

LAW REFORM COMMITTEE

Inquiry into Coroners Act 1985

Melbourne — 28 November 2005

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Dr E. Wigglesworth, AM, honorary senior research fellow, Monash University Accident Research Centre.

The CHAIR — Welcome, Dr Wigglesworth. Thank you very much for taking the time to speak with us today. In view of the time we will move straight into your submission.

Dr WIGGLESWORTH — Thank you very much for allowing me to come this morning. I am mortified that I did not know that the inquiry was in progress until I read about it on the front page of the *Age* about three weeks ago.

I have had a long association with the coroner, and I make no bones about the fact that I am a very strong supporter of the work he has done in developing the coronial database. I have prepared a one-page yellow piece of paper which addresses question 29, which is: how effective is the present system and can it be improved?. My answer to the first part under that is in the first part of my submission. It is yes, and that is based on fact. The answer to the next question is that I think it can be improved, and I have some statements of opinion at the bottom of that yellow piece of paper.

I am talking about railway level crossing accidents in Victoria, a subject with which I have been involved since 1977, when the then Liberal transport minister, Mr Rafferty, asked me to find out what the heck was the cause of the plague of level crossing accidents that were occurring. I wrote two reports. The first was based on a field study, that involved going up and down the length of Victoria.

The second one, which is the one I want to talk about, was based on an inspection of police reports made as part of the coronial brief, and it is those coronial-type papers which I want to talk about. Michelle has a copy of the scientific paper, not that I am inflicting it on you, but I want it to be there to verify what I am saying if you doubt me. The paper went to the Labor transport minister, Steve Crabb, who, mercifully — and I use that word very loosely — was MP for Knox, an area in which there were three level crossings of precisely the type I had identified as being especially dangerous. He came, as I understand it, with a pledge to do something about it, and by gosh he did.

One of the main problems is that metropolitan level crossings in those days were protected only by flashing lights that blinked at you, of the sort identified on my tie, and there was no boom barriers. Time after time after time the coronial report would say the person who was killed was seen to drive slowly and deliberately in front of the train that was approaching over the right-hand shoulder and was not seen because the driver's attention was diverted elsewhere.

Adding boom barriers was very successful indeed. We did a study — also lodged with Michelle — over some 10 years on whether they were successful, and indeed they were. Before the boom barriers went in 61 people died, and after those boom barriers went in 2 died. The rather artificial rate of deaths per 100 crossing years dropped from 5.7 to 0.3. You do not get better results than that anywhere in the accident prevention field, and I make the point that that came about due to the study made possible by the present coronial system.

More than that, the Americans have got the National Academy of Sciences, which includes transport, one part of which is a committee on railway level crossings, believe it or not, which is the official adviser to the federal government. The chairman of that committee was in Australia and invited me to join the committee as one of the only four non-American members. I was, and still am, the only Australian on that committee.

In Washington in January 2000 he introduced me to members of his committee saying that I had written one or two papers on the subject, and a voice from my left said, 'Indeed he has. Ten years ago my boss said, "We need a representative to specialise in level crossing accidents, and you are it"'. He said his heart sank into his boots, because level crossing accidents, as we all know, are either caused by idiots trying to beat the train or lunatics who zigzag around the boom barriers, and he did not relish at all looking into that. His boss said, 'There is a report here from Australia. Read that and do the same'.

This man then said, 'I read it and did not believe it, so I came back the following day and read it again. I was asked to replicate those figures for the state of Ohio, which I did, and that changed my attitude altogether, and the change of attitude that I then presented to my department changed the department's ideas'. Then a voice from the other side of the table said, 'Me too!'. That change of opinion in two major American states came from work that was made possible by the Victorian coronial data system. It was very successful in reducing deaths in Victoria and it was also successful in changing the international approach to what was perceived as a very strained problem into one that is amenable to scientific attack.

In 2004 I decided I would like to have another look at this problem to see if that success was continuing or things had reverted to the norm, and Graeme Johnstone not only made available access to his database but also lent me his research assistant for a limited period. The results that we found were totally astonishing. The accidents had almost stopped happening — there were 26 in 8 years. But what had happened was an enormous increase in suicides. These are persons who want to commit suicide in a way that will be inevitable, so they choose a means of death that is absolutely certain: they throw themselves in front of a train. It is a horrible, hideous business, but that is what happened.

If I can just complete this part of my report, what I said then is that there has been this enormous change with an increase in the number of suicides. There is in fact an international conference on railway level crossings — believe it or not — every second year. In 2002 the topic of suicide was not on the program. I know that for certain because I was the convenor of that meeting. In 2004 we had done our work but too late to present it in London, where the last one was, but we did include a poster paper, a salient description of what we had done, with a lithograph saying, ‘This is what the accident scene is, and this is what the suicide story is’. That was taken up by the Canadians, and next year, in 2006, in Toronto, Canada, a whole day will be devoted to the issue of suicides at railway crossings and on railway lines. Again I make the point that this is an outcome of a report that was made possible by access to the Victorian coronial database. It has been useful nationally and very influential internationally, and I think Victoria stands to gain from it.

So much for the factual part of my story; now for the opinion. At point 8 on my yellow paper I say that I think the office should be made independent. I do not know to what extent the coroner is independent — as a person he is, and I have great admiration for him, but how independent the office is I am not sure. Whether he is able to make adverse comments about state government departments — that is a thing which I would like to see somehow entrenched into the legislation to enable him, without fear, to make any comments that he deems fit. Secondly, I think three years, the present term, is not long enough. I would suggest five years, renewable, because I think that is the minimum length of time for a coroner to come to grips with the complexities of our present day.

The last point I want to make is at 8.2, dealing with increased powers. There is a question in the discussion paper as to whether the person or the organisation targeted by the coroner should be mandated — that is, required — to respond in some way. I think they should. I do not think they should be required to implement the recommendations, because that could be strange if different coroners make different recommendations, and again I come back to the case of level crossing accidents. Two state coroners have investigated them, and both have found that the principal problem is that three-quarters of our level crossings have no protection whatsoever apart from a sign — there are no lights, no booms, no gates, no nothing. Most of these are in the country, and in Victoria I think something like 2500 of our crossings meet that description. The problem is that you do not expect a train to come, and both coroners, independently and some years apart, said that.

The West Australian coroner said the way to overcome this is to put flashing lights on locomotives. The Victorian coroner said the present system is too expensive — \$300 000 for a set of flashing lights is way out of kilter — and we must find a much cheaper way of providing an automatic warning that a train is approaching. You cannot have two different coroners making two different sets of recommendations and expecting the railway system to meet them both. So, those targeted by the coroner should certainly have to respond, and in writing. I do not know the virtues of tabling those comments in Parliament — that is way outside my area of skill — but I do think there should be a requirement to respond. I also think the coroner should have powers to investigate independently of any other investigative arm and independent of the police. Graeme Johnstone’s classic story is the Mistral fan case. I suspect you are aware of that and the work he did there, which was outstanding. But that is not a thing that is amenable to the police.

About six months ago I had my kids over and we put toast in the toaster and 2 minutes afterwards it was on fire and the bread was burning. I sent the toaster to the chief electrical inspector and asked him to have a look. He wrote back saying, ‘It has a label on it, so it is safe’.

The label says ‘Remember that bread can burn. Never leave your toaster unattended’. So I wrote one of my famous or infamous letters, whichever way you wish to describe it, to say that is totally against all modern scholarship. There was technology available that would turn the toaster off if it reached a certain temperature. There was cheaper technology that would turn the toaster off when it reached the time-expired limit. The cheaper one was obviously the one manufacturers preferred. It would be nice for me to be able to tell you that it has now been

resolved; it has not. But it has now gone to the Australia and New Zealand Standards committee, the appropriate one, and it has set up a working party to redraft that standard.

That is the sort of thing the coroner could have power to investigate through the fire brigade, for example. How many fires have started by toasters burning? That has a great advantage — it is independent of police, there is no prosecution in train and moreover it will help to stop people getting burnt before it actually happens. We are counting fires as our database, not deaths. If we were able to do that, there is every possibility in my opinion that the work of the coroner could in fact lead to a reduction in the dangerous items that are frequently found in our homes.

What would it cost? This is my final point: it needs a well-structured scientific infrastructure, probably two or three people. That I guess is something like a quarter of a million dollars or something of that sort. The pool available for carrying out the investigation is about three-quarters of a million dollars. I put down \$1 million, which is pretty small in state budget terms, to take a very useful step forward. I would prefer — how can I say this? — if that were an internal group within the coroner's office that is amenable to pressure from the coroner. I say that in general terms. I have not the slightest doubt that the present coroner would not abuse that power in any way, but if the institutional arrangements are such that a future coroner 'could' influence, you will go and find out and show that I am right, won't you? That sort of thinking is wrong. So I would like to see a scientific group set up within the coroner's office with access to round about three quarters of a million dollars annually to carry out investigations on a tender basis, rather like the National Health and Medical Research Council, you put out 'this is the subject we want to investigate'. As I was asked by Rafferty as minister, 'What is wrong with the present system and how can it be fixed?'.

Once again I appreciate the opportunity to offer these thoughts to the committee and thank you for allowing me to do it.

The CHAIR — Thank you, Dr Wigglesworth. You have obviously used the national database and its predecessor, the Victorian database, to do the work you have done in the area of railway crossing deaths. Are there ways in which that system in your opinion could be improved in order to prevent deaths in other areas such as the toaster example you gave? Or do you think the data is all there; it is just a matter of interrogating it?

Dr WIGGLESWORTH — It is very difficult to answer that question in a yes/no way. I would be happy to let that question evolve as time goes on. For example, when we wanted to look at my railway crossing accidents, suicide jumped out at us instead. Now, that was totally unknown, and the fact that the data are collected under the heading 'rail-related deaths' meant we had to go through the whole lot manually, and when we did that we discovered the unknown problem of suicide. So I would be happy in general to allow the system to remain as it is, with the proviso that if, as a consequence of some future investigation, there is seen to be a need to revise the data set in some way, then I will not say that is mandated, but that can be taken on board.

Mr MAUGHAN — Following up on your comment about suicide jumping out, does that not indicate that there is perhaps a failure in the coroner's system of identifying systemic problems? Clearly the coroner has inquired into a number of suicide-related deaths associated with rail, and yet there does not seem to have been the recommendation that there is a problem and we need to look at what is causing that problem, which might well be discharge problems with hospitals, for example.

Dr WIGGLESWORTH — Let me just make the point that in 2002 I specifically invited the state coroner to take part in our international conference, and he did so. He did not mention suicide because neither he nor I nor anybody else had any idea of the scale. We certainly knew there was the odd case here and there, but we were thinking in terms of two or three cases a year, that sort of number perhaps — small numbers and probably not enough to register on the database. But in fact it turns out to be much, much larger than any of us could expect. We did not have any understanding of the size of the problem we turned up. It flabbergasted me then, and it still surprises me now, and I wish there were some other way of developing that work further. But to answer your question, I do not think it was a weakness.

Let me answer you in a slightly different way, if I may. The coronial database is not as well used as it might be, very largely because many researchers are not aware of its existence. They certainly are at the Monash University Accident Research Centre where I am an honorary, it certainly is well known there, but in many other cases the availability and the utility of that set has not yet been recognised. To take your question one stage further, there is of

course now a national coronial database being built, which I think is accepted by every state bar one. When I last was told about it there was just one state saying it would come to the party but not yet. When that comes about, after 5 years or 10 years of data it will be an incredibly useful tool.

For example, if I go back to occupational health and safety, at the moment we can look at the occupational health and safety deaths in Victoria only, but initiatives in this field are normally state based. I say 'normally state based' because this is the right moment to make that sort of comment. If, for example, Queensland introduced, as it did some time ago, a health and safety program for the construction industry, how do we evaluate it? What we ought to be able to do is say, 'Okay, this is the level in Queensland before the act and this is the level in Queensland after the act. This is what happened in Victoria over the same period of time. Did this work?', and we could answer it. We cannot at the moment because there simply is not enough data. Thank you for the question.

The CHAIR — Just on this issue of railway crossing deaths, it is of particular interest to me because I have had three deaths in my electorate in eight years. In each case it was a young person basically pushing through the emergency gates against the bells, against the flashing lights and against all the warning signals. We estimate there are probably 20 non-compliant people crossing at the crossings every day of the week in my electorate where people cross against all the warning bells and signals. Do you have any views about how suburban railway crossings could be made even safer, given the fact that, notwithstanding all the technology that is there in the warnings, people still ignore them, drive around the boom gates as you say, and cross through the emergency gates even though all the bells are ringing and the lights are flashing?

DR WIGGLESWORTH — If the bells are ringing and the lights are flashing and there are no booms. That is the classical recipe for somebody to cross the line. Typically, I recall the case of a mature lady bringing her daughter home after she passed her cello exam, and they were going home to tell dad. They came to a T-intersection in front of them, and they stopped and they waited and they waited. Behind them was a dirty great B-double, and the driver after a while leant on his hooter and said 'Get going, get going' and frightened the lady until suddenly she saw a gap coming from her left and she drove quite slowly and deliberately — those are the terms of the report — in front of a train which she did not see coming. Although the description you give, Sir, is accurate, okay, the lights were flashing and the bells were ringing, that is not enough stimulus.

The CHAIR — And the boom was down?

Dr WIGGLESWORTH — That is a different kettle of fish, if that is down. I would want to go and look at the circumstances of that particular case before I would make any comment on it. Certainly, there are anomalies. It is probably the time now to have a fresh look at the level crossing situation in Victoria and see where that early work can be built on or improved.

Mr DALLA-RIVA — Just on your 8.2 increased powers, and specifically 8.21, which says there should be a mandatory requirement for entities named in the coroner's reports to respond publicly and in writing. We have had evidence from other people to suggest there could be some legal problems associated with people admitting liability or guilt in a finding. Have you given consideration to your statement that there may of course be exceptions to that submission?

Dr WIGGLESWORTH — I take your point, very much, but I do not know the legalities of that situation. Frankly, your expertise has vastly outstretched mine — that is, mark you, mine is very small. But I would have thought that had there been an adverse comment by the coroner that in itself might define the context in which the reply can be made. I do not think the reply to that need be an admission of guilt, as I understand your question, but I think it can be saying that okay, changes after an event are not necessarily caused by that event. It is something we have had in mind for a long, long time.

Again, I go back to the railway crossings. In Tasmania about three years ago there was a very nasty accident in which a number of people were killed. After that had happened the Tasmanian government then installed a very powerful strobe light, which takes the place of a boom barrier. It was alleged in court that the fact that they had installed that after the event was an admission of guilt before it. The defence adviser, who was me, said, 'Not so. There is a program here of the installation of these devices. The first one was five years ago, the second one was there, the third one was here and the fourth one has now been done. It is an established program. The railways have a limited amount of money and they make it stretch just as far as they possibly can and this is part of a planned program.' I do not think that there has to be any admission of guilt in general. Does that answer your question?

Mr DALLA-RIVA — Yes.

The CHAIR — Dr Wigglesworth, thank you very much for coming in and speaking to us, particularly on your work in the area of an accident prevention in railway crossings and in the use of the national database. We appreciate it..

Witness withdrew.