CORONERS COURT
Te Kōti Kaitirotiro Matewhawhati

Consider Alpine Code legislation: coroner recommends in bus crash findings

Coroner Brigitte Windley is calling on Waka Kotahi and the Ministry of Transport to consider legislating alpine bus safety standards as one of a number of recommendations made in her findings from a case involving an 11-year-old girl who died following a bus crash on Mount Ruapehu.

The crash that killed Hannah Francis in 2018 was "undoubtedly avoidable" and caused by brake failure due to the bus driver's manner of driving, the Coroner has found.

While the bus possessed an "extraordinarily dangerous feature" that, because of its incompletely decommissioned state, had the potential to cause a loss of braking ability, Coroner Windley says it played no role in causing the crash.

"If the driver had managed the gear selection and used the brakes appropriately, the crash should not have occurred," says Coroner Windley.

The Police had decided at the time not to prosecute either the driver or the passenger service operator, and there had also been "a breakdown in communication between Police and WorkSafe that meant there was no focussed investigation into potential workplace health and safety breaches", the Coroner says.

The lack of passenger seatbelts, a small margin for driver error in a bus not specifically designed for alpine environments, and there being no dedicated run-off area in the event of a brake failure were among other factors the Coroner found contributed to Hannah's death, and for which she has made recommendations.

In the aftermath of this crash and other incidents, the industry and relevant agencies created the Bus & Coach Association New Zealand's (BCA) Alpine Code of Practice and launched the joint-agency campaign *Operation Hannah* by NZ Police and Waka Kotahi. However, the Coroner says they require enhancement to effectively improve passenger safety on alpine buses.

"The Alpine Code is voluntary and unaudited, so the extent to which the industry is effectively self-managing the significant risks is simply not known," says Coroner Windley.

"To achieve its goal of raising the bar for passenger service vehicle safety, consideration should be given to legislating the Code. The industry already has a clear understanding of what modifications are required to mitigate the risk of another loss of life. The issue is whether there is the appetite and willingness to voluntarily make the changes and investments that are necessary."

The targets set in the Ministry of Transport's *Road to Zero: New Zealand's road safety strategy for 2020-2030* also feature in Coroner Windley's findings. The Coroner is cautious about relying on the Ministry's assertion that overall, "buses are the safest modes of transport", when the alpine environment presents additional and potentially unique safety risks.

"No greater reason than Hannah's death in these circumstances should be needed for the Ministry of Transport to seriously and genuinely explore opportunities for tangible safety improvements through legislative reform," says the Coroner.

Mandating seatbelts for buses operating in alpine areas, improvements to bus (Class 2) driver training and licencing, including a specific licence endorsement for drivers in New Zealand's alpine environment, are among the eleven recommendations made.

Coroner Windley is also encouraging people to make an informed decision about alpine bus services and, where options are available, compare services with reference to the Alpine Code's safety standards.

"This crash has had lasting effects on many people," says Coroner Windley. "But it is Hannah who is at the centre of this inquiry, and my efforts to speak for her in the hope of giving future protection to the living."

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