2022

THE LEGISLATIVE ASSEMBLY FOR
THE AUSTRALIAN CAPITAL TERRITORY

Coroner's Inquiry into the Death of 'Passenger H'

Presented by
Chris Steel MLA
Minister for Transport and City Services
February 2022

AUSTRALIAN CAPITAL TERRITORY
OFFICE OF THE CORONER

Magistrates Court Building
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Canberra City, ACT 2601
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6 August 2021

By email and post: c/- Matthew.Georgeson@act.gov.au

Mr Shane Rattenbury MLA
Attorney-General of the Australian Capital Territory
GPO Box 1020
Canberra ACT 2601

Dear Attorney-General

CD107 of 2019 – [redacted] (deceased) – Report after inquest pursuant to s 57 of the *Coroners Act 1997*

I have exercised jurisdiction to hold an inquest into the manner and cause of death of [redacted] pursuant to section 13(1)(g) of the *Coroners Act 1997* (**Coroners Act**).

I **enclose** a copy of my findings, which contain comments and or recommendations about a matter of public safety, for the purpose of reporting on this matter to you.

My findings contain information that could reasonably identify [redacted]. I confirm that members of the immediate family have requested that information be deidentified before this report and your response to it are presented to the Legislative Assembly, as you may pursuant to section 57(5) of the Coroners Act.

Please find below the contact details of the next of kin, who has requested their personal information be provided to you for the purpose of receiving a copy of the response that is to be presented to the Legislative Assembly under section 57(4)(b).

[redacted]

Yours sincerely

Coroner Theakston

CORONERS COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into the death of**
Citation:	**[2021] ACTCD 4**
Decision Date:	2 August 2021
Before:	**Coroner Theakston**
Decision:	See [12], [19] & [21]
Catchwords:	**CORONIAL LAW – Cause and manner of death** – matter of public safety – serious head injury arising from a fall – recommendation to conduct joint risk assessment
Legislation Cited:	*Coroners Act 1997* (ACT)
File Number(s):	CD 107 of 2019

CORONER THEAKSTON:

1. The death of was reported to me. She appeared to have died due to a fall. The *Coroners Act 1997* requires deaths which appear to be directly attributable to an accident to be reported to the Coroner.

2. At the request of her family, the content of these reasons have been restricted to what is strictly necessary to explain my findings and recommendations.

Circumstances of Death

3. At the time of her death, was 85 years old. She did not have a history of falls.

4. On 1 May 2019, travelled by bus to, and then from, a community centre. At the end of her return trip, and after the bus had stopped at her driveway, she fell backwards from the bus. This occurred through the open doorway, with her legs remaining in the stairwell. She hit her head on the ground and became unconscious.

5. An ambulance attended and was transported to Canberra Hospital. underwent tests but did not regain consciousness. was declared life extinct at 10:15 pm that same day.

Manner and Cause of Death

6. The bus was operated by Communities@Work, a private organisation that provides support services to the Canberra community. ACT Police interviewed the bus driver and two passengers.

7. The driver explained that [redacted] residence was the first stop on the bus route to return clients to their homes. He stated that he stopped the bus at her driveway. The passenger folding door automatically opened and the driver exited the bus to retrieve [redacted] walker. The walker was stored at the rear of the bus.

8. The driver described having walked halfway down the outside of the bus, on the left-hand side, when he heard a loud noise. He turned around and saw [redacted] laying on the concrete driveway, with her legs in the bus stairwell.

9. A passenger described to police that she was seated in the front right-hand passenger seat of the bus and that [redacted] sat to her immediate left. Those two seats were located opposite the passenger side door. The passenger described the bus stopping, [redacted] standing up, [redacted] attempting to grab a cushion while holding the witness's hand. [redacted] took a step back and fell directly out through the stairwell of the bus, striking her head on the driveway. Another passenger also witnessed the incident and confirmed the first passenger's account.

10. The driver called an ambulance, which attended and transported [redacted] to Canberra Hospital. She was assessed to have a Glasgow Coma Score of 5, which is consistent with a serious head injury. A CT scan was performed. That scan depicted a serious head injury, which was not considered survivable. A decision was made to provide only palliative care and [redacted] died shortly thereafter.

11. At my request, Professor Johan Duflou conducted an external examination of [redacted] and reviewed the medical records. He opined that [redacted] died from a head injury due to a fall. He also assessed that the treatment provided to [redacted] was appropriate given the nature of her injuries.

12. I am required to make findings as to the identity of the deceased person, when and where they died, and the manner and cause of their death. I find that [redacted] died on 1 May 2019 at Canberra Hospital, Yamba Drive, Garran, in the Australian Capital Territory, and that the manner and cause of her death was a head injury due to a fall from a bus.

Matter of Public Safety

13. Paragraph 52(4)(a) of the *Coroners Act 1997* provides that a Coroner must state whether a matter of public safety is found to arise in connection with an inquest, and if so, a Coroner must comment on that matter.

14. Following the incident Communities@Work quickly and appropriately accepted recommendations by WorkSafe and implemented protocols to address the risk of a

passenger falling from one of their buses through the side door. Those protocols were consistent with protocols already implemented by Transport Canberra, and included:

a. the placement of safety signs on each bus informing the passengers to remain seated until the driver is present to assist;

b. drivers reminding passengers to remain seated until the driver is present to assist;

c. bus doors remaining closed on arrival at destinations;

d. bus doors being opened by the driver using the external switch once the driver is present to assist;

e. when a passenger is to exit via the rear door and lift, the side passenger door is to remain closed; and

f. refresher training covering the introduction of the protocols be given to all bus drivers engaged in the transportation of elderly passengers.

15. The buses used by Communities@Work are provided by Transport Canberra and City Services and are supplied with all modifications already completed.

16. Since the incident there has been a change in the bus model provided to Communities@Work. The new bus does not have an external switch to operate the side door. That was identified by Communities@Work as a risk. They consequently placed a plastic yellow chain across the doorway to act as a visual reminder for passengers not to approach the door without the driver's assistance. I am not persuaded that the use of the plastic chain would, in all the circumstances, be an adequate control for the risk of an elderly passenger falling out of the bus. Communities@Work also maintain other controls, including signage directing passengers to remain seated until the driver is ready to assist them in alighting from the bus.

17. [REDACTED] family expressed concern about the elevated seat [REDACTED] had been seated on and the associated step located immediately to the left of that seat, between the seat and the stairwell. It appears that only one seat in the bus is elevated in that manner. The family submitted that the door being open and the presence of that step contributed directly to [REDACTED] fall, the severity of the injury she suffered and ultimately her death.

18. Unfortunately, the evidence is not clear enough for me to make a finding about whether that step contributed to the fall. However, the presence of that step, so close to the stairwell and an open door, must create the risk that any fall due to that step could result in a fall out through the open bus door.

19. In the above circumstances, I find that a matter of public safety does arise. The use of the seat, located on an elevated step adjacent to the opening side door of the bus, represents a serious risk to passengers with mobility issues.

20. As Transport Canberra and City Services and Communities@Work share the responsibility of providing an appropriate and safe transport service, it is important that the two organisations come together and regularly and jointly consider questions of risk and any necessary controls to ameliorate the risks identified. That approach would allow each organisation to bring to the process its experience, judgment and resources. To do otherwise may unnecessarily limit what risks are identified and what controls are thought to be available.

21. Accordingly, I recommend Communities@Work and Transport Canberra and City Services periodically and jointly conduct risk assessments to address risks associated with the service. In the first instance that should include the risk of passengers falling due to existence of the step and the passenger door. The two organisations should also jointly consider and implement any necessary controls to mitigate those risks. Such controls may, for example, involve the adoption of protocols by Communities@Work and modifications to the bus by Transport Canberra and City Services.

22. I extend my condolences to [redacted] family and friends.

I certify that the preceding twenty-two [22] numbered paragraphs are a true copy of the Reasons for findings of his Honour Coroner Theakston

Associate: Linda Cao

Date: 2 August 2021