Review of coroners’ recommendations following fatal cyclist crashes involving heavy vehicles

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Abstract

Heavy vehicles are overrepresented in cyclist fatality crashes. This study is a review of coroners’ findings and recommendations for all cyclist fatality crashes involving a heavy vehicle. Nationally from 2000 to 2016, there were 141 cyclist deaths involving a heavy vehicle, coroners made recommendations in 17 cases with 51 individual recommendations. The recommendations were examined through the lens of the Safe System. Most recommendations focused on Safe People followed by Safe Roads and Safe Vehicles. Despite the range of recommendations from coroners nationally, little direct action has been identified in response to the recommendations to improve cyclist safety.

Background

Crashes involving cyclists and heavy vehicles are infrequent but have severe consequences. Of over 14,000 cyclist crashes from 2002 to 2012 in Victoria, heavy vehicles were involved in fewer than 5 percent of all crashes, yet over a third of fatal crashes (Garratt et al, 2015). This study, conducted through the Amy Gillett Foundation and Toll Group partnership, analysed recommendations made by coroners following heavy vehicle/cyclist fatality crash investigations.

Method

All heavy vehicle/cyclist fatality crashes were identified in the National Coronial Information System (NCIS) from 1 July 2000 to 31 December 2016. Coroners comments and recommendations were extracted from each case and the Safe System informed the analysis.

Results

Nationally from 2000 to 2016, 141 cyclist deaths were identified in the NCIS. Findings were reviewed for 140 cases, one case was excluded as it was still under investigation (Open). Most cyclist fatality crashes involved heavy vehicles classified as ‘Trucks’ (n=118, 84.3%) the remainder involving Bus/Coach (n=22, 15.7%). Figure 1a shows the crash trend and Figure 1b shows the total number of these crashes by state and territory.

Safe Roads and roadsides

Coroners made 13 recommendations in relation to roads and roadsides, including:

- review of the guidelines and design standards
- restriction of parking to improve safety
- increased signage, roadside and on heavy vehicles
- use of technology to activate a head start light for cyclists at bike boxes

Safe Speed

No recommendations were made in relation to speed, posted speed zone nor travel speed.
Safe Vehicles

Coroners made 12 recommendations in relation to vehicles. Most recommendations related to visibility and maximising drivers’ capacity to see outside the cabin, including:

- Rear vision camera – trial and install to maximise driver accessibility and visibility
- Prohibit conventional shaped heavy vehicles unless fitted with appropriate warning technology

Recommendations also included: ensuring all external doors were secured, locked, regularly checked and fitted with alarms, signs to warn other road users about the dangers of being in the blind spot and side underrun bars. Recommendations for bicycles focused working brakes and wider tyres near tram tracks.

Safe People

Coroners made 22 recommendations about people, including:

Public education campaign
- Cyclist safety
- Visibility around trucks
- Safe behaviour with car doors
- Parental supervision of children

Procedural check
- Exterior doors
- Maintenance log and all defects reported
- Bus driver checklist – checked twice a day

Bicycle road races
- Improved planning, standards and training

Death of cyclists due to pass too closely was noted as a considerable concern. Road rules to specify minimum passing distances have been amended in all Australian jurisdictions, except Victoria and Northern Territory.
Discussion/Conclusion

Coronial findings follow extensive investigations however to date most recommendations lead to little action. This review is an initial investigation as part of a larger national study of Coroners’ recommendations and the subsequent action to improve road safety outcomes for all road users.

References