QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Ruth CAPPS**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Southport
FILE NO(s):	2013/2571
DELIVERED ON:	21 December 2016
DELIVERED AT:	Southport
HEARING DATE(s):	4 & 5 August 2016
FINDINGS OF:	James McDougall, Coroner
CATCHWORDS:	Coroners: inquest, motor vehicle accident, fitness to drive guidelines, medical condition and age related change, GP assessment

REPRESENTATION:

Counsel Assisting:	Ms Rhiannon HELSEN
Department of Transport & Main Roads:	Ms Donna CALLAGHAN O/I Ms Lucy Lilienstein, DTMR
Dr Brian Purtle:	Ms Jennifer Rosengren O/I Mr Harry McCay, AVANT Law

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Introduction

1. Ruth Capps died from injuries suffered in a motor vehicle accident that occurred at 10.00am on 18 July 2013 on Mudgeeraba Road at Mudgeeraba. Ruth Capps was a driver of one of the vehicles involved in the accident. The other vehicle was a maxi taxi containing a driver and two passengers. All of the occupants of the maxi taxi were injured, one of them seriously. An inquest into the death of Ms Ruth Capps was held at the Coroners Court at Southport over two days from 4 August 2016 to 5 August 2016.

2. A brief of evidence, which included the Forensic Crash Unit coronial investigation report, as well as numerous statements, photographs and other materials gathered during the coronial investigation, were tendered at the commencement of the inquest. Eleven witnesses were called to give evidence during the course of the inquest.

3. Ms Ruth Capps was 75 years of age at the time of her death. She lived alone, following her husband's death in 1999, and did not have any children. She was in regular contact with her sister who resided in Melbourne. Medically, Ms Capps had a history of Type II diabetes, transient ischemic attack, restless leg syndrome, hypertension, chronic insomnia and chronic lower back pain due to a degenerative condition, osteoarthritis, recurrent falls, sleep apnoea and peptic ulcer disease.

Summary of evidence

4. Ms Capps had a long standing history of chronic back pain, and was prone to falls. She lived alone but received assistance in support of her daily living activities from friends, including her neighbour, Ms Tracey Hughes. Ms Hughes, who gave evidence at the inquest, described Ms Capps as 'very slow' in her movements and required the assistance of a walker or walking stick to mobilize. In her opinion, Ms Capps' mobility had decreased in the two years prior to her death, and her reaction times were slow. She was also prone to randomly fall asleep suddenly at varying times. Another friend, Mr Roy Heslop, who also gave evidence during the inquest, described Ms Capps as *'*very frail*'* and *'*old for her age'.

5. Following a number of falls, Ms Capps was admitted to the Gold Coast Hospital (GCH) for prolonged periods in 2011 and 2012. During this time, it was the assessment of a number of medical consultants that she was not fit to drive due to her limited mobility and slow reaction times. This was clearly communicated to Ms Capps and her treating general practitioner, Dr Charulata Shah from the Health Choice Medical Centre.

6. On 9 January 2012, three of Ms Capps' friends, Mrs Eunice Keppie, Mr Douglas Keppie and Mr John Merritt attended the Mudgeeraba Police Station to report their concerns as to her medical fitness to drive. In a letter written to police, they state that Ms Capps was recently in hospital and could barely walk, requiring the assistance of a walking stick or walker. She had also been observed to have slow reaction times and on numerous occasions, would fall asleep easily, and she did not appear to be in control of her vehicle.

7. Mrs Keppie gave evidence during the inquest. She met Ms Capps through a mutual friend at the Cedar Cutters Club (the Club) and would see her once a week. She describes Ms Capps as *'*very thin and frail' who was 'very slow walking'. Whilst Ms Capps was said to have had the occasional 'dance' by

'moving around the floor' at the Club, Mrs Keppie recalls that Ms Capps often used a walker or walking stick and would shuffle rather than walk. She held genuine concerns as to Ms Capps' ability to drive safely as she did not appear to have 'proper control of her car'. She also describes Ms Capps' as 'tottery', who was quite 'slow talking', and appeared to have slow reaction times. While at the Club, Ms Capps had also been observed to fall asleep quite often.

8. In response to the concerns raised, Senior Constable David Borrowdale of Mudgeeraba Police Station completed a Medical Show Cause report to the Department of Transport and Main Roads (DTMR). This report notes that Officer Borrowdale attended to speak to Ms Capps on 13 January 2012, following the concerns raised about her fitness to drive. She told him that she had a medical certificate, which permitted her to drive. When questioned about recent treatment she had received from the Robina Hospital, she stated that whilst she had been advised by doctors not to drive, she intended to continue to do so. Senior Constable Borrowdale, who gave evidence during the inquest, described Ms Capps as 'very frail', who was 'struggling to get to the door, struggling to walk' and required the aid of a walking stick. In his opinion, Ms Capps' 'would struggle to get into a car, let alone drive the car,' and as such he thought it was 'fairly obvious' that she 'would not have the ability to drive the vehicle'. As a result of the concerns held about Ms Capps' driving ability, Senior Constable Borrowdale referred the matter to the Medical Unit of DTMR.

9. On 25 January 2012, DTMR sent a letter to Ms Capps stating that they proposed to cancel her licence and requested a Medical Certificate for Motor Vehicle Driver (Form 3712) confirming her fitness to drive. She failed to produce her licence or a medical certificate, and as such on 27 February 2012, Ms Capps' driver's licence was cancelled.

10. On 30 March 2012, following a referral by Dr Shah, Ms Capps underwent an Occupational Therapy Driving Assessment with Occupational Therapist, Ms Michelle Palmada. The off road assessment showed that Ms Capps had no cognitive deficits that may have impacted her driving ability, physically, she suffered from reduced right shoulder strength, left-hand pain, reduced strength in knee movements, reported lower back pain and restricted visual fields, which may have impacted on her vehicle positioning, steering, reflexes and speed modulation. Ms Palmada concluded that the on road assessment demonstrated that Ms Capps' condition did impact on her ability to drive safely. She noted that, 'Mrs Capps was unable to demonstrate overall safety and competence in driving areas observed due to multiple vehicle positioning, steering and speed modulation difficulties and errors noted.' She recommended that Ms Capps discontinue driving and surrender her licence.

11. Despite her licence cancellation, it appears that Ms Capps was determined to get her independence back by having her licence reinstated. She told friends that she intended to find a doctor who would reinstate her licence. Records confirm that she had visited different doctors in an attempt to regain her licence.

12. Seven days prior to the fatal crash on 11 July 2013, Ms Capps' licence was reinstated after she was provided with medical clearance by Dr Brian Purtle from the Mudgeeraba Medical Centre. Dr Purtle claims that he had been seeing Ms Capps on and off for the past two years, having last consulted with her on 1 July 2013. Medicare and MEDICAL records, however, confirm that Dr Purtle only started treating Ms Capps on 26 November 2012. He subsequently signed

the requisite Medical Certificate for Motor Vehicle Driver (Form 3712), for renewal of her licence with no conditions attached.

13. On 17 July 2012, the night prior to the incident, Ms Capps drove out to a friend's property at Guanaba. After arriving at 5:00pm she retired to bed that evening at 8:30pm and woke at 7:00am the next morning. She stated that she was tired and had not slept well. She left later that morning to return home, which was around a 45 to 50 minute trip.

14. At around 10:00am on 18 July 2013, Ms Capps was involved in a collision while driving along Mudgeeraba Road, Mudgeeraba. While driving her car southbound along Mudgeeraba Road, Ms Capps was seen to drift onto the wrong side of the road and collide with the front of a maxi taxi travelling northbound. As a result of the collision, Ms Capps sustained serious injury and was pronounced deceased at the GCH at 7:00pm that evening.

Post Mortem findings

15. On 22 July 2013, an external and full internal post-mortem examination was conducted by pathologist, Dr Dianne Little. A number of toxicology tests, as well as a full body CT scan, were also carried out. The external and internal examination revealed multiple injuries, the combined effect of which directly caused Ms Capps' death. These injuries included, a chest injury with multiple fractured ribs on both side causing laceration and contusion of the left lung and haemorrhage and escape of air into the left chest cavity, tear of the aorta in the chest, abdominal injury with laceration and bruising of the spleen, and fractures of the femurs and right wrist.

16. The internal post-mortem examination also revealed that Ms Capps was suffering from severe degenerative narrowing of the coronary arteries, which would likely have decreased her body's ability to cope with the effects of the injuries and would have contributed to her death. The heart was also enlarged with fine scarring.

17. Dr Little noted that it may have been Ms Capps' heart disease, which may have caused her to veer to the wrong side of the road, as both atherosclerotic heart disease and hypertensive heart disease can result in arrhythmias, which can cause a loss of consciousness for brief periods.

18. Toxicological testing revealed low levels of the sedative drug, Nitrazepam and the analgesic drug, paracetamol. Morphine and fentanyl were also detected, having been administered as part of the medical treatment provided by the GCH prior to her death.

19. Dr Little is of the view that Ms Capps' death was caused by multiple injuries sustained as a result of a motor vehicle collision. Her coronary artery atherosclerosis was also listed as a significant condition.

Forensic Crash Unit investigation

20. A full investigation was subsequently conducted into the circumstances of Ms Capps' death by Senior Constable Jenny Lowe and Senior Constable Steve Paris of the Forensic Crash Unit (FCU), Coomera. On 15 September 2014, an extensive and comprehensive report detailing FCU's findings, as well as a number of possible future recommendations, was submitted. Senior Constable Paris was called to give evidence during the inquest.

21. The following is a summary of the relevant portions of the FCU report:-

Location of the collision & condition of the roadway

22. The collision occurred in the northbound lane of Mudgeeraba Road, Mudgeeraba, on the crest of a hill. This section of Mudgeeraba Road is a two lane undivided carriageway allowing traffic to travel north and south, separated by double white continuous painted lines. On the northbound side of the road, the road is further separated into three lanes.

23. The northbound side of the road is separated into three lanes. From west to east, the first lane is separated by white painted chevrons for buses to attend the bus stop without disrupting the flow of traffic. The second lane is to allow through traffic to pass vehicles turning right into Scullin Street via the third lane. The three lanes then all merge together further north to form one lane. The northbound and southbound lanes are separated by double white painted lines, with a break for traffic to legally turn in and out of Scullin Street. This is also a slight left hand bend upon approaching the intersection southbound.

24. At 11:20am on 18 July 2013, SC Lowe attended the scene with Senior Constable Paris. Upon arrival, very fine rain was falling, which fortunately didn't last long. At the time of the incident it had not been raining although it was overcast.

25. The roadway was noted to be sealed bitumen in good condition. There were no obstructions or debris on the roadway that would have contributed to the incident.

26. Investigators observed a white maxi taxi in the northbound lane, facing in a northerly direction. A white Holden Commodore (Ms Capps' vehicle) was facing west, at a right angle to the Toyota maxi taxi. The front of the vehicles had impacted and there was significant damage to Holden Commodore and the front of the taxi.

27. No tyre friction marks were located in relation to the incident, suggesting that there had not been any heavy or emergent braking from either vehicle for any distance. In the northbound lane near the driver's side of the maxi taxi, investigators located road scarring in the form of gouge marks and scratch marks. These markings indicated the area where the front underneath of the Holden Commodore had impacted the ground following impact with the taxi. A number of items were located on the roadway behind the Holden Commodore, which had been dislodged from the boot after impact. There was also debris at the front of both vehicles and glass pieces on the roadway.

Holden Commodore

28. Ms Capps' white Holden Commodore sustained contact damage to the front driver's side of the vehicle after coming into direct contact with the front driver's side of the maxi taxi. The number plate of the maxi taxi had imprinted to the front driver's side of the Commodore. The Commodore's number plate had also made an imprint on the front bumper of the taxi.

29. From the impact, there was induced damage down the driver side of the Commodore. The 'B' pillar had been bent down and inwards, and the frame around the driver's side was also bent. Prior to the FCU investigators arriving on the scene, the driver's side door had been removed by the Queensland Fire Service to access Ms Capps. There was also some induced damage on the

rear driver's side panel causing it to bend, which had allowed the boot to spring open. The panel around the front passenger side also sustained some induced damage stopping the front passenger door from closing. Very little damage was observed to the rear and passenger side of the vehicle, aside from minor induced damage from the collision impact. The windscreen had sustained mostly induced damage, and there was a strike on the inside front passenger side from a walking aid on the front seat.

30. In the interior of the Commodore, the driver's airbag had been deployed on impact. The front dashboard was pushed forward toward the driver. Two cushions were located on the front driver's seat. It appears that Ms Capps was wearing her seatbelt at the time of the crash.

Maxi Taxi

31. The white Toyota maxi taxi sustained contact damage to the front driver's side of the vehicle, including the driver's side door. It appears that as the Holden Commodore came into contact with the maxi taxi, it has jammed into the front driver's side guard and then rotated anticlockwise. The taxi subsequently sustained induced damage to the passenger side front door and the windscreen. There was no other damage to the outside of the vehicle.

32. In the front interior of the maxi taxi both air bags had been deployed. The taxi had been carrying two passengers, who were seated in the single seat near the rear sliding door and the other across the aisle. The passenger in the single seat was not wearing a seat belt at the time of the collision.

Mechanical inspections

33**.** On 23 July 2013, both vehicles involved in the collision were inspected by Mervyn Ritchie, an authorised Vehicle Inspection Officer for the Queensland Police Service. Following an examination of the Holden Commodore, Mr Ritchie observed extensive damage to the front right hand side of the vehicle. He was of the view that the vehicle was in satisfactory mechanical condition prior to the collision. As such, there were no mechanical defects evident, which could have contributed to the cause of the incident. The maxi taxi was also found to be in satisfactory condition, with no mechanical defects, which could have contributed or caused the collision.

Investigation conclusions

34. The FCU investigations revealed that, although Ms Capps was mentally sound, she was clearly very physically frail. It was the general opinion of family and friends that she should not have been driving due to her physical health. Nonetheless, she was provided with a medical certificate suggesting that she was fit to drive by Dr Purtle two weeks before her death.

35. Based upon the FCU investigation, the evidence of her friends, who were motivated entirely by concern for Ms Capp's safety and the safety of other road users and the evidence of medical practitioners, there is grave doubt as to Ms Capps' ability to drive a motor vehicle safely at the time she had her licence renewed. At the time of renewal, there were no conditions placed on Ms Capps' licence as per Table 3, Licence Conditions and the *Assessing Fitness to Drive Manual recommended by Austroads and the National Transport Commission.* Conditions related to Ms Capps would have been age-associated deteriorations, such as:

(a) Driving during off-peak only;
(b) Drive within a 20km radius of place of residence;
(c) Drive in daylight hours only; and
(d) No freeway driving.

36. Considering Ms Capps' propensity to fall asleep and her frail physical condition, SC Lowe was of the view that such conditions should have been added to her licence. She states that the assessment previously conducted of Ms Capps' in April 2012 by the occupational therapist should have been taken into account when Dr Purtle determined that Ms Capps was fit to drive.

Recommendations

37. As a result of the FCU investigation, SC Lowe recommended that the Medical Certificate for drivers over 75 years of age be amended to require that doctors test a person's movement, which should include:

(i) moving feet from brake to accelerator;
(ii) able to move the head to look left, right and over both shoulders; and
(iii) reaction times, particularly the ability to make the right choice when there is an emergent situation.

Medical history

38. From November 2005 until April 2012, Ms Capps attended the Health Choice Medical Centre where she consulted with Dr Sachin Gupta and Dr Charulata insomnia, osteoarthritis, peptic ulcer disease as well as other general, intermittent ailments. Shah. She sought regular treatment for a number of conditions including, Type II diabetes, restless leg syndrome, hypertension, high blood pressure, chronic lower back pain due to a degenerative condition, osteoarthritis, recurrent falls, sleep apnoea and peptic ulcer disease.

39. In September 2010, Ms Capps underwent a Continuous Positive Airway Pressure (CPAP) trial in response to a sleep study showing she had moderate to severe Obstructive Sleep Apnoea.

40. Medical records from the GCH confirm that Ms Capps was admitted on 12 November 2011 following a fall, which caused her to injure her right ankle. The records note that she had a history of increasing falls and decreased mobility over the previous 12 months. Ms Capps was also diagnosed with an iron deficiency, anaemia and a Vitamin B12 deficiency. She was released on 16 November 2011.

41. On 29 November 2011, Ms Capps was again admitted to the GCH following two falls, which caused her to suffer right hip, right ankle and lower back pain. Ms Capps stated that she had fallen in the kitchen and then on another occasion later in the day. She was unsure why or how she had fallen. It was noted that her falls appeared to be secondary to her poor mobility. She was assessed as having a high fall risk having suffered six falls in 12 months. During the admission, it was suggested to Ms Capps by Medical Consultant, Dr Das that she should not drive due to her unsteadiness. It was further suggested that she undergo a fitness driver assessment by her general practitioner. Ms Capps was subsequently reviewed by occupational therapy officers and the social work department. She was discharged from hospital on 23 December 2011.

42. In Ms Capps discharge summary, the following relevant recommendation was made to her General Practitioner: - Driving restrictions*: Due to Ms Capps'*

unsteadiness, Dr Das advised her not to drive at present. Dr Wicks (rehabilitation ward) also instructed Ms Capps not to drive until she had been assessed by her GP. It was requested that the GP perform a fitness to drive assessment.

43. A social work psychological assessment completed during this admission, indicates that Ms Capps had been suffering from repeated falls prior to her admission to hospital. She was reportedly suffering from long standing pain management issues. Whilst she was motivated to regain an earlier level of function and independence so as to enable a return to independent living and driving, it was noted that she continued to be a high risk of falls, and there was concern she would become socially isolated if she could not resume driving.

44. In February 2012, Ms Capps was reviewed by Dr James Fink in the outpatient department of the Robina Hospital. He noted that there was general agreement by the rehabilitation team, medical consultants and her general practitioner that she was 'at risk' for driving due to her physical poor mobility and slow reactions. It was suggested that she should undergo a driving test in order to determine her fitness to drive. He mentions in a letter written to Dr Gupta, that Ms Capps had been contacted by DTMR and was to have an interview with them in the coming weeks. He stated that, *'*I told her that I would ask whether they would consider a driving test to determine her fitness to drive and reiterated that I would not grant her driving privileges without their testing – I am concerned that while she is mentally sharp, her physical mobility and reactions are slow'.

45. Dr Fink was called to give evidence during the inquest. He described Ms Capps' as being *'*extraordinarily slow in her movements' and reiterated his view that, whilst mentally capable, Ms Capps was at risk for driving due to her poor physical mobility and slow reactions. Specifically, he stated *'…*basically, that she'd had two falls that led to inpatient stays – that – that there was any – period of rehabilitations which did not improve her mobility. And although I don't recall a lot of the details of all these admissions, I recall Mrs Capps, from the outpatient clinic reviews and having a lot of these discussions, that I believe her mentally capable. And she was clearly wanting to drive, but continued to tell her that I did not believe that she was physically capable and that she was – that it was probably dangerous.'

46. On 23 February 2012, Ms Capps' attended upon Dr Shah to discuss her recent licence cancellation by DTMR and to request a medical certificate attesting to her fitness to drive. Dr Shah refused Ms Capps' request and advised her that she would need to undertake a driving test before a certificate could be issued.

47. Ms Capps attended upon Dr Shah again on 29 February 2012 in relation to her licence cancellation. On this occasion, Dr Shah noted that: *'*Mrs Capps had difficulty walking and getting in and out of the car. A bit unsteady on her feet-uses walking stick. O/E has slightly delayed response time. Slow movements.'

48. At the inquest, Dr Shah stated that she had concerns as to Ms Capps' ability to drive a car safely, particularly her slow response time. Accordingly, she refused Ms Capps' further request for a medical certificate stating she was fit to drive.

49. On 8 March 2012, Dr Fink wrote a further letter to Dr Shah, which noted that Ms Capps had been deemed unfit to drive by a number of consultants, which she had found disappointing, frustrating and inconvenient. She had been advised by DTMR that she had 30 days to turn her licence in. She returned to

see Dr Fink today to 'see what else could be done – there are no new medical issues!' He provided Ms Capps with some information about options for an OT driving assessment in the community, which she could follow up privately. Dr Fink noted that he had continually told Ms Capps that whilst she may be mentally capable, she is physically slow and unsteady, and as such, her motor skills will be a key feature of this assessment.

50. On 15 March 2012, optometrist, Dr Alan Ming, conducted an eye assessment of Ms Capps for the purpose of determining her fitness to drive. He subsequently wrote to Dr Shah requesting that she assess Ms Capps' blood sugar levels as she 'was extremely tired and was falling asleep and losing concentration during her examination at 9:00am.'

51. On 23 March 2012, Ms Capps attended upon Dr Shah and obtained a referral for a private occupational driving assessment. The findings of the assessment undertaken by Ms Michelle Palmada on 30 March 2012 were that 'That the on-road assessment today demonstrated that Mrs Capps' conditions did appear to impact on her ability to drive safely. As a driver with many years' experience, Mrs Capps was unable to demonstrate overall safety and competence in driving areas observed due to multiple vehicle positioning, steering and speed modulation difficulties and errors noted. It would therefore appear appropriate for Mrs Capps to discontinue driving with the following recommendations: 1. That Mrs Capps surrenders her car licence.'

52. On 18 April 2012, Ms Capps attended upon Dr Shah to discuss the findings of the occupational driving assessment. During the inquest, Dr Shah confirmed that she agreed with Ms Palmada's findings, which accorded with her clinical assessment of Ms Capps. As such, she refused to sign the necessary medical certificate. When discussing the findings of the occupational driving assessment, Ms Capps was said to have been unhappy with the outcome. Other avenues of transportation available to Ms Capps' were also discussed. Following this consultation, Ms Capps' ceased attending the Health Choice Medical Centre.

53. When asked about the nature of Ms Capps' medical condition as of April 2012, Dr Shah stated that it was unlikely her condition would improve given her age, then 74 years.

54. On 10 November 2012, Ms Capps was admitted to the GCH for treatment of her longstanding back ache, which was diagnosed to be due to multi-level disc disease and degenerative spondylolisthesis. Ms Capps did not have her driver's licence at this time.

55. On 26 November 2012, Ms Capps commenced attending Dr Brian Purtle at the Mudgeeraba Medical Centre (the Centre). Between November 2012 and 1 July 2013, Ms Capps attended appointments at the Centre on around 20 occasions, only three of which weren't with Dr Purtle.

56. On 4 December 2012, Ms Capps presented to the Robina Hospital Emergency Department following a fall resulting in laceration and haematomas above her right eye.

57. On 28 December 2012, Ms Capps saw Dr Andrew Haynes at the Centre. He ordered a lumbar spine x-ray, as well as further tests in January 2013, which revealed that she was suffering from a mild crush fracture, osteopenia in the

femoral neck and age deterioration of the spine. Analgesics, including MS Contin and Endone, were regularly prescribed by Dr Purtle to treat pain associated with this condition during the course of various consultations in February, March, April, May and June.

58. Between 10 and 11 January 2013, Ms Capps was admitted to the Medical Assessment Unit at the Robina Hospital with lower back pain.

59. On 18 April 2013, Ms Capps attended a different medical practice and saw Dr Sanjeev Kumar. She requested that Dr Kumar sign a Medical Certificate for Motor Vehicle Driver, however, this was refused and she was referred back to her regular general practitioner.

60. On 1 July 2013, Ms Capps attended upon Dr Purtle for the purpose of obtaining a Medical Fitness to Drive Certificate, which was granted. Notes from this consultation simply state, 'ok still loose stools, rest ok, note tests off Avandia, wants D License, acuity 6/7.5, Blood pressure: 120/80mmHg, hs n.*'* The signed Medical Certificate indicated that further review was required in 12 months' time, with the only necessary condition being *'*requires glasses'.

Assessing fitness to drive guidelines

61. The Assessing Fitness to Drive Guidelines (the Guidelines) for commercial and private vehicle drivers is a publication for health professionals in Australia designed to assist them to assess the fitness of their patients to drive in a 'consistent and appropriate manner, based on current medical evidence'. The Guidelines allow medical practitioners to establish the relevance of certain medical conditions and the impact these conditions have on a person's ability to drive. They also serve to assist driver licensing authorities in making licensing decisions.

62. Relevantly, the Guidelines provide steps involved in assessing a person's fitness to drive, including specific considerations for the assessment of people with multiple medical conditions or age-related change.

63. Part A, s. 4 of the Guidelines outlines general considerations for assessing fitness to drive, particularly the fundamental need for medical practitioners to consider the requirements associated with performing the task of driving. Section 4.2 lists a number of medical conditions likely to affect a person's fitness to drive, which includes diabetes, musculoskeletal conditions and sleep disorders. Section 4.5, titled, *'Multiple Conditions and Age-related Change'*, specifically addresses the additive or compounding detrimental effect multiple conditions or a condition that affects multiple body systems may have on a patient's ability to drive safely. It states that when assessing these types of patients, a medical practitioner needs to undertake the following general approach:
    - Consider the driving task and how various impairments, disabilities and general fitness levels may impact on the functions required to complete driving related tasks.
    - Consider a patient's general functionality, such as domestic and occupational requirements.
    - Conduct a clinical assessment, which focuses on a patient's sensory, motor function and cognitive ability.

64. This section also stipulates that, '…it is insufficient simply to apply the medical standards contained in this publication for each condition separately, as a driver may have several minor impairments that alone may not affect driving but when taken together may make risks associated with driving unacceptable'. As such, a medical practitioner is required to integrate all of the clinical information about the patient, and consider the compounding effect on a patient's overall capacity to drive a vehicle. Specific considerations should also be given as to the need to impose conditions on a patient's licence when one or more medical conditions are progressive.

65. Part A, s. 5.2 of the Guidelines outlines the steps to be followed in the assessment and reporting process. Specifically, the section stipulates the following:
    - Step 1: consider the type of licence held by the patient or being applied for.
    - Step 2: establish relevant medical and driving history of the patient, which includes whether the person has been found unfit to drive a motor vehicle in the past and the reasons, whether there is a history of conditions of impaired consciousness, such as sleep apnoea and the degree of insight the patient has into their ability to drive safely.
    - Step 3: undertake a clinical examination, which includes assessing the functionality of various body systems, focusing on determining the risk of a patient's involvement in a serious motor crash caused by inability to control the vehicle of inability to act and react appropriately to the driving environment.
    - Step 4: consider the clinical examination results in conjunction with the patient's medical history, driving history and driving needs.
    - Step 5: Inform and advise the patient about how their condition may impair their ability to drive safely.
    - Step 6: report to the driver licensing authority as appropriate.
    - Step 7: Maintain appropriate records of the assessment and findings.
    - Step 8: Follow-up with the patient.

66. Part B of the Guidelines provides details as to the Medical Standards related to specific medical conditions. Part B, s. 8 concerns sleep disorders, including sleep apnoea (s. 8.2), and notes that 'excessive daytime sleepiness, which manifests itself as a tendency to doze at inappropriate times when intending to stay awake, can arise from many causes and is associated with an increased risk of motor vehicle crashes.' Section 8.2.2 of the provision, titled, 'identifying and managing people at high crash risk', states that a person with a sleep disorder should avoid or limit driving 'until the disorder is investigated, treated effectively and licence status determined'.

Clinical Forensic Medical Unit Report

67. Forensic Medical Officer, Dr Ian Home was requested to conduct a review of Ms Capps' medical history and the circumstances of her death. Specifically, Dr Home was asked to provide advice as to her fitness to hold a driver's licence

and the sufficiency of assessment undertaken by Dr Brian Purtle. A final report was provided on 29 April 2016.

68. Having considered the relevant material, including Ms Capps' medical records, Dr Home found the following: *The skills required to safely control a motor vehicle include adequate perception of the external environment, well-coordinated physical movements, attention, concentration, judgment information processing and rapid and appropriate responses to external stimuli. A number of issues that would have impacted upon Ms Capps' ability to safely control a motor vehicle were identified. She had a history of decreased mobility, impaired reaction times, chronic lower back pain, obstructive sleep apnoea, poor quality sleep, a dependence on benzodiazepines, reports of a depressed mood and recent opiate analgesic use.*

69. According to the Assessing Fitness to Drive Guidelines, poor quality sleep and daytime drowsiness associated with untreated obstructive sleep apnoea increases the risk of traffic collisions 2 to 7 times. He notes that, *of particular concern, her friends observed Ms Capps fall asleep 'at any time' including whilst drinking tea at a café.*

70. Dr Purtle's notes from his consultation with Ms Capps on 1 July 2013, do not indicate what tests were performed in regards to Ms Capps' driving fitness. As such, Dr Home was unable to provide comment on her physical condition at the time. Based upon the findings of the Occupational Driving Assessment, Dr Home is of the view that Ms Capps was not fit to hold a driver's licence, particularly as she did not undergo a further on-road driving assessment, which would have required her 'to demonstrate significant improvement in her ability to safely control a motor vehicle'. He notes that it was, tragically, Ms Capps' inability to stay within her lane of travel that resulted in her death and the injury of passengers in the other vehicle.

71. Dr Home gave evidence during the inquest. When asked about the affect Ms Capps' multi-medical conditions may have had on her ability to drive, and whether any of the conditions were progressive, Dr Home stated that a number of her ailments were long-term conditions. He further noted that back conditions are usually progressive, and would interfere with a person's mobility. Sleep apnoea was also likely to be a persistent condition.

72. In accordance with the Guideline requirements, Dr Home reiterated the importance of a medical practitioner considering the cumulative effect a person's medical conditions may have on their ability to drive a car safely. In order to conduct such an assessment effectively, Dr Home agreed that a medical practitioner would need to have a very good understanding and knowledge of a person's medical history. He also agreed that it would be 'fundamental' for a medical practitioner assessing a person's fitness to drive, to have an understanding of the reasons a licence was initially withdrawn.

73. In relation to Ms Capps, there is no evidence to suggest that Dr Purtle sourced, or made any attempt to source, her previous medical records from Health Choice Medical Centre. When asked if this would be of concern, Dr Home stated that,
…the big issue is certain conditions are difficult to detect – for example, sleep apnoea. If the patient hasn't told you they've got sleep apnoea and you haven't seen any documentation that they've got sleep apnoea and they don't appear to be drowsy when you see them, then that would be difficult to detect during

the examination. It's fairly common for most practices, if you were changing doctors, to seek a release of information from that other practice so you can get an idea of what has transpired previously.'

74. Dr Home was of the view that had the assessments Dr Purtle claims he carried out in relation to Ms Capps, as outlined in his statement dated 11 July 2016, then these tests would be reasonable in the circumstances. He did note, however, that there are no contemporaneous notes to corroborate that these assessments were actually undertaken. Dr Home confirmed his view that, having considered Ms Capps' medical records, she was not fit to hold a driver's licence. He was firmly of the view that Ms Capps should have been required to undertake a further Occupational Therapy Driving Assessment before a decision was made as to her fitness to drive.

Evidence provided by Dr Brian Purtle

75. During the course of the coronial investigation, Dr Purtle provided three statements, dated 29 July 2013, 1 February 2016 and 11 July 2016. He was also called to give evidence during the inquest. Dr Purtle is a registered Medical Practitioner, who has been in general practice for nearly 50 years. He currently works full-time at the Mudgeeraba Medical Centre, Mudgeeraba, Queensland.

76. Prior to 2005, Ms Capps attended the Centre as a patient where she engaged with Dr Andrew Haynes. On the odd occasion, she would consult with Dr Purtle when Dr Haynes was not available. As Ms Capps ceased attending the Centre in 2005, her previous medical records were unavailable at the time she recommenced as a patient in November 2012. Ms Capps' first consultation with Dr Purtle was on 26 November 2012. He continued to treat her for the next seven months, up until two weeks before her death on 18 July 2013. Ms Capps attended the Centre approximately 20 times during this period, and was treated by Dr Purtle on all but three of these occasions.

77. Despite not having consulted with Ms Capps in any capacity for some 7 years, Dr Purtle made no attempt to source her recent medical records from the Health Choice Medical Centre or local hospitals during his treatment of Ms Capps. Dr Purtle acknowledged that the only information he had of Ms Capps' previous medical history, was from his recollection and Ms Capps self-reporting. His practice was to take a 'very good history' during any initial consultation with a new patient, and then only request past records if he felt it was required. In Ms Capps' case, Dr Purtle did not believe it was necessary to obtain any further medical records.

78. In his most recent statement, which had been sworn two weeks before the inquest, and prepared after consultation with his legal representatives, Dr Purtle stated that the main health conditions he had treated Ms Capps for diabetes, insomnia, chronic lower back pain, anaemia, restless leg syndrome, skin lesions, high cholesterol, chronic diarrhoea and constipation.

79. Although Dr Purtle's records of his consultations with Ms Capps were quite scant, something he claims to regret, further, more comprehensive details were provided in his most recent statement. This was so despite the passing of time and scant notes of consultations. During the inquest, however, Dr Purtle was largely unable to recall details of Ms Capps' medical history and his treatment of her. He could not recall what Ms Capps had told him about her medical history during their initial consultation, nor how she had presented physically at that time. He did state, however, that Ms Capps, 'never appeared frail to me'.

Despite the information provided in his recent statement, he was unable to recall why he had prescribed Ms Capps sleeping tablets, whether he had been aware that she suffered from sleep apnoea, nor if she had mentioned her recent history of recurrent falls.

80. When questioned about the treatment of Ms Capps' chronic back pain and the details provided in his recent statement, Dr Purtle was unable to recall any particulars as to the examinations conducted or information available to him. He conceded that her condition must have been 'significant' as he had prescribed her opiate pain relief. When asked about whether he had considered any further intervention measures to treat Ms Capps' chronic back pain, rather than simply administering pain relief, Dr Purtle stated that he had encouraged Ms Capps to be 'proactive and start doing some physicality rather than sitting around taking pain killers'.

81. Following a lumbar spine x-ray ordered by Dr Haynes in December 2012, it was found that Ms Capps was suffering from a mild crush fracture, osteopenia in the femoral neck and age deterioration of the spine. As a result, Dr Purtle's records suggest that he had prescribed her various analgesics, including Endone and MS Contin, to try and effectively manage her pain. This continued during consultations in March, April, May and June 2013.

82. During Dr Purtle's final consultation with Ms Capps on 1 July 2013, she is said to have advised him that she no longer required pain relief medication for her back condition. When asked during the inquest about whether it was possible for a significant degenerative back condition, like that suffered by Ms Capps, to resolve to such an extent that no pain relief was required, particularly where there had been no further intervention attempted to address the issue, Dr Purtle stated that these conditions can improve where other physical things, such as exercise, are undertaken. He further claimed that Ms Capps' mobility had improved 'significantly' in the three months prior to her death.

Fitness to drive assessment

83. As of July 2013, Dr Purtle states that he had conducted numerous fitness to drive assessments. Specifically, in the 10 years prior, he claims to have carried out around 1500 assessments. As such, he claims to be very familiar with the Guidelines for Medical Practitioners in assessing someone's fitness to drive.

84. Dr Purtle states that Ms Capps made a number of requests for a medical certificate attesting to her fitness to drive, the first during their initial consultation on 26 November 2012. On this occasion, Dr Purtle refused the request on the basis that he didn't have 'sufficient information to be performing the assessment'. When asked what he meant by this statement, Dr Purtle stated that he had only seen her on one occasion, and felt that he needed to get a more comprehensive view of Ms Capps as a patient through his own 'clinical skills'.

85. In relation to the reasons for Ms Capps' licence cancellation, Dr Purtle stated that he was aware Ms Capps had lost her licence whilst in hospital some 15 months prior. Specifically he states, 'I am particularly aware of the case and had refused a request for a driver's licence on at least a couple of occasions in the past.' Although Dr Purtle could remember making that statement, he was unable to recall what his understanding was as to the reasons why Ms Capps had lost her licence. He also never obtained a copy of the correspondence sent

to Ms Capps from DTMR cancelling her licence. He also never asked Ms Capps if she had undergone an Occupational Therapy Driving Assessment.

86. On 1 July 2013, Dr Purtle signed a Medical Certificate for Motor Vehicle Driver (Form 3712) for Ms Capps after he assessed her as fit to drive. He claims that she was no longer taking opiate medication, her balance was apparently good, and she was said to be dancing twice a week. Dr Purtle further claims that he asked Ms Capps to perform a 'hand and feet tapping and rotation, finger pointing, lifting and moving lower limbs'. He also asked her to perform a well-coordinated 'dance step' (Waltz step) during the consultation. As a result of his assessment, he concluded that Ms Capps should be issued with an unconditional licence to be reviewed on an annual basis. He completed and signed the Form 3712, where he incorrectly stated that he had been treating Ms Capps' for two years, even though it had only been eight months.

87. When asked further about this assessment during the inquest, Dr Purtle claimed that he recalled Ms Capps hopping out of her chair quite quickly before performing a Waltz step without the assistance of a walker or a walking stick. When his recollection and account of Ms Capps mobility as allegedly demonstrated on 1 July 2013 was challenged, Dr Purtle asserted that, 'I witnessed it and I'm sure she made that significant improvement in those three months under my care'.

88. When asked during the inquest as to what information he had in July 2013, which enabled him to effectively assess Ms Capps' fitness to drive, that he did not have in November 2012, Dr Purtle stated that he had 'noticed a significant improvement in her overall physical health and she'd come off her analgesics'. He disagreed with the proposition that it would have been fundamental to obtain Ms Capps' recent medical history from her previous treating general practitioner and hospital before conducting a fitness to drive assessment, stating that he 'relied upon his own judgment at the time'. Dr Purtle stated that, 'I felt that I'd carried out a perfectly adequate assessment at the time, and that I knew the patient fairly well'. He also asserted that, having now considered Ms Palmada's Occupational Driving Assessment report, her findings as to Ms Capps' physical appearance did not accord with his clinical findings. He claimed that Ms Capps had made a 'significant change for the better' by 1 July 2013. Dr Purtle further stated that had he been made aware of Ms Palmada's report before July 2013 he still would not have thought Ms Capps should undergo a further Occupational Therapy Driving Assessment.

89. When asked about the Guidelines, Dr Purtle was largely unable to recall specific details and requirements of various provisions, despite asserting his 'familiarity' with the various sections. When specific provisions were explored during the inquest, he claimed to be aware of those sections, which included s. 4.2. This section examines a number of identified conditions, which may affect someone's ability to drive, including, diabetes, musculoskeletal conditions and sleep disorders. Dr Purtle acknowledged that Ms Capps suffered, at least to some degree, from all of those conditions, although he was not aware that she had sleep apnoea. Dr Purtle claimed that he had considered the cumulative effect of Ms Capps' medical conditions, as required by the Guidelines, when he determined that she was fit to drive. Furthermore, he did not believe that Ms Capps required any conditions on her licence, despite the requirements of s.3.4 Part A of the Guidelines.

90. When asked during the inquest about his assessment of Ms Capps on 1 July 2013, the following exchange took place:-

- CA: So you didn't have any information, then, about why she'd lost her licence?
- Purtle: I can't recall.
- CA: Okay. Would you agree that to conduct a proper assessment as to whether someone was fit to drive, it would be fundamental to avail yourself of the reasons why their licence had been cancelled previously?
- Purtle: I'm fairly experienced at deciding what medical state a person's in, and I felt at the time that she was perfectly able to – to pass the test.
- CA: And you felt that you then didn't need to know why her licence had been cancelled previously?
- Purtle: Not on the examination that I carried out, no.
- CA: Okay. Dr Purtle, if you'd been aware of Mrs Capps' complete medical history – and I mean her recent GP records, the hospital records and the reason her licence had been cancelled – would you still have issued Mrs Capps with a medical certificate allowing her to drive?
- Purtle: Yes.

Information from the Department Of Transport and Main Roads

Relevant legislative context

91. In order to ensure that all licence holders are medically fit to drive, DTMR have developed various relevant legislation and procedures. *The Transport Operations (Road Use Management – Driver Licensing) Regulation 2010* (the Licensing Regulation) states that:

Section 50 Eligibility if mental or physical incapacity likely to adversely affect ability to drive safely

(1) A person is not eligible for the grant or renewal of a Queensland driver licence if the chief executive reasonably believes the person has a mental or physical incapacity that is likely to adversely affect the person's ability to drive safely

(2) However, the person is eligible for the grant or renewal of a Queensland driver licence if the chief executive reasonably believes that, by stating conditions on the licence, the person's incapacity is not likely to adversely affect the person's ability to drive safely.

(3) For this section, the chief executive may require the person to give the chief executive a certificate, in the approved form, from a stated type of health professional –

a) Stating the person does not have a mental or physical incapacity likely to affect the person's ability to drive safely; or

b) Providing information about the person's mental or physical incapacity that may allow the chief executive to form a belief as mentioned in subsection (2).

Sections 124, 125 and 126 of the Regulation sets out the process for amending, suspending or cancelling a licence:
Section 124 Grounds for amending, suspending or cancelling a licence

Each of the following is a ground for amending, suspending or cancelling a Queensland driver's licence –

(e) The licensee has a mental or physical incapacity that is likely to adversely affect the licensee's ability to drive safely…

Section 125 Procedure for amending, suspending or cancelling licences

(1) If the chief executive considers a ground exists to amend, suspend or cancel a person's Queensland driver licence (the proposed action), the chief executive may give the person a written notice (the show cause notice).

(2) The show cause notice must –

a. State the proposed action; and
b. State the ground for the proposed action; and
c. Outline the facts and circumstances forming the basis for the ground; and
d. If the proposed action is to amend a condition of the licence – state the proposed amendment; and
e. If the proposed action is to suspend the licence – state the proposed suspension period; and
f. Invite the person to show cause, within a stated time of at least 28 days, why the proposed action should not be taken.

(3) The chief executive may, before or after the end of the time stated in the show cause, extend the time within which the person may show cause.

(4) If, after considering any personal or written representatives made within the time stated or allowed, the chief executive still considers a ground exists to take the proposed action, the chief executive may –

…

c. If the proposed action was to cancel the licence –
   i. Cancel the licence; or
   ii. Suspend the licence for a period; or
   iii. Amend the licence having regard to the representations.

(5) The chief executive must give the person written notice of the decision.

(6) If the chief executive decides to amend, suspend or cancel the licence, the notice must state –
   a. The reasons for the decision; and
   b. That the person may either
      i. Apply for a reconsideration of the decision under s. 132; or
      ii Apply to QCAT for a review of the decision under s. 131(1AA) of the Act; and
   c. That the person is also able, under s. 131(1AA) of the Act, to apply to QCAT for a review of the decision on the reconsideration

(7) Other than for a ground mentioned in s. 124(b), the decision takes effect on the later of the following
   a. The day the notice under subsection (5) is given to the person;
   b. A later day stated in the notice under subsection (5)…

Section 126 Immediate amendment or suspension of Queensland driver licence

i. This section applies if-
   a. The chief executive is given information by a licence holder, or about a licence holder by a health professional, whether or not the licence holder or health professional uses an approved form to give the information; and

   b. Because of the information, the chief executive reasonably considers the licence holder may have a permanent or long-term mental or physical incapacity that is likely to adversely affect the licence holder's ability to drive safely; and

   c. The chief executive reasonably considers –
      i. Public safety has been endangered, or is likely to be endangered, because the licence holder's ability to drive safely is likely to be adversely affected; or
      ii. Immediate amendment or suspension of the licence holders of Queensland driver licence is otherwise necessary in the public interest.

ii. The chief executive may, by written notice to the licence holder, immediately amend or suspend the licence holder's Queensland driver licence.

92. DTMR submit that their approach to medical condition reporting is consistent with the roles and responsibilities of driver licensing authorities, as outlined in the Guidelines

93. It is now a requirement that every driver over the age of 75 who holds a Queensland driver licence must carry a current *Medical Certificate for Motor Vehicle Driver* at all times whilst driving. As of 1 January 2014, Medical Certificates are only valid for a maximum of 12 months.

DTMR's involvement with Ms Capps

94. On 23 January 2012, DTMR received a notification from the Queensland Police Service as to concerns about Ms Capps' fitness to drive. On 25 January 2012, in compliance with s. 125 of the *Licensing Regulation*, DTMR initiated the show cause notice process, which was provided to Ms Capps. This notice stated that based upon the information provided by Queensland Police, DTMR were proposing to cancel her licence. She was requested to provide DTMR with a Medical Certificate for Motor Vehicle Driver (Form 3712) to confirm her fitness to drive. As Ms Capps did not take any action in response to this notice, her licence was cancelled on 27 February 2012. DTMR note that the decision to cancel Ms Capps' licence was not based on their assessment, but rather a failure to obtain a medical certificate confirming her fitness to drive.

95. On 11 July 2013, Ms Capps attended the DTMR Burleigh Waters Customer Service Centre and applied for the reissue of her driver licence. She provided a Medical Certificate for Motor Vehicle Driver confirming her fitness to drive. As

clearance had now been provided by a doctor, who claimed to have been treating Ms Capps for over two years, her licence was reissued.

96. In relation to Ms Capps' licence being renewed, DTMR note that whilst they may have information which suggests that a licence holder has a permanent or long-term mental or physical incapacity that is likely to adversely affect their ability to drive a motor vehicle safely, the licence holder has the right to obtain information from a health professional to prove that they are medically fit to drive. In a large number of cases, having a medical condition will not stop a person from driving. The purpose of the Show Cause Notice is to obtain confirmation from a medical professional that the licence holder is medically fit to continue to drive. DTMR note that medical conditions are not static and that in some situations a person's medical condition may improve to such an extent to warrant reconsideration of their licence status. At any time following a cancellation a medical professional is able to assess their patient's fitness to drive and, taking into account non-driving periods for specific medical conditions, individuals are entitled to re-apply for a licence.

97. In relation to Ms Capps, DTMR note that whilst her licence had been cancelled due to no medical certificate being provided in response to the Show Cause Notice, her subsequent licence application was accompanied by the required medical assessment. As such, DTMR relied upon the assessment of Ms Capps' treating doctor to determine her fitness to drive. Her application for her licence was considered with the information previously provided from police. As the report did not contain detailed information on the medical condition that led Ms Capps to receive treatment at the hospital, and given the Medical Certificate for Motor Vehicle Driver was provided with the licence application, the assessment of her fitness to drive was accepted.

98. In relation to the application submitted by Ms Capps, as signed by Dr Purtle, DTMR noted that the length of time a medical practitioner has been assessing a patient/applicant will be relevant when considering an application for a driver licence. In some cases, DTMR will seek further information from the medical practitioner, who has signed the necessary medical certificate (Form 3712). One of the reasons this clarification may be sought is if the medical practitioner has not been treating the patient/applicant for a 'reasonable period of time', or if DTMR has reason to believe that they are not aware of the person's full medical history. The two year timeframe indicated by Dr Purtle in the Form 3712 is generally considered to be a 'reasonable timeframe'.

Implementation of changes by DTMR

99. As a result of the issues examined during the coronial investigation into Ms Capps' death, DTMR have commenced implementing a number of changes to processes and policies in place in relation to medical condition reporting, including:

    I. *Third party notifications:* Where DTMR received written advice about a person's medical fitness to drive from a third party, such as a relative or friend, and DTMR reasonably believes that the person has a medical condition that is likely to affect their ability to drive safely, DTMR will commence show cause action to amend or cancel the person's driver's licence. Previously, it was DTMR's policy that third party notifications were only accepted from police or health professionals.

II. *Incomplete or incorrect Medical Certificate for Motor Vehicle Driver form F3712:* If DTMR determine that a person's medical certificate does not comply with the medical standards in the Guidelines, where appropriate, DTMR will notify the health professional by phone about the non-compliance and seek agreement on a suitable resolution. Previously, DTMR's policy was to refer the patient/applicant back to their health practitioner to have the error rectified.

III. *Reapplying for a driver licence after cancellation on medical grounds or surrender of the licence:* Where DTMR identify that a person's driver's licence has been cancelled on medical grounds, or the person has previously surrendered their licence, and the person reapplies for a licence, DTMR will contact the health practitioner that issues the current medical certificate to discuss the person's circumstances prior to reissuing a driver licence. The health professional will be requested to confirm that they were aware that the person's licence had been previously cancelled or surrendered on medical grounds. Previously, DTMR would only contact a health practitioner if there were identified inconsistencies between the certificates provided with the information in DTMR's database.

IV. *Review of Medical Certificate for Motor Vehicle Driver form F3712*: To ensure it is fit for purpose, DTMR is presently undertaking a holistic review of the medical certificate in consultation with the Queensland section of the Royal Australian College of General Practitioners. In particular, DTMR have proposed that health professionals will be able to more easily identify whether a person's driver's licence has previously been cancelled or surrendered on medical grounds. It is intended that there will be an emphasis on thoroughness of the medical assessment where the health professional is not familiar with the person and/or the person has only been treated at the practice for a short period of time. Additionally, it is also proposed that health practitioners will be provided with more information in the section where they provide DTMR with a recommendation regarding the person's fitness to drive, so that it is clear what the effect will be on the person's driver licence, including conditions/restrictions and medical certificate expiry dates.

100. During the inquest, DTMR representative, Ms Jennifer Kenny confirmed that DTMR also intended to review the Form 3195, titled, 'Private and Commercial Vehicle Driver's Health Assessment'. This non-compulsory form, which is mentioned in the notes of Form 3712, contains two parts and includes a health questionnaire for an applicant seeking a driver's licence and a checklist for a health practitioner when conducting their clinical assessment of the applicant/patient. DTMR were also asked to consider a number of proposed policies relevant to medical condition reporting. Relevantly, DTMR submitted:

A. Amendment to the Medical Certificate for drivers over the age of 75 be amended to require that doctors test a person's movement, which should include (i) moving feet from brake to accelerator; (ii) able to move the head to look left, right and over both shoulders; and (iii) reaction times, particular the ability to make the right choice when there is an emergent situation.

DTMR is of the view that the Guidelines should be referred to by health practitioners when they are determining whether a patient is fit to drive. The Medical Certificate for Motor Vehicle Drivers forms instructs health practitioners to conduct their medical assessment in accordance with the national medical standards. DTMR are of the view that the three additional tests proposed are only three criteria which are relevant, whereas the Guidelines provide a more comprehensive guidance to conducting an assessment. DTMR maintain that if health practitioners conduct their medical assessments in accordance with the Guidelines, which adequately addresses the range of conditions that may present in an older driver, the inclusion of these additional considerations would be redundant.

B. In addition to a Medical Certificate, the requirement that any driver over the age of 75 years who is applying for their licence following a previous cancellation, undergo an occupational driving test particularly focused on reaction times and the ability to respond in an emergent situation.

DTMR's position is that the person's treating health practitioner is best placed to determine whether they require an Occupational Therapy Driving Assessment, or any other specialist opinion/treatment, as they manage the person's overall health. Furthermore, it would be inappropriate in many cases, for a person with certain medical conditions, such as diabetes, to be required to undertake an Occupational Therapy Driving Assessment, as it would not directly assess the effect of that medical condition on a person's ability to drive. As such, DTMR submit that it would be unreasonable to require every person to undertake an Occupational Therapy Driving Assessment simply because they are 75 years or older and have had their driver licence cancelled on medical grounds, as this would be unfair and not a cost effective imposition. Rather, DTMR supports the person's treating health practitioner making a determination as to whether a person should undertake an Occupational Therapy Driving Assessment before making a determination in relation to whether their patient can meet the requirements to hold a driver licence as provided for under the Guidelines.

Further Non-party Submissions

101. During the coronial investigation, the Royal Automobile Club of Queensland (RACQ) and the Royal Australian College of General Practitioners (RACGP) provided further comment in response to the concerns raised about older drivers and medical condition reporting.

102. RACQ note that issues associated with older drivers were studied extensively in 2011 and 2012 by The Older Driver Safety Advisory Committee (the Committee). The Committee was convened by the Queensland Government in July 2011 to provide input into the development of appropriate policies and initiatives to improve older driver safety outcomes in Queensland. The Centre for Accident Research and Road Safety – Queensland (CARRS-Q) were also heavily involved in the research. The findings of the study were outlined in the 'Older Driver Safety Advisory Committee Report' (the Report), which was issued in December 2012.

103. Ultimately, the Committee agreed upon 26 recommendations relating to various older driver associated issues, including the age at which older driver requirements (including medical certificates) are imposed, frequency of driver licence renewal, on-road testing for selected drivers and encouraging family involvement. DTMR confirmed that a majority of the recommendations detailed in this report have been implemented.

104. RACQ state that they were 'disappointed that the Committee's report did not recommend compulsory reporting by medical practitioners of medical conditions, which impacted a person's ability to drive safely'. They submit that age should not be a consideration in this issue, but rather the type of impairment and the ability to control a motor vehicle. Furthermore, they suggest that medical practitioners should be required to report failed medical certificate assessments to DTMR, RACQ do not support mandatory driver testing for motorists over the age of 75 years.

DTMR's response to RACQ suggestions

105. DTMR are strongly opposed to the suggestion of compulsory reporting, following consultation with the Australian Medical Association and the Royal Australian College of General Practitioners. In particular, concerns were raised as to whether a person who was dependent on their licence for their livelihood and/or mobility would honestly divulge the true extent of their condition, or even seek treatment for a condition, if they were aware that their health practitioner was required to notify DTMR As such, there are concerns that mandatory reporting could compromise the doctor-patient relationship or result in patients continuing to drive without seeking appropriate medical treatment or having a medical condition appropriately managed. This may then result in serious adverse road safety outcomes, which would be contrary to the objective.

106. DTMR's position is to encourage health practitioners to notify DTMR about a person's long term or permanent medical condition if they believe that the person will not notify DTMR, the patient will not comply with the recommended medical treatment, or they pose a risk to public safety.

107. RACGP provided a number of comments in relation to the licensing requirements in place for drivers over the age of 75 years, including:

- RACGP strongly recommend that their members use the Private and Commercial Vehicle Driver's Health Assessment (Form 3195), or alternatively keep their own medical examination records to at least a similar standard.

- RACGP are of the view that the best doctor to perform the medical assessment of the fitness to drive is the applicant's usual General Practitioner, who should be in the best position to know the driver applicant's medical history.

- Form 3712 already provides a question to the driver applicant requiring a signed answer to a question as to whether they have had a show cause notice issued against them. It is noted that 'this should be a warning to an examining doctor to make enquiries to the driver applicant as to the reason, and also enquiries to DTMR if necessary, and in particular to take extra diligence in their examination'.

- RACGP does not support the introduction of 'mandatory reporting', as adopted in South Australia. They submit that the responsibility to notify DTMR of a medical condition likely to affect the driving task should remain with the driver applicant, as is presently the case. They note that there is a strong possibility that some drivers, being aware of a legal requirement for a doctor to report a potentially serious medical condition, might then avoid going to a doctor, and continue to drive without a current medical certificate, or even a current licence.

- RACGP strongly endorses the desirability of conducting an on-road driving assessment, where logistically possible, wherever a doubt exists in the clinical judgment of the examining doctor, as to the fitness of the patient/applicant.

- RACGP has no objection to a suggestion that any driver applicant aged 75 years and over, applying for their licence following a previous cancellation on medical grounds, undergo an on-road driving test by an experienced Occupational Therapist.

108. In direct response to the recommendations made by the FCU investigators, RACGP submitted the following:

    - The existing Form 3195 already makes provision for examination of cervical spine rotation at Part A s. 4.1, and lower limb joint movements, which should cover the issue of foot movement ability from a brake to an accelerator, at s. 4.4 (b). RACGP are of the view that the F3195 form is currently adequate to cover the suggestion of the FCU investigators in relation to the musculoskeletal issues, after which the assessment outcome depends on the thoroughness and clinical judgement of the examining doctor.

    - In addition, F3195 tests reflexes at s. 4.5 and balance at s. 4.6, which are internationally standardized tests, easy to complete in a comprehensive medical examination, and remain valuable.

    - The measurement of reaction times is a more difficult issue within a doctor's office-based medical examination. At present, there are no relatively simple, standardized or verifiable measures of reaction times, suitable for inclusion in the medical assessment of driving fitness. Significantly, it is highlighted that the measurement of reaction times has not been suggested, or been made mandatory by the Guidelines. There is no guidance on how to specifically measure reaction times in the Guidelines, which is presumably due to the standardisation and verification issues associated with such a task. Reaction times are situation specific, and affected by many variables, and are 'probably best considered (and assessed as far as is possible) in the context of an on-road driving assessment'.

    - RACGP respectively submit that in order for reaction times to be examined by medical practitioners in an office setting, there would need to be standardized, relatively simple and verifiable testing methods, which are presently not available.

109. RACGP submit that the present Form 3712 and Form 3195, currently required and recommended for use by DTMR, are adequate for the certification and medical assessment examination of a person's fitness to drive, and should preferably be undertaken by the applicant's treating doctor.

Analysis of the Coronial Issues

The findings required by s. 45 of the Coroners Act 2003

110. In accordance with section 45 of the *Coroners Act 2003* (the Act), a Coroner who is investigating a suspected death must, if possible, make certain findings.

111. On the basis of the evidence presented at the inquest, I make the following findings:

    a. The identity of the deceased person is Ruth Capps;
    b. Ms Capps died following a head-on motor vehicle collision on Mudgeeraba Road, Mudgeeraba;
    c. The date of Ms Capps' death was 18 July 2013;
    d. The place of Ms Capps' death was the Gold Coast Hospital; and
    e. The cause of Ms Capps' death was multiple injuries due to, or as a consequence of, motor vehicle collision.

112. It is clear from the evidence obtained by the FCU investigators during the course of the coronial investigation and the inquest that Ms Capps, whilst driving home to Mudgeeraba at around 10:00am, drifted onto the wrong side of Mudgeeraba Road, and collided with the front of a maxi taxi travelling northbound. There were no tyre friction marks found on the roadway, which suggests that Ms Capps had not attempted to heavily brake prior to the collision. There was no roadway or weather conditions, which contributed to the collision, and both vehicles were mechanically sound.

Was Ruth Capps fit to hold a Queensland driver's licence?

113. Considering Ms Capps' recent medical history in its entirety, as well as the evidence of Dr Shah, Dr Fink and Dr Home during the inquest, I find that Ruth Capps was not fit to hold a Queensland driver's licence. She was frail, had limited mobility, suffered from a number of significant medical conditions, some of which were degenerative, and had recently undertaken an Occupational Therapy Driving Assessment, which had deemed her unfit to drive. Notably, Ms Capps had experienced a number of significant falls, which required hospitalization in recent times, and caused consultants and members of the rehabilitation team at the treating hospital, to conclude that Ms Capps did not have the ability to drive a vehicle safely.

114. Evidence from friends of Ms Capps, who saw her regularly and provided her with care and assistance in her everyday living, also confirmed her frailty, high fall risk and worsening medical condition. They consistently expressed concern as to Ms Capps' ability to drive safely, which was eventually reported to the Queensland Police Service, and caused DTMR to cancel Ms Capps' licence.

115. Despite Ms Capps' licence cancellation, it appears that she was determined to get her independence back by having her licence reinstated.

116. Dr Purtle commenced treating Ms Capps in November 2012, and signed a Medical Certificate for Motor Vehicle Driver in July 2013. During this eight month period, Dr Purtle did not obtain any corroborating information as to Ms Capps' recent medical history. By his own account, he relied solely upon his own recollection of Ms Capps' medical history from when she had previously been a patient of Dr Haynes (some seven years beforehand), as well as Ms Capps' self-reporting. Given Dr Purtle's consistent inability to recall information during the course of the inquest, it seems unlikely that his recollection of Ms Capps' medical history would have been reliable, particularly as previous records were unavailable, and he had only treated her occasionally. In evidence during the inquest, Dr Purtle clearly stated that he did not think it was necessary to obtain any of Ms Capps' recent medical records, as he 'relied upon his own judgment at the time'.

117. Despite claims to the contrary, Dr Purtle clearly had a limited understanding of the circumstances which led to Ms Capps' recent licence cancellation. There is no evidence to suggest that he made any attempt to source information as to the reasons for the cancellation. In evidence, it seemed that Dr Purtle did not believe such steps were necessary, and confidently based his assessment of her fitness to drive on Ms Capps' physical presentation at the time. When Ms Capps' medical history is considered in its entirety, coupled with the evidence provided by her friends and previous treating medical practitioners, Dr Purtle's claims as to her mobility and the significant improvements allegedly made shortly prior to her death, seem highly unlikely.

118. I find that Dr Purtle failed to follow and apply the applicable Guidelines when assessing Ms Capps' fitness to drive. He did not avail himself of Ms Capps' recent medical history, and the reasons she had previously lost her licence. He was not aware that she had sleep apnoea and other relevant conditions, which should have been considered cumulatively when determining her fitness to drive. As such, he did not have sufficient information to perform an appropriate assessment of Ms Capps' fitness to drive.

119. Although Ms Capps may have been cognitively sound, I find that her medical and physical condition as of 1 July 2013 rendered her unfit to hold a Queensland driver's licence and that was so on the 18 July 2013.

The role of medical practitioners in assessing a person's fitness to drive and issuing the necessary medical certificates for a licence application/renewal, particularly following a licence cancellation as a result of a show cause notice.

120. The role of medical practitioners in assessing a person's fitness to drive and issuing a Medical Certificate for Motor Vehicle Driver is crucial to ensuring the safety of all roadway users. The Guidelines clearly establish the medical standards for licensing and provide comprehensive and consistent procedures for medical practitioners to follow when assessing a patient's fitness to drive. It is imperative that these Guidelines are followed by all medical practitioners when undertaking such an assessment, to ensure uniformity and sufficient consideration of all relevant factors. The Medical Certificate for Motor Vehicle Driver (Form 3712) clearly states that an assessment is to be undertaken in accordance with the Guidelines.

121. It is fundamental that a medical practitioner conducting an assessment of a patient's fitness to drive has a thorough and complete understanding of that

patient's medical history and the guideline requirements for undertaking such an assessment.

122. It is reasonable to accept, and the evidence suggests, that a person's treating general practitioner is in the best position to know the applicant's medical history and to assess whether that person is fit to drive a motor vehicle safely. The input of an occupational therapist, specifically tasked to assess driving capability, would also be of assistance on occasion. Subject of course to strict adherence to an assessment regime. This assessment regime, or set of Guidelines, should be drawn by licensing authorities in consultation with various stakeholders including motoring bodies and professional medical colleges and police.

The role and responsibilities of the Department of Transport and Main Roads in relation to assessing driver licence applications/renewals for which a medical certificate is required.

123. As the licensing authority, DTMR has responsibility for assessing and determining whether an application for a driver's licence should be granted. The legislative framework and applicable policies established by DTMR in relation to driver's licence applications is similar to that in other states, and accords with the requirements established in the Guidelines.

124. It is reasonable for DTMR, as the licensing authority, to rely upon the assessment of a medical practitioner when determining if a person is medically fit to drive. When assessing an application for a driver's licence, DTMR consider other relevant information available, as well as the length of time a medical practitioner is said to have treated an applicant. Should the term be relatively short, this may cause further enquiries to be made as to whether the medical practitioner is fully aware of the applicant's medical/driving history.

125. On this occasion, Dr Purtle incorrectly indicated that he had been treating Ms Capps for two years, which was thought to be a reasonable timeframe by DTMR. Understandably, DTMR relied upon the assessment undertaken by Dr Purtle given his apparent familiarity with the patient, which appeared to include the time period when Ms Capps' licence was initially cancelled. It was reasonable, for DTMR to have relied upon Dr Purtle's assessment of Ms Capps' fitness to drive, without seeking any further clarification or information as he had declared that he had been her treating doctor for two years.

Whether any modification is required to the current regime in relation to driver licence application/renewals and associated medical certificates, following a show cause notice.

126. The changes presently being considered and implemented by DTMR will assist to ensure that the Medical Certificate for Motor Vehicle Driver and the process of assessing driver's licence applications, adequately manage concerns associated with medical conditions in older drivers and their fitness to drive.

Whether there are any further measures that could be introduced, which may assist in preventing similar incidents from occurring in the future.

127. FCU investigators proposed that various amendments be made to the Medical Certificate for Motor Vehicle Driver (Form 3712). These include standardised testing of reaction times. There may be circumstances where it is apparent to the doctor that such testing is required and that may require the involvement

of the occupational therapist. DTMR submit that a patient's treating health practitioner is best placed to determine whether such an assessment is necessary.

128. Mandatory reporting by medical practitioners to DTMR for certain medical conditions is not supported by DTMR or RACGP. Reasonable concern has been raised as to the effect such a requirement would have on the patient/doctor relationship, and the possibility that a person may not seek treatment for a condition in the fear that this information will be provided to DTMR Such a requirement could cause some serious adverse road safety outcomes should it be introduced, which would be contrary to the objective.

Recommendations in accordance with s. 46

129. Section 46 of the Act provides that a coroner may comment on anything connected with a death that relates to:
    a. public health and safety,
    b. the administration of justice, or
    c. ways to prevent deaths from happening in similar circumstances in the future.

130. Having regard to the serious issues raised in this inquest I make the following recommendation:

    I. *Review of processes and policies in place in relation to medical reporting by DTMR*

    The proposed changes to processes and policies currently in place in relation to medical condition reporting, as identified and commenced by DTMR, will assist to ensure that the current regime addresses the concerns raised by the death of Ruth Capps and the injuries suffered by Mr Sandeep Sing, Mr Allen Ricard Larder and Ms Rona Winifred Larder. I recommend that DTMR continue to prioritize the implementation of these changes, as well as the ongoing review of the current application process, particularly the content and scope of Form 3712 and Form 3195.

Exercise discretion of the Coroner to refer Dr Purtle in accordance with s.48(4)

131. Section 48 of the *Coroners Act 2003* gives me a discretion to refer information about a person's professional conduct to the relevant professional disciplinary body if I reasonably believe the information might cause that body to inquire or take steps in relation to the conduct. Having regard to the definition of 'disciplinary body' under s. 48(5) of the Act, the disciplinary body for a health practitioner is the relevant Board.

132. Dr Purtle's assessment of Ruth Capps' fitness to drive fell below the standard of care reasonably expected of a medical practitioner in the circumstances. Dr Purtle did not make any attempt to avail himself of her very relevant recent medical history, and has continued to assert his view that such information was not necessary, despite the Guideline requirements. He also made no attempt to ascertain the reasons for Ms Capps' previous licence cancellation. I am not able to say with certainty that, as a direct consequence of Dr Purtle's inadequate assessment, Ruth Capps died and people were injured.

133. During the inquest, Dr Purtle did not demonstrate any insight into his conduct and failings. He maintained, despite significant evidence to the contrary, that had he been aware of Ms Capps' recent medical history, and the findings of the Occupational Therapy Driving Assessment, he would still have signed the Medical Certificate for Motor Vehicle Driver form attesting to Ms Capps' fitness to drive. This statement demonstrates either a serious lack of judgment by Dr Purtle or a high degree of arrogance on his part, or both. I have considered referring Dr Purtle to the Medical Board, however I hold out reasonable hope that he will reflect on these sorry circumstances and behave differently in future.

I close the inquest.

James McDougall
Coroner
Southport