LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON JUSTICE AND COMMUNITY SAFETY
Mr Peter Cain MLA (Chair), Dr Marisa Paterson (Deputy Chair),
Mr Andrew Braddock MLA

Submission Cover Sheet

Inquiry into the Road Safety and Crimes Legislation Amendment Bills 2022

Submission Number: 007

Date Authorised for Publication: 01 February 2023

VICTIMS OF CRIME COMMISSIONER
ACT Human Rights Commission

Standing Committee on Justice and Community Safety
Office of the Legislative Assembly
Via LACommitteeJCS@parliament.act.gov.au

3 January 2023

Dear Committee Secretary,

Submission to the Inquiry into the Road Safety & Crimes Legislation Amendment Bills 2022

Thank you for the opportunity to make a submission in relation to the Standing Committee's Inquiry into the Road Safety & Crimes Legislation Amendment Bills 2022 (the 'Inquiry'). This submission is made specifically in relation to the Road Safety Legislation Amendment Bill 2022.

I request that this submission be published in full.

Yours sincerely

Heidi Yates
Victims of Crime Commissioner

GPO Box 158 Canberra ACT 2601 Phone: (02) 6205 2222 Email: VOCC@act.gov.au

About the ACT Human Rights Commission

1. The ACT Human Rights Commission is an independent agency established by the Human Rights Commission Act 2005 (HRC Act). Its main object is to promote the human rights and welfare of people in the ACT. The HRC Act became effective on 1 November 2006 and the Commission commenced operation on that date. Since 1 April 2016, a restructured Commission has included:

    i. the President and Human Rights Commissioner;

    ii. the Discrimination, Health Services, Disability and Community Services (DHSDCS) Commissioner;

    iii. the Public Advocate and Children and Young People Commissioner (PACYPC); and

    iv. the Victims of Crime Commissioner (VOCC).

About Victim Support ACT

2. The Victims of Crime Commissioner (VOCC) is an independent statutory advocate and the head of Victim Support ACT (VSACT). VSACT is situated within the ACT Human Rights Commission. The VOCC's functions are set out in the *Victims of Crime Act 1994*, the *Victims of Crime (Financial Assistance) Act 2016* and the *Victims of Crime Regulation 2000*.

3. The function of the VOCC is to advocate for the rights and interests of victims of crimes committed in the ACT. Particularly relevant to the subject of this Inquiry, the VOCC's responsibilities include:

    i. advocating for the interests of victims;

    ii. monitoring and promoting compliance with victims rights;

    iii. consulting on and promoting reforms to meet the interests of victims; and

    iv. delivering frontline support services to victims via the Victim Services Scheme (VSS) and the Financial Assistance Scheme (FAS), which operate under the umbrella of 'Victim Support ACT'.

4. The terms of reference of this Inquiry directly relate to the core functions of the VOCC in consulting on and promoting reforms to meet the rights and interests of victim-survivors, including in relation to supporting reforms that increase victim and community safety against the backdrop of addressing systemic deficiencies in the heavy vehicle fitness to drive regime.

Preliminary remarks

5. The VOCC makes this submission in relation to the provisions of the Road Safety Legislation Amendment Bill 2020 ('the Bill') which seeks to improve road safety by strengthening the reporting and monitoring of driver licence holder's fitness to drive frameworks.

6. The Bill's proposed regulatory reforms arise directly from the matter of *R v Livas (No 2)* [2020] ACTSC 116 and subsequent coronial recommendations. The victim-survivors in the Livas matter have had a key role in calling for required change to improve road safety for all Canberrans.

Submissions of Ms Camille Jago and Mr Andrew Corney

7. The VOCC has had the opportunity to consider two separate victim-survivor submissions to this Inquiry that have been published by the Committee. The separate submissions of Ms Camille Jago and Mr Andrew Corney detail their experiences following a motor-vehicle collision that claimed the life of their young son, Blake.

8. We commend their submissions to this Inquiry and acknowledge their extensive advocacy over several years calling for key regulatory reforms, some of which are addressed in this Bill. We consider it immensely important that Government and the Committee listen to the lived-experience of victim-survivors who have been irretrievably impacted by the systemic failings that the Government seeks, in part, to address in this Bill.

The Inquest into the death of Blake Corney

Key Findings and Recommendation (i)

9. The Inquest into the death of Blake Andrew Corney[1] (the 'Inquest') considered if and how the death of Blake might have been prevented if, among other things, heavy vehicle licence regulations were strengthened to require particular types of reporting of suspected and diagnosed medical conditions, such that the offender would not have been licenced to drive.[2] Inherent to this question was how regulatory powers could be improved to safeguard against a 'recalcitrant, ignorant or dishonest driver' to minimise risks to public safety which otherwise rely on the diligence and honesty of drivers to self-report medical conditions to relevant professionals and licencing authorities.[3]

10. Relevant to this Inquiry, Chief Coroner Walker made a key public safety finding that there was insufficient information available to the Road Transport Authority (RTA) in respect to medical conditions of commercial drivers holding heavy vehicle licences.[4] Indeed, Chief Coroner Walker acknowledged the deficiency of a system for heavy vehicle licencing which relied on self-reporting in respect to matters which would impact a person's employment and income.[5]

[1] [2021] ACTCD 6.
[2] Ibid, [21].
[3] Ibid, [24].
[4] Ibid, [81].
[5] Ibid, [46].

11. Recommendation (i) of the Inquest went directly to this finding, recommending that law reform be considered to mandate that health practitioners notify the RTA when they have reasonable cause to believe a patient is suffering from an illness, disability or deficiency that is likely to endanger the public if the patient drives a heavy vehicle. This recommendation was made with a view to such an obligation existing *both* at the time of conducting a medical assessment, *as well as* being an ongoing obligation at any point in time when a health practitioner receives information reasonably causing them to form that belief.[6]

Systemic failings noted in the Inquest informing Recommendation (i)

12. The Inquest detailed the relevant findings of the Supreme Court in *R v Livas (No 2)*.[7] Here, Chief Coroner Walker summarised the facts upon which the offender was found culpable, which included failures in self-reporting a serious suspected medical condition despite ongoing engagement with various health professionals who formed suspicions of a possible diagnosis of sleep apnoea.[8] It is pertinent to note the decision of Justice Mossop which notes the systemic failure of the offender to take reasonable steps in relation to his health and fitness to drive:

> This is not a case involving an immediate and obvious risk of which the offender was conscious at the time of the offending. Rather, it was conduct which involved a systematic failure to take steps which a professional truck driver ought reasonably to have taken... Whether through ignorance or personal failings, the failure by a professional truck driver to properly attend to health issues associated with the management of fatigue and the failure to make any disclosures of the matters of which he was aware involves moral culpability because it imposes upon others increased and unnecessary risks associated with the use of such large dangerous vehicles.[9]

13. As noted above at [10], Chief Coroner Walker noted the deficiency of such a system which relies on self-reporting. Indeed, Justice Mossop noted the offender had several opportunities to investigate or disclose his medical concerns and failed to do so on several occasions.[10] Chief Coroner Walker therefore was of the view that a mandatory obligation for medical practitioners to provide information to licensing authorities would be more likely to identify dangerous drivers in advance of their involvement in motor-vehicle collisions.[11]

Road Safety Legislation Amendment Bill 2022

14. The provisions of the Bill addressed in this submission relate to the proposed introduction of regulation making powers that:

    i. may require health practitioners to report information relating to a person's fitness to drive to the RTA; and

    ii. will permit the RTA to share information relating to an interstate licence holder's fitness to drive with the issuing interstate licensing authority.

15. The VOCC strongly supports the adoption of these reforms, noting the systemic regulatory failings identified by the Inquest noted above. These reforms go directly to commencing the process of improving systems and harmonising the ACT's road transport laws with other jurisdictions.

16. I note that the Bill does not introduce the specific mandatory reporting requirements placed upon health practitioners, but rather enables regulations to be developed and introduced that formalise these requirements with specificity. In this context, the Bill is a first step to formalising the full implementation of Recommendation (i) arising from the Inquest. I note that Ms Jago reflected in her submission to this Inquiry her gratitude for the proposed adoption of the recommendation (i) of the Inquest, and that it has provided her with hope and reassurance that some aspects of the system work.

17. Importantly, these proposed reforms acknowledge the responsibilities of professionals who intersect with fitness to drive requirements as being an important public safety measure to protect against the known deficiencies and unreliability of self-reporting requirements. It is imperative our laws respond to recognised system deficiencies, especially where they have been shown to contribute to circumstances involving irrevocable loss of life.

18. In this context, it is poignant to note the remarks of Mr Corney in his submission to this Inquiry, where he describes the introduction of these regulatory powers as 'vital in a chain of nets' that seeks to create safeguards to prevent people who – knowingly or unknowingly – put the lives of others (and their own) at risk. We consider that these reforms will be a welcome part of a network of protections aimed at reducing the likelihood of dangerous driving in certain contexts.

[6] [2021] ACTCD 6, [82].
[7] [2020] ACTSC 116.
[8] [2021] ACTCD 6, [7].
[9] *R v Livas (No 2)* [2020] ACTSC 116, [35].
[10] Ibid, [57].
[11] [2021] ACTCD 6, [46].