OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Scott Phillip Livermore**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Maroochydore
FILE NO(s):	COR 543/2008
DELIVERED ON:	25 June2010
DELIVERED AT:	Maroochydore
HEARING DATE(s):	24 August, 23 November, 2009, 25 January & 25 June 2010
FINDINGS OF:	C Taylor, Coroner
CATCHWORDS:	CORONERS: Inquest – Motor vehicle accident, reporting of any mental or physical incapacity to the Department of Transport and Main Roads

REPRESENTATION:

Assisting the Coroner	Sen Con Melmeth
Marie Waldock	Mr GJ Barr, Butler McDermott Lawyers

I intend to deliver my findings in relation to this death in accordance with section 45 of the *Coroners Act 2003*.

I find on the evidence before me as follows:

(A) the name of the deceased person be Scott Phillip Livermore;

(B) the deceased person died as a result of injuries that he sustained when a silver 2002 Toyota Corolla hatchback registration number 252-IUF being driven by Maria Janelle Waldock, and in which he was a front passenger, collided head on with a concrete and steel reinforced 182 centimetre tall besser block front boundary fence situated at 97 Alfriston Drive, Buderim;

(C) that the deceased person died on the 29th of May 2008;

(D) the deceased person died at 97 Alfriston Drive, Buderim, in the State of Queensland;

(E) the cause of death as certified by Dr A Jeffries, pathologist, to be:

1(a) Multiple injuries

1(b) Motor vehicle accident (front seat passenger)

It should be said by way of background that in 1996 Ms Waldock, whilst in the United States of America suffered two convulsive seizures both on the same day and was prescribed Dilantin (Phenytoin) by doctors. However, at that time she was not formally diagnosed with epilepsy.

Some three weeks later she returned to Australia and saw a neurologist in New South Wales, namely Dr Kataka who practiced in Newcastle and her medication was changed to Tegretol, being a standard formulation of carbamazepine, which she took for a period of more than 12 months and during that time she had no further seizures.

Thus, after speaking with her neurologist she very gradually stopped taking that medication. Ms Waldock moved to Queensland in 2005 and more particularly to the Sunshine Coast.

On 27th of January 2006 she experienced another secondary generalised tonic-clonic seizure and in consequence on that day she consulted Dr Kleinig at Medicine on Second at Maroochydore whereupon he ordered pathology and diagnostic testing and on that particular occasion she was advised not to drive.

On the 2nd of February 2006 she was reviewed by Dr Kleinig and informed that the results of the testing that she had undergone were basically normal. However, she was referred to a neurologist, Dr Schapel and again Dr Kleinig advised her not to drive until she was seizure-free for at least six months.

Ms Waldock did not attend Dr Schapel's at that stage as she was of the view that the episodes she had previously experienced were due to stress, not epilepsy.

On the 2nd of June 2006 Ms Waldock experienced a further two secondary generalised tonic-clonic seizures and was taken by ambulance to the Nambour General Hospital. Consequently she again attended upon Dr

Kleinig on 5 June 2006 and was given a second referral letter to Dr Schapel.

On 30 June 2006 she attended upon Dr Schapel for examination. Amongst other things Dr Schapel informed Ms Waldock that, based upon the history she and her friend Roslyn had provided, and having had two quite recent secondary generalised tonic-clonic seizures in the month of June 2006, that she had localisation-related epilepsy and further that she should not drive a motor vehicle for the time being.

Dr Schapel again saw Ms Waldock on 8 August 2006 as a result of her having a further secondary generalised tonic-clonic seizure whilst on a plane to Hawaii on 6 July 2006. On this occasion he personally witnessed Ms Waldock display seizure activity of some four minutes duration thus Dr Schapel ordered further blood tests and in addition he requested that Ms Waldock see him the following day.

Ms Waldock duly presented to Dr Schapel as requested on the following day that is 9 August 2006, where she was informed that the blood tests relevantly were normal. However, she was prescribed and commenced to take medication commonly referred to as "Keppra" in a dosage of 500 mg twice a day. Dr Schapel also informed her she should not drive a motor vehicle until she was free of episodes of clinical seizure activity associated with impairment and/or absence of awareness for at least three months.

Follow-up management of her epilepsy was again undertaken by Dr Schapel on 14 September 2006 whereby she informed him that she had not had any further episodes of clinical seizure activity associated with impairment and/or absence of awareness and she confirmed she was still taking her medication in the prescribed dosage and Dr Schapel again advised her she should not drive for the time being.

Dr Schapel was next to review Ms Waldock on 23 November 2006. In any event, Ms Waldock did not present to his practice until the 13th of February 2007. Once again, she informed Dr Schapel she had not had any recent episodes of clinical seizure particularly associated with impairment and/or absence of awareness and that she continued to take her prescribed medication.

As arranged Dr Schapel next saw Ms Waldock on 12 September 2007 where she confirmed she continued to take her medication and remain seizure-free. However, Dr Schapel did not at that time inform Ms Waldock she should not continue to drive.

Moving on now to the incident itself. At approximately 6.15am on 29 May 2008 Ms Waldock was driving her motor vehicle southbound on Gossamer Drive, Buderim whilst the deceased, being her boyfriend of some two months, was seated in the front passenger seat of her motor vehicle. Both Ms Waldock and the deceased were seat-belted.

Ms Waldock was being followed by Mr Aley in his motor vehicle as he was on his way to work. At this time it was cloudy and raining. Both vehicles in question had their headlights on and had travelled approximately 500 metres when they passed in a veering manner on to the right-hand side of the roadway as a Toyota Hiace van being driven by Mr Harriman was attempting to reverse out of the driveway at 26 Gossamer Drive, Buderim. At this stage both motor vehicles were travelling at a reasonably fast rate of speed, given the road conditions.

It was at this location that Mr Aley observed Ms Waldock's vehicle accelerate at speed and it was at approximately this point that Ms Waldock experienced going into a "tunnel" sensation causing her to lose recognition of her surroundings and her motor vehicle to accelerate. Ms Waldock's vehicle has then travelled on and at a distance of approximately 24 metres from the T-intersection of Gossamer Drive and Alfriston Drive she has driven on to the grass footpath. Her vehicle has then started to slide out to the left. The vehicle has then failed to negotiate the right bend in the roadway and travelled in a straight line and in the process has continued across Alfriston Drive and on to the grass footpath and then collided with the relevant boundary fence.

In the result the deceased sustained head and chest injuries which were rapidly fatal. He was then conveyed to the Nambour General Hospital by the government undertaker where he was officially declared life extinct by Dr A Harris at 9.50am on that same day.

Ms Waldock was transported by ambulance to the Nambour General Hospital where she underwent medical treatment for three separate fractures and was hospitalised for seven weeks.

In any event, almost three months after the accident Ms Waldock was again reviewed by Dr Schapel. At that time she informed Dr Schapel that since her last visit to him on 12 September 2007 she had not experienced any episodes of clinical seizure activity particularly associated with impairment and/or absence of awareness. Ms Waldock also informed Dr Schapel that she could recall experiencing "something like being in a tunnel for one to two seconds" immediately prior to the accident in question which was a situation that she had never experienced before notwithstanding that she continued to take her medication as prescribed.

However, Dr Schapel was not convinced Ms Waldock at the relevant time had experienced an episode of clinical seizure activity associated with impairment and/or absence of awareness as there was no eye witness account of observable symptoms albeit that the "tunnel" experience, in Dr Schapel's opinion, can be a symptom associated with the simply partial seizure or alternatively could have been caused by stress, anxiety and agitation which were symptoms Ms Waldock displayed on a number of occasions when he examined her.

In any event, he did increase her dosage of Keppra to 500 mgs in the morning and 1000 mg at night as a cautionary measure.

On the 2nd of December 2008 Queensland Transport, or more particularly the Medical Condition Reporting Unit, issued a show cause notice to Ms Waldock which was based upon a report dated 20 November 2008 that had been received from Snr Const Knight of the Forensic Crash Unit, Coolum. The show cause notice proposed that Ms Waldock's drivers licence be cancelled from the 29th of December 2008 because she has a permanent or long term medical condition that is likely to adversely affect her ability to drive a motor vehicle safely and; further, that she suffered from a medical condition that caused a traffic accident on 29 May 2008.

The evidence discloses that Ms Waldock accepted the department's invitation to voluntarily surrender her drivers licence.

Now, it must be said at this stage that as a result of the tragic accident that led

to Mr Livermore's death on 29 May 2008, the focal point of this inquest, relates to investigating firstly, whether or not there are adequate procedures in place for the notification and/or reporting and assessment of the fitness of a driver of a private motor vehicle with a relevant medical condition to the appropriate driver licence authority, in this case being the Department of Transport and Main Roads. Secondly, whether or not any further procedures that should be put in place, that could have prevented the death or could reduce the likelihood of a death occurring in similar circumstances.

Contextually I have heard evidence from Mr Michael John Skinner, the senior manager of transport policy attached to the Department of Land, Transport and Safety, who is tasked, along with other members of his team, of approximately 25, to look after driver licensing, road rules policy and legislation. Mr Skinner's evidence discloses, amongst other things, that medical condition reporting legislation was introduced in Queensland on the 1st of March 2006 and named "Jet's Law" in recognition of Jet Rowland, a little 22 month old boy who was killed in 2004 when a driver with epilepsy crashed into the car in which he was a passenger.

Under the relevant law, Queensland driver licence holders must promptly report to the Department of Transport and Main Roads any mental or physical incapacity (a medical Condition) that is likely to adversely affect their ability to drive.

In July 2009 Mr Skinner's department introduced a voluntary "medical condition reporting receipt notification" process after consultation and agreement with the Australian Medical Association (Qld) and Queensland Health professionals for the purposes of assisting doctors to identify and manage patients that have been assessed as not being fit to drive (see Exhibit 2).

During the course of the consultation process with the department the Australian Medical Association, Queensland Branch raised what I think seemed, in certain respects to Mr Skinner, to be a legitimate concern with the issue of mandatory reporting requirements for medical practitioners as it was their view there was potential for a breakdown in the doctor/patient relationship, that is that patients, especially those who are commercial drivers dependant upon having a driver's licence to earn a living, may choose not to see a doctor at all thus preventing themselves from being appropriately diagnosed and treated for their medical condition.

Snr Const Knight from the Coolum Forensic Crash Unit also accepted that the AMA concern was soundly based. Mr Skinner also went on to say that since the receipt notification system was introduced in Queensland there had been for the months of July, August, September 2009 approximately 160 notifications in each of those months by health professionals and further, that to his knowledge mandatory or compulsory reporting didn't have the support of the department.

In September 2003 Austreads who, along with the National Transport Commission, actually opposed compulsory reporting published with the approval of the Australian Transport Council and the endorsement of all Australian driver licence authorities' guidelines for medical standards for licensing and clinical management for health professionals in Australia.

The publication is entitled "Assessing Fitness to Drive" and the setting of the relevant standards involved extensive consultation across a wide range of

stake holders including regulators, employers, unions and health professional such as the Royal Australasian College of Physicians, who represent neurologists (see Exhibit 3).

Appendix 3.2 of the said publication indicates there are only two jurisdictions, namely the Northern Territory and South Australia, who have mandatory reporting requirements for health professionals, including medical practitioners. The evidence also discloses that in South Australia from approximately 2003 to May 2005 there had not been any prosecution of a health professional under their mandatory reporting law.

On this subject matter it was Dr Schapel's view that it fell to the individual patient to report in the requisite format their unfitness to drive as he had a concern that if he did so he would, in essence, breach their right to privacy, albeit if he established there was a safety issue that would impact on another person or the community at large then he would act. But, in any event, since he received notification from the Queensland government or at least one of its departments that a patient was, under legislation, required to supply the relevant form he commenced on 30 March 2006 to invariably advise his patients they should notify the relevant transport authority in the appropriate manner on pain of prosecution and fine.

Dr Bradshaw's opinion as a general practitioner was that he would follow the guidelines as set out in "Assessing Fitness to Drive" to assess a patient's capacity to drive and that if he formed the view there was a problem with the patient's driving because, for example, they suffered from epilepsy, then he would inform the Department of Transport of that fact even though it was not mandated by legislation to do so.

In the instant case he did not have cause to inform Ms Waldock whilst he was her treating general practitioner that she should not drive or that she had an obligation to advise the department.

Now, I have considered the whole of the evidence that has been given in the Inquest and the written submissions provided by the police officer assisting, Snr Const Melmeth and Mr Barr, the solicitor acting for the driver of the relevant motor vehicle, being Ms Waldock.

It must firstly be said that pursuant to section 46 a Coroner may, whenever appropriate, comment on anything connected with the death investigated at inquest that relates relevantly to

(a) public safety; or

(b) ways to prevent deaths from happening in similar circumstances in the future.

At the end of the day whether or not I should recommend to the relevant government entity, in this case being the Department of Land, Transport and Safety, that a medical practitioner should by legislative means be mandated to report or give information to the relevant department about a person's medical fitness to hold or to continue to hold a Queensland driver licence seems to me to require the balancing of a number of competing factors.

In relation to public safety there is, on the one hand, the community's right to be protected from persons driving on a public road who suffer from designated medical conditions such as epilepsy to the extent that they present

as an actual or potential risk or danger, not only to themselves but to their passengers and all other users of the roadway.

On the other hand there is the patient's right to privacy but perhaps more importantly, the real likelihood that if a doctor is mandated to report then any patient may choose not to consult a doctor at all for fear of losing their driver's licence, thus posing, in my view, a greater risk or danger to not only themselves but their fellow passengers and to all other road users, including pedestrian traffic that may be in the vicinity of roadways.

I think it is also important to note that out of all the Australian States and Territories it is only the Northern Territory and South Australia that have mandatory reporting.

I mean no disrespect in saying that.

In my view the current legislative provisions combined with the 2009 introduction of the "receipt notification" process are sufficient to protect the public. I am also fortified by the commendable attitude displayed in evidence from a very experienced neurologist, Dr Schapel, and that of an experienced general practitioner, Dr Bradshaw, that they will resort, if deemed necessary in the public interest, to reporting a patient in any event should they hold appropriate concern about their fitness to drive and quite rightly in that regard current health professionals are afforded protection from liability under section 142 of the *Transport Operations (Road Use Management) Act 1995*.

Mr Livermore's death was ultimately a tragic accident and on the evidence I am unable to make any further recommendation as to ways to prevent death such as in the instant case from happening in the future.

In conclusion, on the evidence I am not satisfied in the terms of section 48(2)(a) or (b) of the Coroners Act 2003 such that I should give any information to the Director of Public Prosecutions or the Chief Executive of the relevant department.

The inquest will now be closed.

Coroner Taylor
Maroochydore
25 June 2010