IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2017 2623**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**MR PHILLIP BYRNE, CORONER**
Deceased:	**ERIC GEORGE FIESLEY**
Date of birth:	**27 MARCH 1949**
Date of death:	**5 JUNE 2017**
Cause of death:	**I (a) COMPLICATIONS OF MULTIPLE INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT**
Place of death:	**ROYAL MELBOURNE HOSPITAL**

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Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, PHILLIP BYRNE, Coroner having investigated the death of ERIC GEORGE FIESLEY without holding an inquest:
find that the identity of the deceased was ERIC GEORGE FIESLEY
born on 27 March 1949
and the death occurred on 5 June 2017
at the Royal Melbourne Hospital

from:

1 (a) COMPLICATIONS OF MULTIPLE INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT

Pursuant to section 67(1) of the **Coroners Act 2008** I make findings with respect to **the following circumstances**:

1. Eric George Fiesley, 68 years of age at the time of his untimely death, resided at 3/6 Amelia Court, Mildura. Mr Fiesley was retired, but was engaged in various community organisations, particularly Sunassist, an organisation providing services to the elderly and disabled in his local community. He was also on the Board of Directors at the Mildura Working Mans Club.

2. Mr Fiesley was a vastly experienced motor cyclist and member of the Ulysses Motorcycle Club.

3. Shortly after 10:30am on 8 May 2017 Mr Fiesley was riding his motorbike in a westerly direction along Fifteenth Street, Irymple towards Mildura. As he approached the intersection on Fifteenth Street and Sandilong Avenue, a motor car which had been driven in an easterly direction on Fifteenth Street by Mr Ian Lucas, a gentleman in his early 80's, executed a right hand turn from the right turn lane directly into Mr Fiesley's path of travel. Mr Fiesley had absolutely no opportunity to avoid the collision with the passenger side of Mr Lucas' car.

4. Mr Fiesley was conveyed by ambulance to the Mildura Hospital from where, late in the evening of 8 May 2017, he was transferred to the Royal Melbourne Hospital. On 5 June 2017, Mr Fiesley died due to the injuries sustained in the collision on 8 May 2017.

5. Mr Fiesley's death was reported to the coroner. On 6 June the case was presented to me. Having considered the circumstances and having conferred with a forensic pathologist, I directed an external only post mortem examination. Subsequently, Forensic Pathologist Dr Gregory Young provided a report in which he advised Mr Fiesley died due to:

> I (a) COMPLICATIONS OF MULTIPLE INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT.

Dr Young commented:

> *"Complications of the injuries seen in the deceased, particularly the rib fractures, may include pneumonia (chest infection), increased stress on the heart (including myocardial infarction), multi organ system failure, wound infection and development of deep vein thrombosis and pulmonary thromboembolism. The deceased had documented pneumonia, pulmonary thromboembolism and myocardial infarction."*

6. I asked that a coronial brief of evidence be prepared. Subsequently, in a timely manner, a brief prepared by Senior Constable Justin Poulton of Mildura Highway Patrol was lodged. The brief contains a number of statements. I have had particular regard to a statement provided to investigating police by Mrs Shirley Lucas, the wife of Mr Ian Lucas, who was a front seat passenger in the vehicle driven by her husband. Mrs Lucas stated that her husband came to a stop in the right hand turn lane prior to commencing the right hand turn. I include a short, pertinent excerpt from Mrs Lucas' statement; she said:

> *"There was no other traffic coming towards us, only the motorbike. That's why it seemed so clear. Ian didn't mention the motorbike, so I'm not sure whether he saw the motorbike or not. I don't know why I didn't mention it, by (sic) maybe I should've said there's a motorbike coming down the road."*

adding:

> *"I think Ian was just too slow doing that turn."*

I think Mrs Lucas' assessment is correct and conclude Mr Lucas just did not observe the approaching motorcycle.

7. Detective Sergeant Dr Jenelle Mehegan of the Major Collision Investigation Unit, an expert in motor vehicle accident reconstruction, advised her examination concluded Mr Fiesley was

travelling at "about 55 km/h" when his motorcycle collided with Mr Lucas' car. I add the police investigation determined there were no skid or yaw marks left by the motorcycle on the road surface. I conclude Mr Fiesley had no opportunity to brake.

8. At the conclusion of the summary in Senior Constable Poulton's coronial brief I noted a comment which led me to undertake some further investigation; Senior Constable Poulton opined:

> *"Police belive (sic) the collision and subsequent death could have been prevented, had LUCAS been compelled to undergo a medical review and pass an onroad assessment. New South Wales Roads and Maritime Services require drivers 75+ years to undergo a medical assessment every year. Drivers 85+ years are required to undergo a medical assessment each year* ***and*** *an onroad driving assessment every 2 years –"*

9. Included in the coronial brief was a short statement from Mr Lucas' general practitioner, Dr Nicholas J. Barker. In his statement, referring to Mr Lucas' medical conditions, I noted the following:

> *"Impaired visual acuity – Right 6/9, Left 3/60."*

As this information raised the spectre that due to impaired vision Mr Lucas did not see the approaching motorcycle ridden by Mr Fiesley. A footnote to Dr Barker's statement referred to letters from Dr V Grover, an Ophthalmic Surgeon. To explore this issue further I sought and received from Dr Barker's practice, Red Cliffs Medical Centre, Mr Lucas' medical records.

10. I refer in this formal finding to two particular letters from Dr Grover to Dr Barker, a letter dated 23 February 2017, a little over 2 months prior to the collision, and 1 September 2017, some 4 months after the collision. At the time of the February 2017 review by Dr Grover, it is stated Mr Lucas' vision is 6/12. In respect to the review of 3 August, Dr Grover wrote:

> *"Mr Lucas came for review on 31st August, 2017. He has longstanding problems of herpetic corneal ulcers and herpetic keratitis in the right eye and over the last few years has a few episodes of corneal oedema, losing his eyesight almost completely (my emphasis) and now the use of Zovrex ointment and Flarex drops gradually the cornea has by and large cleared up and there is no reaction to the anterior segment. Vision has improved to 6/9. Intraocular pressure is normal."*

11. In her statement Mrs Lucas said that while her husband couldn't read the paper, "his distance vision was fine." I note that Mr Lucas, who had held a licence for 63 years, had

never had an accident and presumably had an exemplary driving record, handed his licence in several days after this incident. It is a cruel irony that earlier in the morning of the incident, Mr Lucas had in fact been seen by Dr Grover, his ophthalmic surgeon.

12. Although I cannot definitively say that Mr Lucas' sub-optimal vision was a causal, or contributing factor in the collision (it may have been but a momentary lapse by an elderly driver), the circumstances suggest that is a distinct possibility. The issue of fitness of older drivers to continue to drive without some form of assessment after a certain age is somewhat controversial, with different regimes in various States. It also raises the thorny issue of requiring/mandating medical practitioners to refer a patient to VicRoads for a suitability to drive assessment when the patient's ability to drive may, in the opinion of the medical practitioner, be compromised by a medical condition.

13. The issue has relatively recently been the subject of coronial recommendations in this State.

14. Coroner Jamieson, noted that in her considered opinion, the self and community reporting model is "not entirely effective", primarily due to a reluctance of individuals to inform VicRoads of something that may result in their right to continue to drive being jeopardised. In her most recent finding on the issue, into the death of Pamela Louise Elsdon[1], delivered in September 2017, Coroner Jamieson, (referring to an earlier finding[2]), describes the legislative framework in place in Victoria. In that case, Coroner Jamieson made the following recommendation:

> *"I recommend that consideration be given by the Secretary of the Department of Economic Development, Jobs, Transport and Resources, and VicRoads, to adopting a framework requiring mandatory reporting to VicRoads when a medical practitioner forms an opinion that a person with a permanent or long-term injury or illness, is not medically fit to drive."*

15. I note that in a formal response VicRoads advised they do not intend to adopt Coroner Jamieson's recommendation, claiming there was no compelling body of evidence demonstrating that mandatory reporting by medical practitioners is more effective than the present self, community based reference model. In not adopting the recommendation it would appear reliance was placed also upon a notion that mandatory reporting jeopardises the doctor/patient relationship. In my not inconsiderable experience, it has been a family member who, often surreptitiously, formally raises with the authorities the concern regarding fitness to drive; this in turn can impact upon family/family relationships. I note the

[1] COR 2016 5554
[2] Finding without Inquest into the death of Nicholas Barry Carr – COR 2015 4295

department supported the VicRoads response, acknowledging that fitness to drive is an important policy area particularly given an aging population, warranting regular review.

16. In considering whether to make a formal recommendation, I look at the issue from a coronial perspective. My focus is on prevention, involving matters of life, or death. Furthermore, I do not view the prospect of mandatory reporting radical – it prevails in other States. I propose to adopt Coroner Jamieson's recommendation.

FINDING

17. I formally find Eric George Fiesley died at the Royal Melbourne Hospital on 5 June 2017 from complications of multiple injuries received in a motor vehicle collision which occurred at the intersection of Fifteenth Street and Sandilong Avenue, Irymple on 8 May 2017, when a motor car driven by Ian Lucas turned right directly into the path of the motorcycle being ridden in a westerly direction on Fifteenth Street by Eric George Fiesley, giving Mr Fiesley no opportunity to avoid a collision.

RECOMMENDATION

18. I recommend that the Secretary to the Department of Economic Development, Jobs, Transport and Resources, and VicRoads, develop a legislative framework which would require a medical practitioner to report to VicRoads when that practitioner forms an opinion that his/her patient has a medical condition that may render it inappropriate for the patient to continue to drive.

19. I direct that a copy of this finding be provided to the following:

    Ms Sharon Barber, Senior Next of Kin;

    Ms Kellie Gumm, Trauma Program Manager at the Royal Melbourne Hospital;

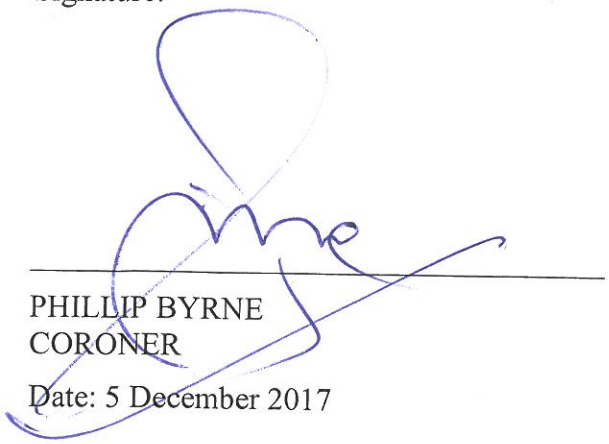
    Senior Constable Justin Poulton, Coroner's Investigator, Victoria Police;

    Transport Accident Commission;

    VicRoads; and

    The Secretary to the Department of Economic Development, Jobs, Transport and Resources.

Signature:



PHILLIP BYRNE
CORONER

Date: 5 December 2017