CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Bernardus Johan Smit**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2015/3518
DELIVERED ON:	5 June 2018
DELIVERED AT:	Brisbane
HEARING DATE(s):	27 October 2017, 20 December 2017, 1 June 2018
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, traffic controller, motor vehicle crash, codeine toxicity of driver, involuntary intoxication due to effects of renal dialysis, fitness to drive due to multiple medical conditions, legislative reform

REPRESENTATION

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Counsel for Dr A Mills:	Ms D Callaghan i/b TressCox Lawyers
Counsel for Dr A Araba:	Mr D Schneidewin i/b Avant Law
Counsel for Dr R Miles:	Ms L Nixon, Lander & Rogers Lawyers
Counsel for husband of driver:	Ms M Zerner i/b Roberts & Kane

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Introduction

1. Bernardus Smit was working as a traffic controller on 8 September 2015 when he was struck by a motor vehicle. He died as a result of injuries he received.

2. The driver of the vehicle told police she had no recollection of what had happened and believed she may have blacked out. She was at the time receiving renal dialysis for End Stage Renal Disease and treatment for multiple myeloma. Analysis of a blood sample taken from the driver at the direction of police after the incident revealed very high levels of morphine and codeine, which medical opinion suggested could have caused a blackout.

3. The same medical opinion also stated the high levels of codeine could be due to the driver taking a therapeutic level of panadeine forte with the codeine accumulating in a renal dialysis patient.

4. Investigations were completed by the Queensland Police Service and no charges were brought against the driver on the basis that involuntary intoxication could not be excluded. The driver has since died from her medical conditions.

5. Workplace Health and Safety Queensland also completed an investigation and did not identify any concerns as to the traffic safety operations put in place by Mr Smit's employer at the time of the incident.

6. Mr Smit's wife Vicki Smit has raised issues concerning potential criminal liability of the driver of the motor vehicle, as well as concerns about her fitness to drive and the obligation on drivers/medical practitioners to report such matters to the driver licencing authority. She has advocated strongly for an inquest into her husband's death.

7. Subject to it being understood a coroner does not make findings as to criminal or civil liability, given those concerns and as there remained a somewhat unclear picture as to the circumstances that led to the driver losing control of her vehicle and whether something like this could be prevented in the future, a decision was made to hold an inquest.

Issues for the inquest

8. A pre-inquest hearing was held on 27 October 2017. The family had concerns generally about the whether the current legislative regime is sufficient to ensure individuals who may be unfit to hold a driver's licence are reported to the Department of Transport and Main Roads and if there should be any mandatory

obligation on health practitioners to report concerns held regarding a patient's ability to drive. They also had concerns about the law governing the offences which may be committed by drivers, who knowingly drive with a physical or mental incapacity, which renders them unfit to drive, and which result in the death of any person.

9. With respect to those issues it was determined by me that if as the evidence unfolded it became apparent such issues were relevant, then they would be considered.

10. After hearing submissions from Counsel Assisting and the legal representatives of the family the following issues were settled for the inquest:

    i. The findings required by s. 45(2) of the *Coroners Act 2003*; namely the identity of the deceased, when, where and how he died and what caused his death.

    ii. The circumstances of the traffic incident on 8 September 2015 that resulted in the deceased's death.

    iii. Whether the driver was fit to hold a Queensland drivers' licence at the time of the traffic incident on 8 September 2015.

    iv. Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the *Coroners Act 2003*.

11. The following witnesses were called to give evidence:

    - Dr Ian Mahoney, CFMU (to give independent evidence as to toxicology findings, driver's fitness to drive, and appropriateness of prescribing practices)
    - Dr Abiodun Araba, (driver's regular GP);
    - Dr Anthony Mills, Clinical Haematologist (treating driver)
    - Dr Rhianna Miles, Renal Physician (treating driver)

12. It was noted the driver was no longer alive and therefore unable to provide evidence of her involvement in the incident or otherwise advocate on her own behalf in relation to any allegations or suggestions of wrongdoing.

13. In these circumstances, and having regard to the focus on fact finding and prevention rather than blame or guilt, I have made a non-publication order in

relation to any information that may identify the driver of the vehicle or her family, and I will not include such identifying information in the findings.

14. Subsequently as a result of hearing evidence on 20 December 2017, I determined that further investigations relating to a number of identified issues should be carried out and the matter was adjourned. Further witnesses were called to give evidence as follows:

    - Senior Constable Linda Whinchup (attended scene, took notebook statement of driver and present at hospital when driver gave a blood sample)
    - Senior Constable Kathryn Thomas (attended at scene and present when driver gave blood sample)
    - Husband of the driver
    - Sergeant Darryl Morrison (FCU investigator)

Autopsy results

15. Forensic Pathologist Dr Rohan Samarasinghe conducted a full internal autopsy. He found the major injuries evident were to the head including skull fractures and brain haemorrhages, which were the primary cause of death. The injuries were consistent with that of a pedestrian struck from his left side. The contact points were in the left lower leg and left on top of the head. The overall pattern of the injuries would suggest his fatal injuries were due to the secondary impact with the windscreen/pillar.

16. Toxicology analysis detected no alcohol and codeine and paracetamol in a non-toxic range.

17. Death was due to the head injuries resulting from the accident.

The circumstances of the traffic incident on 8 September 2015 that resulted in the deceased's death.

18. Bernardus (Ben) Smit was 50 years of age. Ben had been married to Vicki Smit for 23 years and they had two sons aged 17 and 14 at the time. Mrs Smit told the court their marriage together revolved around their work and their sons' wellbeing and their hopes for the future. Ben was a safety conscious person and his death in these sudden circumstances shocked the family. It is clear he is very much missed by his wife, sons, family and friends.

19. On the morning of 8 September 2015, Mr Smit was struck by a motor vehicle whilst at work and died as a result of the injuries he received.

20. Mr Smit was employed as a traffic controller and was assisting at a section of roadworks on a service road running alongside Redbank Plains Road in Brisbane.

21. Around 9.30am, a Toyota Camry was seen travelling north along Redbank Plains Road doing about 50km/hr when it unexpectedly veered left through a line of traffic cones marking off the entrance to the service road. The Camry then struck Mr Smit, who was standing at the rear of his work vehicle parked on a grass verge just to the side of the service road. Witnesses describe seeing Mr Smit fly into the air and then land on the ground some 10 or so metres away. The Camry continued on for approximately 65 metres, impacting a street sign before stopping further down the service road. The driver got out of the car and walked back towards the scene of the collision.

22. Mr Smit's work colleagues and passers-by provided first aid to Mr Smit until the Queensland Ambulance Service arrived. He was placed in an ambulance where he received emergency medical treatment from an emergency doctor and intensive care paramedic. Despite these efforts Mr Smit was pronounced deceased not long after QAS arrival.

23. An autopsy examination confirmed Mr Smit died from head injuries he received as a result of the collision.

24. The driver of the Toyota Camry, who was not injured in the incident, was taken to Ipswich Hospital for a blood sample to be taken. Police questioned the driver whilst she was in hospital and recorded her responses in an official police notebook, which she subsequently agreed to sign. According to her signed notebook statement, the driver could not remember anything about the collision or how she came to veer off the road, and did not realise she had hit someone until she walked back to the scene of the collision. She had no explanation for what had happened. She stated '*I don't know…I was meant to be going straight but I must have went off to the left then I must have hit the guy then the pole…*'. She stated she did not know what caused her to swerve or veer to the left. She further stated '*It's just a blur. I don't remember hitting that guy at all*'.

25. The driver confirmed that to her knowledge there were no defects on her vehicle, the brakes were fully functional, and the condition of the tyres was fine. The driver did not identify any issues regarding the road or weather conditions

or visibility at the time. She confirmed there were no objects in the road or issues with the steering that may have caused her to swerve or veer to the left.

26. QPS also explored whether driver distraction might have caused or contributed to the incident. The driver denied any distractions such as eating, drinking, smoking, using a mobile telephone, or adjusting the radio or anything else in the vehicle. She did state she had 'horrendous coughing' recently, but could not recall whether she may have been coughing at the time of the incident.

27. There was no evidence the driver was speeding at the time of the incident. She told police officers she was going 'slow'; she 'wasn't going fast' and she 'never travels fast'. One eye witness described the vehicle as travelling about 50km/hr (with the speed limit in that area being 60km/hr). The other eye witness did not given any estimate as to the speed of the vehicle.

28. Regarding fatigue, QPS asked the driver when she last slept and also how she was feeling at the time of the crash. She reported having gone to bed at around 10pm the previous evening and woken at 8am that morning. She said she was feeling 'perfectly fine' at the time of the crash. She did report to QPS that she was on dialysis for kidney failure and taking a number of medications. During the interview the driver made no mention that she may have blacked out.

29. When asked sometime later to participate in a formal record of interview the driver declined on legal advice, but told police over the telephone she believed the incident may have been caused as a result of her blacking out. The driver said she was undergoing medical tests to determine if she did indeed suffer a blackout at the time of the incident and if so, why. The driver had disclosed to police when giving her notebook statement that she was on renal dialysis and had myeloma (a form of blood cancer), and was taking several medications for these conditions.

Workplace Health and Safety Investigation

30. Inspector Graham Bell of WHSQ conducted an investigation with the assistance of Inspector Peter Stevens. They both attended at the incident site on 8 September 2015, took photographs, obtained statements and obtained and analysed traffic control documentation at the site.

31. The company employing Mr Smit had been contracted to provide a traffic control on a service road adjacent to where underground piping was being installed. Mr Smit had set up the traffic control system for the site the previous day. To achieve this there were a number of traffic control signs on the verge

of the road prior to the incident site and a number of red cones along the centre of the start of the service road.

32. There were initial allegations that the traffic control signage may have played a part in the incident. It was established during the course of the investigation this signage was placed out in accordance with the Department of Transport and Main Roads' *Manual of Uniform Traffic Control Devices.* The investigation found the traffic control measures in place on that day did not materially contribute to the incident and do not otherwise provide an explanation for why the vehicle veered off the road and struck Mr Smit.

33. The investigation found:

    a. Mr Smit was a competent traffic controller having a Level II Traffic Management Card.

    b. No traffic control devices encroached on Redbank Plains Road

    c. The traffic control devices in place did not require vehicles travelling along Redbank Plains Road to do anything other than to continue travelling along that road

    d. The incident did not give rise to a contravention under the *Work Health and Safety Act 2011.* The cause of the incident related to factors over which the employer and Mr Smit had no control over.

QPS Investigation

34. The Queensland Police investigation was conducted by Sergeant Darryl Morrison of the Ipswich Forensic Crash Unit.

35. The investigation determined the driver of the Toyota Camry Sedan travelled in a northerly direction along Redbank Plains Road when it veered to the left and struck Mr Smit.

36. A mechanical inspection of the vehicle determined there were no defects that could have contributed to the cause of the incident. An examination of the road surface also found no defects that would have contributed to the cause of the incident.

37. Witnesses provided versions to police that indicated no other vehicle, person or object contributed to the cause of the incident and this is supported by the physical evidence at the scene. Witnesses did not see the vehicle that hit Mr Smit slow down prior to the incident or see brake lights of the vehicle come on.

38. Sergeant Morrison confirmed at the inquest that the only traffic cones in place at the time were as indicated by the blue markers in 'Photo 2' of the police report. Those cones were situated to the left of the white line separating the main road from the service road, and did not interfere with the flow of traffic along the main road. The speed limiting sign of 40km was for traffic entering the service road, as indicated by the words 'ON SIDE ROAD'. The traffic control measures in place at the time of the incident did not require the driver to do anything other than continue travelling within her marked lane along Redbank Plains Road, obeying the usual speed limit of 60km.

39.

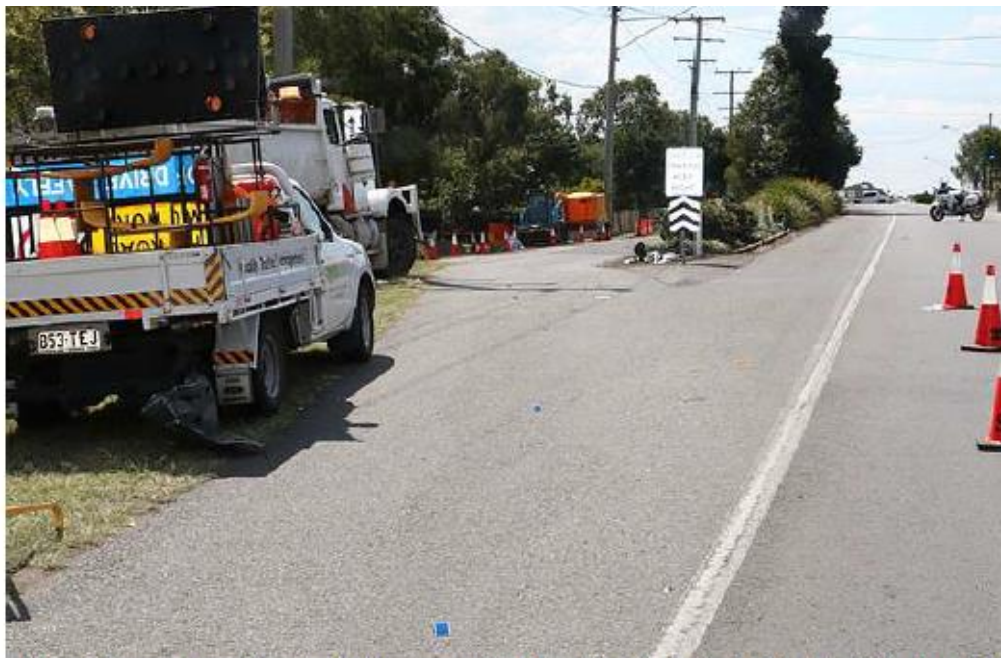

Photo 2: Shows a progressive view looking in a northerly direction along Redbank Plains Road. The front left door panel from the Toyota Camry can been seen on the ground at the right rear of the utility

40. Accordingly I can be satisfied the traffic control measures did not contribute to the incident and do not otherwise provide an explanation for why the vehicle veered off the road and struck Mr Smit.

41. Given a blackout was the possible explanation for the cause of the incident, Sergeant Morrison contacted the Medical Condition Reporting Unit of Queensland Transport on 17 September 2015 requesting a medical show cause be commenced against the driver in relation to her fitness to drive. Her licence was suspended on 26 October 2015.

42. Approximately eight months after the incident and whilst her licence remained suspended, the driver succumbed to her life limiting medical conditions and passed away in May 2016.

43. During the course of the QPS investigation into the incident, the results of the toxicology tests performed on the samples of the driver's blood taken on the day of the incident were forwarded to the Clinical Forensic Medical Unit for an opinion as to the driver's fitness to drive on that day.

44. In February 2016 a CFMU Forensic Medical Officer Dr Ian Mahoney advised, by way of a statement to the QPS, that the driver had significant levels of both codeine and morphine in her blood. In relation to the codeine, Dr Mahoney described it as the highest he had seen in a living person and well within the range where deaths have been attributed to codeine toxicity. He also stated the levels of codeine and morphine detected would be expected to be associated with markedly decreased powers of attention, concentration and judgement, and the ability to safely control a motor vehicle would be impaired. Dr Mahoney agreed the levels of codeine and morphine detected could provide an explanation for the cause of the suspected blackout in this case.

45. As to the driver's knowledge of these levels, Dr Mahoney speculated it may be due to unintentional intoxication. He noted the driver was said to be taking Panadeine Forte at the time of the crash and this medication would be the source of the codeine and morphine. Dr Mahoney ruled out a deliberate overdose of Panadeine Forte, because in an overdose scenario both the codeine and the paracetamol levels would be high. However, just the codeine level was high in this case. Dr Mahoney therefore believed the driver could have been taking her Panadeine Forte in a normal therapeutic fashion, and the high codeine and morphine levels could be explained by the accumulation of these drugs in a renal dialysis patient.

46. In subsequent correspondence with the Coroners Court, Dr Mahoney stated the prescription of Panadeine Forte is not contraindicated in renal failure patients but prescribers are advised to exercise caution. Dr Mahoney also noted medications containing codeine were available over the counter as well as by prescription, and the driver may have accessed codeine without prescriptions. Dr Mahoney advised this is due to change in 2018 with the proposal by the Australian Therapeutic Goods Administration (TGA) to reschedule preparations containing codeine to require a doctor's prescription. This is consistent with information currently published on the TGA's website, with the change introduced on 1 February 2018.

47. Dr Mahoney was asked about the level of diazepam found in the context of the history that the driver had taken a Valium that morning. Valium can cause drowsiness but he said the level found was very low and would have little effect.

48. On the basis of Dr Mahoney's opinion as to involuntary intoxication, which is potentially a defence to a charge of dangerous or careless driving, police decided to take no further action in relation to the driver's involvement in the incident. Dr Mahoney noted in his evidence at the inquest that he was providing his opinion in the context of the prospect of criminal proceedings and looking at whether there were any circumstances, which would bring in the question of "benefit of doubt". He stated he was not considering what was the most likely scenario impacting on the driver clinically. Dr Mahoney said in compiling his initial statement he was aware that in the medical literature there were published cases where black outs had occurred in persons with renal failure taking codeine. Dr Mahoney had been provided with the most recent statement from Dr Miles and on clinical issues relating to renal patients he stated he would defer to her opinion.

49. Sergeant Morrison noted there was no evidence to indicate that whilst the driver was driving along Redbank Plains Road immediately prior to this incident, her ability to drive safely was affected and she knowingly continued to drive in a dangerous manner. Rather, it appeared the loss of control occurred suddenly and possibly immediately and possibly after the driver's loss of consciousness.

Whether the driver was fit to hold a Queensland drivers' licence at the time of the traffic incident on 8 September 2015.

The source of and prescribing of codeine

50. From the driver's medical records obtained during the coronial investigation, including those of her GP and two treating specialists as well as her PBS prescription records, it became apparent the driver was being prescribed Panadeine Forte by one of her specialists, a haematologist, Dr Anthony Mills

51. The driver's GP Dr Araba and her other treating specialist, a renal physician, Dr Rhianna Miles, appear to have been aware of her taking this medication and have expressed no concerns about this being prescribed in a patient with her conditions.

52. Dr Araba stated the driver was on *Continuous Ambulatory Peritoneal Dialysis* and required transfusion frequently due to her persistent anaemia. She had received chemotherapy and a stem cell transplant. At the time of the incident her clinical condition was slowly deteriorating. She reported feeling frequently tired and fatigued. She continued to see a specialist for regular review and fortnightly blood transfusion. Medications included Panadeine Forte, Minax, Acimax, Prednisolone and Maxolon. She also reportedly took a Valium tablet on the morning of the accident

53. Dr Araba stated that in relation to clinical signs of codeine toxicity he did not notice any deterioration in her concentration, attention, speech, cognition or motion function. When he saw her she was lucid, there were no pin point pupils or slurring in her speech. He was unable to comment on how much Panadeine Forte she was taking as he did not prescribe this to her. He did not prescribe Valium for her either. The GP offered that although he had never seen her fatigued, her self-reported extreme fatigue "might have been a major contributing factor" to the incident.

54. Dr Araba saw the driver on 9 September 2015 having made an appointment for her to see him after her son told him about the accident. Dr Araba says she was distressed and upset and she said she thought she might have blacked out but was not sure. She wanted to get answers as to what happened. She appeared remorseful. Dr Araba ascertained she took a Valium in the morning. She was not feeling sleepy. She took her panadeine forte and maxalon for nausea. She was lucid and there was nothing to suggest codeine toxicity.

55. The suggestion of a blackout suggested a possible transient ischaemic attack (TIA stroke), or a lesion/seizure. He sent her for a CT scan of the head and there was no evidence of a CVA or TIA. A referral to an optometrist found no significant visual abnormality. She had never reported suddenly falling asleep but the GP considered the possibility of sleep apnoea and a sleep study at Snore Australia ruled this out.

56. Dr Araba stated in evidence that one of the reasons he was requesting all those tests was because his patient was clearly upset and remorseful about the event. "*She just felt for that unfortunate incident to have happened, resulting in a loss of life, she wanted answers to see if there was anything in particular that could have caused that to happen. That was why she did those tests, almost immediately, in the first week after the event. And I believe even until she passed, she struggled with this particular event.*"

57. Dr Araba had never turned his mind to her driving ability as she never presented as being affected by her medication. Opiates are not contraindicated for driving providing the patient is aware of the possibility, particularly in an opiate naïve patient.

58. If a patient clearly should not drive and they were not obliging by surrendering their licence then Dr Araba considers there may be a moral and legal obligation to report to the relevant authorities for public safety reasons. Dr Araba stated he was aware of the conditions listed in the guidelines for driving and if he was in any doubt he would send the patient to an expert.

59. Dr Rhianna Miles had managed the driver's renal care from January 2013 when she presented with severe acute kidney injury in the setting of multiple myeloma. Although initially managed conservatively, she developed progressive decline in renal function and commenced haemodialysis in November 2013. She had significant vascular access difficulties throughout her time on haemodialysis and eventually transferred across to peritoneal dialysis in September 2014. This continued until her death in 2016. Dialysis was provided as supportive therapy for her various myeloma treatments including stem cell transplantation and chemotherapy options. In 2013 Dr Miles had no concerns with any drowsiness or codeine accumulation. Dr Miles said there would be visible affects and would last some time.

60. Dr Miles did not treat the patient from September 2014 when she commenced on peritoneal dialysis at the Princess Alexandra Hospital. Dr Miles did review her when she was an inpatient at Greenslopes Private Hospital and this occurred on 9 March 2015 and from 12–20 October 2015. Dr Miles had observed the patient being drowsy during the October 2015 admission and stated this was likely while the peritoneal dialysis regimen had been altered from automated peritoneal dialysis to *Continuous Ambulatory Peritoneal Dialysis.* Dr Miles noted electrolyte disturbances creating high levels of certain waste products including urea, creatinine, phosphate and potassium that can contribute to drowsiness. The patient was not drowsy on any occasion as an outpatient during her involvement in her care up to and including September 2014. Dr Miles was never concerned that the patient suffered from codeine accumulation during her involvement as the drowsiness she observed was usually relating to either her renal dysfunction or complications of her myeloma treatment. She did not demonstrate the usual symptoms of narcotisation that one would expect with high codeine levels.

61. Dr Miles stated that in regard to the usage of opiate medication in end-stage renal failure it is her practice to prescribe them in lower doses then those with normal renal function. Analgesic options for those with end-stage renal failure are often limited substantially by the inability to safely prescribe non-steroidal anti-inflammatory drugs, so opiates including panadeine forte and short acting oxycodone are frequently used. Given the risk of accumulation of opiates, all patients are warned of the possibility of the increased side effects and the need to minimise the dosages to the minimum required to provide adequate analgesia. For long-term opiate usage, it is her preference to use fentanyl patches due to their predominant hepatic clearance and safety of use in the end-stage renal failure. Dr Miles only prescribed panadeine forte on one occasion on 1 September 2014 at the request of the patient as she had run out of her supply and had several days until her next review with Dr Mills.

62. In a statement provided to the Court the day before the inquest Dr Miles says (amongst other things) that the driver's behaviour after the incident in speaking with police and being able to respond to those questions is inconsistent with her being adversely affected by codeine. She also notes lack of any drowsiness/impairment the day prior (specialist consultation) or the day after (GP consultation).

63. Dr Miles says in her opinion, taking all that into account, *"it is not possible to conclude that codeine or the (patient's) medication regime otherwise caused a blackout in the absence of any other symptoms of opioid intoxication"*

64. Dr Miles does offer that it could be a case of the driver having an unusual way of metabolising codeine, or her taking of Valium that morning, but again says there were no observations of the driver being drowsy or sedated.

65. Dr Miles stated she is unaware of codeine being able to cause a blackout in the absence of any prior evidence of codeine intoxication, such as drowsiness. Dr Miles had never seen codeine cause a blackout. She accepts there may be reports in the medical literature but these would be very rare. Dr Miles stated the patient may have had a blackout due to her other conditions but not due to codeine. Dr Miles notes she does not have the benefit of clinical observations

taken by the hospital where the driver was taken to immediately after the accident.[1]

66. Dr Miles agrees with the opinion of Dr Mahoney that if the patient had taken an overdose of Panadeine Forte the paracetamol levels would also be high, although not as high as the codeine levels due to the accumulation of codeine. The PBS records did not reveal the patient was obtaining codeine from any other practitioners. Taking into account that codeine is only available over-the-counter in combination with paracetamol, it did not appear to her on the documentation that the patient was obtaining codeine from any other prior source, to contribute to the unusually high codeine detected in her blood.

67. Dr Anthony Mills, a haematologist, provided a statement detailing his care of the driver, whom he had been treating for over five years at the time of the incident. Dr Mills stated that myeloma is an incurable blood cancer related to lymphoma and leukaemia. Myeloma cells interfere with cells that help keep the bones strong. Their presence causes patients to suffer from bone pain and a constellation of other symptoms. At no time did the patient tell him of her involvement in the motor vehicle accident.

68. Dr Mills states he saw the patient regularly to monitor her progress, usually less than a month apart. Given the cancer is incurable the treatment plan was about delaying the progression of the myeloma and managing her complex symptoms. She suffered from fluctuating levels of moderate to severe pain including bone pain. She also had fibromyalgia and osteoarthritis, which caused her further pain. This pain was managed with the prescription of analgesics.

69. Dr Mills trialled a number of analgesics. She had experienced negative side effects including nausea from taking tramadol, fentanyl, oxycodone and buprenorphine. The patient found that Di-Gesic (dextropropoxyphene and paracetamol) controlled her pain with minimal side-affects.

70. Dr Mills routinely tested her renal function because myeloma cells can harm the kidneys and lead to kidney damage in renal failure. In January 2013 she presented with acute renal failure. As a consequence she required dialysis and received treatment by Dr Miles, a nephrologist. Even though her renal function

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[1] The records from Ipswich Hospital show only an attendance with Police to obtain a blood sample and nothing related to observations or treatment for the incident.

improved it was not clinically appropriate to continue to prescribe Di-Gesic and instead they began prescribing Panadeine Forte.

71. Dr Mills described his approach to prescribing her Panadeine Forte, a Schedule 4 drug, which he thought was the best alternative to Di-Gesic and because she had previously experienced negative side effects when trialling oxycodone and fentanyl. He initially wrote a prescription for 20 Panadeine Forte tablets so that he could regularly monitor her reaction and tolerance. As she became more familiar with her own tolerance and pain management needs, he wrote scripts for 120 and later 180 tablets. The pain was well controlled but there were occasions when she experienced acute increases in pain, for which he prescribed Endone.

72. On 18 May 2015 the patient reported she had been experiencing nausea and he considered whether the codeine may have been causing this. He recommended ceasing Panadeine Forte and trialling her on Panadol and Endone instead. When he reviewed her again on 1 June 2015, instead of substituting Panadeine Forte for Panadeine and Endone she had tried reducing the number of Panadeine Forte tablets she was taking. This did not reduce her nausea related symptoms and was providing her with insufficient pain relief. For these reasons, she resumed taking her usual dose of Panadeine Forte.

73. Dr Mills agreed codeine could accumulate in a patient with impaired renal function, however he also noted if a patient's renal function and doses of codeine are kept stable, the patient's blood codeine level will reach a plateau, at which point it is cleared at the rate it is taken and does not continue to accumulate. Dr Mills stated that in this case, the driver had been maintaining a stable dose of Panadeine Forte over a long period of time, had a stable level of renal function, and maintained a regular dialysis regimen. Dr Mills therefore expected her blood codeine level would have plateaued in such a manner.

74. As to any signs or symptoms exhibited by the driver related to possible codeine toxicity, Dr Mills stated that at no point did he observe, nor did the driver report, any such symptoms or signs. Dr Mills stated he regularly treats patients with chronic or acute pain and is very familiar with the indicia of codeine toxicity. He recalls the driver being oriented and lively during his many consultations with her and that she continued to live an active lifestyle throughout most of the time he treated her, with no reports of drowsiness from the Panadeine Forte.

75. Dr Mills also stated not all patients experience drowsiness whilst taking Panadeine Forte, and those who do usually experience it soon after commencing taking the drug. As the driver had been taking a stable dose over a long period of time, Dr Mills believes she would have been at a low risk of experiencing unexpected drowsiness at the time of the motor vehicle accident.

76. Dr Mills noted the opinion of Dr Mahoney and agrees that as the blood results indicated a high level of codeine in proportion to the detected level of paracetamol this indicates that the high blood codeine level would not have been caused by her exceeding her recommended dose of Panadeine Forte.

77. Dr Mills agrees with the opinion of Dr Mahoney that where drugs accumulate in renal failure patients they require decreased frequency of dosing in relation to patients with renal failure using Panadeine Forte on an acute basis, but he does not agree this is the case with respect to patients on chronic, stable doses.

78. Dr Mills also referred to the opinion of Dr Mahoney where he stated that the level of codeine detected would be expected to be associated with markedly decreased powers of attention, concentration and judgement. He stated this would undoubtedly be true of an opioid naive patient, however he believes the patient would have developed a tolerance to codeine’s effects.

79. Dr Mills agreed if there was a blackout he agrees with the opinion of Dr Miles that it was not due to codeine. Dr Miles does not exclude other causes of blackout but this would be speculation. Dr Mills stated that if the accident can be attributed to patient suffering from an acute clinical condition of some type, it may be too simplistic to attribute the accident to an isolated codeine level in a woman who had taken a stable dose for a long time with currently stable, although significantly reduced, renal function.

80. Dr Mills was taken to a document in his records being a form completed in April 2013 for a Disability Support Pension. This referred to her not being able to drive. Dr Mills said this was in the period immediately after her first relapse. He had not assessed her specifically for driving. She was treated intensively for her condition. She had told him she was not driving and he never revisited the matter with her. She always had someone else with her and he presumed she was not driving. In 2015 he probably would have assessed her as being able to drive.

Evidence relating to the condition of the driver after the MVA

81. Queensland Ambulance Service and the scene and provided advanced paramedic care to Mr Smit but there is no evidence they provided any assistance or treatment to the driver or were asked to. QAS also have no specific records of providing any assistance to the driver at the scene. The Medical Director for QAS, Dr Stephen Rashford also attended. He does not recall speaking to or examining the driver of the vehicle and he cannot remember receiving any information regarding any conversation with QAS members and the driver.

82. Senior Constable Lynda Whinchup in the company of Senior Constable Kathryn Thomas attended at the incident scene at approximately 10:30 AM and performed traffic control duties until 11 AM. She was then instructed to take the driver to Ipswich General Hospital to request a specimen of blood from the driver.

83. SC Whinchup then advised the driver she was being detained for the purpose of obtaining a sample of blood and that she would be taken to Ipswich Hospital for that purpose. As they were walking a short distance she heard the driver ask whether she could get her knitting bag out of her car. SC Whinchup thought this was an odd request given the circumstances. The driver was told the contents of the vehicle would be taken for inspection by police and would be released to her when the inspection was completed.

84. At 11:48 AM SC Whinchup made a formal requirement for a blood sample to be taken from the driver in the presence of a medical practitioner who was to take the specimen of blood for a laboratory test. A specimen of blood was taken and then packaged in the prescribed manner for later testing.

85. At 12:01 PM SC Whinchup then told the driver she wanted to ask her some questions about the traffic crash. The driver was advised she had a right to remain silent and that anything she did say may be later used in evidence. At the time her husband was also present and she was asked if she was happy for him to remain and she replied “yes”. She was then asked a series of general questions in relation to the traffic crash. After each question SC Whinchup wrote down the response in her official police notebook. At the end of questioning she invited the driver to sign the notebook as a true representation of the questions asked and answers provided. The driver read and then signed the notebook to this effect. During the course of this being carried out Senior Constable Thomas told her that the traffic controller was deceased.

86. SC Whinchup observed the driver to have no apparent reaction to this news. She recalls the driver complained that the process was taking a long time and she wanted to go home. At around this time the driver produced her driving license. As SC Thomas gave the license back SC Whincup observed the husband snatch it up and say words to the effect of *"you should not have this. I told you not to drive. You know you should not have been driving and now someone is dead."* SC Thomas observed him trying to rip up the license. He was not able to do so and appeared very distressed.

87. SC Whinchup stated that throughout her dealings with the driver she observed her to be very calm and very stoic. She did not see any emotion from her at any time apart from being worried that the press would go to her house to try and interview her and being annoyed at the length of the process. The driver appeared to have memory of events before the crash including the medication she took in the morning before driving, and when the vehicle was last serviced. She appeared to have no memory of the crash itself until she hit the traffic sign.

88. SC Whinchup stated that she had activated her electronic voice recorder but later discovered the recording was not able to be saved due to technical issues.

89. Senior Constable Thomas was present with SC Whinchup when the driver was taken to Ipswich Hospital although due to a number of telephone calls she was receiving SC Thomas was not present during the total interview that was held. She recalls the driver making a request to obtain some of her property from her motor vehicle. She was told by the District Duty Officer that the traffic controller had died and she was instructed to advise the driver of this.

90. SC Thomas observed that the driver was present with a male person who she now knows to be her husband. She heard the driver complain about the length of time the process was taking and that she wanted to go home. She recalls informing the driver of the death and her husband snatching her driver's license and saying words to the effect *"I told you not to drive–you know you should not have been driving and now someone is dead."* He tried to rip up the license as he spoke but only managed to bend it.

91. Sergeant Morrison received an email from SC Whinchup containing details of the conversation she had with the driver as recorded in her notebook. He does not have any recollection of her telling him about the actions of the husband at the hospital as he would have made a note of it and it would have caused him

to obtain a statement from the husband at that time. In evidence SC Whincup says she recalls speaking to a Senior Constable at the FCU and told him the husband had a fit and tried to rip the licence up. Sgt Morrison has no recollection of this being passed on to him, and certainly not in written form. Unfortunately, neither of the two attending police officers made a contemporaneous note of their observations and of this particular conversation at the hospital that day.

92. Sergeant Morrison only became aware of this information about the husband's reaction to hearing Mr Smit had died when he spoke to SC Whinchup on 9 January 2018, when he asked for a statement from her. Sgt Morrison agreed that not having this information probably was a missed opportunity as this would have made him curious and he would have obtained a statement earlier from the husband.

93. A request was subsequently made by me for the husband of the driver to provide a statement. This was taken in January 2018. In the statement he described his wife's medical history consistent with that already recorded through her medical specialists and GP. She was on a lot of medication. A complication of her illnesses was that she suffered from swollen legs and arms. She also had no energy and would often have to use a walker or a wheelchair.

94. At no time during her illness did any of her doctors say to her she was not allowed to drive. She would not drive long distances and only drove to places nearby. She has a disabled parking sign in the vehicle.

95. On the day of the crash she had an appointment to meet some ladies from their church at Redbank Plaza. She left home at about 9:10 AM. A short time later he received a telephone call from police who told him she had been involved in an accident and was at Ipswich General Hospital.

96. He was at the hospital when two police officers spoke to her about the crash. He remembers his wife told the police that she did not remember what happened. He says his wife was checked over by a Doctor and released from the hospital after a couple of hours. She told her husband that she did not remember what happened and she thinks she had a blackout. She told him she remembers leaving home that morning and driving along Redbank Plains Road and does not remember anything after that.

97. His wife did not drive after the accident and subsequently he always drove. He stated she had never had a crash before and believes she was a careful driver.

98. For the whole of the time that his wife was sick he had never known her to have a blackout or even feel faint. She had been very weak at times, which meant she needed a wheelchair but she had never blacked out. He was happy for her to drive short distances.

99. The husband provided a second statement, through his lawyers after discussing his forthcoming appearance at the inquest with a friend of his wife. This friend had attended at the hospital and in later discussions reminded him that he had become very upset when one of the female QPS officers came into the room to advise that Mr Smit had died. She told him that he had pointed finger at his wife and said words to the effect "you should not be driving". He stated this triggered his memory of the day. He had been through a lot with the death of his wife and had tried to blank out a lot. He stated that he does not remember exactly what he said to his wife on that day but he does recall grabbing her licence and trying to tear it up. He could not because it was too hard. He remembers being upset upon hearing that Mr Smit had died.

100. He states that prior to that day he had not previously had a conversation with his wife about her driving and had not previously told her she should not be driving. His wife was a very strong woman and he thinks even if he had said this to her, she would not have listened to him. As far as he knows she was not told by any of her doctors that she could not drive.

101. The husband also gave evidence at the inquest. He stated his wife had said to him she did not trust herself to drive long distances due to her tiredness. He said he believed she was a careful driver and her traffic record was very good. He had not ever personally been a passenger when she was driving as he always drove when they were together. He repeated on a number of occasions that he was really comfortable with her driving short distances.

102. In evidence at the inquest, the husband appeared to have a better recollection of what was said, even though his statement taken only recently suggested he could not recall. He says he used words to the effect *" if you did not drive the man would still be alive".* He was now 90% sure he used these words, as distinct from saying *"I told you not to drive–you know you should not have been driving and now someone is dead".*

103. The husband stated that his wife was checked over by a doctor and released after a couple of hours.

104. Ipswich Hospital records show a presentation for taking a blood sample only and there is no record of specific treatment being provided. The record indicates an arrival at 11:52, being seen for the blood sample at 12:08 and departing at 12:55.

Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the *Coroners Act 2003*.

Assessing Fitness to drive

105. In order to ensure that all license holders are medically fit to drive, the Department of Transport and Main Roads (DTMR) have developed various relevant legislation and procedures. It is now a requirement that every driver over the age of 75 who holds a Queensland driver license must carry a current *Medical Certificate for Motor Vehicle Driver* at all times whilst driving. As of 1 January 2014, Medical Certificates are only valid for a maximum of 12 months.

106. The *Transport Operations (Road Use Management – Driver Licensing) Regulation 2010* ('the Licensing Regulation'), "Jet's law", sets out the regime in relation to medical conditions. Essentially a person is not eligible for the grant or renewal of a Queensland driver license if the Chief Executive of DTMR reasonably believes the person has a mental or physical incapacity that is likely to adversely affect the person's ability to drive safely. The responsibility to give notice of mental or physical incapacity likely to adversely affect ability to drive safely lies with the holder of the driver's licence.

107. As noted in this case Sergeant Morrison contacted the Medical Condition Reporting Unit of Queensland Transport on 17 September 2015 requesting a medical show cause be commenced against the driver in relation to her fitness to drive. Her licence was suspended on 26 October 2015.

108. Submissions were made prior to the inquest by the lawyers for the family that the inquest should consider whether there should be any mandatory obligation on health practitioners to report concerns held regarding a patient's ability to drive.

109. Under the current legislation there is no mandatory reporting applicable for health practitioners. Health practitioners are encouraged to notify license

holders of their legal obligations. There is a discretion to report where the health practitioner thinks that a patient will not notify the department; will not comply with recommended treatments; or will continue to drive despite the advice not to.

110. Health practitioners are strongly encouraged to voluntarily notify DTMR. If a doctor makes a discretionary report, the legislation provides indemnity against liability both civilly and administratively if the report was made in good faith. Additionally, if the health professional would otherwise be required to maintain patient confidentiality, the practitioner is not liable for disciplinary action by disclosing the information.

111. Health practitioners are provided with guidance as to their obligations by referencing the *'Assessing Fitness to Drive'* publication, which also provides advice concerning how to assess a driver's fitness against National Standards for both physical and medical conditions. The publication sets out specific medical conditions likely to affect fitness to drive. Examples include blackouts and seizures

112. The issue on mandatory reporting by health practitioners has been extensively considered in the coronial jurisdiction[2] with a variety of views expressed. The most recent consideration was delivered in December 2016 [3] where Coroner McDougall was not minded to make a recommendation for mandatory reporting. He considered "*reasonable concern had been raised as to the effect that requirement would have on the patient/ doctor relationship, and the possibility that a person may not seek treatment for a condition in the fear this information will be provided to the licensing authorities. Such a requirement could cause serious adverse road safety outcomes should be introduced, which would be contrary to the objective."*

113. In the Capp inquest the Royal Automobile Club of Queensland noted the issue was extensively examined by the Older Driver Safety Advisory Committee in 2011 and 2012. The committee did not recommend compulsory reporting by

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[2] *Inquest into the death of Jet Paul Rowland,* delivered 16/12/2005; I*nquest into the death of Lex Bismark,* delivered 23/2/2006*; Inquest into the deaths of Grace Ann Hornby and ors,* delivered 20/10/2011

[3] *Inquest into the death of Ruth Capps*, delivered 21/12/2016

medical practitioners. The RACQ expressed disappointment with this recommendation.

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

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

116. In this case there is currently no evidence (other than possibly with the benefit of hindsight) that any of the driver's treating medical practitioners were aware of, or had been alerted to, any potential impairment of the driver's ability to safely operate a motor vehicle at any time prior to the incident. To that extent, even if mandatory reporting by doctors was in place, the outcome would not have changed, as there was no reason for them to make such a report.

117. If it had been relevant, given this issue has been recently considered by other coroners, and having considered the representations made in the Capps Inquest, I also would not be minded to make a recommendation for mandatory reporting by health professionals.

Increased Penalty regime for driving offences causing death

118. The third issue suggested by Mr Smit's family relates to criminal sanctions for drivers whose actions result in a death. There is no evidence that the driver had any prior knowledge that her ability to drive safely might be impaired, or that she knowingly continued to drive whilst impaired. In the absence of other evidence to the contrary, the Queensland Police Service determined there

were no grounds upon which to charge the driver with any offence related to her driving.

119. The issue of a mid-range driving offence where death or serious injury occurs has been raised on many occasions and most recently it was considered in the coronial jurisdiction[4] where Coroner O'Connell recommended the State Government consider the introduction of a mid-range driving offence with higher penalties where drivers who drive without due care and attention (as distinct from the separate offence of driving dangerously) in circumstances where death or grievous bodily harm occurs.

120. In October 2017 the State Government announced it would introduce legislation for consideration by Parliament proposing mandatory minimum licence disqualification periods and an increase to the maximum penalty for both careless driving offences and dangerous driving offences where death or grievous bodily harm is caused.

121. According I do not consider it necessary to make any further recommendation relating to that particular issue.

Prescribing of codeine medications

122. Panadeine forte always required a medical practitioner's prescription and despite the very high level found in the driver there appear to be no concerns regarding how panadeine forte was prescribed in this case. The very high level of codeine and morphine occurred most likely due to the effects of the accumulation of these drugs in a renal dialysis patient.

123. Even if there were concerns the driver had obtained codeine through over the counter sources (and there is no evidence of this), since 1 February 2018 the Therapeutic Goods Administration has scheduled all medications containing codeine such that a health practitioner's prescription is required and such preparations can no longer be obtained over the counter.

Conclusions

124. In reaching my conclusions it should be kept in mind the *Coroners Act 2003* provides that a coroner must not include in the findings or any comments or recommendations, statements that a person is or maybe guilty of an offence

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[4] *Inquest into the death of Audrey Anne Dow*, delivered 6/3/2015

or is or maybe civilly liable for something. 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.

125. 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. 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.

126. As well, when determining the significance and interpretation of the evidence the impact of hindsight bias and affected bias must also be considered, where after an event has occurred, particularly where the outcome is serious, there is an inclination to see the event as predictable, despite there being few objective facts to support its prediction.

127. The circumstances as to how Mr Smit died are well established on the evidence. He was simply going about his work as a traffic controller in circumstances where he had no control over what was about to occur.

128. The issue under contention is why the vehicle that hit him veered down the side road in circumstances where it had no need to, and then impacted with him.

129. The initial police investigation considered it was possible that the driver indeed had a blackout due to a high level of codeine and morphine in her system. It was established, based on the toxicology results, that this high level was probably not due to an overdose of medication, but likely due to accumulation of the drugs in a renal dialysis patient.

130. The evidence uncovered at inquest has revealed it is most unlikely that the driver had a blackout due to codeine/morphine toxicity. In this respect I accept the evidence of Dr Miles. In particular the driver's behaviour immediately before and after the tragic crash does not support a blackout from codeine toxicity. I can therefore safely conclude that codeine intoxication did not cause the driver to experience a sudden blackout at the time of the incident.

131. Dr Miles' opinion is not contraindicated by the opinion of Dr Mahoney who accepts Dr Miles' expertise in this area. As well Dr Mahoney's evidence that a blackout due to codeine toxicity was possible was given in the context of

providing an opinion to be utilised in a decision as to whether a prosecution should commence and offering the "benefit of doubt". That is an entirely appropriate approach.

132. There was some support for an assertion that the driver could have suffered a blackout due to any one of her other serious medical condition or a combination of them, although the evidence in that regard is not substantive.

133. The only evidence of "a blackout" is from the driver herself, although it must be said her early consultation with her GP brought this up as a possible reason, but further comprehensive medical investigation did not reveal a cause. Dr Araba says she was distressed and upset and she said she thought she might have blacked out but was not sure. She wanted to get answers as to what happened. She appeared remorseful.

134. Accepting this evidence it is more likely than not the driver did not know what caused her to drive her motor vehicle in the manner she did.

135. Both Dr Miles and Dr Mills agreed the driver could have experienced a blackout for other medical reasons. Dr Mills considered a central nervous system event (such as a seizure) was unlikely given how orientated she appeared immediately after the incident, however he suggested as possibilities including a cardiac event (such as an arrhythmia, which can cause a transient loss of consciousness) or cough syncope (a very rare condition where people can blackout, but usually only in people who have had much more vicious coughing than she had).

136. Dr Araba was unable to find any medical explanation for the cause of the incident despite his investigations. It is noted however that Dr Araba did not consider an arrhythmia. It is submitted this remains a possible explanation for the cause of the incident, but is speculative only and there is no evidence to support a positive finding that a cardiac event was involved. Dr Miles expressed a view that she suspected the driver did have a blackout from undiagnosed cause, which would never be diagnosed now.

137. What can be said is that the medical evidence and the evidence of her husband does support that at times the driver was feeling very tired and fatigued. Codeine itself can cause fatigue. Accepting that the codeine in her system was from therapeutic doses and she was not opiate naïve, it is still possible, even probable, the codeine had some impact and exacerbated the effects the ongoing/chronic fatigue related to her various underlying conditions

and treatments from which she was deteriorating. This may in turn have somewhat impacted on her cognitive abilities as she approached the roadworks, requiring higher levels of attention and cognition to negotiate than if the road was in its normal state.

138. Whether her medical conditions/medication caused a sudden loss of consciousness or she simply fell briefly asleep remains unknown, and unfortunately will remain so. What can be said is that at point in time the driver was unfit to drive.

139. It might be contended in hindsight and given the driver's multiple medical conditions, that tiredness and fatigue should have been red flags for her medical practitioners to have considered her capacity to drive. However, tiredness and fatigue are symptoms of many conditions and can be managed by drivers by avoiding driving or stopping driving when fatigued. In themselves, those symptoms would be insufficient to warrant a consideration of her capacity to drive, particularly if this was only for short distances as her husband attests. Overall the evidence suggests that none of her doctors were aware of, or had been alerted to, any potential impairment of her ability to safely operate a motor vehicle at any time prior to the incident.

140. A related question is whether the driver herself, as the holder of a Queensland drivers' licence, had information that would have required her to notify the Department of Transport and Main Roads of a mental or physical incapacity that was likely to adversely affect her ability to drive safely, as was (and still is) required by the *Transport Operations (Road Use Management – Driver Licensing) Regulation 2010*.

141. This issue was explored with her husband during his evidence at the inquest given his statement witnessed by two police officers who were present at the hospital. If it was accepted the husband said "*I told you not to drive, you know you shouldn't have been driving and now someone is dead"* then this may be evidence supporting a finding the husband did have concerns, and he expressed these concerns to his wife.

142. The husband says he cannot recall what he said that day, but he can recall being upset and trying to rip up his wife's driver licence. His evidence is that he did not have concerns about his wife's driving at any time prior to the incident.

143. Unfortunately the failure of either Police Officer to make a contemporaneous note about the conversation and not passing that information on to the investigating officer impacts on what can be made of that evidence. There is no doubt this was a missed opportunity to have this matter investigated or explored in a timely and perhaps definitive way.

144. It is also noted there is some evidence that supports the husband had some concerns given his evidence he was happy for her to drive only "short distances", his wife did not trust herself to drive longer distances, and the uncontested evidence of his behaviour at the hospital in grabbing her licence and trying to rip it up. He also said he did not raise any concerns with his wife prior to that day, and that even if he had, she was "a very strong woman" and would not have listened to him if he'd told her not to drive.

145. Ultimately the manner in which he changed his evidence at the inquest, contradicting what he had said in two recent statements, does cause some concerns as to his reliability. Despite the problems associated with the lack of contemporaneous evidence of what was said at the hospital, on balance there is sufficient evidence to find the husband did have some concerns about her ability to drive prior to the incident that day. However there is insufficient evidence to establish that this had been communicated to his wife and/or that she knew or should have known that her medical conditions were of a nature that would have required her to notify the Department of Transport and Main Roads of a mental or physical incapacity that was likely to adversely affect her ability to drive safely.

Findings required by s. 45

Identity of the deceased – Bernardus Johan Smit

How he died – Bernardus Smit was 50 years of age when, on the morning of 8 September 2015, he was struck by a car whilst at work and died as a result of the injuries he received.

Mr Smit was employed as a traffic controller and assisting at a section of roadworks on a service road running alongside Redbank Plains Road, Redbank near Ipswich.

Around 9.30am that morning, a Toyota Camry was seen travelling north along Redbank Plains Road doing about 50km/hr when it unexpectedly veered left through a line of traffic cones marking off the entrance to the service road. The Camry then struck Mr Smit, who was standing at the rear of his work vehicle parked on a grass verge just to the side of the service road. Witnesses describe seeing Mr Smit fly into the air and then land on the ground some 10 or so metres away. The Camry continued on for approximately 65 metres before stopping further down the service road, at which point the driver got out of the car and walked back towards the scene of the collision.

It is uncertain why the driver of the vehicle veered down the service road when there was no need. The driver was suffering from a number of medical conditions which resulted in her being tired and fatigued. At the time she offered an explanation that she had a blackout. Tests revealed she had a high level of codeine and morphine in her system. The medical evidence support she was probably taking therapeutic doses of panadeine forte, with the codeine accumulating in a patient on renal dialysis. Expert opinion, based on the evidence of her behaviour prior to and after the incident, supports a finding she did not suffer a blackout due to codeine toxicity.

It is possible the driver suffered a momentary loss of consciousness or fell asleep due to her tiredness and fatigue, but this remains uncertain. The driver has since died from her ongoing medical conditions.

Place of death – Redbank Plains Road REDBANK QLD 4865 AUSTRALIA

Date of death– 08 September 2015

Cause of death – 1(a) Head injuries

1(b) Motor vehicle accident

I close the inquest.

John Lock
Deputy State Coroner
BRISBANE
5 June 2018