QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of John Norman Spence**
TITLE OF COURT:	Coroners Court
JURISDICTION:	SOUTHPORT
DATE:	6 April 2023
FILE NO:	2021/3548
FINDINGS OF:	Carol Lee, Coroner
CATCHWORDS:	CORONERS- Drivers Licensing- Medical Certification- Fitness to Drive- Dementia- Elderly Driver- Notification to Licensing Authority

Table of Contents

Introduction

1. John Norman Spence (Mr Spence) was born in Sydney on 23 February 1962 and died on 5 August 2021 at Beaudesert Boonah Road, Bromelton.
2. Queensland Police Service (Police) reported Mr Spence's death to the Coroner because his death appeared to be a violent or unnatural death and fell within the definition of a reportable death in the *Coroners Act 2003.*
3. The role of a Coroner is to investigate reportable deaths to establish, if possible, the cause of death and how the person died. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

Circumstances

4. Mr Spence was a 59-year-old married man who lived at Birnam with his wife.
5. At approximately 18:00 hours on 5 August 2021, Mr Spence was the single rider of a black Honda VT motorcycle travelling in an easterly direction on Beaudesert Boonah Road at Bromelton. At the same time, Richard White (Mr White), an 89-year-old man, was driving his blue Mercedes Benz sedan in a westerly direction along the same road. Adjacent to the Allen Creek Park, the two collided. Due to the impact, Mr Spence was ejected from his motorcycle onto the northern embankment of the roadway and his motorcycle landed in a waterway culvert. Witnesses called 000 and provided assistance to both drivers whilst awaiting arrival of emergency services.
6. Paramedics from the Queensland Ambulance Service attended the scene and following assessment, declared Mr Spence deceased at 19:07 hours.
7. Officers from the Forensic Crash Unit (FCU) attended and commenced an immediate investigation. They conducted an examination of the scene, took photographs, examined the vehicles and interviewed witnesses, amongst other things.
8. Mr White subsequently passed away on 26 December 2021 for reasons unrelated to the crash.

Forensic Pathologist's Examination

9. In relation to Mr Spence, an external examination, imaging, document review and toxicology studies were undertaken.
10. The opinion of the forensic pathologist as to the cause of death is based on consideration of the circumstances of death and a post-mortem examination including associated imaging and testing.
11. The forensic pathologist summarised the findings on examination as follows:
12. There were significant and unsurvivable injuries to the spine, pelvis, and lower limbs; in particular, the spinal dislocations, and flail chest with

disrupted right atrium.

13. The pelvic and lower limb fractures, severe lower limb complex lacerations, and right lower leg/foot avulsion/amputation are consistent with runover injuries.

14. Rapid toxicology test of blood showed no presence of alcohol or recreational drugs. Sub-therapeutic level of antidepressant medication was detected.

15. An amended report will be issued if there are any other significant findings are the full toxicology routine testing.

16. In the opinion of the forensic pathologist, the cause of death was:

    1(a) Multiple injuries, *due to*

    1(b) Motor vehicle collision (motorcyclist)

17. The forensic pathologist opined that there was no indication of an underlying condition which contributed to the collision. Rather, the injuries were predominantly consistent with an overrun on the part of the Mercedes-Benz S430.

Toxicology

18. Full toxicological analysis was undertaken on samples taken at examination of Mr Spence, yielding the following results:

    Subclavian blood

    Alcohol – not detected

    Amitriptyline - < 0.02 mg/L

    Nortriptyline - < 0.02 mg/L

    Tetrahydrocannabinol (THC) - < 0.004 mg/L

    Chest cavity blood

    Tetrahydrocannabinol (THC) - < 0.007 mg/L

    Vitreous Humour

    Alcohol – not detected

Investigation

19. During the course of the coronial investigation, a significant amount of information has been obtained from various sources. This includes an opinion from the FCU, information from the Department of Transport and Main Roads (TMR), multiple medical records from Mr White's treatment providers and statements from senior treating doctors involved in Mr White's care at referring hospitals (Ipswich and Princess Alexandra Hospitals) and General Practitioner's, together with findings from a previous Coronial Inquest on this issue.

20. Relevant to these findings are the following:

[1] FCU

21. Following an extensive investigation, the following are findings of the FCU:

    a. The incident occurred at about 18:00 hours on Thursday the 5 August 2021.

    b. The incident occurred in the eastbound lane of Beaudesert Boonah Road, Bromelton, approximately 11.5 kilometres west of Beaudesert.

    c. The opposing lanes of traffic are separated by solid white line for eastbound and broken white line for westbound.

    d. The posted speed limit for the Beaudesert Boonah Road is 80km/hr.

    e. The incident involved a blue Mercedes Benz S430 sedan, Queensland registration 962CK4, that was being driven by Mr White.

    f. Mr White was the holder of current Queensland Drivers Licence however his current medical certificate had expired on 7 June 2020, rendering the licence invalid (see below).

    g. The incident also involved a black Honda VT750 motorcycle, Queensland registration 371AD, being ridden by Mr Spence.

    h. The Mercedes-Benz S430 was travelling westbound along Beaudesert Boonah Road and the Honda VT750 was travelling eastbound along the same road.

    i. The weather conditions at the time of the incident were fine and clear and not a contributing factor to the cause of the incident.

    j. There was no oil, potholes or debris that were a contributing factor to the cause of this incident.

    k. The Mercedes-Benz S430 crossed over the dividing lines into the path of the oncoming Honda VT750.

    l. A collision occurred between the front driver's side of the Mercedes-Benz S430 and the front of the Honda VT750.

    m. The impact caused the Mercedes-Benz S430 to rotate 180 degrees coming to rest facing an easterly direction on the eastbound shoulder.

    n. The impact caused the Honda VT750 to be deflected back westerly and down into a waterway running under the roadway.

    o. Extensive front driver's side contact damage was sustained to the Mercedes-Benz S430 resulting in the right suspension components and engine to be displaced back towards the driver.

    p. The damage sustained to both vehicles is consistent and reflective of the mechanism of the collision.

    q. There were no tyre friction marks (skid marks) evident leading into the impact point of the vehicles, indicating that there was no emergency or heavy braking prior to the collision.

22. Having regard to the full circumstances of the incident and the information sourced during the investigation, the FCU opined that it was reasonable to

conclude that the cause of the incident was due to Mr White crossing the centre line into Mr Spence's path. It was surmised that the reasons for Mr White crossing the line was related to his cognitive abilities or a medical episode.

23. Following the incident Mr White's condition rapidly declined, and he was subsequently diagnosed as suffering from Vascular Dementia before passing away on 26 December 2021. Whilst the pursuit of charges was considered by Police against Mr White, they were ultimately abandoned given Mr White's condition.

24. The FCU officer noted that Mr White had attended at least 13 appointments with at least 7 different General Practitioner's (GP) in at least 6 different locations. In relation to the medical assessment of Mr White's fitness to drive most proximate to the incident (26 July 2021), the FCU recommended referral of the practitioner to the Medical Board of Australia having regard to the following factors:

    a. The GP knew Mr White had previously had a motor vehicle accident, in the context of removing sutures arising from injuries sustained therein. Mr White was seeking a licence assessment as he was currently driving without a valid medical certificate.

    b. The GP had some concerns about a mini mental state examination (MMSE) and did not give Mr White a clearance to drive but suggested that he see the Geriatric Department at the Ipswich Hospital for further assessment prior to the medical certificate being completed.

    c. Despite that referral, advice was given to Mr White's live-in carer to *"not allow him to go on highways".*

    d. With the knowledge that Mr White would likely disregard any advice not to drive, the GP could have followed advice from the TMR website specific to medical practitioners in this situation, by completing an online report and notification about Mr White. Whilst it may not have deferred Mr White from driving, any action by TMR by way of correspondence might have given Mr White cause to consider his driving situation.

    e. The GP was unaware of the previous Show Cause reports that had been presented to TMR by Police and his treating doctor from Ipswich Hospital due to the low MMSE score. This may have triggered a greater necessity by TMR to contact Mr White about his licence.

[2] Traffic History Report

25. Previous to the subject incident, Mr White had multiple occurrences whereby he was found driving in excess of the speed limit. He was warned, fined, and accumulated demerit points.

26. As of 7 December 2020, Mr White was on a good driving behaviour period, to expire on 6 December 2021.

27. As of 17 August 2021, Mr White's licence was suspended on medical

grounds and as of 14 September 2021, it was cancelled on medical grounds.

[3] Department of Transport and Main Roads (TMR)

28. Under the *Transport Operations (Road Use Management – Driver Licensing) Regulation 2021* (Qld), there are occasions where a person must hold a medical certificate before being allowed to drive. One such requirement is for people who are 75 years or older[1]. Another is for people suffering from certain mental or physical incapacities[2]. Both of these applied to Mr White.

29. The last medical certification for Mr White to drive was given by a GP on 7 June 2019, with an expiry date of 7 June 2020. After this date, Mr White did not have a medical certificate allowing him to drive, as required by his driver licence conditions.

30. On 12 July 2021, Mr White was issued with correspondence about his medical fitness to drive, based upon information received from Police on 11 July 2021 that he had been involved in a single vehicle traffic accident in June 2021 at Peak Crossing (see below regarding treatment at Ipswich Hospital). The TMR proposed to cancel his licence unless he provided a medical certificate confirming his fitness to drive. Mr White was given until 17 August 2021 to respond and failed to do so. The incident in question occurred in the interim.

31. On 9 August 2021, a notification was made to TMR from a clinician at Ipswich Hospital about Mr White's unfitness to drive. That same day, correspondence was sent to Mr White immediately suspending his licence on medical grounds. This notice replaced the notice given on 12 July 2021.

32. On 14 September 2021, Mr White was sent a notice of cancellation of his licence, effective immediately.

33. At the time of the subject incident, Mr Spence held a valid Queensland Driver licence.

[4] Medical information – Mr White

<u>Clinical records</u>

34. At the time of the incident, Mr White was an 89-year-old retired pharmaceutical representative who lived on a property in the area. He had a long-term, live-in carer (Claire Ekas) who assisted him with independent living.

35. The following relates to Mr White's cognitive status/drivers licensing attendances:

    a. On 17 November 2016, Mr White was seen in the Emergency Department (ED) at Ipswich Hospital after being involved in a high-speed motor vehicle collision, in which it was reported that the other

[1] Section 253 *Transport Operations (Road Use Management—Driver Licensing) Regulation 2021* (Qld).
[2] Section 176 *Transport Operations (Road Use Management—Driver Licensing) Regulation 2021* (Qld).

vehicle had drifted into his lane. He was treated for rib fractures, with nil other significant injuries. Relevantly, there was no head injury and no loss of consciousness. He was treated conservatively and discharged the following day.

b. From the available medical records, Mr White had successfully obtained medical certification for his drivers' licence on 19 April 2018 and 7 June 2019, from a GP at Fassifern Doctors, Boonah. A CT Head scan was performed for reported memory loss on 21 November 2018, which did not demonstrate any intracranial abnormality and global atrophic change. On the latter consultation on 7 June 2019, Mr White was noted to be "*Stable*" and "*Going Well*".

c. On 7 June 2019, a medical certificate was provided by a GP at Fassifern Doctors (the last certification).

d. The last consultation at this practice appeared to be on 3 March 2020, wherein it was noted that Mr White had been to the eye specialist who noted early macular degeneration and that once he had seen the optometrist, Mr White would return for his driver's licence form ("*back for completion*").

e. Another GP at Wishart Village Family Practice documented consultations with Mr White on 11 October 2019 for memory difficulties for which he was referred for a CT Brain scan on 15 October 2019; the results of which were reported as demonstrating global atrophic changes with chronic ischaemic changes in the right frontoparietal region, appropriate for his age, and similar to an earlier scan undertaken in 2018.

f. Mr White was not seen again in that practice until 6 January 2021, when he was seen for "*dementia*". A MMSE was performed, scoring 23/30. This prompted a referral to the Geriatrics Clinic at Ipswich Hospital for an assessment and management of Mr White's rapidly declining memory. Results of investigations were included in the referral.

g. Mr White was offered an appointment at the Geriatric Clinic for 26 May 2021.

h. On 26 May 2021, Mr White failed to attend an Occupational Therapy (OT) assessment in the Memory Clinic at Ipswich Hospital. When Ms Ekas was contacted, she informed the practitioner that Mr White was not interested in attending any clinic and did not wish to be rebooked. A letter was sent to Mr White's GP in this respect.

i. On 4 June 2021, Mr White was seen in the ED of Ipswich Hospital following a single vehicle, low impact motor vehicle collision. A CT Brain scan was performed, and no acute intracranial pathology was reported. Mr White absconded from the ward and following his return facilitated by Police, he was assessed by the on-call medical team and advised to cease driving until assessed by his GP and to obtain another referral to the Geriatric Clinic at Ipswich Hospital. He was also assessed by the duty Geriatrician on 5 June 2021, wherein collateral information was obtained from Ms Ekas to the effect that he had had

4 car accidents in 6 years with 3 cars written off but that they were not all his fault, and he was a good driver. Alcohol use had reportedly played a part in his aggression and advice was given to reduce consumption. A discharge letter was sent to Mr White's nominated GP.

j. On 24 and 27 June 2021, Mr White was seen in the ED at Ipswich Hospital following unwitnessed falls but discharged himself against medical advice on both occasions; having been assessed as having capacity to do so. Collateral information by Ms Ekas was that he was a safe driver. It was reinforced to Ms Ekas of the importance for GP follow up.

k. An unsuccessful attempt at a follow up call was made to Mr White on 25 June 2021 but he failed to return the call before the second presentation on 27 June 2021.

l. When the above information was conveyed to the Geriatrician, a home visit was booked for 28 June 2021. At the home visit, the Nurse Navigator (NN) emphasised for Mr White to attend his GP for a licence assessment.

m. On 30 June 2021, the NN sent an email to another GP Practice ("The GP Practice"), seeking the practice to follow up with Mr White for a licence assessment. The ED notes were attached to the email.

n. On 2 July 2021, a nurse from the GP Practice phoned Ms Ekas in response to the email received from the NN. The nurse was trying to book Mr White in for a review. Ms Ekas took the number of the practice with a view of calling back once she had spoken to Mr White. The nurse reiterated the importance of a review for Mr White's driver licence.

o. On 23 July 2021, an optometrist at Boonah Eyecare found Mr White to be visually eligible for a driver's licence, with spectacles. The optometrist advised Mr White to have the rest of his medical form filled out by his normal doctor to assess his medical eligibility.

p. On 26 July 2021, Mr White consulted a GP at the GP Practice for the purposes of a driver's licence assessment. Mr White's carer reported declining memory problems. A recent single vehicle MVA was noted, with no injuries, and that a Geriatrician had seen him before discharge from Ipswich Hospital. CT and bloods were noted to be "*OK*". A MMSE was performed, yielding a score of 20 out of 30. The GP suggested that he see the Geriatrician again before having his licence renewed and, to this end, a referral was made. Advice was given to Ms Ekas that he was not to drive on highways. In the referral to the Geriatrician, the GP asked whether Mr White would benefit from Aricept (medication used to treat dementia) and whether he could be allowed to drive.

q. On 29 July 2021, an ED "*frequent admissions*" NN at Ipswich Hospital identified that Mr White required cognitive fitness to drive assessment and referred him to the Geriatric CNC.

r. On 2 August 2021, the Geriatric team at Ipswich Hospital contacted the ED to ascertain if Mr White was still driving. A home visit by a nurse practitioner followed, in which it was noted that Mr White was still driving and needed to have his licence assessed, noting that he had had a motor vehicle collision a few weeks previously. It was noted that Mr White had not seen a GP for a long time and advice was given to sticking with a GP with the benefits of good patient-based care in the future. The practitioner ascertained from Ms Ekas that Mr White needed an appointment for removal of his stitches and at the same time, hopefully have his licence reviewed. The practitioner contacted Mr White's GP practice to give the background to facilitate the appointment. During that call, the practice manager informed the practitioner that Mr White had already seen the GP on 26 July 2021. The notes of that consultation were requested to be faxed to the Geriatric clinic at Ipswich Hospital, but it appears that did not occur.

s. Following that visit, a discussion took place with the Consultant Geriatrician at Ipswich Hospital. Mr White was placed on the Geriatric Rapid Access Clinic review list, for the next available appointment.

t. On 5 August 2021, Mr White was admitted to the Princess Alexandra Hospital after the subject motor vehicle collision for treatment of his injuries, and on 7 August 2021, he was transferred to Ipswich Hospital for ongoing management. Following assessment, Mr White was diagnosed with moderate stage Vascular Dementia and following notification on 9 August 2021, his driver's licence was suspended and then cancelled.

u. The Form 9 Cause of Death Certificate completed by Ipswich Hospital staff for Mr White dated 30 December 2021 specified the disease or condition directly leading to his death as Urosepsis, with other significant condition including Vascular Dementia.

Statements

36. In order to further ascertain the facts and clinical decision making behind Mr White's management, statements were obtained from practitioner's including a Geriatrician.

37. A summary of the relevant factors arising from these are as follows:

38. *Ipswich Hospital*

a. The assessments undertaken in the ED on 4 /5 June 2021 and 24/27 June 2021 were limited due to the ED setting and recalcitrant nature of Mr White. He was assessed as having capacity to self-discharge. Collateral information was obtained from his carer that he was a safe driver and only confused when under the influence of alcohol. Although he presented with some memory difficulties and an MMSE score of 23/30, a dementia diagnosis in an ED setting could not be obtained.

b. Many people with mild dementia and a 23/30 MMSE score safely drive.

c. Mr White's memory impairment would not necessarily indicate a diagnosis of dementia. Memory impairment can also be caused by depression, anxiety, alcohol excess, lack of sleep, medical conditions such as acute stroke, cerebral vasculitis, various encephalopathies or obstructive sleep apnoea. Hence, a formal memory clinic assessment is required to rule out secondary causes and confirm a dementia diagnosis.

d. Mr White's presentations to the Ipswich Hospital ED in June 2021 in combination with the collateral information from his carer, did not indicate the need to have his licence cancelled. Cancelling a person's licence has huge implications on their independence, quality of life, autonomy, and doctors would only do it when there are sufficient risks related to the person's driving, such as when a medical condition definitively affects driving, is permanent and irreversible. A standard medical practice when driving ability is questioned but not proven to be lacking is to tell the person involved not to drive until further assessment.

e. A proper assessment is conducted by an OT with an on-road driving lest with an instructor and an OT sitting in the back seat taking notes on how cognitive impairment affects a person's ability to drive. The driving OT assessment was withdrawn from the West Moreton Health and Hospital Services in 2021 due to lack of funding hence Ipswich Hospital doctors could no longer refer patients for these. Reliance is therefore placed on GP's referring to private driving OT's for assessment. When a person lacks insight into their driving capacity, the person may refuse to pay for and participate in a driving test.

f. A GP's review of a licence would involve a repeat of MMSE test, or any other cognitive screening tests relevant, history taking about whether the subject feels confident to drive, whether he/she has had any traffic infringement notices recently and whether the next of kin has observed any unsafe operation of a vehicle. The GP will also refer a person for a driving test if decision regarding safe driving is unclear from history taking. The GP's assessment should happen as soon as practicable, such as the next available GP's appointment which the person is able to attend.

g. After Mr White was admitted to the Princess Alexandra Hospital following the subject accident, he was diagnosed with Vascular Dementia. This was however following a comprehensive assessment, supported by cognitive assessment (SMMSE and MOCA), brain imaging and exclusion of other medical conditions which could cause cognitive decline. He was assessed as completely lacking insight of risks concerning driving and lacking in capacity. The trajectory of disease is rapid and the patient's ability to self-care is compromised, and they start to exhibit behavioural disturbances. Towards the severe stage, they become totally dependent on all cares, fail to recognise family and friends and may lose their ability to communicate. There is no effective treatment.

h. On 19 August 2021, a QCAT application was made for an Interim

Order for Guardianship and Administration, and by 7 September 2021, applications to residential aged care facilities were made. Mr White was transferred to Bundaleer Lodge on 27 September 2021, and he died on 26 December 2021.

39. *General Practice consultation: 26 July 2021*

    a. A GP at the GP Practice undertook the last medical assessment of Mr White before the subject incident, on 26 July 2021.

    b. In 1999, the GP obtained the qualification of Bachelor of Medicine/Bachelor of Surgery. In 2017, the GP became a Fellow of the Royal Australian College of General Practitioners.

    c. Mr White had been a patient of the practice since May 2020. Mr White had attended the practice on three prior occasions prior to his appointment on 26 July 2021.

    d. On 30 June 2021, the practice received correspondence asking for follow up of Mr White about his licence. On 2 July 2021, the practice contacted Ms Ekas. On 26 July 2021, Mr White attended the practice with a view of obtaining a renewal of his medical certificate for his driver licence.

    e. At the consultation, the GP stated that he explained that he did not consider himself to have sufficient experience to make an assessment as to whether Mr White should be cleared to drive, and what (if any) conditions should be attached to Mr White's licence. As such, the GP referred Mr White to a specialist Geriatrician, Dr Alison Cutler, for further assessment.

    f. The GP stated he told Mr White not to drive while waiting for further assessment. Mr White did not appear pleased with this outcome, however, indicated he would attend on Dr Cutler. The GP believed that Mr White would listen to the advice and not drive in the meantime.

    g. After the appointment, the GP stated he called and spoke to Ms Ekas. Ms Ekas indicated Mr White had said his recent motor vehicle crash was not Mr White's fault. Ms Ekas did not have any concerns about his driving and said that he had been routinely driving long distance without trouble. During this conversation, the GP repeated his advice that Mr White should not drive. Ms Ekas indicated she was not sure whether she would be able to stop him from driving. The GP reinforced his view that Mr White should not be driving but said that if Ms Ekas was not able to stop him from driving entirely, she should at least not allow him to drive on highways.

    h. The GP stated that he was not trying to provide a covert suggestion to allow Mr White to drive. However, it was made as a way of, at the very least, trying to limit Mr White's driving until a formal assessment was undertaken.

    i. The GP stated that while he did not report Mr White to TMR, he had given consideration to doing so. The GP explained that, with the

benefit of hindsight, he wished he had. His reasoning for not doing so was as follows:

i. Mr White had been recently discharged from the Ipswich Hospital where it was deemed he had capacity to make decisions and understand risks.

ii. During the consultation on 26 July 2021, Mr White was polite and from the interaction, the GP did not consider Mr White was lacking in capacity.

iii. Mr White had told the GP the recent motor vehicle accident had been caused by rash driving of another car.

iv. Whilst not happy about the need for specialist assessment of his driving capacity, Mr White appeared accepting of it.

v. As the GP had not had a lot of contact with Mr White, the GP did not have a good baseline to determine if there had been a decline in cognition. As such, the GP determined further investigation was required, which is what was arranged.

j. The GP stated that since the incident he had reached out to Dr Rory Melville from the University of Queensland. The purpose of this was to organise a time for Dr Melville to visit the practice and discuss Dr Melville's research project in relation to assessing older drivers. In addition, the GP had engaged in a further course of education, which contained components on assessing fitness to drive and medical record keeping.

[5] Independent Medical Review

40. An independent expert was asked for an opinion about the GP's management of Mr White at the consultation on 26 July 2021. Dr Christopher Pitt is a consultant GP who works in full-time practice. Dr Pitt attained a Fellowship of the Royal Australian College of General Practitioners in 2005. He is a medical educator, examiner, and assessor with extensive experience.

41. In relation to dementia, Dr Pitt explained that relevant guidelines indicate that not all people with dementia should have their licence revoked. There are various stages of the condition, and people will experience a different pattern and timing of impairment.

42. Dr Pitt concluded that although the GP's assessment of Mr White on 26 July 2021 was limited, it was sufficient to inform an appropriate management plan. Dr Pitt noted that the GP did not renew Mr White's medical certificate for his licence but rather referred Mr White to a Geriatrician for further assessment. Dr Pitt noted that the GP's statement to Ms Ekas to try and stop Mr White from driving on highways appeared to be a form of harm minimisation rather than tacit approval for Mr White to drive without a medical certificate. Overall, given Mr White was a relatively new patient to the GP, having only seen him on a few occasions, Dr Pitt concluded the GP did not have reasonable grounds to consider that Mr

White would ignore the advice not to drive. As such, there did not appear to be grounds for the GP to notify the driver licensing authority regarding Mr White.

43. Noting the opinion expressed by the FCU that "[i]*t is evident through Mr White's medical records, that he had a history of being difficult and disregarding any advice given to him…*", Dr Pitt observed that such evidence was not available to the GP.

44. Overall, Dr Pitt concluded the GP's management of Mr White was reasonable.

[6] Reporting Obligations

45. In Queensland, there is no mandatory requirement for health practitioners to report a patient to TMR if that patient has any medical conditions that may impact on their ability to drive. Rather, there is discretionary reporting. A health practitioner's disclosure of a patient's medical fitness to hold a driver licence, is not considered a breach of confidence[3].

46. It has been noted by Austroads 'Assessing Fitness to Drive for Commercial and Private Vehicle Drivers 2022 Edition: Medical Standards for Licensing and Clinical Management Guidelines'[4]:

> *Health professionals have both an ethical and legal duty to maintain patient confidentiality. The ethical duty is generally expressed through codes issued by professional bodies. The legal duty is expressed through legislative and administrative means and includes measures to protect personal information about a specific individual. The duty to protect confidentiality also applies to drive licensing authorities.*
>
> *The patient–professional relationship is built on a foundation of trust. Patients disclose highly personal and sensitive information to health professionals because they trust that the information will remain confidential. If such trust is broken, patients could forgo examination/treatment or modify the information they give to their health professional, potentially placing their health at risk.*

47. In Queensland, the responsibility for reporting medical conditions that may adversely affect a person's ability to drive, falls with the person themself. Whereby, a person who applies for a licence, or renewal of a licence, must give notice of any mental of physical incapacity that is likely to adversely affect their ability to safely drive[5]. Additionally, anyone who is the holder of a driver licence who develops a mental or physical incapacity that is likely to adversely affect their ability to safely drive, must give notice[6].

[7] Fitness to Drive

48. The issue of driver licensing in the context of medical conditions has been

[3] Section 142 *Transport Operations (Road Use Management) Act 1995* (Qld).
[4] Paragraph [3.3.1].
[5] Section 177(1) *Transport Operations (Road Use Management—Driver Licensing) Regulation 2021* (Qld).
[6] Section 178(1) *Transport Operations (Road Use Management—Driver Licensing) Regulation 2021* (Qld).

the subject of a past Coronial Inquest in Queensland[7].

49. One of the recommendations made by the Northern Coroner in that Inquest was directed to the TMR regarding taking the lead in an inter-agency working group on this issue:

> *470. I make the following recommendations and request that the following agencies (identified as peak professional bodies best placed to review comment and implement reform if required) be advised of my recommendations and participate in an inter-agency working group to consider the recommendations arising:*
>
> > *That the Department of Transport and Main Roads take the role as lead agency in the formation of an inter-agency working group (noting they have written to me post inquest volunteering to take on the role, I thank the Department for that) comprising relevant stakeholders including, but not limited to, the following:*
> >
> > - *Department of Transport and Main Roads (Qld)*
> > - *Department of Health (Qld)*
> > - *Austroads*
> > - *APHRA;*
> > - *OHO;*
> > - *AMA (Australia and Qld)*
> > - *RACGP;*
> > - *College of Rural and Remote Medicine*
> > - *Hospital Health Services*
> > - *Medical Board of Australia*
> > - *Australian College of Emergency Medicine (ACEM).*
>
> *Recommendation 1*
>
> *That the inter-working group collaborate to develop an ongoing education and awareness campaign directed to all medical practitioners in the State of Queensland, including hospital based doctors (including rural and remote hospitals) and general practitioners, (including rural and remote general practitioners) and that such campaign be specifically developed to educate medical practitioners about the pathways that already exist, for medical practitioners to report patients directly to the State driver licencing authority in circumstances that are consistent with the Medical Standards provided for in the Austroad assessing fitness to drive guidelines.*

50. By Form 25 dated 22 August 2022, I asked the TMR for information about the status of progress made since this recommendation. The TMR's

[7] Inquest into the deaths of Nicole Sonia Nyholt and Margaret Louise Clark, delivered by the Northern Coroner on 26 June 2020.

response is set out in full, as follows:

> *The first interagency working group meeting was held on 30 April 2021 and was attended by representatives from all the stakeholders listed in the Coroner's recommendation at paragraph 470 of the findings (see Attachment 1), with the additions of the Clinical Forensic Medicine Unit (CFMU) within Queensland Health, the Australia and New Zealand Association of Neurologists (ANZAN) and Epilepsy Society of Australia (ESA). The group met for an extended workshop, including a presentation by the Department of Transport and Main Roads (TMR) on medical condition reporting. The immediate outcomes of the meeting included a number of recommendations by the working group members regarding improvements in messaging around medical condition reporting for medical practitioners.*
>
> *Since this meeting, TMR's Driver Licensing Policy (DLP) team has consulted internally to identify workable strategies for implementing these recommendations. As part of this consultation, it was determined that TMR's website is the main source of information about medical condition reporting in Queensland, and that the website content should be updated to better support medical practitioners by prioritising the key information and improving accessibility. This will provide a resource for medical practitioners to ensure that they always have access to the most up to date information about existing reporting pathways.*
>
> *DLP has developed key messages to support these web changes and circulated these messages to the working group and internal stakeholders for feedback. DLP is currently working with Online Content Support to plan the new Health and Driving Hub web content with an aim to go live by the end of 2022.*

Conclusion

51. After carefully considering the voluminous material obtained during the coronial investigation, I consider that I have sufficient information to make the necessary findings in relation to Mr Spence's death and that an Inquest is not required.

52. I accept the forensic pathologist's opinion as to the cause of death and find that the cause of Mr Spence's death was:

    1(a) Multiple injuries, *due to*

    1(b) Motor vehicle collision (motorcyclist)

53. Whilst I accept the FCU findings about the collision and having regard to all of the circumstances of the investigation, I do not consider it is appropriate to take the further action recommended by the author in relation to the GP. This is because of the following factors:

    a. Medical certification for driver licensing is complex in a GP setting. Preservation of the therapeutic relationship between the patient and the GP is critical, particularly in a rural setting where Mr White lived.

Losing a licence can be catastrophic for a person's independence and had the potential to compromise the seeking of treatment for wider health concerns.

b. Cognitive assessments to assist in certification for driving are specialist in nature. An ED or GP setting is not appropriate for a dementia diagnosis.

c. A registration search of the GP shows that he was an experienced GP, who obtained specialist GP qualifications.

d. The relationship between the GP and Mr White was in the early stages, commencing from approximately May 2020.

e. The GP acted acceptably at the consultation on 26 July 2021 by:

    i. not certifying Mr White as cleared for driving at the consultation.

    ii. referring Mr White for specialist Geriatric assessment at Ipswich Hospital.

    iii. giving advice to his carer that he avoid highways, in the recognition of the reality that he may disregard the advice not to drive at all.

    iv. giving information in good faith, in reliance of indemnity for health professionals[8].

f. Even had the GP notified TMR about his concerns, it is likely that Mr White would have ignored any notices by TMR to suspend or cancel his licence given his past behaviours in this respect. He had already ignored advice given in the ED and correspondence from TMR on 12 July 2021 (pre-incident) proposing to cancel his licence, in circumstances where he was under a good driving behaviour period. Attesting to Mr White's attitude in this respect, is that he purchased the Mercedes-Benz S430 on the day of the incident.

g. With the benefit of hindsight, the GP regrets that he did not report Mr White to TMR and in recognition of this, has embarked on a course of further developing his skills in this complex area.

h. Confounding factors include the following:

    i. Mr White himself was recalcitrant, by driving beyond expiry of his annual medical certification, failure to act on correspondence from the TMR, apparent GP shopping for medical certification and failing to attend the critical memory clinic appointment following referral in January 2021.

    ii. For reasons unknown, Mr White's carer appears to have enabled this behaviour, including the giving of information to his providers that was at best incomplete.

    iii. The limitations of service capability in expedited cognitive and driving assessments in public facilities.

[8] Section 142 of the *Transport Operations (Road Use Management) Act* 1995.

iv. The rapid downward trajectory of Mr White's condition from the onset of the illness.

i. Staff at Ipswich Hospital made repeated and appropriate attempts to engage with Mr White and his carer, in order to facilitate assessments and engage with a regular GP.

j. This issue has been ventilated in the coronial jurisdiction before, to improve education to medical practitioners about the pathways that exist regarding medical certification for fitness to drive, and the wider community. Recommendations have been made as detailed above.

54. Consequently:

    a. I accept the GP's account of what transpired in the consultation of 26 July 2021, and find his management was acceptable, a view which is fortified by an independent expert; the opinion of which I also accept.

    b. I find that the assessments undertaken at the Ipswich Hospital in the ED and attempts made to engage Mr White in participation in assessment for certification for drivers licensing by the Geriatric Clinic and the NN, was acceptable.

55. This issue is complex and comprises an undertaking of a delicate balancing exercise in weighing the rights of licence holders in the setting of autonomy and human rights, against community safety. It not only requires safeguards from licensing authorities, medical practitioners, Police and professional bodies, but also from the wider community, in the management of and timely and accurate reporting of drivers who may no longer be fit to drive. Critically, those closest to the person who is the subject of fitness to drive assessments play a pivotal role. Naturally, this affects us all in supporting family, colleagues, and friends in their transition to accessing other forms of transport.

56. Tragically, the specific set of circumstances that unfolded in this case resulted in Mr Spence's premature death.

57. As the lead agency, I urge the TMR to continue in its efforts with key stakeholders in this respect, including the timely progression of the recommendations made by the Northern Coroner in the Inquest findings referred to above, which are directly relevant to this tragic case.

58. I extend my condolences to Mr Spence's family and friends for their loss.

Findings required by s.45

Identity of the deceased: John Norman Spence

How he died: Collision between a Mercedes Benz sedan and a Honda VT motorcycle on the Beaudesert Boonah Road at Bromelton, as a consequence of the driver of the

	sedan crossing the centre line of the roadway and into the path of the oncoming motorcycle.
Place of death:	Beaudesert-Boonah Road BROMELTON QLD 4285 AUSTRALIA
Date of death:	05 August 2021
Cause of death:	1(a) Multiple injuries, *due to* 1(b) Motor vehicle collision (motorcyclist)

I close the investigations.

Carol Lee
Coroner
CORONERS COURT OF QUEENSLAND - SOUTHERN REGION
6 April 2023