QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDING OF INQUEST

CITATION: **Inquest into the death of Lex Robert Bismark**

TITLE OF COURT: **Coroner's Court**

JURISDICTION: Mt Isa

FILE NO(s): COR\02 1031

DELIVERED ON: **23 February** 2006

DELIVERED AT: Mt Isa

HEARING DATE(s): 16 May 2005, 5,6,7&,8 September 2005, 22, 23 February 2006

FINDINGS OF: Mr Michael Barnes, State Coroner

CATCHWORDS: Coroners: Inquest, motor vehicle accident, fitness to drive

REPRESENTATION:

Counsel Assisting:	Mr John Tate, Crown Law
Family of Mr Bismark	Mr Dennis Lynch, instructed by Rod Madsen, solicitors
Mrs Annas	Mr Greg McGuire, instructed by Anderson Telford, solicitors

Findings of the inquest into the death of Lex Robert Bismark

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The *Coroners Act 1958* provides in s43(1) that after considering all of the evidence given before a coroner at an inquest the coroner shall give his or her findings in open court. What follows are my findings of the inquest held into the death of Lex Robert Bismark.

Introduction

It was NAIDOC week in Mt Isa and numerous Indigenous people who had come to town for commemorative events were in a mood for celebration.

On Friday 12 July 2002, a large group had gathered at the Barkly Hotel which had been booked for a function. Lex Bismark, whose family came from Doomadgee, was among the group.

At about 2.30 am a fight broke out inside the hotel. Soon after, the manager decided to close the hotel and staff ushered everyone outside. The fight continued and escalated in the car park. It spilled onto the Barkly Highway.

Shortly after this happened, a car travelling into town along the highway drove into the crowd and struck three people including Mr Bismark, killing him.

These findings seek to explain how that occurred. They also consider whether the regulations governing fitness to drive a motor vehicle adequately protect the public.

The Coroner's jurisdiction

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The basis of the jurisdiction

Although the inquest was held in 2005, as the death being investigated occurred before 1 December 2003, the date on which the *Coroners Act 2003* was proclaimed, it is a "*pre-commencement death*" within the terms of s100 of that Act and the provisions of the *Coroners Act 1958* (the Act) are therefore preserved in relation to it.

Because the death was "*violent or unnatural*" the police who were summoned to the scene were obliged by s12(1) of the Act to report it to a coroner. Section 7(1)(a)(i) confers jurisdiction on a coroner to investigate such a death and s7B authorises the holding of an inquest into it.

The scope of the Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death.

The Act, in s24, provides that where an inquest is held, it shall be for the purpose of establishing as far as practicable:-

- the fact that a person has died,
- the identity of the deceased,

- when, where and how the death occurred, and
- whether anyone should be charged with a criminal offence alleging he/she caused the death.

After considering all of the evidence presented at the inquest, findings must be given in relation to each of those matters to the extent that they are able to be proven.

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial, where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [1]

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning 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. As a result, the Act authorises a coroner to make preventive recommendations,[2] referred to as "*riders*" but prohibits findings or riders being framed in a way that appears to determine questions of civil liability or suggests a person is guilty of any criminal offence.[3]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because s34 of the Act provides that "*the coroner may admit any evidence the coroner thinks fit"* provided the coroner considers it necessary to establish any of the matters within the scope of the inquest.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt, an inquiry rather than a trial.[4]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable.[5] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[6]

Of course, when determining whether anyone should be committed for trial, a coroner can only have regard to evidence that could be admitted in a criminal

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[1] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[2] s43(5)
[3] s43(6)
[4] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[5] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[6] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J

trial and will only commit if he/she considers an offence could be proven to the criminal standard of beyond reasonable doubt.

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[7] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[8] makes clear, that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

The investigation

I turn now to a description of the investigation. Police and the ambulance service had been called to attend the hotel on account of the fight that had occurred inside the hotel and were *en route* there when they were informed of the accident that resulted in Mr Bismark's death. Four officers arrived soon after the accident and set about assisting the ambulance officer's ministering to the injured and securing the scene. Police officers with traffic accident investigation training and experience were called out and attended the scene about an hour after the accident had occurred. Some months later, an accident scene analyst from Brisbane also attended and made measurements and a plan. A scenes of crime officer went to the accident site on the night. Photographs were taken of the scene and the vehicle involved in the incident was impounded and subsequently inspected.

The investigation was reasonably thorough, although some significant aspects were overlooked until the inquest commenced. The investigation was perhaps made more difficult for police by the fact that the driver of the car was severely assaulted by the crowd immediately after the accident. She was an elderly woman and police naturally felt sympathy for her. Public opinion, to the extent that can be gauged from the local media, was firmly on her side, with scant attention given to the fact that she had killed someone. The officer in charge of the Mt Isa Criminal Investigation Branch gave evidence that he made social calls to the driver on a number of occasions after the incident. The officer who was investigating Mr Bismark's death had to deal with a situation where the suspect for an offence of dangerous driving causing the death was a complainant in the serious assault matter being investigated by his plain clothed colleagues. He was told by one of them that she would not agree to being interviewed by him as part of the death investigation. To get any version from the driver of how the accident occurred, the investigating officer had to rely on the statements given by her to detectives investigating the offences committed against her. Understandably, they were insufficient for his purposes.

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[7] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13

[8] (1990) 65 ALJR 167 at 168

The inquest

At the request of the local coroner, I took responsibility for the inquest on account of the difficulty of fitting such a lengthy matter into the diary of a single magistrate court.

Directions hearings

A directions hearing was convened on 16 May 2005. Leave to appear was granted to the family of Mr Bismark and to Mrs Annas, the driver of the vehicle involved in the accident. Mr Tate of Crown Law was appointed counsel assisting the coroner. Those who had been granted leave to appear to were authorised to access the investigation report.

A view and the taking of evidence

On 4 September, in the night time, a view of the scene was undertaken by the court and those with leave to appear. The inquest commenced on 5 September and evidence was given over the succeeding three days. Forty one witnesses gave evidence. Mrs Annas, the driver of the car that struck the deceased, claimed privilege against self incrimination and gave no evidence. After three days of evidence, a further view of the scene was undertaken. On this occasion the crash analyst also attended. Eighty seven exhibits were tendered. On the fourth day Mrs Annas' general practitioner was recalled and it became apparent that Mrs Annas' eyesight may have been relevant to an understanding of the accident. The inquest was therefore adjourned so that expert evidence could be obtained in relation to that issue.

It reconvened on 22 February 2006 to hear evidence from an ophthalmologist and a doctor, both who had treated Mrs Annas. Sadly, in the intervening period Mrs Annas died. I am, of course, still obliged to make findings concerning the details of Mr Bismark's death.

The evidence

I turn now to the evidence. Of course, I can not even summarise all of the information contained in the exhibits and transcript but I consider it appropriate to record here the evidence I believe is necessary to understand the findings I have made.

Background

The National Aborigines' and Islanders' Day Observation Committee gave its name to NAIDOC Week. It is a time each year when the Indigenous peoples around Australia celebrate the survival of their culture and plan for the future.

On Friday 12 July 2002, NAIDOC week was winding down in Mt Isa. One of the numerous events enjoyed that week included a function at the Barkly Hotel. At that time, the hotel sported a public bar, a bistro bar, a night club and a bottle shop. On the night in question, the bottle shop and the bistro closed at 8.30, the nightclub opened at 10.00 and the public bar closed at 11.30.

Therefore, by 2.30am on Saturday morning, those who were still celebrating at the hotel were all in the nightclub. The exact number of patrons present is not known with certainty; the hotel manger estimated that there were 80 to 90 people there while the security officer estimates the number to be about 150. The staff consisted of the manager, the security officer, two female bar attendants, a male “glassie” and a male disc jockey.

Regrettably, and perhaps predictably, interpersonal violence flared among the drinkers. As so often is the case, the first victim was a woman who was knocked to the floor and kicked in the head by her male assailant, an intimate acquaintance. Understandably, this caused others present to attack the assailant and a fight erupted.

The hotel staff managed to quell the immediate violence by evicting the fighters. Outside the hotel, in the large car park that fronts the Barkly Highway, a large number of people, some of whom had allegedly been evicted or refused entry to another licensed premises nearby, were milling about. Violence soon erupted among this group and the manager decided to close the hotel. At this stage, all of the patrons were ushered outside.

An overview of the area

A description of the area may be helpful. The hotel is situated on the eastern side of the Barkly Highway, a four lane road with a concrete median strip separating the two north and two southbound lanes. It occupies the whole block so that there are side streets running east from the highway at each end of the hotel: Sulphide Street on the northern side and Kentia Street on the south, with traffic lights controlling that intersection. Looking south from Sulphide Street, the first 50 metres of the property is open space with no obvious dedicated purpose. It ends at a crescent shaped driveway that arches around a lawn with a fountain and sweeps past the entrance to the reception area and the night club before re-emerging on the highway 25 metres further south. Access to this driveway is also available from Sulphide Street, adjacent to the front of the hotel across the open space referred to earlier. South of the southern most driveway entrance, a large paved car park abuts the highway. The car involved in the accident came to rest approximately 20 metres south of this driveway adjacent to the car park. A better understanding of the scene can be gained from the sketch plan annexed to exhibit 61.

The crowd

Crowd numbers are notoriously difficult to estimate, particularly in the conditions that prevailed on the night in question when the lighting was variable and the people were moving around. Therefore, it is not surprising that the evidence on this point is wildly conflicting, with estimates ranging from 40 or 50 and up to 200. I have no way of conclusively resolving this conflict but having regard to the evidence of the hotel staff that there were around one hundred people inside and the uncontradicted evidence that there were more in the car park, I accept that there were well over one hundred people outside the hotel soon after it closed and the patrons were all ushered out.

Eye witness accounts of the accident

There is no compelling chronological account of what happened next. There were no surveillance cameras or helicopters carrying news crews recording the events. All we have are glimpses and disjointed snippets from various perspectives provided by active participants and startled observers of varying degrees of sobriety.

On everyone's evidence, after the hotel closed the antagonisms again flared and a number of fights erupted. Some of these fights became increasingly violent and their participants numerous. Combatants were seen to use pieces of timber and lumps of concrete in the fighting. One woman was seen brandishing a tyre lever. Estimates of the number involved in the actual fighting range from 10 to 20 to 50. Many more stood around watching. It is impossible to make precise findings about this aspect of the matter, but I accept that there were numerous fights erupting and subsiding in the 15 minutes after the hotel closed.

The fighting was not restricted to a discrete area. Rather, it seems some people were fighting in the car park, others on the crescent shaped lawn and some were fighting on the southbound lanes of the Barkly Highway. Of course these brawls were not static; they surged around the area as people joined in and others sought to arm themselves with implements of battle. Others in the crowd were intent on leaving the area and large numbers were streaming across the road to two telephone boxes that are on the western side of the highway.

Mr Bismark was among a group of people who were involved in or watching a fight that was taking place on the southern lanes of the highway. This group had to get off the road when at least one, possibly more, vehicles came along. They resumed their position on the road after the traffic had passed.

Mr Bismark was wearing dark blue clothes, as were some others in the group. One of the other people on the road was wearing white pants and an orange shirt.

At about 2.40am, Mrs Annas drove down the Barkly Highway in a southerly direction from her home at Soldiers Hill. She says in her statements that she was fresh from a sleep and not affected by any alcohol or other drugs, although I note she told hospital staff that she had taken 30 mg of Serapax about seven hours before the accident. She told police that as she approached the intersection of the highway and Kentia Street she saw a group of Aboriginal people milling around on the footpath.

A person watching from the footpath says he saw her car coming towards the group and yelled at them to get off the road. They did not heed this warning

Mrs Annas says:-

> "*I looked up at the traffic lights and saw that the lights were green. I continued on and looked back down onto the road. When I looked back down onto the road I saw all of these Aborigines were on the road in front of me.* "[9]

She continues:-

> *When I looked at the lights, I only looked away from the road for what I would say would be one second before looking back at the road and seeing the Aborigines in front of my car.*[10]
>
> *When I first saw them I knew that it was not possible for me to stop in time without hitting someone in the group. I put my brakes on as hard as I could and steered the car for the thinnest part of the group. I could not stop before hitting the people because they were too close to my car and because it was so sudden.*[11]

Mrs Annas was correct when she said she was too close to the group to stop without hitting anyone. Three people were struck and seen to fly up into the air before falling onto the roadway. The car went under Mr Bismark and he landed on its bonnet. It is likely that the windscreen then crashed into his head before he was thrown onto the ground. The other two people received relatively minor injuries. Mr Bismark's injuries were fatal. They are detailed below.

Mrs Annas was then attacked by members of the crowd, incensed no doubt that she had driven into them. She was severely beaten and suffered serious injuries.

At about 2.44am the ambulance was called to the Barkly Hotel to attend to the woman who had earlier been assaulted inside. As they were *en route* they were advised of the motor vehicle accident and immediately attended to Mr Bismark when they arrived at the scene at about 2.47. It was quickly recognised that he had very serious injuries. His heart stopped before he could be loaded into the ambulance and it seems clear that by the time he reached the hospital he was already dead.

Mr Bismark's aunt, who had known him all his life, was brought to the hospital and she identified his body to police.

On 16 July an autopsy was performed on Mr Bismark's body by the local Government Medical Officer, Dr Lola Power, who found injuries consistent with his having been struck by a motor vehicle. She found that his brain stem was totally disorganised and shredded. She noted avulsion of the brain stem and upper cervical cord and a fracture of the proximal cervical spine between C1 and C2. Analysis of Mr Bismark's blood showed an alcohol level of .27%

[9] exhibit 55 para 9
[10] exhibit 55 para 10
[11] exhibit 55 para 11

The cause of the accident

The central question is, why did Mrs Annas run into the people? On the evidence there are three possibilities; it was too dark for a competent and careful driver to see the people on the road, Mrs Annas failed to keep sufficient lookout or her eyesight made her driving dangerous.

Having regard to the examination of the scene, the tests undertaken by Sgt Ruller, and his expertise in crash investigations, I consider the following can be proven :-

- After the application of its brakes, the vehicle skidded for 23 metres before coming to a stop.

- A change in the skid marks after 9 metres suggests it was at that point that the vehicle hit the people.

- The speed of the vehicle when it commenced skidding was in the range 51 to 58km/h. At these speeds, the vehicle would travel between 14 and 16.1 metres per second.

- At best, even competent and alert drivers take a second or two to react to seeing something on the road. That involves them first recognising the thing as a hazard, determining what action they need to take and carrying that out. The length of that delay can depend upon whether the driver is expecting to see anything on the road and how visible the thing is.

From those factors I can deduce that Mrs Annas only saw the people on the road when she was somewhere between 23 and 40 metres from them.

I am prepared to accept that neither Mrs Annas nor a reasonably prudent driver would have expected to see people on the road outside the hotel at 2.44 in the morning and that this would add to the delay in responding to the danger.

However, Mrs Annas' explanation of why she did not see the people that is quoted earlier is not convincing. It will be recalled that she claimed she looked away from the road to look at the traffic lights situated at the intersection just south of the hotel. An inspection of the locality makes clear that the road slopes gently upward in the vicinity of the accident scene with a low crest just past the point of impact. It then slopes gently downwards through the intersection in question. It is quite straight. Therefore, looking at the traffic lights as she approached the spot where the people were fighting on the road would not have required Mrs Annas to have "*looked away*"; they were directly in front of her, at about eye level.

She gave another explanation to a journalist who spoke to her in hospital. In an interview recorded on 15 July 2002, she said that the people she hit had just run out in front of her, giving her insufficient time to stop.[12]

That explanation is also untenable as there is abundant evidence indicating that there had been a lot of people on the road for some minutes before Mrs Annas came along.

She told a doctor and nurse who attended to her, when she was taken to the hospital immediately after the accident, that there were "*multiple people on the road"* who she "*saw at the last moment.*"

Why did she not see the people in sufficient time to avoid driving into them?

An important issue is the level of lighting at the scene. There were certainly two orange street lights positioned over the curb side lane inbound. One was approximately 50 metres north of where the car came to a stop after the accident and the other was 50 metres further south. There were also 3 or 4 lights on poles along the hotel property line adjoining the highway. Strip lights of neon tubes ran along the top of the first floor of the hotel and around the roof of the bottle shop, which is next to the car park. A large spotlight is positioned near the top of the second storey of the hotel. Its beam is directed over the car park. There were two street lights on the opposite side of the highway but like the ones on the southbound lanes these were also approximately 50 metres each side of the accident site. The shops on the western side of the highway had minimal security lighting. The phone boxes on the western side of the highway, which were approximately 30 metres south of the accident scene, had the usual lights. The lighting on the hotel was able to be controlled by the hotel staff; the other lighting was constant.

Considerable evidence, much of it conflicting, was given as to which of the hotel lights were on at the time of the accident. The hotel manager said the spotlight was controlled by a timer and he thought that it was still on at the time of the accident. His assistant manager agreed with this as did a woman who was at the hotel assisting a friend who was working there as a disc jockey. Against this is the evidence of Constable Kirkpatrick who said that when he arrived soon after the accident, the spotlight was off but the other hotel lighting was on. This version is supported by Ms Tronc and Ms Major, both of whom impressed me as reliable witnesses. Both of these women say they specifically remember the spotlight going off shortly before the accident and the negative impact that had on visibility. A number of another witnesses support this account. The spotlight is controlled by a switch on the second floor of the hotel. The switches for some of the other lights are in a box on the outside of the bottle shop and so it is entirely feasible that the spotlight was turned off while the other lights remained on until the pre-set timer or timers caused them to be extinguished. This would also explain why all of the hotel lights were off when the scenes of crime officers arrived. Accordingly, I find

[12] exhibit 72 and 73

that at the time of the accident, the hotel spotlight was off but the other lights referred to above were on.

I pause here to note that the spotlight, which was the greatest source of illumination of the scene, seems to have been was deliberately extinguished by the hotel management while numerous patrons were milling around in the car park. This was a dangerous and ill considered action.

As a result of undertaking two views of the scene, both lit and unlit, and driving at night along the material part of the route taken by Mrs Annas, I conclude that visibility was poor, particularly at the exact spot where the accident happened. It is between two street lights and in something of a shadow. There is no contrasting backdrop to highlight the figures of those who might be on the road. Indeed, after the spotlight went out, one of the witnesses described how the figures on the street became silhouettes and shadows. She said that unless a viewer was familiar with a person's outline or clothing the viewer would not have been able to recognise them. Another witness described how at that time you could not see people's faces anymore and would have had to have to recognised them by their voices.

Was it so dark in the area where Mr Bismark and the others were standing that a reasonably careful driver would not have seen them in time to avoid colliding with them or do the circumstances of the incident suggest some other reason for the collision?

Of relevance are the actions of other drivers in the vicinity.

A security patrolman came across the people making their way across the outbound lane to the phone boxes after he moved off from the traffic lights at the intersection of Gardenia St and the highway. He was travelling north on the lane farthest from the hotel. He said that he did not see the people until they were illuminated by his headlights. He said that he was only 20 to 30 feet away from them when he first saw them but he managed to stop because he was travelling slowly, having been stationary at the traffic lights which are approximately 100 metres from where he saw the people. Another vehicle came along soon after and its driver also saw the people on the road and managed to pick a path among them, but presumably the light from the security guard's car would have made it easier for this second driver to see them.

A number of vehicles also managed to travel down the southbound lanes when the fighters and onlookers were on the road, although one of those vehicles was driven by Ms Major, who knew that the people were in the vicinity and she was planning to stop at the hotel. I have insufficient evidence about the other car or cars to draw conclusions from the conduct of that/those driver/s.

The people on the road were not standing still. Their movement would make their presence easier to detect by a person who was keeping a proper lookout. While undoubtedly some of the people on the road were wearing dark

clothing and nearly all had dark skin, there was also evidence that some had bright and light coloured clothing. The other very relevant factor is the number of people involved. Mr Bismark was not a lone figure lurking in the shadows; he was part of a large, dynamic and volatile crowd.

In my view, having regard to all of the evidence, I consider that the physical conditions prevailing at the time of the accident, that is the lighting, the topography, the clothing worn by the people one the road, do not either alone or in combination, sufficiently explain why Mrs Annas did not see the people sooner.

The remaining factor which must be considered is Mrs Annas' eyesight. The medical records tendered in evidence show that Mrs Annas had been prescribed glasses since 1984, although only for reading. She had been consulting various medical practitioners in connection with problems concerning her eyes and eyesight since at least 1991.

In 2002, the year of the accident resulting in Mr Bismark's death, Mrs Annas had a number of consultations of note. On 25 January she visited Dr Kelly at the Mt Isa Hospital, complaining of a painful right eye. On examination Mrs Annas was found to have cataracts in both eyes and a visual acuity of 6/36 in both eyes. The notes of that consultation indicate that she was "*advised strongly not to drive"* and told that surgery may improve her vision and she may in the future be able to drive "*but until then she is unsafe.*"

On 2 February, Mrs Annas was examined by an ophthalmologist, Dr Foster, who confirmed that her eyesight was as found by Dr Kelly, and advised her of the prognosis should she undergo surgery. Dr Foster says Mrs Annas told him that she had given up driving because of her poor eyesight and he confirmed in evidence that her eyesight was very poor.

On 1 July 2002 Mrs Annas attended at the surgery of her usual GP complaining of a painful left eye and her eyesight was again tested. The notes record her acuity as being: right eye – 6/36 and left eye – 6/60. She was advised to go to the hospital with a referral letter that noted "*her vision is normally quite impaired*."

Mrs Annas' vision had improved slightly when she was again seen by Dr Foster at the Mt Isa Hospital on 11 July. He recorded her vision on that day as being 6/36 in both eyes but he noted that the cataracts in her eyes had worsened since he had seen her in February. This examination was made just two days before the accident.

In layman's terms, a visual acuity level of 6/36 means that on testing, Mrs Annas could only identify symbols that a normal sighted person could identify from 36 metres when she was 6 metres from the symbols. An acuity level of 6/12 is usually considered the limit for safe driving.

As a result of considering all of the evidence I am persuaded that the dominant factor in the accident was Mrs Annas' poor vision. She could not

see sufficiently well to drive safely in the daytime, let alone at night, and she knew this. It is also concerning that she sought to mislead the police officers investigating the accident by telling them "*I do not need these glasses when I am driving or looking at things in the distance."*[13]

Findings required by s43(2)

I am required to find, so far as has been proved, who the deceased was and when, where and how he came by his death.

As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses, I am able to make the following findings.

Identity of the deceased – The deceased was Lex Robert Bismark

Place of death – Mr Bismark died on the Barkly Highway in Mt Isa

Date of death – He died on 13 July 2002.

Cause of death – Mr Bismark died a result of avulsion of the brain stem and upper cervical spinal cord suffered when he was run down by a car driven by Hazel Annas.

The committal question

Normally I would also be required to consider whether Mrs Annas should be committed for trial on a charge of dangerous driving causing death. However in view of her demise that issue no longer requires determination.

Issues of concern, riders and recommendations

Pursuant to s43(5) of the Act I am authorised to make riders or recommendations designed to reduce the occurrence of similar deaths to the one investigated by this inquest. In accordance with that power I make the following observation and recommendations.

Extent of the police investigation

It is likely that on the night of Mr Bismark's death numerous criminal offences were committed: a man was killed, two others were run down by a motor vehicle, the driver of that vehicle was seriously assaulted and the vehicle was extensively damaged, yet no one was charged with any offence.

The officers investigating this matter were placed in an invidious position in that the "*suspect*" for a possible dangerous driving causing death charge was also the complainant in a possible serious assault charge. It may be that this made it difficult for them to assiduously pursue the death investigation. They certainly obtained extensive technical evidence concerning the mechanics of the accident but they seem to have given scant attention to a more obvious

[13] exhibit 55 para 7

explanation of the tragedy, even though the only accounts they had from the driver were untenable. All of the information concerning Mrs Annas' poor eyesight and compromised acuity was available to the investigators, but none of it was accessed and provided to the Director of Public Prosecutions when the police sought advice as to whether Mrs Annas should be charged. There is no basis for suspecting that this line of inquiry was deliberately ignored but it is a salutary reminder to us all to remain vigilant and inquiring when undertaking these investigations.

The role of medical practitioners in assessing fitness to drive.

Mrs Annas knew she was unfit to drive yet she continued to do so. While she may have had a moral obligation to advise the Department of Transport of her incapacity, she had no legal obligation to do so until she applied to have her licence renewed. That will change on 1 March 2006 when amendments to the Transport Operations Road Use Management Act (the TORUM Act) which will require drivers to advise the Department as soon as they are diagnosed with a permanent or long term medical condition that could affect their driving, come into effect.

However, in view of her willingness to drive when she knew that she was placing herself and other road users in danger, I am not persuaded that Mrs Annas, or people like her, will comply with this obligation. If a person is willing to risk his or her life by driving when he or she can't see, it seems unlikely that the risk of a fine if they are caught will dissuade them. And how would they be caught in any event? A police officer intercepting such a driver would have no reasonable means of assessing that drivers physical capacity to drive or reason to try and access the driver's medical records unless the driver had been involved in an accident – too little, too late.

It is apparent that at least four medical practitioners were aware that Mrs Annas' poor eyesight rendered her unfit to drive. Any of them could have notified the Department of her incapacity because the TORUM Act relieves a practitioner of the usual obligation of confidentiality and protects a practitioner from any civil redress for contacting the Department. None of them did. Had this been done, Mrs Anass' licence would have been cancelled and she would have been required to forfeit it to local police. This would have made it less likely she would then drive in Mt Isa. Dr Foster said that he did not do so in this case because Mrs Annas told him that she was no longer driving. He also said that in 12 years of practice he had never taken this step.

There is apparently reluctance among some medical practitioners to make such reports based in part on a fear that if a patient knows his/her incapacities will be reported, he/she may avoid seeking medical attention.

I can readily appreciate the undesirability of that happening and indeed the whole issue of fitness to drive, particularly among the elderly living in rural areas where public transport is limited, is a vexed one; surrendering a driving licence can have a major impact on such a person's continued ability to live independently.

I am also aware that there have been a number of high-level reviews by AUSTROADS and others that have looked at the issue, and indeed the Queensland Department of Transport is currently again considering it. Progress has been made in assisting medical practitioners to make better informed assessments of a patient's fitness to drive.

The missing link, in the safety chain is, in my view, an obligation on medical practitioners to report their assessments when a practitioner concludes the patient can no longer safely drive. South Australia and the Northern Territory have adopted this approach.

Of course it would be regrettable if mandatory reporting caused some patients to avoid seeking medical attention. However, as this case shows, when doctors are not obliged to report their patient's incapacities, the lives of others are placed at risk. When balancing the competing interests, it is fairly easy to conclude that the risk of a patient not seeking treatment should not be given greater weight than the risk of an impaired driver harming him or herself and/or others.

It might be argued that if such a regulatory scheme were introduced some patients might avoid doctors and continue to drive. This case shows that we would be no worse off in so far as those drivers are concerned and we would clearly be increasing road safety by having appropriate action taken in relation to the rest.

Recommendation – Compulsory reporting of impaired drivers

Accordingly, I recommend that the law be amended so that if a medical practitioner concludes that a person they believe is licensed to drive is incapable of doing so safely because of any physical or psychological impairment, it is compulsory for the medical practitioner to report that conclusion to the Department of Transport.

This inquest is now closed.

Michael Barnes
State Coroner
23 February 2006