Inquest into the death of Paul Phillip Mathew Carpenter

FINDINGS

Paul Phillip Mathew Carpenter was born on 16 March 1998; he died at Wagga Wagga Base Hospital on 16 September 2009. He was just 11½ years old. He was affectionately known as "Pauly Boy" to his family which included his dad Paul senior, Mum Sandra Roos, his older brother Dillon (then 14 years old), his sister Louisa (then 12 years old) and his younger brother Owen (then 9 years old) and his extended family who lived in Junee namely his Grandmother Virginia, Uncle Mathew, Aunt Colleen, Uncle Gary and cousins Samantha, Jace, Bradley, Jenisha and TeeJay. He was obviously much loved and is and always will be much missed.

A coroner's function is to attempt to answer five questions namely, who died? When did he or she die? Where did he or she die? What was the cause of death? And finally, what was the manner of death? The cause of death is the immediate physical cause. The manner of death refers to a way a person dies, including the surrounding circumstances. A coroner may also make recommendations concerning public health or safety issues arising out of the death in question.

Paul died on the afternoon of 16 September 2009. He had returned to 71 Lisgar Street, Junee, the home of his Aunty Colleen, with his younger brother Owen on the school bus driven by Mr. Vince Hollis. After he alighted the school bus, Paul together with KL, attempted to ride the side of the school bus (a practice we have come to know as "bus surfing") by hanging on to the emergency exit step found midway

between the door and the rear of the vehicle. Paul slipped once the bus was in motion and fell under the rear passenger tyres of the vehicle. Despite attempts by an off duty paramedic and family members he died at Wagga Wagga Base Hospital about one and a half hours later.

In relation to Paul's tragic death there is no issue in relation to the identity, date, place or direct cause of his death. The sole issue to be determined by this inquest was in relation to the manner of Paul's death arising out of the surrounding circumstances.

Mr. Hammond, Counsel Assisting identified during his opening address a number of issues to be dealt with during the course of this inquest. In relation to these findings I have distilled those issues to the following:

1. What was the incidence of "bus surfing" prior to Paul's death on 16 September 2009?
2. Was Mr. Hollis the driver of the bus aware of the practice of "bus surfing" prior to 16 September 2009;
3. Did Mr. Hollis' manner of driving the school bus on 16 September 2009 contribute to Paul's death?
4. If Mr. Hollis was aware that a child or children were "bus surfing" what steps did he take to stop it from happening?
5. If Mr Hollis was aware that a child or children had been "bus surfing" did he take adequate care when departing 71 Lisgar Street, Junee to ensure that no children were hanging or gripping the emergency footrest on the bus?
6. Did Mr. and Mrs Dwyer, the owners of the bus company, have any safety management systems in place to deal with issues such as "bus surfing"?

7. Did the design of the footrest play a part in Paul's death?

I will deal with each of the issues in turn.

1. What was the incidence of "bus surfing" prior to 16 September 2009?

Over the first one and a half days of the inquest I heard evidence from a number of child witness. These included those who had witnessed Paul's fatal attempt at "bus surfing" on 16 September 2009 and those who prior to the accident had participated in or witnessed others who had participated in the practice of "bus surfing".

I made a non-publication order in relation to all the names of the child witnesses whom I note gave their evidence by way of AVL. That non-publication order continues with the handing down of these findings.

It seems clear from the evidence of all the children that "bus surfing" was the practice of grabbing hold of the emergency step located on the sides of the bus, lifting their feet off the ground so that the balls of their feet were up against the side of the bus and holding on as the bus took off and accelerated down the road. Whilst carrying out the activity, the children were suspended in what can only be described as a foetal type position, hanging from the emergency footrest.

In relation to the practice of "bus surfing" prior to Paul's fatal accident I note that there were a number of major inconsistencies in relation to the evidence given by the children particularly in regard to whom and how many times they

or their fellow bus passengers undertook the activity of “bus surfing”. I will comment on the evidence of each of the children in turn:

a) AB – he was as at 16 September 2009 only 7 years old. He admitted that he had “bus surfed” on one occasion. He got off the afternoon school bus after the Carpenter brothers and EF. Prior to his “bus surfing” experience he had witnessed Paul Carpenter and KL and EF “bus surfing”. It was his evidence that he didn’t bus surf again as his older brother had reported his actions to his parents and he had been reprimanded;

b) CD – the older brother of AB. At the time of the accident he was 9 years old. It was CD’s evidence that he had never bus surfed but had witnessed his younger brother take part in the activity on one occasion and promptly informed his parents. It was also his evidence that he had seen KL bus surf on at least 8 separate occasions, twice KL undertook this activity at the same time as Paul. Later in the proceedings I heard evidence from a number of other witnesses who had indicated that CD had “bus surfed”. He however denied this. I found CD to be the most truthful and erudite of all the child witnesses and preferred his evidence in this regard.

c) EF – at the time of Paul’s death EF was 11 years old. He conceded that he had “bus surfed” twice prior to Paul’s death. There was clear evidence during the proceedings from other witnesses, including GH, that Mr. Hollis had caught him attempting or actually “bus surfing” and EF was subsequently reprimanded. However, EF refused to admit that he had been caught or reprimanded by Mr. Hollis. He also denied that he had ever seen KL or Paul Carpenter “bus surfing”. As

a result of the clear inconsistencies in EF's evidence I formed the view that he was not a witness of truth;

d) GH – who was on the bus on 16 September 2009 and witnessed others "bus surf" on a number of other occasions. At the time of the accident she was 12 years old. GH's evidence can be summarised as follows:

i. That she had made an active effort to block out her memories of Paul's accident;

ii. She had witnessed AB "bus surf" on one occasion;

iii. She never witnessed CD "bus surfing";

iv. She had seen EF "bus surfing" and had told Mr. Hollis about it which resulted in Mr. Hollis "getting up him" saying words to the effect of "don't do it. It's not safe"

GH did not have a great recollection of the events leading up to the accident. But I accept it would have been a traumatic event for a girl her age to witness and that she had made a concerted effort not to recall the events over the past couple of years. At no time during the course of her evidence did she seek to grandstand or embellish her evidence. Accordingly, as she had provided the police with an electronically recorded statement the day after the accident her inconsistencies between that statement and what she said in court can be readily explained. Accordingly, I found her to be a witness of truth.

e) KL – who rode on the bus daily with Paul to school. At the time of the accident KL was 9 years old. He is now 11 years old. KL first gave evidence to police two days after the accident by way of an

electronically recorded interview. A second recorded interview was conducted 6 weeks later as KL wanted to correct a number of matters. KL's evidence ultimately was inter-alia that:

i. That he was "bus surfing" with Paul at the time of the accident (that is, both holding onto and being suspended from the footrest at the same time) despite indicating previously that he tried to stop Paul from "bus surfing" on the day of the accident and had reached out to stop him;

ii. On that fatal day when he "bus surfed" with Paul he was positioned on the footrest closest to the front of the bus. Paul was closer to the rear of the bus. He jumped off before Paul. After he jumped off he looked away. Next time he looked up he observed Paul on the ground "having been squashed by the bus" and the bus further up the street. He had not observed Paul actually being run over;

iii. That Paul had "bus surfed" the school bus only four or five times prior to the accident, however, in his first statement to police he had indicated that Paul had "bus surfed" ten times;

iv. That he himself had "bus surfed" only twice. The first occasion was about a month before the accident and the second and final time being the day of Paul's fatal accident. This was in my view in stark contrast to his earlier statement where he had indicated that he had "bus surfed" on the last day of school the previous year.

v. That EF had “bus surfed” on a number of occasions up to ten times. He had not seen EF bus surf as he would disembark prior to EF but had heard him talking about it;

vi. He denied that he had “bus surfed “ 8 times;

KL has obviously been deeply affected and will continue to be affected by witnessing Paul’s death. He was very young at the time. Many of the changes to his evidence over time can simply be explained as a young boy facing up to the reality of an activity that he participated in that was highly dangerous and that ultimately led to the death of someone that he cared deeply about and looked up to. He may also have been concerned about reactions of loved ones including his parents to his behaviour and possible involvement.

KL admitted in evidence that he would often compete and try and beat Paul at many activities. He told me that he often thought he was capable of doing things better than Paul. Paul had clearly “bus surfed” on a number of occasions and enjoyed boasting about it to his friends and younger brother. Despite his evidence to the contrary I am of the view on balance, that KL had “bus surfed” on more than the two occasions indicated.

Accordingly, I am satisfied on the balance of probabilities that Paul’s death was not an isolated incident of “bus surfing”. It was an activity undertaken by some of the children who rode the Eurongilly bus service home from school, on a number of occasions. It was occurring with some regularity in the weeks up to Paul’s death. There was clearly discussion about it amongst the

youngsters and it was something that they set out to at least attempt and possibly out do each other in (hanging on for a further distance down the road) despite it being clearly dangerous.

2. Was Mr. Hollis the driver of the bus aware of the practice of "bus surfing" prior to 16 September 2009;

Mr. Hollis gave his evidence on the third day of the inquest. During the course of his cross-examination by Mr. Hammond he was referred to a number of documents:

1. the transcript of statements made by him and recorded by the police in car video when the Police arrived at the scene of the accident on 16 September 2009[1];
2. the transcript of a recorded interview with police conducted shortly after the accident on 16 September 2009;[2]
3. further statement made by him to police dated 11 May 2011[3]; and
4. handwritten letter by him to the NSW Department of Transport and Infrastructure dated 17 May 2010[4].

What became abundantly clear during the course of his evidence was that Mr. Hollis was trying to distance himself from statements made during the course of his recorded interview and police in car video. For the purpose of

1 Exhibit 2 (volume 1) tab 31;
2 Exhibit 2 (volume 1) tab 6;
3 Exhibit 2 (volume 1) tab 7;
4 Exhibit 2 (volume2) tab W;

these findings I reproduce the most significant of the statements he made on 16 September 2009:

- *"A ..over the last few weeks and since I've been driving the bus I have noticed children doing this, hanging on the side of a, a little tie-down and getting dragged along, and I've spoken to them on several occasions not to do it and, and to, explaining to them how dangerous this practice is."*[5]

- *"A Cause that's where that, that thing is, about halfway up the bus, that ah. little tie. It's a tie-down thing…..but the kids were grabbing hold of it and getting dragged along. They thought it was great fun.*

  Qu:84 Ah hmmm

  A As it, before it got not much speed up. That's what they were doing."[6]

- *"Q125 now, you said you, that the kids, that school kids I am assuming…*

  A Mmm

  Q126 ..were hanging onto the rail. So it…

  A Not, not many of them. Um, there's only a couple of them I, I think that started it. I think one, even one of the Carpenters might have done it a couple of times too.

  Q126 Ah hmmm

  A But ah, here was a couple, and I've certainly talked to them about it and told them how dangerous it was and not to do it but…

  Q127 Mmm. So had Paul done it before?

  A not that I know of.

  Q128 OK

  A No. I think KL might have done it actually once"[7]

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5 Answer 24 page 3 ERISP dated 16 September 2009;

6 Answers 83 & 84 ERISP dated 16 September 2009;

7 Question 125 to Answer 130 ERISP dated 16 September 2009

Mr. Hollis' explanation for the departure from his initial statements to police was twofold. Firstly, that he was shocked and distressed after the accident and that he did not watch the DVD of the recorded interview nor did he read the transcript until sometime after the event and did not realise what he had said at the time and what it had implied.

Secondly, immediately after the accident he had walked around the bus and had observed various smudges including fingerprints. From these observations he was able to draw several conclusions based on various assumptions and it was to these assumptions he was referring when he was being interviewed or discussing the accident with police after the accident.

Accordingly, Mr Hollis asserted initially during his oral evidence that he did not see, observe or have any direct knowledge of any incidence of "bus surfing" or children riding the side of the bus with their legs off the ground or being dragged along the ground at the time of the accident.

However, in my view, Mr Hollis' evidence evolved during the course of his cross-examination by Mr. Roberts SC., counsel for the family. Firstly, he conceded that he had caught EF next to the bus "touching" the footrest on one occasion. On this occasion he asserts that the bus had not moved but was in gear and he was about to put the bus into motion. At that time he had opened the doors of the bus and beckoned to EF to come inside and warned him that standing or holding on to the footrest was dangerous and not to do it. Thereafter, he conceded that he had observed EF on another later occasion hanging onto (or gripping) the footrest with both his hands whilst the bus had travelled a short distance (a few metres). As far as he was aware EF's feet were not up on the side of the bus but being dragged along the footpath. After this event, he spoke to all the children in the group and

warned them about the dangers of such an activity and they should move away from the bus.

Mr. Williams SC. counsel for Mr. Hollis (and Mr. and Mrs Dwyer) submitted inter-alia that:

1. Mr. Hollis was in effect a victim of hindsight in that he had attempted to reconstruct events based on what he knew about the children and what he saw and assumed after the accident;
2. the only knowledge that he could be found to have was that EF on two occasions had stood by the bus and touched or held on to the rail. This he said could have been simply as nothing more than "playing superman" and attempting to hold the bus back from the road; He was clearly unaware that the kids were hanging onto the rail whilst placing their feet up against the bus;
3. that the children who participated in this practice of "bus surfing" were seeking to do it covertly, and effectively did so except for the occasions when EF got caught;

Accordingly, he submitted that it was plausible that Mr. Hollis was unaware that the children were participating in this activity with the regularity with which it was happening leading up to the accident.

I simply do not agree.

In the interviews with police immediately after the accident Mr. Hollis made numerous references to:

1. the children grabbing the rail (or tie down as he then referred to it) and dragging their feet as the bus was in motion[8];
2. that the children found the activity lots of fun and funny[9];

[8] Exhibit 2 (volume 1) tab 6 question 24 and answer

3. that kids will be kids[10];

4. that they were doing it to impress their friends and showing off to GH[11];

5. that he thought that KL has also previously grabbed on to the rail and he reprimanded him for it.[12].

Furthermore in his letter to the Department of Transport and Infrastructure he stated:

"I did see 2 of the boys hanging on the little metal foot rest as the bus started off and banging on the side of he bus on several occasions. I spoke to them of the dangers and I told them to always move away from the bus when I dropped them off. I didn't tell their parents or Mr. Dwyer"

Accordingly, I am satisfied that Mr. Hollis was aware as at 16 September 2009 that at least EF and maybe the other boys were engaging in the risky behaviour of hanging or clutching the footrest after alighting the bus and once the bus was put in motion. I accept that he may not have been aware that they were putting their feet up on the side of the bus during the course of this activity. However, I fail to see a distinction in the level of risk with respect to the behaviour. That is, whether the children were gripping the bar and being dragged along by the bus with their feet on the ground or placing their feet on the side of the bus. In my view the behaviour/ conduct was very high risk and to quote Mr. Dwyer potentially "disastrous", which it ultimately proved to be.

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9 Ibid question 132 and question 313;

10 Ibid at question 25

11 Ibid at question 56

12 Ibid question 127 – 128 and 307

3. Did Mr. Hollis' manner of driving the school bus on 16 September 2009 contribute to Paul's death?

Mr. Carpenter, Paul's father had indicated prior to the commencement of this inquest, in particular by way of letter dated 17 November 2009[13], that tyre tracks he had observed at the scene coupled with what he had understood to have occurred from speaking with Owen and Samantha that Mr. Hollis may have swerved the bus in an attempt to dislodge the boys from hanging off the footrest having seen them in the left hand side mirror.

I note however Mr. Roberts SC on behalf of the family indicated that no such submissions would be made at the close of the evidence.

For the sake of completeness however I summarise why such a scenario was on balance not possible:

1. That no tyre tracks, marks or indentations were recorded by Senior Constable Paul Cox the crime scene officer who attended after the accident;
2. that IJ who witnessed the accident gave evidence the bus drove straight onto the road;
3. Neither KL nor GH indicated in their evidence that the bus swerved when proceeding onto the road on the day of the accident. Furthermore, I note that after KL jumped off the footrest on that fateful afternoon and the next time he looked up Paul was already lying on the ground and the bus was up the road.

[13] Exhibit 2(volume 1) tab 17

4. As Mr. Hollis was aware that a child or children had been "bus surfing" what steps did he take to stop it from happening?

Mr. Hollis' evidence was that the only steps he did take in relation to the kids "bus surfing" was to reprimand them and warn them that it was dangerous and move away from the bus. If I take Mr. Hollis' evidence at its highest he dealt with his knowledge by first reprimanding EF after he caught him engaging in the activity (whether he was aware that his feet were up on the side of the bus or on the ground) and he raised the matter with all the boys at a later date.

It is clear that Mr. Hollis did **not** inform:

1. Mr. Dwyer that the kids were undertaking such risky behaviour;
2. the parents of the children on the bus (whom he knew or suspected) that they were engaging in such risky behaviour;
3. the Principal of Eurongilly School, Ms. Jenny Hart that the students were engaging in such risky behaviour.

5. As Mr. Hollis was aware that a child or children had been "bus surfing", did he take adequate care when departing 71 Lisgar Street, to ensure no children were hanging or gripping the footrest on the bus?

Mr. Roberts SC., counsel for the family submitted that as Mr. Hollis was aware that the children were engaging in a practice of hanging on or gripping the footrest as the bus was departing. Accordingly, Mr. Hollis should have ensured that he did not drive away without ensuring either that;

1. the children were not holding onto the footrest by checking his left mirror; or
2. ensuring that he knew precisely where the kids were.

This was an activity, as described by Mr. Williams SC, the children performed by way of stealth. They sought not to get caught. It is clear from the evidence of IJ that both brothers alighted from the school bus, walked away from the bus and chucked their bags to the ground and then ran back and grabbed the handrail. The bus was in motion when they jumped onto the side of the bus hanging or gripping the footrest.

All drivers are supposed to keep a proper lookout. Mr. Hollis was pulling away from the kerb and did have to keep a proper look out. However, I do not accept on balance that it was possible for him to be keeping an eye out for traffic coming around the corner into Lisgar Street from Dagmar Lane by checking his right side mirrors at the same time as keeping an eye on the left hand side of the bus to ensure that the children were keeping a safe distance.

Moreover, Mr. Hollis' evidence on the night of the accident was that when the Carpenter boys alighted from the bus they moved a distance of approximately 3 metres dropping their bags. His evidence in this regard did not alter throughout the various versions of his evidence. I also note it was corroborated by IJ who observed the bus pull up and the boys get off the bus on the day of the accident.

6. Did Mr and Mrs Dwyer, the owners of the bus company have any safety management systems in place to deal with issues such as "bus surfing"?

As at 16 September 2009, the bus service run by Mr. and Mrs. Dwyer was regulated by the Department of Transport (NSW), which had established the Bus Operator Accreditation Scheme (BOAS).

BOAS was implemented in 2005 and by 2007 standards and conditions had been formalised including standards for safety management systems, which in summary required accredited operators to:

1. have an integrated set of work practices and procedures for monitoring and improving the safety of their bus operation by identifying risks and developing procedures to manage those risks;
2. take responsibility for the safety of their operation and to ensure that all staff were aware of their safety obligations;

Mr. Dwyer's evidence was that at the date of Paul's death the safety management system he had in place comprised of:

1. A safety policy written in an exercise book and kept by Mr. Dwyer which has subsequently been lost;

2. Exercise books contained in each of his buses for the drivers to write in and record any relevant details including incidents involving either the bus or children;
3. Daily contact with the drivers at his Newsagency, where he would orally be advised of any issue with respect to the buses or the children.

It is abundantly clear that Mr. Dwyer was never told of any of the incidents Mr. Hollis observed with respect to the boys hanging onto or gripping the footrest as the bus was about to or did depart.

Mr. Dwyer had indicated that the behaviour observed by Mr. Hollis was potentially disastrous and if he had know about it he would have spoken to the school principal Ms. Jenny Hart and also the parents of the children concerned.

Mr. Ison who was employed by Mr. Dwyer shortly after Paul's death was familiar with the bureaucracy and standards imposed by the Department of Infrastructure and Transport (NSW) and BOAS. He described Mr. Dwyer's safety management system as "basic but adequate".

The safety management systems that are required to be in place by the Department of Transport in essence require that bus operators and drivers be fully apprised of the risks associated with running a rural or regional bus service. I accept that those risks are unique and quite distinct from a bus service run in a metropolitan area. Whatever basic training or orientation was provided to Mr. Hollis when he commenced his employment with Mr. Dwyer, in my view concentrated on the physical risks of actually driving the bus. It was the evidence of Mr. Hollis, Mr. Anderson and Mr. Dwyer that when their respective employment was commenced their inductions (if it can called that) was being driven around the route, being introduced to the

passengers and parents and being advised of any road risks. No assessment was made of any of the behavioural risks that may have been posed by the children from time to time. If one examines "the Safety Management System – A guide for bus and coach operators"[14], school children misbehaviour is identified as one of the likely industry hazards. This was never addressed in Mr. Dwyer's bus operation.

I doubt further paperwork would have prevented Paul's death. However, communication about the highly risky behaviours being undertaken by the children may possibly have.

7. Did the design of the footrest play a part in the death of Paul?

It is clear after hearing all the evidence over the past four days that if the children had been unable to grip the footrest they would have been able to suspend themselves on the side of the bus or be dragged along the side of the moving bus with their feet on the ground.

Paul's tragic death has led the Australian Motor Vehicle Certification Board and the Department of Infrastructure and Transport (NSW) to review the design of the emergency footrest. That review is on going pursuant to the statement from Stephen Hoy dated 22 June 2011[15].

The emergency footrests in their current form in my view present a clear hazard; The fact that they can be gripped with relative ease by young hands makes them dangerously enticing to children. A review of their design is required urgently in order to eliminate their enticing appeal.

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14 Exhibit 2 (volume 2) Tab A

15 exhibit

CONCLUSION

Paul Phillip Carpenter died in tragic circumstances. He was an eleven-year-old boy full of life, fun and adventure. His use like his brother and friends of the emergency footrest to “bus surf” was nothing but an example of a young boy seeking to break the rules, take risks and push boundaries. It had on this occasion a catastrophic result. This inquest has delved into the surrounding circumstances of his death. There is no doubt some things should have been done differently but at the end of the day even if the school, parents and Mr. Dwyer had been notified that this behaviour was being undertaken by the kids Paul may still have “bus surfed” on the 16 September 2009 and the outcome no different. However, any opportunity that Paul’s parents had to possibly avoid his death was effectively taken out of their hands.

Accordingly I now turn to the findings I am required to make pursuant to section 81 of the Coroners Act 2008.

I find that Paul Phillip Mathew Carpenter died at Wagga Wagga Base Hospital on 16 September 2009 directly from a Comminuted Fractured Skull with Cerebral oedema as a result from being run over by the rear passenger side wheels of the school bus.

Pursuant to section 82 of the Coroners Act 2008 I make the following recommendations arising out of the death and subsequent inquest into the death of Paul Carpenter:

1. That the Department of Education and Communities liaise and consult with the Department of Transport, the Bus Safety Advisory Committee and other

appropriate stakeholders to develop an element bus safety awareness within the curriculum of schools in rural and regional areas of NSW, particularly in light of “bus surfing” and any other activity that involves hanging on to, climbing on to or being dragged along by a moving bus or vehicle;

2. That the Department of Infrastructure and Transport (C’th) revise the appropriate design rule as a matter of urgency to ensure that all external emergency footrests that are less than 1500mm above the ground shall be designed so that it is not possible to fully wrap fingers around the footrest form.

24 June 2011

Magistrate Sharon Freund

Deputy State Coroner