QUEENSLAND COURTS

INNISFAIL CORONER
FINDINGS

CITATION:	Inquest into the death of JOHN ERNEST VENTURATO
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Innisfail
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FINDINGS OF:	J Brassington, Coroner
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REPRESENTATION:

Assisting:	Ms Julie Sharp
For Sgt Byers and SC Davis:	Mr A Braithwaite (Gilshenan and Luton Legal Practice)
For the Commissioner of the Queensland Police Service:	Inspector W Kelly

INTRODUCTION

1. Just before 5.30 a.m on 6 September 2005 John Venturato said goodbye to his wife of many years to travel to Tully. There he planned to meet up with his friends and go on an overnight reef fishing expedition. To get to Tully he had to drive his Holden Jackaroo four wheel drive from his home in El Arish and south along the Bruce Highway. On the Bruce Highway, at Feluga, he drove into the side of house being moved north along the Bruce Highway. He was killed instantly.

2. John Venturato was 69 years old when he died. He was a highly respected man in the Tully region and head of the State Emergency Service (SES) in Tully. He was committed to his work in the SES, to the community and most of all to his family. Given his particular commitment to safety and his knowledge of traffic control the circumstances of the collision have puzzled all those who knew him.

3. Pursuant to s. 28 (1) of the *Coroners Act 2003* (the Act) an inquest was held into the death of Mr. Venturato. These are my findings. These findings and comments will be distributed in accordance with requirements of ss. 45 (4) and 46 (2) of the Act.

THE CORONIAL JURISDICTION

4. I have jurisdiction to inquire into the cause and circumstances of Mr. Venturato's death under the Act as his death occurred on 6 September 2005 and was a reportable death. Mr. Venturato's death was a '*reportable death*' in accordance with s. 8(2) and (3)(b) of the Act because it was a "*was a violent or otherwise unnatural death*" that occurred in Queensland. I am unaware of any other Coroner investigating the death.

5. Section 45(2) of the Act provides that when investigating a death the coroner must as far as possible find:-
   - Who the deceased person is; and

- How the person died; and
- When the person died; and
- Where the person died; and
- What caused the person to die.

6. A Coroner may also comment on anything connected with a death investigated that relates to public safety or the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.[1] When such comments are made a written copy of those findings must be given to the persons set out in s. 46 (2).

7. Section 28 of the Act provides for the holding of an inquest if the Coroner considers it desirable. In this case the holding of an inquest was considered desirable.

8. I now turn to matters of law and procedure that I must apply to the conduct of the proceedings and the making of my findings. A coronial investigation is an inquisitorial process. Its focus is finding out what happened and not on determining guilt, attributing blame or apportioning liability. Rather its purpose is to inform the family and public how the death occurred with a view to reducing the likelihood of similar deaths.[2] A Coroner must not include in the findings any statement that a person is or may be guilty of an offence or civilly liable for something.[3]

9. A Coroner is not bound by the rules of evidence but may inform herself in any way considered appropriate.[4] However, the Coroner must act judicially and have regard to the rules of natural justice and procedural

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1 Coroners Act 2003, section 46.

2 From the summary of functions by the State Coroner in the matter of Wait et al 17 March 2008 cited by Mr Braithwaite.

3 Coroners Act 2003, section 45(5). See also R v Shan Eve Tennent; Ex parte Jager [2000] TSSR 64 where Cox CJ said of the similar Tasmanian provision: the focus of an inquest conducted under the Act being the ascertainment of facts without deducing from those facts any determination of blame, and the mischief sought to be avoided being the public naming of persons as suspected of criminal activity when they may never be charged. Section 46(3) provides the same prohibition with respect to comments.

4 Coroners Act 2003, section 37

fairness.[5] Leave was given for the two police officers involved with the escort and the Queensland Police Service to be represented at the inquest. The Venturato family was not represented but Counsel assisting endeavoured to ensure that they were consulted with respect to any questions that they wished to have asked. I have provided copies of relevant material to Queensland Transport and the Department of Main Roads for any comment that they might wish to provide.

10. When making findings the civil standard of proof, the balance of probabilities, is applied. However the principles of *Briginshaw v Briginshaw* must be adhered too. In the coronial context these are conveniently set out in the often cited judgment of Gobbo J in *Anderson v Blashki* [6] :

> *In Briginshaw v Briginshaw (1938) 60 CLR 336, at 362 to 363, Dixon J, as he then was, provided a classic statement as to the appropriate standard of proof to be used in civil cases: " . . . reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect inferences"*

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5 This means that 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 Annetts v McCann (1990) 65 ALJR 167 at 168 makes clear, that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

6 [1993]2 VR 89 at 95

MY FINDINGS

11. The inquest took place over five days. Following oral submissions from counsel assisting I received written submissions from each of the parties granted leave to appear which I found most helpful in formulating these findings.

12. It is necessary to traverse the evidence given at the inquest and received during the investigation to understand both my findings and the recommendations made. I have summarised some of the evidence I consider necessary both to explain my findings and recommendations. I have of course considered all the evidence before me even if not specifically referred to in these findings.

BACKGROUND

13. At about 2 am on 6 September 2005 a convoy of vehicles left the Victoria Mill at Ingham. The purpose of the convoy was to escort a wide load to Innisfail. The wide load was a house that was 8.9 m wide, 4.5 high and 27 m long. The route of the wide load was largely along the Bruce Highway through Cardwell, Tully and then to Innisfail.

14. The collision between the wide load and Mr Venturato occurred on the Bruce Highway at Feluga, between Tully and Innisfail. At the collision point the Bruce Highway was 7.3 m wide to the edge lines[7] with the edge of the shoulder (after which there is slanted grass verge) 10.1 m wide.

15. The house was being moved by A J Myles House Relocators as a commercial contract. The proprietor of that company, Anthony James Myles, was the driver of a prime mover that moved the house. The prime mover pulled a hydraulic adjustable flat top trailer, described as a low loader, upon which the house was secured.

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[7] Edge lines are sometimes referred to as fog lines and are painted to assist drivers and to define the line between the travelled way and the pavement shoulder.

16. The order of vehicles in the convoy is set out below from the first in the convoy to the last:
    1. Philip Blair – Pilot Vehicle
    2. Neville Byers – Police Vehicle
    3. Anthony Myles and Lisa Maccarone – driver of wide load and passenger
    4. David Dracchio – escort vehicle
    5. Robert Myles – escort vehicles
    6. Melissa Davis – Police vehicle
    7. Angie Gear – Pilot vehicle
    8. Lester Hardie – Main Roads vehicle

17. Vehicles 4 – 9 were positioned behind the wide load. There were only two vehicles in front of the wide load to notify oncoming vehicles of the wide load – the pilot vehicle and the police vehicle driven by Sergeant Byers.

18. Sergeant Byers was a very experienced police officer but had limited experience in escort duties for wide loads. He estimated he had only done 4 – 5 such escorts in the last few years before this matter and of that number he had been the lead driver only on two occasions. He had never received any training in his responsibilities as an escort driver. At the time no such training was available from the Queensland Police Service (the QPS).

19. Sergeant Byers had not expected to do this escort. He was allocated the special duty late on 5 September 2005. On that day he worked a shift of 3pm – 11pm At the conclusion of the shift, in his own words, he went home to have a couple of hours sleep and then returned to the station at about 1.30am to join the convoy at the mill for a 2am departure. He had approximately 1 and ½ hours sleep. Given his experience as a police officer (and his experience of extended shift work) he denied being fatigued.

20. At the inquest Sergeant Byers explained his responsibilities, as he understood them:

> *Just check the load and make sure the dimensions more or less comply with the permit. Check the lights. Get the guy to sign it….speak to the pilot and just work out where you're going to go in relation to loads and just general familiarisation with yourself with the load and check it out and make sure everything is in order and its not going to fall off and hurt somebody or something like that.*

21. Philip Blair was the pilot vehicle driver. He had twenty years experience in this role. To obtain his pilot license he completed a two day course. Subsequent to that training he maintained his license by annual renewal with no further specific training requirements. He had escorted similar loads (i.e. houses) over this route previously.

22. To lead this convoy he was driving a Nissan Patrol 4WD. It had a typical yellow and black traffic sign mounted on the roof saying "Oversize Load Ahead". On either side of the sign were two amber flashing lights. By law he has to stay on the correct side of the road. His was the first vehicle that would warn drivers of the wide load following. He used a magna torch (red light) with a cone that he put out the window in an arc motion. Different methods were used to warn drivers: some cars would pull up and he then verbally advised them as to the load; he would use CB radio communication to warn trucks; and other cars would simply drive by. On particular parts of the road where there was no place for motor vehicles to pull up (i.e. the Murray Flats south of Tully where the road is elevated and falls away sharply to prevent flooding) cars were halted by Mr. Blair until the house came through that section.

The Legal Framework Permitting the Transport of a Wide Load

23. The *Transport Operations (Road Use Management) Regulation 1995* and its successor (which commenced operation on 5 September 2005) the *Transport Operations (Road Use Management – Mass Dimensions and*

Loading) Regulation 2005 made it an offence to have a vehicle on the road that was above the standard dimensions set out in the Regulation – relevantly here 2.5 m wide and 4.6 m high.

24. Under s. 11A of the 1995 Regulation the Commissioner of Police may issue a permit to allow travel upon the road. Section 11A (5) requires particular conditions to be included on a permit. The 2005 Regulation contains equivalent provisions in s. 51. The 2005 Regulation also contains transitional provisions to preserve permits, and guidelines issued under the 1995 Regulation.

25. In this case the Permit for a single trip Excess Dimension Vehicle was issued on 5 September 2005 by Senior Constable Bow. The task of issuing permits in the Service is restricted to Superintendents' of Traffic. These Superintendents' receive a delegation of powers from the Commissioner to permit them to issue permits. No special training is received before the powers can be exercised. Senior Constable Bow relied upon the QPS Traffic Manual for guidance in the issue of permits.

26. The paperwork for the permits was prepared by Lisa Maccarone, a part time employee of A J Myles & Co. She filled out the following forms:
    - A form requesting the 'special' services of a Police Officer from the Queensland Police Service to escort the wide load ;
    - An application for permit which is a Queensland Police Service form that names the roads to be driven on and the start and finish times and the date of transportation
    - A form submitted to the Department of Main Roads with similar information
    - A form submitted with similar information to Ergon Energy and Queensland Rail

27. The Department of Main Roads required modification of the house as the original dimensions (11 metres wide) would have endangered trees in the

Cardwell Ranges. The width of the house was then reduced to just below 9 metres and the roof taken off.

28. The approvals from Main Roads, Ergon Energy and Queensland Rail are exhibits in the proceedings. The approvals were then faxed by Ms Maccarone to Ingham Police.

29. No where in the permit applications is it required to note that the width of the road that the load will be travelling on. The relevant sections of the route along the Bruce Highway upon which the house travelled were on average between 7 ½ and 8 metres wide. In effect the house blocked the entire road.

30. The permit issued by Senior Constable Bow was in the standard form with standard conditions including:
    - Vehicle must comply with conditions as stated in the Queensland Transport Performance Guidelines for Excess Dimension Special Purpose Vehicles and Vehicles Carrying Indivisible Articles Requiring Pilots/Escorts.
    - Original or copy of permit issued to be carried by the driver of the unit or driver of the lead escort/pilot vehicle and produced on request by a police officer or authorised officer.
    - Other conditions which relate to dismantling traffic signs and reporting damage

31. The permit permits the insertion of modified conditions – none were inserted on this occasion.

32. Senior Constable Bow was experienced in the escort of wide loads although he too had received no training (as noted already none was available at this time to any police officer) in that role. He had planned to do the escort on this occasion. However, at the last moment the role was handed over to Sergeant Byers.

33. In evidence Senior Constable Bow testified he was confident that the reference to the performance guidelines in the permit was sufficient to ensure safety guidelines for a load of this size. The additional conditions in clause 4 of the permit are consistent with the conditions that are mandated to be included in 10.9 of the QPS Traffic Manual (applicable at the relevant time).

34. The relevant copy (version 1 January 1999) of the *Performance Guidelines for Excess Dimension* applicable at this time was tendered in the proceedings.

35. The convoy was travelling at night so illumination was required.

36. The reference to the performance guidelines in the permit directly included in the permit the requirements for illumination in 4.2.2 in the *Performance Guideline for Excess Dimension* (Form Number 6 Version 1 January 1999) that was in force on 6 September 2005. Relevantly these provided the following requirements:

> *4.2.1 When operating out of daylight hours, any oversize vehicle/combination must comply with all applicable requirements for warning devices specified in section 4.1.*
>
> *4.2.2 (Front and rear markers) Any oversize vehicle/combination driven out of daylight hours must display amber lights at the front and red lights at the rear of the vehicle or load.*
>
> *The front and rear lights must be:*
> *evenly spaced in a line across the vehicle and load;*
> *at intervals of no more than 70 cm;*
> *starting and finishing within 15 cm of the side;*
> *at least 1 m but not more than 2 m above the ground; and*
> *being of equal wattage to the vehicles clearance lamps.*

4.2.3 (Side markers) Any oversize vehicle/combination driven out of daylight hours must display yellow lights to the front and red to the rear along both sides of the projecting load, or along the side of the vehicle if there is no projecting load.

The side markers must be no more than 2 m apart.

4.2.4 A warning light must be displayed if the vehicle/combination is wider than 2.5 m or longer than 22 m.

4.2.5 If a load or equipment is higher than 4.6 m, it must have a white light illuminating the front of the highest point of the vehicle or load.

The light must be directed or shielded so as not to dazzle any driver.

37. Not included in the permit were the additional conditions for illuminating and delineating excess dimension indivisible loads in 10.7.1 of the Traffic Manual (applicable as of 5 September 2005). Relevantly, this requirement is:

Members authorised to issue permits for the movement of oversize vehicles should ensure that the following conditions regarding illumination and delineation of the load are endorsed on the permit:

When the excess dimension indivisible load exceeds 3.5 m in width:

At least one red and yellow reflectorised fluorescent diamond grade strip with a minimum width of 200 millimetres and length of 1.00 metre shall be affixed vertically as well as horizontally to each edge on the lower sides facing the front and rear of the excess dimension indivisible load; and

In addition, where an excess dimension indivisible load exceeds 15 metres in length a similar reflectorised strip shall be affixed horizontally to the centre lower edge of each side of the excess dimension indivisible load.

When the excess dimension indivisible load exceeds 4.6 m in width, in addition to the requirements contained in paragraph (i):

At least one pulsating amber light shall be affixed to four positions on each of the front and rear of the excess dimension indivisible load in

such a way that each of the pulsating amber lights is at an approximately equal distance from the centre of the load and its extremity; and

At least two rotating flashing amber lights or strobe-type flashing amber lights shall be affixed to the roof of the motor vehicle;

When the excess dimension indivisible load exceeds 3.5 metres in width and the movement of the load is to occur during the hours of darkness, the front of the load shall be floodlit in such a way as to be fully illuminated; and

The requirements in paragraphs (i) to (iv) shall be complied with prior to and during the movement of the excess dimension indivisible load to the determined place. In addition the reflectorised strips and or lighting required to be fitted in accordance with paragraphs (i) to (iv) shall be affixed in a way as to be clearly seen by other approaching road users.

38. When this requirement in the Traffic Manual (as was applicable in 2005) was drawn to Senior Constable Bow's attention he was surprised that it was more rigorous then the Performance Guidelines in some respects.

39. The difficulty for Sergeant Byers in checking the load complied with the permit is that there was no illumination requirements endorsed on the permit and he did not have access to a copy of the performance guidelines referred to in the permit. He also noted that he had not recently checked the Traffic Manual.

40. Unfortunately the actual lighting on the vehicle was not recorded by photographs or note at the time of the collision before some lighting was removed. Therefore the state of the lighting is taken from the evidence of the witnesses and photographs taken after the collision.

41. Mr Myles evidence was that his lighting scheme complied with the requirements of the Northern and Far Northern regions. He had delineator

on the corners, lights down the side (required in the Far Northern Region), two spotlights back on to the load, two beacons on his truck and two flashing lights on the back. Mr Myles lit his vehicle in adherence to police instructions and was not aware of any particular written instruction setting out lighting requirements.[8]

42. Sergeant Byer's evidence was that the only area of non-compliance with the Traffic Manual requirement in the lighting was the omission of the 1 m strip vertically and horizontally in (1)(a). The actual reflector strip was horizontal only and appeared less then the required width. There was also no pulsating amber lights as required in (2)(a) of the Manual apparent on the front of the house. Such lights are apparent in photo 42 on the rear of the house.

43. Sergeant Byer's said that on the night he could see the house illuminated about 1 kilometre away as a reflection in his rear view mirror.

THE TRIP FROM TULLY TO FELUGA

44. The progress of the convoy was relatively trouble free until Tully was reached. The pilot, Mr. Blair, had closed the road at the northern end of the Cardwell ranges to permit the house to cross.

45. At Tully there was a difficult manoeuvre to get the house through the traffic lights. When this was completed the convoy set out on the Feluga section of the Bruce Highway. Before they set out Mr. Myles received messages that there was a bit of fog just north of Tully and as the convoy moved along the Highway, Mr. Myles said fog did commence as a mist at around the Mission Beach turn off which reduced visibility. As the convoy progressed he described the fog coming in as patchy.

46. Just before 5.30am it was still dark with patchy fog. Mr. Myles testified he used the term "patchy fog" to describe when fog comes in heavier then

[8] Transcript day 2 p 92 and 93

becomes a lighter mist and then a heavier fog.[9] Essentially he was driving in and out of heavier areas of fog. This type of fog is characteristic of the early morning weather conditions on the Feluga Straight. Sergeant Byers described the conditions as foggy with fog increasing. His visibility was such that he could see headlights about 100 m ahead. In his response to questions from counsel assisting he conceded that at this time he was contemplating stopping the convoy:[10]

> If you could just help us to understand. You've said that the fog was getting to a point where you were concerned that the load should be removed?-- I was considering or contemplating in my own mind. I didn't discuss it with anybody. I was just thinking, "If it gets any heavier we're going to have to find somewhere to pull up." But it wasn't dense fog, it wasn't fog you couldn't see through. You still had visibility, and when Mr Venturato come along I still had about 100 metres of visibility at least.

47. The *Performance Guidelines for Pilot and Escort Vehicles and Drivers* (Version 1 January 1999), in force at this time apply, to the operation of a vehicle as a pilot vehicle, or escort vehicle, and are incorporated into the permit as a condition. Escort vehicle, for the purpose of the guidelines, mean a vehicle that is being used to (a) transport a police officer, or other person authorised to direct traffic; and (b) to warn other road users of the presence of an oversize vehicle or combination. Guideline 7.2 (No travel in low visibility) provides:

> *The driver of a pilot/escort vehicle accompanying an oversize vehicle/combination must not permit the oversize vehicle/combination to travel if, due to circumstances such as fog, heavy rain, smoke, dust or insect plague:*
>
> - *visibility is less than 250 m in the daytime; or*
> - *the headlights of a vehicle approaching within 250m could not be seen at night*
>
> *If an oversize vehicle/combination being escorted is already travelling when the visibility is reduced to a level described in 7.2.1 the pilot/escort vehicle operator must direct the driver of the oversize*

[9] Transcript day 2 p.97 - 102
[10] Transcript day 1 p. 87

vehicle/combination to drive to the nearest safe parking area and wait until visibility improves beyond that level before permitting the continuation of the journey.

48. Sergeant Byers conceded he was unaware of the performance guidelines with respect to pilot and escort vehicles.[11] The pilot, Mr. Blair, was aware of the requirement to halt the load if visibility was compromised but not of the formal requirement (at the time of this incident).[12]

49. A concerning feature for Sergeant Byers north of Tully was also an increased number of vehicles that began to go past the pilot and continue on the road towards his police car that was straddling the white centre line. The increase in motor vehicles travelling past the pilot vehicle north of Tully was noted by a number of the witnesses in the convoy. Each witness clearly considered the explanation was the fault of these drivers in deliberately failing to stop rather then the drivers did not understand the warnings or were having difficulty discerning and processing information in the foggy conditions. For example, Sergeant Byers[13]

> When you saw the car come through before Mr Venturato did that concern you?-- It did, yes. It was in very close proximity between.
>
> Did it concern you that the reason the driver passed you was that they couldn't see you?-- No. Sometimes people won't stop.

50. Nevertheless the weather conditions were of concern to Sergeant Byers. In response to the weather conditions Sergeant Byers dropped back to be closer to the truck. Mr Myers considered he was, at the time of the collision, 200 – 300 metres away with Mr. Blair about 600 metres away. He was also contemplating, as noted previously, the need to halt the convoy but at this time there was no suitable place that he knew of to halt the load.[14]

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11 Transcript day 2 p. 18
12 Transcript day 2 p. 54
13 Transcript day 2 p. 15
14 Transcript day 1 p. 87

51. The speed of the convoy at this time was relatively slow. Mr. Blair thought the truck was travelling at about 20 km/ hour. Sgt. Byers testified that in clear visibility the convoy was travelling at about 60 – 70 km per hour but as the fog increased this speed decreased to 30 – 40 km/hour.

52. In his initial interview with police investigators Sergeant Byers estimated that at this time he was 50 – 70 m from the truck with the pilot truck a considerable distance ahead.[15] Sergeant Byers could not give an exact estimate as to how far ahead the pilot vehicle was because he could not see him because of the fog. Mr Blair's own estimate varied from between being 700 metres and 1 km in front of the house at the time of the collision.

53. The other members of the convoy, in their initial statements and evidence in the inquest did not consider visibility compromised by the fog:
    - Mr. Blair conceded the conditions were foggy (or a "haze of fog"[16]) when Mr. Venturato's motor vehicle came through but insisted he could see the lights of the convoy in the distance.
    - Mr Hardie said there was fog but it was not thick and the procession could clearly be seen.
    - Constable Davis said the mist was coming in but she could clearly see the vehicle ahead of her and the side of the roadway.
    - Mr Robert Myles described the mist as light.
    - Angie Gear testified that the mist did thicken prior to the accident but that it had not reached a stage where she herself (an experienced pilot) would have called a halt to the convoy. She also noted the fog thickened considerably after the accident.
    - Anthony Myles did not think the patchy fog was dangerous but observed that heavier fog came in after the collision.

54. The observations of the members of the convoy are consistent. However, they are making the observations from their position without knowledge

[15] Transcript Day 2 p. 7
[16] Transcript p. 56

that drivers coming towards them may be themselves in thicker fog then the convoy that might impact on the visibility of the convoy. Before turning to a consideration of the evidence relating to the actual collision I will traverse the evidence of the drivers who were ahead of Mr. Venturato in encountering the convoy.

55. Firstly, Toni Richards was 23 years of old at the time of these events. She was driving from El Arish to her work in Townsville. The time, and her observations, make it very likely that the vehicle behind her as she turned south onto the Bruce Highway was that of Mr. Venturato.

56. Ms Richards was travelling at about 100 km/hour through the El Arish range. On the range she followed fairly closely a Toyota dual cab vehicle. As she drove out of the range she saw the pilot vehicle with an "Oversize load" warning sign. She said she travelled for some kilometres and did not see the wide load. At the bottom of the range the conditions were very foggy but this lightened a little as she drove down the Bruce Highway. She could see flashing lights in the distance but because of the fog could not make out what they were. She then saw a police vehicle with his arm out gesturing for her to move over. At this time she could not see, and did not understand, that the oversize load was a house taking up the entire road. Ahead she could see lights but not a shape. Watching the car in front pull completely off the road onto a grass slope she did the same. Where she pulled off there was a drain and she had to move on quickly to stop. It was only when the load moved by she realized it was a house. The side of the house was so close she could have touched it.

57. Gail Blair turned onto the Bruce Highway at Midegnoo Road[17]. She saw the pilot vehicle lights pass before she turned onto the highway but assumed that the flashing light was from a bin tractor from the cane fields. As she approached the orange flashing light she noticed it was a car, but because of the fog could not tell what type of car it was. In examination by

[17] Approximately 1.6 km south of the collision

counsel assisting she described the thickness of the fog, on a scale of 1 – 10 as 8 ½ - 9.[18] The person in the car was waving his right arm out of the window and they appeared to have something shiny in their hand and they were waving it to summon her off the road.

58. She moved over towards the edge of the road. She was not travelling fast, only in first gear and then saw a truck heading north along the highway flashing headlights. She considered the headlights made the conditions worse for her because as they flashed their lights everything went white and she could not see in front of her. She was off the highway and she said as the truck was flashing the lights she concentrated and saw the outline of a building on her side of the road coming towards her. She drove fully off the highway and down the side embankment. She could not remember seeing any lights or reflectors on the outer side of the house to warn me that the load was over her side of the road. She thought the house passed her fairly quickly.

59. Jason Barkle, with his father as the driver, turned onto the Bruce Highway from the Tully-Mission Beach Road.[19] He described the fog as a heavy fog that limited visibility. As he turned onto the Bruce Highway he saw the police flashing lights. In the fog he estimated that they were visible about 50 – 60 m away. His father, realizing it was a wide load pulled off the side of the road but with the driver's side wheel near the white line of the edge of the road to stop going down the side of the embankment. As they sat in the car they saw the truck coming towards them with a large load. It was only when it was 20 m away from the utility he saw the load was a house. As the truck came towards him he thought it got very close to their vehicle – so close that his father and brother actually ducked down.

60. Mr Allingham encountered the convoy between Old Tully Road and the Tully-Mission Beach Road. He described the conditions as 'a bad fog' and was driving at 60 km/hour or less. He says he *saw the blue flashing lights*

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[18] Transcript day 3 p. 118

[19] Approximately 6 ½ km from the collision

coming towards me which appeared on my side of the road. I tried to work out what was going on, but the vehicle had high beamed me. The high beam on this vehicle appeared to be going up and down.

61. Phillip Cox, a truck driver, encountered the convoy about 5 or 10 minutes from his home at Feluga Road Tully.[20] He says: *I recall there being moderate patchy fog on the highway. I came across a vehicle headed north with two flashing amber lights. These were not rotating lights, more like hazard lights flashing and alternating. This vehicle also had one spotlight between the headlights. It was a white spotlight that was flashing. Because of the spotlight's brightness I did not see any wide load escort sign on the vehicle. I could not distinguish anything about the type of vehicle it was, the colour of it or any signs. Also because of the lights colours and patterns I immediately thought it was an Ambulance coming the other way. It was not quite in the middle of the road. I didn't have to go a long way off the road to avoid it. I was travelling at approximately 80 km/hour. Within half a kilometre of passing the first vehicle I then saw police flashing lights approaching me. As it got closer to me I realised the police car was in the middle of the road. When I first saw the pilot vehicle I thought it was an Ambulance. When I next saw the police car I thought it was accompanying the Ambulance. As I realized the police car was in the middle of the road I checked my speedo and I saw I was doing a bit over 80 kmh. I moved over so the left wheels of my car were over the left continuous white line of the highway. As I passed the police car, for some reason it then occurred to me that this was a wide load escort. I then looked ahead to see how wide the actual load was. I was looking down the side lights of the truck trying to see how wide the load actually was. I couldn't tell because of the fog. I was trying to see the red flag on the side of the load but couldn't see it. I was looking ahead also for the next guide post which was approximately 20 – 30 metres in front of me. I was trying to see how far a distance I had before I got to the guide post and whether I would have to stop to avoid hitting it to allow the wide load to get past me.*

[20] He puts his stop at near the Mission Beach Road turn off – approximately 6 ½ km from the intersection.

I still couldn't see how wide the load was. At this point I had moved right over to the left side of the road so my right tyres were just on the edge of the bitumen shoulder of the road and my left wheels were in the dirt. At this time I would have been driving 60 km/hour. My foot was covering the brake. I was approximately 20 – 25 metres away from the guide post and then I could suddenly see the wall of the house coming towards me. The side of the house was above and nearly as far out as the guide post. I then quickly swerved right off the road into the table drain and stopped.

62. The evidence of the drivers encountering the convoy north of Tully, given in their statements and the testimony at the inquest, is persuasive that this disparate group of drivers were confused as to what was happening on the road. Their evidence is persuasive that their visibility was impaired by the foggy conditions and that the lighting, signage and other actions of the pilot vehicle, the police vehicle and the truck did not convey to them until they were very close to the truck the imperative of leaving the road. The witnesses giving evidence were clearly still troubled by their encounter years after the event. I do not accept that this was the fault of these drivers. They were clearly anxious to convey how concerned they were as to their encounter and how close some of them felt that they had come to colliding with the convoy.

63. There is some conflict between the evidence of the drivers and those in the convoy. To some extent the conflict is one of perception. That is those in the convoy were confident they were easily seen and did not appreciate that visibility had deteriorated to the extent testified too by the other drivers. In resolving any conflict I am assisted by Sergeant Byer's evidence who frankly testified to his growing apprehension as to the visibility and his evidence that at or just before the collision his visibility was reduced to about 100 m in the conditions. I prefer Sergeant Byers account as to the conditions immediately before the collision then the testimony of others in the convoy: he was a police officer well used to estimating distances, he was concerned as to the weather conditions and

his evidence is consistent with the other witnesses who were not in the convoy.

64. At this time it is also helpful in understanding the confusion experienced by the drivers on the morning of 6 September 2005 to refer to the report and evidence of Professor Troutbeck who provided a report to me that discussing the measures and procedures used to escort the house. Professor Troutbeck's qualifications and expertise include being a qualified professional Civil Engineer and a Fellow of the Institution of Engineers, Australia, a holder of the Professorial Chair in Civil Engineering at Queensland University of Technology, Chairman of the Australian and New Zealand Standards Committee for safety barrier design and testing and a foundation member of the committee when the first standard was produced, a member of the Transportation Research Board committee on Roadside Safety Features (the Transportation Research Board is part of the US National Academies' of Science that develops US standards for safety barrier testing and installation for US roads) and co-chair of the sub-committee on International Research on Roadside Safety Features for the Transportation Research Board committee on Roadside Safety Design (the International research sub-committee reviews international standards and exchanges information on the performance of safety barriers around the world).

65. In evidence he noted that while the members of the convoy clearly believed they could be easily seen studies have shown that people believe they can be seen three to four times further from where they can actually be seen.

66. He also wrote in his report that there was also often a misconception that more light makes objects more conspicuous:[21]

"*In fact they can be less conspicuous. Austroads reported that:*

[21] Report of Professor Troutbeck p. 30 of 59

> *The effectiveness of reflective signs may be reduced by glare. This may be a surface reflection from a high intensity streetlight or from the sun, or it may be glare from the excessive brightness of a high-class retro reflective material lit only by the vehicle headlights. Highly retro-reflective backgrounds can make a legend on any sign unreadable, and on large signs the background should always be of a lesser brightness than the legend. High-class retro-reflective materials with a glossy surface can suffer from surface reflections if care is not taken in their sitting and orientation with respect to street lights and vehicle headlights.*

While this quote refers principally to retro-reflective signs, it is applicable here as numerous headlights and rotating lights may present a significant glare problem to some drivers. Professor Wood from the QUT school of Optometry has written:

> *Glare from on-coming headlamps has been shown to exacerbate the effects of simulated mild lens opacities, such that dynamic visual acuity, the ability to resolve details of a moving object, is reduced by a factor of six in the presence of glare from vehicle headlights on low beam compared to high beam.*

The light from the revolving lights may have resulted in glare for older drivers. The effects of glare for older drivers is more significant. A report from Austroads states:

> *Further, older drivers have much less tolerance for glare and are disabled by glare for longer, which further reduces their visual abilities at night and prolonged exposure can result in muscle fatigue and tenseness which has been associated with poor driving performance. With the greater scattering of light in the ageing eye, it would be expected that an older driver would find a given level of glare more disabling and uncomfortable than a younger driver would. Sensitivity to glare occurs when the light entering the eye is bright enough to interfere with the central*

image that is being focussed upon the retina. The resulting reduction in the quality of the retinal image is often accompanied by significant loss of visual contrast, so that details of objects are lost. Many reasons have been advanced for the increasing sensitivity to glare that older adults experience: smaller pupil size, thickening and yellowing of the lens, and a tendency of the humor of the eye to become more opaque.

67. Professor Troutbeck also comments on the significance of the distances between the escort vehicle and the truck to how a driver processes information:[22]

The New Zealand "Load Pilot driver code"' looks at this issue and states

If you're travelling at open road speeds (100 km/hr) 500m ahead of the oversize vehicle, road users have approximately 10 seconds to understand any information you've given them and take appropriate action before the oversize vehicle draws level. Avoid travelling too far ahead of the vehicle as approaching drivers may think there's no hazard and forget your warning. Traffic travelling in the opposite direction should see your vehicle five to ten seconds before meeting the oversize vehicle.

You also need to make sure that approaching road users can see you in enough time to understand your advance warning. They need to see you from a distance of at least three times the speed limit (or three times the speed of that section of road) in metres. So, on the open road at 100 km/h drivers approaching you head on should see you from at least 300 m. If the oversize vehicle is on a section of winding road where approaching traffic has poor visibility, move forward to a section of the road where road users can see you clearly.

Austroads reported that about 12 seconds of travel time is required they stated:

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[22] Report of Professor Troutbeck p. 28 and 29 of 59

"For signs requiring complex decisions, such as services or tourist facility signs, a distance equivalent to about 12 seconds or travel time is normally used."

Assuming that the excess load is travelling at 70 km/h, then the oncoming vehicle is travelling at 100 km/h, then a 10 s period between being shown the sign and being expected to act requires about 470 m between the load and police vehicle and between the pilot and the police vehicle….

68. The evidence of Sergeant Byers in his taped record of interview (7 September 2005) is at the time of the collision he was 50 – 70 m in front of the prime mover. Professor Troutbeck says:

Assuming the oncoming vehicle was travelling at 80 km/h and the escort vehicles at 30 km/h with a separation of 100 m between the vehicles then there would be 3.3 seconds between vehicles in opposing directions passing the two vehicles. With the truck and the police car separated by 100 m the closing speed between the oncoming vehicles and the escort vehicles would need to be less than 36 km/h. It is therefore important that the escort team be aware of the safety implications of being to close together.[23]

69. As he made clear in his evidence a reduction of the distance between the police vehicle and the prime mover would decrease the reaction time for a driver. The reduced visibility due to fog would also mean a reduction of reaction times as lights may not be as visible.

THE COLLISION

70. The collision between Mr. Venturato's vehicle and the prime mover occurred on the Bruce Highway about 900 m south of the Djarawong East Road which cuts across the Bruce Highway.[24] This section of the road is a single two – lane strip of bitumen divided by intermittent white lines at

[23] Report Professor Troutbeck p. 29 of 69

[24] See Sgt Logue's evidence transcript day 1 p. 19

the point of impact. The straight section of the highway is about 8 kilometres long.[25] Mr. Venturato was coming from El Arish and had left home at about 5.20am. He would have travelled through the El Arish range and then exited them onto the flats commencing the Feluga straight.

71. This is the probable location he would have encountered the pilot vehicle driven by Phillip Blair. Mr. Blair testified that he encountered the vehicle as he was approaching the Southern side of the El Arish ranges. In the 4 – 5 minutes prior to Mr. Venturato's vehicle going past he saw another 3 - 4 vehicles. He then saw two to three other motor vehicles going past him and they did not pull up or slow down. However, all the vehicles except Mr. Venturato's 4WD did eventually stop or pull over. He said at the inquest:[26]

> Was the visibility, as far as you can recall - was - was it ever any worse than that?-- About average, like - because it was night-time. It was dark. Just like average, like, in - in the dark, you know.
>
> Mmm?-- And you see the headlights coming towards you.
>
> When Mr Venturato was approaching you could obviously see his headlights. Can you say anything about the position that he maintained on the road?-- It was maintained on the correct side of the road.
>
> And wasn't swerving or anything-----?-- No.
>
> -----like that?-- After he went past me whether he was swerving or not I would not - I wouldn't know. I had my torch out to try and slow him down and let him know to pull over, but he looked pretty straight to me when he come - come onto me.

72. He estimated the speed of this vehicle as about 80km/hour.

73. Sgt Byers described at the inquest what happened next [27]:

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25 It is sometimes referred to in the evidence as the Feluga Straights

26 Transcript Day 2 p. 59

27 Transcript Day 2 p. 21

When he came along, I became concerned because the pilot said to me, "There's one coming at you. He's not going to stop - move over - not - wasn't going to stop", or - I can't remember the exact words. I've got some words written in my notebook. The words written in my notebook are - slightly different from what's in the - in the thing. But I was concerned when he come towards me when he said, "There's one coming at you and not" - "There's one coming at you. He's not going to stop" or "he's not slowing" - or "There's one coming at you fast and not slowing down", or something like that.

Right?-- And I waited for him to come, and then I saw him when he was about 100 metres away and approaching me. I was on the incorrect side of the road at that time and moved over, facing him. I flashed the headlights of the police vehicle a number of times to get him to stop. When he didn't stop, I moved over to the left-hand side of the road slightly and he went straight past me. He didn't slow down. He didn't deviate. I didn't see any - any indication of him even noticing I was there. I called over the 2-way radio at the truck driver, said "He's not going to stop. Move over", or something like that. The truck driver appeared to veer to the left, and then

I heard a loud collision followed by a scraping sound, then I pulled over to the left-hand side of the road basically-----

Okay. Did Mr Venturato veer in his path at all?-- He did not veer. He did not even move.

Okay; so it was - he was in the correct position on the road-----?-- His-----

-----the entire time?-- His left wheels were about the fog line, around about there, of the white line on the left-hand side of the road. He just kept on that path. He didn't change speed, he didn't change direct - didn't change speed, didn't change direction. He just kept going straight on to the load.

74. At this time Sgt. Byers had his strobe lighting and red and blue flashing lights on top of his motor vehicle activated.

75. Mr. Myles, the driver of the prime mover, gives a similar account of the speed of the collision. As the warning of the pilot vehicle came through he could see the headlights of Mr. Venturato's motor vehicle: his vehicle came straight ahead, not slowing or veering, Sgt. Byer's moved over to the right lane but as the car did not deviate he moved back to the correct lane, Mr. Myles started to move over to the left but it was too late and the vehicle crashed into the house. When the car struck Mr. Myles noted that he was on the edge of the bitumen. The car struck the house and

continued going off the road into a cane paddock. Mr. Myles noted that everything went very quickly given the speed that the 4WD was travelling.

76. Constable Melissa Davis who was at the rear of the convoy heard the pilot's warning that a vehicle was coming fast and was not going to stop. She heard a really loud crash and could see the lights under the right hand side of the house. She saw the dark coloured 4WD, Mr Venturato's vehicle emerge with the top almost completely removed. The 4WD shot straight past her. She knew there must be serious injury and did a u turn and located the 4WD in the cane field. Mr. Venturato was deceased.

77. The initial impact point of the 4WD with the prime mover was on the left hand side of the house when facing south. This conclusion is supported by the damage to the house, debris found and the evidence of witnesses. The major damage to the vehicle of Mr. Venturato was that the roof was ripped off and the steering wheel bent backward. Mr. Venturato was decapitated. DNA testing and other evidence satisfies me as to his identity.

THE INVESTIGATION

78. The principal investigating officer was Sergeant Tony Logue. He arrived at the scene of the collision at about 7am. At this time the house had been moved from the position that it had been in at the time of the collision. Hence Sergeant Logue was not able to view the scene, and as the inquest evidence revealed the house, in a state that was unaltered from the time of the collision. When Sergeant Logue saw the scene (at 7am) it was a clear fine day.

79. Given that the collision took place on the Bruce Highway the urgency to clear the highway is understandable. However, the consequence to the coronial investigation is that there were significant gaps in the recording of the appearance of the house (especially illumination) on the trailer that

was unfortunate. The first photographs of the house and semi-trailer were taken about 30 - 45 minutes after Sgt. Logue arrived on the scene.[28]

80. Sergeant Logue observed no brake marks from either Mr. Venturato's vehicle or from the semi- trailer carrying the house on the Bruce Highway. When he saw the house Sergeant Logue, with the help of some other officers took measurements of the wide load. The load was 8.85 m wide and 17 m long. It had a height of 4.2 m.

81. Having read the investigation report I am satisfied it was conducted by Sergeant Logue and his supervising officers with the utmost probity. He concluded that the weather had no impact on the incident relying on the evidence of the members of the convoy. The initial report to the Coroner included no other evidence as to the conditions save those who were members of the convoy. This was because no other driver (not in the convoy) was available. However, the Venturato family assembled a substantial body of material from others who had encountered the convoy. Particularly useful are the statements of those who were north of Tully when they met the convoy. My predecessor at Tully forwarded this material to the QPS investigator. Having received the material the QPS obtained a substantial amount of further material. I do not criticise the original investigation that focuses on the actual event and is reliant upon witnesses coming forward. Nevertheless, a coronial investigation is necessarily better informed when evidence is available from all perspectives. I thank the Venturato family for their assistance in providing the coronial investigation with this material. As I have made plain in my findings I consider that the evidence of other road users very useful. It is of particular assistance in formulating recommendations in this matter.

82. I am not persuaded to the requisite standard of the conclusion that the weather played no role in the fatal collision. The convoy continued in conditions of reduced visibility. Sergeant Byers was concerned with

[28] Transcript p. 12

visibility and contemplating finding a safe place to rest the convoy. The combination of low visibility and decreased distance between the police escort and the truck (and increased distance between the pilot and the police escort) would have meant the reaction time between being aware of, and appreciating the size of the load, would have been very short. The comments of Professor Troutbeck are useful in appreciating that in this case Mr. Venturato may have had less then 3 seconds to execute what he describes as a difficult driving task. As an older driver the response times of Mr. Venturato may have been somewhat slower when compared to a younger driver. The evidence of the other drivers on the road that morning provides strong corroborative evidence of the difficult situation they confronted.

83. Notwithstanding these matters I do not consider I can draw a definitive conclusion as to why Mr. Venturato collided with the vehicle. All I have read and heard in evidence supports he was a most careful and responsible man who, given his vast SES experience would have appreciated the significance of the pilot and police vehicles even if he could not appreciate the size of the load or was affected by glare. Sergeant Byers, and all the witnesses in the convoy, are definite that Mr. Venturato's vehicle did not slow or stop or deviate from its path even when he must have known that a collision was imminent. There were no brake marks and the witnesses remarked that the lack of the sound of braking was something that they particularly remembered.

84. Investigating police examined the records of Mr Venturato's phone and found no evidence of outward calls at the time of the collision. The autopsy (conducted by Doctor Birchley) found no evidence of coronary artery disease or any other physical cause for collapse. Given the injuries sustained by Mr. Venturato no examination of the brain was possible.

85. There is no evidence whatsoever or indeed any suggestion at all that the collision was deliberate. Mechanical inspection of Mr. Venturato's motor vehicle revealed no defect that would have contributed to the collision.

86. Regrettably, I find I cannot be satisfied to the requisite standard as to what caused the collision.

FINDINGS REQUIRED UNDER SECTION 45(2) OF THE CORONERS ACT

87. I am able to make the following findings pursuant to s. 45(2) of the Act:

> Identity of the Deceased: The deceased was John Ernest Venturato
> When the Person Died: 6 September 2005
> Where the Person Died: The Bruce Highway about 900 metres south of the Djarawong East Road which cuts across the Bruce Highway near Feluga.
> What caused the Person to die: These findings set out the circumstances of the death of Mr. Venturato. The cause of his death was severe head injury due to, or as a consequence of a motor vehicle accident.

COMMENTS AND PREVENTATIVE RECOMMENDATIONS

88. Section 46 (relevantly) permits a coroner to comment on anything connected with a death investigated that relates to public health or ways to prevent deaths from happening in similar circumstances in the future.

89. In determining whether or not to make comments I have considered the submissions of the QPS that relevantly argued:

> *Despite the apparently broader language used in s.46 when compared to its predecessor provision, there are still important limitations upon the role of comment in coronial hearings. In particular, an inquest should not be conducted solely in order to facilitate the making of comments or recommendations, and the precautionary note has been sounded that the power to comment "may easily be attended by philosophical self-indulgence"*

…..

> *Not only must there be evidence to establish that comments made under s.46 are "connected with" a death investigated at an Inquest, it must also be kept on mind that the higher courts have stressed that coroners must recognise the damage to reputations and the exacerbation of personal suffering that such comments may bring. These considerations become matters of some significance in terms of determining the sufficiency of evidence heard before an inquest, before it can be said that the point has been reached at which a matter is sufficiently "connected with" a death, in order to enliven the ancillary power under s.46 to comment upon it.*

90. Notwithstanding that no definitive conclusions can be drawn as to the cause of the collision between Mr. Venturato and the wide load the evidence has revealed a number of matters that I consider I should comment and make recommendations upon directed to reducing the risk of another driver being killed in a collision with a wide load. I am satisfied that many other drivers on the morning of 6 September 2005 encountered difficulty in negotiating the traffic conditions created by the combination of the wide load and the weather. Many of these drivers expressed the view that they considered themselves lucky not to have collided with the load. Consequently I consider that the required nexus is shown to enliven the power to make comments to prevent similar deaths in future. Coroners have no power of course to enforce their recommendations. Whether or not they are implemented or even considered will depend on those reading these findings. Queensland Transport has informed the inquest that they are presently conducting a consultation process with relevant stakeholders as part of an extensive review of the operating conditions for oversize vehicles so there is the opportunity for stakeholders to consider matters raised in these findings.

91. In making these recommendations I have particularly assisted by the evidence and report of Professor Troutbeck who had the opportunity to examine the coronial material including transcripts of interviews and

material assembled by Mrs Rowena Venturato. Given the relevance of Professor Troutbeck's report to their statutory responsibilities I have also provided a copy of that report to Queensland Transport and the Department of Main Roads for any comments that they might wish to make.

92. The submissions from the QPS essentially submitted that I should be cautious in adopting fully the recommendations of Professor Troutbeck on the basis that "*he did not present as a useful witness",* he was not aware of what was "*occurring in those departments regarding wide loads"* and he was not an expert in the field of excess dimension loads. I consider none of these criticisms should prevent me from relying on Professor Troutbeck's report as urged to do so by Counsel assisting. I have already canvassed some of his extensive qualifications. I consider that he is clearly qualified as an expert with respect to advising on road safety particular on the issue as to safety barriers to notify road users to road hazards. The effect of his report is to provide his opinion as to what might prevent deaths in the future in similar circumstances as to those faced by Mr Venturato on 6 September 2005. In that context I consider it of great value to this inquest.

93. I turn now to the issues raised in Professor Troutbeck's report:

PERMITS AND PROCEDURES AND RISK MANAGEMENT

94. The process of the issue of the permit for the transport of the vehicle is set out in the review of the evidence. In short, for oversize vehicles over 5.5 metres operating under a police permit the police officer issues the permit and is responsible for setting the conditions. It is standard practice for police to include in the permit that the movement is to conducted in compliance with the conditions of the Guidelines. The relevant Guidelines are issued under the *Transport Operations (Road Use Management – Mass Dimensions and Loading) Regulation 2005* and are aimed at establishing a safe and efficient method to move oversize vehicles over

5.5 metres. The QPS Traffic Manual also includes other conditions that should be included in the permits and the responsibilities of officers have undertaking escort duties.

95. Since 2005, as Senior Constable Bow informed the inquest, there has been a review of all wide load escorts. Issuing officers are now given a matrix to follow that sets out the width, length and height of loads and what particular requirements (i.e. lighting and escorts) are to go with that load. Regional guidelines have also been issued. This matrix was considered by Professor Troutbeck in his report. The matrix requires two police escorts and two escort vehicles (at least) for oversize loads above 6.5 m. The placing of escorts is the responsibility of the police escort. In this case the configuration was consistent with the *Performance Guidelines for Pilot and Escort Vehicles and Drivers*. The *Performance Guidelines for Pilot and Escort Vehicles and Drivers* also include the requirement that there be no travel in low visibility as referred to previously.

96. Professor Troutbeck considers the risk assessment and issues involved in an oversize escort are very different when the oversize load effectively blocks the highway as opposed to where there is an obstruction but vehicles can effectively pass. He says:

> *The risks associated with moving a load that is as wide as or wider than the road are significantly different from those when the road (or carriageway in the case of a divided road) is considerably wider than the load. The procedures when transporting a load should not only depend on the width of the load but also the width of the road.*
>
> *Unless, there is sufficient lateral distance between the load when the truck is travelling in its normal lateral position, then the road must be considered to be blocked in a similar fashion to road works. The procedures and permit conditions from Main Roads and Queensland Police Service should have been more explicit when describing the risk when transporting a 8.9 m wide load on a road that is essentially 7 m*

between the edge lines. This results in more higher risks than on wider roads.[29]

97. In his report Professor Troutbeck has noted some of the comments of other drivers who were surprised as to how far they were required to get off the road. He goes on: [30]

Under these conditions the road has to be considered to be blocked albeit that the blockage is moving. Better methods of protecting motorists when the road is blocked should be employed here.

98. As part of his proposal the Professor makes the suggestions that a Traffic Safety Management Plan be prepared before the escort sets off and be distributed to all members of the escort. He suggests that such a Traffic Safety Management Plan should include:

- Descriptions of the operation principles of the escort that are dependent on the size of the load
- General views of the road including the pavement, shoulders and typical verges
- Identification of locations where the load can be stopped (and these will differ according to the different dimensions)
- Identification of locations where the excess dimension vehicle can be turned around to travel in opposite directions
- Identification of locations where the excess dimension vehicle can stop to allow other motorists to pass
- Showing important intersections along the route. He suggests a strip map would be useful for the purpose
- The plan should be recently developed and accurate.

99. The Professor notes that construction companies are expected to develop Traffic Guidance Schemes were their activities have changed traffic

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29 Report at p. 12

30 Paragraph 28 of p. 13

conditions and routes, the expected delays and the procedures to increase safety to the motoring public.

100. QPS did not support this recommendation submitting that Performance Guidelines used in conjunction with the Main Roads Department Conditions of Operation together with trained and experienced escort operators is the appropriate method of transporting wide loads. Counsel representing the police officers in the escort submitted that it would be reasonable for protocols in place which equips those responsible for the transport of wide loads to have access to a route map which sets out various locations when the load can be pulled off the road.

101. While some members of the convoy had driven the route before there was no such map (as referred to by Professor Troutbeck) of easily accessible, safe stops. Sergeant Byers testified[31]

> We - hadn't got to that stage but I thought if we pull up somewhere worse. And I was thinking, well, perhaps we could pull up on that - top of that thing around there. And I was trying to think, well, when I last went through there, how wide it was. And the only place that I could think about pulling over was - with any safety, would have been around [Indistinct] where there's that turn off to the right that goes towards - there's a little servo there which goes towarc Mission Beach. And I thought to myself, "You may be able to pull over there". But you're dealing with a - a load which, unless there's specific provision on the side of the road for you to pull over, there's nowhere you pull over. It's like going to Townsville, if you see a truck stop, you know you ca pull in there. Of if you know there's a wide area yourself, you can pull in there. But unfortunately going north to Tully, I didn't have much of an idea of where you could pull off that load. And I thought, if it got any worse, I'd do - take that action.

102. A plan of the type referred to by Professor Troutbeck would have provided the information required by Sergeant Byers.

103. I accept some that the practical application of the recommendation may be difficult nevertheless I am satisfied that for oversize loads that would effectively block the road such a plan would increase the safety of both

[31] At p. 87

those escorting the load and other road users. The practical aspects of implementation may well be mitigated by drawing the distinction recommended between wide loads that are effectively road blockages from those that present a risk but provide some road access past the road. Accordingly I recommend that:

A traffic safety management plan be developed and distributed to all escort members before the escort takes place and that plan be required as part of the permit process where the wide load effectively blocks the road to other road users.

I also recommend that the procedures and permit conditions from Main Roads and Queensland Police Service be more explicit when describing the risk of transporting a wide load on a two lane road.

WARNING SIGNS AND INFORMATION TO ONCOMING DRIVERS

104. Professor Troutbeck draws what I consider to be the entirely reasonable conclusion that in the circumstances where a wide load effectively blocks the road oncoming vehicles are at greater risk then those motorists following the convoy. It is therefore vitally important that information be given to these motorists and that information is quickly comprehended for drivers to react appropriately.

Warning Signs

105. Warning signs used by pilot vehicles are determined by Queensland Transport *"Performance Guidelines for Pilot and Escort Vehicles and Drivers*" and require that[32] a sign "OVERSIZE LOAD AHEAD" to be fitted to the roof of escort and pilot vehicles. The same warning sign is used when transporting all excess dimension loads over 2.5 m wide and longer then 25 m. The use of signs, particularly in rural areas, is very common. The sign is in accordance with Australian Standards. I accept Professor Troutbeck's conclusion that:

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[32] And now

Drivers often fail to react, or are slower to react to a sign unless they can see a reason for it. They fail to comprehend the value of the sign unless its need is obvious. More drivers will respond to the environment then to a sign alone. Consequently seeing the "Oversize Load Ahead" warning sign alone would not cause drivers to stop. The Main Roads Road Planning and Design Manual states:

> *"Drivers do not use all of the information made available to them – they frequently do not see a sign. Their awareness of a sign often depends on the relevance assigned to the sign by the driver"*

106. I also consider the text of the New Zealand "Load Pilot Driver Code"[33] provides a useful example of how signs can be utilised to be more effective:

> *Signs are the easiest way to give road users advance warning of the hazard you're escorting. Make sure your sign suitably describes the oversize load – the first message an approaching road user gets is often the most important one, because it makes them aware and prepares them to take action.*
>
> *The following tables are from the Rule, Schedule 4. Choose the sign that best suits the load you are piloting.*

107. The list of signs in the New Zealand Code include:

- DANGER SLOW DOWN
- WIDE LOAD FOLLOWS or WIDE LOAD AHEAD
- HOUSE FOLLOWS or HOUSE AHEAD
- LONG LOAD FOLLOWS or LONG LOAD AHEAD.

[33] Www.landtransport.govt.nz/commercial/docs/load-pilot-code.pdf

108. The New Zealand Code also suggests what signs various escort vehicles should consider displaying to provide a staggered system of warning.

109. In contrast to the explicit warning required by the New Zealand Code pilots of oversize loads in Queensland require that:

> *A warning sign must have a face showing:*
>
> *(a) the word OVERSIZE in black upper-case lettering conforming with Australian Standard AS 1744, Forms of Letters and Numerals for Road Signs in typeface Series C(N);*
>
> *(b) the letters must be at least 200 mm high; and*
>
> *(c) the top and bottom of the lettering must be at least 125mm from the top and bottom of the sign respectively.*

110. The QPS submit that:

> *The QPS agree that the more information and warning you give motorists creates a safer environment. The more compliance and the speed at which this compliance is achieved would create a safer environment. The use of appropriate signage is not a QPS area of responsibility. Any change of signage has to be in compliance with the National Standards*

111. As I understand the Queensland Transport submission the guidelines governing the operation of oversize vehicles are developed for loads under 5.5 m while for loads over 5.5 m with a police escort the police officer issuing the permit is actually responsible for setting the appropriate conditions that may apply to ensure the safe movement of the vehicle.[34] Queensland Transport does acknowledge that it is not the practice for the permits to depart from the performance guidelines issued by Queensland Transport. This is understandable given the individual QPS officers issuing permits may lack the requisite expertise to depart from the guidelines. Nevertheless the present system of guidelines and police

[34] Queensland Transport submission dated 10 November 2008

permits does not comprehensively assign responsibility to who determines signage for wide loads then 5.5 m. The present Queensland Transport review may wish to consider this issue.

112. Inquest witnesses who encountered the wide load on 6 September 2005 commented that they were astonished to find the road blocked by the house and that they were required to get completely off the road onto the grass verge. Oversize loads on the roads are not uncommon on roads and in particular rural roads. However, oversize loads that block the entire Bruce Highway are not expected. One of the simplest, least costly remedies to improve awareness of the danger of oversize loads would be, as Professor Troutbeck recommended, let people know immediately what follows.

I recommend that more informative signs be used when transporting very wide loads (over 5 m) on two lane rural lanes in Queensland.

Gesturing to stop

113. Professor Troutbeck considered that the most appropriate form of delivering information about the size of the wide load was for the pilot to inform the drivers. This did occur where practicable in this case by CB radio or actual conversation with the pilot by passing drivers.[35] Many other drivers were not stopped or did not stop to receive specific warning. The more usual method was for the pilot, Mr. Blair, to put out his Magna torch and shine it gesturing with what is described as the right arc movement to move over. This method is in accordance with the guidelines and indeed the pilot is limited to using hand signals under the guidelines.[36]

114. Professor Troutbeck refers to the New Zealand code that notes:

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[35] Transcript day 2 p. 53

[36] 9.1 of the Performance Guideline for Pilot and Escort Vehicles and Drives (1999 version and 2008 version)

If you want a road user to slow down and pull over, the right arc method probably won't work. Ideally road users should be brought to a stop so you can direct them to a safe parking area.

Don't expect a road user to pull over, particularly if there are no obvious places to do so. It's better to plan where traffic can be stopped safely and then stop and direct traffic at these points. Never leave road users in any doubt what they're meant to be doing.

115. It became apparent in the inquest that members of the convoy had an expectation that drivers should immediately pull over and stop when the pilot vehicle passed.[37] The statutory obligation on all drivers approaching a wide load is to give way. Section 79A of the *Transport Operations (Road Use Management – Road Rules) Regulation 1999* states

> *(1) A driver must give way to an oversize vehicle that is being escorted by a pilot or escort vehicle*
> *Maximum penalty – 20 penalty units*
> *(2) This section applies to a driver despite any other section that would otherwise require the driver of an oversize vehicle to give way to the driver.*

116. So in the absence of a definitive gesture (by signal or sign) to stop the driver is not lawfully obligated to stop. The pilot has the power however, as was exercised to the entrance to the Cardwell ranges and on the Murray Flats in this case, to stop vehicles at a point to wait the progress of the convoy. The rationale for a stationary traffic control stop point at these points was that the section of the road provided no area for the driver to pull safely off the road.

117. Professor Troutbeck recommends that all drivers from opposing directions be stopped and advised of the width of the road and that escort

[37] Transcript day 3 p. 72 per Ms Gear

or police direct drivers, from the opposing direction, to a safe spot to stop, rather then motorists finding a suitable place themselves. He also recommends that a section of road, defined by locations where vehicles can be stopped, be secured to prevent vehicles entering the section while the excess load is moving.

118. The QPS submission cautions against this recommendation suggesting that the recommendation creates a dangerous situation particularly increasing the risk of following vehicles colliding with the rear of stationary vehicles.

119. I consider that this may well be a valid ground of objection. There have been appalling tragedies on northern roads from such collisions. There are also valid reasons also for Professor Troutbeck's recommendations. Given the complex issues relating to these recommendations I consider it more appropriate to refer the issue to the QPS and Queensland Transport for consideration as to whether review of existing notification procedures should be considered.

Spacing of Vehicles

120. Timing of receipt of information on the roads is critical to comprehension. Drivers typically cannot comprehend commands given in quick succession. The driving task around a wide vehicle, that may be unexpected, constitutes a difficult driving task. Older drivers may face particular disadvantage and they need to be accommodated for by allowing more time between decision points and by giving drivers sufficient time to comprehend and react to information and signals.[38]

121. I have already set out the implications of the spacing on the reaction time for drivers in this case (as discussed by Professor Troutbeck). The QPS submission is that "*it disagrees with the professor's assumption with regard to space and speed. Mr Venturato was given sufficient warning to*

[38] See p. 28 of Professor Troutbeck's report.

reduce his speed". It is unclear on what basis the QPS disagrees with the Professor's calculations which are scientifically based and factual. Given his qualifications I accept them. They establish to my satisfaction that reduction of the spacing between the house and the police escort reduced the warning time available to drivers to less then that recommended by the guidelines. I have already set out the reasons why I do not consider that I can make the finding that this reduction contributed to the death of Mr. Venturato. However, I certainly do not consider the state of the evidence is such that I could rule out that the reduction, made in conditions of reduced visibility, did not contribute to the collision. Given the absolutely critical importance of providing sufficient warning to drivers of danger ahead I adopt Professor Troutbeck's recommendation on this issue:

> **It is recommended that more attention be given to the appropriate spacing between the first pilot vehicle, police vehicles and the wide load while the escort is underway. This aspect should be included in any training given to police officers.**

GLARE AND ITS EFFECT

122. Professor Troutbeck has recommended that the lighting practices be reviewed to demonstrate if issues of glare are likely to be a problem for drivers, particularly older drivers.[39] The basis of this recommendation is, as he reports,[40] the misconception that the more light makes objects more conspicuous. In fact they can be less conspicuous. As already noted glare may be a particular issue for older drivers.

123. The QPS submission is that there *was no evidence place before me on the issue of glare in particular prolonged exposure to glare. Lighting and Reflectivity Standards is not a QPS area of responsibility.*

124. I find it difficult to accept this submission as there was, as already cited, substantial evidence from other drivers that in the foggy conditions they

[39] Professor Troutbecks report dated 12/11/08 paragraph 68 page 31
[40] Professor Troutbeck's report p. 64 page 30

had difficulty identifying what objects were ahead. Indeed one driver[41] could not identify the oversize sign of the pilot because of the spotlights brightness.

125. I consider that glare from lighting is a significant issue when the sole early warning for drivers is the sign on the pilot vehicle. Without sighting the sign the pilot vehicle's purpose may be confusing (as indeed the evidence discloses as the witness thought the pilot was for an ambulance). With due respect to the QPS submission the evidence from Mr. Myles establishes that he has had to on many occasions changed illumination on his vehicle at the request of different police districts.[42] For example, on this occasion his evidence is that he essentially combined the lighting requirements of Cairns and Townsville to ensure he complied with all requirements. Indeed it is reasonable to suspect that the lighting on the oversize load my not have been in strict compliance with that required by the Performance Guidelines and the Traffic Manual as there were so many permutations of lighting required to be complied with by the company of Mr. Myles.

126. The essence of the recommendation by Professor Troutbeck is to draw to the attention of those who designate lighting that increased illumination may not necessarily increase the visibility of the vehicle when the issue of glare is factored into the equation. The great assistance of expert evidence is that often it helps to dispel what might thought to be common sense knowledge. In this case the evidence of those in the convoy was essentially that they considered that they had to be visible as they had a large amount of lighting including illuminators, delineators, spotlights and sirens. In the absence of expert knowledge their assumption was reasonable but, in the light of that expert knowledge, there was a risk they were wrong. I have no information before me by the QPS how decisions are made to designate illumination schemes but I consider it must be in the best interests of road users, including members of the QPS who are at

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41 See statement of Phillip Cox

42 Transcript day 2 p. 91

the front line in escorting these oversize loads, that such decisions should be made after consultation with experts as to what are the actual effects of a chosen illumination scheme. Accordingly I adopt the recommendation of Professor Troutbeck.

I recommend that the lighting practices be reviewed to demonstrate if issues of glare are likely to be a problem for drivers, particularly older drivers.

TRAINING

127. The escorting of wide loads is not a straight forward exercise. It raises issues of great complexity involving risk assessments to be made quickly in difficult circumstances. To perform this role properly requires a comprehensive knowledge both of the needs and limitations of the transporting vehicles and the difficulties facing road users encountering such a convoy. The consequences of choices need also to be understood. The police officers involved in this convoy had no training in such escorts as none was available. Hence there were decisions made that may not have been made if training in issues raised in Professor Troutbeck's report were available. For example, rather then placing two police vehicles in front of the convoy as visibility was reduced the distance between the one police vehicle and the house was reduced thus reducing the period of time available to drivers for the last warning system. I do not ascribe blame to the officers in this case for those choices. I am satisfied they did the best they could with the resources available to them at that time.

128. The provision of training for police officers escorting wide loads has been addressed subsequent to the death of Mr. Venturato (although I understand the review of policy and procedures associated with the conduct of excess dimension/mass vehicle escorts was not related to this case). As from 27 February 2009 police officers will only be permitted to perform unsupervised excess dimension/load vehicle escorts after having successfully completed a two tiered training program consisting of

theoretical training and practical assessment. A Level 2 trained escort officer is to initially perform only supervised escorts until declared Level 1 competent. The development of such training is to be welcomed.

129. Escort and pilot drivers are also required to undergo training before being licensed with the training provided by an external training service provider. Queensland Transport advises the course includes undergoing familiarization with the relevant guidelines and consequently escort operators should have a good understanding of all conditions contained in these guidelines.

130. Once licensed the escort or pilot driver is required to keep a current license but it appears there is no ongoing training component. Given the importance of practical experience in this type of work this may not present as a particular problem. Nevertheless the evidence revealed gaps in knowledge of those involved in the convoy: the requirement for specific illumination in the guidelines, the requirements to halt where visibility was less then 250 m. Easy access to current performance guidelines was cited as an issue by witnesses. Mrs. Gear[43] was concerned that Performance Guidelines (and critical roadmaps) were no longer available over the counter at Queensland Transport but the information was available on the Internet.[44] Electronic delivery of information is undoubtedly cheap and efficient. However, Government departments must be cognizant that fast broadband in rural areas is still expensive and difficult to access particularly for those people who lack familiarity with computers. Mrs. Gear, in her evidence, often communicated changes and furnished other drivers with guidelines she had downloaded because of their lack of access to the Internet.[45] Mr. Blair made similar complaints as to the difficulty of finding out about updates.[46] As submissions were not received as to this issue I draw the matter of delivery of information in an efficient

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43 Transcript day 3 p 68

44 Queensland Transport also advises the guidelines are available at the Government Bookshop.

45 Transcript day 3 p 68

46 Transcript day 2 p 40

and effective manner to the attention of Queensland Transport and the Department of Main Roads for consideration in the review.

OTHER ISSUES

131. Professor Troutbeck raised two further issues. They are the issue of fatigue and the issue of 'specials'. Fatigue was raised because of the short rest period for the police escorts between working a full shift (to 11pm on 5 September 2005) and returning to commence the escort at 2am 6 September 2005. The issue of fatigue has a well recognised effect on road safety. Professor Troutbeck cites an Austroads report on rural road safety stating:

> *So, not surprisingly, lack of sleep leads to impaired performance, attention and reaction time, leading to errors with the potential for road crashes, especially for shift workers and teenagers. Arnedt et al in particular compared the effects of alcohol ingestion with those of prolonged wakefulness on a simulated driving task among 19 – 35 year old health males… the findings suggested impairments in simulated driving are evident even at relatively modest blood alcohol levels, and that wakefulness prolonged by as little as 3 hours can produce decrements in the ability to maintain speed and road position as those found at the legal limits of alcohol consumption.*

132. The police officers in this case denied been fatigued and indeed had short sleeps before commencing the escort. The evidence does not support any conclusion that fatigue impaired their decision making. Nevertheless the QPS may wish to consider, if it has not done so, enforcing set rest periods, including when 'special' duties are undertaken, to ensure officers are not placed in a position where decisions may be influenced by fatigue.

133. Finally Professor Troutbeck recommends that the Queensland Police Service and Queensland Transport review the procedures of transporting wide indivisible loads on two lane rural roads. He also recommends that

the QPS risk matrix make a distinction between wide loads carried on two lane roads and those carried on roads with more then two loads. I would support this recommendation. However, information as been provided that such a review is already underway. These recommendations may be more appropriately considered in that review. I trust these findings provide some assistance to that review.

CONCLUSIONS

134. I regret I cannot provide certain answers to Mrs Venturato and her family as to why Mr. Venturato died.

135. The evidence as it stands does not allow me to draw conclusions to the requisite standard as to what caused Mr. Venturato to collide with the wide load. What is clear is that the transport of the wide load north of Tully on 6 September 2005 could have been done better but that is not necessarily the reason for the collision. The close analysis of any complex procedure, whether the process failed or not, will likely find it wanting. That does not mean that individuals did not do their best in the circumstances in which they found themselves. What it does mean is that the risks identified should be addressed to prevent repetition.

136. I trust the family and friends of Mr. Venturato can take some consolation that the inquest has permitted the making of recommendations that might assist those who are entrusted with regulating such wide load transports with more information to protect road users encountering the same situation that confronted Mr. Venturato. I extend to Mrs Venturato and her family my condolences for their loss.

137. I want to thank Ms Sharp, Counsel assisting me at this inquest, for all her work in this matter.

138. I now close the inquest.

J M Brassington

Coroner
Innisfail
22 December 2008