IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2016 5539

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

*Section 67 of the **Coroners Act 2008***

I, AUDREY JAMIESON, Coroner having investigated the death of JUNE SHIRLEY DANGERFIELD

without holding an inquest:

find that the identity of the deceased was JUNE SHIRLEY DANGERFIELD

born 28 May 1928

and the death occurred on 22 November 2016

at Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria 3052

from:

1 (a) MULTIPLE INJURIES (NECK, CHEST, ABDOMEN)

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

1. June Shirley Dangerfield was 88 years of age and was living independently in Balwyn at the time of her death. In February 2016, Mrs Dangerfield spent three weeks in Box Hill Hospital due to a bout of pneumonia. She spent a further six weeks in Peter James Rehabilitation hospital.

2. At a time prior to 4.00pm on 21 November 2016, Mrs Dangerfield left her home in her vehicle, a 2005 Toyota Corolla (TJN 287).

3. At approximately 10.30pm, Mrs Dangerfield drove west on King Street in Templestowe. She failed to navigate a sweeping left hand bend in the road and crossed over a grassy embankment where the left wing mirror struck a sign and dislodged from her vehicle. Mrs Dangerfield continued crossing the eastbound lane and drove onto the footpath before hitting a tree in a head on collision.

4. Witnesses contacted Emergency Services; ambulance paramedics and the metropolitan fire brigade arrived shortly thereafter. Mrs Dangerfield was conscious and spoke to paramedics. Ambulance paramedics transported Mrs Dangerfield to the Royal Melbourne Hospital at around midnight.

5. In the emergency department (**ED**) Mrs Dangerfield was given an admission diagnosis of multiple injuries but she evidently felt little to no pain and was conscious. She suffered respiratory distress due to a collapsed lung, tachycardia and unstable blood pressure. Mrs Dangerfield was resuscitated in the ED and required ongoing blood products[1] and medication for blood pressure support.

6. Royal Melbourne Hospital medical practitioners identified that Mrs Dangerfield had suffered multiple injuries, including: a C2 vertebra fracture, liver lacerations and a large intra-peritoneal haematoma. After discussions with her family, Mrs Dangerfield was provided palliative care.

7. At 3.25am on 22 November 2016, Mrs Dangerfield was declared deceased.

INVESTIGATIONS

Forensic pathology investigation

8. Professor Stephen Cordner, Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VFIM**), performed an external examination upon the body of June Shirley Dangerfield, reviewed a post mortem computed tomography (**CT**) scan and referred to the Victoria Police Report of Death, Form 83.

[1] Components of blood, including platelets and plasma, which is provided in the form of transfusions.

9. Professor Cordner identified a number of injuries upon external examination, including: right periorbital haemorrhage, various bruises including bruises which indicated Mrs Dangerfield wore a seatbelt at the time of the collision, and swelling in both legs indicative of oedema.

10. Toxicological analysis of post mortem blood detected medication associated with Hospital admission: ketamine[2] and lignocaine.[3] Analysis also detected doxepin at a therapeutic concentration (~0.2mg/L).[4] No ethanol or "alcohol" was detected.

11. Professor Cordner formulated the medical cause of Mrs Dangerfield's death as multiple injuries (neck, chest, abdomen).

Police investigation

12. Upon attending the site of the collision at King Street Templestowe, Victoria Police noted that the weather was inclement. Storms and heavy rain had led to power outages in the area and, as a result, the streetlights on King Street were not operational. Police officers noted that King Street is a winding road with a significant westerly, downhill slope. The posted speed limit sign was 70km per hour.

13. Senior Constable (**SC**) Steve Donlon was the nominated Coroner's investigator.[5] At my direction, SC Donlon conducted an investigation of the circumstances surrounding Mrs Dangerfield's death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by witness to the collision Emma-Jane Clark, General Practitioner Dr Neil Cameron and Detective Sergeant of the Major Collision Investigation Unit (MCIU) Christian Lyons Von Tunk.

14. In the course of the investigation, police learned that Ms Clark had seen Mrs Dangerfield driving erratically prior to the incident. At approximately 10.20pm, Ms Clark drove southward on Victoria Street in Doncaster with passenger Collin Furphy. Mrs

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[2] An anaesthetic normally used for short and medium duration operations as an induction agent.

[3] A local anaesthetic often administered to patients prior to surgery or during resuscitation attempts.

[4] A medication used to treat depression. Therapeutic post mortem blood concentrations are known to range up to ~0.8mg/L.

[5] A Coroner's investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the Coroner to assist the coroner with his/her investigation into a reportable death. The Coroner's investigator receives directions from a coroner and carries out the role subject to those directions.

Dangerfield's vehicle swerved onto the wrong side of the road and Ms Clarke had to take evasive action to avoid a collision. They noticed that a small, elderly lady was driving the car and the interior light was on inside the vehicle.

15. Ms Clarke stated that she performed a u-turn to follow Mrs Dangerfield, who continued to drive erratically and swerved onto the wrong side of the road once more. Mrs Dangerfield stopped her car for a red light at the intersection of Victoria Street and George Street. She continued on to the intersection of Victoria Street and King Street where she stopped her car in the middle of the intersection. Mrs Dangerfield then turned left onto King Street from the centre lane, instead of the dedicated slip lane.

16. Ms Clarke and Mr Furphy followed Mrs Dangerfield on King Street at approximately 60km/h. They witnessed further erratic driving and so Mr Furphy contacted emergency services immediately prior to the collision.

17. Senior Constable Brenton Goodall was a first responder at the scene of the collision. He provided a statement to the Court which documented a conversation between an ambulance paramedic and Mrs Dangerfield. Mrs Dangerfield told the paramedic that she had been driving '*all day*' looking for petrol. When asked if she could have gone home, Mrs Dangerfield replied '*I was looking for home*'.

18. Dr Cameron stated that he first saw Mrs Dangerfield in April 2011 at the North Balwyn Medical Clinic. Despite a number of medical conditions and issues, Dr Cameron stated that Mrs Dangerfield managed independent living very well with some assistance from her family. She also was part of the clinic's walking group which clinic Nurse Fran Plant also attended. Ms Plant would periodically and unofficially update Dr Cameron about Mrs Dangerfield's health. Mrs Dangerfield reliably attended her clinic appointments and appointments with health specialists.

19. On 9 March 2016, Dr Cameron said that he requested an Occupational Therapy Driver Assessment by VicRoads after Mrs Dangerfield's treatment for pneumonia was completed. He was concerned about her capacity and was not prepared to declare Mrs Dangerfield *'fit to drive'*. Dr Cameron stated that, after he filled out the obligatory VicRoads form, Mrs Dangerfield was informed that her licence was temporarily suspended but Dr Cameron did not receive any official correspondence.

20. Dr Cameron said that he assumed Mrs Dangerfield did not pass the assessment as she requested to re-attempt the driving test. On 6 June 2016, another VicRoads assessment request form was filled out. Dr Cameron could not recall the outcome precisely but recalled that specific conditions had been placed on Mrs Dangerfield's licence following the assessment. Once again, he did not receive any official correspondence in relation to the assessment nor the results.

21. Dr Cameron commented that the opacity of the assessment process was highly unsatisfactory. He stated that the '*imperfect science of "fitness to drive" is plagued by problems and has been a concern across the board for general practitioners over many years. Without a coordinated approach from all agencies involved, little will change.*'

Further Investigation

22. In light of Dr Cameron's statement, I requested a statement from VicRoads to address: why Mrs Dangerfield's driver's licence was initially suspended, on what basis it was restored and whether there were any conditions associated with her restored driver's licence.

23. VicRoads Manager of Medical & Driver Reviews Serge Zandegu responded with a detailed chronology of VicRoads dealings with Mrs Dangerfield between 21 March 2016 and the date of her death. Mr Zandegu created the response with reference to records kept by the State of Victoria Roads Corporation.

24. On 21 March 2016, the Roads Corporation received a medical report from Dr Cameron which indicated that Mrs Dangerfield was not fit to drive. Dr Cameron wrote that Mrs Dangerfield was not fit to drive in light of a recent episode and he recommended an occupational therapy driving assessment. Dr Cameron advised the Roads Corporation that Mrs Dangerfield suffered congested cardiac failure, osteoporosis, and had a recent episode of confusion due to sepsis.

25. On 24 March 2016, the Roads Corporation sent Mrs Dangerfield a Notice of Variation of her driver licence with the condition that she only drive with an occupational therapist and/or occupational therapist for her driving assessment. Mrs Dangerfield was told to provide the report within eight weeks.

26. On 16 May 2016, the Roads Corporation received an occupational therapy driving assessment report from Ms Amber Barclay dated 30 April 2016. The report noted a number of concerns, including: failure to turn at an intersection where a traffic light was amber, two occasions of incorrectly driving through a roundabout, failure to recognise an intersection and intervention of the occupational therapist to avoid hitting a curb.

27. On 24 May 2016, the Roads Corporation informed Mrs Dangerfield that she required a further occupational driving assessment for consideration of a local area licence. She was granted four weeks to provide the second report.

28. On 15 June 2016, the Roads Corporation received a further medical report from Dr Cameron dated 6 June 2016. The report advised that Mrs Dangerfield was not fit to drive due to a number of medical conditions. However, Dr Cameron also indicated that Mrs Dangerfield had recently overcome a serious illness and she was fit to undergo further driving assessment.

29. On 27 June 2016, Mrs Dangerfield had a second occupational therapy driving assessment. The assessment was for an unrestricted driver's licence and Mrs Dangerfield failed the assessment due to a number of errors, including: late indications, turning from the incorrect lane, lack of observation of a one way lane in a car park and she was slow to merge and drive at same speed as other vehicles on the freeway. The occupational therapist had to intervene to avoid an unsafe lane change on the freeway. The occupational therapist recommended that Mrs Dangerfield be reassessed for a local area licence.

30. The Roads Corporation reviewed Mrs Dangerfield's assessment report and determined that she ought to have lessons with an occupational therapist, prior to undergoing further assessment. On 13 July 2016, the Roads Corporation advised Mrs Dangerfield that the current conditions would remain on her licence and that she needed to have further lessons prior to attempting the assessment for a third time.

31. On 5 September 2016, the Roads Corporation received the third occupational therapy driving assessment report in relation to Mrs Dangerfield since March that year. The report stated that she had a 'satisfactory' assessment for a local driver's licence. The occupational therapist stated that Mrs Dangerfield's driving had improved after the lessons she had taken. However, the occupational therapist recommended the following

conditions were placed on her licence, Mrs Dangerfield: may only drive within a 5 kilometre radius of her home, must not drive at night, may only drive a vehicle with automatic transmission and undergoes a further occupational therapy driving assessment in 12 months' time.

32. The occupational therapist's recommended conditions were added to Mrs Dangerfield's licence, and she was notified by the Roads Corporation on 8 September 2017. The conditions took effect as of 13 September 2016. Additionally, Mrs Dangerfield was informed that she would be required to provide an updated medical report in September 2017 and that, based on the contents of that report, a further driver's assessment may be required.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death:

1. Mrs Dangerfield was witnessed driving erratically and dangerously for several minutes prior to the collision with the tree on King Street in Templestowe. She told an attending paramedic she had been in the car for a long period as she was unable to locate a petrol station or her home.

2. Mrs Dangerfield was considered unfit to drive by her general medical practitioner. On two occasions, Dr Cameron reported his concerns about her capacity to VicRoads. Dr Cameron stated that the opacity of the assessment process had been frustrating and he was not aware that Mrs Dangerfield had been provided with a conditional driver's licence. Dr Cameron was also not aware that his patient would be required to undergo further medical assessment in one year's time to ascertain whether another occupational therapy driver's assessment was warranted.

3. In response to a number of previous coronial findings[6] relevant to fitness to drive and the inadequacy of a self-reporting model, Executive Director Access and Operations Anita Cunrow provided a detailed outline of activities that VicRoads would undertake in 2018 to improve the existing system within which concerns about fitness to drive are reported.

[6] COR 2016 5554, COR 2016 4011, and COR 2016 5554.

4. Acting Secretary of the Department of Economic Development, Jobs, Transport and Resources Gillian Miles[7] similarly described a range of activities being undertaken by Transport for Victoria[8] aimed at developing evidence to inform policy in this area.

5. The immediate surrounding circumstances of Mrs Dangerfield's death highlight that a regular general practitioner is best placed to shed light on their patient's fitness to drive. The circumstances of Mrs Dangerfield's death, and Dr Cameron's comments about the frustrations of general practitioners, may inform VicRoads and Transport for Victoria in relation to their activities to improve the existing system within which concerns about fitness to drive are reported.

6. I keenly await the reports from VicRoads and Transport for Victoria as to the outcomes of their activities.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendations:

1. With a view to promoting public health and safety through an improved model for fitness to drive assessments, **I recommend** that, in the course of their current review, VicRoads and Transport for Victoria consider a mechanism for providing feedback to reporting General Practitioners.

[7] Dr Gillian Miles is now the Head of Transport for Victoria.

[8] The statutory office that, as of April 2017, is responsible for road safety legislation and regulation.

FINDINGS

The investigation has identified that Mrs Dangerfield caused the collision with the tree due to her poor and dangerous driving. Additionally, the investigation has identified that Mrs Dangerfield failed two occupational driving assessments for an unrestricted licence before receiving a satisfactory report subsequent to a third assessment for a conditional licence.

I accept and adopt the medical cause of death formulated by Professor Cordner and I find that June Shirley Dangerfield died from multiple injuries (neck, chest, abdomen).

Pursuant to section 73(1A) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

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

Robyn Williamson
Transport for Victoria
VicRoads
Transport Accident Commission

Signature:

AUDREY JAMIESON
CORONER
Date: **30 July 2018**