IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 4263

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	Simon McGregor, Coroner
Deceased:	**John Edwin Wilks**
Date of birth:	6 December 1940
Date of death:	26 August 2017
Cause of death:	Bronchopneumonia complicating fractured ribs sustained in a fall on a bus
Place of death:	Monash Medical Centre 246 Clayton Road, Clayton, Victoria

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INTRODUCTION

1. John Edwin Wilks was a 76-year-old wheelchair user who lived in Mulgrave at the time of his death.

2. On 13 August 2017 Mr Wilks was riding the Route 813 bus when it turned from Police Road onto Springvale Road. During this turn, Mr Wilks' wheelchair tilted and fell onto its side.

3. Mr Wilks was injured in the fall and was admitted to the Monash Medical Centre that day. His condition deteriorated and he died on 26 August 2017.

PURPOSE OF A CORONIAL INVESTIGATION

4. Mr Wilks' death was reported to the coroner as it appeared to have resulted, directly or indirectly, from an accident or injury and was therefore a 'reportable death' for the purposes of the *Coroners Act 2008*.

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

6. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

7. The Coroner's Investigator, Leading Senior Constable Robert Hansen of Victoria Police, prepared a coronial brief in this matter. The brief includes statements from witnesses including family, the forensic pathologist who examined Mr Wilks, a treating clinician and investigating officers.

8. LSC Hansen also included information relating to wheelchair safety on public buses. The Coroners Prevention Unit (CPU)[1] obtained further materials regarding this issue.

9. After considering all the material obtained during the coronial investigation I determined that I had sufficient information to complete my task as coroner and that further investigation was not required. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

10. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established on the balance of probabilities.[2]

11. In considering the issues associated with this finding, I have been mindful of Mr Wilks' basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act* 2006 (Vic) (Charter). In this investigation, sections 8 (Equality), 9 (Right to life), and 10 (Freedom from degrading treatment), 12 (Freedom of Movement) and the Public Authorities Obligation in section 38 are all particularly relevant.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

12. Mr Wilks suffered a stroke around 2013. This caused paralysis in his left side and he required the use of a wheelchair. Although unable to stand, he was able to transfer himself in and out of a wheelchair. His daughter, Aileen Pierce, states that he '*could get around and was very independent*'.[3]

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[1] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[2] This is subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[3] Statement of Aileen Pierce dated 1 February 2018, Coronial Brief.

Injury on 13 August 2017

13. On 13 August 2017 Mr Wilks was travelling to a club meeting in his motorised wheelchair. At 9.40am he boarded a Route 813 bus (operated by Ventura Bus Lines) on Hansworth Street in Mulgrave. The driver, Laurentiu Pop, assisted him in boarding.[4]

14. Mr Wilks positioned himself on the left side of the bus in a zone marked for disabled passengers. He was facing toward the front of the bus. A 'grabrail' ran along the wall of the bus near his left side.[5]

15. Mr Pop states that he asked Mr Wilks if he knew how to block his wheels and that Mr Wilks replied that he did. Mr Pop then asked it was alright to proceed and Mr Wilks said it was.[6]

16. Mr Pop proceeded along Route 813 onto Police Road and toward Springvale Road. At 9.48am Mr Pop made a left-hand turn onto Springvale Road, driving at around 26-27 kph.[7]

17. As the bus was turning, Mr Wilks' wheelchair began to tilt to the right and he shouted about his wheelchair being unbalanced. Mr Pop states that he slowed his turn after he heard Mr Wilks shouting. Mr Wilks' chair continued to tilt until it fell over onto its side. Mr Wilks fell out of the wheelchair and onto the floor of the bus, striking the floor with the right side of his body.[8]

18. Mr Wilks had not been holding on to the grabrail, which was near his paralysed left side.[9]

19. Several other passengers moved to help Mr Wilks. Following Ventura Bus Lines procedure, Mr Pop stopped at the next bus stop then went to assist Mr Wilks. Mr Pop and the other passengers assisted Mr Wilks back into his wheelchair. Mr Pop continued to the Springvale Railway station where he stopped and assisted Mr Wilks in leaving the bus.[10]

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4 Statement of Aileen Pierce dated 1 February 2018, Coronial Brief; Statement of Laurentiu Pop dated 27 January 2018, Coronial Brief.

5 Statement of Aileen Pierce dated 1 February 2018, Coronial Brief; Statement of Laurentiu Pop dated 27 January 2018, Coronial Brief; Still images from Ventura Bus Lines internal CCTV, Coronial Brief Exhibit 2.

6 Statement of Laurentiu Pop dated 27 January 2018, Coronial Brief.

7 Statement of Laurentiu Pop dated 27 January 2018, Coronial Brief; Incident report from Venture Bus Lines, Coronial Brief Exhibit 4.

8 Statement of Laurentiu Pop dated 27 January 2018, Coronial Brief.

9 Still images from Ventura Bus Lines internal CCTV, Coronial Brief Exhibit 2.

10 Ibid.

20. Mr Wilks told Mr Pop that he wasn't feeling well. Mr Pop asked if he needed any assistance but Mr Wilks said he did not because he had his phone. Mr Pop proceeded along his route.[11]

Treatment in hospital and deterioration

21. Mr Wilks called emergency services and was taken by Ambulance to Monash Medical Centre in Clayton. He was admitted to hospital with rib fractures on his right side and a small right haemothorax. He was initially treated with painkillers.[12]

22. On 16 August 2017, Mr Wilks became acutely short of breath and was diagnosed with pneumonia and respiratory failure. He required admission to the Intensive Care Unit (ICU) where he was treated for four days. He received intravenous antibiotics and intensive chest physiotherapy.[13]

23. Despite treatment, Mr Wilks' condition deteriorated. On 21 August 2017 he required transfer to the respiratory high dependency unit where he developed worsening respiratory failure. On 24 August 2017 Mr Wilks and his family decided to have no more medical intervention.[14]

24. On 26 August 2017 Mr Wilks was transferred to the palliative care unit at McCulloch House and he died shortly afterward.[15]

IDENTITY AND CAUSE OF DEATH

25. On 26 August 2017 Ms Pierce visually identified her father's body. Identity is not in dispute and requires no further investigation.

26. On 30 August 2017 Dr Sarah Parsons, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Mr Wilks' body and reviewed a post mortem computed tomography (CT) scan. Dr Parsons completed a report, dated

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[11] Ibid.
[12] Statement of Aileen Pierce dated 1 February 2018, Coronial Brief; Statement of Dr Ralph Junckerstorff dated 1 December 2017, Coronial Brief.
[13] Statement of Dr Ralph Junckerstorff dated 1 December 2017, Coronial Brief.
[14] Statement of Aileen Pierce dated 1 February 2018, Coronial Brief; Statement of Dr Ralph Junckerstorff dated 1 December 2017, Coronial Brief.
[15] E-medical deposition of Dr Melissa Mitchell dated 26 August 2017.

23 October 2017, in which she formulated the cause of death as '*I(a) Bronchopneumonia complicating fractured ribs sustained in a fall on a bus*'.

27. I accept Dr Parsons' opinion as to the medical cause of death.

INCIDENT INVESTIGATION AND REPORTING

Ventura Bus Lines

28. On 14 August 2017 Ms Pierce contacted Public Transport Victoria (PTV) to submit a complaint regarding her father's injury the previous day. During this call she described the circumstances of the injury and informed PTV that Mr Wilks was in hospital and that he had broken ribs and potentially had a punctured lung.[16]

29. PTV sent this information to Ventura Bus Lines (Ventura) that day. Ventura staff reviewed CCTV of Mr Wilks' injury. They concluded that no driver interview was required and did not initiate any disciplinary action. An email was sent to Ms Pierce and the matter was closed.[17]

WorkSafe

30. The *Occupational Health and Safety Act 2004* (OHS Act) requires any employer to notify WorkSafe if an incident satisfying the criterion in section 37 of the OHS Act occurs at a workplace under their management and control.[18]

31. WorkSafe advises that the term 'workplace' in the OHS Act applies to vehicles on which employees work.[19] The criterion in section 37 of the OHS Act includes any incident that resulted in '*a person requiring immediate treatment as an in-patient in a hospital*'.[20]

32. Upon reviewing the Coronial Brief, WorkSafe informed the Court that:

'*[I]t appears likely that Ventura Bus Lines was an employer with management and control of the bus on which the incident occurred and that the incident resulted in a person requiring immediate treatment as in-patient in hospital. If this was the case, once Ventura Bus Lines*

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[16] Email from Public Transport Victoria to Ventura Bus Lines dated 14 August 2017, Coronial Brief.
[17] Complaint Detail from Ventura
[18] *Occupational Health and Safety Act 2004* (Vic) s 38.
[19] Letter from WorkSafe to the Court dated 6 April 2018.
[20] *Occupational Health and Safety Act 2004* (Vic) s 37(1)(c).

became aware that the incident had resulted in the deceased being admitted to Monash Medical Centre, it should have notified WorkSafe regarding the incident.'[21]

Transport Safety Victoria and the Chief Investigator

33. The *Bus Safety Act 2009* (Vic) requires an accredited bus operator to notify the Director, Transport Safety of prescribed incidents, including an incident that results in '*a person requiring immediate treatment as an in-patient in a hospital*'.[22]

34. The Director, Transport Safety would then be required to report the incident to the Chief Investigator, Transport Safety (the Chief Investigator). Transport Safety Victoria has confirmed that the incident involving Mr Wilks' injury was not reported to them.[23]

Victoria Police Traffic Incident System

35. Victoria Police maintains a Traffic Incident System (TIS) database to record details of motor vehicle collisions or incidents.[24]

36. The Victoria Police Manual describes the event to which a TIS report attaches as a 'collision'. The term 'collision' is not defined in the Manual, nor is the term 'motor traffic incident'.[25]

37. Mr Wilks' injury was not reported to Victoria Police at the time it occurred, so there was no opportunity to record the incident in the TIS at that time.[26]

38. Police first became aware of the incident on 26 August 2017 when LSC Hansen and First Constable Brendan Cunningham were dispatched to Monash Medical Centre in relation to Mr Wilks' death. LSC Hansen and FC Cunningham did not report the incident to TIS at this time.[27]

39. The Victoria Police reporting guideline requires that a TIS report must be made '*where an injury is reported at a later time as a result of a collision previously identified as a non-injury*'. The deceased persons policy requires that '*where it is found the deceased has sustained an*

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[21] Letter from WorkSafe to the Court dated 6 April 2018.
[22] *Bus Safety Act 2009* (Vic) s 65; *Bus Safety Regulations 2010* (Vic) r 24.
[23] Letter from the Office of the Chief Investigator, Transport Safety to the Court dated 17 April 2018.
[24] Submissions on behalf of the Chief Commissioner of Police dated 1 August 2018.
[25] Ibid.
[26] Ibid.
[27] Ibid.

injury in a motor vehicle accident in the preceding 30 days', a Police member must take actions including '*amend the notes in the original TIS report*'.[28]

40. According to Victoria Police:

'*When LSC Hansen became aware of Mr Wilks' death he was then in possession of information that would allow a TIS report to be completed. At that time, the deceased persons policy required him to update a TIS report which did not exist because there had been no prior report made. The understandable conclusion LSC Hansen reached was that because there was no collision there was no need to record this information.*'[29]

41. LSC Hansen was concerned by this incident not becoming part of the TIS and reported concerns about the TIS reporting criteria to the Court when he provided the Coronial Brief.[30]

42. Along with reports from Victoria Police members, another source of information used by the TIS Support Team is notifications from the Coroners Court that a reportable death involving a motor vehicle has occurred. The Coroners Court did not notify the TIS Support Team about Mr Wilks' death.[31]

COMMENTS

43. In preparing the Coronial Brief, LSC Hansen researched the issue of wheelchair safety on public buses. He provided policy documents on this issue as annexures to the Brief and expressed concerns about two main issues:

    (a) reporting mechanisms and requirements for incidents such as Mr Wilks'; and

    (b) the lack of restraint mechanisms to prevent wheelchair-related injuries on public buses.

44. The CPU was directed to review LSC Hansen's documents and concerns.

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[28] Ibid.
[29] Ibid [reference omitted].
[30] Summary, Coronial Brief; Submissions on behalf of the Chief Commissioner of Police dated 1 August 2018.
[31] Submissions on behalf of the Chief Commissioner of Police dated 1 August 2018.

Chief Investigator's report and recommendations in 2006 injury

45. The Chief Investigator[32] investigated an incident in December 2006 which has similarities to Mr Wilks' injury.[33]

46. A bus passenger was seated on a powered mobility scooter, parked in an allocated space for such vehicles in the bus. He was holding onto a grabrail to stabilise himself for much of his journey. At one point he released the grabrail and engaged in conversation with another passenger. At this time the bus turned, and the passenger's scooter fell onto its side. The passenger was injured but did not die.[34]

47. The Chief Investigator identified three safety issues and proposed Recommended Safety Actions to respond to these issues. Although the first issue related specifically to the operator of the bus involved in the 2006 injury, the other two issues are relevant to Mr Wilks' case.

48. The second safety issue was that route buses were not required to display advisory signage warning that occupiers of mobility aids should maintain a secure handhold during transit. The Chief Investigator recommended that all suburban and interurban route bus operates display appropriate advisory signage to this point.

49. The passenger involved in the 2006 incident was able to secure himself by a handhold, but this is not the case for all wheelchair users. In particular, the grabrail on Mr Wilks' bus was next to his paralysed left side. Although it is possible that if he were oriented in the opposite direction he might have been able to secure himself using his right arm, many other wheelchair users will be unable to secure themselves by a handhold regardless of which direction they are facing.

50. The third safety issue identified by the Chief Investigator was the following:

'There is no legislative requirement for bus operators to provide for the restraint and securement of occupied wheelchairs and mobility aids by any means other than the physical ability of the occupant to maintain a grasp on available handholds. Industry stakeholders are

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[32] The Chief Investigator, Transport Safety is the successor in law of the Chief Investigator, Transport and Marine Safety Investigations, the entity which performed the investigation into the 2006 incident: *Transport Integration Act 2010* (Vic) s 179(3). I have not distinguished the two entities in this finding in order to avoid confusion and because of the similarities between their functions.

[33] Office of the Chief Investigator, Transport and Marine Safety Investigations, Transport Safety Investigation Report No 2006/05.

[34] Ibid.

yet to resolve questions regarding the formulation of standards and protocols to control and regulate the carriage of occupied, powered mobility aids.'

51. The Chief Investigator recommended the following safety action:

'That the Bus Industry Confederation develops standards and specifications for fixed on-board restraint systems for powered and other wheeled mobility aids on buses and coaches.'

Wheelchair restraint systems

52. The third safety issue remains relevant today. If a restraint system more effective than a handhold had been in place on Mr Wilks' bus, his death might have been prevented.

53. The CPU consulted a number of organisations involved in bus safety regarding their positions on wheelchair restraint systems. Their responses illustrate the continuing difficulties in this area but also suggest a path forward.

Chief Investigator, Transport Safety

54. The Office of the Chief Investigator confirmed that they still endorse the recommendations made following the 2006 injury. They also confirmed that they are unaware of any actions taken the bus industry as a result of these recommendations.[35]

55. The Chief Investigator has no powers to require entities to respond to their recommendations or to follow up on recommendations made in safety investigation reports.

56. I will not make a formal recommendation on the subject, but I would comment that amendments to the *Transport Integration Act 2010* giving the Chief Investigator powers to this effect might be beneficial to transport safety.

VicRoads

57. VicRoads advised that, where an occupant must travel in their wheelchair in a private vehicle or a wheelchair accessible taxi, Victorian law requires that the vehicle be equipped with a Wheelchair Tie-down and Occupant Restraint System (WTORS). This includes an occupant

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[35] Letter from the Office of the Chief Investigator, Transport Safety to the Court dated 17 April 2018.

restraint system (seatbelts) and a wheelchair restraint system that secures the wheelchair to the vehicle using at least four tie-down points with approved wheelchair restraints.[36]

58. VicRoads noted that the lead agency governing public route buses was Public Transport Victoria (PTV) but provided their views on the issue from a road safety standpoint regarding the transport of wheelchair users in vehicles.

59. VicRoads understand that, due to the design and construction of route buses, the fitment of wheelchair restraint systems such as a WTORS would present technical challenges. These include that, as the buses were not designed for the fitment of seat belts, their floor construction might be unable to withstand the forces of anchorage points, including those of a WTORS, in the case of an impact.

60. VicRoads noted that technical challenges may be posed by the wide variety of mobility devices available on the market. There is no guarantee that all devices are suitable to be restrained by systems such as a WTORS, and the introduction of a wheelchair restraint system in public route buses may necessitate a restriction on the range of mobility aids granted access to these buses.

61. I agree that technical challenges and broader road safety concerns must be prominently considered in any future action on wheelchair safety in public buses.

62. To this end, VicRoads suggested that a study on best practices on the transportation of wheelchair occupants in public buses is necessary to determine what practical interventions to improve safety may work best.

Transport Safety Victoria

63. Transport Safety Victoria (TSV) support the principle that the responsibility for safety rests on those who are best able to eliminate or reduce the risk so far as is reasonably practicable. In this case, they noted that the relevant persons include bus operators, bus drivers and the individuals using mobility devices.[37]

64. In wheelchair restraint systems, TSV distinguish between 'active restraint systems' and 'passive restraint systems'. Active restraint systems anchor mobility devices into allocated

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[36] Letter from VicRoads to the Court dated 15 June 2018.
[37] Letter from Transport Safety Victoria to the Court dated 4 May 2018.

spaces and passive restraint systems restrict the movement of wheelchairs and other mobility devices within an allocated space.

65. The WTORS system discussed by VicRoads would be an active restraint system. A grabrail for passengers to hold on to, the system with which Mr Wilks' bus was equipped, is an example of a passive restraint system.

66. The *Disability Standards for Accessible Public Transport Guidelines 2004* recognise the use of both active and passive restraint systems. Active restraint systems are explicitly required in some circumstances: the guidelines state that '*regulations that normally require passengers to wear safety belts apply equally to all passengers. This means that operators of services on which safety belts are mandatory must provide restraints for use by people with disabilities.*'[38]

67. Route buses (such as the bus Mr Wilks was riding) are not required to have seatbelts, and so are not required to have active restraint systems in place. TSV advise that route buses are generally fitted with the passive restraint system of a handrail for passengers to hold on to, located near bulkheads to assist in limiting movement of wheelchairs or mobility aids.

68. TSV agree that an active restraint system would have prevented Mr Wilks' fall but, after taking into account other considerations, they do not support mandatory fitting of active restraint systems on route buses.

69. They first note that Mr Wilks' injury is the only reported incident they are aware of since 2010. As there are millions of passenger journeys each year, they conclude that the likelihood of such an event occurring in the future is low.

70. TSV then raise a number of reasons why active restraint systems may be unsuitable for route bus services.

71. They note that the devices may present a slip, trip or fall risk for other passengers, including bus safety workers, when not in use. Other reasons for finding active restraint systems impractical focus on the role of bus drivers:

- the time it would take for drivers to secure a wheelchair or other mobility device;
- the need for drivers to be suitably trained to do so competently; and

[38] *Disability Standards for Accessible Public Transport Guidelines 2004* s 9.6(2).

- the requirement for drivers to vacate their position with passengers onboard and potentially with the engine running could pose a hazard to both passengers on the bus and members of the public who are nearby the bus.

72. TSV acknowledge that further analysis of these matters would be required to fully assess the reasonable practicality of a mandatory fitting of active restraint systems. They suggest that such an assessment would need to include, first, a thorough consideration of the likelihood of an event such as Mr Wilks' fall happening again and, secondly, an assessment of the cost impact of installing active restraint systems on route buses.

Ventura Bus Lines

73. Ventura Bus Lines (Ventura), the operator of the bus where Mr Wilks' injury occurred, sent a letter outlining their positions on safety precautions for wheelchair users on public buses.[39]

74. Ventura agreed with other parties that systems requiring anchorage are impractical, both because varying types of mobility device would need to be restrained by one system and became the tracks, restrains and clamps would be a potential trip hazard for other customers.

75. As an alternative, Ventura proposed that the best practice for transport of mobility devices is for the mobility devices to be tethered to a rearward facing device known as an 'ironing board device'.

76. Their letter states that:

'Ventura had mandated the "ironing board device" and tether belt in their specification for all new public buses to be built in Ventura. We are aware that some interstate operators, such as State Transit Authority (NSW) have also made this decision to include tethered belts in all new buses.'

77. Ventura would support a mandatory requirement that mobility devices be tethered to a rearward facing 'ironing board device' and that such a device, with tether, be fitted to all new public buses to be built in the future.

78. However, Ventura noted that they would find retrofitting this device into existing buses problematic due to the bus wheel arches' construction and differing seat layouts.

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[39] Letter from Andrew Cornwall (Managing Director, Ventura Bus Lines) to the Court dated 5 April 2018.

79. I commend Ventura for their efforts to proactively increase safety in new buses even when these efforts are not mandated by current law.

Bus Industry Confederation and Bus Association Victoria

80. Michael Apps, Executive Director of the Bus Industry Confederation (BIC), responded to the CPU on behalf of both BIC and Bus Association Victoria (BAV).[40]

81. Mr Apps advised that BAV is unable to confirm whether it responded in any way to the Chief Investigator's recommendations following the 2006 injury.

82. He stated that since 2006 the national bus industry, mainly through BIC, has worked with relevant stakeholders to improve the level of disability access in respect of bus travel. He noted that representatives have been involved with State and Commonwealth sponsored committees regarding improving disability access and education initiatives both for public transport users and for bus operators.

83. Mr Apps supplied the Court with a BIC Issues Paper on 'Mobility Device and their Restraint on Buses and Coaches' dated April 2012 and updated in May 2013.

84. Among other points, the Issues Paper notes that buses are required to meet stringent seat strength and anchorage requirements under Australian Design Rules and that these requirements cannot be met by a mobility device, whether it is restrained or not. It states that '*the actual restraint of mobility devices is an imperfect science that results in people with disabilities being put at greater safety risk in order to obtain equal access to services*'.

85. The Issues Paper does, however, include this passage:

'*In relation to the restraint of mobility devices the accepted wisdom and practice is for mobility devices to be rearward facing against what is known as an "ironing board device". Some passengers with disabilities tether their device to the ironing board device. The practice of facing rearward is not accepted by many people with disabilities who wish to face to the front of the vehicle like most other passengers. This is a less safe option.*'

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[40] Letter from Michael Apps to the Court dated 20 April 2018.

86. BIC also notes that bus operators' practice varies on when and how drivers will assist wheelchair users in boarding buses. The Issues Paper summarises the industry's operational policy and advice given to drivers as:

'The driver should only leave the driving position to assist a passenger to enter or leave the bus to set and return the access ramp. This should only occur after the driver believes it is safe and reasonable that the bus is secure. All other reasonable assistance that is required should be provided by a carer, e.g. getting on and off the bus and [manoeuvring] into an allocated wheelchair space [for] seating and for any restraint requirements.'

87. The Issues Paper does not address the situation of a wheelchair user like Mr Wilks travelling independently without a carer.

Incident reporting and rarity of reported injuries

88. Several of the consulted parties noted that, in considering what regulations might be appropriate, it is important to consider the frequency of injuries such as Mr Wilks' occurring on buses.

89. Whilst I have no hesitation accepting this submission, as far as it goes, this case itself offers a possible systemic explanation for the lack of such reported incidents. Any consideration of the frequency of such injuries is derived from the baseline number of reported incidents. The fact that this incident was not reported to WorkSafe or Transport Safety Victoria indicates that there may be a systemic reporting issue which could be distorting the accuracy of any estimates of the frequency of such injuries.

Traffic Incident System

90. This incident was not included in the TIS because, first, no police report was made at the time of Mr Wilks' injury and, secondly, because LSC Hansen and FC Cunningham did not report the death to the TIS due to their interpretation of Victoria Police guidelines and policies.[41]

91. Submissions from Victoria Police emphasise that they make no criticism of LSC Hansen or FC Cunningham for not reporting Mr Wilks' death to TIS.

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[41] Submissions on behalf of the Chief Commissioner of Police dated 1 August 2018.

92. I concur that LSC Hansen and FC Cunningham made reasonable conclusions about Victoria Police guidelines and policies and interpreted the term 'collision' in a reasonable way.

93. Victoria Police acknowledge that '*the usage of the term "collision" within the [Victoria Police Manual]* could *discourage members from making the TIS report for a narrow category of incidents involving an injury or fatality where no report is made to police of the relevant event (collision or otherwise) at the time of the event*'.

94. They submit that '*these obstacles could be practically removed by including a specific definition of collision within the [Victoria Police Manual] which expressly recognises "other non-collision crashes".*' However, any such change would need to be carried out in consultation with the Capability Department as they are responsible for the coordination of policy reviews.

95. According to their submission, the Victoria Police Manual places an obligation upon Victoria Police members to investigate all collisions reported to them, and so expanding the definition could have unforeseen consequences. Normal policy review processes must consider these possible consequences before any changes are made.

96. I accept Victoria Police's position. I find that they are responding appropriately to the issues in the Manual which were raised by reporting issues following Mr Wilks' death.

97. Victoria Police also note that a further amendment could be made to the deceased persons guideline to capture circumstances where no previous report of a collision has been made, but a fatality has resulted. I also encourage consideration of such an amendment.

Access to transport for people with disabilities

98. Wheelchair users must not only be able to access public buses, they must feel safe on them, and they ought not be physically imperilled by the manner in which these systems are operated. Mr Wilks' death has highlighted that previously identified systemic risks remain unresolved. These risks combine to limit accessibility of the public transport system for people with disabilities, and to reduce the reportage of this fact.

99. The Victorian Government's 'Absolutely Everyone' State Disability Plan 2017-2020 (State Disability Plan) emphasises the importance of public transport to people with disabilities:

'*Accessible public transport is critical for people with a disability. People with a disability need accessible public transport so they can easily travel to school, work and social events.*

Universal access to public transport services and facilities provides opportunities for people with a disability to make their contribution and lead a satisfying life. This means making public transport easy to use across all parts of the system including buses, trains, trams, taxis, and other commercial passenger vehicles.'[42]

100. In addition to the policy clearly set out in this Plan, the subject matter of this investigation, as set out in the preceding paragraphs, appears to intersect with certain human rights that the Parliament of Victoria charged its Public Authorities with protecting and promoting, unless a particular limitation of those rights is reasonable and has been demonstrably justified.[43]

101. In this investigation, sections 8 (Equality), 9 (Right to life), 10 (Freedom from degrading treatment), 12 (Freedom of Movement) and the Public Authorities Obligation in section 38 appear to be engaged. Public Transport Victoria, Transport Safety Victoria and the Minister for Public Transport are all Public Authorities for the purposes of the Charter.

102. Whilst any limitation of the above rights in this case might potentially be unreasonable, that was not a discrete focus of my investigation. For this reason, I intend to distribute a copy of this finding to the Victorian Equal Opportunity and Human Rights Commission so that they might consider it in the exercise of their statutory functions.[44] Further, I recommend the Public Authorities identified in these reasons request the Commission conduct a section 41(c) review of the compatibility of the programs and practices described herein with the human rights set out in the Charter.

103. Such a review has prospects of guiding those Public Authorities, in balancing and prioritising the competing issues surveyed in these findings, toward the resolution of any perceived Gordian Knot which may have contributed to the apparent inaction on this issue since 2006.

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[42] Victorian Government, 'Absolutely Everyone' State Disability Plan 2017-2020 (December 2016) p 11.

[43] See sections 6 and 7 of the Charter.

[44] In addition to those functions, the Commission has recently reported on this space. See *Who's on board? Public transport for people with disabilities in Victoria* (September 2013) at https://humanrightscommission.vic.gov.au/home/our-resources-and-publications/reports/item/695-whos-on-board-public-transport-for-people-with-disabilities-in-victoria

FINDINGS

104. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) The identity of the deceased was John Edwin Wilks, born 6 December 1940;

    (b) The death occurred on 26 August 2017 at the Monash Medical Centre in Clayton from bronchopneumonia complicating fractured ribs sustained in a fall on a bus; and

    (c) The death occurred in the circumstances described above.

105. I commend the efforts of LSC Hansen as Coroner's Investigator and his commitment to the death prevention and public safety purpose of a coronial investigation.

106. I wish to convey my sincere condolences to Mr Wilks' family for his tragic death.

RECOMMENDATIONS

1. Based on my investigation, I find that requirements should be introduced to require effective wheelchair restraints on Victorian public buses. However, the submissions of organisations involved in bus safety revealed a number of practical issues that must first be resolved, in particular relating to the fitting of devices into existing buses and the role of drivers in assisting passengers with any new system.

   These issues require further consideration, and a discussion process involving relevant bodies must occur before specific requirements are formulated.

   The voices of people with disabilities must be heard during this process. The State Disability Plan was developed by the Office for Disability in consultation with people with disabilities, and that Office is the most natural body to support the inclusion of people with disabilities in the process.

   Pursuant to section 72(2) of the *Coroners Act 2008*, **I recommend:**

   > that Public Transport Victoria, Bus Association Victoria and the Office for Disability form a working group to consider and recommend how the *Bus Safety Act 2009* can be amended to require the mandatory installation of appropriate wheelchair restraints on

Victorian public buses to prevent falls among wheelchair users, and to specify what form these restraints should take.

2. It may be some time before tangible results emerge from the formation of a working group. During this time, wheelchair users' safety may remain at risk while on public buses. Bus operators and regulators should take interim measures to minimise this risk, even if not required by legislation.

Many of the factors requiring consideration by a working group involve the difficulties in applying any new requirements to existing buses, and do not apply to newly built buses. Ventura Bus Lines has demonstrated that they are willing to go beyond the legislation and mandate that the 'ironing board device' be fitted in new public buses. This mandate will serve to protect wheelchair users in the present and may lessen the future cost of any legislative requirement regarding wheelchair restraint systems.

Pursuant to section 72(2) of the *Coroners Act 2008*, **I recommend:**

> that the Minister for Public Transport engage with route bus operators to encourage adopting Ventura Bus Lines' policy of mandating the 'ironing board device' and tether belt in their specifications for all new public buses.

3. The lack of reporting of Mr Wilks' injury to WorkSafe or Transport Safety Victoria may indicate a systemic issue in reporting such incidents. Without an accurate understanding of the frequency and nature of injuries on public buses, bus safety cannot be effectively promoted.

Pursuant to section 72(2) of the *Coroners Act 2008*, **I recommend:**

> that the Minister for Public Transport engage with route bus operators to review procedures for reporting injuries which occur on public buses.

4. Recommendations 1, 2 and 3 should be given a human rights context to assist those Public Authorities in balancing and prioritising the competing issues surveyed in these findings.

Pursuant to section 72(2) of the *Coroners Act 2008*, **I recommend:**

> that no later than 18 months from the date of this decision, the Public Transport Victoria, Transport Safety Victoria and the Minister for Public Transport request the Victorian Equal Opportunity and Human Rights Commission to conduct a review

under section 41(c) of the Charter of any improvements to programs and practices made in response to recommendations 1 to 3 in this decision.

5. Pursuant to section 72(2) of the *Coroners Act 2008*, **I recommend** that once the Review in Recommended 4 is completed, each Public Authority should develop a plan to apply the Review's findings and recommendations to all bus transport systems within their remit within an additional three months.

Pursuant to section 73(1A) of the *Coroners Act 2008*, I order that this Finding be published on the internet.

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

(a) Aileen Pierce, senior next of kin

(b) Kristen Hilton, Victorian Equal Opportunity and Human Rights Commissioner;

(c) Ventura Bus Lines;

(d) Public Transport Victoria;

(e) Transport Safety Victoria;

(f) WorkSafe Victoria;

(g) Bus Association Victoria;

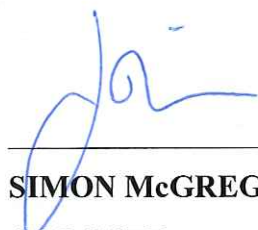
(h) Office for Disability, Department of Health and Human Services;

(i) Chief Commissioner of Victoria Police;

(j) The Hon Melissa Horne MP, Minister for Public Transport;

(k) Leading Senior Constable Robert Hansen, Victoria Police, Coroner's Investigator.

Signature:



SIMON McGREGOR
CORONER
Date: 19 March 2019