alcohol concentration (BAC) and a limit of one peer passenger.
32. In the short period in which he held a driver's licence, Mr Johnstone had accumulated the following traffic offences:
 - 16 February 2009: Breaching the peer passenger restriction.

¹¹ Refer to p.11 of inquest brief

- 5 March 2009: Exceeding the speed limit by 15-25kph.
 - 5 September 2009: Exceeding the speed limit by 25-30kph.
33. As a result of the 5 September 2009 offence, his licence had been suspended for one month. Due to his past offending, VicRoads advised that at the time of the crash Mr Johnstone was in fact subject to a one passenger of any kind restriction in addition to the peer passenger restriction.¹²
34. Shortly after this fatal crash occurred, Victoria Police advised the Court that an administrative error was identified within the system that managed demerit point data. Effectively, the error meant that demerit points accrued by Victorian drivers for a peer passenger restriction offence were not applied. There was some speculation as to whether this error would have affected the licence status of Mr Johnstone. The issue was not further explored at the inquest however as I was satisfied the error had since been rectified, while a number of other variables could have influenced his licence status on the day.¹³ Further, one could not be sure that Mr Johnstone would have refrained from driving on the night of the crash even if he had indeed been suspended.

The Vehicle

35. The vehicle involved was a blue 2007 Ford Falcon XR-6 sedan, with a standard 6 cylinder petrol injected automatic transmission. The vehicle was fitted with A.B.S. and S.R.S. with airbags at both front seating positions and standard alloy XR6 rims. LSC Miles stated, "*The car itself, while not exceeding the power-to-weight ratios for "P" plate drivers, is still a large vehicle, with a large engine capacity, easily capable of speeds of 200 kilometres per hour or more.*"¹⁴ The vehicle was owned by Mr Johnstone and registered to his parents' Wallan address. It was unregistered at the time of the crash. The vehicle was purchased on 25 October 2008 and was under finance, however the loan repayments were not being met and the vehicle was to be repossessed.
36. The Victoria Police Mechanical Investigation Unit inspected the Ford sedan following the crash. The mechanical inspection did not reveal any mechanical fault which would have caused or contributed to the collision and there were no performance modifications identified.

¹² Refer to p.20 of Ms Cavallo's statement

¹³ T.3

¹⁴ Refer to p.228 of inquest brief

Environmental conditions

37. At the time of the collision it was dark, the roads were dry and it was a relatively mild night. The police investigation did not identify any issues with the road environment that may have contributed to the collision.

Post Mortem Examinations

38. An external examination was performed by Dr Paul Bedford, Forensic Pathologist at the Victorian Institute of Forensic Medicine. He formulated the cause of death and in his Inspection and Report noted by way of comment that *“there are multiple skeletal injuries leading to extensive blood loss and death.”*
39. A Toxicology Report revealed the presence of alcohol at a level of 0.19 g/100mL. In an attachment to that report it was noted in part:
- The legal limit for blood ethanol for fully licensed car drivers is 0.05% (gram/100mL).
 - Blood Alcohol Concentrations (BAC) in excess of 0.15% can cause considerable depression of the Central Nervous System (CNS).
40. I note that Mr Johnstone was subject to a zero BAC limit as a probationary driver. Toxicology tests were also conducted on the four deceased passengers, which revealed:
- Anthony Iannetta had a BAC of 0.06g/100ml.
 - Ben Hall had a BAC of 0.11g/100ml.
 - William Te-Whare had a BAC of 0.00g/100mL.
 - Mathew Lister had a BAC of 0.03g/100ml.

Coroner’s Role

41. The coroner’s role is to investigate deaths independently not only for the purposes of establishing the medical cause and circumstances of those deaths but also to contribute to a reduction in the number of preventable deaths and the promotion of public health and safety.¹⁵

¹⁵ Preamble, Coroners Act 2008 (Vic)

In this role and in the course of investigating this death I have been assisted by the Coroners Prevention Unit.¹⁶

The Inquest

42. Given the magnitude of loss of life that had occurred, I deemed there was a public interest in the crash and a need to highlight young driver, and in particular, passenger safety issues. A one day inquest was held on 13 November 2012. Evidence was heard from the following individuals:

- LSC Miles, police informant.
- Ms Elizabeth Waller, Major Projects Manager for Road Safety at the Transport Accident Commission (TAC).
- Ms Antonietta Cavallo, Manager Road User Behaviour at VicRoads.

43. Both Ms Waller and Ms Cavallo provided comprehensive reports upon request to the Coroner to inform the coronial investigation prior to the inquest.

Scope

44. As I indicated at the commencement of the inquest, a primary focus was to examine the relevant measures in place to reduce the incidence of crashes of this nature and to identify any opportunities to strengthen these efforts. While Mr Johnstone was a probationary driver, the intention was not to critique the current graduated licensing system in place. The evidence was clear that Mr Johnstone's driving behaviour was not merely the result of inexperience or immaturity associated with his young age, but in part due to a complete disregard for the various laws in place to prevent such a horrific incident.

45. The specific safety issues explored at the inquest included:

- Mr Johnstone's behaviour on the night in the context of young drivers generally.

¹⁶ The Coroners Prevention Unit is a specialist service for coroners created to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety.

- The capacity for young people to develop the necessary resilience and decision-making skills required to resist peer pressure and make safe decisions in the context of either seeking or accepting a ride with a high-risk driver – including ways to achieve this.
- Peer passenger legislation and the possibility of imposing penalties on passengers who knowingly breach a passenger restriction.
- Night driving restrictions for young probationary drivers.
- Longer-term engineering solutions to address high-risk driving behaviour (specifically excessive speeding and drink driving) among those drivers with little self-control, and who are not amenable to conventional road safety measures.

Issues and Evidence

Mr Johnstone's behaviour

46. From the outset it was clear that despite young drivers being over-represented in our road trauma statistics¹⁷, the majority of young drivers do behave responsibly on our roads most of the time, and their behaviour can generally be distinguished from the deplorable¹⁸ manner of driving exhibited by Mr Johnstone. Mr Johnstone was considered to fall at the extreme end of a minority group¹⁹ of high-risk young drivers who are not influenced by conventional road safety interventions, unwilling to abide by the law and seemingly immune to the prospect of being intercepted by police.
47. LSC Miles did not hold back in his evidence to the inquest; asserting that it was Mr Johnstone who was solely to blame for the deaths. According to his evidence Mr Johnstone had shown *"no respect for the law or any other persons around."*²⁰ He described the crash as *"one of the worst cases I've come across in the six years I've been in Victoria Police and the finger*

¹⁷ VicRoads advised that probationary drivers have three times the crash rate of more experienced drivers, regardless of kilometres driven (p.3 of Ms Cavallo's statement). TAC also noted that young drivers account for 22% of the TAC's hospitalised claims (p.2 of Ms Waller's statement).

¹⁸ As described by LSC Miles, T.12

¹⁹ VicRoads advised that around 7% of young Australians fall into this minority group of high-risk individuals (Smart et al. 2005 as referenced by Ms Cavallo on p1 of her statement).

²⁰ T.13

needs – can only be pointed at one person and that's Steven Johnstone as – that has caused the collision."²¹

48. The thrust of his evidence revealed that Mr Johnstone had driven at speeds in the order of 150kph in 40-60kph zones, ran red lights, was using his mobile phone whilst driving, was in breach of his P1 licence conditions including zero blood alcohol (twice Mr Johnstone was told not to drive but Mr Johnstone stated *"I do it all the time."*²²), driving with more than one passenger and failing to ensure sufficient and properly fastened seatbelts for passengers. Mr Johnstone's vehicle was unregistered.

49. Ms Cavallo distinguished the profile of Mr Johnstone from the majority of other young persons, stating in part:

*"They're unlikely to respond to fines, demerit points or license or vehicle sanctions that help control behaviour of most drivers. Such young people require specific professional intervention when they come to notice in childhood and/or adolescence to address key areas of deficient such as impulsiveness, alcohol, substance abuse. They are different to the majority of young drivers who are at risk mainly due to effects of youthfulness, immaturity, experience and lifestyles and who respond well to graduated licensing and traffic enforcement systems, and who become safe drivers over time and gain experience..."*²³

50. Ms Cavallo noted that treating young people with *"signs of impulsiveness, .. lack of control, ...personality and adjustment emotional issuesis not the realm of VicRoads"* however she highlighted that in an effort *"...to reduce social and health harms.."* it was necessary to look *"...more and more to early intervention to childhood and preadolescent, adolescent times."*²⁴

51. In reviewing recent research into young driver risk-taking behaviour Ms Cavallo told the inquest that *"...most researchers are now saying that it takes time for - particularly young males and, some young women - to really grasp risk, the concept of risk, and the consequences on behaviour.....as a result, they can lack a - some judgement when put in*

²¹ T.p.13

²² T.12

²³ T.17-18

²⁴ T.p18

risky situations, they have a lower sensitivity to risk...”²⁵ Ms Cavallo went on to refer to other research into managing such behaviour through “vehicle technology” and the various options under consideration, discussed below.

Education of young road users (potential passengers and drivers) and the role of parents

52. In regard to the role of the passengers, LSC Miles stated in part: “Ben Hall was able to be coerced by his friend...The others were trying to get home... sometimes with the young adults and the youth that we have it’s, it’s a bit about just following along.....they were all holding on for dear life, no-one was ... wanting to speak up or anything like that, they were all in fear.”²⁶
53. The passengers all had an opportunity to alight from the vehicle when the group stopped briefly in the car park of Bundoora Square. In their submission, VicRoads suggested that the passengers may not have opted to leave the vehicle however because “given the location, the time of night and their ages, that may not have appeared to them as a real choice, as they might not have felt safe being left alone late at night with no means of getting home.”
54. Evidence was heard from both Ms Cavallo and Ms Waller regarding the extensive range of educational and behavioural programs available to improve the capacity of young people to develop the necessary resilience and decision-making skills required to resist peer pressure and make safe decisions, in the context of either seeking or accepting a ride with a high-risk driver. These included for example, *Make a Film, Make a Difference*, the “Vanessa” mobile cinema and *Look After Your Mates*. Both the TAC and VicRoads also currently support the community program *Fit2Drive*, in which responsible peer passenger behaviour features. Approximately 150 secondary schools across Victoria currently participate in the program, mainly at Year 11 level. This is an enrichment program to enhance the other core road safety education initiatives. The inquest did not go so far as to determine whether the five passengers in this crash had ever participated in such a course.
55. Ms Cavallo noted however that there was little published evidence on the success of these and similar programs in modifying behaviour and, importantly, in reducing crash risk.²⁷ While the

²⁵ T.22-23

²⁶ T.13,14

²⁷ Statement of Ms Cavallo, p10 (para 4.7).

Fit2Drive program was based on best practice principles, Ms Cavallo advised that no quantitative evaluation of the impact of the intervention was currently available but they were planning to try to do so in future.²⁸ In their submission, TAC emphasised their desire to ensure that programs were positive and sustainable.²⁹

56. The inquest touched on the role of parents and carers in addressing road safety issues for young persons. Both VicRoads and the TAC emphasised the vital role that parents and carers can have in influencing their children's driving habits from an early age, and monitoring their behaviour in later years. VicRoads has developed a range of online resources to support parents for supervising learner drivers and supporting their probationary drivers as part of the graduated licensing system. Ms Cavallo referred to material currently available and also further developments aimed at purchasing safer vehicles for their children and reinforcing graduated licensing rules.³⁰
57. In discussing the role of parents/carers in managing driver and passenger safety, Ms Cavallo stated in part: "...*We are trying to capitalise on the influence that parents can have...research suggests...parents can play a very positive role. It's not an easy role as they're negotiating this route to independence with their child but they can play a very positive role.*"³¹
58. Ms Waller provided similar evidence: "...*parental role modelling can play an important role in preventing the development of problem behaviours.....when it comes to young people, we like to start early, the earlier the better.. it goes right back to the very early childhood...*"³²
59. Of course there are inherent challenges for parents and carers in monitoring their children, particularly as they move to a stage of independence and often move away from home. Ms Waller for example told the inquest that parents may feel less empowered in influencing their children's behaviour "...*because their children are reaching adulthood, and that they may ... engage in those behaviours anyway...so this isn't an easy thing to resolve at all, but what we can support parents...research shows ...that where you have a really strong connection with*

²⁸ T.34

²⁹ Submission of TAC

³⁰ T.30-31

³¹ T29, 30

³² T.54-55

*young people and another important person in their life, particularly an adult, that can really improve their safety.. ”*³³

60. Both TAC and VicRoads advised that they were also working together to develop a parenting strategy and communication program for parents with children in their first six months of solo driving. This program is to be trialled in 2013. The resources will emphasise the importance of monitoring children, understanding where they are, who they are with, when they are coming home, and setting boundaries around their behaviours or around their mobility.³⁴

Imposing penalties on passengers who breach passenger restrictions

61. The presence of multiple passengers significantly increases a young driver’s crash risk.³⁵ Peer passenger restrictions, first introduced in Victoria in July 2008, are designed to lessen this crash risk by restricting the number of peer passengers (aged 16-21 years) for a probationary “P1” driver. Another obvious benefit is that in the event of a collision, fewer vehicle occupants are at risk of injury. Ms Cavallo advised the inquest that a preliminary evaluation of Victoria’s graduated licensing system indicates that first year probationary drivers involved in casualty and serious crashes with two or more peer passengers has reduced by almost 60% following the introduction of this restriction.³⁶
62. The effectiveness of this measure is contingent on compliance. Currently when a passenger restriction is breached a penalty applies only to the driver in control of the motor vehicle. Mr Johnstone was clearly not influenced by the likely consequences of breaching the passenger restriction. The prospect of introducing a penalty for passengers to further increase compliance levels with the passenger restriction was discussed at the inquest.
63. Various complications were outlined by Ms Cavallo that could make such a penalty challenging to implement.³⁷ Further, there was no known research on the effectiveness of such an approach, while the motivations for travelling illegally as a peer passenger could also vary.

³³ T.56

³⁴ T.55

³⁵ T.27

³⁶ Refer to p.26 of *Victoria’s Graduated Licensing System Evaluation Interim Report* released February 2012.

³⁷ T.28

64. Ms Cavallo did however advise that the existing passenger restriction was often used by young individuals as a justification not to ride illegally as a passenger in a probationary driver's vehicle where the restriction applies. Ms Cavallo stated in part: *"What we do know in talking to ... young people since we've had the peer passenger restriction in place since July 2008 in Victoria is what peers tend to do is say since the laws come in I use that law as an excuse not to get in..."* She went on to indicate that it was surprising because despite the initial concern of young people, *"... once it comes in it can be very empowering in an interesting way..."*³⁸

Night time driving restrictions

65. The crash risk for young drivers is much greater when they drive at night.³⁹ Ms Cavallo advised that previous Victorian governments had considered the introduction of night driving restrictions for probationary drivers in their first year of driving. Despite research evidence overseas that night driving restrictions are highly effective in reducing young driver crash rates, such an intervention appears to remain somewhat unpopular.

66. Ms Cavallo stated that Western Australia is currently the only Australian jurisdiction to have introduced a night driving restriction. Importantly however, the minimum age to drive solo in WA is 17 years (in contrast to 18 years for Victoria). The restriction may also have an impact on the mobility of young people and their personal safety. Whether Mr Johnstone would have complied with a night driving restriction is of course also questionable.

67. In their submission to me, VicRoads advised that they would continue to monitor research and explore further regulatory interventions such as night driving restrictions and offences for peer passengers to enter vehicles. However, VicRoads noted that: *"..these particular options are less likely to be effective in reducing the road toll involving the atypical group (which is largely immune to the positive effect of regulatory intervention), could be difficult to enforce and risk creating an unjustifiable burden on the vast majority of mainly compliant young drivers."*

³⁸ T.28

³⁹ Statement of Ms Cavallo, p14.

Engineering strategies to address drink driving

68. With respect to drink driving Ms Cavallo stated in evidence that *“as soon as we start seeing the behaviour emerge, we do apply interlocks. It's just if we can detect them early enough.”*⁴⁰ Yet despite admitting that he regularly drove whilst under the influence of alcohol⁴¹, Mr Johnstone had never been apprehended for drink driving. Had he been, an alcohol interlock device may have been fitted to his vehicle upon being relicensed. The critical role of on-road enforcement of drink driving laws is evident here.
69. The possibility of expanding the circumstances in which alcohol interlock devices are fitted to the vehicles of certain drivers, such as those subject to a zero BAC, was put to Ms Cavallo. Ms Cavallo stated *“ .. It's not a cheap intervention, there's a balance there around the cost for the total community versus the benefit to try and prevent it, but it's not something that should not be looked at.”*
70. Ms Cavallo also advised the court that passive alcohol sensor technology is currently under development in Europe and the USA. These promising devices can detect alcohol in exhaled breath or the skin of a driver and prevent the vehicle from starting if the driver is impaired by alcohol.⁴² In the long term, these devices could offer an effective means to address drink driving on our roads, particularly for those drivers with no ability to separate drinking from driving.

Engineering strategies to address excessive speeding

71. In her statement, Ms Cavallo noted that optional electronic speed limiting devices were becoming available in some luxury model light vehicles, and in some vehicles after-market fitting was possible. These devices are capable of detecting the speed limit in a given zone and preventing the vehicle from exceeding the limit by adjusting the fuel supply and/or applying the brakes independent of driver input.⁴³ For some who do not have a strong level of self control, having speed limiters in the future might be one way to try to reduce extreme risk

⁴⁰ T.50

⁴¹ Refer to inquest brief, p.117

⁴² T.25-26

⁴³ Statement of Ms Cavallo, p.8

taking.⁴⁴ Ms Cavallo also discussed a promising development by Ford in the United States called “My Key” technology where an upper speed limit can be programmed into a unique set of keys for a young driver, while a separate set can be used by the parents.⁴⁵ Ms Cavallo advised that this was an area being closely monitored and would like to see trialled.⁴⁶

72. Ms Waller also noted that vehicle technologies offer tremendous potential but it was a long-term intervention.⁴⁷ In their submission to me, TAC advised that they will continue to work collaboratively with their road safety partners to support research in the development of longer term engineering technology to support young person safety.

Finding

73. I find that Mr Johnstone unfortunately died from multiple injuries when the vehicle he was driving on Plenty Road, Mill Park struck a tree causing not only his senseless death but also the tragic loss of life of four of the five passengers⁴⁸ travelling with him. Mr Johnstone was in breach of the road rules and his licence conditions. He was grossly intoxicated and driving at ferocious and excessive speeds in the period leading up to the collision.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

1. The extensive array of road safety measures in place that were designed to prevent such a horrific crash from occurring sadly had no impact on Mr Johnstone. He not only risked his life but also the lives of the five passengers in his vehicle and other innocent road users who could have easily come into his path on the night. A driver such as Mr Johnstone clearly presents a significant challenge to road safety agencies. TAC submitted to me that whilst Mr Johnstone was seemingly immune to various positive influences, *“this is not a reason to give*

⁴⁴ T.23-24

⁴⁵ T.24

⁴⁶ T.25

⁴⁷ T.70

⁴⁸ Coroners Nos. 255/10, 256/10 257/10 and 258/10.

up” and they would continue to work together in an integrated approach with their road safety partners.

2. Victoria’s road safety strategy is based on a principle that human error is inevitable and that every road user deserves to feel safe on our roads⁴⁹. It is clear in this case that if we are to avoid a repeated incident, prevention strategies cannot rely solely on a driver’s willingness to comply with existing laws.
3. While Mr Johnstone was resistant to the various road safety interventions in place, five other individuals were present on the night of this crash and at one stage, all had an opportunity to alight from Mr Johnstone’s vehicle. Having already travelled at excessive speed and run multiple red lights, it is alarming that none of these passengers were able to make the decision to leave the vehicle or confront the driver. It is likely a difficult situation faced regularly by many young persons. Strengthening the capacity of young persons to make safe decisions through community and school-based programs should be an ongoing goal for road safety agencies. To deter young persons from breaching a peer passenger restriction in the first instance, the feasibility of imposing penalties for passengers in addition to the driver seems worthy of further investigation.
4. Mr Johnstone had incurred two traffic offences for speeding in the short period in which he was licenced. His Ford XR6 was capable of reaching speeds of over 200kph. He travelled at speeds of up to 180kph on the night of the crash and displayed no sense of self-control, exceeding the speed limit throughout the night. It is difficult to comprehend why it is necessary for our motor vehicles to be capable of travelling at such speeds well in excess of the maximum speed limit imposed on our public roads. While there is currently poor consumer demand for speed limiters and considerable time is required before such technology becomes widespread across our vehicle fleet,⁵⁰ it is promising to hear that such technology is under development and may one day be an effective method to address such extreme behaviour.⁵¹
5. For Mr Johnstone to drive intoxicated on the night and in such an appalling manner over a sustained period of time and not come to the attention of authorities is extremely concerning

⁴⁹ Refer to *Victoria’s Road Safety Strategy – Have Your Say* discussion paper released September 2012.

⁵⁰ T.23-24

⁵¹ T.23

and I strongly support Victoria Police in their continued efforts to detect high-risk drivers on our roads. The minority group of high-risk drivers pose an unacceptable threat to other innocent road users. With respect to enforcement, I also note that Victoria's hoon legislation was strengthened on 1 July 2011 via the *Road Safety Amendment (Hoon Driving) Act 2011*. Motor vehicles can now be impounded for 30 days in contrast to the former 48 hour period. A vehicle overloading offence (having more passengers than there seatbelts in a car, as was the case in this incident) has also been made an offence subject to vehicle impoundment.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

1. In an effort to improve compliance levels with passenger restrictions imposed on probationary drivers, I recommend that VicRoads undertake a review into the appropriateness and feasibility of creating an offence for passengers who knowingly breach a vehicle passenger restriction.
2. I recommend that VicRoads examine the impact of the night driving restriction currently imposed on probationary drivers in Western Australia, to gather further evidence to inform the ongoing review into the feasibility of night driving restrictions for probationary drivers in Victoria.
3. I recommend that VicRoads and the Transport Accident Commission (TAC), in association with their other road safety education partners, undertake an evaluation of the "Fit2Drive" community road safety program for secondary school students to determine the success of the program in empowering participants to make safe decisions, modifying their behaviour and ultimately in reducing their crash risk.
4. I recommend that VicRoads investigate options to expand the circumstances in which alcohol ignition interlock devices are fitted to the vehicles of certain drivers who have demonstrated a propensity to repeatedly engage in high-risk driving behaviours, particularly probationary drivers.
5. I recommend that VicRoads, in collaboration with their road safety partners, continue to monitor and trial where necessary, emerging vehicle safety technology with the real potential

to address excessive speeding and drink driving, in particular for those high-risk drivers who have demonstrated poor self control and a failure to respond to conventional road safety interventions. Such technology would include passive alcohol sensors, vehicle speed limiters and Ford's "My Key" technology.

I direct that a copy of this finding be provided to the following agencies directed a recommendation:

Gary Liddle, Chief Executive Officer – VicRoads

Janet Dore, Chief Executive Officer – Transport Accident Commission

I direct that a copy of this finding be provided to the following individuals for information purposes only:

Interested Parties

The Hon. Terry Mulder, Minister for Roads

The Hon. Peter Ryan, Minister for Police and Emergency Services

The Hon. Robert Clark, Attorney-General

Ken Lay, Chief Commissioner of Police

Signature:



HEATHER SPOONER
CORONER

Date: 21 December 2012

