TRANSCRIPT

ROAD SAFETY COMMITTEE

Inquiry into motorcycle safety

Melbourne — 17 October 2011

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Witnesses

Judge J. Coate, state coroner,

Ms S. Hauge, manager, and

Mr D. Hogan, team leader, coroners prevention unit, Coroners Court of Victoria.

The CHAIR — Welcome to the public hearings of the Road Safety Committee's inquiry into motorcycle safety. The committee has received some 68 written submissions, and we are very pleased to have a number of the people who have made submissions speak to them or give viva voce evidence on a range of issues. The purpose of the hearings is to gain further evidence from selected witnesses that might assist the committee with its inquiry into motorcycle safety and reducing the incidence of death and injury. We thank you for attending.

There are a number of people who may have recording devices or telephones. We would ask them to turn them off. Hansard will be the only method of material being recorded. You are reminded that anything you say or publish before the committee today is protected by parliamentary privilege. However, statements made outside of this room do not have that benefit of privilege. I would also remind people to try to keep noise to a minimum. That will assist the work of Hansard, as they are recording the proceedings.

With those words of preamble, I would like to welcome the state coroner, Judge Jennifer Coate. Thank you for your time here today together with Mr David Hogan and Samantha Hauge. We invite you to speak to us, and we will then have the opportunity to ask questions later on.

Judge COATE — Let me start by saying thank you for inviting us to attend. We are really delighted to be here and have the opportunity to hopefully engage in a discussion rather than a lecture. What I propose to do is just spend a few minutes introducing the jurisdiction of the Coroners Court of Victoria to you, and then I am going to hand over to David Hogan, who is a team leader inside the coroners prevention unit. He is going to speak to the terms of reference and address what we can assist you with in terms of the terms of reference and then give you the opportunity to ask us any questions. Samantha Hauge to my right is the manager of our coroners prevention unit, and as I have indicated to you, David Hogan is a team leader inside the prevention unit.

Just very briefly, the function of the Coroners Court of Victoria is to independently investigate what are called 'reportable deaths'. I will come back to that in a moment. Our function is to do three things in that investigation, or four, I suppose: independently investigate, establish the identity of a deceased person, their medical cause of death, and then the circumstances in which they have died. That really is most often the focus of the work that we do — the circumstances in which the death has occurred. Why do we do that? We do that to contribute to any reduction we can achieve in preventable deaths, and of course that is where our minds meet, no doubt, in terms of this inquiry. And also we aim to promote public health and safety and the administration of justice in the context of those investigations in which we are involved.

In regard to a reportable death, I will not go through the entire list. Obviously for our purposes today a death that occurs as a result of accident or injury is a death reportable to the coroner. So obviously for motorcycle deaths that occur in Victoria, either the cause of death or the consequences of that will be deaths that are reported to the coroner.

Our investigations are conducted generally in the first instance by members of Victoria Police. It may be the major collision investigation unit if it is a multiple fatality, if it is a fatality that involves one of the emergency services or indeed if it is a fatality that involves police, as in a police pursuit. But primarily they are our investigators: Victoria Police and the major collision unit. Then the members of the coroners prevention unit will, back inside our court, assist the coroners in their investigations, gathering information for the larger purposes of the promotion of public health and safety, and you will hear about that in just a moment.

The coroners prevention unit was commenced in 2008, but I think it would be fair to say it really started to effectively be operational in the wake of the new act, which became operational on 1 November 2009. The role of the prevention unit is to assist coroners in their public health and safety role. Coroners are all lawyers, so we do not come with any specialised training in public health and safety or epidemiology or aircraft engineering or all of the other areas of expertise.

The CHAIR — You are limiting the skills of your profession!

Judge COATE — That's it! So that is the reason the initiative of the creation of the coroners prevention unit has added such a terrific dimension to the work that we are able to do. That has been part of the package. Also with the change in legislation that has meant now that with any recommendation that a coroner makes as a result of an inquiry, be it with inquest or without, it is mandatory for the body that is the recipient of the inquiry to respond in writing to that coroner's recommendation. That is a very new initiative post 1 November 2009,

and I suppose we are just starting to see that develop now as a body of work. David will speak to you a little bit about that as we go through.

I am going to hand over to David now, who as I said is going to address the actual terms of reference.

Mr HOGAN — Thanks, Your Honour. We thought we would just make a few points addressing each of the terms of reference to base our discussion later on about the details that we have provided.

Starting with the first term of reference, the trends over time and the crash types, including on-road and off-road crashes and different levels of breakdown for rural/urban, experience levels et cetera, the Coroners Court does not maintain a database of sufficient detail to examine these trends on a systematic sort of basis. We rely on the road safety agencies basically for such information. We have developed a database which holds all data of reported deaths, including motorcyclist deaths in Victoria. This database includes items such as what you would expect around age, sex, residential and incident suburb, the intent and the mechanism of injury. But because the number of causes of death we have in the court are so broad, there are simply not the resources to systematically code for all sorts of risk factors around different causes of death.

The information on rural/urban location, rider experience and motorcycle type is typically determined by coroners on a case-by-case basis as a part of their investigation. Determining whether a crash occurred at an on-road or off-road location is a bit more complex, so the criterion for inclusion in the road toll — so an on-road death — is that the incident must have occurred on a public road. The court works closely with and has had observer status on the fatality review panel, and the court assists the panel in assessing deaths for inclusion in the official road toll through the provision of coronial information.

The Coroners Court can also utilise the National Coroners Information System, which is a national database containing coroner-reported deaths.

In terms of the second term of reference, the changing face of motorcycling and in particular patterns of motorcycle usage, because coroners predominantly investigate motorcycle deaths on a case-by-case basis, it is difficult therefore for individual coroners to identify changes or patterns over time, although one of the jobs, I guess, of the coroners prevention unit is to stay abreast of these sorts of issues, current strategies and current policies to make sure that we can provide that information to investigating coroners where required.

In relation to the third term of reference, the attitudes of riders to safety and risk-taking, including drugs, alcohol, speed, the use of protective clothing and fatigue, individual coroners may have explored these issues as a part of their investigations. The coroners prevention unit examined all recommendations made by Victorian coroners between 2000 and September 2011. Coroners made recommendations in relation to 23 fatal motorcycle crashes. Five of these occurred off-road.

In relation to the risk-taking sort of area, in three crashes recommendations were made for site-specific improvements to reduce the speed limit or to deter speeding motorists. No recommendations were made by a coroner in regard to drugs and alcohol, protective clothing or fatigue in relation to motorcycle deaths. Aside from these formal recommendations, coroners may also make comment in connection with a death and may direct that a copy of their finding be forwarded to relevant agencies for their information.

In terms of the fourth point of reference, riders' and drivers' attitudes to each other, the court considers that it is unable to comment on this, although individual coroners may have considered that issue. Of the 23 fatal motorcycle crashes resulting in recommendations, none of them related to rider and driver attitudes towards each other.

On the fifth term of reference, responsibilities for improving the safety of off-road riders, the term 'off-road' appears to be used quite loosely. It is understood that in theory off-road riding can also occur on-road because a proportion of forest trail networks in Victoria are actually classified as public roads.

The safety of motorcycle riding in off-road settings is an issue that has been subject to particular attention by coroners recently. The coroners prevention unit has provided assistance to coroners in three separate investigations but each concerned different settings in terms of off-road motorcycling. It is evident that off-road motorcycling is a diverse activity and may take various forms. The main groups that we as a court have

examined are trail bike riding in areas such as forests, parks and bushland; riding on private property for work or leisure; and riding on official tracks and venues used for sport or leisure.

Between 2000 and 2010 the coroners prevention unit identified 68 off-road motorcyclist deaths in Victoria. About half of these deaths — exactly half actually, 34 — concerned trail bike riders in forest, park or bush settings. VicRoads has advised the CPU that 20 of the 34 trail bike rider deaths were counted in the official road toll because the deaths occurred on what were declared as public roads. The non-fatal injury toll associated with off-road riding is also significant, as identified by the recent Victorian Auditor-General's Office report.

It is evident that there is no lead agency responsible for addressing off-road motorcycling in Victoria. The diversity of off-road motorcycling appears to complicate the issue of identifying those agencies that are best placed to respond. A collaborative approach would certainly be beneficial to draw on the knowledge and expertise of various stakeholders. Trail bike riding appears to be one particular area requiring further scrutiny in that regard.

Coroners have made recent recommendations in response to this issue, including that the Department of Health establish a Victorian injury prevention strategy and place off-road motorcycling as a priority, and that VicRoads establish a subcommittee of the then Victorian Motorcycling Advisory Council to address the issue of off-road motorcycling. This recommendation was also repeated by another coroner. It was the intent through that recommendation that that subcommittee would contain the relevant members and agencies that would be able to contribute to the safety of off-road motorcycling in Victoria.

The Coroners Court of Victoria has been advised that the Department of Health has released the Victorian Public Health and Wellbeing Plan 2011–2015, with injury prevention listed as a key priority area. The plan provides the opportunity to coordinate injury prevention in line with statewide prevention and population health goals. It is the understanding of the court that the Department of Health at the moment is establishing what those injury prevention priorities and actions will be across the board.

The Victorian Motorcycle Advisory Council has since been replaced by the Motorcycle Advisory Group, which reports directly to VicRoads. The court at the moment is unaware essentially of their involvement or proposed involvement in off-road riding at this time.

For term of reference (f), the efficiency and effectiveness of the accredited provider scheme in the delivery and administration of motorcycle licensing, the Coroners Court is aware of the general debate regarding the adequacy of the current motorcycle licensing system in Victoria but is not able to specifically comment on the subject of the accredited training and test provider schemes as such. The court is aware that VicRoads released a discussion paper in 2010 on options for improving the graduated licensing system for motorcyclists in Victoria. The court is supportive of improvements to the motorcycle licensing system to better equip novice riders with sufficient knowledge and skills to minimise their risk of future injury.

For term of reference (g), countermeasures used in Victoria, Australia and other comparable overseas jurisdictions, the Coroners Court relies on the road safety agencies to inform coronial investigations and to advise on promising countermeasures available to reduce motorcyclists' injuries. The coroners prevention unit is also designed to support coroners by bringing to their attention available countermeasures.

The coroners prevention unit examined all recommendations made to Victorian coroners between 2000 and September 2011, and there were 18 recommendations made in relation to off-road crashes by Victorian coroners. In 11 crashes recommendations were directed at site-specific improvements to the road environment. There were no coronial recommendations made in relation to behavioural change programs. There were no coronial recommendations made in relation to the design and technology of motorcycles. No coronial recommendations were made in relation to protective gear. In two crashes recommendations were directed at the licensing system. The coroners called for power-to-weight ratio restrictions for learner and probationary riders and compulsory defensive riding courses upon graduating from the probationary period prior to being able to ride larger, more powerful bikes.

Recommendations have also been made in two deaths in relation to improving emergency response times at particular sites. Those recommendations have involved details such as emergency markers being in place so that they can identify where incidents occur, adequacy of mobile phone systems in rural areas, the provision of roadside telephones, and in one instance provision of a helicopter landing site in the immediate area.

For term of reference (h), new initiatives to reduce motorcycle crashes and injuries, the court is not able to comment on new initiatives in the motorcycling safety field, although Victorian coroners certainly welcome information on new initiatives to inform their investigations. Perhaps off-road motorcycling, which accounts for a considerable proportion of all injuries but receives minimal attention, is one area that could benefit from further action.

As to term of reference (i), the appropriateness of the TAC premium for motorcyclists, all motorcyclists in Victoria must pay a TAC premium as part of their vehicle registration. We are not able to provide any additional comment on that, nor have any coronial recommendations been made in that regard.

For term of reference (j), the effectiveness of the motorcycle safety levy, again we are not able to provide any specific comment on this. The court is aware of a call for the safety levy to apply to motorcycle licences rather than vehicle registrations in an effort to address the safety of returning riders, such as those who return to riding after a considerable period of non-riding. This measure would require motorcycle licences to be separate from car licences. A safety levy attached to the licence may then deter riders from retaining their licence despite not riding. Upon returning they would then be required to undergo a licence test. However, this has not been specifically considered by a Victorian coroner to our knowledge.

On term of reference (k), the ways government can work with non-government stakeholders to achieve motorcycle safety outcomes, coroners regularly seek input from relevant stakeholders as part of their investigations, particularly those who may be impacted by those recommendations. Close working relationships between agencies are certainly important in progressing road safety in Victoria. As an example, the coroners prevention unit undertook a systematic review of deaths investigated by coroners over 11 Christmas holiday periods. This review was initiated at the request of Victoria Police to support their ongoing efforts in reducing the number of fatal crashes. The court worked closely with Victoria Police, VicRoads, MUARC — the Monash University Accident Research Centre — and the TAC throughout this review. The coroners prevention unit continues to have ongoing discussions with Victoria Police in relation to motorcycle safety. Consideration was given to undertaking a systematic review of all motorcyclist fatalities in Victoria similar to the Christmas holiday road toll review; however, given the current parliamentary inquiry, a decision was made to await the outcome of the final report by the Road Safety Committee prior to dedicating resources to such a review.

The Coroners Court is also represented in a driveway safety committee, a statewide group that was formed in response to a series of child run-over deaths in driveways. The success of this committee is a further example of the benefits to be gained through stakeholder collaborations and drawing on the experience and expertise of others to achieve a shared objective.

In terms of final comments, coroners serve a unique and important public health and safety role by independently investigating deaths in Victoria. Coroners are able to make recommendations where necessary in an effort to reduce the incidence of future death and injury. Between 2000 and September 2011 coroners have made recommendations in relation to 23 fatal motorcycle crashes. A total of 36 individual recommendations were made.

Off-road motorcycle riding, and in particular trail bike riding on public land, appears to be an emerging area of concern that would benefit from further attention. The diversity of off-road motorcycling has complicated the issue of identifying the agencies best placed to respond. Responsibilities could be divided across the main off-road riding settings. A collaborative approach may also be beneficial to draw on the knowledge and expertise of various stakeholders.

Judge COATE — Chair, we have copies of the notes David was using to do his presentation. To assist the members on the inquiry we are happy to leave all of you copies of those notes.

The CHAIR — Thank you, Judge Coate, we would be pleased to take delivery of those notes. One copy for the executive officer would be of great help. We have a number of questions that we would like to raise with you. The first question will be from my colleague Mr Languiller.

Mr LANGUILLER — Thank you, Judge. Thank you all for your submissions; they were useful. The committee notes that some coroners make specific recommendations in relation to motorcycle fatalities. What happens to these recommendations? Are they followed up on?

I wish to refer to your submission and the record of investigation by Coroner Andrew Thomas Capell into the death of Cody Joshua Williams. I note the recommendation, and if I may I will read it in order to make sure that the record has it clearly. This relates to the inquest of 23 June 2009, and I quote:

> Given the recommendations made in the Monash University report and in the Royal Children's Hospital report and given the tragic death of Cody I urge consideration of the introduction of some regulation that will ensure that children under a certain age cannot ride a motorcycle off-road until a certain level of competency/hazard appreciation has been achieved. This could be achieved through a membership of a recognised motorcycle club with supervision of club members and coaches in a controlled environment.

He continues further, and this is dated 23 June 2009. I wonder if you can comment on that?

Judge COATE — Comment upon?

Mr LANGUILLER — You make recommendations — —

Judge COATE — Yes, what happens to them.

Mr LANGUILLER — In this case in 2009. What actually happened? Did you follow that up? Has there been any outcome? You have written to agencies, you have made recommendations. We would be interested in knowing, first of all, if your recommendations have been taken on, and whether you have followed them up, if I may ask with respect.

Judge COATE — Perhaps I will take that on. Our jobs are to investigate the circumstances surrounding the death, as I indicated, make findings of fact about the circumstances in which the death occurred, and then make any comments or recommendations about public health and safety that arise from the investigation. The new legislative framework that we work in now gives us a capacity to publish on our website our recommendations and mandates the entity who is the recipient of our recommendations. They must respond to us in writing within three months. That is a legislative requirement that is new. A, we are not resourced to follow up what they do or do not do; but B, we would have to be careful about taking on the responsibility to actually enforce our orders, just like any other court. A court makes a finding, it makes an order — it does not then go out and enforce the order.

The previous government, which was responsible for this new act, made a number of investigations into whether or not it should be mandatory to implement a recommendation of the coroner and decided that they would not make it mandatory to implement the recommendation, rather mandatory that there be a response to it and we publish it. I think the thinking behind it was that the public pressure of having your response published on the court's website would create sufficient impetus to ensure that the body responsible would be held to account.

Mr LANGUILLER — For the purpose of being clear procedurally — I am not legally trained, so I do not know — —

Judge COATE — That is okay.

Mr LANGUILLER — So your coroner makes a recommendation — —

Judge COATE — Yes.

Mr LANGUILLER — Who would that recommendation be sent to?

Judge COATE — That is where our prevention unit comes to the fore, so we rely on their expertise to tell us who the appropriate body is to help us identify. The appropriate body will use again the expertise of the prevention unit to frame that recommendation into public health language rather than lawyer's language, so we are endeavouring to be as targeted as we can to the body who is the recipient of our recommendation.

Mr LANGUILLER — If I may further, in this particular case what was the case? Was it referred on to a minister presumably, or you cannot comment?

Judge COATE — I cannot tell you about the particular case.

Mr LANGUILLER — So you would not know whether it was responded to either?

Judge COATE — It was a regional coroner, so no. We do not monitor all of the findings of the court. I could certainly find it for you.

Mr LANGUILLER — If you could.

Judge COATE — I am very happy to do that.

Mr LANGUILLER — Just as a case study it would be interesting to know what has actually happened in terms of whether a recommendation is made, who is it made to and where that recommendation was made was it followed up on — just procedurally, if you could.

Judge COATE — If it was formalised into a recommendation post 1 November 2009, you will be able to get onto our website and have a look yourself at what response came in, because part of what was — —

Ms HAUGE — This was pre 1 November.

Judge COATE — Was it? I thought you said it was June 2009.

The CHAIR — Andrew Capell was June 2009, which would be pre that reporting requirement.

Judge COATE — Sorry, yes.

The CHAIR — Perhaps to this issue of a recommendation that has not necessarily been followed through or responded to specifically, which might be a relevant point to note, and whether there are any earlier coroners recommendations that have been passed on but not necessarily been the beneficiary of a post-November 2009 response might also be something of interest.

Judge COATE — We would be happy to assist you with those recommendations that you have heard David refer to — the number of recommendations for that work that was done inside the prevention unit from January 2000 through to 2010.

The CHAIR — Yes. I think it would be interesting.

Judge COATE — If you would like to collect those.

Mr LANGUILLER — Yes. If I may just clarify the intent of my question, it is that of course the committee values your recommendations and your work and the committee would certainly be interested in knowing whichever agency is relevant or pertinent to the case actually follows up on or not.

Judge COATE — Yes.

Mr LANGUILLER — Thank you.

The CHAIR — I would add too that in a number of the cases there have been recommendations about there being a minimum age to use an off-road trail bike. In farming communities that would be an amazingly difficult matter to come up with some sensible policy guidelines overall, but I think it is still of relevance to examine what the recommendations have been and to see where they have landed and what the response has been.

Judge COATE — We can certainly pull those together and provide you with those.

The CHAIR — Thank you.

Mr TILLEY — Thank you, Your Honour, for the assistance you are giving the inquiry today. My question relates to another one of the recommendations, and in particular an inquest that was heard in chambers into the death of a 21-year-old male on 15 January 2010. It was heard by Coroner Spanos. I will go to the recommendation:

> I recommend that VicRoads establish a subcommittee of the Victorian Motorcycling Advisory Council —

which has now been replaced, as you are no doubt aware, by the Motorcycle Advisory Group —

whose prime responsibility is to examine off-road motorcycling incidents in order to develop evidence-based strategies to reduce the number of injuries and fatalities.

You can take my question on notice and get back to the committee. Has the coroner been advised by VicRoads that such a body — subcommittee — has been appointed or the recommendation has been taken on board as yet?

Judge COATE — We can certainly find that out for you and get back to you about that. That one is certainly — I will get the date right now — post-1 November 2009, so that one will be published.

Ms HAUGE — There should actually be a response from VicRoads on our website, but we are happy to send that through to you.

Mr TILLEY — Okay.

Judge COATE — Sometimes the response is, 'We are working on it', and that is understandable because some of these recommendations are obviously quite complex and take some time to actually implement, so it is not unreasonable that they say that at the three-month mark, because the three-month mark is the compulsory time at which they are required to respond. It might be that what they are telling us is that, 'Work is under way and we will continue to report back to you'. Part of what Samantha Hauge does as the manager of the unit is ensure that those responses are published up on our website as they come in so that the entire public of Victoria can look at what is happening in response to our recommendations. But we certainly can assist the committee and give you responses.

The CHAIR — Good. Thank you.

Mr TILLEY — Can I go on with an unrelated one, just to follow up in relation to the quality of inquest briefs submitted particularly by Victoria Police. You did make mention that the major collision unit investigates multiple fatalities in the state of Victoria, but those incidents where significant motorcycle fatalities occur will probably be single cycle and the investigation more than likely would be undertaken by the officer on the spot who does not necessarily have the breadth of experience that those who are part of the major collision unit would have. Are you able to give some comment in relation to the quality of the evidence that is provided by Victoria Police in enabling the court to be able to significantly investigate from that brief?

Judge COATE — The short answer is it is variable, the quality of the initial content of the investigation. We are doing some work on that with Victoria Police at the moment and trying to standardise the way in which that report material comes to us depending on the nature of the investigation — there is quite a lot of work going on — but we, as the investigating coroner, also have the capacity of course to ask further questions, request further information, seek directed statements from individuals, and we will often do that. That is where the important work of the prevention unit comes in. If they say to us what is really important to understand about the particular circumstances of this death, the sorts of information that trained epidemiologists and people working in the health field can tell us and say, 'We have got no information about A, B and C and driver fatigue, driver clothing, driver attitudes. Can we please, through you, go back and get our investigating member to get that information for us?', we can do that. It is resource intensive and leads to complaints about delay, but the quality is important for us, so we will take that on and can do that. Our capacity to do that has been enhanced recently by the new act.

The CHAIR — Thank you.

Mr PERERA — You have highlighted that one of the major impediments to responding to all motorcycling injuries has been the lack of a lead agency to coordinate efforts. Given the large amount of data collected by your office and also other agencies, how do you coordinate the data you have collected? Is there an issue?

Judge COATE — David?

Mr HOGAN — The question is in regards to the quality of the data available?

Judge COATE — And the sharing — —

The CHAIR — Do you share data with other organisations?

Ms HAUGE — We are starting to.

Mr HOGAN — Yes. We are certainly starting to, but also through coronial findings. A lot of the data that we actually produce is included directly in the coronial findings. We ensure that they are directed to the relevant road safety agency so they can have access to that data basically. We also quite often have a fairly collaborative process — for instance, for off-road motorcycling we worked with the Department of Sustainability and Environment and also VicRoads in terms of identifying the distribution of the deaths around the state which had occurred on classified state roads and which had occurred technically off-road. That was a very collaborative relationship we had with those groups. But we would encourage road safety agencies if they request specific data that we have, to certainly make a request of the court for that data.

Mr PERERA — So the issue is not having a lead coordinating agency to get all the data?

Mr HOGAN — For us to collect this sort of data is very labour intensive because we need to get the briefs of evidence of all of the deaths essentially and manually hand code the different variables of the different risk factors that we have identified. When you compare that to the type of data collected for on-road crashes, which is all systematically collected by Victoria Police going through to VicRoads and then through to the TAC, there is not that sort of level of systematic coding, I guess, or systematic data collection for off-road deaths as there is for on-road. That sort of approach would be immensely beneficial because you would be able to essentially press a couple of buttons and get the type of answers that you want rather than spending months intensively researching these things.

Mr PERERA — Do you have any particular recommendations?

Mr HOGAN — Again, in line with the coronial recommendations that there be a multi-agency response to these types of deaths — I think that would certainly be warranted. I guess it would be up to those agencies or someone else to make the decision about how exactly they may collect that data and who would be the main agency responsible for the collation of that data.

Ms HAUGE — And perhaps if there is some agreement on what is universally collected. There are a lot of us out there and we are all handpicking what we want and what we are interested in. It would be good if there was agreement on the certain variables that were collected.

Mr TILLEY — Just on that, are you referring to the DCA codes in particular when the collision reports are prepared? Under those codes I think there are a hundred and something different scenarios for collecting crash data. So the off-road on those DCA codes could be expanded, incorporating — —

Mr HOGAN — That is the nature of what we would be suggesting, I guess, yes, in terms of having a standardised coding set. I cannot speak in any great detail about DCA, but having that sort of established dataset, as you would for on-road motorcycling, would be very beneficial for off-road.

Mr ELSBURY — Thank you very much, Your Honour, for coming this afternoon. My question is pretty straightforward. What specific outcomes would you like to see from the committee's inquiry?

Mr TILLEY — Where do you start?

Mr ELSBURY — I mean, there is the obvious of course, but what would you like to see as the result of all of this work that we are putting in?

Judge COATE — I think some of the issues that we have touched upon this afternoon with respect to interagency collaboration, that is a fairly common theme in terms of sometimes creating barriers between the ways in which all the various government and non-government agencies can do their work. So recommendations directed towards an enhancement of that interagency collaboration I think would be good. I think David has highlighted an area in particular of concern in terms of the trends that we are able to observe sitting inside our court about the off-road area, and so we would be very grateful to this inquiry if your attention was in particular focused on that. There were a very significant number of fatalities in that area where there does not appear to be, certainly on our observations at the moment, a particular lead agency or focus. I will leave it at that.

The CHAIR — Should you have some other deliberations over the next period of time, feel free to liaise with our secretariat and executive officer, Your Honour. We would be happy to take any wider thoughts that may emerge there or through the work of David as he is doing some of the assessment of previous recommendations and where they may have finished and whether they need to be revived for the work of our committee.

Judge COATE — Yes, I will reserve on that issue. Once I am in the position to have a look at all of those recommendations that have come through, a few things might stand out from that body of recommendations that would be of use to highlight to you, so I will certainly do that.

Ms HAUGE — May I also just add that we have not looked at issues of the protective clothing or registration and all that only because it has not been referred into the unit since our establishment, so I know that we will touch on those issues down the track. But I just wanted to let you know that we are not remaining silent because we are not in support of some of those initiatives, or in support.

The CHAIR — Yes. Thank you. We are getting some good material in front of the inquiry in relation to some of those matters as well.

Ms HAUGE — Yes, that is right.

Mr LANGUILLER — I have a supplementary question given your comment, I am sorry, with your indulgence. I refer to the data collection and in fact to the very comment you just made in relation to protective and safety gear, and I quote from a submission that the committee received this morning from a rider who in fact survived a crash and, to be fair on you, is sitting in the public gallery, and he said:

> I owe my life to wearing my protective gear.

Now if I may refer to your principal role of identifying the cause of death. Is it not the case that seeking information from other agencies that may be there and are there before you in relation to the wearing of protective gear, safety helmets and other things is in fact, if I may suggest, an important part of your data collection and an important part of you actually identifying the cause of death? I am asking, do you ask the question, 'Was the rider using protective gear, helmet and other gear?', and would that not be the cause of death or a contributing factor — —

Judge COATE — A contributing factor?

Mr LANGUILLER — Therefore if you do not do it as a matter of course — —

Judge COATE — If they were or were not wearing protection gear?

Mr LANGUILLER — Correct. I just took your comment on board in terms of you actually do not do it.

Judge COATE — I cannot do better than say it depends, because it really will depend on the circumstances in which the deaths occurred, and there are so many variables about those circumstances that to give a general answer might not be all that helpful. But to the question about whether or not it is important to understand whether or not a motorcycle rider who was fatally injured had protective gear, then my short answer to you is yes, it should be a question that is asked. Because we do not have a consistent set of questions that are asked as yet we might not, at first instance, get that information back. I hope that is helpful. I am just being as responsible as I can — —

Mr LANGUILLER — It does, and to be fair I am mindful of the fact that it is labour intensive and I am mindful of resources, but if one may abstract from the issue of funding for a minute, in an ideal world would you not think that perhaps asking those questions and making sure that there is a standard set of questions which includes whether the rider was using protective safety gear or not should be part of your work?

Judge COATE — And to just come back and try to tie this together, on that note, Chair, with your permission, in answer to the question, 'What would be of assistance to you from this inquiry?', I have thought about that question. What would be of considerable assistance to us is if the committee identified, for example, a set of recurring issues that have come before you — like protective gear, fatigue, size of engine, experience of rider — as important recurring features and questions to ask at the time of investigation so that the coronial

inquiry could then collect that information and be in a position to look at it more systematically. That would be of terrific assistance to us.

The CHAIR — That is a good note to finish on too and something for our executive staff team to just compile some of those issues that come forward as the witness today did attribute, among other factors, because there were major force of impact injuries that were sustained, the calibre of aspects of his protective clothing and his helmet in particular.

Judge COATE — Terrific.

The CHAIR — Your Honour, thank you for your time.

Judge COATE — It was a pleasure. Thank you for inviting us.

The CHAIR — Thank you for bringing your staff with you as well.

Judge COATE — Good luck with your inquiry. Sam can be the point of contact for you for the purposes of further information to get back to you.

The CHAIR — Thank you. We appreciate it.

Witnesses withdrew.