QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND
FINDINGS OF INQUEST

CITATION:	**Inquest into the deaths of Nicole Sonia Nyholt and Margaret Louisa Clark**
TITLE OF COURT:	Coroners Court Queensland
JURISDICTION:	CAIRNS
FILE NO(s):	2015/2233
DELIVERED ON:	26 June 2020
DELIVERED AT:	CAIRNS
HEARING DATE(s):	16 May 2019, 8 July 2019, 6 - 7 February 2020, 10 - 14 February 2020
DATE OF LAST SUBMISSONS:	29 April 2020
FINDINGS OF:	Nerida Wilson, Northern Coroner
CATCHWORDS:	Coroners: inquest, Ravenshoe café explosion; licence holder; medical fitness to drive; assessing fitness to drive; seizure; epilepsy; obligations of medical and general practitioners, continuity of care; Austroad guidelines; Transport and Main Roads; voluntary and good faith notifications to licencing authority; recommendation for working group to review fitness to drive protocols and provide education for medical profession.

REPRESENTATION:

Counsel Assisting the Coroner:	Mr J. Crawfoot
Counsel for Department of Transport and Main Roads	Ms S. Williams i/b Eliane Yuille
Counsel for Dr Kenneth Connolly	Ms M. Zerner i/b Meridan Lawyers
Counsel for Queensland Health and RN Rachel Olorenshaw	Ms S. Robb i/b Minter Ellison
Counsel for Dr Suzette Pyke and Dr Briana Van Beekhuizen	Mr J. Trevino i/b HWL Ebsworth Lawyers
Counsel on behalf of Cairns Hinterland Hospital and Health Service, Dr Ian Reddie, Dr Rory Howard and RN Jennifer Pollock	Ms S. Gallagher i/b Helen Price Cairns Hinterland Hospital Health Service
Counsel for Dr Anju Pandey	Mr A. Luchich i/b Avant Mutual
Counsel for Mr Brian Scutt	Mr K. Goodwin (*pro bono*)
Counsel for Mrs Robyn Scutt	Ms R. Logan i/b Legal Aid Queensland

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Publication

Section 45 of the *Coroners Act* 2003 ('the Act') provides that when an inquest is held, the coroner's written findings must be given to the family of the person in relation to whom the inquest has been held, each of the persons or organisations granted leave to appear at the inquest, and to officials with responsibility over any areas the subject of recommendations. These are my 84-page findings in relation to Nicole Sonia Nyholt and Margaret Louisa Clark. They will be distributed in accordance with the requirements of the Act and posted on the website of the Coroners Court of Queensland.

Relevant Legislation

Pursuant to s45 (5) of the Act a coroner must not include in the findings any statement that a person is, or may be:

a) guilty of an offence; or
b) civilly liable for something.

The focus of an inquest is to discover what happened, not to ascribe guilt or attribute blame or apportion liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths in future.

Comments and recommendations

Pursuant to the Act: A coroner may, whenever appropriate, comment on anything connected with a death investigated at an inquest that relates to:

46 (1)(a) "public health or safety" and

46(1)(c) "ways to prevent deaths from happening in similar circumstances in the future."

Introduction

1. On 9 June 2015 Mr Brian Andrew Scutt aged 60 years whilst driving a 1994 Toyota Landcruiser, Queensland registration 060JKO, veered off the main road in the township of Ravenshoe and continued in a straight line mounting the gutter and travelling across vacant land before colliding with a 180kg LPG gas cylinder positioned at the rear of the Serves You Right Café located on 59 Grigg Street, Ravenshoe.

2. The impact of the collision caused the following chain of events:

    - the gas cylinder ruptured;

- the gas cylinder was forced through a concrete block wall into the kitchen area of the café;
- the liquid contents of the gas cylinder were released and vapourised creating a gas field;
- the gas mixed with the surrounding oxygen and ignited upon contact with a heat source in the kitchen of the café, thereby causing an explosion reaching temperatures between 1200°C and 2000°C.[1]

3. Nineteen people were present inside the café at the time, including the deceased Ms Nicole Sonia Nyholt (aged 37) and Ms Margaret Louisa Clark (aged 82). Both Ms Nyholt and Ms Clark sustained non-survivable burns as result of the explosion. Both succumbed to their injuries in the days following the explosion.

4. All occupants of the café received burns of varying degree, ranging from minor hand burns to burns between 10% and 60% of the body.

5. Ravenshoe is a rural town on the outskirts of the Atherton Tablelands, almost 200kms (a 2 hour drive) south west of Cairns. It has a population of 1400 people. The explosion devastated the people of the small close knit township. Ms Nyholt, Mrs Clark and Mr Scutt were all local to the town and were widely known in the community. These findings mark the fifth anniversary of the tragedy.

6. The aftermath of the explosion required a significant emergency response including airlift to nearest major hospitals. Extraordinary efforts by a number of emergency service personnel have since been publicly recognised.

7. The people of Ravenshoe galvanised to raise funds for the many people affected by the tragedy. A number of survivors attended the inquest. Some provided statements describing the lasting impact on their lives. A number of the witnesses to the event were friends of the persons involved. Many remain shocked, bewildered and saddened by the shocking events of 9 June 2015.

8. The police investigation established that Mr Scutt had a known medical history of seizures which was relevant to his fitness to drive and therefore directly relevant to the events.

9. Two key witnesses to inquest, Mr Scutts's general practitioner Dr Kenneth Connolly and Mr Brian Scutt, died prior to the commencement of inquest. I determined upon hearing submissions that an inquest could proceed noting Dr Connolly provided a statement responding to targeted questions prior to his death. Dr Connolly and Mr Scutt were each represented at the inquest. There were no objections raised by any person with leave to appear to the course adopted.

[1] T1.21/32-45

Issues for Inquest

10. **The following were identified as issues for inquest:**

1) The findings required by s.45 (2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how they died and what caused their deaths;

2) The circumstances surrounding the collision of Brian Andrew Scutt's motor vehicle at 59 Grigg Street, Ravenshoe on 9 June 2015 (referred to as the Ravenshoe Café Explosion) that resulted in the deaths of Nicole Sonia Nyholt and Margaret Louisa Clark;

3) Taking into account Brain Andrew Scutt's presentations for seizures at the Atherton Hospital

    a. the adequacy and appropriateness of the treatment and care provided by the hospital;
    b. the obligations, if any, for treating practitioners at the Atherton Hospital to notify the Queensland Department of Transport and Main Roads of Mr Scutt's history of seizures.

4) The extent of general practitioner Dr Kenneth Conolly's knowledge of Brian Andrew Scutt's seizure history and;

    a. whether in the circumstances Dr Conolly's medical care was adequate and appropriate and;
    b. the obligation, if any, for Dr Conolly, to notify the Queensland Department of Transport and Main Roads of Mr Scutt's history of seizures.

5) Taking into account Mr Scutt's seizure history, the obligation of Mr Scutt:

    a. to comply with medical advice not to drive; and
    b. to notify the Queensland Department of Transport and Main Roads of his history of seizures.

6) Whether as at 9 June 2015, with reference to a history of seizures, Brian Andrew Scutt was fit to hold a Queensland Drivers Licence;

7) As at current date, the obligations (if any) on a medical practitioner, or person, to make a notification (voluntary or otherwise) to the Department of Transport and Main Roads in relation to Brian Andrew Scutt's known seizure activity

8) Whether a duty should be imposed on medical practitioner, who having examined a person who is the holder of a driver's licence or learner's permit:

    a. forms a reasonable belief that the person is suffering from any illness, disability or deficiency and;

b. the nature of any illness, disability or deficiency would, if that person drove a motor vehicle, be likely to endanger the public

To then notify the Department of Transport of Main Roads and Transport of the name and address of that person and the nature of the illness, disability or deficiency.

11. The inquest took place over two sittings:

I. **Atherton Courthouse from 6-7 February 2020**. The Atherton courthouse was the most suitable courthouse proximate to the scene of the explosion and sittings there provided for witnesses who resided on the Atherton Tablelands to give their evidence, and also provided for an opportunity for members of the local community to attend and should they wish to do so. The witnesses who gave evidence in person during these sittings included:

i. Cassandra Pengelly;
ii. Ingrid Mowbray;
iii. Veronica Featherston;
iv. Simon Harden;
v. Thomas Squires; and
vi. Noeleen Avenell.
vii. Guiseppe Torrisi
viii. Nicola Baker
ix. Steven Jensen
x. Scott Ezard
xi. Russell Moseley
xii. Garry Ryan

II. **Cairns Courthouse from 10-14 February 2020**. These sitting primarily took in the evidence of experts and professional witnesses. Mr Scutt's wife gave evidence during these sittings. The witnesses who gave evidence in person during these sittings included:

xiii. Lillias Gyetvay
xiv. Dr Rory Howard
xv. Dr Reddie
xvi. Jennifer Pollock
xvii. Darrell Thompson
xviii. Dr Suzette Pyke
xix. Shayne Russel-Brereton
xx. Rachel Olorenshaw
xxi. Dr Anju Pandey
xxii. Narelle Groves
xxiii. Dr Briana Van Beekhuizen
xxiv. John Mudge
xxv. Robyn Scutt
xxvi. Joanne Selby

xxvii. Dr Drew Wenck
xxviii. Dr Daniel McLaughlin
xxix. Nadine Dumont
xxx. Dr Christopher Pitt
xxxi. Dr Neil Bartels

12. In the formulation of these findings, I have distilled and referred only to that evidence and material relevant to the basis for my findings and recommendations. I do not refer to all of the material, evidence or submissions.

13. I have had the benefit of, and regard to, the comprehensive submissions of in-house Counsel Assisting the inquest, Mr Joseph Crawfoot, and where applicable I have incorporated and adopted those submissions. Similarly, I have had regard to the significant written submission filed on behalf of Dr Connolly and I have incorporated and adopted those submissions where applicable.

14. I have also had regard to the submissions on behalf of all those with leave to appear and thank them at the outset for their consideration of all matters before the inquest.

Criminal proceedings against Mr Brian Scutt

15. Mr Brian Scutt survived the collision and explosion. On 9 June 2015 was admitted to the Intensive Care Unit at the Cairns Hospital.

16. Mr Scutt was subsequently charged with three offences under the Criminal Code:

- Dangerous operation of a motor vehicle causing death or grievous bodily harm;
- Dangerous operation of a motor vehicle causing death or grievous bodily harm; and
- Dangerous operation of a motor vehicle

17. All charges were referred to the Mental Health Court on 9 February 2017.

18. That referral was heard on 7 September 2018. On that date the Mental Health Court determined that:

i. Mr Scutt was not suffering from unsoundness of mind at the time of the alleged offences however;
ii. was not fit for trial and that such unfitness was of a permanent nature.

19. On 28 November 2018 all criminal charges against Mr Scutt were discontinued pursuant to the *Mental Health* Act.

20. Mr Scutt died on 1 August 2019. His cause of death was given as:

1(a) Aspiration pneumonia, due to or as a cause of

1(b) Epilepsy

Events on 9 June 2015

21. Mr Scutt resided at Ascham Street, Ravenshoe. This residence was directly opposite the Ravenshoe State Primary School campus.

22. From Ascham Street vehicles can turn either left onto Grigg Street (into the township of Ravenshoe) or right onto Moore Street (out of Ravenshoe). Grigg Street and Moore Street are a continuous section of sealed road, however the intersection with Ascham Street at the Cedar Creek Bridge is the demarcation point between the two.

23. A left-hand turn onto Grigg Street would take the driver towards the Ravenshoe town centre. A right hand onto Moore Street would take the driver across the North Cedar Creek Bridge, away from the town centre towards the Kennedy Highway. The North Cedar Creek Bridge is also referred to as the Grigg Street Bridge.

Ingrid Mowbray

24. Ingrid Mowbray described observing Mr Scutt in Ascham Street prior to the explosion.

25. Ms Mowbray was a teacher at the Ravenshoe State School, Primary School campus. She knew Mr Scutt in the context that he lived across the road from that campus. She deposed that she would park her car near his house. She knew him to "*wave hello*" and "*just say a few greetings*". She would see him in this context approximately twice per week.[2] She had been working at the Primary School campus for about 10 years.[3]

26. Ms Mowbray deposed to a sequence of events on the morning of 9 June 2015 commencing at about 11am or 11:30am. She had driven from the Primary School campus to the bakery that was next door to the Serves You Right Café. She purchased lunch then drove to the Ravenshoe State School, High School campus that was located on Moore Street, towards the intersection with the Kennedy Highway.

27. At the High School campus, she collected a student then drove back down Moore Street, towards the town centre. She turned left onto Ascham Street to

[2] T1.7/33-45
[3] T1.8/1-3

head back to the Primary School campus. After turning onto Ascham Street she deposed to driving past Mr Scutt who was driving towards her in the oncoming lane in his Landcruiser.

28. Ms Mowbray deposed to having had a clear view of Mr Scutt and described him as appearing "*happy*" and she believed there was something in his body language that suggested he recognised Ms Mowbray to be driving a new car. She observed Mr Scutt was "*smiling*" and "*nodded his head in greeting*".[4] After passing him she parked her own vehicle outside the primary school in Ascham Street and at that time she heard "*a big explosion, a big bang*".[5] Ms Mowbray did not observe the direction Mr Scutt turned from Ascham Street. However it was inferred that he made a left hand turn onto Grigg Street, towards the town centre

29. She had initially discounted the noise as having come from a nearby gun club and on that basis had "*ignored it*".[6]

30. After hearing the noise, Ms Mowbray returned to her classroom, and when prompted by students, looked out and observed smoke rising up from the direction of the town centre.[7]

Cassandra Pengelly

31. Ms Pengelly had known Mr Scutt for approximately 10 years prior to the events on 9 June 2015. Whilst Ms Pengelly did not know Mr Scutt "*well*" she knew him as the type of person that would "*always wave and smile back*".[8] I accept she was able to recognise him by sight and recognise some changes in his usual character or behaviour.

32. On 9 June 2015, Ms Pengelly described driving her motor vehicle along Moore Street, away from the town centre towards the Kennedy Highway, sometime before midday. Ms Pengelly described driving across the North Cedar Creek Bridge (which then becomes Moore Street) at which time she observed Mr Scutt's Landcruiser crossing the bridge from the opposite direction heading towards the town centre.

33. The bridge is divided by unbroken double white lines. In the walkthrough Ms Pengelly expressed the belief that she had been "*white lining it*" (very close to the double white lines) as she travelled across the bridge. She placed the drivers side of Mr Scutt's Landcruiser (travelling towards her from the opposite direction) as being within one metre of the double white line at time of passing.

34. At the Inquest Ms Pengelly deposed in oral evidence that it was "*odd*" for her to pass Mr Scutt on the bridge as she would ordinarily see him coming out of

[4] T1.13/15-21
[5] T1.13/26-27
[6] T1.14/4-6
[7] T1.14/15-21
[8] Exhibit C5.41 at paragraphs 4 and 10, see also T1.24-25/45-2

Ascham Street.[9] She was firm in her evidence that she had not observed Mr Scutt turn out from any other street, prior to passing each other on the Bridge.[10]

35. As they passed each other on the bridge, Ms Pengelly directly observed Mr Scutt as follows:

> "*I recall waving to Brian, as I always did*". "*On this occasion Brian's vehicle was right beside mine……. he did not wave back*." "*I thought this was strange*".[11]
>
> "*I did notice when he turned towards me, that it was a slow turn of his head and I would say that his eyes looked vague and glassy, like no one was there*".[12]
>
> "*His head was kind of down. He was staring. He had a strange look – a funny look on his face*"[13]

36. Ms Pengelly deposed:

> "*I just thought he mustn't have been talking to me. I didn't really think about it a lot till later, afterwards, but it did remind me of a friend that had a seizure years ago, an epileptic fit*"[14]

37. In her addendum statement Ms Pengelly further stated: "*there was no recognition in his facial expression to suggest that he recognised it was me*".[15]

38. I accept Ms Pengelly had known Mr Scutt for a period of time such and that she was able to discern such an unusual change in his character.

39. In her written statement Ms Pengelly estimated she was driving at approximately 40km/h. In relation to Mr Scutt's Landcruiser her evidence is that his speed "*seemed okay*". She did not think the speed of the Landcruiser was out of the ordinary.[16]

40. Ms Pengelly deposed that after she passed Mr Scutt, she continued driving along Moore Street towards the intersection with the Kennedy Highway. Approximately 20 to 30 seconds after they had passed Ms Pengelly heard a loud 'bang'.[17] I accept that sound was the explosion at the café.

Sergeant Scott Ezard

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[9] T1.23/44-46
[10] T1.23/40-44
[11] Exhibit C5.41 page 2 of 3
[12] Exhibit C5.41 page 2 of 3
[13] T1.24/21-22
[14] T1.24/34-36
[15] Exhibit 5.41.1 at paragraph 9
[16] T1.25/24-34
[17] T1.25/7-20

41. QPS Forensic Crash Unit Investigator Sergeant Ezard gave evidence as to the route and trajectory of the Landcruiser from this point.

42. Sergeant Ezard deposed that the direction of travel (Mr Scutt coming in to town over the bridge) as observed by Ms Pengelly was the more likely scenario immediately prior to the collision (not from Ascham Street closer to town).[18] His basis for that opinion was that the Landcruiser maintained a straight trajectory from roadway to point of collision with the gas bottles. An immediate turn left from Ascham Street would have required a steering input that likely would have placed him on a different trajectory.[19]

43. Whilst Ms Mowbray presumed Mr Scutt turned left out of Ascham Street into Grigg Street, I find he in fact turned right out of Ascham St in the first instance, heading away from the town centre and crossing the bridge. For some unknown reason he turned around and drove back over the bridge and into the town centre.

44. For reasons traversed later I have concluded that Mr Scutt may have been distracted by the continuation or onset of a medical event and became confused as to the direction he was travelling in, or was intentionally heading out of town then changed his mind (perhaps beset by the onset of his seizure) and turned around to seek help.

Simon Harden and Thomas Squires

45. There were two witness to the trajectory taken by the Mr Scutt's Landcruiser upon entering the township, Simon Harden and Thomas Squires.

46. Mr Harden had known Mr Scutt for approximately 15 years. On 9 June 2015 Mr Harden was delivering plants to the 'Octopi Community Shop'.

47. Mr Harden deposed that as he exited the shop to return to his own vehicle, he heard the sound of the vehicle accelerating.[20] The sound of the acceleration caused Mr Harden to look up, and he saw the Landcruiser.

48. Mr Harden was unable to observe who was driving the Landcruiser.

49. The sound of the acceleration gave Mr Harden concern that something was "*going wrong*".[21] Mr Harden then gave evidence that he saw the Landcruiser, travelling off Grigg Street, mounting the footpath at a point out the front of the Mower Shop travelling through a park area, and behind a toilet block before he lost sight of it. Immediately after losing sight of the Landcruiser he observed a "*big explosion*".[22]

[18] T2.33/45-46
[19] T2.34/1-11
[20] T11.41/27-29
[21] T1.42/37
[22] T1.44/2

50. Mr Harden's observations are consistent with that documented in the trajectory map[23] prepared by the Queensland Police Service.

51. Relevantly, Mr Harden did not observe the Landcruiser altering course or applying brakes.[24]

52. Witness Thomas Squires had the opposing vantage point to Mr Harden and was positioned closer to the Landcruiser as it travelled through the park area. He states it was approximately 12pm when he heard "*a really, loud engine, sort of like it was 'redlining'* ".[25] He then observed Mr Scutt's Landcruiser travelling through the park. He could observe Mr Scutt in the driver seat. He described Mr Scutt's appearance as:

> "*he was sort of slumped to the [left][26] side. I couldn't see if his eyes were closed or not, but he was sort of slumped to the side and his arms were down*"[27]

53. Mr Squires could not observe Mr Scutt's arms near the steering wheel.[28] He estimated the Landcruiser was travelling at about 50-60 kilometres per hour.[29]

54. Mr Squires was standing about 50metres from the rear of the café when he observed the Landcruiser collide with the gas bottle and the subsequent explosion.

55. After observing the explosion he and another witness Aaron Miller, ran up to render assistance.

The aftermath of the explosion

56. Mr Squires assisted Mr Miller and others (Graham Jensen and Steven Jensen) to extract a female person, who was "*badly burnt*", from the rear of the café. That female person was Ms Noeleen Avenell. After assisting in extracting Ms Avenell from the café, Mr Squires turned his attention to Mr Scutt's Landcruiser.

57. Mr Squires observed that Mr Scutt was still inside the Landcruiser and unconscious.[30] A number of persons including Mr Squires and Mr Steven Jensen assisted in extracting Mr Scutt from his Landcruiser and placing him on the ground near the toilet block. Mr Squires deposed that in the course of

[23] Exhibit E3.2
[24] T1.44/5-10
[25] T1.47/29-30
[26] T1.48/9-10
[27] T1.48/2-4
[28] T1.
[29] T1.48/18
[30] T1.18

moving Mr Scutt he regained consciousness. He heard Mr Scutt say "*what have I done*" and begin "*resisting*" the aid they attempted to provide.[31]

58. Mr Squires informed Mr Scutt that he had been in a crash. Mr Scutt repeated "*what have I done? What's happened*".[32]

Events inside the Serves you Right Café

59. Nicole Nyholt's parents, Johannes and Vicki, owned the café having purchased the site in 2011. At the time of these events Johannes and Vicki were overseas on holiday, having departed on 29 May 2011. Their daughter Nicole was managing the café in their absence.[33]

60. Ms Noeleen Avenell was employed as a cook at the café. She was working inside the kitchen at the time of the collision and explosion. Ms Avenell was called to give evidence at the Inquest. She had known Mr Scutt for approximately 19 years.[34]

61. Ms Avenell commenced work at 7:30am on the Tuesday. The café opened for business at 9am. Ms Avenell recalled that Ms Nyholt arrived at the Café sometime between 8:30am and 9am. Ms Avenell's attention was focused in the kitchen, as such she did not have clear observation of Ms Nyholt's movements or the number of customers in the dining area however she did recall that by 10:30am the number of food orders were starting to increase.

62. Ms Avenell produced a hand drawn map of the layout of the café and approximate location of various features within the café.[35] The map drawn by Ms Avenell placed Ms Nyholt as working behind the service counter and coffee area inside the café. Ms Avenell deposed this particular day (Tuesday) would ordinarily have been a quiet day but it was busier on this occasion because of a group of persons from the local Respite Centre that had attended for lunch.[36]

63. On that day, members of the Queensland Fire and Rescue Service (QFRS) were delivering training at the Ravenshoe Respite Centre and had been invited by the residents to join them for lunch at the café. QFES Officers Senior Firefighter (SF) Guiseppe 'Joe' Torrisi, A/Inspector Michael Beck and Captain Robert Doyle; SF Torrisi were all present at the café that day, having assisted the respite centre residents out of the bus and into the café. They gave evidence at the inquest.

[31] T1.51/25-28
[32] T1.51/28
[33] Exhibit C5.37 and Exhibit C5.38
[34] T11.55/9-10
[35] Exhibit C3.1 at page 5
[36] T1.59/3-6

64. Eight (8) members of the Ravenshoe Respite centre attended the cafe; among them, Ms Margaret Clark. In combination with the attending members of the QFRS that group totalled 11 in number.

65. SF Torrisi gave evidence that the respite residents invited the QFRS members to lunch at the Café; he estimated they arrived there just before midday. After ordering meals, they sat as a group at a large table in the dining area of the Café. SF Torrisi produced a map of where the different persons were seated; Ms Clark was seated opposite to SF Torrisi. The map produced by Ms Avenell marked the position of the large table.[37]

66. Immediately before the collision Ms Avenell was working at the oil fryer preparing meals. At the time of the collision she recalled an event that she described as "*an almighty crash*".[38] The force of the collision caused the oil fryer to tip forward spilling hot oil onto Ms Avenell's stomach, down her right leg and into her shoes. Ms Avenell was surrounded by fire but unaware of what had occurred.

67. SF Torrisi heard a "*clang bang like pots and pans falling down*" coming from the kitchen area.[39] When he looked towards the kitchen area he observed a "*cloud*", then heard someone yell "*fire*".[40] He then turned and observed Ms Clarke was seated in a wheelchair; he heard A/Inspector Beck say words to the effect: "*lets go*" and almost immediately SF Torrisi felt the force of the explosion blow him out the café door.

68. Then next time he observed Ms Clark was near the toilet block at the rear of the Café where she was receiving treatment for burns. SF Torrisi was not aware of how she came to be moved from inside the café to that location.[41] Whilst the evidence called at Inquest was unable to establish Ms Clark's movements from the time of the explosion to when she received medical treatment, it was noted Ms Clark made the following disclosure to her daughter during her admission at Cairns Hospital:

> "*She heard the collision and looked up to see a fire-ball coming towards her. She said she stood up, turned, and tried to run outside, but immediately tripped / fell-over and the fire-ball passed over her, burning her back and legs*".[42]

69. Ms Nyholt survived the explosion and came to be in the toilet block at the rear of the café. Ms Nicole Baker, Nicole's best friend gave evidence at the Inquest, as to those circumstances. Upon hearing the explosion she drove into the town

[37] Exhibit 3.1 at page 5
[38] T1.59/32-32
[39] T1.65/18-24
[40] T1.65/31-33
[41] T1.66/2-11
[42] Exhibit A2.5 at page 27

centre.[43] When she arrived at the café she asked where Ms Nyholt was and was informed that she was in the toilet.

70. Ms Baker observed that Ms Nyholt was burned and attempts were being made by others to apply water to her burns. Ms Baker then sought assistance from a Queensland Ambulance Officer who assisted to move Ms Nyholt out of the toilet block and lay her on the ground outside. During this time, she observed that Ms Nyholt was given an oxygen mask, she also observed local general practitioner Dr Kenneth Connolly administer Ms Nyholt an injection for pain relief.[44] Ms Baker remained with Ms Nyholt until she was loaded into an ambulance and taken from the scene.

Scientific evidence re cause of explosion

71. In terms of understanding the technical aspects of the explosion the Inquest heard evidence from Sergeant Russell Moseley, a Scientific Officer with the Far North District Scientific Section. He deposed that he examined the café on both the 10th and 22nd of June 2015 in order to identify the ignition source for the gas.

72. Sergeant Mosely confirmed that the Landcruiser that had been operated by Mr Scutt, had collided with a 180kg gas cylinder located outside the rear of the café; that the gas bottle had been ruptured by the collision, and the cylinder forced through a concrete block wall into the kitchen area of the café.[45]

73. Sergeant Moseley confirmed the contents of the gas cylinders as liquefied petroleum gas of which propane is a component. Propane is a highly flammable gas, which experimentally under laboratory conditions, has an ignition point between 500°C and 550°C. [46] Sergeant Moseley clarified that the ignition point could also be as high as 700°C. Outside of laboratory conditions those ignition points would be higher.

74. The properties of the LPG were such that when the pressure was released the liquid vaporized into gas form. That gas was heavier than the surrounding air, this caused it to sink towards the floor. The gas would not have ignited on its own but instead needed to reach the necessary ratio of gas to oxygen. Once that ratio was reached it was capable of igniting.[47]

75. The ignition of that mixture then generated convection currents that mixed the gas and oxygen further, propagating the flame through the gas field. The flame moved rapidly through the building heating the air which is what created the explosion.[48] Because of the speed at which the residual gas burned it was not

[43] T2.4/8-12
[44] T2.6/1-4
[45] T2.20/4-9
[46] T2.20/19-26
[47] T2.21/30-35
[48] T2.21/42-47

sustained for long enough to ignite other objects within the café such as furniture, fittings or structural elements.[49]

76. With regard to that ignition point Sergeant Mosely opined there were two possible points of ignition, either a heat source within the kitchen area or a heat source emanating from the Landcruiser engine.

77. Gas cookers were in operation at the time of the collision.

78. Whilst the gas supply to the gas cooker would have been cut off at the time of the collision there would have been residual heat within the hob/trivet. The gas that would have been burning at the cooktop would have reached temperatures between 1200°C and 2000°C,[50] more than double the ignition temperature required under laboratory conditions.

79. In relation to the second possible heat source from the Landcruiser engine, Sergeant Moseley deposed that, experimentally, exhaust systems were known to reach at least 600°C,[51] Sergeant Mosely conceded though that he had not inspected the Landcruiser or conducted any testing of it.[52]

80. On that issue the Inquest also heard evidence from Sergeant Scott Ezard. In his experience he considered it "*highly unlikely*" that the Landcruiser engine could have reached temperatures exceeding 550°C to 600°C. He opined that the coolant in vehicle, which is water-based, would boil at approximately 100°C and in that respect, it was unlikely that the Landcruiser engine could continue to operate at the temperatures required to be a viable point of ignition.[53]

81. I **find** that that the ignition point for the explosion was a gas cooktop inside the café kitchen. The combination of gas, oxygen and ignition point provided the factors that caused the explosion.

Construction and design of the Café

82. There was evidence before the Inquest that the location of the gas cylinders was compliant with safety requirements at the time of the explosion. Impact protection was not required for the cylinders.[54] Additionally the café itself was assessed to be a safe and lawful building, the position and size of the exits exceeded minimum standards, and the travel distance for any person inside the café, to a single exit were well within acceptable distances.[55]

[49] T2.22/1-5
[50] T2.20/35-40
[51] T2.21-22/47-2
[52] T2.23/40-42
[53] T2.35-36/47-2
[54] Exhibit I5
[55] Exhibit I3

83. The construction of the concrete block wall where the collision occurred did not require steel reinforcement or to be fire rated. It was not designed or required to withstand the impact of any impact by a vehicle or explosion.[56]

84. I find there were no aspects of the construction or design of the café, whether by a failure to meet required standards, or otherwise, that contributed to the explosion or the injuries sustained by any person inside.

Nicole Sonia Nyholt

85. Ms Nyholt was born on 1 November 1977; she was aged 37 years at the time of these events.

86. Ms Nyholt was airlifted from the site to the Townsville Hospital. The airlift departed Ravenshoe at 4:05pm and arrived at the Townsville Hospital at 5:25pm.[57] She was triaged in the Emergency Department of the Townsville Hospital at 5:35pm.[58] She underwent a CT scan that showed oedematous pancreas with surrounding free fluid, most likely related to her burn injuries.[59]

87. At the time of her admission Ms Nyholt was assessed as having burns to 90% of her body with 80% being full thickness burns. She did not have any penetrating blast injuries.

88. Between 7:30pm and 11:15pm Ms Nyholt went into theatre where she underwent escharotomy and fasciotomy of all four limbs with wound debridement.[60]

89. Following initial treatment at Townsville Hospital Ms Nyholt was transferred by Careflight to the Royal Brisbane and Women's Hospital (RBWH). She departed Townsville on 10 June 2015 at 12:40am and arrived in Brisbane at 4:50am.[61]

90. Upon arrival at RBWH she was further assessed by the Burns Team. The percentage of burns to her total body surface area (TBSA) was assessed as 86%. Of those burns 84% were deep partial thickness or full thickness (DPT/FT) and 2% were superficial partial thickness (SPT).

91. Ms Nyholt was intubated and sedated. Her burns were assessed as non-survivable.[62] At that time Ms Nyholt's parents were overseas. Ms Nyholt was managed in the Intensive Care Unit.

[56] Exhibit I3
[57] Exhibit A1.4
[58] Exhibit A1.9 at page 7
[59] Exhibit A1.7 at page 1
[60] Exhibit A1.9 at page 8
[61] Exhibit A1.3 at page 1
[62] Exhibit A1.7 at page 2

92. On 12 June 2015, Ms Nyholt's parents returned from overseas and travelled directly to the RBWH. After a period of time together Ms Nyholt's treatment was withdrawn, she was extubated at 4:15am.[63] Ms Nyholt was declared deceased at 4:42am. [I note in the statement read by Nicole's father at the conclusion of inquest he expressed his deep appreciation to their daughter Michelle for maintaining a bedside vigil until they returned from overseas].

93. An external examination autopsy was performed on 16 June 2015. Nicole's cause of death was given as:

1(a). Burns, *due to, or as a consequence of*,
1(b). Gas explosion, *due to, or as a consequence of*,
1(c). Motor vehicle collision with building.

94. I accept and adopt the cause of death as concluded by the Forensic Pathologist.

Margret Louisa Clark

95. Ms Clark was born 17 April 1933; she was aged 82 years at the time of these events.

96. Ms Clark was transferred from the scene of the explosion to the Atherton Hospital by Ambulance. She arrived at the Atherton Hospital at 2:36pm.[64] She was triaged at the Emergency Department and assessed to have TBSA burns of 43-45% of which 37% were assessed as partial thickness and 6% full thickness.

97. She was given pain relief and her burns were dressed. She was assessed as requiring additional treatment at the Burns Team at Cairns Hospital. She was transferred by ambulance to the Cairns Hospital that same day and was triaged at 9:23pm.[65] Ms Clark underwent debridement and dressings. Ms Clark was then transferred to RBWH for further treatment.

98. Ms Clark was medically discharged from the Cairns Hospital on 10 June 2015.[66] Arrangements were made with the Royal Flying Doctor Service to transport Ms Clark to Brisbane.

99. Due to poor weather Ms Clark's care flight was initially delayed until the early hours of 11 June 2015. She arrived at RBWH at approximately 8:30am / 9:00am that day.

[63] Exhibit A1.7 at page 2
[64] Exhibit A2.4 at page 5
[65] Exhibit A2.5 at page 12
[66] Exhibit A2.5 at page 130

100. At RBWH Ms Clark underwent skin graft surgery to approximately 40% of her body. That surgery was conducted on 12 June 2015. During her admission at RBWH Ms Clark experienced a number of complications, including:

a) Low blood pressure;
b) Systemic inflammatory response syndrome (SIRS);
c) Atrial fibrillation; and
d) Failure of her clotting, respiratory and kidney systems.[67]

101. Ms Clark's pre-existing medical conditions (including hypertension, hypercholesterolaemia and diabetes)[68] were considered to contribute to those complications. Ms Clark did not recover from her injuries and was declared deceased at 8:45pm on 14 June 2015.

102. On 16 June 2015 Ms Clark underwent a full external and internal autopsy examination that included a whole-body CT scan. The CT scan identified pre-existing natural disease, including calcification of the coronary arteries of the heart. Ms Clark's cause of death was given as:

1(a). Burns, *due to, or as a consequence of,*
1(b). Gas explosion, *due to, or as a consequence of*,
1(c). Motor vehicle collision with building

Other significant conditions:
2. Atrial fibrillation, hypertension, diabetes mellitus, hypercholesterolaemia, obesity.

103. I accept and adopt the cause of death as concluded by the Forensic Pathologist.

[67] Exhibit A2.1 at page 4
[68] Exhibit A2.5 at page 2

QPS Forensic Crash Unit Investigation

104. Senior Vehicle Inspection Officer (SVIO) Ryan deposed that the Landcruiser was in satisfactory mechanical condition and there were no defects.[69] I find that no mechanical defect contributed to the manner in which the Landcruiser was operated on 9 June 2015.

105. In his evidence SVIO Ryan further deposed that both rear tyre tread surfaces of the Landcruiser displayed dirt contamination. SVIO Ryan opined that this could be accounted for by the Landcruiser being stationary but with the wheels still spinning.[70]

106. The circumstances of the collision were such that the Landcruiser became embedded in the rear wall of the café.

107. SVIO Ryan deposed the mechanical inspection confirmed the Landcruiser was in gear at the time of the collision although he was unable to identify what gear.[71]

108. SVIO Ryan deposed that whilst he could not identify which gear the vehicle was in at the point of collision, he confirmed it was not in low-range; he therefore excluded the vehicle as being in either first or second gear. He conceded the Landcruiser may have been in third gear but he considered it more likely to have been in fourth. [72]

109. The evidence given by Mr Harden and Mr Squires, as to their estimate of the speed of the Landcruiser and the 'revving noises' were put to SVIO Ryan and he was asked if that altered his opinion as to the likely gear the Landcruiser was in. With those observations he considered it more likely that the Landcruiser was in fourth gear. [73] SVIO Ryan further deposed that his inspection of the Landcruiser revealed the accelerator cable was in the half-applied position, pulled down and had seized approximately 35mm from the rest position.[74]

110. SVIO Ryan opined that the cause of the accelerator cable seizing was from fire damage. He considered that the fire had in effect preserved the position of the accelerator pedal as it was at the time of the collision.[75]

111. When SVIO Ryan was further asked to consider the description of the Landcruiser "*redlining*" (as deposed by Mr Squires), SVIO Ryan considered that both third and fourth gears were possible in that scenario, indicating revolutions

[69] T2.17/26-27
[70] T2.16/23-26, see also the evidence of Sergeant Ezard at T2.28/32-36
[71] T2.16/33-37
[72] T2.16/43-46
[73] T2.17/5-7
[74] T2.17/10-15
[75] T2.17/18-20

of 4000 to 4500RPM. In that scenario he opined it was likely the accelerator was 'flat to the floor'.[76]

112. Having regard to the evidence of Mr Squires, that Mr Scutt appeared "*slumped to the left*" with his arms away from the wheel, and the evidence of Mr Harden, and the forensic examination of the trajectory of the vehicle, I **find** that that there was no attempt by Mr Scutt to steer or decelerate prior to the collision. The vehicle traversed an almost straight line from the roadway before impacting with the gas cylinders.

Brian Scutt's seizure history

113. Mr Scutt's medical records were in evidence at the Inquest. [77] The following observations can be made and are uncontroversial:

- Mr Scutt underwent a kidney transplant in 1995;
- Mr Scutt received regular ongoing treatment in relation to the kidney transplant at the renal clinic at the Cairns Hospital;
- In relation to his ongoing treatment, following his kidney transplant, Mr Scutt was prescribed medication to prevent rejection of the transplant;
- Beyond his treatment at the Cairns Hospital, Mr Scutt had received treatment from the Ravenshoe Medical Centre (the Medical Centre)78 substantially for matters related to monitoring his renal function and other minor illnesses;79
- Dr Kenneth Connolly was a General Practitioner at the Centre;
- For the period between 13 April 2000 and 4 June 2015 Mr Scutt accessed a total of 86 consultations with a General Practitioner;
- Of those 86 consultations, 59 were with Dr Connolly;
- Mr Scutt also received treatment from the Ravenshoe Health Care Clinic (the Clinic) which was operated by the Cairns Hinterland Hospital and Health Service (CHHHS);
- For the period between 24 June 1995 and 14 May 2015 Mr Scutt accessed a total of 99 consultations at the Clinic, those consultations substantially concerned having his blood pressure checked or collecting medication;
- Dr Connolly practised at the Clinic on a limited basis and had contact with Mr Scutt at the Clinic on one occasion, 25 August 2014;[80]
- Mr Scutt also received treatment at the Atherton Hospital, in relation to monitoring his renal function and workplace injuries.

114. The records from the Atherton Hospital, the Ravenshoe Clinic, and the Ravenshoe Medical Centre reference a medical history of fits and seizures.

[76] T2.18/1-9
[77] BOE D9
[78] Exhibit D9.2
[79] Exhibit D7.2
[80] Exhibit D9.8 at page 28 and Exhibit D7.3 at paragraph 62

Seizure on 7 March 2004

115. Mr Scutt's first documented seizure was known to have occurred on Sunday, 7 March 2004. At 2:56am that day a call was placed to '000' by either Mrs Scutt or their son. Mr Scutt had been found collapsed on the kitchen floor of his residence.[81]

116. An ambulance was dispatched at 02:59am from the Ravenshoe QAS Station. In attendance was then A/Station Officer Bradley Bragg[82] and Student Paramedic Lillias Gyetvay. They arrived at the Scutt residence (17 Ascham Street, Ravenshoe) at 3:11am.[83] Whilst Student Paramedic Gyetvay provided primary care, A/Station Officer Bragg made observations.

117. At the Inquest Student Paramedic Gyetvay gave evidence that Mr Scutt was conscious but was experiencing "*altered* consciousness" in that he was "*responsive to voice but was unable to make sense of any directions and unable to answer any questions he was given. He was trying to stand but was unable to stand himself*".[84] She described Mr Scutt as being 'confused' and 'combative'.

118. QAS Notes recorded in relation to this attendance noted Mr Scutt was located in the kitchen having had a "*tonic / clonic convulsion*" for an unknown period of time. QAS then transported Mr Scutt to the Atherton Hospital. They departed his residence at 03:36am and arrived at the Hospital at 04:17am; a travel time of 41 minutes. On arrival at the Hospital A/Station Officer Bragg observed that Mr Scutt was conscious, orientated and "*alert with normal vital signs*".[85]

119. Mr Scutt first presented to the Atherton Hospital Emergency Department where he was seen by Registered Nurse (RN) Jennifer Pollock at 4:30am. Triage notes recorded that Mr Scutt had been found by his son having a "*tonic-clonic type seizure*".[86] RN Pollock also noted a conversation with QAS Officers that on their arrival at his residence Mr Scutt was "*definitely in a post ictal state*".

120. The last entry made by RN Pollock on 7 March 2004 was at 05:20am. The final progress note intimated that Mr Scutt may have been discharged from the Emergency Department shortly thereafter.

121. The next progress note was created at 11:20am on 7 March 2004 by Dr Ian Reddie. This progress note identified Mr Scutt as an 'in patient'. It was apparent on these notes Mr Scutt had by this time been admitted to wards.

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[81] Exhibit D1.8 at paragraph 4
[82] Exhibit D10.1
[83] Exhibit D10.5 at page 1 of 45 (Case #75A71 – Page 1 of 4)
[84] Exhibit D1.8 (Statement of Lillias-Ann-Katicia GYETVAY) at paragraph 6
[85] Exhibit D10.1 (Statement of Bradley Bragg) at paragraph 7
[86] Exhibit D1.1 – A

122. RN Pollock in evidence noted that the triage notes would form part of a patient file that would travel with the patient from the Emergency Department to the Wards such that any doctor subsequently reviewing the file would have access to those triage notes.

123. The continuity of the clinical information between the Emergency Department Triage Notes and the Ward Notes, would make it more likely than not that Mr Scutt remained at Atherton Hospital between 5:20am and 11:20am although progress notes do not reflect the care and treatment he may have received in the interim.

124. At 08:30am on 8 March 2004, Mr Scutt was reviewed by SMO Dr Rory Howard. He affirmed the plan for a CT scan (as developed by Dr Reddie) and advised Mr Scutt at the same time that he should not drive for a period of six months. That advice was given with reference to the Austroads 'Assessing Fitness to Drive' Guidelines and noting it was Mr Scutt's 'first seizure'. [87]

125. Following this review, Mr Scutt was transported by QAS Officers to the Cairns Hospital where he underwent the CT scan. This occurred on 8 March 2004 between 09:39am and 05:03pm.

126. Upon his return Mr Scutt was reviewed by Dr Howard, who by that time was apprised of the results from the CT scan.[88] The CT scan did not reveal an underlying cause for the seizure.

127. With respect of the scan Dr Howard deposed it was a 'non contrast' CT was because Mr Scutt's creatinine levels were 0.18. That reading showed Mr Scutt had a level of kidney impairment. The relevance of this was in order to observe greater definition of the blood vessels a radioactive dye is required to be injected into the patient. Because that dye was adverse to kidney function it would not be used in patients with already impaired kidney function.

128. Mr Scutt's kidney transplant meant he was not a suitable candidate to have the dye injected. The limitation of the non-contrast CT being performed on Mr Scutt was that the "*subtle changes of a brain tumour*" [had they been present] may not have been visible, although this was considered to be rare. There was no evidence of Mr Scutt having a brain tumour.

129. Dr Howard deposed in oral evidence:

> *"Seizures happen for a number of reasons. If you stress anybody enough, they will seize. If you disrupt their chemistry, they will seize. If they have a brain tumour or bleed in their brain, they can have a seizure. If you can't find any cause for seizures, it's called epilepsy. And so in epilepsy, by definition, all the blood tests we would do at Atherton are*

[87] Exhibit L2 at page 57 (69 of 145)
[88] Exhibit D1.2 – B at page 4 of 6

normal specialised neurological tests where you record brainwave activity may be normally, but usually are not"[89]

130. Dr Howard qualified that by stating whilst a specialist (neurologist) might make the diagnosis a non-specialist would have the capacity to make the diagnosis provided the appropriate suite of tests (such as a CT and EEG) had been conducted.

131. Dr Howard deposed in oral evidence that an EEG would not have resolved any subtleties that may have been lost on a non-contrast CT. The EEG would measure electrical brainwaves, a contrast CT by comparison would be looking for "*optical evidence of any altered blood vessels in the brain*".[90]

132. Dr Howard further qualified his response by stating that "*a [tincture] of time*"[91] may be required [to observe whether there is any recurrence] and that one fit of itself may not be epilepsy if the EEG is normal. He further deposed:

"*if you have a fit and you find no reason for it, and your EEG is completely normal, you can say 'well', you know it may have just been a fit from some sort of stress that we don't understand, but whereas if the EEG is abnormal in a way that allows you to say ' yeah this is epilepsy', then you can make a diagnosis after one fit. But sometimes you'll just sit on the fence for a little bit, and if ten years go past and they don't have another fit, then they probably don't. But if they then have another fit then okay, probably epilepsy and it's not unusual not to treat with drugs after one fit, but after two you normally would"*[92]

133. In cross-examination by Counsel for Dr Connolly, Dr Howard further deposed that it would be "*reasonable*", after testing had been done and results were 'normal', for a medical practitioner, whether GP or specialist, "*to await the clinical course*" i.e. a recurrence of seizure activity or not, before developing any additional treatment plan or referrals.

134. Dr Howard deposed that the treatment and care he provided to Mr Scutt was not for the purpose of a medical assessment to drive or for the issuing of a licence, rather it was for the purpose of Mr Scutt having presented having had a seizure. However as an "*aside*" to that he nonetheless gave advice top Mr Scutt that he should not drive.

135. Dr Howard considered at that moment in time there was a risk if Mr Scutt continued to drive. He gave the following evidence:

"*He's just had a seizure, as far as we knew it was his first seizure, [and] until you define the nature of that seizure and how likely it is to happen*

[89] T3.21/24-29
[90] T3.30/13-14
[91] T3.26.30-34
[92] T3.25-26/33-1

again, particularly when you're driving then of course it's going to influence your safety in your car"[93]

136. Notwithstanding the results of the CT scan that did not reveal any underlying cause and were, in effect 'normal', Dr Howard deposed that his assessment of the risk associated with Mr Scutt driving remained unchanged. He deposed as follows:

"*Because most seizures, as I was saying before, epilepsy is seizures of unknown cause … but by definition, most people who have fits, have epilepsy, and you would expect their scan to be normal. It's a little bit different these days we have MRI scans, we have much more complicated scans, that are redefining this to some degree, but in 2004 a normal CT scan is what you would expect in someone who has epilepsy*"[94]

137. With respect to the treating team at the Atherton Hospital, Dr Howard deposed that their obligations as to the ongoing treatment and care of Mr Scutt would have been as follows:

"*The routine thing would be we would organise any further referrals that were necessary, in this case he should be referred to have an EEG, to the neurology department, and we would then, I would expect that we would write a discharge summary to the General Practitioner, detailing this was the management plan and we would have expected the patient to go back to the General Practitioner … for him or her to … follow up the patient*"[95]

138. As to why it would be appropriate to refer back to a General Practitioner, in that instance, rather than the treating team at the Atherton Hospital taking up those follow up requirements, Dr Howard deposed as follows:

"*We simply at that time, as with now, simply don't have the resources to conduct outpatient clinics and follow up. It's also better done by a GP … there's a whole circle of health care for anybody who has anything going on, and the GP is at the centre of that, he or she, they are trained to coordinate everything, they have a little bit of knowledge about everything … a GP knows the patient. The GP is best placed to coordinate holistic care.*"[96]

139. In cross-examination by Counsel for the Cairns Hinterland Hospital and Health Service Ms Gallagher, Dr Howard reiterated his view that upon Mr Scutt's discharge from Atherton Hospital, the hospital did not have a continuing obligation to care for him.[97]

[93] T3.21/17-20
[94] T3.22/31-41
[95] T3.23/5-11
[96] T3.23/26-40
[97] T3.35/11-14

140. Dr Howard was also taken to the Medical Board of Australia, Code of Conduct document (as in effect from March 2014), and accepted the proposition that, that the central coordinating role for a patient falls to the General Practitioner and that standard would have applied in 2004 notwithstanding the Code of Conduct did not exist in that form at that time.[98]

141. Dr Howard's contact with Mr Scutt ceased at or about 05:00pm on 8 March 2004 however the progress notes from Atherton Hospital confirm that Mr Scutt remained admitted as an inpatient until approximately 10:30am on 9 March 2004. In that intervening period he was again seen by Dr Reddie.

142. Dr Reddie had a final consultation with Mr Scutt prior to discharge on the morning of 9 March 2004. The treatment plan developed at that instance was for an EEG to be performed on Mr Scutt. Dr Reddie reiterated the advice that Mr Scutt should not drive for the next six months.

143. Had Mr Scutt complied with the advice given, the earliest occasion he could have resumed driving would have been 10 September 2004.

144. Dr Reddie subsequently sent a facsimile to the Far North Queensland Neurodiagnostic Unit located at the Cairns Hospital requesting an EEG.[99] The facsimile also requested that a copy of the EEG report be sent to Dr Connolly of the Ravenshoe Medical Centre.

145. Dr Reddie also made arrangements for Mr Scutt's discharge plan and summary to be sent by facsimile (attention of Dr Connolly) to the Ravenshoe Medical Centre. As to whether that facsimile was sent (by the hospital) and or received by Dr Connolly was a matter of conjecture at Inquest.

146. The patient records of Mr Scutt, provided by the Ravenshoe Medical Centre, did not contain a copy of the discharge summary. Dr Connolly deposed in a written statement provided to the inquest prior to his death, that from the year 2000, or thereabouts, the Medical Centre commenced using an electronic medical record system. The process, upon correspondence being received in relation to a patient, was to enter that correspondence into the electronic system.[100]

147. With reference to the usual practice for record keeping at the Medical Centre, Dr Connolly deposed the absence of medical records indicated a likelihood that they were not received.

148. Dr Reddie deposed there were administrative processes in place that would facilitated the transmission of the discharge summary, (that it he would not have sent it himself).[101]

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[98] T3.35/46
[99] Exhibit D1.6 – F
[100] Exhibit D7.3 at paragraphs 13-14
[101] T3.45/28-30

149. RN Pollock deposed that there had been occasions when she had cause to interact with Dr Connolly in relation to other patients. She indicated that material would on occasion be forwarded to Dr Connolly. As a general proposition RN Pollock deposed:

"We've gotten better over time, but our presentations to ED we do send on notes to our GPs. Back in 2004 things weren't as streamlined as what they are today".[102]

150. No evidence was called from any other clinical or administrative personnel of the Atherton Hospital, as to the nature of performance of communication systems, in other areas of the Hospital, as at 2004.

151. I am satisfied the discharge summary was sent via usual administrative processes (most likely facsimile) to Dr Connolly by the Atherton Hospital.

152. However I have no evidence before me that Dr Connolly ever received a copy of Mr Scutt's 2004 discharge summary from the Atherton Hospital. Dr Reddie's discharge summary is not included in the records obtained from the medical centre. I note however Dr Connolly did receive a copy of the EEG report. (Dr Reddie requested it be provided to Dr Connolly by the Cairns Hospital when available, which it was).

153. Mr Scutt attended the Ravenshoe Medical Centre one week after discharge from the Atherton Hospital on 16 March 2004, and then again on 29 March 2004 and 31 May 2004. On each of those occasions he was seen by Dr Connolly.

154. Those attendances appear to be unrelated to the seizure event on 7 March 2004. There is no record in the notes from each of those attendances to indicate any discussion between Dr Connolly and Mr Scutt about his fitness or ability to drive. I would not have expected that to be the case in circumstances where the discharge summary had not made its way to file, and Mr Scutt had not yet undertaken the EEG and Dr Connolly was therefore unaware of the seizure. Mr Scutt remained silent about his hospitalisation.

155. After Mr Scutt's discharge from the Atherton Hospital on 10 March 2004 it is relevant to note that at 6:50pm on 6 April 2004, RN Pollock created a progress note of a phone call received from Mr Scutt's wife (Robyn). During that conversation RN Pollock recalled being told Mr Scutt was "*driving despite MO advice*".[103]

156. RN Pollock discussed three options with Ms Scutt which included making contact with his General Practitioner (Dr Connolly) with a view to Mr Scutt's driver licence being suspended until the medical condition was determined and medical clearance given.[104] Contemporaneous notes made by RN Pollock in

[102] T3.57/1-3
[103] Exhibit D1.9 (Statement of Jennifer Pollock) at paragraph 15 and Exhibit D1.1 – A
[104] Exhibit D1.9 (Statement of Jennifer Pollock) at paragraph 16

relation to this conversation confirm that the course of action was agreed upon by Mrs Scutt.

157. The is no record in the Ravenshoe Medical Centre notes of Mrs Scutt raising her concerns (as she indicated she would) with Dr Connolly regarding her husband driving against medical advice.

158. Mrs Scutt deposed in oral evidence that she had no independent recollection of such a phone call with RN Pollock but accepted that it occurred and that she was a participant in the call.[105]

159. On 4 June 2004 Mr Scutt underwent the EEG procedure (per Dr Reddie's case management plan in March 2004) at the Far North Queensland Nuerodiagnositic Unit. The reporting doctor for this procedure was Dr John Archer.

160. Medical records from the Medical Centre and the Atherton Hospital confirm Mr Scutt attended both facilities on 29 June 2004 seeking results of the EEG that had been initiated by Dr Reddie.[106] As of that date the results were not available.[107]

161. As of 2 August 2004, the results of the EEG were known. Progress notes recorded in Mr Scutt's patient file at the Medical Centre confirm he attended a consultation that day. The progress notes documented Mr Scutt as having had "*one observed grand mal convulsion*" and that the EEG was "*normal*". These terms were consistent with those documented in the EEG report. Dr Connolly was unable to determine when he received the results but he accepted that the relevant notes had been created by him in the patient file.

162. I find that as at 2 August 2004 Dr Connolly had was cognisant of Mr Scutt's EEG report and results.

163. The EEG report documented Mr Scutt had a normal CT and the "*last attack*" had occurred on 9 March 2004. That date is likely attributable to the initiating referral letter, generated by Dr Reddie, dated 9 March 2004.[108] Dr Reddie's referral letter was silent on the exact date of the seizure, other than it had occurred "*recently*".

164. I am satisfied that Dr Connolly was aware:

- That Mr Scutt had experienced a seizure;
- The appropriate referrals for Mr Scutt had already been made;
- That there were no underlying issues requiring further investigation.

[105] T5.34/38-43
[106] Exhibit D9.5 at page 11
[107] Exhibit D9.2 at page 5 of 70
[108] Exhibit D1.6 – F at page 3 of 3.

165. I accept therefore that it was appropriate for Dr Connolly to await the clinical course.

166. Dr Connolly deposed, that he likely did not have a discussion with Mr Scutt about driving (not driving) on the basis that the EEG (and presumably the CT) were normal.[109]

167. The current Austroad guidelines (first published 1998 and second edition in 2001) then provided for a discretionary 3-6 month minimum non driving period in circumstances of a first seizure (regardless of test results). The activation of the non driving period would have required either a self report by Mr Scutt, a good faith notification by the hospital or GP and consideration by the licencing authority. (The guidelines have evolved and now provided for a discretionary 12 month non driving period in such circumstances).

168. In any event at 2 August 2004 (at the time of his consultation with Dr Connolly), Mr Scutt was within the advised non-driving period advised by Doctors Howard and Reddie. Mr Scutt did not relay this information to Dr Connolly.

169. I note that 5 years later he advised Dr Pyke at the Atherton Hospital that he had in fact stopped driving for only a one month period after discharge in 2004. So as at the 2 August 2004 consultation he was driving a vehicle against the medical advice of hospital doctors.

170. I am satisfied having regard to the evidence in relation to Mr Scutt's overall demeanour, temperament and character that he was unlikely to volunteer to Dr Connolly that he had been advised not to drive by doctors at the Atherton Hospital. I was left the impression at Inquest that Mr Scutt would resist any such suggestion (to not drive) at all costs.

Seizure on 19 May 2009

171. Mr Scutt's second documented seizure occurred on Tuesday, 19 May 2009. At 2:35am that day a call was placed to '000' by Mrs Scutt. Mr Scutt was experiencing convulsions at his residence. An ambulance was dispatched at 02:37am from the Ravenshoe QAS Station. They were at the scene at 02:47am. Mr Scutt received treatment from Advanced Care Paramedic (ACP) Darrel Thompson.

172. ACP Thompson made notes in relation to his treatment of Mr Scutt. These were recorded in the Electronic Ambulance Report Form. ACP Thompson noted Mrs Scutt had been woken from her sleep by Mr Scutt "*thrashing around as he got out of bed at 0200 this am*".

[109] Exhibit D7.3 at paragraph 42

173. The Electronic Ambulance Report Form generated in relation to this event contained information concerning Mr Scutt's pre-existing history. It documented:
"Seizure/s Unknown type occurrence 4 Year/s ago >> single seizure, investigated, unknown aetiology"

174. When examined at the Inquest, ACP Thompson deposed in oral evidence that Mrs Scutt the likely source of that past history provided to him because Mr Scutt:

"Didn't want anything to do with us and didn't want to talk and denied having seizures, ever having a seizure, having seizures that night, totally denied everything"[110]

175. ACP Thompson also documented Mr Scutt had experienced a "*full tonic clonic seizure*" lasting approximately 2-3 minutes following which he was "*unrousable*" for about 15 minutes.

176. ACP Thompson deposed that Mr Scutt was initially "*confused*" and "*aggressive*" but after receiving oxygen treatment, Mr Scutt's level of confusion began to reduce. ACP Thompson attributed the aggressive behaviour to Mr Scutt's *post-ictal* state rather than it being part of his general character.

177. ACP Thompson had known Mr Scutt for a period of time, had opportunities to interact with him in public settings, and considered the aggressive demeanour at the time of his attendance to be inconsistent with his other dealings.

178. Based on the history taken, and the observations made at the time of his attendance, ACP Thompson formed the following opinion with respect to the medical condition that was affecting Mr Scutt:

"He had had a seizure, his wife described it well enough that I considered he'd had a full tonic-clonic seizure of a significant time. During that time it's usual for a patient not to be breathing and that means their brain does become starved of oxygen which causes the post-ictal period, because of that there could be further damage. Also, he's denying that he had a seizure, the wife's saying he had a seizure, if it's a seizure in isolation and that he's not medicated for seizures just generally it could be caused by something else, it could be caused by a brain bleed it could be caused by something else"[111]

179. On that basis ACP Thompson indicated that Mr Scutt should be taken to Hospital for the purpose of further assessment. Whilst ACP Thompson accepted that Mr Scutt was able to articulate that he did not want to be taken to Hospital, ACP Thompson considered that Mr Scutt was still in a post-ictal state and as such did not have the requisite capacity to refuse.

[110] T3.64/18-20
[111] T3.65/20-29

180. Mr Scutt was transported to the Atherton Hospital. He was loaded into the ambulance at 03:16am and arrived at the Atherton Hospital at 03:56am. QAS involvement in relation to this event ceased at 04:29am.[112]

181. Between first attending Mr Scutt's residence and arriving at Atherton Hospital, ACP Thompson deposed in oral evidence that Mr Scutt's condition improved such that his Glasgow Coma Scale (GCS) was 15, as demonstrated by Mr Scutt's ability to answer ACP Thompson's questions correctly, obey commands that were given and his eyes being open.

182. Upon presenting to the Atherton Hospital Emergency Department, Mr Scutt was initially triaged before being seen by Dr Suzette Pyke (then a Senior Medical Officer) sometime around 05:00am.[113] The triage notes were consistent with the history taken by the ACP Thompson.

183. When called to give evidence at the Inquest, Dr Pyke was then working in as a General Practitioner in South East Queensland.

184. Dr Pyke reviewed the history taken by QAS and the triage notes. In conversation with Mr Scutt, she took additional information that she documented in progress notes. Her progress notes were timed at 05:00am, she deposed that they would have been written up after her consultation with Mr Scutt.

185. At the time of that consultation Dr Pyke was cognisant that Mr Scutt had previously experienced a seizure in March 2004.[114] Noting that Dr Pyke documented the results from the blood tests, non-contrast CT and EEG (conducted in 2004). I am Dr Pyke obtained that information from Mr Scutt's patient file.

186. In terms of Mr Scutt's willingness to receive treatment at that first instance, Dr Pyke deposed that she had no independent recollection of his demeanour at that time, although with reference to her progress notes she expressed the opinion that he had been "*anxious*" and was declining further testing.

187. Based on Mr Scutt's presenting symptoms and history Dr Pyke formed the opinion that Mr Scutt had experienced a tonic-clonic seizure, and that it was his second. She was unable to determine the cause of the seizure. In oral evidence Dr Pyke confirmed that her reference to the 'second seizure' was with reference to the seizure of March 2004 that she had documented in her progress notes.

188. The initial plan (as documented by Dr Pyke) was:

- Admit Mr Scutt to medical ward;
- Conduct blood testing; and

[112] Exhibit D10.5 at page 12 of 45(Case #5813406 – Page 2 of 5)
[113] Exhibit D2.6 (Statement of Dr Suzette Pyke)
[114] Exhibit D2.6 (Statement of Dr Suzette Pyke) clinical notes at page 7 of 14

- Head CT scan.[115]

189. At 8:30am Dr Pyke made notes of a conversation with Mr Scutt during which she recorded his refusal to undergo the CT scan at Cairns. Dr Pyke then recorded advice to the effect: "*I explained the consequences including not being able to drive for a prolonged time. He [Mr Scutt] says he needs to drive for work & only stopped for 1/12 [one month] last time. I told him that I will be reporting his inability to drive. He will follow up with Dr Connolly (letter sent)*".[116]

190. In oral evidence Dr Pyke was uncertain as to whether she gave any specific time to Mr Scutt (in months or years) as to the period he should abstain from driving.

191. Based on the history taken, Dr Pyke considered the Mr Scutt had previously abstained from driving for a period of time (in 2004), although not for as long as he had been advised. Dr Pyke was unaware of the previous period advised (namely 6 months). On that basis Dr Pyke did consider that Mr Scutt was likely to be non-compliant, to some degree, with any further period of non-driving, as advised by her.

192. The treatment plan documented at 08:30am was:

- CT Head;
- Chase bloods;
- Discuss with neurologist regarding management; and
- Follow up with physician.

193. In a further progress note at 11:00pm Dr Pyke documented a change in Mr Scutt's willingness to undergo further investigation. She documented that he was then willing to undergo the investigation "*because his wife and son want him to*".

194. With reference to her progress notes Dr Pyke confirmed that she did consult with the Neurology Registrar at the Townsville Hospital. The advice taken from the Neurology registrar was to treat the seizure as a 'first seizure', to conduct an MRI of the brain and consider anti-convulsants if Mr Scutt had another seizure.

195. Dr Pyke deposed that the change in Mr Scutt's willingness to undergo investigations, and the Neurology Registrar's advice to treat this instance as a 'first seizure' did not alter any of her own views / advice in relation to a period of non-driving.

196. Following Dr Pyke's consultation with the Neurology Registrar, Mr Scutt's management plan was amended (from what was developed at 08:30am) to:

[115] Exhibit D2.6 (Statement of Dr Suzette Pyke) at paragraph 10.11 and clinical notes at page 10 of 14
[116] Exhibit D2.6 (Statement of Dr Suzette Pyke) clinical notes at page 10 of 14

- MRI Brain; and
- Letter to Dr Connolly

197. Under cross-examination by Counsel for Dr Connolly, Dr Pyke accepted this amended plan represented a 'stepped approach'. Wherein the previous plan had contemplated a referral to a physician, the revised plan was developed on the basis that the MRI would be conducted first (then reviewed) before a decision was taken to further refer Mr Scutt

198. Dr Pyke documented that Dr Tawake (visiting medical officer to Atherton Hospital) would need to sign a request form for the MRI in the following week. When Dr Pyke was examined as to whether she followed up with Dr Tawake in relation to the MRI forms, she was unable to recall.

199. During cross-examination by Counsel for Dr Connolly, Dr Pyke accepted that Mr Scutt was a public patient and therefore the MRI would have been organised through the public hospital system. Dr Pyke further accepted that it would be the responsibility of the hospital to write to Mr Scutt and notify him when his appointment had been scheduled.

200. Mr Scutt was discharged from the Atherton Hospital Emergency Department at 11:00am. At no time was Mr Scutt admitted to wards, as distinct from the 2004 presentation.

201. Notwithstanding that she requested that Mr Scutt not drive until further notice and that she would be advising the Transport Department of her decision, Dr Pyke did not make a formal notification to Transport and Main Roads regarding Mr Scutt's unfitness to drive.

202. In oral evidence Dr Pyke deposed that at no stage during her time with Mr Scutt was she treating him for the purposes of undertaking a medical examination as to his fitness to drive. In plain terms, she deposed that the basis of her treatment and care for Mr Scutt was:

"*to manage his presentation as having had a seizure, and to establish a cause for that, if there was a cause, and to manage that seizure [as an Emergency Department doctor]*"

203. Following his discharge Dr Pyke sent a letter (by facsimile) to Dr Connolly with respect of Mr Scutt's treatment on this occasion. Dr Pyke produced a copy of that letter to the inquest.[117] The letter is stamped as having been faxed on 19 May 2009.

204. I find the facsimile dated 19 May 2009 under the hand of Dr Pyke was sent by the Atherton Hospital on 19 May 2009 and received by the Ravenshoe Medical

[117] Exhibit D2.5 – E

Centre and on a date likely to also be 19 May 2009. I do not go as far as to say that Dr Connolly became aware of the letter on 19 May 2009.

205. It is a matter of relevance that within the letter to Dr Connolly, it was noted Mr Scutt had refused to have the CT scan done but, he had agreed to the MRI. Furthermore, the letter noted that Mr Scutt "*would be contacted with the appointment at a later date*". On that basis, Dr Pyke accepted during examination, that her communication to Dr Connolly would have enlivened an expectation by the GP that the MRI would be done.

206. Noting that Dr Pyke was unable to recall whether she followed up with Dr Tawake, the proposition was put to her that <u>if</u> that follow up and referral for the MRI had not occurred, whether Dr Connolly should have been notified of that change. Dr Pyke deposed:

"*I expect if [the MRI] didn't take place it was because it, was an error in terms of follow up, and in which case if it slips through the cracks as such, then there would be no notification to Dr Connolly*".

207. Dr Pyke accepted that upon Mr Scutt being discharged

"*[our] obligation would have been to follow up on the part of the plan that was our responsibility. Beyond that, he was being discharged back to his GP's care*".

208. In cross-examination by Counsel for Dr Connolly, Dr Pyke further accepted:

"*any test that a Hospital orders they have continuity of care to follow that up, even if the GP could order it themselves*"

209. It is accepted that the Atherton Hospital did not follow up with the MRI as per the management plan, that it 'slipped through the cracks' due to an error by the hospital, and that Dr Connolly was not notified that they had not followed up with Mr Scutt.

210. In that regard Dr Pyke considered Dr Connolly's obligations to be:

"*As a GP myself, receiving correspondence from a hospital along those lines, I would record that in the patient's past history so that it's there for me to refer to, I would also consider calling the patient in to discuss driving with the patient and then subsequently would try to ensure, at future appointments, try to ensure that the follow up that was planned had occurred*".

211. The final paragraph of the letter from Dr Pyke to Dr Connolly stated:

"*I have advised him [Mr Scutt] that he will not be able to drive until further notice, and I have asked him to discuss this with you for reinforcement when he sees you next*".[118]

212. Mr Scutt next attended the Ravenshoe Medical Centre on 21 May 2009 (two days after discharge from the Atherton Hospital), He was seen by Dr Connolly.[119] Records indicate that the reason for his attendance was described as "*dizziness*". Dr Connolly took Mr Scutt's blood pressure and recorded that as 145/80. As to management of the 'dizziness' Dr Connolly noted: "*stop jumping up quick / practice rising slowly*".

213. There is no indication in the medical record of Dr Connolly for that day, discussing the content of Dr Pyke's facsimile letter dated 19 May 2009 with Mr Scutt either with regard to the seizure event her advice to him with respect of not driving, or the recommendation for an MRI.
214. There is also no indication in the records that Mr Scutt self-reported his seizure and recent admission to the Atherton Hospital to Dr Connolly.

215. I conclude and find that as at 21 May 2009 consultation Dr Connolly remained unaware of the letter of discharge from Atherton Hospital. With reference to Dr Connolly's progress notes, none of the issues raised in Dr Pyke's letter were discussed or touched upon – not the presentation at the Atherton Hospital, the seizure, or the discharge plan or referral for an EEG. Similarly, there is no report by Mr Scutt to his GP recorded in the notes indicating was admitted to the Atherton Hospital only days prior. The reason for the consultation is referred to as 'dizziness'. I have formed a view that Mr Scutt did not report the true nature of his condition and underplayed his symptoms to Dr Connolly during that consultation.

216. Notwithstanding that I have already accepted that the discharge letter had been faxed from the Atherton Hospital to the medical centre, I further find there is no evidence before me to suggest that had Dr Connolly been appraised of the content of the discharge letter of 19 May or advised of Mr Scutt's condition and recent hospital admission by Mr Scutt himself as at the 21 May consultation.

217. I am however satisfied that sometime after the 21 May 2009 consultation, Dr Connolly became aware of the discharge letter of 19 May 2009. There is no evidence before me to suggest that Dr Connolly recalled Mr Scutt, or followed up with him to reinforce Dr Pyke's decision that Mr Scutt not drive, or to ensure that the proposed treatment plan had been facilitated, or generally to inform himself as to his patients condition.

218. I am asked to accept in written submissions on behalf of Dr Connolly he did not re-call Mr Scutt because the hospital was organising the MRI, and Dr Pyke had (already) advised Mr Scutt not to drive.

[118] Exhibit D2.5 – E at page 2 of 2
[119] Exhibit D9.2 at page 10 of 70

219. I do not accept that submission. By any accepted standard of general medical practice Dr Connolly upon reading the discharge letter (at any time), would then be aware that his patient had either under, or falsely reported to him on 21 May, and was seized with a professional obligation to re-call or follow up with Mr Scutt.

220. It was entirely reasonable that Dr Connolly believed the hospital would follow through with the referral for the MRI test. It was not however reasonable as his medical practitioner of longstanding, and by then aware of the recent hospital admission for the seizure and an earlier seizure in 2004, not to follow up with his patient as a result of the information contained in the discharge letter addressed to him. To remain absolutely silent or passive and not, at the very least, discuss the letter with Mr Scutt is concerning and lost a potential opportunity for the general practitioner to open up care and treatment pathways with his own patient.

221. The letter was personally addressed to Dr Ken Connolly at the Ravenshoe Medical Centre and commences "*I saw Brian early this morning in ED following a tonic colonic seizure.*" Brian Scutt's recent seizure was clinically significant. Driving posed serious harm both to the patient and other road users. The local hospital had specifically directed a request to Mr Scutt's GP to reinforce their advices.

222. Dr Connolly had an obligation for the continuity and coherence of Mr Scutt's overall care. He was Mr Scutt's long term treating practitioner was by now aware of two prior seizures (albeit some 5 years apart). The letter advised Dr Connolly that an MRI was pending. One's long term treating practitioner might be interested in the outcome of such a test and enquire if results were not forthcoming.

223. I note with the benefit of reflection that Mr Scutt did not ever have an MRI and that such a test might have provided information not before known. Not to have this test was a missed opportunity in Mr Scutt's care and treatment.

224. My recommendations arising from this inquest will include further reinforcement by peak medical bodies in relation to obligations for continuity of care and ensuring any potential for gaps in handover and provision of discharge notes and letters of referral are identified. I note the Cairns Hinterland Hospital and Health Service have developed and implemented a procedure for discharge summary distribution with an emphasis on communication between doctors and patients and doctors and doctors for ongoing care. I commend this protocol as a basis for discussions amongst stakeholders (reference CHHSD IM Proc HIM 292 V6-12/21).

Seizures on 18 August 2014

225. There were two documented seizure events on 18 August 2014. One in the morning and the second in the afternoon.

18 August 2014 – AM

226. At 04:47am Ms Scutt placed a call to QAS and assigned case ID #5695187.[120] The case given on that occasion was "*generalised fitting seizures*".[121] As a result of this call Critical Care Medical Paramedic (CCMP) Shayne Russell-Brereton was dispatched from the Ravenshoe Ambulance Station at 04:48am. He arrived at the Scutt residence at 04:56am. He was the only QAS Officer to attend in relation to this case.

227. CCMP Russell-Brereton gave evidence at the inquest. He stated that upon arrival at the Scutt residence he had a conversation with Ms Scutt who then took him into a room within the residence where Mr Scutt was observed lying in a recumbent position. CCMP Russell-Brereton observed Mr Scutt to be "*awake and alert*" to follow his movement into the room and also inform CCMP Russell-Brereton that whatever had made Mrs Scutt call QAS "*had stopped*".

228. In further conversation with CCMP Russell-Brereton, Mr Scutt denied having had a seizure.[122] CCMP Russell-Brereton observed Mr Scutt appeared confused, he then took a history of the event from Mrs Scutt based on which he formed the opinion Mr Scutt had had a seizure, notwithstanding the denial given.[123]

229. CCMP Russell-Brereton then made the following assessment:

> "*At this point I could see he was in the post ictal phase. Brian was awake and alert, he was very tired, and mildly confused, but not confused enough to alter his conscious state. In other words he had no memory of the event*".[124]

230. Mr Scutt then refused to roll up his sleeve so that his blood pressure could be taken. CCMP Russell-Brereton gave advice to Mr Scutt:

> "*If you have had a seizure you need to go to the Hospital and be seen by a doctor*".[125]

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[120] Exhibit D10.5 at page 29 of 45 (Cased ID 5695187 – Page 4 of 4)
[121] Exhibit D10.3 at paragraph 14
[122] Exhibit D10.3 at paragraph 24
[123] Exhibit D10.3 at paragraphs 23 to 27
[124] Exhibit D10.3 at paragraph 28
[125] Exhibit D10.3 at paragraph 28

231. Mr Scutt further refused to allow CCMP Russell-Brereton to do an assessment, would not allow his blood pressure or temperature to be taken. He refused an ECG and again refused to attend the Atherton Hospital. CCMP Russell-Brereton considered that he had been given a valid refusal of medical treatment and assessment. [126]

232. At 05:44am Mrs Scutt placed a call to 13Health (Session ID #1747009), Nurse Rachel Olorenshaw received the call and gave advice.[127] The call was recorded and a copy of that recording and associated transcript were tendered at the inquest.[128] That call was then escalated to the after-hours GP Helpline.

233. The call to GP Helpline was placed at 06:02am (Session ID #9202273), Dr Anju Pandey was the General Practitioner that received the call and gave advice.[129] The call was recorded and a copy of that recording and associated transcript were tendered at the inquest.[130] The call concluded at 6:14am.

234. During that call Mrs Scutt indicated to the doctor assigned to the Qld Health telephone Contact Centre she was calling about her husband Brian and that at 5.00am he had a fit and that he did not want to go with the ambulance this time.

235. I extract relevant dialogue below:

- *Doctor: Thank you. Can you tell me again the reason of the call this morning?*

- *Caller: Okay, first of all, I'll just let you know, he's very oppositional defiant kind of thing and he's frightened that when I'm talking I'm going to get him to go to hospital for something, so he might interrupt what we're saying. What was your question to me?*

- *Doctor: Why are you calling us today?*

- *Caller: Why I'm calling you. Okay, at five o'clock he had a fit. He's got a kidney transplant so sometimes the medication - I don't know what - he's had about five fits over the last 15 years. Each time he's been - the ambulance has taken him with them. But he doesn't want to go so this time when the ambulance came - this fit was different. He had it while he was asleep and he didn't gain consciousness afterwards. He just went back to sleep again. But then when I rang the - when the ambulance came he woke - he called them - he's very deaf. But they woke him up. Then because he refused to go to hospital the ambo just put that tip thing on his finger and checked his heart and said it was 95 and said that's not too bad. He was still confused at that stage.*

[126] Exhibit D10.3 at paragraph 39
[127] Exhibit D5.1.1
[128] Exhibits D5.1.2 and D5.1.3
[129] Exhibit D5.2.1
[130] Exhibits D5.2.2 and D5.2.3

- *Anyway, then the ambo stayed for a while and he said look call them again if he has another one, because Brian just refused to go. So after that I just sat with him. But his eyes - over the next 20 minutes or so his eyes were still rolling back into his head and he was having the shakes again, which sometimes he has without a full fit, in the past couple of years when he gets stressed or I don't know what happens. So I have no idea why he has the fits. But what I'm worried about today is he had had the alarm clock set to 5:30 because he works for a fella and he had to go out bush and feed cattle who've been mustered up and put in the yard without food and water. So he'd be driving and at a place alone by himself where if anything happened nobody would know. So that's the reason I contacted the health line.*

- *Doctor: Okay, when was the last time he had fits prior to this?*

- *Caller: I can't actually remember because - but in the last year he's had some of those just the shaking, the rigid kind of things, but not actually a full fit. This time he made funny strange distressed noises, and I was sleeping in the other room and I heard him so I came in. Then it was easy for me to roll him on his side, fortunately, because he was on his right side. I could tip him over and he was trying to vomit. But he didn't actually vomit so that [unclear] [passed] and then just continued with the kind of shaking but he didn't wake up. Then he just gradually after a while went back to sleep again. Of course in that time I'd rung the ambulance.*

- *Doctor: Okay. Look, you know what Robin. You need to go to hospital.*
- *Caller: Beg your pardon.*
- *Doctor: He needs to - he can't go out driving. He needs to go to hospital.*
- *Caller: Okay, thank you very much.*
- *Doctor: So do you think you can take him to hospital?*
- *Caller: I don't know if he will go with me and if anything happened on the way - like if he started to have another fit or something and I was on - like he doesn't seem like he's going to now.*
- *Doctor: Is he alert and awake now?*
- *Caller: Yes, he's alert and awake now. He's watching TV. He got up and made himself a cup of tea and he managed all that all right.*
- *Doctor: How far is the hospital from your place?*
- *Caller: 45 minutes' drive.*
- *Doctor: If his symptoms happen again and he [unclear], what you do is you pull over and call the ambulance.*
- *Caller: Okay.*
- *Doctor: I mean you've called the ambulance before [unclear]. If you want you can call the ambulance but...*
- *Caller: Yeah, I don't want to disturb them. It's distracting them from something else. I can just take it from there, yeah.*
- *Doctor: Take him to hospital. He needs to go to hospital. He can't go driving without a [person there].*
- *Caller: No.*

- *Doctor: So he needs to be investigated at the hospital. He needs blood tests. He needs a lot of other things done.*
- *Caller: Now, should I ring the hospital before I leave?*
- *Doctor: No, that's fine. You don't need to do that. You can just...*
- *[Over speaking]*
- *Caller: [Just go in] where the ambulances go in.*
- *Doctor: Go to the emergency.*
- *Caller: Okay.*
- *Doctor: But he's alert and awake and walking now.*
- *Caller: Yes.*
- *Doctor: If you think that he starts - before he goes he starts becoming bad again obviously call the ambulance, or if anything happens on the way call the ambulance. How long ago was the last one?*
- *Caller: Pardon?*
- *Doctor: The last fit, how long ago was that?*
- *Caller: Five o'clock.*
- *Doctor: So he hasn't had anything since five o'clock?*
- *Caller: Well he had - after that he had those kind of - for about 20 minutes he had - his eyes would be rolling up to the top of his head and he'd be shaking a bit. But it wasn't - it didn't turn into anything and he's got clearer and clearer, and it's now ten past six here.*
- *Doctor: So he's been alert and awake for half an hour?*
- *Caller: No, maybe - yeah, when I first started talking to the nurse. Yeah, maybe it would be about half an hour now.*
- *Doctor: All right then. So [how about you] take him to hospital now…*
- *[Over speaking]*
- *Caller: Now the only other thing is that there's some areas between here and the hospital where there's no mobile reception and it's like a range on hills and things.*
- *Doctor: Maybe call the ambulance then. Do you want to call the ambulance?*
- *Caller: I might be better to do that. Do you think it's important that he's checked out because I can't - like if I'm on a hilly road or something and there's nowhere for me to pull over and I can't [unclear].*
- *Doctor: Yes, tell them that he's called them before and tell them that he didn't want to go to hospital but he needs to go to hospital and they should come and take him there.*
- *Caller: Okay.*
- *Doctor: Okay?*
- *Caller: Thank you very much.*
- *Doctor: All right then. Thanks for calling, bye.*
- *Caller: Brian, the doctor said you need to go to hospital to be checked out.*
- *Male: I'm not fucking going to hospital. No, I'm not going, [unclear] me.*
- *Caller: Brian.*
- *Male: I'm not going no-where.*

236. Mrs Scutt was unaware that the recording was still activated at the conclusion of the call. Mr Scutt's response in the last lines of the transcript (the full audio version was played in court) captured her husband's unguarded and emphatic response. It also provided some insight into Mr Scutt's general demeanour and obstinate attitude. Mrs Scutt's candour regarding aspects of her marriage during her oral evidence reflect the snapshot distilled in this conversation.

237. As a result of the conversation with and advice given by Dr Pandey, Mrs Scutt placed a second call to QAS; that call was taken at 06:28am and assigned case ID #5695399.[131] The basis of the call was solely to make arrangements for Mr Scutt to be transported to the Atherton Hospital. CCMP Russell-Brereton attended the Scutt residence on a second occasion in response to the call, he arrived at 06:38am.

238. Upon arrival at the Scutt residence CCMP Russell-Brereton had a conversation with Ms Scutt and she discussed the advice she had received from Nurse Olorenshaw and Dr Pandey. CCMP Russell-Brereton observed Mr Scutt's demeanour at that time as "*annoyed*". Whilst Mr Scutt voluntarily entered the ambulance, he declined all other medical assistance and examinations offered by CCMP Russell-Brereton.

239. Mr Scutt was then transported to Atherton Hospital, arriving at 07:24am where he presented to the Emergency Department.[132] A handover was completed between CCMP Russell-Brereton and a Registered Nurse. The triage time was documented as 7:46am.[133]

240. At 09:53am Mr Scutt was seen by Dr Briana Van Beekhuizen, a Senior Medical Officer with the Atherton Hospital. She was the only SMO in the Emergency Department on that occasion, although she deposed there was also Principal House Officer and ED Registrar present. Mr Scutt was not admitted to wards, but remained within the Emergency Department for the duration of his presentation. The basis for his presentation and treatment was a seizure.

241. Dr Van Beekhuizen further confirmed in oral evidence that the basis of her treatment was information provided by Mr Scutt and at the time of his presentation there were no indicia of the seizure still manifesting. In addition to the information provided in relation to the seizure that morning, Mr Scutt also volunteered information in relation to his seizure in 2009, which he indicated was his most recent, though not the only previous one. Dr Van Beekhuizen did not review Mr Scutt's hospital record.

242. That history, as provided by Mr Scutt, did not reconcile with the triage notes which stated "*happens once/yr*". Dr Van Beekhuizen did not recall whether she explored that discrepancy with Mr Scutt during her consultation with him. She accepted there was no record of such conversation in her clinical notes.

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[131] Exhibit D10.5 at page 33 of 35 (Case ID #5695399 – Page 3 of 3)
[132] Exhibit D10.5 at page 32 of 45 (Case #5695399 – Page 3 of 3)
[133] Exhibit D4.1

243. When examined as to whether she had cause to consider Mr Scutt's patient file held by the hospital, having regard to the information that had been provided, Dr Van Beekhuizen responded:

"*Not at that particular moment because he told me clearly, the seizures and what it was about*"

244. Dr Van Beekhuizen qualified her interactions with Mr Scutt when she deposed:

"*He was answering questions, he didn't generally offer information*"

245. She further deposed:

"*He didn't want to be there, he kept telling me: 'when can I get out of here'*"

246. As to whether a reference to Mr Scutt's patient file was required in that instance, Dr Van Beekhuizen deposed:

"*The referral to a patient's file is not necessarily something that happens in the Emergency Department, unless there's an unclear reason or presentation, so we go to the file for further information if we're not clear about what we're treating. Mr Scutt gave me no reason to be unclear … the reasons I would look at a file is to get more information, if I felt I needed it at the time, to deal with the presenting complaint at the time*"

247. Mr Scutt's disclosure of past seizures, also included disclosures about there being past investigations from which no cause was found. The only investigations that had been completed at that stage were:

- The blood work, non-contrast CT and EEG in 2004; and
- The blood work in 2009.

248. Dr Van Beekhuizen accepted in cross-examination by Counsel for Dr Connolly that she did not document in her progress notes, the nature of the investigations, when they were conducted, or the time of any seizures prior to 2009.

249. When examined as to whether she considered generating any additional referrals for Mr Scutt at that instance, Dr Van Beekhuizen responded:

"*As I've said in my notes, no I didn't generate a referral at that point in time*"
"*Mr Scutt had spoken clearly about his seizures being exactly the same as previous, and because the seizures had been fully investigated, so at that point in time I thought there was no clinical indication for me to generate further ongoing referrals and investigation*"

250. Based on Dr Van Beekhuizen's clinical observations, including the history as provided by Mr Scutt, she developed a management plan including strategies to reduce possible 'triggers' for his seizures such as a relaxation techniques and sleep hygiene. She further advised him not to drive or operate heavy machinery for a period of 2 years and encouraged him to see his GP.

251. Dr Van Beekhuizen further deposed that her discussion with Mr Scutt in relation to the non-driving period included counselling him with regard to the risk of harm to himself, and others, were he to have a seizure whilst driving.

252. Counsel for Dr Connolly posed a hypothetical scenario and was asked if she had been aware of such information whether it would have changed her management plan including:

- Having had a fit that was different to previous ones;
- Having an episode after the original fit of his eyes rolling back into his head and tremors; and
- Having shaking and rigid episodes in the previous year but actual fit.

"*In the hypothetical scenario that a patient presented and gave me that information that clearly would trigger that alternative pathway that I've mentioned in my statement … I would be more, well, I would be strongly suggesting his admission and then further investigation through that admission and or referral to neurology depending on, that's for the inpatient team to manage*".

253. Dr Van Beekhuizen deposed that she was not aware, at the time of her consultation with Mr Scutt, that she had the capacity to make a voluntary notification to the Licensing Authority in relation to any concerns she held in relation to Mr Scutt's condition or his continued driving. She deposed that it was only through this inquest that she gained that awareness. I accept that evidence. I am satisfied she did however appreciate the potential for harm if Mr Scutt were to drive noting she arbitrarily advised a term of non-driving on Mr Scutt was two years.

254. There was a missed opportunity by the hospital to make a good faith notification to TMR at this time; as noted above Austroad guidelines in effect at that time provided a discretionary non driving period, however to be enlivened (in the formal sense) required either a notification by the licence holder, and / or a good faith notification by the hospital doctor. I accept that Dr Van Beekhuizen was not aware of this pathway. She was also reassured that the patient would comply with a non driving period and would attend his GP, who she assumed by then would be in charge of her faxed notes.

255. I will recommend that the Qld Department of Transport and Main Roads facilitate an educational campaign for the professional development of general

practitioners, and doctors within Health and Hospital Services, to better understand the pathways to notify and report medical conditions that impact on fitness to drive. Front line medical personnel are often the first to diagnose conditions that impact on the ability to drive safely on the roads and that the reporting mechanism and avenues for report need to be well defined and understood in the first instance. In a hospital setting it would not be difficult to have a fax back type system in place to TMR or to a specific email address.

256. Thereafter it is incumbent on the state licencing authorities to assess and facilitate processes to satisfy the authority of a licence holders continued fitness to drive.

257. With reference to the current Austroad guidelines a seizure would be sufficient to trigger a period of non-driving and a 'show cause period'.

258. In this case Dr Van Beekhuizen had no recollection of receiving any literature within her work environment in relation to the systems or means by which a voluntary notification might be made.

259. Dr Van Beekhuizen deposed that Mr Scutt's indication that he was seeing his GP the following day was "*reassuring*". She further deposed that she had no reason to doubt his expressed intention to see his GP the next day. (Mr Scutt in fact next attended upon Dr Connolly one week later on 25 August 2014).

260. Dr Van Beekhuizen had Mr Scutt under observation for a period no greater than 25 minutes (9:53am to 10:18am),[134] a period that she considered "*fairly standard*", to be with a patient within an Emergency Department setting.

261. As result of that consultation, Dr Van Beekhuizen prepared clinical notes.[135] She confirmed a presentation to the Hospital on account of the seizure Mr Scutt experienced that morning. Mr Scutt told her he would attend his GP the following day, he declined further investigation and expressed a desire to be discharged from the Hospital so that he could get to work.

262. Dr Van Beekhuizen in evidence said "*The fax system at that point of time is a fax machine at our desk and it has numbers pre-programmed into it. I had been there a week. I put the notes and hit Ravenshoe Clinic*".[136] Dr Van Beekhuizen deposed she possibly sent the fax to the Ravenshoe Primary Health Clinic (and not the Ravenshoe Medical Centre). The note was not addressed specifically to Dr Connolly. I accept Dr Van Beekhuizen faxed the clinical note as deposed to.

[134] Exhibit D4.2 – B
[135] Exhibit D4.2 – B
[136] D5 of evidence

263. The clinical note from Dr Van Beekhuizen was collated with Mr Scutt's patient file at the Ravenshoe clinic. The document is time and date stamped as 18 August 2014 at 14:54.[137]

264. Dr Connolly deposed that the ordinary practice (when at the clinic, not the medical centre) would be for correspondence to be presented to him in a folder which he would then review co-sign and acknowledge receipt. The clinical notes prepared by Dr Van Beekhuizen located on the clinic file, were not endorsed by Dr Connolly as was his usual practice. Mr Scutt next attended upon Dr Connolly at the clinic on 25 August 2014 (one week after these seizure events). I refer to the consultation further below.

18 August 2014 – PM

265. On the afternoon of 18 August 2014 Mr Scutt was working on Mt Ruby Station at Silver Valley, he worked on an ad-hoc casual basis for the station owner Mr John Mudge. On this occasion Mr Scutt was the passenger in a vehicle being driven on the station by Mr Mudge; they had been checking and repairing fences.

266. At approximately midday they were driving back to the station homestead when Mr Mudge observed Mr Scutt become red in the face and put his hand up to his forehead. Mr Mudge asked: "*Brian are you alright*"? Mr Scutt replied: "*I have a headache*".[138]

267. After a period of a 'couple of minutes' Mr Mudge heard Mr Scutt gasp then observed him to "*straighten up and go rigid*". He observed that Mr Scutt's body (including feet and arms) straightened and that "*his fists were clenched*".[139] Mr Scutt began to lean across Mr Mudge as he was driving. Whilst Mr Scutt was not observed to be convulsing he was "*stiff as a board*", his eyes were observed to be open and unblinking and "*staring at the roof of the vehicle*".[140]

268. Mr Mudge then drove to a cottage on the station where he asked another station worker to call an ambulance; that call was received by QAS at 2:44pm and assigned case ID #5697030.[141] Mr Mudge and the station worker, on advice from QAS, took Mr Scutt from the vehicle and lay him on the ground in the recovery position.

269. QAS records confirm they were onsite at 3:09pm and with Mr Scutt at 3:11pm.[142] On that basis it should be concluded that there was a a period of 27

[137] Exhibit D9.8 at page 13 of 28
[138] Exhibit C1.24 (Statement of John Mudge) at paragraph 13
[139] Exhibit C1.24 (Statement of John Mudge) at paragraph 13
[140] Exhibit C1.24 (Statement of John Mudge) at paragraph 14
[141] Exhibit D10.5 at page 33 of 45 (Case #5697030 – Page 1 of 5)
[142] Exhibit D10.5 (Case 5697030) at page 1 of 5

minutes between the call being received and QAS attending Mr Scutt. Mr Scutt's condition to remain unchanged during that time.[143]

270. The QAS Officer that attended was Advanced Care Paramedic (ACP) Lawrence Brimacombe; he was stationed at the Mount Garnet Ambulance Station. The advice he received prior to attending was that the patient (Mr Scutt) had been "*seizing*" at the station at Silver Valley.[144]

271. When ACP Brimacombe arrived to treat Mr Scutt, he observed that he was mobile and communicative.[145]

272. Whilst Mr Scutt agreed to be assessed in the ambulance he refused to be transported to the Atherton Hospital. His refusal was against the advice of ACP Brimacombe[146] however Mr Scutt had the requisite capacity to refuse. The assessment of Mr Scutt's vital signs in the ambulance did not disclose anything outside normal limits.[147]

273. The EARF that was completed by ACP Brimacombe noted a phone call with 'Dr Brianna' (Van Beekhuizen). When cross-examined by Counsel for Dr Connolly in relation to the entry Dr Van Beekhuizen deposed she had no recollection of any such call and accepted there was no corresponding progress note with the Atherton Hospital patient file for Mr Scutt.

274. The EARF by ACP Brimacombe stated:

> Consultations
>
> 15:11 QAS Garnet consult with ADH treating Dr from ED. Dr Briana provided background details on the kidney transplant and meds. Pt admission this AM for tonic / clonic seizure – NIL cause identified. QAS Garnet informed Dr pt refusing transport. (Doctor: _ BRIANA)

275. I accept that during this conversation Dr Van Beekhuizen confirmed details of the presentation to Atherton Hospital with respect to a seizure that morning and ACP Brimacombe informed Dr Van Beekhuizen of Mr Scutt's refusal to be transported back to the Hospital for further investigation.

276. Whilst Mr Scutt refused to attend the Atherton Hospital he did acquiesce to being transported to Ravenshoe Medical Centre with a view to being seen by

[143] Exhibit C1.24 (Statement of John Mudge) at paragraph 14
[144] Exhibit D10.2 (Statement of Lawrence Brimacombe) at paragraph 5
[145] Exhibit D10.2.1 (Statement of Lawrence Brimacombe) at paragraph 3
[146] Exhibit D10.2 at paragraphs 8 and 9
[147] Exhibit D10.2.1 at paragraph 4

Dr Connolly.[148] In his statement ACP Brimacombe deposed that Mr Scutt's "*boss*" (Mr Mudge), drove Mr Scutt in a convoy with QAS.[149]

277. Mr Mudge deposed in oral evidence that he was not involved in transporting Mr Scutt. It remains unresolved as to who drove Mr Scutt to the Ravenshoe Medical Centre.

278. The convoy arrived outside of clinic hours; Mr Scutt was not therefore seen by Dr Connolly. At that time Mr Scutt was assessed as having the capacity to refuse further treatment as such ACP Brimacombe completed his involvement, this occurred at 4:40pm.[150] Prior to completing his involvement ACP Brimacombe had a conversation with Mr Scutt in which Mr Scutt agreed to attend Dr Connolly the following day.[151]

279. There are no records from the Ravenshoe Medical Centre to confirm Mr Scutt attended on 19 August 2014.

Consultation with GP on 25 August 2014 – Ravenshoe Primary Health Clinic

280. One week after these seizures, on 25 August 2014, Mr Scutt presented at the Clinic where he was seen by Dr Connolly. The reasons for the presentation was documented as "*had a fit or turn on Friday*". By reference to the date of the consultation, the Friday would have been 22 August 2014.

281. Counsel for Dr Connolly invites me to consider whether in fact Mr Scutt did attend on Dr Connolly at the clinic on 25 August. There is a notation in patients clinic files for that date, and it is accepted that Dr Connolly made the entry and in the absence information is gleaned from any other source I accept the note on the face of it and find Brain Scutt attended upon Dr Connolly in person at the Ravenshoe Clinic on 25 August 2014.

282. As to the reference to 'Friday' I am left with two possibilities that either:

    i. the "Friday' seizure documented on this occasion was separate (and in addition) to and distinct from the seizures with which Mr Scutt had presented to Dr Van Beekhuizen or ACP Brimacombe on Monday, 18 August 2014; or

    ii. Mr Scutt was confused, and mixed up his days when speaking with Dr Connolly.

[148] Exhibit D10.2 at paragraph 9
[149] Exhibit D10.2 at paragraph 9
[150] Exhibit D10.5 at page 33 (Case #5697030 – Page 1 of 5)
[151] Exhibit D10.2 (Statement of Lawrence Brimacombe) at paragraph 10

283. As noted above there is no evidence that Dr Connolly was aware of Dr van Beekhuizen's clinical note (which I accept from the electronic date / time stamp on the top of the document was received into the clinic) at the time of their consultation on 25 August. I am unable to reconcile why the note did not come to Dr Connolly's attention by the time of this appointment with Mr Scutt some one week after it was sent to the clinic. (I also not this would be the third such occurrence in relation to Mr Scutt's medical records 2004; 2009 and the instant date).

284. Dr Connolly himself records on 25 August that Mr Scutt "*Had a fit or turn on Friday*". This information was evidently self-reported by Mr Scutt during the consultation. The fact that the fit / turn described did not reconcile with the Monday presentation at the Atherton Hospital (which Dr Connolly did not know about) was incidental in my view, to the fact of the very recent seizure (irrespective of the day, was true). There are many reasons why Mr Scutt may have mixed up his days. In any event at that moment in time Dr Connolly was as at 25 August then aware of:

i. the 2004 seizure (from the EEG test results provided to him);
ii. the 2009 seizure and admission from the discharge letter sent by Dr Pyke to him;
iii. a seizure that occurred in the days prior to this the instant consultation.

285. Dr Connolly did not record any further detail about the seizure / fit reported to him by Mr Scutt. The record does not indicate that Dr Connolly enquired or tested or established the true circumstances in relation to any aspect of the matter. Had he done so Dr Connolly may have established that the QAS had been called to Mr Scutt on multiple occasions on 18 August (exactly one week prior). If he did not make further enquiry of his patient it was poor practice. If he did enquire it is not reflected in his record and is therefore also poor practice.

286. As at the date of the consultation on 25 August, Dr Connolly had knowledge that Mr Scutt had a seizure history (by now spanning isolated recorded incidents over a 10 year period) of unknown cause and origin. The self report by Mr Scutt did not, and should have, triggered immediate enquiry of Mr Scutt by his long standing GP, requesting further detail regarding the circumstances of the seizure suffered only one week prior (or indeed as recently as Friday if Mr Scutt was correct and not referring to his hospital presentation on the Monday prior).

287. Dr Connolly's clinical (and clinic) record is completely silent. He recorded the information but did nothing further. He recorded this information by then in full knowledge that some years prior a hospital doctor had requested his 'reinforcement' that the patient not drive for a period of time after the seizure.

288. A GP knowing his patient suffered a seizure in days prior is also in the best position to consider and discuss not driving with the patient.

289. Although not mandated by law Dr Connolly had a discretion to advise TMR of a medical condition. A medical condition may have been imposed on his licence until further investigation.

290. Pursuant to current Austroad guidelines a person is not fit to hold an unconditional licence if they have had a seizure. There is a discretion for the licencing authority to impose a 12 month non driving period (taking into account information provided by the treating doctor). This in no way abrogates a licence holders obligation at law to inform the licencing authority. Mr Scutt did not.

291. As at 25 August 2014, Dr Connolly, because of his prior knowledge of the patient's seizure history, in combination with the reported recent seizure event, had a professional obligation to consider Mr Scutt's immediate fitness to drive. There was no evidence before the inquest that Dr Connolly discussed the matter with his patient or exercised his discretion to report to TMR.

292. This was the last occasion Mr Scutt received any medical attention in relation to seizures prior to the explosion at the café some 10 months later on 9 June 2015.

Circumstances leading up to 9 June 2015

293. I accept the submissions of Counsel for Dr Connolly that Mr Scutt had deteriorated physically and mentally in the months leading up to the accident. This is highly relevant as it demonstrates Mr Scutt's state of mind and health condition leading up to the accident. There were a number of opportunities Mr Scutt had to seek medical attention in the immediate period prior to the accident. The evidence before the inquest in regard to Mr Scutt's decline in his physical and mental health was not contested. I summarise those submissions as follows:

a) Mr Bolder was a friend of Mr Scutt's. He recalls about three weeks prior to the accident, Mr Scutt telling him his chest was hurting and that he had chest cancer (there is no evidence Mr Scutt had been diagnosed with cancer or consulted a doctor concerning chest pain)[152];

b) Mr Corbett a friend who saw Mr Scutt on a regular basis over the last few years said, "*I did notice that Scutty had been a bit different for the past three weeks and it appeared as though something was bothering him. On a couple of occasions I saw him sitting in his car at the park near the bridge into town. I spoke to him and could tell that there was something on his mind. I recall asking him if there was something wrong,*

[152] Ex C1.1 para 97

to which he replied that there wasn't. I could tell that he didn't want to talk, which seem (sic) *out of character for him*"[153];

c) Mr Felton was a lifetime friend of Mr Scutt, knowing him since their school days. He last saw Mr Scutt on 7 June 2015 (two days prior to the accident). He does not recall Mr Scutt being physically unwell but says Mr Scutt was talking about going to jail nearly all day. He says, "*I would say that he was really fixated about going to jail*" (there is no evidence Mr Scutt had had any interactions with police or that he was under investigation for any offence). Mr Scutt told him, "*I have got it into my head and I can't get it out*"[154];

d) Ms McConnell was a more recent friend of Mr Scutt. She recalls the week before the accident Mr Scutt asking her to retrieve a text message on his phone which said something about someone was going to get him. She went through his phone and could not find any message. He also said it had something to do with the Garnet Police.[155] Mr Scutt also told her a week prior to the accident he had not got his medications. She told him he needed to change doctors[156];

e) Mr Moore was an associate of Mr Scutt. He owned the local roadhouse. He recalls seeing Mr Scutt two to three weeks before the accident. He had not seen Mr Scutt for two weeks which was unusual as he was used to seeing him almost every day. Mr Scutt had a conversation with Mr Moore and his partner Amia. They noted he had not been well. Mr Scutt said, "*Oh I been crook, I keep falling down all the time…yeah they told me I might have had a bit of a heart attack…I knocked myself around a bit but I'm alright*". Mr Moore said, "*Well do you really think you should be driving until you know for sure?*". Mr Scutt responded, "*yeah I'm fine now*"[157];

f) Ms Amia is Mr Moore's partner. She recalls seeing Mr Scutt two weeks prior to the accident. To her he looked weak and was breathing heavily. Mr Scutt was not laughing and joking like he used to and looked like he had lost weight. Mr Scutt said, "*I don't know I keep blacking out and*

[153] Ex C1.6, p4
[154] Ex C1.10, p4
[155] Ex C1.20, para 7
[156] Ex C1.20, para 6
[157] Ex C1.21, p2

falling down on the floor". She says Mr Moore said "*you should see the doctor*" "*you should not drive the car*"[158]; g) Mr James Scutt, Mr Scutt's son recalls his father only having seizures when he was really stressed out. He said, "*It is not something I can detail but I know Dad and I could tell he was stressed about something over the last month. He has probably been the most stressed in the last month that I have ever seen or can remember. I remember asking him if something was bugging him but he brushed me off and told me it was all fine but I know there was something going on*"[159];

h) Ms Timson was a friend of Mrs Scutt. She knew Mr Scutt through association. She saw Mr Scutt about two to four days before the accident. She did not think Mr Scutt looked well. She observed that he looked purplish, deep red in the face. She said to Mr Scutt, "*Do you think you should be driving*?" Mr Scutt never replied and just drove off[160];

i) Mr Mudge says that two weeks prior to the accident Steve Dobel told him that Mr Scutt had been diagnosed with bowel cancer and it had spread to other parts of his body[161] (there is no evidence Mr Scutt had bowel cancer).

294. In oral evidence Mrs Scutt recalled an event in or around May Day at Mt Garnet. She said words to the effect, "*Brian came back that night distraught and paranoid and he's seen a police car turn around and he thought they were coming back to get him. He kept on saying I'm going to jail. I'm not going to be here when I get home. I'm not going to be here..go to jail. He went to the police station a lot saying I'm going to jail and you're not wanted for anything. Friends of his saw him on the side of the road leaning on the steering wheel and thinks he might have some sort of event or seizure"*.[162]

295. Mr Scutt's paranoia about the police was corroborated by Senior Constable ('SC') Fenn. She deposed that she had spoken with Mr Scutt during the three weeks leading up to the accident. Mr Scutt seemed to be of the belief that police were looking for him and wanted to speak to him about an incident that had alleged to have occurred at the Mt Garnet library. She had no knowledge of the incident and as far as she knew, the police were not looking for him.

[158] Ex C1.11, p2
[159] Ex C1.28, p4
[160] Ex C1.31
[161] Ex C1.24, para 22
[162] Day 5 of evidence

296. SC Fenn says on Friday 29 May 2015, Mr Scutt had told Sergeant Batt's wife that he felt like hanging himself. Mrs Batt says Mr Scutt had regularly attended her property to enquire about a horse float which was for sale. On one occasion he said, "*is the Sarge in? I want to commit suicide. I have a rope in the car*". She told him to go home and that she would have her husband go and see him.[163]

297. SC Fenn and Sergeant Batt attended on Mr Scutt's residence. SC Fenn states, "*SCUTT came outside and spoke to us at the front gate. I could see that his eyes were bloodshot and watery like he had been crying. He admitted to having feelings of depression; that he hadn't slept for three nights; that he couldn't cope anymore and had thought that afternoon of using the rope in his car to hang himself. He further stated that he was going to see Dr Connolly on the following Monday the 1st of June 2015*".[164] Sergeant Batt said Mr Scutt told him that he was still concerned that police were looking for him and he felt like he wanted to hang himself.[165]

298. SC Fenn spoke with Mrs Scutt. She voiced concerns about Mr Scutt being paranoid about the police and not sleeping. Mrs Scutt agreed Mr Scutt should go to the hospital that day and that she should not wait until Monday.[166] Mr Scutt seemed relieved and was willing to go the Atherton Hospital and to be taken by his wife.[167] Sergeant Batt says it was explained to Mr Scutt by himself and SC Fenn that he must be honest with the doctor and tell the doctor everything including his thoughts of wanting to hang himself.[168]

299. SC Fenn and Sergeant Batt stayed at the premises until Mrs Scutt drove away with Mr Scutt to the hospital.[169]

300. This event was corroborated by Mrs Scutt. In oral evidence she said the policeman and woman asked Mr Scutt to take away the rope because he was thinking about harming himself. She said words to the effect, "*They suggested that Brian go down and be examined by a doctor at the Atherton Hospital. We went down there and the doctor gave him three sleeping tablets. When Brian asked him about seizures, he said that might just be a lack of sleep or something like that*".[170]

301. Mr Scutt was reviewed at the Atherton Hospital Emergency Department. The 'Presenting Problem' is recorded as "*requesting tablets to help him sleep*".[171] The clinical notes record, "*trouble sleeping past few weeks due to work*

[163] Ex C5.3, p3
[164] ExC2.15, para 15
[165] Ex C5.4, p3
[166] Ex C2.15, para 17
[167] Ex C2.15, para18
[168] Ex C5.4, p3
[169] Ex C2.15, p3
[170] D5 of evidence
[171] Ex D9.5, p22

schedule. Temazepam 10mg nocte provided x3 tablets".[172] There is no reference to recent seizure activity, or Mr Scutt's suicidal ideations in the hospital record.

302. On 31 May 2015, SC Fenn and Sergeant Batt visited Mr Scutt. He advised them he was doing much better and had managed to get a couple of nights good sleep. He appeared much happier and appeared to be extremely happy how things had improved.[173]

303. Mr Scutt had seen Dr Connolly on 4 June 2015. This was in relation to an infected sebaceous cyst on his back. Mr Scutt was prescribed an oral antibiotic.[174] Dr Connolly's invariable practice was only to note any exceptions or issues he had identified in a patient's clinical record.[175] Despite Mr Scutt being unwell and suffering from an array of symptoms including increased seizure activity, paranoia and recent suicidal ideations I accept that there is no evidence he raised any of these issues with Dr Connolly.

304. Mrs Scutt said in oral evidence Mr Scutt would see Dr Dr Connolly for blood tests and minor things and that Mr Scutt would only do the minimum necessary. She said words to the effect, "*when he came home with the antibiotics with cyst on his back I was hoping he was going to talk about seizures but he didn't*".[176]

305. Mrs Scutt accepted that Mr Scutt had significant resistance around seeking medical attention for his seizures. Mrs Scutt was not sure why but stated, "*Just fear I suppose*".[177]

306. In the week or so prior to the accident Mr Scutt told Mrs Scutt he had fallen over on some rocks and that he was having trouble with his balance. She had suggested he should get checked out by the Doctor because of his shakes, and she states, "*I even mentioned that he could hurt someone if he gets the shakes while driving. Brian wouldn't listen, he would just start talking about the Police taking him away again*".[178]

307. On around 5 June 2015, Mr Scutt again attended on the Batt's house. He was looking for Sergeant Batt. Mrs Batt was present when Mr Scutt told Sergeant Batt "*I want to cut my own throat. I have the knives*".[179] Sergeant Batt does not refer to this in his statement but says that Mr Scutt again mentioned that police were looking for him.[180]

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[172] Ex D9.5, p24
[173] Ex C5.4, p3
[174] Ex D7.2, p2
[175] Ex D7.3, p2
[176] D5 of evidence
[177] D5 of evidence
[178] Ex C1.29
[179] Ex C5.3, p2
[180] Ex C5.4, p4

308. In response to a question I asked Mrs Scutt in evidence she said as follows:

Maybe about three days before the accident. I had a – I had a sit down talk with him and I said, "Look, Brian, I'm really concerned about you driving and I'm concerned that, you know, you might kill somebody or, you know, hurt somebody." And all – all he did was kind of wait for me to get out of the way so he could see the TV, because I was behind – between him and the TV, trying to get his attention. And that was – that was all it was to – that was it".

309. When then asked by me if it would have been helpful if one of his treating doctors had removed his licence she responded:

"Yes. Our marriage wasn't a 50/50. It wasn't a level playing field that - you know, – Brian did - if he were cornered, you know, he'd lash out. And I don't necessarily mean physically."

"He'd feel threatened and had big problems communicating".[181]

"There was a whole lot more going on then what I was aware of".

"His mental health was going down and he wasn't able to make an appropriate decision or appropriate reaction if he'd been told not to drive".

310. Further, in oral evidence Mrs Scutt said words to the effect, "*what I can see in hindsight now once he got into mental health was that he wasn't well mentally. If I hear a car pull out the front of the house I would look at the window. He would assume it was the police going to take him away*". She confirmed this was over the last month or so prior to the accident.[182]

Day of the Accident

311. On the day of the accident Mrs Scutt was aware her husband had been unwell. At around 10.45am she received a telephone call from Mr Scutt. He sounded like he was vomiting or going to vomit. He told her he felt really sick. She suggested he contact Stephanie McConnell who had been helping Mr Scutt with some of his problems. He made a throw away comment about getting through it.[183]

312. In oral evidence Mrs Scutt recalls Mr Scutt told her he felt terrible or something like that. She stated words to the effect, "*I didn't want to tell him to stay home*

[181] D5 of evidence
[182] D5 of evidence
[183] Ex C1.29, para 9

but I think I asked him to go back to bed or something like that. I couldn't leave the library".[184]

313. On the day of the accident, Ms Featherstone a friend of 20 years received two telephone calls from Mr Scutt. She recalls Mr Scutt saying, "*I am trying to get in touch with Robyn, I am really sick, I feel really sick, I don't know where she is I am trying to find where she is, I am trying to ring her*". She says he sounded like he was spewy sick and sounded doey. In his second call, he said "*I am sick, I am sick*". She says he was spitting in between saying how sick he felt. He was also making another sound like a cough or a groan. Ms Featherstone recalls saying, "*Can you ring the medical centre and see if you get the doctor to come and see you*". He replied, "*yeah righto mate, I talk to you a bit later*".[185]

Post-Accident (mental health) assessment of Mr Scutt

314. On 9 June 2015, Dr Mackintosh of the Cairns Base Hospital records, "*Son reports a possible suicide attempt two days ago with overdose of medications (?paracetamol)*".[186] Mr Scutt's paracetamol level was checked and it was within normal limits.[187]

315. On 14 June 2015, a family meeting was conducted at the hospital. Mrs Scutt and her son were present. Mr Scutt's son reported he had witnessed several more episodes (reference to tonic clonic movements he had seen around 8 years previously), with the last being query around several months ago and that they are usually attributed to stress.[188] Mrs Scutt reported Mr Scutt had a recent episode of collapse while in the passenger seat of the car. She did not witness it, but Mr Scutt had said he had slumped and ended up under the glove box. He could not explain why this happened. She also reported Mr Scutt's recent paranoia, an incident when Mr Scutt ran his car off the road and that Mr Scutt had had trouble with his balance.[189]

316. On 29 June 2015, Mrs Scutt was interviewed by the Liaison Psychiatry Service. A psychiatry consultation was requested by Dr Wenk, the ICU consultant. Mrs Scutt advised:
    a. The last two episodes of twitching (that is, post August 2014) were not investigated in a hospital;
    b. Mr Scutt had been having 'shakes' over the last 2 months, intermittently occurring. These occur similar to the previous episodes he had however have begun occurring more frequently;

[184] D5 of evidence
[185] Ex C1.9, p2
[186] Ex D9.3, p70
[187] Ex D9.3, p336
[188] Ex D9.3, 114
[189] Ex D9.3, p114

c. The doctor in the Atherton Hospital said the shakes were most likely due to reduced sleep, he was prescribed sleeping tablets on the 29th of May and had deep sleep on the Friday, Saturday and Sunday night;
d. He had a history of paranoid behaviour over the last 3 months, with multiple presentations to local police. This due to a strong belief police wanted to take him to jail – he told her if he goes to jail he would take tablets to commit suicide;
e. Strongly denied any recent suicidal attempts;
f. He had been frequently complaining of nausea, almost to the point of vomiting over the last few months;
g. On at least two occasions he experienced urinary incontinence;
h. He complained of muscle aches and shoulder pain, reporting severe headaches post 'shaking' episodes;
i. He was suffering ongoing sleep disturbance over the last 3 months;
j. He had not noticed any depression over the last 3 months;
k. No issues with mobility but she had concerns about him falling overnight.[190]

317. Mrs Scutt reported three specific incidents to the psychiatrist. They were:
a. On 30 April 2015, Mr Scutt phoned her saying he was parked downtown and had allegedly been having shaking attacks – with shakes lasting a second, no incontinence and no convulsion identified by him;
b. On 6 June 2015, Mr Scutt phoned his wife and told her he ran off the road into a cane field and later that day calling to say he had fallen over on the rocks, that he was very unstable on his feet and unable to stand up;
c. On the day before the accident Mr Scutt had significant anxiety, was non receptive to communication from her and she told him that she was not comfortable with him driving.[191]

318. Under cross examination, Mrs Scutt had no recollection of these meetings at the Cairns Base Hospital, and what was or was not said. It is not clear why Mrs Scutt did not mention the incident wherein the police took away a rope because Mr Scutt was thinking of killing himself.

319. When directly questioned by me as to whether (these events) were an accident, Mrs Scutt said words to the effect, "*I don't know. It is spoken of as an accident. My impression and I am not trying to and I am not trying to say what I am saying is true it seems like his mental health was going down and he was not able to make an appropriate decision or an appropriate reaction if he had been told not to drive*".[192]

320. The evidence clearly supports Mr Scutt was generally reluctant to seek medical assistance for his seizures and was dismissive of his health.[193] Further, that he

[190] Ex D9.3, p43
[191] Ex D9.3, p43
[192] D5 of evidence
[193] See statement of Mrs Scutt C1.29; statement of Ms Wilkerson C1.37 at para 6; statement of Ms Murray

had been made aware on three separate occasions that following a seizure he was not allowed to drive. Mrs Scutt was also aware of this restriction as evidenced by her phone call to the Atherton Hospital on 10 March 2004[194] and her presence at the hospital on 19 May 2009 when Dr Pyke told Mr Scutt he was not able to drive. However, from her oral evidence it seems she had no to very little influence over Mr Scutt. She stated, "*pretty much the whole marriage he did what he wanted*".[195] Further complicating matters was the deterioration in Mr Scutt's mental health prior to the accident.

321. On the evidence Mr Scutt had suffered two further seizures and/or symptoms post August 2014 which reflected seizure like activity (intermittent 'shaking attacks'). Further, he had experienced at least one episode of a blackout (slumped under the glovebox) and had run off the road while driving his car. Mr Scutt knew from his previous presentations to hospital that he was not able to drive following such events. His own friends and wife and tried to dissuade him from driving in the weeks leading up to the accident and that he should seek medical attention. He would not listen. Further, on the actual day of the accident, Mr Scutt was clearly unwell and chose to drive despite his symptoms and the advice from Ms Featherstone to get a doctor to come to see him.

Post-accident (medical) assessment of Mr Scutt

322. In the aftermath of the explosion Mr Scutt was treated by student paramedic Narelle Groves. Ms Groves was not employed by the Queensland Ambulance Service at the time. Ms Groves deposed that when she first had contact he was "*very disorientated, very confused, not very coherent on where he was or what was happening around him*".[196] Ms Groves had a conversation with her in which he disclosed feeling pain in his chest and back.[197]

323. When examined as to whether she considered Mr Scutt to be orientated in place, Ms Groves deposed that he was not. Ms Scutt communicated to Ms Groves that he thought he was at the Medical Centre.[198]

324. Flight Paramedic (FP) Joanne Selby assumed the care of Mr Scutt from Ms Groves. FP Selby was the author of the EARF (Electronic Ambulance Report Form) identified with case number 6562011. That EARF documented the vital signs of Mr Scutt after the explosion. The EARF confirmed the readings were taken at or about 1:17pm,[199] approximately one hour after the explosion.

325. The case description taken by FP Selby was as follows:

C5.35.1, p2-3; Atherton Hospital records – Dr Reddie's notes; Dr Pykes notes; Ex D10.3 statement of Shayne Bereton

[194] Ex D1.1-A

[195] D5 of evidence

[196] T4.38/1-4

[197] T4.38/13-14

[198] T4.39/1-9

[199] Exhibit D10.5 at page 45

"*Pt a driver of a vehicle which crashed into a shop in the main street. The crash caused gas bottles to explode creating a mass casualty incident with up to 20 pts with burns and trauma. This patient had complained of chest pain prior to crash. 12L ECG showed sinus bradycardia with incomplete LBBB (left bundle branch block) …*"[200]

326. In relation to the reference to 'chest pain prior to crash' FP Selby accepted that whilst Mr Scutt had disclosed to her that he was experiencing chest pain, the disclosure was made in the context of that pain being experienced after the collision.[201] FP Selby also deposed that at the time of these conversations with Mr Scutt he appeared "*alert and orientated*", this represented a change in his condition from the time Ms Groves had seen him.

327. Following treatment at the scene Mr Scutt was transferred to Cairns Hospital, Intensive Care Unit (ICU). Dr Drew Wenk gave evidence at the Inquest in relation to the treatment that Mr Scutt received there. Dr Wenk opined that the most common medical conditions that may cause acute unconsciousness in a driver were:

- An acute myocardial infarction;
- An acute arrhythmia; and/or
- An epileptic fit of some nature.[202]

328. Dr Wenk deposed that after Mr Scutt was admitted to ICU an ECG was performed on him. That ECG showed "*no acute changes*".[203]

329. An echocardiogram performed on 9 July 2015 confirmed "*normal ejection [fraction] to 70%*".[204] Dr Wenk opined this was an indication of no vascular abnormalities. Dr Wenk confirmed that the time between the explosion and the performance of the echocardiogram would not have affected the results i.e. if there had been a heart attack or infarct it would have still been capable of detection on 9 July 2015.[205]

330. With respect of EEG's performed on Mr Scutt after his admission, Dr Wenk confirmed there was no indication of arrhythmia.[206] Additionally Dr Wenk confirmed there were no observations of Mr Scutt that would suggest a seizure either.[207]

[200] Exhibit D10.5 at page 40
[201] T5.57/3-8 and Exhibit 2.39 at paragraph 8
[202] Exhibit D6.1 at paragraph 15
[203] T6.5/5
[204] T6.5/5-7
[205] T6.5/24-28
[206] T6.6/11-12
[207] T6.6/14-15

331. Dr Wenk was invited to comment on the readings taken by FP Selby. Dr Wenk identified sinus bradycardia as a "*pulse rate less than 60*".[208] It was noted on the EARF that Mr Scut had a pulse rate of 60[209] which Dr Wenk considered "*just meets the definition of sinus bradycardia*".[210]

332. In relation to the left bundle branch block (LBBB) Dr Wenk identified that as relating to the process of the heart depolarising and repolarising from the right side to the left side of the heart. At a normal rate that process would take between .08 of a second up to .1 of a second. However in Mr Scutt's case, the ECG that was performed by FP Selby revealed that process was taking between .1 and .12 of second which was the left bundle branch block.[211]

333. As to the prognostic significance of that LBBB, Dr Wenk did not place any weight on it, noting that Mr Scutt had been in a motor vehicle collision, and was in the immediate vicinity of the explosion. Dr Wenk identified that it would be something they would monitor. He considered it to be "*slightly abnormal*".[212]

334. Dr Wenk also commented that two of the medications Mr Scutt was known to be administered at the time of the collision (Diltiazem and Propanolol) both had the effect of slowing the heart rate, and that may also account for some of the reading that were obtained by FP Selby.[213]

335. The only other medical issue noted that in the days following the collision / explosion whilst Mr Scutt was in the Intensive Care Unit at the Cairns Hospital, he experienced a "*mild rise*" in troponin levels (a substance leaking from damaged heart cells). Dr Wenk considered this was consistent with a mild myocardial contusion from the collision.[214]

336. Dr McLaughlin a neurologist specialising in epilepsy, gave expert evidence at inquest. He had been in practice for 28 years. He defined epilepsy by three different categories. Relevant to this Inquest was the category of epilepsy defined by the occurrence of two seizures more than 24 hours apart and with both seizures not provoked by external triggers or illnesses that may produce a seizure.[215]

337. Upon review of Mr Scutt's medical material, Dr McLaughlin was satisfied that Mr Scutt met the necessary criteria to be diagnosed as epileptic.[216] Whilst there was evidence heard at the Inquest from Mrs Scutt, that her husband was experiencing increased episodes of shaking, Dr McLaughlin considered there was insufficient information available to make any determination as to whether

[208] T6.8/39-40
[209] Exhibit D10.5 at page 41
[210] T6.8/41-42
[211] T6.8-9/43-5
[212] T6.9/7-
[213] T6.9-10/41-4 and Exhibit D6.2
[214] T6.8/14-24 and Exhibit D6.2
[215] T5.95/12-15
[216] T5.98/30-34

Mr Scutt's seizures were increasing in frequency, or indeed whether those shaking episodes were epileptiform or not.[217]

338. Dr McLaughlin was satisfied that Mr Scutt's seizure history met the clinical criteria for a diagnosis of epilepsy and accepted that at the time of 2004 seizure, (with regard to the follow up examinations arising from that presentation, no diagnosis of epilepsy could have been made at that time.[218]

339. Dr McLaughlin also accepted that the advice given to Dr Pyke in 2009, that that event should be treated as a 'first seizure' would have been appropriate advice.[219] Dr McLaughlin also accepted that even had the MRI been conducted in 2009 (noting the results obtained in 2015) it likely still would have shown that it was 'normal'.[220] Dr McLaughlin considered that in that scenario the course of treatment at that stage would not have been to commence treatment with medication, but to observe the patient for a period of six months.[221]

340. Dr McLaughlin opined that the diagnosis of epilepsy was not confirmed until the occurrence of the 2014 seizure. That seizure in effect became additional information by which the previous seizures (in 2004 and 2009) would be re-evaluated.[222] In his opinion the appropriate course of action would have been to obtain an opinion from a neurologist although he accepted a case remained for continuing to observe Mr Scutt if it were clear there were no other seizure events.[223]

[217] T5.98-99/44-11
[218] T5.100/1-9
[219] T5.100/36-39
[220] T5.100/18-27
[221] T5.100/41-44
[222] T5.101/9-18
[223] T5.101/20-25

FITNESS TO DRIVE

341. On the balance of probabilities, I find that:

i. On 9 June 2015 Brian Scutt whilst driving a vehicle experienced an epileptic seizure and he temporarily lost consciousness and he lost control of his vehicle and veered off the main road in the township of Ravenshoe mounting the gutter and travelling almost 170 metres across parkland before colliding with a 180kg LPG gas cylinder thereby triggering an explosion in the Serves You Right Café resulting in injuries that caused the deaths of Margaret Clark and Nicole Nyholt.

ii. Based on seizure activity reported as at August 2014 and the deterioration in his physical and mental health in the months leading up to the accident including two seizures in 2015 for which Mr Scutt did not seek medical attention or present to the hospital; and taking into account his poor health on the day of the accident, I find that Brian Andrew Scutt was not fit to drive at the time of the accident on 9 June 2015 and should not have held an unconditional drivers licence.

Expert Evidence regarding the role of General Practitioners

342. The inquest examined the role and obligation of general practitioners in circumstances such as these, specifically the nexus between injuries that may impact of fitness to drive and any ensuing obligations.

343. Expert evidence as to the role of a General Practitioner and the care and treatment provided to Mr Scutt by Dr Connolly was provided by Dr Christopher Pitt (engaged by me to provide an expert report) and Dr Neil Bartels OAM (engaged on behalf of Dr Connolly).

344. In relation to the 2004 seizure, Dr Pitt opined that once Dr Connolly had received the EEG results, two options available to him:

- Recall Mr Scutt to discuss the results; or
- Noting that it was a first seizure and the results were normal, it would have been appropriate to wait for Mr Scutt's next presentation before discussing the results.

345. It is accepted that Dr Connolly adopted the latter approach in this instance.

346. Whilst it is accepted that he acted appropriately in waiting for Mr Scutt to re-present before discussing the results, it was the evidence of Dr Pitt that Dr Connolly's notes could have elucidated more details about an ongoing

management plan.[224] It is accepted, by reference to the evidence of Dr McLaughlin, that all examinations that might have been performed at that instance had been completed. Based on those examinations Mr Scutt would not have met the criteria for a diagnosis of epilepsy and as such it would have been appropriate for Dr Connolly to adopt an approach of continuing to observe Mr Scutt.

347. It was further open to Dr Connolly, at the time of receiving the EEG results, to have a discussion with Mr Scutt about his ability to continue driving. Dr Connolly's progress notes for the consultation on 2 August 2004 did not reflect that such a conversation took place.

348. In relation to the 2009 seizure, Dr Pitt opined:

"*I think that Dr Pyke did a very good job of working Mr Scutt up medically and arranging a number of appropriate follow up investigations and appointments. And so in that situation, Dr Pyke had almost done Dr Connolly's job for him*".

349. Whilst Dr Pitt did not consider there to be a need for Dr Connolly to have followed up with Dr Pyke in relation to the possible MRI identified in her letter. He did consider that Dr Connolly should have had a conversation with Mr Scutt as to whether it had occurred and if not, it was open to him to generate a new referral.[225] That is a conversation Dr Pitt expected should be documented. There was no record of such conversation in Mr Scutt's patient file at the Medical Centre or the Primary Health Clinic.

350. Dr Pitt opined that in circumstances where a patient represented a significant risk either to themselves or others then that may shift some of the responsibility of the autonomous patient to the GP to conduct additional follow up. Whilst Dr Pitt accepted that a patient who experiences seizures, and continues to drive, could represent a significant risk, he considered it would first be necessary to establish what the variables where in terms of the patient and the nature of their illness. Dr Pitt conceded a GP would in effect conduct a risk assessment with the patient to determine those variable. Dr Pitt agreed there was no evidence in the patient records of Mr Scutt, as held by the Medical Centre or the Primary Health Clinic to indicate that Dr Connolly conducted such a risk assessment.[226]

351. Regardless of any risk assessment, Dr Pitt considered that there should been a conversation between Dr Connolly and Mr Scutt during which advice should be given not to drive for a certain period after a seizure. It was observed within the patient file for Mr Scutt, notwithstanding the presence of progress notes and correspondence in relation to seizure events, that no conversation was documented with respect of advice not to drive. It was the opinion of Dr Pitt that such conversations should have been documented.[227]

[224] T6.19/11-15
[225] T6.25/1-20
[226] T6.22-23/41-10
[227] T6.23-24/37-13

352. Regarding the presentation to Dr Van Beekzhuizen, two scenarios were put to Dr Pitt, the first where Dr Connolly had received and considered Dr Van Beekhuizen's clinical summary and the second where he had not received the clinical summary but had nonetheless been informed by Mr Scutt of his having had a seizure in that time period.

353. In the first scenario Dr Connolly would have been informed that:

- Mr Scutt had experienced a seizure;
- That it was his third seizure (with reference to the 2004 and 2009 events); and
- There was no reference to EEGs, MRIs, bloodwork or CT scans.

354. In that instance Dr Pitt considered the obligation then fell to Dr Connolly to take the initiative, obtain a history of the seizure and make the necessary investigations and referrals.[228]

355. Dr Pitt did not consider Dr Connolly's obligations to be different with respect of the second scenario.[229] Additionally, in circumstances where the progress note contained the Clinic records was the only information available to Dr Connolly at that time, it was the opinion of Dr Pitt that Dr Connolly should have elucidated further history about the fit.[230]

356. Looking globally at Mr Scutt's history of seizure between 2004 and 2014 Dr Pitt considered that Dr Connolly's level of care, with respect of seizure-related activity, was "*minimal*" and "*passive*".[231] It was the opinion of Dr Pitt that Dr Connolly was part of a healthcare team, in conjunction with the practitioners at the Atherton Hospital for the betterment of the patient.

357. Dr Neil Bartels OAM also gave expert evidence at the Inquest. Dr Bartels provided opinion as to the management plans that should have been developed in relation to Mr Scutt's various presentations to the Emergency Department at the Atherton Hospital. I accept Counsel Assisting submission on this matter and defer to (and prefer) the evidence of Neurologist, Dr Andrew McLaughlin on the appropriateness of treatment provided in those instances.

358. Dr Bartels deposed the General Practitioner was part of a team that provided good medical practice to a patient. He accepted the GP had the central co-ordinating role within that team.[232]

[228] T6.26/1-29
[229] T6.27/5-28
[230] T6.27/24-28
[231] T6.27/36
[232] T6.67/14-42

359. Dr Bartels conceded there was nothing in the material held at the Medical Centre of Primary Health Clinic that evidenced Dr Connolly having treated or managed Mr Scutt for epilepsy.[233]

Mr Scutt's drivers licence renewal applications

360. There was evidence before the Inquest that between 2004 and 2014, Mr Scutt renewed his driver licence on three occasions, in 2004, 2008 and 2014. The renewal of the driver licence in 2004 pre-dated the first documented seizure event and at that time there was no obligation on a licence holder to notify the Licensing Authority of any medical condition that may affect their ability to drive.

361. However as at 2008 Mr Scutt was obliged to make such a notification. On 24 December 2008, when he renewed his licence, he was required to disclose whether he had then, or previously, had epilepsy, he declared 'no'. For reasons identified in the evidence of Dr McLaughlin, it is submitted that declaration was correct having regard to his circumstances at that time.

362. On that same licence renewal Mr Scutt was also prompted to disclose whether he had "*any medical condition*" that was likely to adversely affect his ability to drive safely. Mr Scutt declared 'no'. Noting at that time Mr Scutt had experienced one isolated seizure in 2004, which had been fully investigated, and found to have no underlying cause it is further submitted that his declaration in this instance was strictly correct (from his perspective) with regard to his circumstances at the time of renewal.

363. At the time of the licence renewal of 16 January 2014 Mr Scutt was prompted to disclose whether he had "*been diagnosed with epilepsy or experienced a seizure at any time*". To that he declared 'no'. Mr Scutt was technically correct to declare that he did not have epilepsy, however his declaration of not having had a seizure was incorrect.

364. As at 14 August 2014 Mr Scutt was obliged to report his condition to TMR for a 28-day immediate suspension ("show cause period") and consideration of a conditional licence for non-driving period of 12 months. He did not comply with those reporting obligations.

365. The evidence before the Inquest was such that Mr Scutt had experienced three seizures in a period between 14 August 2014 and 22 August 2014. Having regard to that evidence and his decline prior to 9 June 2015 Mr Scutt was not fit drive as of 9 June 2015 and should not have held an unconditional drivers licence.

[233] T6.67/1-4

Evidence of the Department of Transport and Main Roads

Current Notification System

366. At the core of the inquest was the consideration of whether the existing legislation, whereby medical practitioners can presently make a voluntary notification to the licensing authority, should be amended such that there was a positive duty to inform the licensing authority of a licence holder's inability to drive by virtue of an illness, disability or deficiency.

367. The inquest heard evidence from Ms Nadine Dumont, Manager of Driver Licensing Policy at the Department. She deposed as to the frequency of use of the voluntary notification system. The frequency of use was analysed with respect of the different iterations of the legislation.

368. With respect of the period 1 March 2006 to 26 June 2008, there were a total of 59,052 voluntary notifications in relation to medical conditions. Ms Dumont deposed that because of the manner in which databases were kept during that period it may be that figure was not a true reflection of the number of notifications received.

369. For the period 27 June 2008 to 1 September 2010, Ms Dumont deposed that the Department received 69,373 voluntary notifications with respect of medical conditions.

370. With respect of the period between September 2010 and January 2019, the Department received a total of 989,211 notifications with respect of medical conditions.

371. The combined number of voluntary notifications for the entire period was 1,117,636.

372. Of all those notifications, Ms Dumont deposed that 6312 resulted in the cancellation of driver licences. However in 367,974 cases, additional conditions were placed on the licence holder's driver licence.

Notifications by Medical Practitioners

373. Of all those notifications, Ms Dumont deposed that 29,254 were generated by medical practitioners. There was no additional breakdown as to whether those were from General Practitioners or any other area of practice, such as in Dr Reddie's case as an Ophthalmologist.

374. The system as it presently exists allows medical practitioners to make a notification by any of the following means:

a. An online (Departmental) portal
b. An email to the Medical Condition Reporting (MCR) Unit (within the Department)
c. Written advice on official letterhead, or with an office stamp
d. A Medical Condition Notification form (F4842)
e. A Medical Condition Notification form from the AFTD publication[234]

375. It was deposed by Ms Dumont that the process, upon receiving a notification, was to issue a '*Notice of Immediate Suspension and Proposed Cancellation*'. Presently suspensions take effect, five days after the issuing of the notice. Thereafter the licence holder has 28 days within which to 'show cause' as to why their licence should not be cancelled.

376. It was deposed by Ms Dumont that the medical practitioner, in addition to receiving confirmation that their notification has been received, will also be informed as to what action has been taken, for example the issuing of the a '*Notice of Immediate Suspension and Proposed Cancellation*'.[235]

377. It is submitted in that regard, that the present system for the exchange of information between medical practitioners and the Department is sufficient, for medical practitioners to maintain adequate records of their client's history.

378. It is further submitted that the present system is not adapted for use to the favour of one area of medical practice or another. In that regard it is submitted that the present system would allow for a medical practitioner within an Emergency Department to make a notification in the same manner and with the same 'ease' as a General Practitioner.

379. It is however accepted that a medical practitioner working within an Emergency Department is operating within a more dynamic environment. It was put to Ms Dumont that a person may present to the Emergency Department for an 'acute episode' or 'an acute exacerbation of a chronic episode'. It was further put to Ms Dumont that in those circumstances a different notification pathway may be

[234] Exhibit M1 at page 7 of 9
[235] T5.67/26-37

required for those not working within a General Practice setting noting the GP may have more time, and patient history, on which to base their assessment.[236]

380. Whether a notification should have been made was, and remains, a matter of discretion by the medical practitioner based on the available medical evidence, an assessment of the potential risks to the patient or others, and other relevant guidelines or policies.

Notification by other Third Parties

381. Whilst it is noted that a 'Third Party' might include an officer of the Queensland Police Service, relative, neighbour or friend,[237] for the purposes of the inquest and these submissions, the focus will be given to relatives.

382. Under cross-examination by Counsel for Dr Connolly, Ms Dumont conceded that it was the policy position of Department, prior to August 2016, that it did not allow notifications from other parties such as family members or relatives.[238]

383. Ms Dumont deposed there remained some risk of vexatious notifications being made by family members or relatives, however it was an important source of information and warranted promotion amongst the broader community (as well as the medical community).

384. Noting that Mrs Scutt had an awareness of her husband's seizure activity and held concerns about his continuing to drive it is submitted that the policy settings of the Department between 2004 and 9 June 2015 were such that the Department would not have accepted a third party notification from her during that period.

385. Whilst those policy settings have since been changed, Ms Dumont deposed that a family member would still be required to provide some material to substantiate their notification, before the Department would take action. Whilst no evidence was heard at the inquest as to what that material may include, arguably it would require some medical documentation, potentially a discharge summary or letter from medical practitioner.

Training and Awareness

386. It is submitted that one of the issues that emerged with respect of effectiveness of the existing voluntary notification system was manner in which medical practitioners were trained, notified or informed of the available pathway.

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[236] T5/88
[237] Exhibit M1 at page 7 of 9
[238] T5/82 – L8-17

387. It was the evidence of Dr Van Beekhuizen that she was wholly unaware of the voluntary notification system until these Inquest proceedings. As against that Dr Pyke was aware, at the time of she treated Mr Scutt, that she had the capacity to make a notification.

388. At the time Drs Howard and Reddie treated Mr Scutt there was no legislated requirement or obligation for any party to make a notification to the Licensing Authority.

389. Notwithstanding that the legislation had been in effect since 1 March 2006, it appears that it was not until the legislation was named 'Jett's Law' in 2008 that an education campaign was developed. It was the evidence of the Department that they consulted with the Royal Australian College of General Practitioners (RACGP) and the Australian Medical Association (AMA) over a twelve month period following the naming of 'Jett's Law'.

390. Both the RACGP and AMA were identified as 'peak bodies' representing the interests of their members. They did not have 100 per cent reach with respect of all medical practitioners. For example it was identified that the College of Rural and Remote Medicine (CRRM), another peak body, was not a part of the consultation process. In that regard, medical practitioners who may have been a member of the CRRM, but not the RACGP or AMA would not have received information about the legislation.

391. It was also deposed by Ms Dumont that since 2016 the Department no longer has available to it, access to the AMA or RACGP mail out system due to changes in privacy legislation. Similarly the Department did not have access to the AHPRA mailing list.

392. AHPRA was identified as the agency most likely to capture all medical practitioners registered in Queensland, noting that it now encapsulates the Medical Board of Queensland, which maintains the complete list of medical practitioners operating within the State of Queensland (and nationally).

393. Another potential limitation was that the Department was unable to conduct any check to ensure, the members of those peak bodies had received the information that had been distributed. Ms Dumont deposed that:

"*because of privacy legislation, we weren't privy to their lists. So all we were able to do was to provide that information to those peak bodies, who then provided confirmation that it was sent out to their lists*"

394. The Department further identified that a mail out with conducted in conjunction with the Medical Board of Queensland, however that mail out was limited to General Practitioners. In focusing on the role of the General Practitioner, Ms Dumont opined:

"*it would be difficult for an emergency department doctor to holistically know somebody's health history and they would only be going off the information that they had at that point in time whereas generally speaking a person will have an ongoing relationship with a general practitioner. So that's why TMR believes that GPs are best placed to more holistically look at somebody's health*"

395. Ms Dumont conceded she was not speaking as an expert with respect of that opinion, but it did frame or inform the Department's rationale in terms of the literature it developed and promulgated. However Ms Dumont conceded that in a scenario with an acute presentation by a person to an Emergency Department (like those by Mr Scutt) would, were a mandatory notification system in effect, such presentation would enliven the duty on the medical practitioner operating in that setting.

396. Ms Dumont also deposed that the Department was unable to find any "*clear record*" that consultation was had with Queensland Health to ensure medical practitioners employed by it, were provided with the relevant literature. It was further identified by the Department that there was a geographic gap in the reach of presentations delivered by the Department to Hospitals in relation to the legislation concerning voluntary notifications.

397. There was no evidence of the Atherton Hospital having received any presentation from the Department in relation to the making of voluntary notifications.

398. It was conceded by Ms Dumont that there remained knowledge gaps amongst medical practitioners as to the existence of the legislation and the availability of the notification system.

Implementation of a Mandatory Reporting System

399. On the issue of changes that would be required to existing systems, to facilitate a mandatory notification regime, it was deposed that in addition to changes in legislation, changes would also be required to:

- The Department's database;
- Registration and licensing system;
- Additional communication campaigns; and
- Additional administrative impost.

400. It is submitted that the current notification 'portals' remain adequate and would not require any additional changes in circumstances where a mandatory notification system might be introduced. It was the assessment of the

Department that the imposition of a mandatory reporting requirement on medical practitioners would have "*minimal impediments*" for them.[239]

401. Whilst neither the AMA nor the RACGP sought to be joined as parties to the Inquest. It is the position of the AMA that the possession of a licence to drive is a "*privilege, not a right*". It acknowledges the jurisdiction of the State(s) to determine the criteria by which licences are issued and also withdrawn. The AMA acknowledges medical practitioners have a role to identify patients that may have a medical condition that may impair their ability to drive. To that effect the position of the AMA is that:

"*Determining that the degree of impairment constitutes a serious and immediate risk to the public, is a matter requiring careful and comprehensive diagnosis, as well as a judgement as to how an impairment identified in a medical consultation may manifest in a real-life driving situation*"

402. It is the position of the AMA that:

"*the role of the medical profession in determining fitness to drive should be confined to (a) diagnosing medical conditions, (b) assessing as far as reasonably possible the degree of functional impairment arising from those medical conditions, (c) advising the patient that he or she is not fit to drive, and (d) subject to the patient's consent, imparting that information to a licencing authority on request*"

403. Whilst it is preferable for a patient to consent to the notification being made, medical practitioners should also evaluate (in circumstances where consent is not sought or given) the potential implications of no notification being made.[240]

Further comments regarding fitness to drive guidelines

404. The default standard provided by the Austroad guidelines is that in **all** cases all persons who have experienced a seizure are deemed unfit immediately following the event to hold an unconditional licence pending a show cause period (and thereafter requiring annual reviews against certain criteria before further consideration).

405. I trust that the outcome of this inquest will also raise community awareness that it is incumbent upon all individuals who hold a driver's license to understand their obligations at law.

406. In Queensland a licence holder who has a medical condition likely to adversely affect their ability to drive safely has a statutory responsibility to notify the

[239] Exhibit M1 at page 8 of 9
[240] Austroads (Assessing Fitness to Drive) – 'Roles and Responsibilities of Health Professionals'

Department of transport and main roads as soon as they become aware of the condition, and not wait until their licence is due for renewal.

407. A holder of a driver's license must also notify transport and main roads if there is an increase or aggravation in a previously reported medical condition.

408. Failure of the person to notify transport and main roads about a relevant medical condition is an offence.

409. A licence holder who has a mental or physical incapacity likely to adversely affect their ability to drive safely is a ground for suspending or cancelling a Queensland driver licence. Transport and Main Roads may issue a person with a show cause giving that person 28 days to show cause before proposed action to amend suspend or cancel the driver's license should not be taken.

410. Similar action can be taken if Transport and Main Roads receives information from a third party that a person may have a permanent or long-term medical condition likely to adversely affect their ability to drive safely.

411. Driver's with a permanent or long-term medical condition that may affect their ability to drive safely but who are deemed fit to hold a licence may do so in accord with a current medical certificate. Driver's who are required to drive in accordance with the medical certificate must comply with any conditions or restrictions on the certificate new person

412. The department of transport and main roads must take steps to inform licence holders of their obligations to report a medical condition that may impact their ability to drive safely and upon renewal driver is informed that they must report any medical condition adversely affecting their ability to drive at the time of the application.

413. It is the currently held view by the Queensland Department of Transport and Main Roads that a persons treating health professional (usually the treating GP) is the most appropriate authority, having the right skills, professional training and experience to make an assessment and recommendation on whether the person's health or any medical condition increases their risk of a crash on the road.

414. Standards for assessing fitness to drive for commercial and private vehicle drivers are set out in the relevant Austroad is publication and include standards for both private and commercial drivers and covers a range of medical conditions that can affect a person's ability to drive safely. Austroads fitness to drive standards are principally designed to guide and support assessments made by health professionals and to ensure that assessments are conducted in a consistent manner. The publication is accessible and hardcopy or online at the Austroad's website. Where a persons treating GP believes that more information is required to assess the person's medical fitness to drive the GP

should refer the person to an appropriate specialist to inform the GPs assessment of the person's medical fitness to drive.

415. Health professionals play a key role in assessing person's medical fitness to drive however the responsibility for issuing, renewing, amending, suspending or cancelling a person's Queensland driver's license is the responsibility of the department of transport and main roads. Those decisions are made based on a full consideration of the assessment and recommendation made by persons treating health professional.

416. TMR will accept and investigate third-party notifications from concerned relatives, neighbours or friends in addition to health professionals and police about a licence holder who may have a medical condition that may affect their ability to drive safely

417. As I understand it from evidence and submissions at inquest the Australian Health Practitioner Regulation Agency (AHPRA) is bound by privacy constraints impacting on the ability of TMR to provide information packs to doctors through their peak bodies. Alternative notification mechanisms have been identified and implemented. I trust that the recommendations arising from this inquest will provide a forum to enable the continuation of streamlined notification mechanisms between TMR and medical practitioners.

418. Health professionals who are concerned that their patient may choose not to report a medical condition or continue to drive against medical advice can report their concerns to Transport and Main Roads. In those circumstances a health professional will not be held liable, civilly or under an administrative process, the giving information in good faith about a person's medical fitness to hold, or to continue to hold a Queensland driver's license.

419. I stress however that in Queensland legal responsibility for reporting a medical condition that may adversely affect a person's ability to drive safely rests absolutely with the licence holder. (commonly referred to as Jet's Law).

420. Medical fitness to drive is a trending issue and is and has been the subject of a number of coronial investigations (aside from inquests). There is also anecdotal evidence of doctor shopping in order for drivers to retain their licenses.

421. I trust that the formation of the executive working group arising from the recommendations in this inquest will traverse how best to support all medical and general practitioners. Assessing fitness to drive places a significant burden on general practitioners and has the potential to affect the doctor-patient relationship in circumstances where the patient is resistant to advice and reliant on their licence for employment and to remain mobile and independent.

422. I trust that the interagency working group will continue to review the scaffolding required for medical and general practitioners who are at the frontline of this process.

423. In this particular case Mr Scutt was clearly resistant to any and all advice not to drive despite being advised not to do so in 2004 2009 and 2014 by doctors at the Atherton Hospital. Each doctor provided Mr Scutt with specific timeframes and directed him back to his GP.

424. On each occasion Mr Scutt indicated that he understood he was not to drive and that he would attend upon his GP. Each of those doctors discharged their obligations and were not mandated to formally report Mr Scutt's condition to Transport and Main Roads. I was left with the impression that had the doctors appreciated and been aware of the pathway to make a notification to TMR they may have done so. Arising from the inquest that it could be generally accepted that information packs for medical practitioners had not been disseminated to the Atherton Hospital at the relevant time, and that the dissemination of information at that time had been confined to a select radius marginally extending outside the south-east corner of Queensland.

Analysis of the coronial issues

Issue 2

The circumstances surrounding the collision of Brian Andrew Scutt's motor vehicle at 59 Grigg Street, Ravenshoe on 9 June 2015 (referred to as the Ravenshoe Café Explosion) that resulted in the deaths of Nicole Sonia Nyholt and Margaret Louisa Clark;

425. Mr Brian Scutt had a background of seizures for which he episodically presented to the Emergency Department at the Atherton Hospital and his general practitioner Dr Kenneth Connolly. By 18 August 2014, Mr Scutt's seizures met the clinical definition for epilepsy. Whilst Mr Scutt's seizures had been investigated in 2004 they were not the subject of any further investigations until 2015, after the collision.

426. Mr Scutt demonstrated an aversion to receiving treatment in relation to his seizures but not in relation to other medical issues, such as management of his renal transplant.

427. By 10:39am on the morning of 9 June 2015 Mr Scutt was known to be unwell.

428. Sometime between 10:40am and 12pm that day Mr Scutt made the decision to drive his vehicle. He was not fit to drive at the time.

429. Shortly before entering the Ravenshoe town centre Mr Scutt experienced a seizure that resulted in a period of unconsciousness. Mr Scutt ceased to

operate his vehicle he left the roadway and his foot remained engaged with the accelerator. His vehicle collided with the gas cylinders located at the rear of the Serves Your Right Café triggering an explosion.

Issue 3

Taking into account Brain Andrew Scutt's presentations for seizures at the Atherton Hospital

a. *the adequacy and appropriateness of the treatment and care provided by the hospital;*
b. *the obligations, if any, for treating practitioners at the Atherton Hospital to notify the Queensland Department of Transport and Main Roads of Mr Scutt's history of seizures.*

430. In respect of the presentation to the Atherton Hospital on 7 March 2004 the treatment and care Mr Scutt received was adequate in all the circumstances noting that it was a first seizure and all necessary examinations were conducted. Those tests were negative for any obvious cause or condition.

431. On 19 May 2009 the treatment and care Mr Scutt received was adequate in all the circumstances noting that it was still to be classified as a first seizure. Dr Pyke's referral for the MRI was not ultimately facilitated for Mr Scutt. That was likely a 'hospital error or oversight' and this referral 'fell through the cracks'. This was a lost opportunity in the overall care and treatment of Mr Scutt.

432. I find that Dr Pyke discharged her obligations to the patient and including the preparation of a comprehensive letter personally addressed and sent to the patients GP upon discharge. That the letter did not find its way to Dr Connolly until sometime after his next appointment with Mr Scutt had no bearing on Dr Pyke or the Atherton Hospital.

433. Whilst the Atherton Hospital did not facilitate the MRI it remained open, having regard to the evidence of Dr McLaughlin, to continue observe the course taken by Mr Scutt in relation to his seizures. I find that the care and treatment received by Mr Scutt on this occasion at the Atherton Hospital was adequate and appropriate.

434. With respect if the presentation to the Atherton Hospital on 18 August 2014 it was open to Dr Van Beekhuizen, consider a provisional diagnosis of epilepsy. Dr McLaughlin considered that an opinion from a Neurologist should have been sought at that point, although he conceded it remained open to continue observing Mr Scutt provided there were no other seizure events. Upon discharge Mr Scutt ceased to be under the care of Atherton Hospital.

435. It was noted that whilst Dr Van Beekhuizen did not seek an opinion of a neurologist she did develop a clinical pathway for Mr Scutt back to his GP. A pathway that Mr Scutt indicated a willingness and consent to undertake.

436. Dr VanBeekhuizen prepared an accurate clinical summary of Mr Scutts presentation. I accept that she faxed that summary to the Ravenshoe Clinic and intended it for the attention and information of Mr Scutt's GP. She encouraged him to see his GP, Mr Scutt advised he was seeing his GP tomorrow. He declined any further investigations. She set out sufficient information in the clinical summary faxed and intended for Dr Connolly.

437. I find that the care and treatment received by Mr Scutt on this occasion at the Atherton Hospital was adequate and appropriate. That the clinical summary did not find its way to Dr Connolly had no bearing on Dr Pyke or the Atherton Hospital. I note that in fact Mr Scutt did have his very next GP consult at the Ravenshoe Clinic (not at the medical centre) it seems entirely appropriate (and perhaps co-incidental) that the summary was faxed to the clinic, and may not have been in error as suggested.

438. Mr Scutt experienced a further seizure on the afternoon of 18 August 2014. There was evidence of communication between QAS and Dr Van Beekhuizen that afternoon. Arising from that discussion QAS conveyed Mr Scutt to his GP clinic in Ravenshoe.

439. The Ravenshoe Medical Centre was closed by the time of QAS arrival with Mr Scutt. Whilst these attempts were consistent with the management plan that had been developed that morning at Atherton Hospital, neither Dr Van Beekhuizen nor any other medical practitioner of the Atherton Hospital had the responsibility for the care and treatment of that second seizure, noting that Mr Scutt did not present again to the Emergency Department.

440. In those circumstances it is submitted that the care and treatment provided to Mr Scutt by the Atherton Hospital on 18 August 2014 was adequate and appropriate.

441. At no time during any of Mr Scutt's presentation to the Atherton Hospital for seizures was there any mandate on any of the medical practitioners who provided treatment, to notify the Queensland Department of Transport and Main Roads of Mr Scutt's seizure events. Any notification that might have been made would have been on a voluntary basis and subject to the necessary risk assessments and guidelines.

442. Whilst there was no obligation for any of the medical practitioners to make a notification to the Department, each doctor advised Mr Scutt that he should abstain from driving for a period of time.

Issue 4

The extent of general practitioner Dr Kenneth Conolly's knowledge of Brian Andrew Scutt's seizure history and;

a. whether in the circumstances Dr Conolly's medical care was adequate and appropriate and;
b. the obligation, if any, for Dr Conolly, to notify the Queensland Department of Transport and Main Roads of Mr Scutt's history of seizures.

443. It is submitted with respect of the 2004 and 2009 seizures Dr Connolly had knowledge of each seizure event and the treatment that was provided to him on each occasion, by virtue of:

- The EEG report of Dr Archer; (2004)
- The discharge summary letter of Dr Pyke; (2009)
- The progress notes made by Dr Connolly; and (2014)

444. Dr Connolly was not seized of the discharge notes from Dr Van Beekhuizen from the August 2014 presentation to the Atherton Hospital at the time of his consultation with Mr Scutt one week later. However I find that Mr Scutt himself reported fit / seizure to Dr Connolly during that consultation and that was recorded by Dr Connolly.

445. Dr Connolly would not have had knowledge of any seizure treated by the Queensland Ambulance Service, Dr Pandey or Nurse Oloresnshaw.

446. Dr Connolly would however have had exclusive knowledge of the seizure reported by Mr Scutt at the Primary Health Clinic on 25 August 2014.

447. At the time of Mr Scutt's engagement with Dr Connolly in relation to the EEG results of 2004 it is submitted that Dr Connolly care and treatment was adequate and appropriate, noting that he was aware that examinations had been conducted and normal results observed. It was appropriate for Dr Connolly to maintain a period of observation following that time however his progress notes do not disclose any active steps taken in that regard.

448. At the time of Mr Scutt's engagement with Dr Connolly following the 2009 seizure, up to the time Dr Connolly became aware of the discharge letter under the hand of Dr Pyke I find that his overall care and treatment of Mr Scutt was adequate and appropriate.

449. Sometime after the 21 May 2009 consultation, Dr Connolly became aware of the discharge letter of 19 May 2009. There is no evidence before me to suggest that Dr Connolly recalled Mr Scutt, or followed up with him to reinforce Dr Pyke's decision that Mr Scutt not drive, or to ensure that the proposed treatment plan

had been facilitated, or generally to inform himself as to his patients condition. I find that failure fell short of adequate and appropriate medical care and treatment for reasons provided in these findings.

450. With respect of the 2014 seizures it is submitted Dr Connolly's care and treatment of Mr Scutt was not adequate or appropriate. There is no indication in the clinical record that Dr Connolly made further enquiry or development a treatment plan for his patient upon being advised of his fit / seizure against a background of his fit/seizure history.

451. There was no evidence of Dr Connolly treating Mr Scutt for epilepsy or seizure activity or providing any advice that Mr Scutt abstain from driving.

452. I accept that Dr Connolly was not under any mandatory duty or obligation to notify the Department ff Transport of any of the seizure events. A good faith referral by the doctor was and remains discretionary. However, I find that in 2004 he could and should have exercised that discretion noting the risk of harm to his patient and to other road users.

Issue 5

Taking into account Mr Scutt's seizure history, the obligation of Mr Scutt:

a. *to comply with medical advice not to drive; and*
b. *to notify the Queensland Department of Transport and Main Roads of his history of seizures.*

453. As an autonomous patient Mr Scutt was never obliged or compelled to abide by the advice given to him by the medical practitioners at the Atherton Hospital. However as at the time of renewing his licence on 16 January 2014 he was obliged to make a positive declaration to the Department of his seizure history. Mr Scutt instead made false declaration that he had not previously had seizures.

Issue 6

Whether as at 9 June 2015, with reference to a history of seizures, Brian Andrew Scutt was fit to hold a Queensland Drivers Licence;

454. Mr Scutt was not fit to drive on 9 June 2015.

Issue 7

As at current date, the obligations (if any) on a medical practitioner, or person, to make a notification (voluntary or otherwise) to the Department of Transport and Main Roads in relation to Brian Andrew Scutt's known seizure activity

455. There are presently no obligations or duties on any medical practitioner in the State of Queensland requiring them to make a notification to the Department of Transport of any medical condition that may adversely affect a person's ability to drive.

456. As a licence holder Mr Scutt's was the only person required to mandatorily notify the Department of Transport.

Issue 8

Whether a duty should be imposed on medical practitioner, who having examined a person who is the holder of a driver's licence or learner's permit:

a. forms a reasonable belief that the person is suffering from any illness, disability or deficiency and;
b. the nature of any illness, disability or deficiency would, if that person drove a motor vehicle, be likely to endanger the public

To then notify the Department of Transport of Main Roads and Transport of the name and address of that person and the nature of the illness, disability or deficiency.

457. I have formed a view that a duty should **not** be imposed on medical practitioners to notify the Department of Transport of an illness, disability or deficiency that would, if the licence holder drove a motor vehicle, be likely to endanger the public.

458. The evidence at the Inquest was such that protocols currently exist, and are used by medical practitioners, to make voluntary notifications to the Department as required.

459. Medical Practitioners bring their judgement and experience to bear in determining whether a voluntary notification should be made, either with or without the consent of the patient. The medical practitioner should consider whether the patient:

- Is able to appreciate the impact of their condition;
- Is unable to appreciate or understand the advice of the medical practitioner due to cognitive impairment; or

- Continues to drive despite appropriate advice and is likely to endanger the public.

460. In making a decision whether or not to report the medical practitioner should also consider:

- Whether there is an immediate risk to public safety;
- Risks associated with making the notification in terms of the patient's ongoing treatment or care as balanced against the implications of non-disclosure; and
- Whether there is a serious or imminent threat to health, life or safety of any person.

461. It is submitted that making a mandatory reporting obligation would remove a fundamental element of the judgement and discretion that a medical practitioner is required to make. It may also erode fundamental aspects of a doctor patient alliance.

Comment in accordance with s46

462. The inquest identified that gaps exist in terms of educating medical practitioners about making good faith voluntary notification and the pathway by which that could be done.

463. It seems to me that one of the salient issues arising from this inquest is whether or not patient care can be better triaged and managed between systems. In this case, Mr Scutt was lost to both the Hospital system and his GP in respect of any long term monitoring and care and treatment plan. Every event occurred, and was treated, in isolation. On each of those occasions it seems the GP was not immediately aware of the state of events.

464. Mr Scutt's also managed for a significant period of time, to seemingly manipulate information and was selective in his reporting aspects of his condition and treatment to all doctors and hospitals (and his family).

465. The lost connection between hospital and GP, relied therefore on Mr Scutt to essentially to become the conduit for his own care and treatment.

466. Whilst many persons would self-report and advise their GP of recent Hospital presentations or admissions, there are also many who do not. Mr Scutt was such a person.

467. He disregarded the requests of his family not to drive; he failed to take the advice of friends not to drive; and of most significance, on three separate occasions, he did not heed the advice of medical practitioners not to drive.

468. It looms large that had Mr Scutt's licence been suspended or revoked in 2014, or medical conditions endorsed on his licence, he may not have been driving on the day of the explosion. Of course, this is also speculative, noting Mr Scutt's wilful disregard over a period of 11 years, of all advices not to drive. It may well be that he continued to drive, even with limitations imposed.

469. The advantage, however, is that he would then be known to 'the system', he would then have come to the attention of Transport and Main Roads, his general practitioner, and perhaps even local police. He would have been monitored. Perhaps even he would have been compliant in such circumstances.

470. I make the following recommendations and request that the following agencies (identified as peak professional bodies best placed to review comment and implement reform if required) be advised of my recommendations and participate in an interagency working group to consider the recommendations arising:

- That the Department of transport and Main Roads take the role as lead agency in the formation of an inter-agency working group (noting they have written to me post inquest volunteering to take on the role, I thank the Department for that) comprising relevant stakeholders including, but not limited to, the following:

  - Department of Transport and Main Roads (Qld);
  - Department of Health (Qld)
  - Austroads
  - APHRA;
  - OHO;
  - AMA (Australia and Qld)
  - RACGP;
  - College of Rural and Remote Medicine
  - Hospital Health Services
  - Medical Board of Australia
  - Australian College of Emergency Medicine (ACEM)

Recommendation 1

That the inter-working group collaborate to develop an ongoing education and awareness campaign directed to all medical practitioners in the State of Queensland, including hospital based doctors (including rural and remote hospitals) and general practitioners, (including rural and remote general practitioners) and that such campaign be specifically developed to educate medical practitioners about the pathways that already exist, for medical practitioners to report patients directly to the State driver licencing authority in circumstances that are consistent with the Medical Standards provided for in the Austroad assessing fitness to drive guidelines.

Recommendation 2

A working group of relevant stakeholders review the current standards and guidelines in respect of continuity of care, discharge, and handovers relevant as between doctors and patients, and doctors and doctors, and hospitals and General practitioners.

Recommendation 3

That consideration be given to a community campaign targeted at licence holders reminding them of their obligations to immediately report to TMR any medical events (including seizures and epilepsy) which may impact on their fitness to drive.

Acknowledgment and condolences

471. I conclude by acknowledging the families of those who died in the café explosion.

472. To Nicole Nyholt's family and to the family of Margaret Clarke, we extend our deepest sympathies and wish you well in your healing.

473. To all emergency service personnel who attended the scene that day and who were involved in the care, treatment, triage and of the injured persons, I acknowledge those extraordinary efforts.

474. To Queensland Police investigating officer Sergeant Brett Devine, and Forensic Crash Unit co-ordinator Sergeant Scott Ezard for their comprehensive investigation reports and assistance to the coronial investigation.

475. We also acknowledge the wider community of Ravenshoe, many citizens, if not most, knew one or more of the persons involved in this tragedy. As I said at the outset, the town remains bewildered and saddened by the turn of events that day.

476. I acknowledge Counsel assisting the inquest, Mr Joseph Crawfoot. I acknowledge all Counsel and their instructors for their efforts to shed light on the facts of this difficult matter and for the respect and sensitivity demonstrated to the Nyholt, Clark, Scutt and Connolly families all of whom were affected in some way by these events.

Findings required by s. 45

477. With respect to the matters required under s.45(2) of the *Coroners Act* It is submitted that:

Identity of the deceased – The identity of the deceased are Nicole Sonia Nyholt and Margaret Louisa Clark;

How they died – On 9 June 2015 Brian Scutt whilst driving a vehicle experienced an epileptic seizure and he temporarily lost consciousness and he lost control of his vehicle and veered off the main road in the township of Ravenshoe mounting the gutter and travelling almost 170 metres across parkland before colliding with a 180kg LPG gas cylinder thereby triggering an explosion in the Serves You Right Café resulting in injuries that caused the deaths of Margaret Clark and Nicole Nyholt. The impact of the collision caused the following chain of events:

- the gas cylinder ruptured;
- the gas cylinder was forced through a concrete block wall into the kitchen area of the café;
- the liquid contents of the gas cylinder were released and vapourised creating a gasfield;
- the gas mixed with the surrounding oxygen and ignited upon contact with a heat source in the kitchen of the café, thereby causing an explosion reaching temperatures between 1200°C and 2000°C.[241.]

Nineteen people were present inside the café at the time, including the deceased Ms Nicole Sonia Nyholt (aged 37) and Ms Margaret Louisa Clark (aged 82). Both Ms Nyholt and Ms Clark sustained non-survivable burns as result of the explosion. Both succumbed to their injuries in the days following the explosion.

Based on seizure activity and the deterioration in his physical and mental health in the months leading up to the accident and taking into account his poor health on the day of the accident, I find that Brian Andrew Scutt was not medically fit to drive at the

[241] T1.21/32-45

time of the accident on 9 June 2015 and should not then have held an unconditional drivers licence.

Date of death – Ms Nyholt died on 12 June 2015 and Ms Clark died on 14 June 2015.

Place of death – Both Ms Nyholt and Ms Clark died at the Royal Brisbane and Women's Hospital in Brisbane, Queensland.

Cause of death - **The cause of Ms Nyholt's death was**:

1(a). Burns, due to, or as a consequence of,
1(b). Gas explosion, due to, or as a consequence of,
1(c). Motor vehicle collision with building.

The cause of Ms Clark's death was:
1(a). Burns, due to, or as a consequence of,
1(b). Gas explosion, due to, or as a consequence of,
1(c). Motor vehicle collision with building
Other significant conditions:
2. Atrial fibrillation, hypertension, diabetes mellitus, hypercholesterolaemia, obesity.

I close the inquest.

Nerida Wilson
Northern Coroner
CAIRNS
26 June 2020