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**THE LEGISLATIVE ASSEMBLY FOR
THE AUSTRALIAN CAPITAL TERRITORY**

RESPONSE TO THE CORONER'S INQUIRY INTO THE DEATH OF 'PASSENGER H'

**Presented by
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RESPONSE TO THE CORONER'S INQUIRY INTO THE DEATH OF 'PASSENGER H' ON 1 MAY 2019

Overview

On 2 August 2021, Coroner Theakston released his findings and recommendations arising from the inquiry into the death of 'Passenger H'.

The inquiry found that on 1 May 2019, 'Passenger H' died after falling backwards out of a community bus provided by Communities @ Work. 'Passenger H' travelled by bus to and from a community centre and her home. At the end of her return trip, and after the bus had stopped at her driveway, she fell backwards through an open side door of the vehicle and suffered a serious head injury. An ambulance transported 'Passenger H' to hospital where she was ultimately declared deceased at 10:15pm on the same day.

Coroner's recommendation and key issues

The *Coroners Act 1997* (ACT) requires a coroner to comment upon any matter of public safety that arises in connection with an inquest.

Coroner Theakston has noted that following the incident, Communities@Work quickly and appropriately accepted recommendations made by WorkSafe and implemented protocols to address the risk of passengers falling from community buses in the same manner. These protocols were consistent with protocols already implemented by Transport Canberra and included the bus doors being opened by the driver using an external switch once the driver is present to assist passengers out of the bus.

The buses used by Communities@Work are provided by Transport Canberra and City Services (TCCS). Coroner Theakston has noted that since the incident, there has been a change in the bus model provided to Communities@Work and the new models no longer come with an external switch. The family of 'Passenger H' has also expressed concern regarding the placement of an elevated seat located in close proximity to the stairwell and doorway.

Coroner Theakston found there to be a matter of public safety due to the presence of a step being close to the stairwell and an open door of the bus.

Coroner Theakston recommended that Communities@Work and TCCS periodically and jointly conduct risk assessments to address risks associated with the service.

- a. Such assessments should include consideration of the risk of passengers falling due to the placement of the step and the passenger door.
- b. The two organisations should also jointly consider and implement any necessary controls to mitigate those risks.

ACT Government response to the recommendations and key issues

In response to the findings and subsequent recommendations from the Coroner, TCCS has engaged an external consultant to undertake an independent risk assessment on behalf of TCCS and Communities@Work of the vehicles used to provide the community bus services.

Due to COVID-19 lockdown restrictions and interstate travel restrictions, the consultant was unable to travel to the ACT to undertake the physical inspection of the vehicles until November 2021.

The consultant has advised that they are expecting to have the final report completed by mid-February. As such, an additional six months is requested to complete and implement this risk assessment given the unknown impacts of COVID-19 into the future.

The report will provide guidance on matters such as safe systems of work and operation of the vehicles. It is expected to include workflow recommendations for wheelchair lifters and drivers, and assessment of vehicle types with a focus on bus access types, circulation and access space, steps and handrail assessment and guides.

Upon receiving the completed report, TCCS and Communities@Work will meet to discuss findings of the risk assessment and any subsequent recommendations the independent assessor identifies.

The implementation timeline for modifications or changes to the service will be known following this joint review of the assessment in early 2022. TCCS is committed to undertaking any necessary works as quickly as possible to ensure the ongoing safety of community bus passengers.

TCCS is also committed to ongoing joint assessment of risks associated with the delivery of community bus services. The Directorate is represented on the Community Transport Forum which meets regularly to discuss and identify service improvements and safety matters that may need to be addressed.

TCCS will continue to take part in this forum and where appropriate, meet with Communities@Work to jointly consider questions of risk and necessary controls to improve the risks identified.

Conclusion

The ACT Government acknowledges the tragic death of 'Passenger H' on 1 May 2019 and the effect that her loss has had on her family, friends and community.

The ACT Government is committed to working with community partners to ensure the safety of passengers using community bus services now and into the future.