CORRECTED TRANSCRIPT

ROAD SAFETY COMMITTEE
Inquiry into the Country Road Toll and Crashes Involving Roadside Objects
Melbourne – 7 June 2004

Members
Mr B. W. Bishop
Mr J. H. Eren
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Chair: Mr I. D. Trezise
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Staff
Executive Officer: Ms A. Douglas
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Witness
Mr G. D. Johnstone, State Coroner.

Necessary corrections to be notified to executive officer of committee
The CHAIR — I welcome the State Coroner, Graeme Johnstone, to the committee. Thank you, Graeme, for your time and input.

Mr JOHNSTONE — Thank you, Ian.

The CHAIR — As you aware we are conducting two parliamentary inquiries at the present time. The first is into the country road toll, and the second, which is obviously related, is into crashes involving roadside objects. We will be reporting to the Parliament in March 2005, so we have a little bit of time up our sleeves. We will soon get to August, September and October, so we need to start putting pen to paper, so we have not got that much time at all. The inquiry we are conducting is operating under parliamentary privilege, so what you say today cannot be used against you in the future.

Mr JOHNSTONE — I do not know about that! It might be!

The CHAIR — Hansard staff are taking a transcript, and we will provide you with a copy.

Mr JOHNSTONE — To start with, I have a fundamental difficulty and I think you should know about it. I will deal with it the best I can.

The CHAIR — Yes, fine.

Mr JOHNSTONE — I will be as open as I can be.

Early last year I directed that we start an inquiry into single-vehicle run-off-road collisions into fixed objects as a result of some information I received on a series of incidents along the Frankston Freeway. For a number of reasons that has not yet been completed, but there are certainly some cases in the pipeline at the moment that I will be focusing on. We have got a number of submissions from agencies, including the CFA and individuals, relating to that inquiry. So in a sense we are both working along the same track.

As an independent judicial officer and investigator I probably have got to be a bit cautious about what I say.

The CHAIR — Yes, I appreciate that.

Mr JOHNSTONE — But I think I need to put on record for you that I am doing this. I am also doing an inquiry, but whether I do that publicly or whether I do it by way of chambers finding on the papers and the material that I have, I am not quite sure yet. One of the cases I am trying at the moment to get together to look at is one incident that occurred on the Geelong Freeway. It was into a roadside barrier. In fact there are two incidents that occurred on the Geelong Freeway into roadside barriers, but for a number of reasons I have been involved in them lately.

Mr STONEY — Is that since the road was upgraded or before?

Mr JOHNSTONE — Yes, since the road was upgraded.

Mr MULDER — Were they barriers or fixed objects? They were poles, were they?

Mr JOHNSTONE — Poles, yes. Fixed objects. Into fixed objects, not barriers. I am sorry. Did I say barriers?

The CHAIR — Yes.

Mr JOHNSTONE — I meant fixed objects. My philosophy fundamentally, and I do not have any difficulty with this being on the public record, is that the consequences of human error should not be such as to result in the death of an individual.

There are the consequences of human error. Our systems ought to be robust enough, where practical or practicable, to protect individuals against the consequences of human error. Now that is not to say that blame does not come into that process. At some levels it does; at some levels it does not. You could say that a minor slip by any one of us on a country road might result in us running into a roadside object — being a tree, a pole or something else.
I do not think it is practicable to remove all roadside objects, but it might be practicable to think about when one upgrades a road about how you design it to reduce the risks of individuals who lose control of their vehicles for a number of reasons and going into those roadside objects.

I think it is a significant amount of the road toll — and I do not have the exact figures here — where single vehicles go into fixed roadside objects. We did a single-vehicle collision vehicle inquest, or a series of inquests, back in 1995, 1996. I do not know whether you have got that material, but in that material comment was made.

On 6 May I delivered a finding recommended the removal of obvious roadside hazards, which may also be assisted by uniform training for council or maintenance workers and subcontractors; improvements in the signage and warnings on approaches to kerbs; and that improved mechanisms needed to be developed by agencies such as VicRoads and police with the aim of identifying hazards in timely areas that may be associated with areas such as road design.

I do not think that is being done well enough at the moment. I do not think either of those things are being done well enough at the moment.

There was a finding by coroner Noreen Toohey in relation to a series of freeway crossover-related deaths on the Old Geelong Road, the Maltby Bypass, the South Eastern Freeway, the Western Ring Road and the Princes Highway at Little River. There were nine deaths for joint inquest. She did that and delivered the finding on 16 August 2001.

That suggested basically in the recommendations that VicRoads ought to look at its standard and how it operated its standard in relation to the implementation of barriers and where it put the barriers in. In other words, where and when the barriers were put in.

You can see on the Eastern Freeway certain examples of Briffen barriers being installed to avoid vehicles running into roadside objects — poles on bridges et cetera.

It is not a big leap to take her finding and say that that would be something that needed to be looked at, because obviously by the time she got to deliver that finding those Briffen barriers were in place along the Eastern Freeway.

The CHAIR — In regards to a finding like that, does VicRoads formally have to reply on that with regards to its response to those types of findings?

Mr JOHNSTONE — No, it does not have to formally reply. There is no requirement for formal replying to any coroner recommendations in Victoria. There are in the ACT and Northern Territory, I think, in relation to deaths in custody.

The CHAIR — Yes.

Mr STONEY — Do you think it would be a good idea if it was required to respond?

Mr JOHNSTONE — For a long time I would have said no. Now I think it would be a good idea. The only problem with that is that there is a downside to it from my office’s point of view, and that is resourcing in relation to handling the responses to the recommendations. The thing about coroner’s recommendations is that they are recommendations only. For a number of reasons government or other agencies — community groups — might not take them up. It might be that the coroner has not looked at certain matters that they have taken into consideration, that the agencies have to take into consideration, and therefore the recommendation is impractical. It may be that the recommendation can be rejigged in a way which is a lot simpler, a lot cheaper or a lot more effective, and implemented in a way which saves resources — in other words the letter is not followed, but the effect is.

The CHAIR — Yes.

Mr JOHNSTONE — It may be that the agency can write back to the coroner and say, ‘Look, we do not agree with your recommendation for these reasons. We think there is an alternative recommendation that we are adopting. We are adopting it for this reason. We believe that will solve the problem’. Or they may say they believe the problem is not solvable, practically and economically.
If the loop is completed I think that coroners would learn much more about developing recommendations, and there would far more accountability within the community, at least in government circles. There needs to be sufficient resources in the coroner’s office to manage that, and there also needs to be sufficient time for an agency to respond. A response system would be useful.

Certainly a number of agencies do respond to us reasonably well and promptly — that is, the police and WorkCover. VicRoads does respond, however I have not seen the detail of the response on this document. I know there was some early response on it, but I think there is final detail because I think Monash University did some research on the recommendation, but that circle has not been completed for me. This is the recommendation in the nine freeway crossover deaths. Certainly the Geelong Road upgrade cut across that finding, if you like.

There have been other recommendations in relation to roadside hazards on visibility in relation to railway level crossings, on visibility in relation to where you plant trees so that you ensure maximum visibility for motorists when they are approaching crossroads etcetera or entering a new road. These are all areas that need a lot of improvement in relation to developing standards, maintenance and training and having council employees who are really being your eyes and ears, your hazard identifiers, as it were, and your and risk managers, so that in simple form on a daily basis a council employee actually starts to identify the hazards and starts to realise where the hazards are. I see plenty of examples when I drive around of areas where trees block your approach to a crossroad. They have obviously been planted not so long ago, or there are issues of trees being planted that are really thick, heavy, fast-growing trees which eventually will have large trunks, and they are close to the roadway.

The CHAIR — Without pre-empting our findings, one issue we have probably gleaned from meeting with dozens of councils across rural and regional Victoria in the last couple of months is that, to me anyway, there are only a few councils that do a programmed road safety audit on their network. The vast majority of councils, I would suggest, do very informal audit work.

Mr JOHNSTONE — I think I recommended in the matter of Morris — if I remember rightly; I have not reread it before coming here — an audit process. I certainly did in one finding, if it is not in the Morris matter. I remember in one finding I make a recommendation for a road audit process. The Morris matter was a single-vehicle run-off-road collision in 1995-96, and I delivered a finding in 1998. I identified high accident frequency issues using information from the towing industry.

On management of risk there is another finding, which is not here, that I can give you, that goes into a lot more depth in relation to the use of a standardised risk management body. Obviously Standards Australia has developed a management standard — I think it is 4360; I think that is it — for local councils across the board and having a standardised way in which you do your hazard identification and risk management. It would be far more beneficial than on an ad hoc council-by-council basis, and far more cost effective I would imagine.

The CHAIR — I may have been unfair on councils, but that is how I viewed it anyway — that is, that only a few councils did a formal audit process at the present time, which was surprising to me.

Mr STONEY — I think that is about right.

Mr JOHNSTONE — The case I am talking about, I think, was Jankovic. I did it back in about 1998-99, but I will get that out and send it up to you.

The CHAIR — Yes, that would be good.

Mr JOHNSTONE — That was really about those issues — not so much hazard identification from a roadside perspective but from a road perspective. I think there were potholes on the road or the road should have had some advance warning about speed and it did not.

Mr STONEY — Could you just explain when there is a death on the road how the system works through to your office? Do you go out to every case, or how does it actually work?

Mr JOHNSTONE — I rarely will go to road-related crashes unless it is a police pursuit-related matter, or a multiple fatality, probably above four or five. What happens is that the case is investigated by the local police in the area. In some cases they will be investigated by the major collision investigation unit of Victoria Police, and the quality of the investigation will depend on the skill and knowledge of the policeman.
Mr STONEY — That was going to be my next question.

Mr JOHNSTONE — Generally what happens with police-related matters is the investigation is done to find an offence. Once you have found the offence then the matter is finished, finalised. With a coronial investigation, however, the real nature of the investigation is to try and find all of the factors involved in the death. To find all of the factors you need to go far beyond just investigating for blame; you need to look a whole range of system things, but I do not think that is done very well. What could usefully happen across the board is a standard investigation process in relation to a fatality whereby every police officer investigates to that standard so you have a minimum amount of information collected, because I am quite sure there is a lot of information that goes missing because the questions are not asked. If the death occurs in Dimboola, for example, the local policeman in Dimboola will do the investigation and he may or may not be skilled in accident investigation matters.

Mr STONEY — Therefore, your finding is based very heavily on the local policeman’s viewpoint and assessment of the accident.

Mr JOHNSTONE — Yes.

The CHAIR — Would you go back to experience, knowledge?

Mr JOHNSTONE — I think it is really a matter of investigating for factors involved in death. If you look at human error as one part of the process, you are looking at the human interaction, human behaviour, vehicle design, vehicle response, maintenance and the like. In the human factors you are looking at the training, the education and the like. Then you are looking at the road, the weather, the roadside furniture, road design issues, road maintenance issues and a range of issues. There are a number of findings. There is the recent finding in relation to the Pettet family who died in Koo Wee Rup: a large transport lost control on the road at Koo Wee Rup and killed the Pettet family and one member of another family. Essentially it was a road design issue but there were other side issues related to that. The major collision investigation unit did the investigation for the coroner but there were still a lot of issues missing in that investigation.

Mr STONEY — To use that as an example, did that particular one come up as a road issue or was it just that the driver lost control?

Mr JOHNSTONE — It came up as a road issue but I think the focus of the police was more on seeing if they could charge him and whether it was driver behaviour — driver of the tanker that is. I eventually found that really it was a road issue.

Mr STONEY — I remember several truck drivers reported that they had had similar experiences and eventually it came out that under certain circumstances you cannot hold your truck on that bend.

Mr JOHNSTONE — That is right.

Mr MULDER — The issue of fatalities whereby the person involved has been found to have drugs in their system, there were some figures put out last year which, I think, quite shocked a number of people. Has that been a growing trend? Is it getting worse?

Mr JOHNSTONE — I think it has always been there.

Mr MULDER — Sixteen per cent?

Mr JOHNSTONE — I think it is a bit greater than that actually. With the single vehicle collision inquest we only did about 127 cases. It was a combined study because we combined with the Monash University Accident Research Centre; the accident investigation squad, which was the forerunner of the major collision investigation unit in the coroner’s office; the Victorian Institute of Forensic Medicine; and I think the Royal Automobile Club of Victoria and the Transport Accident Commission were involved. We looked at 127 fatalities and we investigated them as they happened to a certain standard. We found that the vast majority of drug and alcohol-related cases were low levels of drugs and low levels of alcohol — really low levels of alcohol of .05 per cent and .08 per cent. However, if you look at human error and you think about the problem as a consequence of human error, then you are thinking in terms of how protective the system could be to protect even those people who have taken drugs from actually killing themselves. Of course, you may not be able to avoid that but if the road system is designed in
a way that is protective and the vehicle systems are designed in a way which is protective, then you are reducing the harm and you are reducing the fatality rate.

Obviously you attack the drugs and driving issue and the alcohol issue and the speed issue and those related matters but you also have to think in terms of managing human error. You can have gross human error where drivers drive at ridiculous speeds with far too much alcohol and far too many drugs on board and nothing will save them — that is the sort of behavioural blame issue, if you like. However, the minor consequences of low levels of human error — you are overtired and you lose concentration. If you or I are driving on a country road we probably do not realise how tired we are, or you lose concentration or get a flash of sunlight in your eye and you are distracted for a moment and you lose control. If you think of it like that, it is not a large step to take it to the next stage of saying if you are protective of that sort of incident then you are protective of a lot more as well.

The CHAIR — I would be interested in your thoughts on what I call in-car accessories — mobile phones are the first one that come to mind — and their effect on driver behaviour.

Mr JOHNSTONE — I think ideally they should not be there, but I do not think practically you are going to achieve that result.

Mr STONEY — You are talking about in-car kits and not hand held, aren’t you?

Mr JOHNSTONE — Hand helds should not happen, end of story. That should not happen. I have a car kit, and I use it — I think we all probably have them and we use them. As much as possible I pull over to the side of the road, but sometimes that is not possible.

Mr STONEY — From what you have said, your findings are sometimes compromised by the quality of the information you get.

Mr JOHNSTONE — It will also depend on the skill and experience of the coroner.

Mr STONEY — Sorting out the wheat from the chaff?

Mr JOHNSTONE — And the preventative focus of the coroner — whether the coroner really has a preventative focus to the work he or she does.

Mr STONEY — Carrying on from that, obviously your comments as to the cause of death somehow should be used to improve infrastructure and identify problems on the road which need fixing. Are you in a position to verbally suggest to the committee any type of recommendation we could consider which could help that occur, help your office — just in broad terms?

Mr JOHNSTONE — Help my office?

Mr STONEY — Help you identify —

Mr JOHNSTONE — I think we should be looking at New Zealand and England. England has been operating a standard investigation procedure for motor vehicle collisions.

Mr STONEY — You mentioned that earlier.

Mr JOHNSTONE — That has gone to New Zealand. I am trying to get a copy of an assessment that was done for the New Zealand police accident investigators. If all our fatal motor vehicle collisions were investigated to an improved standard of looking at factors and not necessarily just focusing on blame, then I think that would be a huge step forward. I am quite sure there are many factors which are not identified at the scene and not followed through with: work relatedness, for example. One could say that as a coroner I work fairly late at night or get up fairly early in the morning, if I am overtired there might be a work-related factor in a collision I have. Or a parliamentarian drives home after a long session in Parliament — there is a work relatedness there. There will be many cases where that slips through to the keeper and no-one identifies the work relatedness in the motor vehicle collision so it is underestimated significantly, or the fact that there should have been a work system in place to manage this particular event.
I think that would be of enormous help. That means, and I have said this before, the quality of the investigation
done by the major collision investigation unit needs to be recognised. I think if you talk to the major collision
investigation unit they are under-resourced for the work they do and the results they achieve. Helping enhance their
skills and the way they look at motor vehicle collisions in actually trying to identify all of the factors in the incident,
including road design, maintenance and all that sort of thing, if one did that and used their skills as the base for
training other police in investigation and managing that process, along with the police from the coroners office, I
think that would be a great improvement. It is resource intensive and it is a significantly unrecognised area of police
work. The other aspect of that is the skills of the accident investigation engineers in Victoria Police — there are
only two of them but Victoria would be lost without them. They are underestimated and undervalued and that is
something which needs addressing quite seriously. Coronial recommendations and a mandatory response
process — I would be in favour of that. Improved training of coroners — —

The CHAIR — When you talk about a mandatory response system, getting back to the point we discussed
before where VicRoads, for example, is not at the present time compelled to respond.

Mr JOHNSTONE — There should be a mandatory response — perhaps response within nine months. It
gives them plenty of time to do a lot of work and look at the issue seriously and respond. Obviously it is a
resourcing issue — it has to be managed so that information does not just go into a filing cabinet and sit there.

Mr STONEY — It is what you do with the information.

Mr JOHNSTONE — It is what you do with the information. The training of coroners, and the closing of
the loop as well.

Mr MULDER — What is the process for the training of coroners?

Mr JOHNSTONE — That is a hard question. There was no training program until May of last year when
the Sir Zelman Cowan Centre for Continuing Legal Education and the Judicial College of Victoria got together
and put together a training package for coroners across Australia. That was held for three days in May and there
will be another one in May of next year: a package is being put together by the judicial college and the Zelman
Cowan centre.

Mr MULDER — Is that based on any other model around the world?

Mr JOHNSTONE — There is no other model around the world. That is the difficulty. Coroners work in
the country is ad hoc. For country magistrates coroner’s work is part of their day-to-day work but it does not
receive a high priority because they have other things to do — Children’s Court, Magistrates Court. Coroner’s
work requires a different level of thinking. You have to think in terms of human error, in terms of systems, in terms
of factors and what you do to solve the problem; comments, recommendations and how they link together; what
the patterns have been and whether this is part of a pattern or something unusual; what is the quality of the
investigation — if you have not seen many of them you will not know. It is like the country policeman who have
not done one of these before — they put it together the best way they know how but often they
do not pick up all of the points.

I learned a very good lesson when I was a coroner back in 1988 or 1989. I was in the new Coronial Services Centre
and we were doing a hearing into a single vehicle run-off-road collision into a pub. The gentleman had a reading of
.22 per cent or something like that. It was in Dandenong Road just outside the Oakleigh courthouse where the road
swings to the left. There is a median in the centre, you have the Oakleigh courthouse on one corner and on the
opposite corner, which is down a bit lower, there is a hotel. This gentleman was doing about 80 kilometres — it
was a 70-kilometre-an-hour zone — it was at night, the road was wet and he lost control on this slight bend, went
straight across the road and into the pub corner and killed himself. I heard the summary evidence about what
happened — we did not go into any greater depth in this case than what the policeman told us
happened — we did not call any witnesses. It was a young constable in the witness box and I said, ‘Okay, thanks
very much, you can leave the box’. He said to me, ‘No, there is more’, I said, ‘There is more? He had a reading of
.22 per cent, he was slightly over the speed limit and lost control. It is pretty obvious what happened, isn’t it?’. He
said, ‘No, it isn’t. If you look at that road, I did a search on the VicRoads database and I identified eight similar
collisions where everyone survived.’ They all lost control on that corner, some within the speed limit, some just
outside the speed limit. Most were on wet roads. He said, ‘There is a problem on the road as well as a problem with
the driver’. That taught me a very significant lesson. Remember that was in 1988 or 1989 — a number of years

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ago. He was doing his job better than I was doing mine because he was thinking laterally about how you solve a problem, and he was not a trained accident investigator. That is really what I think your committee is probably about. He taught me an absolutely brilliant lesson.

The CHAIR — One issue we have come across in our travels throughout rural Victoria is where there has perhaps been an accident or a council has identified, for example, a tree that is in a dangerous condition corresponding to the road, they have had difficulty having it removed through the bureaucratic process of dealing with agencies like the Department of Sustainability and Environment. Hence, the trees remain because of an environmental issue or concern.

Mr JOHNSTONE — Is there a replanting program?

The CHAIR — There is a replanting program — if a tree is removed I think there is a program of planting 40 trees for every tree which is removed. That obviously raises its own issues.

Mr JOHNSTONE — It does. I think the real problem is often the risk management is undertaken on an incorrect basis — that is, the risk management is based on you wait for a collision, see how many collisions there have been in that particular corner or spot and then you work out how you manage it. Our systems should be sophisticated enough to be able to manage a risk because the risk is there and it is going to happen sometime. There are pretty obvious risk areas and you know it is going to happen because you have seen it happen before in other spots. If you look at the Pettet finding in the Koo Wee Rup matter, that is what I was talking about — risk management means a lot more than using accident data to identify your hazard and manage your risk. You have got to be far more proactive than that. I think it is going to be difficult for agencies to get their head around that. It is obviously a costly business, not necessarily fully achievable.

Mr STONEY — Have you had any issues with cruise control that may have contributed to an accident?

Mr JOHNSTONE — Not that we have been able to identify. Again it could be there but it is not necessarily something that has been looked at. But if I give you the Pettet finding and the other finding of Jankovic, I think you will see where I am coming from. This is not unusual thinking. It is James Reason’s approach to accident prevention. He is the English accident investigator. It is the way the aircraft industry tries to reduce the risk of crashes. It is the way the English accident investigation system is trying to move. It is a recognised model which we do not do well enough because we think too legally.

Mr MULDER — Can I ask you about findings? We have had some discussions about road design and road conditions. Does the maintenance of roads by road authorities figure prominently?

Mr JOHNSTONE — Pettet is one of the cases about road maintenance, so that fits. There is a greater issue, and the issue is getting all councils to work uniformly towards the injury prevention and safety process. That is relevant to the farm inquiry and relevant to a range of other things as well, including the committee on farm safety issue, so it is relevant to what it is doing. I have had a circumstance where I live. I wrote a letter to council about a particular issue and it received little attention. It was a direct safety issue, and the safety issue is still there.

Mr MULDER — Was it a maintenance or design issue?

Mr JOHNSTONE — It is a design and traffic control issue where pedestrians and cars are likely to mix and be at risk of death.

Mr STONEY — Did you write just as a ratepayer?

Mr JOHNSTONE — Yes.

Mr STONEY — Do you think if you had written as the coroner the council might have sat up?

Mr JOHNSTONE — Yes, but I cannot do that.

Mr STONEY — No, I understand that. I am trying to work through whether if in fact the coroner in the future might be able to make firmer recommendations to road authorities and whether it may assist the whole process. I know you do now, but I am thinking about how we can strengthen that.
Mr JOHNSTONE — I think it could be strengthened. The uniform and systematic approach to having all councils moving in the same direction would be useful.

Mr STONEY — It would require a lot more resources for you I suppose?

Mr JOHNSTONE — No, I think it means resources for councils too. My resource issue would be relatively low in the sense that you would just need a system to manage the responses, so you are probably talking about one officer. You are probably talking about upgrading the computer system to cope with it, or it might be part of an officer. But when one is looking at the issue of having a standard risk management approach to road design and maintenance issues, then you are looking at resources for local councils right across the board to get them trained up. After all, you would have an enormous number of risk managers out there if they were well trained in a simple method of identifying risk areas, overhanging branches over signs and that sort of thing. You see them all the time. You see signs put up and there is a tree there so you cannot see the sign until you are right on it, or poles put up so you cannot see the sign until you are right on it, and all of those sorts of things.

The CHAIR — Having been on this committee for four years, that is how I spend my time now, Graeme. I drive around and I cannot help but look for hazards on roads. I point them out to my kids, and they are totally bored.

Mr JOHNSTONE — I do it all the time myself.

Mr STONEY — So do I.

Mr MULDER — With the new Road Management Bill we have a process coming into place whereby councils will carry out an audit on their roads and establish a maintenance program, and that maintenance program is what gives them their legal protection. But of course one of the criteria is available resources for setting up the road management plan and the road maintenance plan. Under-resourced councils can point to a lack of resources, and therefore they only grade a road every six or 10 months and patch it every so often. The plans are in place but they are still determined by resources, not by what is best practice.

Mr JOHNSTONE — I understand that. That is probably a never-ending problem. I do not know how you resolve that.

Mr MULDER — What restricts your ability to make a recommendation as a coroner in relation to a road that may need some changes to the design work?

Mr JOHNSTONE — It has to be relevant to the death.

Mr MULDER — It has to be relevant to the death.

Mr JOHNSTONE — If there has been a very good quality investigation done by the police generally you will get most of the information. Sometimes when you are doing an inquest, like Pettet, a lot more information comes out as you are running an inquest. In fact, that happens invariably more often than not. We cannot run inquests in the vast majority of cases. We get 4200 deaths reported to us annually and about 1600 to 1800 deaths are true coroner’s case deaths, the rest are natural case deaths. We have to investigate a range of things from medical error through to work-related death through to road death. We run inquests into about 250 cases. You cannot run inquests into all of the 4200 deaths, otherwise you would not achieve anything. It is a matter of a better ability to identify the hot spot areas. We have a suicide researcher, a work-related death researcher, and a general injury researcher, whose contract will terminate in October. We certainly do not have a road safety researcher. We identify cases by a range of means including watching the newspapers to identify issues, or using our own intuition about problem areas, but sometimes intuition is wrong and things might be going through that you have not seen as problem areas because you do not have a research process that enables you to better identify the problem areas, although the information is there; you just do not necessarily have the ability to get it out.

The CHAIR — Is there a need for a road research position within the coroner’s office?

Mr JOHNSTONE — It would be useful. We have looked at general injury; it would be useful to move on to road research. But the real problem we have with our research unit is that we have no management process for it. It is managed by a registrar who is a clerk of courts and they are not skilled research managers, so our researchers are constantly battling to get more research guidance rather than clerical guidance. So that is a problem.
The CHAIR — In regard to the inquiry that I think you are doing at the present time with single vehicle run-off-road crashes, are recommendations available?

Mr JOHNSTONE — I will be making recommendations when all the information is together for the case that I am using as the centre case. The question is whether I run an inquest or just do it by a detailed chambers finding, which might mean 20 or 30 pages of quoting all the necessary material and making a recommendation.

Mr STONEY — Will that be available to us?

Mr JOHNSTONE — It will be if it is completed by the time you are about to complete your inquiry.

Mr STONEY — Have you any time line for yours?

Mr JOHNSTONE — When the police officer finishes his investigation; that is the problem. You can probably glean from what I have said broadly what I will be looking at. I will not be making any recommendations for my own office; I will be making recommendations for outside agencies. I make recommendations for my own office but rarely in the way in which I have spoken to you because I do not think that is appropriate and I do not think you build your own resources by your own recommendations.

The CHAIR — Fair enough.

Mr JOHNSTONE — Sometimes you might have to but I do not think that is appropriate.

Mr STONEY — So what percentage chance would you put on — —

Mr JOHNSTONE — To getting it complete?

Mr STONEY — Before we have to finalise ours?

Mr JOHNSTONE — I will do my best!

Mr STONEY — That is a good answer. It makes sense to try and put as much extra information into ours.

Mr JOHNSTONE — But you will probably have more knowledge than I when you have finished because you have had a more general look at the issue.

Mr STONEY — Perhaps not at some of the specifics that you will be looking at, which I think would add to it.

Mr JOHNSTONE — That is why I thought I had better come and talk to you.

The CHAIR — We appreciate that.

Mr JOHNSTONE — I think the road safety issue is about working together and that whole process because the more we do together, the better the result will be in the end. I will try and get you some more material. Do you have material on the number of collisions?

The CHAIR — We are pretty much getting all our statistics from the various organisations — VicRoads, Victoria Police.

Mr JOHNSTONE — I did make a recommendation about the inadequacy of the data collection process because it is only reported to the police in the event that there is an injury or they turn up at the scene. I think there would be an enormous amount of material in insurance databases — —

The CHAIR — We have just completed an inquiry into older road users and we made that recommendation.

Mr JOHNSTONE — Into off-road use?

The CHAIR — Older road users.
**Mr JOHNSTONE** — The VicRoads database is limited by the reporting. We get most of the fatality stuff but there would be a whole lot of near misses where no-one is injured but there is a fatality waiting to happen, and that is not good risk management. Then there is the National Coroners Information System, so I will send some information to you about that.

**The CHAIR** — Thank you Graeme. We appreciate your time.

Committee adjourned.