QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Maximilian Patrick MCDOWALL**
TITLE OF COURT:	Coroners Court of Queensland
JURISDICTION:	BRISBANE
FILE NO(s):	2021/2306
DELIVERED ON	24 October 2024
DELIVERED AT:	Brisbane
HEARING DATE(s):	Monday 22 April 2024 and Tuesday 23 April 2024
FINDINGS OF:	Donald MacKenzie, Coroner
CATCHWORDS:	Coroners: Inquest, Cyclist deceased in road traffic crash with Brisbane City Council bus, simultaneous traffic light access to both cyclist and bus, Brisbane City Council Bus driver blind spots, failure of bus driver to observe cyclist, failure of cyclist to appreciate danger, improvements to traffic light signalling and bus driver awareness systems.

REPRESENTATION:

COUNSEL ASSISTING:	Ms Emily COOPER (Counsel)
For the McDOWALL FAMILY:	Mr D.J. SCHNEIDEWIN instructed by Turner Freeman Lawyers (Solicitors)
For the BRISBANE CITY COUNCIL:	Mr D.A. QUAYLE (Counsel) instructed by HBM Lawyers (Solicitors)
For the DEPARTMENT OF TRANSPORT and MAIN ROADS:	Mr P. CROFTS (Legal Officer)
For Mr RUDNICKI:	Ms C McGEE (Solicitor) Gilshenan & Luton Legal Practice (Solicitors)

***WARNING: These Findings contain still images (NOT graphic) of the deceased from the police investigation report**

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Introduction

1. On 27 May 2021, Maximilian Patrick McDOWALL (referred to as "Max") died aged 20 years when he sustained multiple injuries whilst riding his bicycle. He had been travelling along a dedicated bike/pedestrian path when, upon crossing the intersection of the Southeast busway ("SE Busway") with O'Keefe St and Gillingham St (the intersection), he was struck by a bus which was turning left onto the busway. Andrew Rudnicki was the driver of the bus, which was a Brisbane City Council ("BCC") bus. Max died at the scene. His death was investigated by the Queensland Police Service Forensic Crash Unit.

2. On 10 August 2021, Mr Rudnicki was charged with an offence pursuant to section 62(1)(aa) of the *Transport Operations (Road Use Management – Road Rules) Regulation 2009* (TORUM-RR) as it existed at the time.[1] That offence related to failing to give way to Max on his bicycle as he proceeded across the intersection.

3. A police investigation was finalised and a report dated 19 October 2021 was provided to the investigating Coroner (at the time, Coroner Clements). It was determined that no inquest would be held and, on 23 February 2022, Coroner Clements issued findings pursuant to s 45 of the *Coroners Act 2003* (the Act).[2]

4. Relevantly, she found:

"Introduction

Maximilian Patrick McDowall, known as Max, lived with his family at Donaldson Street Greenslopes in Queensland. He was born on 8 February 2001. He died when he was 20 years of age on 27 May 2021 due to multiple injuries sustained when he was cycling, and a collision occurred with a bus. The incident occurred on O'Keefe Street, Woolloongabba in Queensland.

Mr McDowall was riding his bicycle westbound along a shared footpath which was part of the Veloway 1 (VI) dedicated bikeway between Lower River Terrace, South Brisbane, and Eight Mile Plains.

The shared pathway was on the south side of, and parallel to O'Keefe Street. Mr McDowall was riding up a slight incline approaching the crossing at the entry to the south east busway. The intersection is governed by traffic lights. Mr McDowall entered the crossing on a green light.

At the same time the Brisbane City Council bus, registered number 289XZZ, was also proceeding west along O'Keefe Street. The bus driver was Andrew Rudnicki, who was aged 67. The bus was stationary at a red light behind other vehicles. The driver indicated the intention to turn left into the busway. When the light changed to green, and an oncoming pedestrian and cyclist had cleared the entrance to the busway, the driver made a left turn into the busway. This occurred on the same green light Mr McDowall entered the crossing, proceeding straight ahead. The collision occurred at 4.06pm.

Mr McDowall was attended upon by Queensland Ambulance Service officers, but he had sustained nonsurvivable injuries. He was declared deceased at 4.30 p.m.

[1] The charge has since been amended such that the element contained in (aa) of failing to give way to a rider of a bicycle is now included in the body of the charge in (a).
[2] Exhibit F2

An external only post-mortem examination confirmed the cause of death was:

1(a) multiple injuries, due to, or as a consequence of

1(b) motor vehicle collision (pedestrian).

Toxicology testing

Autopsy proceedings included toxicology testing which established a negative result for Mr McDowall relating to the presence of alcohol or drugs.

…

Conclusion

Max McDowall was only 20 years of age when he died in a terrible collision with a bus when he was cycling. His loss will remain a devastating pain for his family and friends.

His bicycle was a fixed gear bicycle fitted with cantilever brakes on both wheels, and standard pedals.

He was riding on a shared pathway which was a part of a dedicated bikeway, (Veloway I). The pathway crosses the entry / exit of the South- East Busway to/from O'Keefe Street at Woolloongabba. A traffic light governs the crossing presenting a green light to cyclists and pedestrians crossing the busway entry/egress. At the same time, a bus was turning into the busway on the same green light. The bus was slightly ahead of the cyclist.

Buses are required by traffic laws to give way to pedestrians and cyclists. This did not occur.

In the circumstances that occurred on 27 May 2021, the investigator established extensive areas of "blind spots'' excluding the bus driver from sighting a cyclist/pedestrian as they move in the same direction as the bus.

I conclude the bus driver did not see Mr McDowall cycling until after the collision occurred.

I conclude that the cyclist Mr McDowall was unaware that the bus was turning left at the same time he was commencing to travel across the intersection. The traffic light was showing "green" for both to proceed with their intended paths of travel.

Any collision between a cyclist/pedestrian and a bus is likely to cause serious or fatal injury to the person.

The only real means of safeguarding pedestrians and cyclists is physical separation. This requires planning for the future and review of existing arrangements, as well as the will for change and commitment of funding.

There are innumerable intersections where pedestrians/cyclists cross the roadway which are governed by traffic lights. Approximately 450 of these intersections in the Brisbane City Council specifically safeguard pedestrians, by showing a red turning arrow until a set period has passed enabling a person to have exclusive entry to the crossing before vehicles.

These pedestrian protection traffic signals show an illuminated "green man" indicating exclusive commencement to enter the crossing by pedestrians (and cyclists at this intersection.) Turning vehicles are held on a red turning arrow. There follows a flashing "redman", indicating a pedestrian/ cyclist should not commence to cross, but a person on the crossing can complete their passage.

The underlying right of way remains entitling a pedestrian to cross, and a vehicle to give way.

Until July 2014 the crossing had traffic light phasing operating which signalled a "green man" and green cycle directing exclusive priority entry to the crossing, followed by a flashing "redman" during which time a bus could proceed across the crossing, but must give way to the pedestrian / cyclist completes passage.

The crossing at the entry to the busway on O'Keefe Street is said to be unusual. There was more use of the crossing by pedestrians and cyclists than buses entering or exiting the busway."

5. On 22 March 2022, the s61 (aa) of the *Transport Operations Road Use Management (Road Rules) Regulations* charge against Mr Rudnicki for Failing to Give Way when Turning at Intersection with Traffic lights was discontinued by the Queensland Police Service Prosecutions section.

6. On 30 March 2022, Max's parents applied to the State Coroner for an inquest pursuant to s 30(4) of the Act. On 16 March 2023, the State Coroner accepted the application and ordered that an inquest would be held. He stated:

"I acknowledge that there is a significant dispute about the facts surrounding the collision between the bus and Mr McDowall's bicycle which may be clarified by evidence at an inquest.

I agree with the submission that the increased level of interaction between cyclists, who are encouraged to use Brisbane City Council bike-paths, and other vehicles at points of intersection between bike-paths, roads and busways is a powerful reason the public interest is served by an inquest.

An inquest might identify recommendations to improve the level of separation between buses and cyclists at the scene of Mr McDowall's death and more broadly, which may prevent similar deaths in the future."

7. The Inquest into this death took place on Monday, 22 and Tuesday, 23 April , 2024. The final written submissions were received on 7 August, 2024.

The Coronial Jurisdiction

8. A coroner's powers of investigation are supported by a number of specific powers under the Act. Pursuant to s11 of the *Coroners Act 2003* (the Act), a Coroner may investigate the suspected death of a person if directed to by the State Coroner, and the State Coroner suspects that the person is dead and their death was a reportable death.

9. A coroner investigating a death has a discretionary power to order that an inquest be held if the Coroner is satisfied it is in the public interest to hold the inquest (s28(1)). Subject to exceptions, an inquest must be held by the Coroners Court and in open court (s31(1)). The Coroners Court must publish a notice of the matter to be investigated, the issues to be investigated and of the date, time and place of the inquest (s32). A coroner holding an inquest may hold a pre-inquest conference to decide, inter alia, what issues are to be investigated, who may appear and what witnesses will give evidence (s34). Further, a Coroner holding an inquest has a discretionary power to order a person to attend an inquest to give evidence as a witness (s37(4)).

10. Section 45(2) of the Act provides:

> *A coroner who is investigating a death or suspected death must, if possible, find –*
>
> *(a) who the deceased person is; and*
> *(b) how the person died; and*
> *(c) when the person died; and*
> *(d) where the person died, and in particular whether the person died in Queensland; and*
> *(e) what caused the person to die.*

11. Further, by s46(1) of the Act a Coroner may, whenever appropriate, comment on anything connected with a death investigated at an inquest that relates to:

    a. public health or safety;
    b. the administration of justice; or
    c. ways to prevent similar deaths from happening in similar circumstances in the future.

12. After considering all of the evidence presented at the inquest, findings must be given in relation to each of these matters to the extent that they are able to be proved. An inquest is not a trial between opposing parties but an inquiry into the death (or suspected death). Lord Lane CJ in *R v South London Coroner; Ex parte Thompson* (1982) 126 S.J. 625 described a coronial inquest in this way:

> *"…an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends,"… (and) … "the function of an inquest is to seek out and record as many of the facts concerning the death as [the] public interest requires."*

13. The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorizes a coroner to make preventative recommendations (s46) but prohibits findings being framed in a way that appears to determine questions of civil liability or suggests a person is guilty of any criminal offence (s45(5)).

14. Two important observations should be made: First, whilst this Court, pursuant to Section 3 (d)(ii) of the Coroners Act (Qld) has the object of commenting on matters related to "the administration of justice", it is improper for an inferior Court created by statute, such as the Coroners Court of Queensland, which is not of higher jurisdiction in the appellant hierarchy, to review an order of a another Court of equal or superior jurisdiction such as the Supreme, District and Magistrates Courts of Queensland. Second, I must not include in any Findings any statement that a person is, or may be, (a) guilty of an offence or (b) civilly liable for something.

15. Second, Judicial officers have no right to critique or criticise a prosecutorial discretion such as whether or not to prosecute a particular charge, to enter a nolle prosequi, to proceed by way of ex officio indictment, to present particular evidence, to decide the particular charge to be laid or prosecuted and what advice is given to the Attorney-General in relation to the lodging of an appeal. In *DPP v Tutera* [2023] VSCA 188, the Victorian Court of Appeal, citing High Court of Australia authority, said:

> *"[79] It is axiomatic that decisions made in the exercise of prosecutorial discretion are not amenable to review or enquiry by the court. (see Barton v The Queen (1980) 147 CLR 75; Maxwell v The Queen (1996) 184 CLR 501 513-514). There is an important constitutional division between the executive and the judiciary with respect to the bringing, maintenance and discontinuance of criminal charges."*

16. The appropriate persons to whom such complaints about prosecuting authorities are the Commissioner of Police, Director of Public Prosecutions or the Attorney-General. Further, as a matter of good public policy, it is undesirous for a judicial or jury verdict to be reviewed by a Coroner whose role is primarily a therapeutic one where the standard of proof is on the balance of probabilities and compulsive powers, not permitted in criminal jurisdiction, are available.[3] However, a Coroner retains a "residual investigatory function" beyond a review of a previous court's decision within the above-mentioned constraints.[4]

17. Section 37 of the Act provides that "*the Coroners Court is not bound by the rules of evidence but may inform itself in any way it considers appropriate*". This flexibility has been explained as a consequence of being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial. However, the rules of evidence and the cornerstone of relevance should not be disregarded and in all cases the evidence relied upon must be logically or rationally probative of the fact to be determined.[5]

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[3] *Domaszewicz v State Coroner* (2004) 11 VR 237 at [81[] and *Rolfe v Territory Coroner [2023] NTCA 8 [53].*

[4] Mirror newspapers v Waller (1985) 1 NSWLR 1 at [16].

[5] See Evatt, J in *R v War Pensions Entitlement Appeal Tribunal; Ex parte Bott* (1933) 50 CLR 228 at 256; Lockhart J in *Pearce v Button* (1986) 65 ALR 83, at 97; *Lillywhite v Chief*

18. As stated earlier, a Coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the Briginshaw sliding scale is applicable.[6] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[7] It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[8] This means no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As the High Court made clear in *Annetts v McCann*[9] this includes making submissions against Findings damaging to a person's reputation.

Executive Liquor Licensing Division [2008] QCA 88 at [34]; Priest v West [2012] VSCA 327 at [14] (Coroners Court matter) and *Epeabaka v MIMA* (1997) 150 ALR 397 at 400.

[6] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J

[7] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361 per Sir Owen Dixon J

[8] *Harmsworth v State Coroner* [1989] VR 989 at 994; Freckelton I., "Inquest Law" in The Inquest Handbook, Selby H., Federation Press, 1998 at p 13

[9] (1990) 65 ALJR 167 at 168

The Queensland Police Service Investigation

19. Max's death was investigated by the Queensland Police Service Forensic Crash Unit, specifically SGT Carl Cutler. Sergeant Cutler investigated the circumstances and cause of this fatal road traffic crash, in particular, the traffic light sequencing in place at the time. During the course of the investigation, SGT Cutler organised a re-enactment, obtained CCTV footage and blind spot mapping in an effort to demonstrate what might have been visible to Mr Rudnicki in the lead up to the collision. Arising from the police investigation, the following facts are pertinent:

    a. The intersection is best demonstrated by the below photograph described as 'image 1' from the police report[10]:

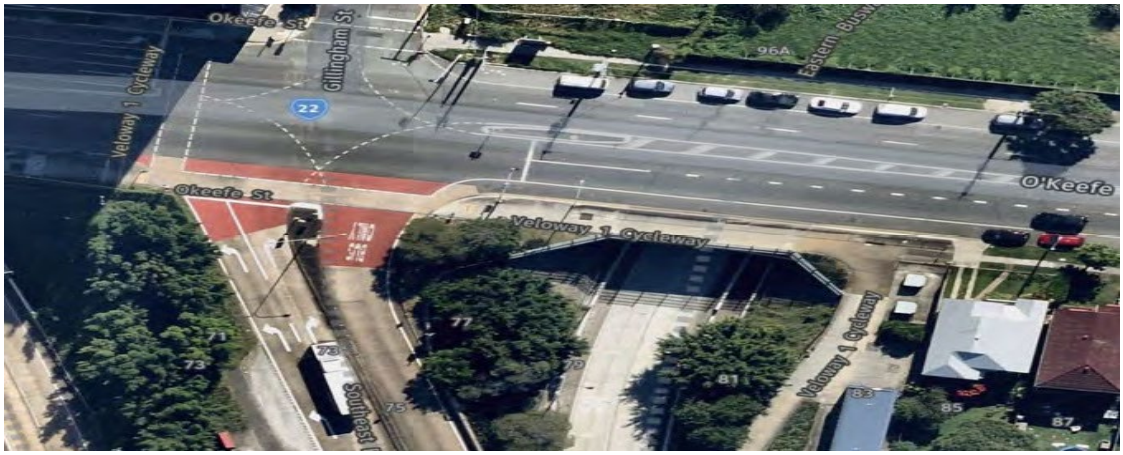


Image 1: Aerial photograph (orientated north) of the intersection of O'Keefe Street and the south-east busway, Woolloongabba. O'Keefe Street runs East/West (right to left of the photograph)Gillingham Street approaches the intersection (see "22") from the North (top of the photograph) and the South-east busway joins from the southeast. The direction of travel of the bus was westerly turning south into the South-east busway. Max was riding his bicycle also westerly but heading straight across the intersection in the pedestrian lane. The Point of collision was near the "bus only" letters at the entrance to the South-east busway.

    b. Max was travelling along the dedicated bicycle/pedestrian pathway in a westerly direction, towards the direction of the traffic lights.

    c. Max did not stop as he approached the traffic lights-rather than a flashing red man (as depicted in the photo below with the cyclist stopped), the pedestrian light was green.[11]

[10] Exhibit A5; Transcript Day 1; 1-6
[11] A5, p 26 (image 20)

Image 2: Reconstruction photograph (orientated east) of the intersection of O'Keefe Street and the south-east busway, Woolloongabba. The cyclist is in the identical starting position of Max about to head west across pedestrian crossing and the bus is turning in a similar matter to the bus that struck him on his bicycle in the right foreground area of this photograph.

d. The bicycle/pedestrian pathway travelled by Max was uphill, suggesting that a cyclist would need to be pedalling hard to ensure they could get through it with enough power.[12] In the CCTV footage, Max is observed to be travelling faster than the bus and he was standing on the bike pedals, increasing cadence.[13]

e. Mr Rudnicki's BCC bus was also travelling in a westerly direction, but turned left into the SE busway[14] and both were travelling with a green traffic light at the time.

f. Max came into contact with the left rear side of the bus and ultimately was run over by the left rear wheel.

[12] Transcript Day 1; 1-10 lines 42-48
[13] A5 p 20 (image 8); Transcript Day 1; 1-13 lines 12-38
[14] A5, p 26 (image 20)

20. These two photographs are from QPS Investigation Report p31 of Exhibit A5.

Image 3: CCTV Footage just prior to this road traffic crash

Image 4: CCTV Footage just prior to this road traffic crash

21. A still image from the bus CCTV shows Mr Rudnicki in his normal sitting position:

Image 3: A still image from the bus CCTV17 shows Mr Rudnicki in his normal sitting position

22. Based on the re-enactment conducted the cyclist in that exercise can be viewed out the bus driver's door at the approximate time of impact[15]:

23. In the final second of the pre collision movement of the vehicles it appears that Max may have made a steering input to the left prior to contact between the front tyre of the bike and the bus and then the right shoulder of Max before he falls to the ground. The bus telemetry indicates that the bus accelerates from being stopped at the red light to 17kmh before slowing to 8kmh while slowing for the pedestrian and cycle to clear the crossing before accelerating to 21kmh at impact. The duration for the entire incident from Max joining the O'Keefe Street path to impact is about 10 seconds.

[15] A5, p23 (image 12). Noting that this is an approximate impact position, based on the CCTV footage – see evidence SGT Cutler, Transcript Day 1; 1-14; lines 40-46.

24. These images are from the QPS Investigation Report A5, p 26 - images 15-16.

Image 4: Approximate position of Max from slightly in front of the bus driver's seat from the re-construction. Noting that this is an approximate impact position, based on the CCTV footage – see evidence SGT Cutler, Transcript Day 1; 1-14; lines 40-46.

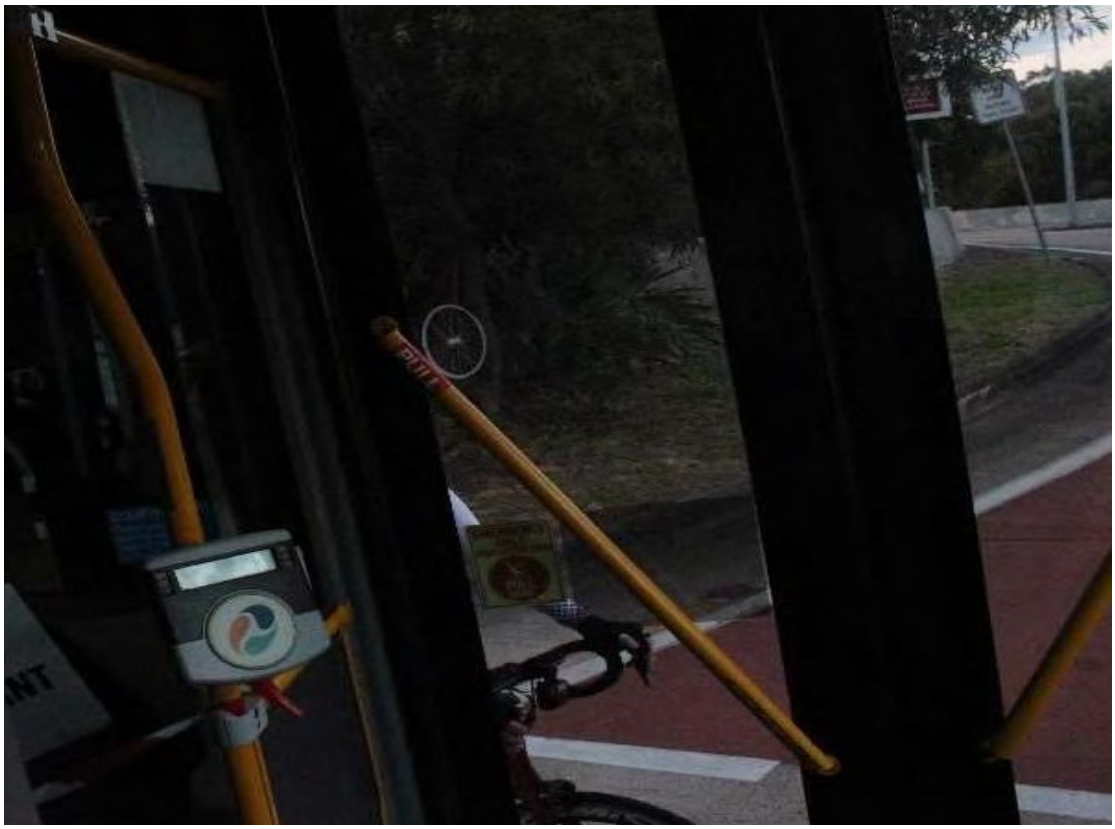


Image 5: Approximate position of Max (further back from Image 4) taken at the bus driver's seat during the re-construction. Noting that this is an approximate impact position, based on the CCTV footage – see evidence SGT Cutler, Transcript Day 1; 1-14; lines 40-46.

25. In accordance with the Transport Operation Road Use Road Rules Regulations, Mr Rudnicki was legally required to give way to all pedestrians, including cyclists, crossing the intersection. In terms of warning signage visible to Max as he approached the intersection in his capacity as a pedestrian/cyclist, the following photo is relevant:[16]

Image 6: Photograph taken at night hours after this road traffic crash (orientated west – the director of travel of Max across the pedestrian lane).

26. Whilst stationary at the intersection and giving way to another cyclist and a pedestrian traveling in the opposite direction across the pedestrian strip (eastward), Mr Rudnicki had activated the left indicators of the bus which were blinking and are visible from viewing the CCTV footage. Mr Rudnicki's bus had three indicators down the left hand side – the first at the very front corner (just above the bumper bar), the second just behind the front door below the wheelchair symbol, and the third in between the rear door and the rear wheel.

27. The CCTV footage shows Max coming around the corner and onto the pedestrian/cyclist path alongside the bus (along O'Keefe St). The footage shows that the left indicator lights on the bus were operational. The left indicators should have been visible to Max in his position on the path.

[16] A5, p 7 (QPS Report image No. 7).

The Inquest

28. The Inquest into this death took place on Monday, 22 and Tuesday, 23 April 2024.

29. The issues to be examined were:

    1. An examination of the circumstances surrounding Mr McDowall's death on 27 May 2021 as required by s 45(2) of the *Coroners Act 2003*, in particular:

        a. the ability of the bus operator to be able to sight Mr McDowall; and
        b. what steps the bus operator took so as to keep a lookout for Mr McDowall.

    2. The appropriateness of the traffic light sequence as it operated at the relevant intersection as at 27 May 2021

    3. The appropriateness and adequacy of the design of the subject intersection as at 27 May 2021 including:

        a. whether the design of the intersection complied with the relevant standard;
        b. whether an appropriate and adequate risk assessment and/or review of the design of the intersection was undertaken prior to May 2021.

    4. In light of the developments made to the relevant intersection since 27 May 2021, whether any further recommendations might be made to improve safety at the relevant intersection for both operators and pedestrians.

30. The factual scenario before this Inquest varied little from the Findings of Coroner Clements and were uncontroversial to the following extent:

31. In the immediate lead up to his death, Max had been travelling along a dedicated cyclist/pedestrian path when, upon crossing the intersection, he was struck by a bus which was turning left into the South East Busway. Mr Rudnicki was the driver of the bus, which was a BCC maroon 'Glider' bus. The route was described as the '61' route which, at the relevant time, was travelling from Ashgrove to Coorparoo Junction. The traffic lights at the intersection were sequenced such that both Max and Mr Rudnicki had green lights at the same time.

32. Max had been a cyclist in the area since he was a primary school student. He was regarded by his parents as an experienced and cautious cyclist who was in general, risk adverse. He had never mentioned to his parents having experienced any issues or incidents at this intersection. At the relevant time, Max was on his way to work at the Queensland University of Technology. The normal route he took from his home to work (which included the intersection) was a trip he would complete once or twice a week. He had been doing so for some two years.

33. Mr Rudnicki had been a bus driver for BCC since 1988. He had driven the 61 route hundreds of times, with half being in the direction travelled at the relevant time.[17] His licensing was up-to-date and there were no issues identified with his training history.[18]

[17] Transcript Day1: p17 ll 42-49 to p18 ll1-5 and A5 QPS Report p14
[18] Exhibit C7 [28] to [29]

34. Evidence was heard from seven witnesses, over 22-23 April 2024, namely:

- SGT Carl Cutler (Forensic Crash Unit Investigator, QPS)
- Andrew Rudnicki, (Bus driver, BCC)
- David Kroning (Traffic Network Manager, Transport and Planning Operations Branch, BCC)
- Kirsty Bilton (Director (Traffic Engineering), Safer Roads Infrastructure Team, Engineering and Technology Branch, DTMR)
- Lindsay Enright(Inner City Planning Manager, Transport Planning and Operations Branch, BCC)
- Karen McGraa (Manager, Operational Capability, Transport Operation, BCC)
- John Hatchman (Fleet Engineer, Engineering and Assets Management Branch, BCC)

Evidence of SGT Carl Cutler

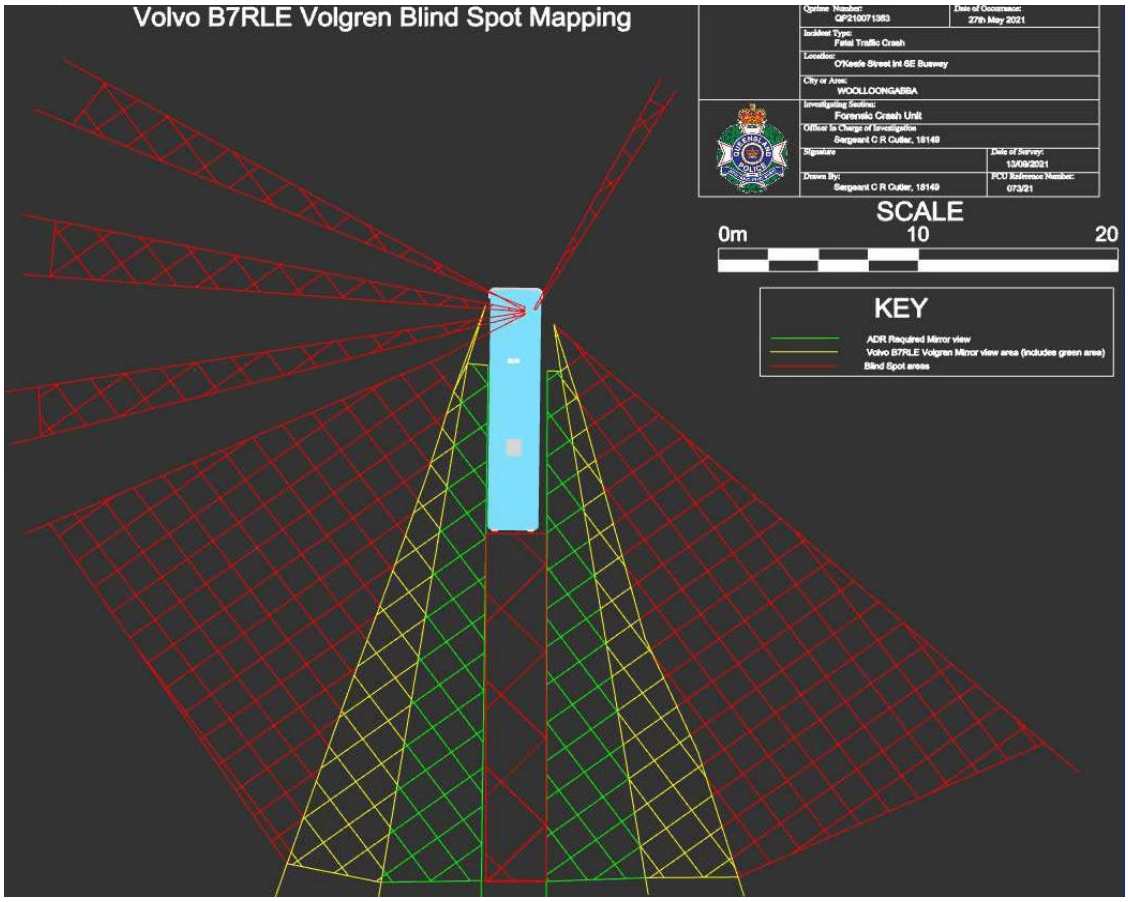
35. SGT Carl Cutler reiterated the basic determinations of the QPS investigation.[19] The report by SGT Cutler was tendered and he also gave evidence. He has extensive experience as a forensic crash investigator, having been performing such work since 1998 firstly in New Zealand, and then in Queensland. He was specifically questioned in relation to several specific areas.

[19] Transcript Day 1 pp 6-31

Blind Spot Mapping

36. SGT Cutler considered there were blind spot issues with the bus, so as part of his investigation he arranged for the bus to be mapped so as to identify areas which could not be viewed from the driver's position either by direct line of sight or by use of the mirrors. This process included liaison with the Department of Transport and Main Roads (DTMR), in order to establish the required minimum field of vision when using the external rear view mirrors.[20]

37. A number of maps and diagrams were examined. First, a map indicating the blind spots on the bus in a neutral position, as follows:



38. The coloured areas were indicative of the following:

(i) The green area represented that which was required by regulation to be able to be viewed by the external mirrors;[21]

(ii) The yellow area represented actual external mirror view when one looked through it;

(iii) The red represented the external blind spots for the driver of the bus;[22]

(iv) The black areas or the areas without the cross-hatching represent where the driver can see unaided or without obstruction.[23]

[20] A5, p 27; Transcript Day 1; 1-15 from line 5 onwards
[21] see also evidence of Hatchman (Transcript Day 2; 1-57; lines 40-46 – 1-58; lines 1-3).
[22] Transcript Day 1; 1-15; lines 27-34.
[23] Transcript Day 1; 1-25; lines 7-11.

39. The mapping was conducted on the basis of the driver sitting in the driver's seat of the bus in a neutral position and only turning their head to use the external mirrors – not leaning their body forwards or backwards. This is because a driver cannot be expected to be looking out the external mirrors 100% of the time, nor are they expected to have to stand in their seat so as to increase their field of view.[24] Each of the maps referred to in SGT Cutler's report showed the location of Max on his bicycle at various stages in the lead up to the collision. At each stage, Max was located within a red area, representing that he was within the driver's blind spot.[25]

40. The only opportunity for Mr Rudnicki to sight Max was at the narrow point in time where Max would move from one blind spot, to the next.[26] When taken to the blind spot mapping during his evidence, Mr Rudnicki confirmed that the extent of the blind spots on the bus, as depicted in the mapping, was not known to him at the relevant time.[27]

Traffic lights sequencing

41. As part of his investigation, SGT Cutler requested information from BCC which confirmed that the traffic lights were operating without issue and as intended at the relevant time.[28] In the days following the incident, SGT Cutler returned to the scene and had observed a change to the sequencing. This was explained as:

> *---That the pedestrian crossing sometimes but not always required manual activation, and that there was – that instead of just staying green, as it had previously, until there was a demand for another phase – – Yes? – – that there was the five seconds and then the flashing red signal and countdown for 24 seconds.*[29]

42. Although the countdown described above had been changed in the days following the collision, the fact that both the traffic and pedestrian lights turned green at the same time had not changed. It was this, being the start of the traffic lights signal phasing, that was the issue for SGT Cutler and it remained unchanged from the date of the collision.[30]

Sun Blindness

43. SGT Cutler considered the impact of the setting sun. He considered that, because of the low position of the sun at approximately 16:00 hours on the afternoon, this could have been a factor for both Max and Mr Rudnicki as they travelled in a westerly direction along O'Keefe Street. In terms of how the setting sun might have affected Max, SGT Cutler explained that 'sun strike' may have been encountered. This is based on SGT Cutler's viewing of the CCTV footage, which appeared to show Max coming from the shadow cast from the buildings on the other side of the road, into the bright light presented by the sun which was positioned slightly above

[24] Transcript Day 1; 1-16; lines 40-49
[25] Transcript Day 1; 1-16; lines 35-38; A5, p 28-30 (images 23-28).
[26] Transcript Day 1; 1-26; lines 20-36; A5 p 29-30 (refer images 26-27).
[27] Transcript Day 1; 1-43; lines 41-49 – 1-44; lines 1-29.
[28] A5, p 11-13; C1; Transcript Day 1; 1-23; lines 27-35.
[29] Transcript Day 1; 1-23; lines 16-22.
[30] Transcript Day 1; 1-24; lines 35-44.

and to his right. The bright light striking him as he was approaching the intersection crossing could have affected his vision. This was described as being a result of the sudden change from being in shadow, to then being in the bright light of the sun, and the ability of Max to be able to adjust to that sudden change.[31]

Disobedience to the Traffic Signals

44. SGT Cutler gave evidence that since completing his investigation, he had returned to the scene between three and five times. On each occasion, he witnessed complacency by pedestrians who, it appeared, were willing to disobey the traffic lights even in the setting of having a uniformed police officer standing in the vicinity.[32] SGT Cutler had not returned to the scene in recent times and was not aware of the current condition of the intersection.[33]

Speed of the bus

45. In terms of speed, the bus telemetry indicated that the bus accelerated from being stopped at the red light to 17km/hr, before then slowing to 8km/hr whilst the pedestrians travelling easterly crossed the intersection. The bus then accelerated to 21 km/hr to continue turning into the intersection up until the point of impact.[34] Mr Rudnicki disagreed with this assessment during his evidence, saying: *"---I disagree with that because I was – from standing position, I was turning left, it can't be 20ks per hour when you're turning left."*[35]

Speed of Max

46. All three direct eye-witnesses of Max's riding, Mr Brendan REID, Mr Blake NGATAI-STOKES and Mr Callum HAIR describe Max as "going at the same speed" as the bus, "start to speed up" "accelerating", "head down while pedalling. He wasn't looking around" and "going fast":[36] (my italics below)

> REID: *"I remember being stopped at traffic lights on O'Keefe Street. The lights went green and the bus started moving. I remember looking out the left side windows and I saw a bicycle come out of the cycle way and turn left to go the same direction as the bus along the footpath on O'Keefe Street. The bicycle and bus were both going about the same speed. As the bus and bike both approached the intersection, I saw the bicycle rider start to speed up to go across the crossing. There was a green light for the bicycle and for the bus at the same time. I don't think the bus driver saw the bicycle rider. The bus driver was not speeding he was coming into the turn slow. When the bus turned, he ran over the bike and rider. I felt the bump as we went over the bike. The driver then stopped the bus and turned off the bus."*

[31] A5, p 31-32; Transcript Day 1; p17; ll 8-16; 25-38

[32] A5, p 34; Transcript Day 1; 1-20; lines 45-49 – 1-21; lines 1-15
[33] Transcript Day 1; 1-21; lines 33-38.
[34] QPS Investigation Report A5, p 21.
[35] Transcript Day 1; 1-52; lines 21-35.
[36] Pages 16 and 17 A5 QPS Investigation Report

NGATAI-STOKES: "*The bus was on O'Keefe Street approaching the left turn into the busway. We had stopped for a red light on O'Keefe Street. The light turned green and the bus started moving off and started a left turn into the busway. I just happened to look up and see the cyclist going the same way. He looked like he was accelerating. It all happened very quickly. The bus driver had already started moving for his left turn into the busway. The cyclist was on the footpath and it looked to me like he was intending to ride across the crossing with the green light. The bus had entered the intersection already, but I am not sure if the driver had already started turning. I realised that neither the bus or bicycle were going to stop. The driver of the bus hadn't seen him. I also think that that the cyclist hadn't seen that the bus was turning as he had his head down while pedalling. He wasn't looking around".*

HAIR*: "I remember seeing the bus travelling West on O'Keefe Street up the hill towards the busway entrance. I walked across the crossing from west to east on a green pedestrian walk light. The bus was about 20 metres from the intersection when I was aware of it and it was indicating to turn left into the busway. The bus was in the left lane. As I was stepping off the crossing the cyclist passed me heading in the opposite direction West on O'Keefe Street. He was going fast. He passed me to my left where the "LOOK" sign is painted on the footpath. - I know that the pedestrian crossing light was still green at this time. I heard the crash and turned around and saw the cyclist halfway under the bus. I did not actually see where the cycle and bus collided. I was about 5-10 metres from the intersection".*

Other matters

47. There were no issues identified with either Mr Rudnicki or Max being distracted by third party vehicles, a telecommunications device, the road surface or weather conditions or evidence of any mechanical defect with either the bicycle or the bus contributing to this road traffic crash.[37]

Cause of the collision

48. SGT Cutler's evidence to the inquest as to the cause of the collision was as follows:

"---So I'm of the opinion that the crash has occurred when the bus and cycle have both entered the intersection on a green light for the respective vehicles. The bus driver was intending to turn left into the busway, and the cyclist intended to travel across the crossing of the busway. Both directions received green signals at the same time. The bus driver had a mistaken belief that the crossing was clear for him to finish his turning manoeuvre and was in a give-way position for the cyclist crossing from his left. I believe that the cyclist, although having right of way across the crossing, has failed to identify the bus that was slightly ahead, then adjacent of him and indicated to turn left into the busway entrance. Having considered all the material obtained in this investigation and having a mind to the highly dynamic situation that was occurring, I'm of the belief that the deceased cyclist was in the best position to identify the hazard occurring and take evasive action. However, the bus driver was in a give-way situation."[38]

[37] Transcript Day 1; 1-8; lines 29-35; A5, p 8-9
[38] Transcript Day 1; 1-20; lines 4-21

49. SGT Cutler explained that, in his opinion, Max was in the best position to identify the hazard, as follows:

> *"---Sure. My opinion based on that is that Max has come and joined the O'Keefe Street pathway with the bus visible to him, and heading in that same direction as him it's indicated to turn left and it's visible to him, particularly when he's in the shadow because he would have had the sun strike at that time, and they're both moving dynamically approaching the crossing, and I believe that he should have been able to see the bus. Can't explain why that wasn't see."*[39]

50. It was accepted by SGT Cutler that Max would not have known that Mr Rudnicki could, or could not, see him in his position on the bikeway.40 In cross-examination, the following "hypothetical" point was made to SGT Cutler: *Perhaps Max, having seen Mr Rudnicki's bus commence to turn the bus at a slowing 17km/hour, then stop to give way to the pedestrian and cyclist travelling in the easterly direction, remained stationary to give way to him? or At least by the bus slowing, Max would have had time to cross the intersection at head of the bus?*[41] Neither was accepted by SGT Cutler. It did not change SGT Cutler's opinion that Max had the best visibility available to him.[42]

51. The following three possible explanations for Max's travel are:

    (i) Max saw the green pedestrian light and the bus giving way to a pedestrian and cyclist travelling across the intersection towards him and assumed the bus driver would also wait for him;

    (ii) Given that Max had his head down and was moving with cadence uphill, he did not see the bus at all;

    (iii) Max did see the bus, and thought by the speed at which he was travelling that he could beat the bus before it turned into the SE busway.

Evidence of Mr Rudnicki

52. Mr Rudnicki claimed privilege under s 39 of the Act and was subsequently directed to answer questions under cover of a blanket privilege. By virtue of such direction being made, Mr Rudnicki's evidence given at the inquest is inadmissible against him in any other proceeding, other than a proceeding for perjury.[43] He had provided two versions of events to police at the scene and completed a bus incident report the day after the collision.[44] The versions to police were captured on body-worn camera (BWC).

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[39] Transcript Day 1; 1-20; lines 37-43.
[40] Transcript Day 1; 1-27; lines 46-47
[41] Transcript Day 1; 1-27; lines39-49–1-28; lines 1-24.
[42] Transcript Day 1; 1-28; lines29-33.
[43] *Coroners Act 2003* (Qld), s 39(3).
[44] Transcript Day 1; 1-18 from line 10; A5, p13-14; D10 (first version); D7 (second version); C2.2 (bus incident report)

53. A summary of these versions is as follows:

a. He really didn't know what happened;

b. At the relevant intersection, he stopped at a red light and waited for it to change to green;

c. Upon the light changing to green he waited for 1 x pedestrian and 1 x cyclist to make their way across the intersection and then started to turn left into the busway;

d. Suddenly he bumped over something – stopped the bus – and heard screaming;

e. As he was approaching the intersection he did not notice anything or anyone coming up the cyclist/pedestrian pathway;

f. He had a green light at the same time as the cyclist and pedestrian crossing the intersection;

g. He gave way to the cyclist and pedestrian who were travelling towards the bus in the opposite direction (eastwards) to that of Max.

h. When he started to move the bus he checked his left-hand mirror and there was nobody there;

i. He checked his left-hand mirror before he conducted the left turn;

j. He doesn't remember checking his right hand mirror;

k. He felt the bump about halfway around the corner, towards the rear of the bus around the door;

l. There was nothing distracting him at the time, in that he wasn't:
   i. eating or drinking;
   ii. changing the radio;
   iii. on the phone or the radio.

m. The weather was perfect in terms of visibility and he was wearing his prescription sunglasses – he could see clearly;

n. Max had to have come from behind – he did not see Max.

54. Mr Rudnicki's evidence to the inquest was generally consistent with his previous versions provided. It can be summarised as follows[45]:

55. He had been a bus driver with BCC for 35 years. He was familiar with the 61 Glider route;

(ii) The relevant intersection was just a 'normal intersection' but the problem was that the lights were that the pedestrian and general traffic had a

[45] Transcript Day 1; pp 1-53

green light at the same time – if they had been separated it would be *'problem solved';*

(iii) He had personally not had any issues with the relevant intersection before;

(iv) He turned on his indicator and waited for the green light;

(v) He started to turn left and estimated he was going no faster than 10 km/hr at the time he felt a bump on entry to the SE busway;

(vi) He could see the pedestrian and cyclist travelling towards him, but did not see anything in the opposite direction;

(vii) To check the opposite direction he turned his head left whilst seated in the driver's seat and looked at the left mirror, but couldn't see anything in the mirror;

(viii) The mirror is different to that used on cars and provides a different sort of vision – he estimated the field of vision from looking at the mirror is perhaps three to five metres;

(ix) He recalled it was a sunny day but did not recall the sun being in his eyes – when asked if the sun was an issue for him on the day, he could not remember if it was or was not;

(x) He had a Perspex driver protection screen in place at the time and it was in the closed position – this did not obstruct his view through the mirrors;

(xi) At no stage prior to feeling the bump did he see a cyclist to the left of his bus.

56. Mr Rudnicki was taken to a still image taken from the bus CCTV footage which was sitting at a position higher to that of the driver's seat.[46] The image depicted at least partially the front tyre and handlebars of Max's bicycle through the driver's front door. Mr Rudnicki confirmed that he did not see Max that on the day.[47] In terms of blind spots, he knew the bus had blind spots because 'every vehicle got a blind spot'. He said that he wasn't able to see every part of the footpath on the left-hand side going up to O'Keefe Street. When he looked in his left-hand mirror, there was nothing there.[48]

57. Mr Rudnicki accepted that on the majority of occasions when he has turned left at the relevant intersection, he would not have been able to see the majority of the pedestrian pathway behind him. Notwithstanding that, he would proceed to turn given he had a green light. Mr Rudnicki said that there was nothing he could do about a blind spot. When asked if a shoulder check was possible, his evidence was that it could not be done:

> *"---Shoulder check? You can't do it because you've got a wall behind you. Okay?---Like, that step – the barrier obstruct you that way. You can't see because there's double – double pipes there. You can't – you can see only out of right because you've got a window and see traffic incoming on your right."*[49]

[46] Transcript Day 1; 1-47 lines 20-49
[47] Transcript Day 1; 1-41 lines 20-49.
[48] Transcript Day 1; 1-42; lines 10-33.
[49] Transcript Day 1; 1-43; lines 6-11.

58. In conclusion, Mr Rudnicki's responded to a question that a red arrow preventing him from turning left whilst the pedestrians had a green man to walk across '*would be excellent*'[50] was encouraging.

59. The remaining witnesses were:

- David Kroning (Traffic Network Manager, Transport Planning and Operations Branch, BSS)
- Kirsty Bilton (Director (Traffic Engineering), Safe Roads Infrastructure Team, Engineering and Technology Branch, DTMR)
- Lindsay Enright (Inner-City Planning Manager, Transport Planning and Operations Branch, BCC)
- Karen McGraa (Manager, Operational Capability, Transport Operation, BCC)
- John Hatchman (Fleet Engineer, Engineering and Assets Management Branch, BCC)

60. Their evidence was technical and specific to issues in this Inquest (2), (3) and (4). I have not dealt with specifically their evidence save for where it is relevant to these three more therapeutic issues.

61. Written submissions were provided by Counsel Assisting and the other parties to the inquest. For the most part, these submissions were of great assistance, and I thank Counsel Assisting and the other representatives for their efforts in this respect.

Consideration of issues

62. As stated earlier there were four issues considered at Inquest which I will address individual in accordance with the evidence and submissions. I will address the s45 findings in full under a separate heading below.

1. An examination of the circumstances surrounding Mr McDowall's death on 27 May 2021 as required by s 45(2) of the *Coroners Act 2003*, in particular:

a. the ability of the bus operator to be able to sight Mr McDowall; and

b. what steps the bus operator took so as to keep a lookout for Mr McDowall[51]

63. Whilst Mr Rudnicki's bus was equipped with rear and external side mirrors mounted and angled in accordance with the applicable standards, the evidence supports a conclusion that there were a number of blind spots in the blind spot mapping relating to the left-hand side of the bus. A conclusion that Mr Rudnicki checked his left mirror briefly and did not see Max is unremarkable. There was no other reasonable option by which Mr Rudnicki could have kept a lookout for Max, save for checking his left mirror continually. This of course would have been

[50] Transcript Day 1; 1-45; lines 3-14.

[51] These issues are dealt with together given the overlap in the evidence.

a dangerous act as he approached the front of the intersection to commence his left turn into the SE busway. It is also reasonable to conclude that Max was almost entirely within the blind spots of the bus in the lead up to the collision occurring.

64. Accordingly, I find that there were narrow opportunities for Mr Rudnicki to sight Max as he moved from one blind spot to the next short of keeping a continual lookout through his left mirror as he approached the left turn to the SE Busway. Whatever might have been seen by Max at this time, or going through Max's mind at this time, the evidence supports the conclusion that Max was not seen by Mr Rudnicki. No legal representative suggested otherwise.

65. Counsel Assisting Ms Cooper submitted that it was unreasonable to expect Mr Rudnicki to spend 100% of his viewing time on the left hand side of the bus which would have been necessary to site Max who was accelerating fast, with his head down and passing through several blind spots. In submissions for Mr Rudnicki, Ms McGee submitted that her client's responsibilities were not confined to only looking at the left hand side of the bus where Max was struck and Mr Rudnicki was not aware of the extent of the blind spots as depicted in the Blind Spot Mapping.

66. Mr Quayle, on behalf of the Brisbane City Council, in particularly helpful submissions on this point, submitted:

> *"The central element (in Mr Rudnicki's inability to see Mr McDowall) was the coincidental positions and speeds they were both in, and travelling at, in particular:*
>
> *a. if Mr McDowall had been travelling more slowly and so arrived at the shared path later the bus would have been further west and Mr McDowall would likely have been in sight of the bus mirrors;*
> *b. if the bus had been further west in the queue of traffic or moved away earlier, then again Mr McDowall would likely have been in sight of the bus mirrors;*
> *c. if the bus had been further east and/or moved towards the subject intersection more slowly, Mr McDowall would have been further advanced and likely have become visible to Mr Rudnicki as he drew level with, or passed, the bus."*

Submissions on behalf of the family

67. At the Preliminary Inquest Conference, I made it very clear to the legal representatives that this Inquest was not about apportioning blame or identifying criminal or civil liability. This is a therapeutic jurisdiction. Section 45 of the Coroners Act (Qld) proscribes such an approach for good reasons of public policy. Coroners have greater coercive powers than prosecution authorities, judges and lawyers such as Section 39 of the Act. That power to compel a citizen to give evidence, as was the case with Mr Rudnicki, should not be used to establish blame and criminal or civil liability.

68. The submissions of the family to this Inquest were primarily designed to show Mr Rudnicki as the culprit. They answered a new set of issues in relation to the road traffic crash, devoted seven out of the nine pages of their submissions to Mr Rudnicki's apparent criminal or civil negligence and did not acknowledged that

this death was of multi-facetted causes. And that included the behaviour of Max. The criticism of Mr Rudnicki "accelerating from 8 km/hour to 21 km/hour" which was a safe and lawful speed. Had Max not placed himself beside the bus, it would have been an unremarkable speed. The family submission rejects any suggestion that Max was a contributor; ignoring his possible simple inattention, the evidence of accelerating fast with the head down from three eyewitnesses and obfuscates the critical problem: that the bus and Max both were facing a green light simultaneously. There is no explanation for Max's apparent failure to observe any of the three flashing indicator lights on the left-hand side of the bus as he rode beside it.

69. Curiously, the family submitted that it was reasonable to assume that Max was aware that Mr Rudnicki's bus was likely to turn left[52] yet by proceeding ahead, for unclear reasons, this decision was not a contributor to this tragedy.

70. I do not accept that "the only reasonable finding to make is that Max proceeded in a manner that was reasonable in the circumstances and in a way any reasonable cyclist would have". That is myopic. In a causative sense, the evidence shows that the circumstances surrounding Max's death were multi-factorial: there were shortcomings of Mr Rudnicki's vigilance, the Brisbane City Council and the Department of Transport and Main Roads traffic light design at the subject road traffic crash intersection. Included in the causative circumstances was Max's decision, weighing only approximately 100 kgs (including his bicycle) with no protection and limited acceleration and braking powers to his human capabilities, to "incautiously" ride within a metre of a moving 12 tonne Brisbane City Council bus.

71. As Counsel for the Brisbane City Council insightfully said:

> "Coupled with the reality of two dynamic things moving independently of each other, Mr Rudnicki's inability to see Mr McDowall was not, on the evidence, reflective of any shortcoming in the bus, the road geometry, the subject intersection including the traffic light sequence, the conduct of Mr Rudnicki or Mr McDowall. Rather the incident was, at this level of abstraction, the result of a conflagration of every day events and circumstances which, in the bespoke situation in question, had tragic consequences." [53]

2. The appropriateness of the traffic light sequence as it operated at the relevant intersection as at 27 May 2021.

Submissions of Max's Family on the issue

72. Submissions of Max's Family in relation to the traffic light sequencing at the O'Keefe Street/South-east Busway intersection at the time of Max's death were highly critical:

> *" … It was inappropriate, posed a risk to pedestrians and cyclist entering upon the intersection, and clearly contributed to Max's death. So much can be accepted by the decision to change the light sequencing shortly after the incident.*

[52] See paragraph 25 Submissions of Max's family (7 August, 2024).
[53] Submission of BCC paragraph 11.

Indeed, Mr Kroning agreed that the light sequencing at the time of the incident posed a risk to pedestrians and cyclists entering upon the intersection, including the risk of death, even when there was no non-compliance with the traffic signal on the part of road users, pedestrians and cyclists at the intersection, as was the case in the subject circumstances.

It seems the light sequencing was changed in 2014 because of some concerns that pedestrians and cyclists entering upon the intersection had been non-compliant with the signals then in place. However, it does not appear that any, or any adequate risk assessment of the changes made in 2014 was undertaken to identify and manage the risk the changes posed when there was no non-compliance.

If the light sequencing had been operational in the way in which it was changed following Max's death, it is unlikely Max would have died." [54]

Operation of the traffic lights

73. 64. The Brisbane City Council acknowledged that traffic signals at the relevant intersection are an asset and the responsibility for the operation and maintenance of those signals.[55] I conclude that the traffic lights were operating correctly, as they were intended, at the time of the collision.[56] The traffic signal plan confirmed that the pedestrian light for the SE Busway crossing was 'Green Walk' at the same time as the green traffic light for vehicles travelling in the westbound direction on O'Keefe St.[57] Motorists were, despite being on a green light, required to give way to pedestrians and cyclists before crossing the intersection.

74. 65. BCC has many intersections which do not control turning vehicles, such that both pedestrian and motorists will see a green man (pedestrian) and a green light for motorists. Pedestrians continue to cross the roadway, but motorists are required by Australian Road Rules to give way to pedestrians on a crossing (as was the case here).[58]

Pedestrian protection

75. By 2010, road design championing pedestrian protection with a shift in the approach to traffic signal sequencing, had a focus towards implementing pedestrian protection.[59] This involved a turning vehicle being held at the traffic light by a red turn arrow for the time allotted to the green-man "pedestrian". This sequence allowed for pedestrians and cyclists to establish themselves on the crossing in clear sight of motorists, prior to motorists being permitted to turn.[60]

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[54] Page 8 of the McDowell family submissions paragraphs [35]-[38]

[55] C3.1 at [19]; Transcript Day 1; 1-58 lines 2-4.

[56] Transcript Day 1; 1-11 lines 45-47; C1-C2.

[57] C1, p2; A5, p 11

[58] C3 at [16].

[59] See for example: The findings of Inquest into the death of Mijin SHIN (nsw.gov.au). 5 November, 2014

[60] C3.1 at [25]; Evidence of Kroning (Transcript Day 1: 1-59; lines 41-49 – 1-60; lines 1-9).

76. Such a traffic light sequence not been implemented at the intersection of O'Keefe Street and the South-east Busway at the time of the collision. This was because:

    (i) It was not regulated until 2016.
    (ii) Such regulation did not involve back-dating, such that BCC was not required to go back and retrofit and install pedestrian protection at intersections that had already been constructed per the standards of the day.
    (iii) Since 2017, pedestrian protection was being implemented at newly constructed intersections.
    (iv) While the relevant intersection sat as one of many intersections which, whilst installed pursuant to the standards of the day, required upgrading to meet current safety standards, not all of these intersections could be upgraded. This was due to budget considerations and manpower constraints. As put by Mr Enright, due to the sheer number of intersections over Brisbane City, not all could be updated in one hit.
    (v) Upgrading of existing intersections were prioritised in accordance with demonstrated needs and under existing BCC budget arrangements. BCC utilised relevant crash data as well as customer complaints to assess the need and priority that an existing intersection should receive.
    (vi) At the time prior to the collision, the relevant intersection had very low crash data and the intersection had been classified as low risk.
    (vii) Crash data at any intersection was an important consideration in whether or not pedestrian protection would be implemented at an existing intersection.
    (viii) Crash data and severity of any crashes were the main drivers for inclusion on the federal government 'Black Spot Program', a program aimed at funding and implementing improvements at known or potentially high severity crash sites.
    (ix) Prior to May 2021, this intersection had no serious crash history.
    (x) As put by Mr Kroning during his evidence, pedestrian protection was not put in place because:

    "---The intersection was deemed low risk from a road operator point of view. There was very minimal left-turning traffic across this – this movement. There's high pedestrian volumes. From – from a road operator point of view there was good sight visibility to – to the conflict point. And the intersection was not wide. We weren't – we weren't – we weren't subject to double left turns or any other measure that would require us to put ped protection in. We were also governed by – by the use of public funds in a responsible manner. … So providing something without a documented – without documented evidence to say it really is a risk is not something that we would likely have done in the past."[61]

77. In terms of making changes to traffic signals at intersections generally, the Court heard evidence that the complexity of the task was dependant on the intersection itself: its age, the existing hardware and the extent of the wiring in existence. The following considerations are also relevant:

    (i) Volumes of traffic, pedestrians, cyclists, vehicles;
    (ii) The types of vehicles;
    (iii) The movements of those vehicles;
    (iv) The speed environment.[62]

[61] Evidence of Kroning (Transcript Day 1: 1-71; lines 40-49 – 1-72; lines 1-2).
[62] Evidence of Bilton (Transcript Day 2: 1-5; lines 24-30).

Traffic light sequencing in place at the time

78. The evidence supports that the traffic light sequence for the intersection was put in place by BCC as a result of lobbying and requests for change by the cyclist network.[63] The particular sequence had been in place at the intersection since 22 July 2014 and remained in place at the time of the collision.[64]

79. In summary, the change made in July 2014 was brought about by the long wait for cyclists if caught on a red pedestrian light, coupled with the low level of busway traffic turning into the busway from O'Keefe Street. This meant that cyclists were generally crossing the intersection on a red pedestrian light – this gave rise to a suggestion for cyclists and pedestrians to have a very long, automatic green light for crossing which would last until shortly before the lights changed. This change was implemented at the intersection with the effect of giving pedestrians a green man for a longer period of time (90 seconds). There was no formal risk assessment conducted by BCC in implementing this change.[65]

80. However, the evidence is that the risk was assessed in other ways, as follows:

> *The emails suggest that Mr Calos, while there hasn't been a formal risk assessment, he's certainly gone through, looked at how the intersection would likely operate, what the risks are, how could we mitigate those risks, and in this case, yes, we're looking at walk for green for this intersection. But on top of that there was extra measures. There was additional signage proposed. There was pavement markers proposed. There was consultation with – with the bus operators, and there was consultation with the bicycle user groups to – to allow people or – and part of those discussions were that the signals have changed, bicycle and pedestrians need to be aware that there's changes, and if – if there's a red man showing then it's essentially a situation where there is a bus present that's looking to – to turn into or out of the – the busway*.[66]

81. These steps are also confirmed by the email from Mr Calos and the evidence from Ms McGraa about notification to bus drivers of the change in sequencing and to be alert for cyclists.[67] In terms of complaints from the general public about the traffic signals at the intersection, whilst prior to Max's death BCC was aware of some 'near misses' between cyclists and buses as well as some concerns from bus operators regarding pedestrian non-conformance with the traffic lights[68], the evidence is that the relevant intersection had also been cited by cyclists as being a positive example of traffic light sequencing.[69]

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[63] Refer emails from the public to BCC at C9.1 p 62-63 & 129-130

[64] C3 at Annexure 3; C3.1 at p 16.

[65] Evidence of Kroning (Transcript Day 1: 1-68; lines 5-41

[66] Evidence of Kroning (Transcript Day 1: 1-69; lines 18-28).

[67] C9.1 p 1357-1358; C7 at [19(b)]; C9.1 p 145.

[68] Evidence of Kroning (Transcript Day 1: 1-64; lines 24-30); refer Traffic Crash Report of 13.04.2017 at C9.1 p 220

[69] Email to BCC dated 1 February 2021 at C9.1 p 1328-1329

82. Concerns from bus drivers and the Carina Bus Depot had been put forward to BCC, some of which are as follows:

    (i) In July 2017, Ms McGraa (Carina Bus Depot) had completed a hazard report which raised the issue of '*Bus and bike riders both have green signal at entrance to busway. Bike riders and bus required to exercise care; however, visibility is difficult for bus drivers*'.[70]

    (ii) In August 2017, Ms McGraa emailed the Safety Manager reporting an incident that had occurred in April 2017 between a cyclist and a bus at the intersection and suggesting a left-turn arrow.[71]

    (iii) In July 2019, Mr McPhail (Carina Bus Depot) informed BCC of an issue relating to the line of sight of buses turning from O'Keefe St into the busway portal – McPhail's email noted an additional issue with the driver protection barriers distorting/blocking the view for a shoulder check to be performed for cyclists on approach to the left turn.[72]

    (iv) In February 2020, Ms McGraa attended a meeting of the Workplace Consultative Committee Meeting where it was noted that *'safety at O'Keefe St is still unsafe where cyclists are in a blind spot for outbound Glider buses'*. Creation of an extra lane was requested.[73]

83. It was understood by Ms McGraa that:

    (i) The investigations of her July 2017 concerns were with the Transport and Operations Branch of BCC, and such investigations were long and ongoing.[74]

    (ii) A risk assessment was being led regarding the road.[75]

    (iii) Ongoing work was being conducted in that corridor relating to a range of factors.[76]

84. BCC had considered installing flashing yellow lights at the intersection, which had previously been trialled at a different intersection in Brisbane. It had been determined that the flashing lights hadn't worked at that intersection, and it was thus considered that it may not be worthwhile to install them at the relevant intersection. This was because people would get used to the flashing lights, so whilst they might be effective initially, they lose that effectiveness after a period of time.[77]

85. The next stage was to look at implementing pedestrian protection at the intersection. However, it was determined that the volumes of traffic along O'Keefe St at that time were extremely high. To have a bus stopped in the left-hand lane

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[70] C7.1 at [9(cb)].
[71] C7.1 at [9(cd)-(ce)].
[72] Email to BCC dated 1 February 2021 at C9.1 p 1328-1329.
[73] C7.1 at [9(dc)].
[74] Evidence of McGraa (Transcript Day 2: 1-41; lines 38-46).
[75] C7.1 at [9(ce)].
[76] Evidence of McGraa (Transcript Day 2: 1-44; lines 16-24).
[77] Evidence of Kroning (Transcript Day 1: 1-64; lines 37-49 - 1-65; lines 1-21); C9.1 p 1357.

on a red arrow to allow pedestrians to cross would likely cause traffic to queue back and cause significant delay, and possibly accidents at that location.[78] Minutes from the Workplace Consultative Committee Meeting held in June 2020 noted in the action register next to the item *"Can a left turn only lane be installed at O'Keefe St busway entry portal?": "There is insufficient width to add a bus only left turn into the portal. Numerous safety measures and warnings are in place at this location and has been deemed low risk. COMPLETE."*[79]

86. When asked to explain, in the context of the near-misses and concerns from the bus drivers and Carina Bus Depot that had been reported to BCC, why pedestrian protection had not been installed at the intersection earlier, Mr Kroning said:

> "---*So at that time there was a road safety audit carrying on from the upgrade of that entire corridor, and it was deemed inappropriate to – to go and change how that intersection was – would operate, given that there was already a road safety audit done. The road safety audit didn't identify any significant issues with the operation of traffic signals, and essentially they were looking at it from a corridor perspective to make that entire corridor much safer as a whole*."[80]

87. Pedestrian protection was installed at the relevant intersection following Max's death, and indeed as a result of Max's death.[81] An image of the intersection demonstrates that a dedicated left turn lane is now in place with buses held on a red arrow whilst pedestrians commence across the intersection.[82]

88. In terms of why this collision caused for a reconsideration of the risk posed by this intersection, Mr Enright's evidence to the inquest was as follows:

> *"---So, in general, if you go before the incident occurred – bearing in mind that, I suppose, the changes in the light sequences were put in about seven years before that – there had been no over alarming or crash histories or crises occurring at that thing that would have flagged a review of the intersection. And, you know, unfortunately, with a thing as large as Brisbane, incidents that occur flag us to look at something. If no incidents occurred, it's not flagged to look at it. When this incident was looked at, from what I've read of the review reports that – that they did, the key issue was now taking into account the evidence that the bus driver could not see anyone on the shared path immediately next to it, that there was, basically, a – it's a shared path, not a bike lane, but a shared path with lots of cyclists on it – a left turn movement across that facility posed a risk in terms of potential visibility issues. So that bit was taken on board from the report that we received. And looking at that, I think they looked at about two or three options, from what I've seen. The recommendation out of that internal review was that the safest option to put in was a left-turn pocket for buses with a control signal. That did two things. It – it – it removed the conflict between cyclists and buses, but by the same time, it enabled the green light to stay on for – long time for O'Keefe Road itself. Nine – I think it's something like 97 per cent of all movements on O'Keefe Street are through movements. So by putting in the left-turn pocket and the*

[78] Evidence of Kroning (Transcript Day 1: 1-65; lines 21-26).
[79] C7.1 at [9(dd)].
[80] Evidence of Kroning (Transcript Day 1: 1-65; lines 40-46).
[81] C3.1, Attachment 1 p 28; Evidence of Kroning (Transcript Day 1: 1-68; lines 13-18); C9.1 from p 1380-1439; Evidence of Enright (Transcript Day 2: 1-27; lines 10-11).
[82] C9.1, p 1437.

light change, it didn't interfere with the general traffic in O'Keefe, and that was seen as being the best solution to resolve the conflict without compromising the role of the road itself."[83]

89. The phasing of the lights created the situation where there was no separation between pedestrians/cyclists crossing the busway and vehicles entering the busway. As SGT Cutler said in his evidence, it provided both pedestrians and motorists with the mindset that "I have right of way and I'm good to travel through the intersection."[84] This intersection is one that would have benefited greatly from pedestrian protection being installed, this is especially the case in the context of the vast areas of blind spots surrounding any bus turning left into the SE busway. Whilst it cannot be stated with any degree of certainty, I conclude that the installation of such pedestrian protection might have prevented Max's death if Mr Rudnicki had been held on a red arrow.

90. As for why pedestrian protection had not been installed at the intersection prior to May 2021, in balancing the available evidence, I conclude that this was not unreasonable. This is in the context of:

    (i) The available crash data which contributed to the intersection being rated as low risk;

    (ii) The signage installed at the intersection aimed at raising awareness to both pedestrians and vehicles about the need to keep a lookout;

    (iii) The road safety audit in progress at the relevant time which included the relevant intersection as part of a broader upgrade of the Old Cleveland Road Corridor;[85]

    (iv) The overall busyness of the intersection when compared to other intersections;

    (v) Other factors required to be balanced (i.e. budget constraints, manpower); and

    (vi) Whilst there had been regular and ongoing concerns put forward to BCC from the Carina Bus Depot about the visibility and safety issues[86], there was a lack of knowledge from BCC or DTMR (from those who gave evidence at the inquest) of the full extent of the blind spots surrounding the bus as depicted by the blind spot mapping conducted by SGT Cutler.[87]

[83] Evidence of Enright (Transcript Day 2: 1-27; lines 24-44).
[84] Transcript Day 1; 1-12 lines 23-27.
[85] Evidence of Enright (Transcript Day 2: 1-24; lines 10-46).
[86] Evidence of McGraa (Transcript Day 2: 1-46; lines 4-9).
[87] Evidence of Bilton (Transcript Day 1: 1-17; lines 5-13); Evidence of McGraa (Transcript Day 2: 1-47; line 24); Evidence of Hatchman (Transcript Day 2: 1-57; lines 25-32).

3. The appropriateness and adequacy of the design of the subject intersection as at 27 May 2021 including:

a. whether the design of the intersection complied with the relevant standard;

b. whether an appropriate and adequate risk assessment and/or review of the design of the intersection was undertaken prior to May 2021.

91. The evidence available to the Court is that the design of the intersection was compliant with the relevant standards in place at the time it was constructed. Those standards did not take into account the blind spots on any given vehicle known to use the intersection.[88]

92. In explaining what guidance is provided to authorities regarding road design, Ms Bilton explained that Austroads provides the national guidance. State specific elements which are required are captured in specific Queensland supplementary guides, namely the Traffic and Road Use Management Manual (currently harmonising to the Queensland Guide to Traffic Management). In addition to the National and State guidelines, the Court heard that local councils can also have their own internal guides and policies, as BCC does. The evidence provided by both BCC and DTMR was that the relevant intersection was designed to reflect the road rules that were in place at the time. It was not until recently that the approach to design changed from being 'driver focused', to 'pedestrian focused'.[89]

93. 'Driver focused' was explained to mean: "---*It was very much focused on – on moving people around, moving vehicles around the network, rather than moving – moving people or moving pedestrians and active transport users around the network."*

94. 'Pedestrian focused' was explained to mean: "---*It's only very recently that there's been more of a focus on pedestrians, pedestrian safety and implementing measures that looks at – at protecting at least the initial walk period of a – of a set of signals. Yes."*

95. The intersection was commissioned in January 2001. At that time, the design essentially meant that both pedestrians and vehicles could get a green light at the same time, and the road rules would take precedence with vehicles giving way to pedestrians on the crossing. This reflects how the relevant intersection was designed. It was not uncommon for intersections to be designed in this way; rather it was the default position/standard of almost all traffic signals in Brisbane.[90]

96. Whilst in designing the intersection the extent of the blind spots on the bus was not considered, the evidence available to the Court is that the extent of the blind

[88] Evidence of Bilton (Transcript Day 2: 1-17; lines 15-23).
[89] Evidence of Bilton (Transcript Day 2: 1-8; lines 18-26); Evidence of Enright (Transcript Day 2: 1-21; lines 20-28); C8 at [45] Evidence of Kroning (Transcript Day 1: 1-58; lines 47-49 – 1-59; lines 1-22).
[90] Evidence of Kroning (Transcript Day 1: 1-59; lines 17-27); Evidence of Bilton (Transcript Day 2; 1-16; lines 14-24).

spots, as shown by the blind spot mapping, were also not really known (at least by those who gave evidence at the inquest). There is also no evidence that the blind spots should have been considered at the time the intersection was designed back in 2001.

97. Taking into account the above context, I find that the design of the O'Keefe Street/South-East busway, Woolloongabba intersection was adequate and appropriate.

4. In light of the developments made to the relevant intersection since 27 May 2021, whether any further recommendations might be made to improve safety at the relevant intersection for both bus operators and pedestrians.

98. This Court owes a substantial gratitude to Counsel for the BCC and the Council for the substantial provision of voluminous documentation outlining the historical background to this fatal road traffic crash, coupled with comprehensive and reasoned submissions. I do not wish to cite them verbatim with the exception of the submissions on this fourth issue:

> *"Formal Issue 4*
> *19. By reason of the incident the risk profile of the subject intersection, in particular in relation to conflicts between left turning buses and pedestrians, was revised and reprioritised. As a result, substantial upgrade works were carried out.*
>
> *20. A signal controlled, dedicated left-turn bus lane on O'Keefe Street westbound at the point of the subject intersection was created in concert with a new traffic island on O'Keefe Street. As such, pedestrians at the subject intersection enjoy complete protection (assuming compliance with signalling) – no conflict can now arise between the movements of a compliant pedestrian and those of a compliant bus turning left.*
>
> *21. The changes that have been made are a complete answer to any risks which the subject intersection's pre-incident design, including the light sequence operational at it, presented. In these circumstances, the Council submits that no further recommendations in relation to safety of the relevant intersection are necessary."*

99. I adopt this submission. However, I have made more general recommendations.

Comments and recommendations

100. Section 46 of the Act empowers a Coroner to comment on matters connected with a death relating to:

    a) public health and safety;

    b) the administration of justice; or

    c) ways to prevent deaths from happening in similar circumstances in the future.

Incident reports

101. It was noted by Ms McGraa in her evidence that bus incidents are recorded by the completion of an incident report. The completion of such a report is a purely subjective account on the part of a bus driver, as there is no criteria or definition available to assist bus drivers as to when or in what circumstances an incident report should be completed.[91]

102. This has the effect that, by way of extreme example, whilst a 'near-miss' between a bus with a cyclist or another vehicle at an intersection might not result in any impact or injury, the bus driver might not deem it serious enough to report.

103. Whilst Ms McGraa in her role as Depot Manager would progress issues that she was told about anecdotally from those she oversaw, there may be greater benefit in having written incident reports from bus drivers that can be referred to on any given issue. The completion of such an incident report could very well contribute to the overall data-set available to BCC for any given intersection, so that when issues are identified with an intersection and need to be reported to BCC, there are specific written incidents to refer to, rather than broad, collective, anecdotal information.

104. RECOMMENDATION 1: I recommend that the Brisbane City Council review the bus drive Incident Report protocol and, to that end, incorporate in any bus driver's training and training manual guidance and a set of criteria to assist bus drivers in providing appropriate information in an Incident Report.

Training

105. With respect to how bus drivers are trained regarding Blind Spot Mapping blind spots on a bus, the evidence of Ms McGraa was to the effect that they are taught to check their mirrors, to look over their shoulder and essentially similar things to what **people** are taught to drive a car. Ms McGraa also spoke of hazard awareness training for pedestrians and cyclists and using a 'mobile eye', which assists drivers in detecting certain movements around the front of the bus.[92]

106. RECOMMENDATION 2: I recommend that the Brisbane City Council incorporate in any bus driver's training and training manual guidance on Blind Spot Mapping to assist bus drivers identifying hazard awareness of pedestrians and cyclists.

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[91] C7 at [20]; Evidence of McGraa (Transcript Day 2: 1-46; lines 11-27).
[92] Evidence of McGraa (Transcript Day 2: 1-48; lines 1-6).

Camera Mirrors

107. Mr Hatchman gave evidence about 'blind spot monitoring technology' which, by using 3D intelligent cameras, can monitor potential blind spots around a heavy vehicle and then alert the driver of the presence of a pedestrian, cyclist or another vehicle. The technology is intelligent enough to recognise shapes and symbols and can provide information to the driver via warnings, both visual and audible, that there may be an object in the blind spot. This technology is not being actively adopted at by BCC.[93]

108. What has been pursued by BCC in recent years is the installation of camera mirrors' on BCC buses. This was explained by Mr Hatchman as follows:

> *"--- So as a result of an increasing number of attacks on our bus drivers, or bus operators in the vehicles, the State Government has provided funding to council to fit full driver's barriers. So that's a barrier that essentially doesn't encapsulate the driver, but provides a greater deal of protection for the driver from physical assault. Part of that solution is to fit rear-view camera systems. And the reasoning for that is to improve the vision of the left side mirror. So traditionally when you look through a traditional mirror you actually look to your left through the windscreen to see the mirror on the other side of the windscreen. When you fit a full driver's barrier on the left-hand side, you also have to look through the barrier glass and the windscreen to see the mirror.*
>
> *As a result of that, in order to mitigate that risk of looking through multiple pieces of glass, it was decided to trial and install rear-view camera systems. The benefit of that is the monitor that the driver is looking at can then be located inside the barrier. So you don't need to look through the barrier glass. Nor do you need to look through the windscreen. The driver has direct vision of the monitor and that's the case for both left and right-hand side mirrors*."[94]

109. Mr Hatchman explained that the rear-view cameras have two types of mirrors on each side, a Class 2 and a Class 4. When shown the blind spot mapping undertaken by SGT Cutler, Mr Hatchman said that the larger area of red hatching (blind spot) would be mostly covered by the Class 4.[95] He told the court that BCC currently have camera mirrors installed on approximately 110 buses, with an ongoing program funded by Translink for approximately 270 buses. With a total of 1265 buses in the BCC fleet, an extension of the current funding will be required so as to ensure all buses have the camera mirrors installed.

110. RECOMMENDATION 3: I recommend that the Brisbane City Council and Translink Services install in its full fleet, technology of the type described as "mobile eye" and "camera mirrors" to assist bus drivers identifying hazard awareness training for pedestrians and cyclists.

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[93] Evidence of Hatchman (Transcript Day 2: 1-58; lines 33-47).

[94] Evidence of Hatchman (Transcript Day 2: 1-59; lines 33-46 – 1-60; lines 1-2).

[95] Evidence of Hatchman (Transcript Day 2: 1-61; lines 14 & 28-35).

Intersection design

111. Whilst the evidence available to the Court is that the design of the intersection was compliant with the relevant standards in place at the time it was constructed, it is also apparent from the evidence that blind spots on any given vehicle known to use the intersection was not something that would have been considered. The current standards are also silent as to blind spots.

112. It was noted during the inquest that blind spots will differ as between types of vehicles. However, in the circumstances of this intersection, it was known that the only vehicle turning left into the SE Busway was a BCC 61 Glider bus. It would have been beneficial for such information to have been available and considered when the O'Keefe Street/South-east Busway intersection was designed.

113. RECOMMENDATION 4: I recommend that the Brisbane City Council and the Department of Transport and Main Roads undertake a programmed review of every intersection in the Brisbane metropolitan area with a view to eventually prioritising the installation of a red arrow prohibition of any vehicles crossing pedestrian lanes **which have a "green man" light. An assessment of the level of risk posed by the blind spots on BCC buses at any intersection should be a critical factor.**

Conclusion

114. Max was obviously a cherished young man who was lost to his family too soon. His death has brought to the attention a dangerous problem with pedestrian and bicycle safety at Brisbane intersections. The positive is that pedestrian traffic light sequencing to reduce this danger, if red lights are obeyed, should prevent a repeat of this tragic collision. Such changes have been rolled out by authorities since this tragedy and, indeed at the intersection of O'Keefe Street and the South-east busway, Woolloongabba. Max's legacy will be the heightened awareness of this road traffic issue for cyclists and pedestrians and the installation of such traffic design systems.

115. The point was rightly made during the inquest that this collision did not involve Max and Mr Rudnicki being non-compliant with their respective traffic signals. The cause of Max's death was multi-facetted. There were principally three causes:

1. The existence of multiple blind spots preventing Mr Rudnicki from becoming aware of Max's position behind and at the left-hand side of the bus. Ancillary to this cause was the lack of training of BCC bus drivers in respect of these blind spots.
2. The design of a traffic light system at the O'Keefe Street/ South-east Busway intersection permitting BCC buses and pedestrians simultaneous access to the southern pedestrian lane.
3. Max's failure to realise the danger in which he placed himself by either ignoring (which is unlikely) or not seeing the flashing indicator lights of Mr Rudnicki's bus probably because he had his head down trying to accelerate through the pedestrian lane.

116. As SGT Cutler, the QPS investigating Officer opined:

> *"---So I'm of the opinion that the crash has occurred when the bus and cycle have both entered the intersection on a green light for the respective vehicles. The bus driver was intending to turn left into the busway, and the cyclist intended to travel across the crossing of the busway. Both directions received green signals at the same time. The bus driver had a mistaken belief that the crossing was clear for him to finish his turning manoeuvre and was in a give-way position for the cyclist crossing from his left. I believe that the cyclist, although having right of way across the crossing, has failed to identify the bus that was slightly ahead, then adjacent of him and indicated to turn left into the busway entrance. Having considered all the material obtained in this investigation and having a mind to the highly dynamic situation that was occurring, I'm of the belief that the deceased cyclist was in the best position to identify the hazard occurring and take evasive action. However, the bus driver was in a give-way situation."*

117. I accept these determinations by of SGT Cutler and adopt the earlier findings of Coroner Clements.

118. It was certainly the legal duty of Mr Rudnicki to take care not to collide with Max and his bicycle. Good minds will differ on whether Mr Rudnicki's lookout was reasonable. However, that was not an issue for this Inquest. I agree with Coroner Clements original findings and what is common ground: that Mr Rudnicki did not see Max. There is no evidence that Mr Rudnicki recklessly ignored Max's potential presence. Critical was the absence of a proper understanding by Mr Rudnicki (and BCC bus drivers generally) of the extent "blind spots" on the non-driver's side of a bus confront a bus driver with particularly when turning left. Further, the need for Mr Rudnicki to peruse the entire vista around his bus, not just the left hand side, caused him to be unaware of Max.

119. Despite the McDowall family's submissions to the contrary, Max's behaviour also contributed to his tragic death. Commonsense dictates that, weighing only approximately 100 kgs (including his bicycle) with no protection and powers of acceleration and braking limited only to his human capabilities, Max should have been very cautious riding within a metre of a moving 12 tonne Brisbane City Council bus. The eye-witnesses and CCTV footage clearly show Max with his head down which is consistent with his concentration being upon getting across, at speed, the uphill incline of the pedestrian strip. Although he apparently did not, it is difficult to understand how or why, Max did not notice the flashing left-turning indicators of the bus.

120. Having said that, I find that the principal cause of this collision was the design and sequencing of the pedestrian road traffic light at the intersection of O'Keefe Street and the south-east busway at Buranda. It provided lawful simultaneous access to the same pedestrian lane for both a bus and bicycle. Of course, that has been rectified by the provision today of a "no left turn" red arrow preventing bus drivers crossing while the pedestrian lane (Max's path) has a "green man" right of way.

121. The challenge is to install in as many intersections as possible such pedestrian road traffic lights. As Mr Enright explained, the City of Brisbane covers in excess of 1,300 square kilometres, has a population of about 1.2 million which is

predicted to rise to between 1.5 and 1.7 million by 2041 has a road network which consists of 5,700 km of road and has more than 1,000 signalised intersections, constructed footpaths, shared pathways and bikeways.[96] The Council is the local government for that area and that population. It has sophisticated and evolving planning instruments that are designed to ensure the orderly and safe development of Brisbane including the *Brisbane City Plan* 2014, the *Transport Plan for Brisbane Implementation Plan* created in 2018 and the *Move Safe Brisbane Report* of 2018. [97]

122. He said:

> *"It follows from the matters just recorded, and the self-evident fact that the conduct of all governments is constrained by budgetary limitations that road infrastructure design and operation, so far as it concerns existing infrastructure as opposed to new or upgraded infrastructure, is a reactive process."*[98]

123. I am indebted to counsel for their assistance. I am especially grateful for the substantial resources allocated by the Brisbane City Council and Department of Transport and Main Roads in providing data and its interpretation regarding the subject intersection to this Inquest.

Findings required by s. 45

Identity of the deceased –	Maximilian Patrick McDOWALL
How he died –	The deceased was a cyclist who, whilst riding, was struck by a Brisbane City Council bus which did not give way to his crossing a pedestrian strip at the intersection of South-east Busway and O'Keefe Street, Woolloongabba
Place of death –	Intersection of South-east Busway and O'Keefe Street, Woolloongabba
Date of death–	27 May 2021
Cause of death –	1(a). Multiple injuries; due to, or as a consequence of 1(b). Motor Vehicle Collision (cyclist)

I close the inquest.

Donald MacKenzie
Coroner
BRISBANE
24 October 2024

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[96] Enright Ex C8 [8] to [12]
[97] Ibid [11]
[98] As Mr Enright Ex C8 at [22], and Mr Kroning at C3.1 [7]