OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Grace Ann Hornby, Jessica Lee Hornby, Denise Ann Mansell and Anthony Paul Thomson**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Maroochydore
DELIVERED ON:	20 October 2011
DELIVERED AT:	Maroochydore
HEARING DATES:	15 March 2011, 24 May 2011
PLACE OF HEARING:	Maroochydore
FINDINGS OF:	Coroner Bernadette Callaghan
CATCHWORDS:	motor vehicle accident, adequacy of safety precautions at intersection, mandatory reporting by health professionals concerning impaired drivers

REPRESENTATION:

Counsel Assisting the Coroner: Alana Martens and Melinda Zerner

Counsel Representing:

Hornby Family being represented by G Ferguson from Ferguson Cannon Lawyers.
J Rosengren instructed by Blake Dawson for Dr Philip Bird.
AC Braithwaite solicitor Gilshenan Luton for Senior Constable Flannery, Sergeant Darren Taylor and Acting Former Senior Sergeant Neville Kunkel.
M Kelly for Commissioner of Police

[1] I deliver my findings pursuant to Section 45 of the *Coroners Act* 2003. The deceased persons are Grace Ann Hornby, Jessica Lee Hornby, Denise Ann Mansell and Anthony Paul Thomson and they died as a result of a traffic accident on 8 May 2009 at approximately 6:15pm at the intersection of Nambour Connection Road and Blackall Street, Woombye.

[2] The accident occurred when a 2001 red Toyota Corella sedan turned right from the Nambour Connection Road into Blackall Street crossing the path of a 1988 red Peugeot sedan travelling north on the Nambour Connection Road.

[3] Denise Ann Mansell, a 60 year old female was the driver of the Toyota Corella. Her twin grand-daughters Grace Ann Hornby and Jessica Lee Hornby aged five were in the back seat of the vehicle.

[4] Anthony Paul Thomson a 43 year old male was the driver of the Peugeot. Mr Christopher Ray a 29 year old male was in the passenger seat. Mr Ray resided with Mr Thomson.

[5] As a result of the accident Mr Thomson, Ms Mansell and both her grand-daughters all died at the scene. Mr Ray survived the incident but suffered serious injuries.

[6] It is clear that the deaths of all of these people have had a devastating effect on their families and friends.

[7] I stated at the pre-inquest hearing that the police investigation into the deaths had been very thorough. Changes had occurred concerning the intersection – the speed limit had been reduced and overhead lighting had been introduced so I was of the view at that time that there would be no further recommendations that I could make arising from the inquest that could possibly make the road safer. Department of Main Roads has prepared a report and I will be addressing this later in this decision. There was one aspect in the police investigation concerning a report by Senior constable Flannery where following an interview that he had conducted with Mr Thomson concerning a previous road incident Senior constable Flannery had made a report questioning whether Mr Thomson ought to continue to drive and hold a drivers license. It was unclear what happened to that report and I was specifically interested in pursuing that at the inquest.

[8] At the time of the accident Ms Mansell and Mr Thomson both held Open Class C drivers license. There were no restrictions recorded against Mr Thomson's drivers license. Ms Mansell had a condition of her holding a drivers license that she wear corrective lenses (Exhibit C1 and C2).

[9] Mr Thomson had extensive traffic history including driving under the influence of alcohol and had been disqualified from driving on several occasions. (Exhibit C2).

[10] Ms Mansell had one offence on her traffic history and that was for using a hand held mobile phone whilst driving (Exhibit C1).

[11] The speed limit in the area at the time of the accident was 80 kilometres per hour (Exhibit B1, P1).

[12] Senior Constable Church, an experienced accident investigation officer, carried out the investigation on behalf of Queensland Police Service. He determined that immediately prior to the accident Ms Mansell was driving along the Nambour Connection Road in a southerly direction. She approached the intersection with Blackall Street, Woombye, and turned right to go into Blackall Street entering the opposing lanes of traffic. At that time Mr Thomson was travelling in a northerly direction along the Nambour Connection Road towards Nambour. (Exhibit D1)

[13] The intersection is provided with mercury vapour type street lighting and Senior Constable Church was of the opinion that this was not adequate to illuminate the rapidly approaching Peugeot. (Exhibit B1, P20)

[14] There were three witnesses to the accident (Mr Lough, Ms Verner and Ms Jarrett). All were travelling in the same direction as Mr Thomson. All recall been overtaken by Mr Thomson's vehicle which they all believed was travelling well in excess of the speed limit.

[15] Mr Lough did give an estimation in his statement as to what he believed Mr Thomson's speed limit was but I am of the view that it is very difficult to ascertain what speed another vehicle is travelling in other than to say that the other vehicle was travelling somewhat faster as it was overtaking the vehicles in which the three witnesses were travelling.

[16] Mechanical inspections of both the Corella and the Peugeot were conducted. The mechanical inspection concluded that the Corella was in an unsatisfactory mechanical condition due to leak at the right rear shock absorber however that condition was of a minor nature and was not serious enough to have contributed to the cause of the accident. (Exhibit B1 page 12).

[17] The mechanical inspection of the Peugeot concluded that the front and rear disc brake pads were in a satisfactory condition with no apparent leaks in the hydraulic braking system. The inspection also concluded that at the time of the accident the Peugeot's headlights were operating on low beam however the headlight reflectors were in an unsatisfactory condition as the reflective film which coats the units were in poor condition which would reduce headlight illumination efficiency. The right front light reflector was considered to be in a very poor condition with what appeared to be maroon or burgundy colour overspray over the top and bottom part of the rear of the reflector. Senior Constable Church was of the opinion that this would make the Peugeot's lights difficult to see (Exhibit B1, P11 and 23). The mechanical inspection on the Peugeot concluded that it was in an unsatisfactory mechanical condition due to the park brake (which did not lock the left rear wheel when applied) and the headlight reflectors. (Exhibit B1, P11)

[18] Senior Constable Church made the following conclusions in his report –

(a) The collision occurred at the intersection of the Nambour Connection Road and Blackall Street, Woombye at 6.15 pm on Friday the 8th May 2009;

(b) The red Toyota Corella registration number 550-IGI driven by Denise Ann Mansell was attempting to turn right from the Nambour Connection Road into Blackall Street;

(c) That a red Peugeot Sedan registration number 968-LMN was travelling on Nambour Connection Road towards the intersection driven by Paul Anthony Thomson;

(d) That there is a system of overhead street lighting provided at the intersection that was operating properly at the time of the incident;

(e) That there was fine weather conditions at the time and just after sunset;

(f) That there was no evidence to suggest any road defects or conditions that has contributed to this incident;

(g) That there is no evidence of any mechanical faults that may have contributed towards this incident; however the condition of the headlights of the Peugeot sedan was not satisfactory due to inefficient illumination;

(h) That there is no evidence to suggest negligence on the part of any other parties directly or indirectly involved in this incident;

(i) That this incident has occurred as a result of contributing factors that do not lie solely on one party;

(j) That if the Toyota had appropriately given way to the approaching Peugeot Sedan then this incident may have been averted;

(k) That if the headlights (reflective properties) of the Peugeot had been of a satisfactory standard the lights may have been more obvious to the other road users, especially to the driver of the turning vehicle;

(l) Due to the lack of headlight illumination and the excessive high speed that the Peugeot sedan was travelling immediately prior to the collision it would be unreasonable to expect the driver of the Toyota Corella to give way to a vehicle that she could not see;

(m) That the combination of the speed and poor headlight illumination it would have been extremely hard to see and or to judge the time and distance of its approach;

(n) That according to witnesses the Peugeot sedan was driven at an excessive speed approaching the intersection;

(o) That in support of the witness evidence preliminary speed estimates of the Peugeot sedan indicates that the speed was approximately 120 kilometres per hour at the time of the crash, 40 kilometres per hour over the limit;

(p) That Senior Constable Flannery identified medical causes as to the fitness of Thomson to obtain or hold a Queensland drivers license when he conducted an interviewed with him on the 24th of December 2008;

(q) During the interview Thomson stated: some years prior to the interview he had suffered a brain injury some years prior and subsequently had front lobe damage and suffer short term memory loss;

(r) That he suffers short term memory loss and was taking several prescribed medications for a variety of medical conditions;

(s) Observations made by police during the interview were that he appeared confused and gave a variation of answers to the questions by police;

(t) That his speech was slow and was unable to provide details in a chronological order;

(u) Unfortunately there is no record of the Queensland Transport Department receiving that report and Thomson was allowed to continue to drive a motor vehicle placing other road users at risk.

(Exhibit B1 page 23)

[19] Senior Constable Church did not make any recommendations at the conclusion of his report but noted that the intersection was under review by the State Government and its agencies and that the speed limit had been reduced to 70 kilometres per hour. Further he noted that police enforcement had been strategically increased in the area by the Sunshine Coast District Traffic Branch and Nambour police patrols. Senior Constable Church concluded his report by making reference to 'Jet's Law' (s 50 to s 52 of the *Transport Operations Road Use Management (Driver Licensing) Regulation* 2010) which he considered relevant to the accident.

Autopsy and Toxicology results

[20] Autopsies were conducted on all of those who died at the accident.

[21] Toxicology examination of Ms Mansell's Femoral blood revealed the presence of approximately 20 milligrams per kilogram of paracetamol.

[22] Toxicology examination of Mr Thomson's Femoral blood revealed the presence of the following –

- Amphetamine at 0.6 milligrams per kilogram
- Alprazolam at 0.2 milligrams per kilogram

- Amitriptyline in an amount lower than 0.02 milligrams per kilogram
- Nortriptyline in an amount lower than 0.02 milligrams per kilogram
- Tramadol at 3.8 milligrams per kilogram
- Tetrahydrocannabinol at 0.004 milligrams per kilogram
- Tetrahydrocannabinol – 9 – Carboxylic Acid at 0.018 milligrams per kilogram

(Exhibit A6)

Additional Material and Investigations

[23] Following enquiries as to exactly what had transpired in relation to Senior Constable Flannery's memorandum and why that had not been forwarded to the Department of Transport a report was provided by Senior Sergeant Garry Brayley, the officer in charge of the Nambour Police Station. (Exhibit B2)

[24] As a result of the information detailed in Senior Constable Flannery's memorandum and the toxicology results of Mr Thomson, Mr Thomson's medical records were obtained and statements were provided by his general practitioner Dr Phillip Wignall (Exhibit D1) and his psychiatrist, Dr Phillip Bird (Exhibit D7).

[25] Further to this a report was obtained from Dr Adam Griffin of the Clinical Forensic Medicine Unit, commenting on the toxicology examination of Mr Thomson's blood during autopsy. (Exhibit D6)

[26] Dr Bird's legal representation provided a report from an Associate Professor, Donald Grant, psychiatrist, concerning Dr Bird's management of Mr Thomson. (Exhibit D8)

[27] The Department of Transport and Main Roads provided a report into the accident on 9 November 2009. This report draws upon the Crash Investigation report and the independent report by consultants GHD commissioned by the Department concerning the intersection. The report made a number of recommendations specific to Blackall Street intersection. (Exhibit C5) During the course of the inquest the Department provided an update on the status of the recommendations made in its report. (Exhibit C6)

[28] During the inquest an issue arose concerning some uncertainty surrounding Dr Bird's prescribing of Dexamphetamine to Mr Thomson. Dr Bird provided correspondence addressing that concern. (Exhibit D10). Further to this a report was obtained from Dr Sue Ballantyne, the Director of Drugs Dependency Unit, concerning Dr Bird's prescription of Dexamphetamine to Mr Thomson. (Exhibit D12)

Issues

[29] During the coronal investigation and the inquest the following issues emerged for determination –

(a) Whether the current legislative regime was sufficient to ensure individuals who may be unfit to hold a drivers license are reported to the Department of Transport and Main Roads (the Department) and whether there should be any mandatory obligation on health practitioners to report concerns held regarding patient's ability to drive;

(b) The Queensland Police Service's processes and procedures with regard to notifying the Department of concerns held regarding individuals who are holders of driver licenses;

(c) Whether Mr Thomson was prescribed appropriate levels of medications;

(d) Whether Mr Thomson was fit to hold a Queensland drivers license; and

(e) Whether the intersection where the accident occurred required any further modification.

Sufficiency of the current legislative regime

[30] On 1 March 2006 Jet's Law (s 50 to s 52 of the *Transport Operations (Road Use Management Drivers Licensing) Regulation* 2010) ("the Regulation") came into effect. The provisions introduced a mandatory requirement for driver license holders to report any long term or permanent medical condition that may affect their ability to drive. Section 51(1) of the Regulation requires individuals who hold a drivers license to notify of any mental or physical incapacity that is likely to adversely affect their ability to drive safely at the time of applying for or renewing a Queensland drivers license. Section 51(2) of the Regulation requires the license holder to provide notification of either of the following that is likely to adversely affect the holder's ability to drive safely –

(a) Any permanent or long term mental or physical incapacity;
(b) Any permanent or long term increase in or other aggravation of a mental or physical incapacity if notice has already been given.

[31] A person's medical fitness to drive is assessed for both physical and mental medical conditions against the national standards contained in the Ausroads Medical Guideline Assessing Fitness to Drive.

[32] The Assessing Fitness to Drive publication recommends that doctors should advise patients if a medical condition impacts on their ability to drive safely whether in the short or long term. It also recommends that if in the course of treatment a patient's condition is found to impact on their ability to drive safely the health professional should in the first instance encourage the patient to report their condition to the relevant driving licensing authority. (Exhibit C4 page 4, 12 and 16).

[33] In relation to prescription medication the Assessing Fitness to Drive publication recommends that medical practitioners dispensing or prescribing drugs for the first time should provide a patient with a general warning to be vigilant for responses that may affect ordinary activities including driving. Similar warnings should accompany changes in dosage or alternate drug treatment.

[34] A further recommendation is that patients receiving continuing long term drug treatment should be evaluated for their reliability in taking the drugs according to directions and their understanding of the possibility that the effect the drug may have on other drugs being taken (Exhibit C4 page 53).

[35] Mr Skinner, Senior Manager (Transport Policy), Department of Transport advised that after the introduction of Jet's Law in 2006 the Department undertook an awareness program for the general public and health professionals concerning the requirement to report the development of any long term or permanent medical conditions that were likely to adversely affect a person's ability to drive safely. (Transcript 2-31)

[36] In evidence Dr Wignall and Dr Bird both advised they were familiar with the guidelines surrounding the notification to the Department. (Transcript 2-45 and 1-99).

[37] Mr Skinner advised that in June 2009, shortly after the accident, the Department implemented an automated receipt notification process. The process involves an automated letter to the doctor informing them that the Department received a notification concerning an individual (Transcript 2-32). Mr Skinner confirmed that the introduction of the automated receipt notification process was after the accident but not as a consequence of the accident. (Transcript 1-37).

[38] Mr Skinner gave evidence that in 2007/2008 the Department gave consideration as to whether mandatory obligations should be placed on health practitioners to require a health practitioner to report any patient they suspect is physically or mentally unfit to drive. At the time concerns were raised by the Australian Medical Association that if a patient knew a health practitioner had to advise the Department then the patient may not seek treatment and this may make their illness worse and/or exacerbate the risk of them driving with an untreated illness. The Australian Medical Association's view was that it was safer for the patient to receive treatment. (Transcript 2-33).

[39] This matter has been considered by Coroner Taylor in his findings into the death of Scott Phillip Livermore handed down on 25 June 2010. Coroner Taylor considered that there was a number of competing factors – the community's right to be protected from people driving on a public road who suffer from designated medical conditions to the extent that they present an actual or potential risk versus the patient's right to privacy and the real likelihood that if a doctor is mandated to report then any patient may choose not to consult a doctor at all for fear of losing their drivers license. Coroner Taylor was of the opinion that the risk of the patient not consulting a medical practitioner posed a greater risk or danger to themselves, passengers, other road users and pedestrians. Coroner Taylor concluded that the current legislative

regime, without mandatory reporting for medical practitioners was sufficient. I agree with Coroner Taylor.

[40] State Coroner Barnes in the inquest into the death of Lex Robert Bismark (handed down on 23 February 2006) recommended 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 be compulsory for the medical practitioner to report that conclusion to the Department. State Coroner Barnes concluded that he was not persuaded that a person would comply with their obligation to report their condition to the Department and found that the "missing link in the safety chain is an obligation on medical practitioners to report their assessments when a practitioner concludes the patient can no longer safely drive". Subsequent to this decision in 2007/2008 the Department in consultation with the Australian Medical Association considered this issue and determined that it was not appropriate that medical practitioners should be mandated by legislative means to report a patient to the Department. In this case none of the medical practitioners treating Mr Thomson were of the view that he was incapable of driving and therefore would not have been in a position to report Mr Thomson to the Department.

[41] The submission on behalf of the Hornby family outlines what they believe are the inadequacies of the Assessing Fitness to Drive publication recommendations. They submit that the publication currently does not require a doctor to provide the patient with a written warning or notification in relation to the effects of drugs or a combination of drugs may have on activities including driving and recommend that this publication be amended to require medical practitioners provide patients with written advice in relation to the effects that drugs or a combination of drugs may have on activities including driving. Requiring this could have an impact on the relationship between doctor and patient to the detriment of the ongoing welfare of the patient. I refer to my comments above.

Queensland Police Service Procedures and Processes following an individual Police Officer raising a concern with regards to a person's ability to drive a motor vehicle.

[42] On 18 December 2008 Senior Constable Flannery received information regarding a two vehicle accident which involved a driver making contact with a parked car at the Nambour RSL. Mr Thomson was the driver of the vehicle. (Exhibit B1)

[43] Subsequently Mr Thomson attended the Nambour Police Station and was interview by Senior Constable Flannery. Senior Constable Flannery observed Mr Thomson had delayed reactions and responses during the course of two to three interviews. As a result Senior Constable Flannery considered Mr Thomson may not be suitable to hold a drivers license. Senior Constable Flannery discussed his concerns regarding Mr Thomson with Sergeant Taylor who was the shift supervisor at the time. Sergeant Taylor advised Senior Constable Flannery that a memorandum could be provided detailing Senior Constable Flannery's concerns which could then be forwarded through the

chain of command in order for a show cause notice to be generated by the Department. (Transcript 1-25).

[44] On 13 January 2009 Senior Constable Flannery furnished a memorandum to the officer in charge of the Nambour Police Station outlining his concerns. The memorandum noted the following –

(a) Mr Thomson reported that he had a brain injury and had frontal lobe brain damage which effected his memory;

(b) Mr Thomson denied any recollection of the event for which he was being interviewed;

(c) Suffers short term memory loss and takes a series of medications including Dexamphetamine, Kalma, Termol (sic), Oxycodeine for a variety of health complaints;

(d) During the interview Mr Thomson appeared to be confused, his speech was slow, he was unable to provide details in chronological order and when asked the same questions again gave a different answer;

(e) Mr Thomson' demeanour caused concern for his mental and physical capacity to be the holder of a drivers license.

And due to these concerns the police believe that Mr Thomson should prove he was a fit and proper person to hold a drivers license. (Exhibit B1).

[45] Senior Constable Flannery's evidence was that he did not believe that Mr Thomson was affected by alcohol or drugs at the time he interviewed him. (Transcript 1-23).

[46] The procedure followed by the police was that a junior officer would communicate their concerns up the chain of command until it reached the superintendent of traffic who would then liaise with the Department.

[47] Senior Constable Flannery's evidence was that at the time he completed his memorandum it was uploaded electronically to QPrime and a hard copy was placed in his supervisor's tray.

[48] Senior Sergeant Brayley, the current officer in charge of Nambour Station conducted a review in November 2010 as to why the memorandum was not actioned. He identified that the correspondence index did not contain any entry in relation to Senior Constable Flannery's memorandum and that the hard copy of the report had been misplaced. Further he confirmed that Senior Constable Flannery scanned and linked the signed copy of the memorandum to the relevant crash report in QPrime and that Senior Constable Flannery's shift supervisor, Sergeant Taylor, generated a QPrime task on 16 January 2009 and forwarded it to the Nambour Station Traffic Adjudication Unit. (Exhibit B2).

[49] Sergeant Taylor's evidence was that both the hard copy and electronic version should have ended up with the Acting Senior Sergeant Kunkel for him to

action. (Transcript 1-39). Sergeant Kunkel was the Acting Superintendent of Traffic at the relevant time and was the only member of the Nambour Station Traffic Adjudication Unit.

[50] The QPrime task was not actioned by any police officer and was closed on 17 July 2009 following Mr Thomson's death. (Exhibit B2 page 3)

[51] Sergeant Taylor indicated in evidence that he never saw a hard copy of the memorandum. Similarly Sergeant Horneman (who was acting as the officer in charge of the Nambour Police Station at the relevant period of time) and Sergeant Kunkel stated in evidence that they had never seen a copy of Senior Constable Flannery's memorandum until sometime after the accident.

[52] Evidence at the inquest revealed that when an individual police officer opened the QPrime system they would be able to see tasks that have been allocated to them as an individual. However if a police office was a member of a unit then they would need to perform an additional log-in to be able to view any tasks that had been allocated to a particular unit. Evidence also revealed that there was no notification system within QPrime to alert a particular police officer that they were a member of a particular unit or portfolio. (Transcript 1-36).

[53] Sergeant Kunkel who retired from the Police Service in 2009 indicated during evidence that he had not had a lot of training in QPrime as he was absent when it was introduced. However he stated that he was proficient with QPrime to the extent that he was able to log in and run a program. He was also aware of the ability to assign and receive tasks via QPrime. Sergeant Kunkel believed that he had not been provided with any information that he was part of Nambour Station Traffic Adjudication Unit nor that he was needed to check tasks allocated to that unit.

[54] Mr Skinner indicated that if Senior Constable Flannery's memorandum had been received by the Department then a show cause notice would have been issued to Mr Thomson asking him to indicate why the Department should not cancel his license.

[55] Sergeant Taylor advised that he took over from Sergeant Kunkel following Sergeant Kunkel's retirement and that QPrime had been modified to show that Sergeant Taylor works within the Traffic Adjudication Unit. Sergeant Taylor advised that he sends reports to the Department electronically. (Transcript 1-37).

[56] The procedure for providing notification to the Department is essentially the same as at the time of accident, however, the process now utilises an electronic method through QPrime rather than a hard copy facsimile been sent to the Department. The relevant report that is logged in QPrime is now forwarded via email to the Department requiring a receipt to be generated when the email has been received by the Department. A local bring up system has been adopted by Sergeant Taylor to follow up any emails where notification of receipt is not received. (Transcript 1-45).

[57] Submission from W. Kelly, Counsel for Commissioner, Queensland Police Service outlines the procedures that have been put in place to overcome the mishandling of the memorandum from Senior Constable Flannery. Now reports concerning a request for show cause proceedings are initiated by officers who have attended to traffic crashes or traffic related incidents where the conduct of the driver, the demeanour of a driver or their manner of driving is an issue. These concerns are detailed by way of an occurrence report generated via QPrime reporting system. All reports to the Department are immediately generated by way of email by the Superintendent of Traffic. A copy of the message sent as well as notification of receipt of that message is also scanned into the occurrence. A supplementary report at the hand of the Superintendent of Traffic along with a new task and bring up date is generated to ensure that constant updates with respect to that file are addressed. This ensures continual contact with the Department to ascertain the status of Show Cause proceedings. The QPrime information network provides an automatic update of tasks that are overdue. The standard time allowed is 28 days. Mr Kelly also advised that procedures within Nambour Police Station had been reviewed and that all staff were advised of their respective portfolios on a regular basis by the Officer in Charge. This is also the case when officers are on Recreation or Sick Leave. The respective working units including the Nambour Station Traffic Adjudication Unit can be accessed by all staff at Nambour Station and any other officer with QPrime access.

[58] These procedures I believe would satisfy the concerns raised in the submissions by the Hornby family and I do believe they address the problems identified by the inappropriate handling of Senior Constable Flannery's memorandum concerning the ability of Mr. Thomson to drive safely. Because of this I do not believe that there is any necessity for me to make any recommendations concerning the operations within the Queensland Police Service with regards to notifications to the Department on a person's suitability to continue to hold a Queensland Drivers License.

Mr Thomson's Medications

Mr Thomson's Medical History

[59] Mr Thomson's medical records from the Royal Brisbane Women's Hospital (RBWH) indicate that he was admitted on 2 November 1997 in relation to an alleged assault three days earlier. A CT scan conducted at the Nambour Hospital revealed a moderately large right temporoparietal extradural haematoma. The CT scan was reviewed by the RBWH and in addition to the large haematoma a small right temporal contusion was observed. (Exhibit D5)

[60] On 3 November 1997 Mr Thomson underwent surgery for a craniotomy and an evacuation of an extradural haematoma. He was discharged on 7 November 1997 and was deemed to have made a reasonable recovery. Mr Thomson failed to attend his outpatient appointment.

[61] Between July 2001 and his death Mr Thomson was treated at the Aerodrome Road Medical Practice. He was primarily seen by general practitioner Dr Philip

Wignall. Dr Wignall has been a general practitioner for approximately 35 years. (Exhibit D1)

[62] Dr Wignall summarised Mr Thomson's medical conditions as including –

(a) Poor performance due to attention span and learning difficulties;

(b) Early experimentation with recreational drugs;

(c) 1989 motorcycle accident resulting in spinal injuries which were severe;

(d) A severe head injury sustained in a fall-down a flight of steps (1999);

(e) Transferred from the Nambour General Hospital to the Royal Brisbane Hospital for cranial surgery.

(f) Hepatitis C;

(g) Keratoconus of the eyes. His right eye was treated successfully and had a graft to his left eye. Was punched in the same eye and ruptured the graft in 2007 which was repaired. Mr Thomson had to wear glasses at all times for driving;

(h) Came under the care of Dr Philip Bird, psychiatrist, for the treatment of anxiety, depression, ADDH and chronic pain management 2006;

(i) Drug abuse. Admitted to ATODS at the Nambour General Hospital and was put on a methadone/subutex program;

(j) Drug seeking behaviour resulting in refusal of medications and no referrals to ATODS.

[63] Dr Wignall indicated that Mr Thomson suffered multiple fractures in the thoracic spine and neck in a motorcycle accident in 1989 and was of the view that Mr Thomson suffered from severe chronic back pain. For this pain he was prescribed Endone, Tramal and MS Contin. Dr Wignall's evidence was that he prescribed these drugs in an attempt to manage the pain but found this difficult as Mr Thomson was on a program for drug abuse previously and he had to get permission from the Drug Dependence Unit to allow him to prescribe these medications. Dr Wignall confirmed that prior to Mr Thomson's death he was on Tramadol and Oxycodeine for pain and that these medications were effective in controlling Mr Thomson's back pain. (Transcript 2-54).

[64] Dr Wignall believed that as a result of Mr Thomson's head injury that Mr Thomson had trouble with impulsive behaviour and mood disturbance. (Transcript 2-43)

[65] In July 2006 Dr Wignall referred Mr Thomson to Dr Bird for assessment of possible ADDH.

[66] Dr Bird had worked as a consultant psychiatrist since 1997 and holds a fellowship with the Royal Australian and New Zealand College of Psychiatry. Dr Bird ran a clinic for Attention Deficit Hyperactive Disorder (ADHD).

[67] Dr Cradick, one of Dr Bird's colleagues, identified that Mr Thomson fulfilled all of the diagnostic criteria for ADHD. Dr Bird was satisfied that Mr Thomson suffered from ADHD and had described the symptoms as being present since childhood and before any head injury suffered by Mr Thomson.

[68] From 2006 up until his death Mr Thomson received treatment from Dr Bird in relation to his ADHD.

[69] Dr Bird noted that Mr Thomson presented as a complex and challenging case with elements of anxiety, irritability and depression.

[70] Dr Bird indicated that Mr Thomson's known medical conditions were ADHD, anxiety, major depression, and substance abuse in remission, back pain, chronic insomnia, migraines and an acquired brain injury. (Exhibit D7).

Appropriate Levels of Medication

[71] The focus of Dr Bird's treatment in the initial stages was to establish a therapeutic relationship with Mr Thomson and address his cannabis use. Dr Bird prescribed Amisulpride (Solian). Urine tests were ordered to monitor Mr Thomson's use of cannabis. These tests showed Mr Thomson was reducing his cannabis use.

[72] At this stage Dr Bird considered it appropriate to commence treating Mr Thomson's ADHD with Dexamphetamine at a daily dose of 40 milligrams. This was approved by the Drug Dependant Unit (DDU). This daily dose was to be collected three times per week.

[73] February 2007 the collection regime was modified to twice weekly and then in May 2007 it was further modified to weekly collections. In July 2007 the DDU granted approval for Dr Bird to prescribe 60 milligrams daily of Dexamphetamine to be collected weekly. Then in January 2008 the DDU approved for Mr Thomson's prescription of Dexamphetamine to be collected fortnightly. (Exhibit D10).

[74] Dr Bird considered that the Dexamphetamine was affective in the treatment of Mr Thomson's ADHD and enabled him to focus and continue his study in a way that had not been previously possible. (Exhibit D7). This was supported in evidence by Dr Wignall who considered Mr Thomson had become more focused on what he was doing.

[75] Dr Bird confirmed that he had last seen Mr Thomson on 20 April 2009 and that he had prescribed –

(a) Dexamphetamine 2 x 5 milligrams six times daily;
(b) Alprazolam 2 milligrams fives times daily;
(c) Amisulpride 100 milligrams daily;
(d) Oxazepam 30 milligrams at night;

(e) Tramadol 200 milligrams twice daily;
(f) Oxycodeine 20 milligrams sustained release twice daily.

(Exhibit D7)

[76] Alprazolam was to manage Mr Thomson's anxiety and had been prescribed to Mr Thomson prior to Dr Bird's involvement. Dr Bird was of the view that Mr Thomson had been stable on this medication for quite some time. (Exhibit D7).

[77] Amisulpride is an atypical anti-psychotic medication Dr Bird prescribed to Mr Thomson to reduce his anxiety and abnormal thinking. Mr Thomson reported to Dr Bird that he found this medication effective. Dr Bird was satisfied from Mr Thomson's improved presentation that it was having the desired effect of significantly improving Mr Thomson's anxiety levels. (Exhibit D7).

[78] Dr Bird prescribed Oxazepam to treat Mr Thomson's insomnia.

[79] Tramadol was prescribed by Dr Bird to treat Mr Thomson's back pain. Whilst a relatively large dose was prescribed Dr Bird considered it appropriate because Mr Thomson complained of severe and chronic back pain. (Exhibit D7).

[80] Oxycodeine a narcotic analgesic was also used to manage Mr Thomson's chronic back pain. (Exhibit D7).

[81] Dr Bird was of the view that the combination of medications prescribed to Mr Thomson was not unusual in the treatment of a patient with the medical conditions such as those suffered by Mr Thomson.

[82] Dr Grant, a consultant psychiatrist and Associate Professor of Psychiatry, provided a report to Dr Bird's legal representatives. Dr Grant has practiced as a psychiatrist for over 20 years and provided evidence of Dr Bird's management including prescription of medications to Mr Thomson.

[83] Dr Grant was of the view that Mr Thomson's diagnosis of ADHD was appropriate and the prescription of Dexamphetamine was appropriate to manage that. Dr Grant acknowledged that a dose of 60 milligrams daily was at the upper end of the recognised therapeutic range. Dr Grant was of the opinion that providing Mr Thomson with a fortnightly prescription for Dexamphetamine was appropriate. (Exhibit D8, page 2; Transcript 2-19).

[84] Dr Grant believed that a prescription of Dexamphetamine for an ADHD sufferer would improve their ability to drive. (Transcript 1-12).

[85] Dr Grant was of the opinion that the prescription Amisulpride as an adjunctive medication to treat Mr Thomson's ADHD was appropriate in the low dose that it was prescribed. (Exhibit D8, page 3).

[86] Dr Grant was of the opinion that the high dose of Alprazolam was appropriate to manager the significant extent of Mr Thomson's anxiety disorder. (Exhibit D8, page 3).

[87] Dr Grant was of the opinion that the prescription of Oxazepam at night was appropriate to manage Mr Thomson's sleep disturbance. He was of the view that the dose was a moderate and standard night time dose. (Exhibit D8, page 3).

[88] Dr Grant was of the opinion the prescriptions of Tramadol and Oxycodeine were appropriate to manage Mr Thomson's significant chronic disabling back pain. Dr Grant stated that this medication was normally prescribed by a General Practitioner or a specialist in pain management and he was not in a position to determine whether the doses were at the upper end of the therapeutic level. However, he was of the view that it was appropriate for Dr Bird to manage this prescription to ensure Mr Thomson did not doctor shop or become over-dependent on the medication as there were concerns of Mr Thomson over-using. (Exhibit D9, page 4).

[89] At all relevant times Dr Bird held approval for the DDU to prescribe Dexamphetamine to Mr Thomson. Dr Sue Ballantyne the Director of DDU confirmed when collection conditions apply to an approval it is usual practice that the medical practitioner issues a single prescription for the medications but arranges for the pharmacist to release medications to the patient at the required intervals. (Exhibit D12).

[90] The arrangements Dr Bird had put in place with Terry White Chemist Maroochydore were to ensure that Mr Thomson was only dispensed his medication fortnightly in accordance with the conditions of approval with the DDU. (Exhibit D10). The correspondence and records for Terry White Chemist Maroochydore confirmed the medication was dispensed fortnightly. (Exhibit D11).

Consuming Excess Drugs

[91] Dr Wignall was of the opinion that at times he believed Mr Thomson was inclined to doctor shop and was often deceitful by claiming that his medications were stolen or lost. Dr Wignall's medical records indicate the possibility of Mr Thomson engaging in drug seeking behaviour on 14 August 2004 (for Oxycodeine), 25 January 2005 (for Oxycodeine), 17 September 2007 (for Alprazolam) and 28 March 2008 (for Alprazolam).

[92] Dr Bird's records also reveal a number of instances of behaviour by Mr Thomson which could be considered drug seeking behaviour such as claiming medications had been lost or stolen and requesting medication at a higher dosage. These instances occurred on 15 November 2006 (Alprazolam), 13 December 2006 (Solian), 7 February 2008, 13 June 2007, 17 September 2007 and 21 April 2008 (Alprazolam). (Exhibit D1)

[93] Up until April 2009 it would appear that Mr Thomson was prescribed Oxycodeine from a number of medical practitioners primarily from Dr Wignall's medical practice.

[94] On 3 April 2009 Dr Wilmott, Dr Wignall's locum, noted that Mr Thomson had requested a script for Oxycodeine. Dr Wilmott believed that Mr Thomson

should have had enough Oxycodeine to last until 6 April 2009 and suspected that Mr Thomson was over using his medication. Dr Wilmott raised this issue with Mr Thomson and attempted to contact Dr Bird and the DDU however he was unable to reach them at the time of the appointment. (Exhibit D1). On the same day Dr Wilmott forwarded a letter to Dr Bird outlining his concerns. (Exhibit D2.2, page 63).

[95] At Mr Thomson's next appointment Dr Bird spoke to him about Dr Wilmott's concerns. Dr Bird felt that Mr Thomson was becoming dependant on Oxycodeine which had occurred previously. At this time Dr Bird decided that he would become the sole prescriber of Oxycodeine and made arrangements for the Oxycodeine to be collected at the same pharmacy under the same conditions that the Dexamphetamine was being collected. Dr Bird determined that he would notify Mr Thomson's other treating medical practitioners and the DDU. (Exhibit D7). On 17 April 2009 Dr Bird wrote to Mr Thomson's general practice noting that he had spoken to the DDU and had agreed to provide Mr Thomson's prescription for Oxycodeine after receiving approval from the DDU. (Exhibit D1, page 46).

[96] On 30 April 2009 Dr Bird saw Mr Thomson for the last time. Mr Thomson indicated his function was continuing to improve and he was able to engage appropriately. Dr Bird provided Mr Thomson with a script for Oxycodeine to 60 tablets that would last one month. Dr Bird recalled explaining to Mr Thomson that there would be no further supply even if the medication was lost. At the last appointment Dr Bird requested a urinary drug screen from Mr Thomson.

[97] Dr Grant believed that Dr Bird took timely and thorough action in 2009 when it was believed that Mr Thomson may have been using more Oxycodeine than was prescribed.

[98] Dr Griffin, the Deputy Director of the Clinical Forensic Medical Unit, gave evidence that drug screens only reveal the presence of drugs not the levels and that blood tests are not routinely conducted to monitor levels of Dexamphetamine, Alprazolam and Tramadol because of the cost and clinical usefulness.

[99] Dr Griffin provided a report commenting on the drug levels identified in the blood collection from Mr Thomson at autopsy this is Exhibit D6.

[100] Dr Griffin reported that Dexamphetamine would be detected as amphetamine in a blood sample and the finding of amphetamine in Mr Thomson's blood sample was not surprising given Mr Thomson's prescription. Dr Griffin indicated that it was unlikely Mr Thomson had consumed amphetamine obtained illegally as this is generally reflected in the blood sample as methyl amphetamine. (Transcript 1-79).

[101] Dr Griffin indicated that if Mr Thomson had taken his prescribed dose of Dexamphetamine then the expected level of amphetamine would have been between .06 to .1 milligrams per kilogram. (Exhibit D6, page 2). Dr Griffin was of the opinion that Mr Thomson would have had tolerance to any adverse

affects of Dexamphetamine taken at the prescribed level as he had been prescribed this medication for over a year and a half and that this would not have impaired his ability to drive. (Transcript 1-79).

[102] Dr Griffin was of the opinion that amphetamine being present at a very high level (six times the expected maximum therapeutic dose) was not consistent with prescribed dosing amount and suggests an overdose of Dexamphetamine. This high reading was unlikely to have been affected by any post-mortem redistribution. (Exhibit D6, page 6).

[103] Dr Griffin was unable to comment with respect to the effect on Mr Thomson of the higher then therapeutic level of amphetamine.

[104] Dr Griffin reported that Alprazolam acts as a central nervous system depressant in that it causes sedation and reduces anxiety with doziness, slurring of speech and muscle incoordination occurring at higher blood levels. (Exhibit D6). Dr Griffin was of the opinion Mr Thomson would have had a tolerance to any adverse affects of Alprazolam taken at the prescribed level as he had been prescribed this medication for over nine months and this prescription would not have impaired his ability to drive. (Transcript 1-81 and 1-85).

[105] Dr Griffin was of the view that Mr Thomson had taken a significant dose of Alprazolam likely twice the prescribed amount.

[106] Dr Griffin was of the view that high dosage of Tramadol may cause seizure or fits, agitation, confusion, hyperthermia and tachycardia. (Exhibit D6 page 5). Tramadol was present in Mr Thomson's post-mortem blood at a level known to be associated with fatality and four and a half times the expected amount given his prescription. Dr Griffin indicated that Tramadol increases slightly following death however post-mortem redistribution would not account for the high levels recorded in Mr Thomson's blood. (Transcript 1-82). Dr Griffin was of the opinion Mr Thomson would have had a tolerance to any adverse affects of the Tramadol taken at the prescribed level as he had been prescribed this medication for over four months and this prescription would not have impaired his ability to drive.

[107] Dr Griffin noted Amitriptyline was recorded as detectable levels only and was well below the expected level for a dose of 150 milligrams per day.

[108] Tetrahydrocannabinol is likely to increase with post-mortem redistribution. Tetrahydrocannabinol 9 Carbolic Acid is more reliable however Dr Griffin indicated that it is difficult to determine how long this stays in an individual system as it depends on whether they regularly use cannabis. Dr Griffin would say that Mr Thomson had consumed cannabis sometime prior to his death but how much and when this occurred could not be determined. (Transcript 1-82)

[109] Dr Bird was surprised by Mr Thomson's post-mortem toxicology results which suggested Mr Thomson may have overdosed on his Dexamphetamine, his Alprazolam and his Tramadol. This was because Mr Thomson had been picking up his medications reliably. Dr Bird noted that toxicology results referred to the presence of Amitriptyline and confirmed that he did not

prescribe this medication and was not aware Mr Thomson was taking it. Dr Wignall also confirmed in evidence that he did not prescribe it and that Mr Thomson had never been prescribed a Tricyclic antidepressant whilst he had been treating him.

[110] Dr Bird said in evidence that he was not aware that Mr Thomson had been taking any illicit substances. Dr Bird was asked in evidence if he was ever concerned from a clinical prospective that Mr Thomson may have been overdosing on medications. Dr Bird responded by saying that at consultation Mr Thomson was coherent and organised in his thoughts. He could follow the train of consultation and could give reasonable answers to questions posed to him. Further Dr Bird advised the inquest that he was concerned at all times that Mr Thomson was behaving responsibly and that he was very strict about how Mr Thomson took his medication.

Whether Mr Thomson was fit to hold a Queensland Drivers License

[111] Both Dr Wignall and Dr Bird were aware of legislation requiring license holders to notify the Department of any conditions that affected their ability to drive safely. Dr Wignall had indicated that he had previously reported concerns about patient's ability to drive safely to the Department and Dr Bird had previously advised particular patients to cease driving.

[112] Dr Bird stated that he did not believe that the medications Mr Thomson was taking would impact on his ability to drive and probably improved his capacity to drive as it would improve his ability to concentrate and make appropriate decisions. (Transcript 1-100).

[113] Dr Bird and Dr Wignall were both of the view that Mr Thomson's brain injury did not affect Mr Thomson's ability to drive. Dr Bird did not believe that Mr Thomson's brain injury caused neurological deterioration over time, memory impairment, confusion or impairment of muscular power or control.

[114] Dr Wignall noted in his statement that Mr Thomson's ability to drive was difficult to assess however during consultations he never appeared impaired from a coordinational physical sense.

[115] Dr Bird was of the opinion that the way in which Mr Thomson presented could often give a negative first impression. His speech had been slurred following his head injury and his diagnosis of keratoconus meant that he was required to wear dark glasses. Because of this it would be easy to assume that he was intoxicated or that he had been consuming large quantities of drugs. Mr Thomson was also often opposed to questioning and had a general distrust of authority figures. (Transcript 1-98).

[116] Dr Bird saw Mr Thomson over a long period of time and was of the opinion that Mr Thomson's presentation was consistent, he was articulate, he was able to engage in conversation and follow what Dr Bird was saying and interact appropriately. Mr Thomson was able to comply with a complex regime of medication and provide appropriate feedback. (Transcript 1-98).

[117] According to Dr Bird Mr Thomson never displayed or complained of short term memory loss and was not confused by questions. Dr Bird was asked about the observations by Senior Constable Flannery and indicated that he was not surprised by Mr Thomson's behaviour with the police and he suspected that it was an attempt by Mr Thomson to evade the possible consequences of his actions. (Transcript 1-98 and Transcript 1-99).

[118] Dr Bird was of the view that Mr Thomson demonstrated a motivation to continue his therapy and this was despite at times inconsistency with his attendance at the clinic. Dr Bird indicated that Mr Thomson was very consistent in collecting his medication that was regulated. (Transcript 1-97).

[119] Overall Dr Bird felt Mr Thomson was doing better in his last few presentations. As at the last consultation in April 2009 Dr Bird reported that –

(a) He was not concerned that Mr Thomson was continually or habitually using illicit drugs;
(b) Mr Thomson did not present in a confused state or with significant memory impairment;
(c) There were no indications Mr Thomson was suffering from an acute episode of any of his mental health conditions; and
(d) Mr Thomson's presentation and the information he provided suggested Mr Thomson was taking the prescribed medications. (Exhibit D7 page 5).

[120] Dr Bird indicated that even if legislation had required mandatory reporting he would not have notified the Department because he did not see any evidence that Mr Thomson's ability to drive was impaired. (Transcript 1-110).

[121] Dr Grant was of the opinion that Mr Thomson was likely to have been well used to his medications and likely to have developed a tolerance to their side effects. He also believed Dr Bird saw Mr Thomson regularly and monitored his response to medications. Dr Grant was of the view that during consultations Mr Thomson showed no significant evidence of any effects from the combined medications that would have impaired his ability to drive. (Exhibit D8).

[122] Dr Griffin was satisfied that the cumulative effect of Mr Thomson's medication taken at the prescribed amounts would not have impaired his ability to drive. (Transcript 1-86).

Whether the intersection where the accident occurred required review.

[123] Following the fatal accident the speed limit was reduced from 80 kilometres per hour to 70 kilometres per hour. (Exhibit B1).

[124] The Department conducted a review of the Nambour Connection Road Blackall Street intersection. This review was concluded in November 2009. The purpose of the review was to determine whether any road factors contributed to the accident and determine what appropriate treatment should be carried out at the intersection to prevent further accidents. (Exhibit C5, page 9).

[125] The review noted that the intersection had previously been reviewed in 2007 as part of the "Safer Roads Sooner" project. The project resulted in modifications to the intersection in 2007 and the report concluded that there had been no reported crashes at the intersection since the 2007 project was completed. (Exhibit C5).

[126] In 2007 the community pushed strongly for a signalised intersection however this was rejected by the Department on the basis that the rural context of the road, operating speeds of approximately 90 kilometres per hour, the horizontal curve and the 5.8 per cent down grade to the southern approach was such that the deceleration distance for trucks was too great from the point at which the traffic lights would become visible. (Exhibit C5 page 14).

[127] The review noted that the community of Woombye strongly opposed the medium closure for access to Blackall Street at the intersection. (Exhibit C5).

[128] The review noted that the type of lighting at the intersection was known as "flag lighting" which is not intended to provided illumination of the road surface in the way the road lighting is applied on major roads in urban areas, rather it was intended to alert approaching drivers to the existence of an intersection. The review noted that the current lighting would not have complied with the 2007 Standards for lighting of this type. (To comply with Standards, lighting was required on the northbound carriage way to extend south to the commencement of the auxiliary lane for the left turners wishing to exit at Blackall Street). However the region made a decision not to change the lighting in order to stretch the available funding. The review concluded that this was a reasonable judgment to make. (Exhibit C5 page 14).

[129] Due to the local community's wish for signalised intersection following the accident the Department engaged engineering consultants GHD to prepare an independent report. GHD investigated the following options:

- Traffic signals,
- Medium closures,
- Round-a-bout, and
- Enhancements to the existing intersection (Exhibit C5 page 17).

[130] The GHD report noted that there had been 56 recorded accidents at and in the vicinity of Blackall Street and Nambour Connection Road between 1 January 1990 and 2 June 2009. Thirty-six involved vehicles turning right out of Blackall Street and four (including this accident) involved vehicles turning right from the Nambour Connection Road into Blackall Street.

[131] GHD rejected traffic signals as an option due to the speed environment on the Nambour Connection Road, the horizontal curve, the down-gradient on the southern approach and the braking distance involved. (Exhibit C5 page 18).

[132] GHD also rejected a round-a-bout as an option due to the high approach speeds on the Nambour Connection Road, the gradient on Nambour Connection Road, the inability to economically realign Nambour Connection Road so as to introduce speed reduction curvature and the construction cost and time. (Exhibit C5 page 18).

[133] GHD rejected enhancing the existing intersection as an option despite acknowledging that some safety improvements could be achieved by enhancing road lighting and installation of a permanent speed camera because of the residual risk of high severity crashes due to high operating speeds, conflicting traffic movements and continued traffic growth.

[134] GHD recommended the option of closing the medium at the intersection, that is preventing road users from turning right from the Nambour Connection Road into Blackall Street and three other sections and providing a U-turn facility at another section. (Exhibit C5 page 19). The local community does not want this.

[135] Despite the GHD report the review reconsidered the option of traffic signals at the intersection. It was considered that the fundamental difficulty was the operating speed of traffic on the Nambour Connection Road approaching from the south. Speed measurements taken after the accident indicated the existing 70 kilometres per hour speed signs were not being complied with and some 15 per cent of vehicle was travelling at speeds of 80 kilometres per hour or higher.

[136] The review noted that traffic signals could be considered at the intersection when on-going monitoring of operating speed demonstrated that 85 per cent of vehicles travelled at speeds not exceeding 70 kilometres per hour and 99 per cent of vehicles travelled at speeds not exceeding 80 kilometres per hour.

[137] A variety of methods were outlined in the report detailing various efforts that could be employed to reduce vehicle speed.

[138] The review recommended that the current intersection configuration remain in place whilst endeavouring to lower the speed environment on the southern approach adopting a variety of strategies.

[139] The Department provided a report to the Coroner in May 2011 outlining the implementation of the recommendations made in the report of November 2009. (Exhibit C5 page 21).

[140] Most of the recommendations to attempt to reduce the speed have been implemented.

[141] Road lighting has also been improved so that lighting on the Nambour Connection Road is lit from the Woombye entrance sign to 200 metres north of the Blackall Street.

Conclusions

[142] Mandatory reporting by health professionals concerning licensing is a balancing exercise between a patients's right to privacy and to seek treatment without the threat of being reported and public safety concerns. I refer to my earlier

comments with regards to mandatory reporting and I will not be making a recommendation that such occurs.

[143] The evidence demonstrated that Dr Bird and Dr Wignall were well aware of their responsibilities with respect to prescribing medications and monitoring Mr Thomson and his ability to drive safely. Neither doctor had any concerns with regards to Mr Thomson's ability to drive safely.

[144] Therefore in this case even if medical practitioners had been required to mandatory report there would have been no report to the Department concerning Mr Thomson.

[145] Senior Constable Flannery's memorandum should have been actioned and forwarded to the Department. Whilst it is reasonable for the memorandum to be reviewed by the chain of command before been provided to an outside organisation steps should be taken to ensure that there is no opportunity for such memorandums to not be properly actioned. I am satisfied that the steps taken by the Queensland Police Service outlined previously in this decision addresses the problems highlighted by Senior Constable Flannery's memorandum concerning Mr Thomson not being actioned.

[146] Dr Wignall and Dr Bird both advise that they would have undertaken further investigations should they have received a show cause notice from the Department. However, given their comments with regards to their views concerning Mr Thomson's ability to drive I do not believe that this would have resulted in Mr Thomson's drivers license being taken from him.

[147] The evidence demonstrates that there was a failing at the Nambour Police Station with regards to the proper actioning of Senior Constable Flannery's memorandum – procedures have now been put into place to address this.

[148] Medications prescribed for Mr Thomson were appropriate in the circumstances.

[149] Dr Wignall and Dr Bird were both aware of Mr Thomson's history of doctor shopping and took appropriate action as required. Further when the doctors became aware of a possible escalation in this behaviour in early 2009 concerning the use of Oxycodeine Dr Bird in consultation with Dr Wilmott and Dr Wignall put interventions in place to address the issue. The evidence is that these interventions were appropriate and that even if drug urine screening had been ordered earlier it would not have revealed the levels of drugs Mr Thomson was taking.

[150] It would appear that at the time of accident Mr Thomson had taken well in excess of his prescribed medications and that he had taken medication not prescribed by either Dr Bird or Dr Wignall. The evidence is that if he had taken the prescribed medication at the prescribed dosage then he would have been fit to drive.

[151] The inquest was unable to determine the likely effect of Mr Thomson over medicating himself as there is no evidence as to whether this had occurred on previous occasions. Further the inquest was unable to establish how Mr

Thomson had access to the additional medications he took including the Amitriptyline which both Dr Wignall and Dr Bird denied prescribing.

[152] Neither Dr Bird nor Dr Wignall considered that Mr Thomson's ability to drive was affected by his frontal lobe injury or the medications he had been prescribed. Dr Bird and Dr Wignall had far more interactions with Mr Thomson then the police and they were better placed to assess whether Mr Thomson's frontal lobe injury or his medications affected his ability to drive.

[153] Prior to receiving information from the Department Senior Constable Church gave his opinion regarding the appropriateness of the intersection and strategies to make the intersection safer. I am of the view that given the extensive examination conducted by the Department that the Department's review should be preferred and the Department is the most appropriate body to determine solutions to ensure that the intersection is safe for road users.

Findings required by Section 45

[154] On the basis of the evidence presented at the inquest I make the following findings:-

(a) The identity of the deceased persons –

(i) The deceased persons are Grace Ann Hornby, Jessica Lee Hornby, Denise Ann Mansell and Anthony Paul Thomson;

(b) How the deceased persons died –

(i) The deceased persons died as a result of injuries sustained in a two vehicle traffic accident

(ii) The accident occurred between a Toyota Corolla driven by Ms Mansell and a Peugeot driven by Mr Thomson;

(iii) The accident happened due to a range of contributing factors including –

1. The lack of headlight illumination of the Peugeot;

2. The excessive high speed that the Peugeot was travelling immediately prior to the collision; and

3. The possible side effects from excessive doses of prescribed and unprescribed medication Mr Thomson had taken prior to the accident.

(c) Date of deaths –

(i) In each case the deceased person died on 8 May 2009.

(d) Place of deaths –

(i) In each case the deceased person died on the Nambour Connection Road at the intersection of Blackall Street, Woombye.

(e) Cause of deaths –

(i) In the case of Grace Ann Hornby, Jessica Lee Hornby and Denise Ann Mansell they died as a result of or as a consequence of multiple injuries suffered in the accident.

(ii) In the case of Anthony Paul Thomson he died as a result of a ruptured aorta.

Recommendations

[155] Section 46 of the Act provides that I may make a comment on anything connected with the death that relates to public health and safety, the administration of justice or the way to prevent deaths from happening in similar circumstances in the future.

[156] I intend to only make one recommendation. The Department of Transport should continue to review the intersection of the Nambour Connection Road and Blackall Street with a view to considering whether traffic lights ought to be installed at the intersection or whether the medium ought to be closed.

Bernadette Callaghan
Coroner
20 October 2011