Court Reference: 4776 / 2006

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of SCOTT PEOPLES

Delivered On:	11 October 2010
Delivered At:	Shepparton
Hearing Dates:	26 and 27 August, 25 September, 2008 30 November, 1 and 2 December, 2009
Findings of:	GERARD ROBERT BRYANT
Representation:	Jane Dixon SC with Esther James for the Peoples Family Mr Barrett for the Blay family Mr Wraight for Vic Roads Ms Greenham for Chief Commissioner of Police Mr Mueller for Cycling Victoria
Place of death:	Maroondah Highway, Merton, Victoria 3175
PCSU	
Counsel Assisting the Coroner	Mr John Goetz - Counsel Assisting

Court Reference: 4776 /2006

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

In the Coroners Court of Victoria at Shepparton

I, GERARD ROBERT BRYANT, Coroner

having investigated the death of:

Details of deceased:

Surname: PEOPLES

First name: SCOTT

AND having held an inquest in relation to this death on 26 and 27 August, 25 September, 2008, 30 November, 1 and 2 December, 2009

at Shepparton

find that the identity of the deceased was SCOTT PEOPLES

and the death occurred on 15th December, 2006

between the 157 and 158 kilometre posts on the Maroondah Highway, Merton, Victoria 3715

from 1a. MULTIPLE INJURIES SUSTAINED IN A MOTOR VEHICLE ACCIDENT (CYCLIST)

in the following circumstances:

INTRODUCTION

1. Scott David Peoples ("Peoples") was 20 years of age at the time of his death. He was a promising young cyclist who would ride between 600 to 800 kilometres a week when in training. He was familiar with the roads around Euroa and Merton and would often train by himself on these roads, riding up to 100 kilometres a day[1].

[1] Exhibit 51 statement of Shane Peoples

2. He had accomplished a great deal in cycling for someone so young. His father Shane Peoples, informed the police that earlier in 2006 he was selected to ride with the Victorian Institute of Sport. Tragically, 2 days after his death his family received notification that he had been accepted to ride with a professional cycling team in Europe in 2007. He would never fulfil that dream.

3. On 15 December 2006 at approximately 8.00am Peoples arrived in Euroa for a training ride that would take him to Merton via the Euroa Merton road to the Maroondah Highway, at this intersection he travelled south. The road between the 157 and 158 kilometre post is a straight stretch of road with an overtaking lane for south bound traffic.

4. The road is slightly uphill but there is no impediment to field of view from the beginning of the overtaking lane to where the road merges into a dual carriageway near the Merton gap. The road is paved bitumen and had a paved shoulder either side which is approximately 2 metres wide. The shoulder is delineated from the road by a solid white line.

5. On the same day Kenneth Charles Blay ("Blay") left his home in Borambola, near Wagga Wagga NSW at around 6.40 am. Blay who was 73 years of age, was driving his white Nissan patrol and was the sole occupant of the vehicle. He was intending to visit his grandchildren in Warrandyte Victoria.

6. At approximately 10.10 am at a point 560 metres south of the 158 kilometre post, Peoples was struck from behind by the vehicle driven by Blay. Damage to Blay's vehicle was observed to the front left hand side of the vehicle and in particular to the bull bar and the headlight.

7. The force of the collision propelled Peoples 30 metres from the point of impact. The pathologist that conducted the post mortem examination commented that, *"The nature and severity of the injuries were such that death would have occurred almost instantaneously following impact"*. All efforts by Blay and passing motorists and emergency personnel that later attended, were unsuccessful in reviving Peoples.

8. Blay was spoken to by police at the scene and later at the Yea hospital. He stated to police that at no time prior to the collision did he see Peoples. He stated that he knew that a collision had occurred due to the noise of the impact.

9. The police investigation was assigned to Senior Constable Rachelle Weidemann, ("Weidemann") from the Benalla Traffic Management Unit ("BTMU"). Her work was supervised by a Sergeant Wittingslow ("Wittingslow") from the same unit. Following further police investigation, Blay was charged and pleaded guilty to one count of careless driving. Blay did not appear at the Mansfield Magistrates Court on 1 August 2007, where he was fined $1287 with statutory costs of $38.70. He was disqualified from driving for a period of 3 years.

10. On 29 May 2007, a decision was made not to hold an Inquest into the death of Peoples by the State Coroners Office ("SCO"). The family of Peoples sought a review of that decision, and on 21 December 2007 a decision was made to hold an Inquest, based on the material contained in the Inquest brief prepared by Weidemann from the BTMU.The first mention prior to the inquest being held took place at the Shepparton Coroners Court on 19 February 2008.

JURISDICTION

11. This inquest was commenced before the commencement of the Coroners Act 2008. It was not completed until after the new Act had come into force. In accordance with Schedule 1 clause 7 of the transitional provisions contained in the 2008 Act, the old act continues to apply to this inquest. The findings from this inquest are however to be deemed to be findings made under section 67 and 68 of the new Act.

12. Deaths required to be reported to the coroner are set out in the *Coroners Act 1985 (Vic)*[2]. There is no issue that Peoples death was sudden and unexpected and unnatural and the direct result of injury and therefore a reportable death.

13. S19(1) of the Coroners Act 1985 sets out the matters a coroner must find if possible when investigating a reportable death. The section provides that:

> (1) A coroner investigating a death must find if possible-
>
> (a) The identity of the deceased; and
>
> (b) How death occurred; and
>
> (c) The cause of death; and
>
> (d) The particulars needed to register the death under the Births, Deaths and Marriages Registration Act 1996

Section 19 (2) contains a power for the coroner to make 'comments' on matters connected with the death in the following terms:

> A coroner may comment on any matter connected with the death including public health or safety or the administration of justice

Section 21 (2) contains the power for a coroner to make recommendations on matters connected with the death:

> A coroner may make recommendations to any minister or public statutory authority on any matter connected with a death which the coroner investigated, including public health or safety or the administration of justice.

19(1) (a) Identity of the deceased

No issue was raised during the Inquest as to the identity of Peoples

19(1) (b) Cause of death

This paragraph is usually interpreted as meaning the "medical" cause of death. No issue was raised during the Inquest as to the cause of death noted by the pathologist.

19 (1) (c) How death occurred

It is the interpretation of this section which has been the major focus of the Inquest, and was the subject of an appeal to the Supreme Court by the Chief Commissioner of Police, which was withdrawn before the issues could be decided by that Court.

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[2] See Sections 3 and 15 Coroners Act 1985 (Vic)

This section is generally interpreted as requiring a coroner to find the facts and circumstances surrounding the death whilst ensuring that the coroner contains the investigation and subsequent findings to those matters which fall within the description of being sufficiently proximate to and connected to the death.[3] What is sufficiently proximate to or connected with the death is sometimes difficult to ascertain during the running of an inquest, and often much evidence is heard before a coroner finally decides on those questions that have arisen when findings are made.

14. In discharging my statutory obligation under section 19 (1) (b) it is useful to start with an appraisal of the police investigation into Peoples death.

POLICE INVESTIGATION

Investigation of the crash scene

15. Weidemann arrived at the crash scene at approximately 10.50 am. She took photographs and measurements of the scene[4]. The vehicle driven by Blay was assessed by police and no mechanical fault was found which could have contributed to the accident.[5]

16. The Major Collision Investigation Unit ("MCIU") were informed of the collision by Sergeant McRae from Eildon police who had also attended the scene. The collision did not meet the criteria for mandatory attendance by the unit outlined in the Victoria Police Manual.[6] Whilst the unit did not attend the actual crash scene, a member from the unit did assist Weidemann with her investigations of the collision in the ensuing period after the collision.

17. Weidemann forwarded to a Sergeant Bellion ("Bellion") at the MCIU by email, an incident fact sheet, a traffic incident report and a smart roads sketch plan.[7] Based on this information Bellion was able to estimate the speed of Blay's car at the time of impact to be 73 km/hr. No photographs of the crash scence were provided.

18. In evidence at the inquest Weidemann stated that the road appeared straight from the 158 kilometre post onward, and that there were no substantial crest or undulations in the road over that distance to where the collision occurred some 560 metres south of that post.[8]

19. Weidemann also agreed that a driver driving in the direction of Blay would have had at least 500 to 600 metres of umimpeded vision.[9]

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[3] Militano v State Coroner [Unreported 18.12.92 SC Vic 10162/1991 per Hayne JJ]; Chief Commissioner of Police v Hallenstein [1996] 2 VR 1 ; Clancy v West [1996] 2 VR 647; Harmsworth v The state Coroner {1989} VR 989

[4] T p 29 - 30

[5] See statement of Sergeant Steven McRae dated 18 /02/07 and statement of Senior Constable Karabatsos dated 1/1/07

[6] See Exhibit P 10

[7] T39 and T 542 and 543

[8] T62

[9] T 62 and 75

20. Weidemann spoke to a witness at the scene, Mr Bruce Borchardt. He stated that he did not see where on the road the collision had occurred. He said that at the time of the collision he was travelling 100 metres behind Blay at a speed of 100 km/hr and was gaining on Blay.[10] In a subsequent statement made to New South Wales Police[11], he stated, "There *was hardly any traffic on the road and it was a clear sunny day. The visibility was good. I had driven through some smoke earlier however; there was no smoke at this section of the highway".*[12]

21. Further statements obtained by police and included in the inquest brief, confirm there was good visibility in the area of the collision.[13]

22. In a summary prepared by Weidemann,[14] she stated that, *"after inspecting the collision scene, taking measurements and photographs, and taking into account witness accounts to the collision, an exact point of impact cannot be established".*

23. Weidemann stated that[15] if Peoples had been travelling on or to the right of the white edge line, the strong easterly wind may have caused Peoples to have unexpectedly moved by the wind into the path of the approaching traffic. If Blay was travelling to the right or left of the line she states that Blay had said that he may have been checking to see if the right lane was clear for him to merge as he was overtaking lane was soon ending, this may have caused him to take his eyes from the road ahead. Fatigue was also considered as possible factor.

24. Weidemann stated that overriding all those possibilities and taking into account the location of the collision, the traffic and weather conditions at the time of the collision, a reasonable and prudent driver should have seen Peoples riding his bicycle on the roadway ahead. This chain of reasoning led to the charge of careless driving being laid against Blay.

25. During the course of the inquest Bellion was provided with photographs of the crash scene and made a further statement dated 15 September 2008. Bellion gave evidence that whilst his speed estimate would not change, he was now able to identify a point of impact. He indicated that the accident occurred in the shoulder just to the left of the white line.[16]

26. Bellion also gave evidence that even if he had been provided with photos of the scene, and had determined that the accident had occurred inside the shoulder, that based on the information at

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[10] TT p 10

[11] See Exhibit 7

[12] Ibid

[13] See statement of Matthew Phillips dated 4 /01/07 where he states, *"Visibility was good and there was no smoke to talk about in the area of the collision and all the way from Mansfield"* and statement from Dane Hansen dated 09/01/07 where he stated, *"It was a perfectly clear day as we approached where there appeared to be something going on..I say this because of the way the cars were positioned. The road we travelling on was a straight stretch of road with no bumps or hills. There is a steady incline with two lanes, one for overtaking as you go up the hill".*

[14] Exhibit P51 Summary attached to inquest brief

[15] Exhibit P1 p17

[16] T p 581

the scene, without knowing about the drivers medical condition, it would have been classed as a careless driving incident and left to local police to investigate.[17]

Interview of Blay

27. At approximately 12.45 Senior Constables Weidemann and Skerritt, conducted an interview with Blay at the Yea hospital. The form of the questions, which were not tape recorded, was based on a guide issued by the MCIU.[18]

28. Weidemann spoke to Blay at the Yea hospital following the collision. She detailed the discussion in her statement tendered at the inquest. Blay stated the following:

a) described himself as a full licence holder with 52 years driving experience[19]

b) said that he did not see Peoples prior to the collision, and that otherwise he did not know how the collision occurred.[20]

c) described himself as being familiar with the road and location.[21]

d) said that he was driving at a reasonable speed in good road conditions, had plenty of sleep and that the condition of the vehicle was good.[22]

e) described himself as being in excellent health.[23]

f) described the scene as being smoke and wind effected.[24]

g) in answer to a question did he attend a doctor for any illness or complaint said that he was prescribed warfarin.[25]

h) described his eyesight as "All right" and that he had his eyesight checked about two and a half months ago.[26]

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[17] T p 554

[18] Exhibit P22

[19] Ibid page5

[20] Ibid pages 5,7 and 8

[21] Ibid page 5

[22] Ibid pages 7,10 and 11

[23] Ibid page 5

[24] Ibid page 6 and 7

[25] Ibid page 13

[26] Ibid pages 14 and 15

29. On the basis of the answers given by Blay and Weidemann's investigation of the crash scene[27], Blay was charged with careless driving. He was able to drive for almost 12 months after the death of Peoples, as he was not sentenced until 1 August 2007 and the three year loss of licence was stayed until 29 November 2007.

30. The original inquest brief provided to the coroner, and upon which a decision to hold an inquest was made, did not refer to an earlier accident involving Blay and another cyclist on 19 January 2004.

31. The original inquest brief included information on the medical background on Blay inclusive of his answers to Weidemann at the Yea hospital. Weidemann also gave evidence that she was told that Blay had undergone blood tests and an eye test and that he was fine.[28]

32. Medical records subpoenaed in the course of the inquest revealed that Blay suffered a stroke in late 2003 which resulted in a condition known as "hemianopia" which resulted in Blay loosing vision on the left side up to the mid line.[29]In effect he had no peripheral vision on the left hand side of his field of vision.

19 January 2004 Accident

33. Unknown to police at the time of interview, was the existence of an earlier collision involving Blay and another cyclist Stephen Plummer ("Plummer"). This collision occurred on the same road nearly 2 years beforehand.

34. A traffic incident report compiled by Senior Constable Gillard,("Gillard") of the Mansfield police at the time of the collision states:

> Vehicle 1 travelling in an easterly direction in bright sunshine. Bicycle rider approached a shadow over east bound lane from large tree. As both vehicle 1 and bicycle entered shadow vehicle 1 has made contact with bicycle and a collision has occurred dislodging bicycle rider. Vehicle 1 driver shaken but not injured. Bicycle rider wearing black bicycle outfit.

35. Blay was not charged with any offence arising from this collision. Gillard believed that whilst Blay was at fault there was no evidence that an offence had been committed.[30]He based this view on the following circumstances

a) No independent witnesses[31]
b) Plummer was riding in the car lane[32]

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[27] Ibid page 17

[28] T p46

[29] T p453 to 455 and see Exhibit P24

[30] T p 390 see also T p402

[31] T 390

c) Plummer was wearing dark clothing[33]

d) Plummer had entered a shadow cast by a tree on a sunny day just as the car in front of Blay goes from his shadow into the sun he (Blay) goes into the shadow with Mr Plummer and didn't see him.[34]

36. In a later statement obtained from the cyclist Plummer on 13 August 2008, he states:

> On Monday 19 January 2004 at about 3.45 pm. I was riding east along the Maroondah Highway about 4 kilometres west of Bonnie Doon. I was riding from Alexandra back to Mansfield. I was wearing predominately black and white lycra with a bright blue helmet. I had the sun behind me and it was a bright sunny day. There was no shade in that section of the road. That section of the road is narrow without a shoulder so I was keeping as far to the left hand side as possible without riding in the gravel. I was overtaken by one car and then struck from behind by another car. I believe the two cars were travelling very close together. The first car went past me and I was struck almost immediately by the second vehicle.

37. Evidence at this inquest was that:

a) Victoria LEAP system did not record the 2004 accident

b) The accident was recorded in the Traffic Incident System ("TIS") by Gillard.

c) At the time of the compilation of the original inquest brief Weidemann was unaware of the TIS entry.

d) The TIS system, which I will discuss in some detail later in this finding, was introduced in January 2006 to improve online management of collision reports. The TIS contains a search function which allows the user to search for accidents prior to 2006, which includes the January 2004 collision.[35]

e) The TIS was not developed as an investigative tool, and training was not given to police to use the system in this way, but it had the capacity to be used as an investigative tool.[36]

f) Police became aware of the earlier collision following information provided by Plummer to either Gillard or to a Sergeant Ross ("Ross") from Mansfield police.[37]

g) Ross accessed the TIS system on 11 August 2007 and passed on the information to Wittingslow who accessed TIS on 15 August 2007.[38] Wittingslow gave evidence that he

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[32] T 404

[33] T 442

[34] T 403

[35] See statement of Sergeant Cowan 13/08/08 (Exhibit p 42) and transcript ("T") at p644 and 645.

[36] T p 645 and 645

[37] See statement of Sergeant Ross dated 2 /12/09 (Exhibit P50)

[38] Ibid

visited Weidemann at her home some time in August or September 2007 and told her about the earlier accident.[39]Subpoened records from the TIS indicate that Weidemann accessed TIS on 19 February 2008.

Blay's medical condition

38. Medical records subpoenaed for this inquest indicate that on or about 15 September 2003 Blay suffered a stroke whilst on holiday in Queensland. He was referred by an opthamologist to a neurologist Dr Saines. Visual field tests conducted in Queensland on 15 October 2003 showed Blay had a profound visual defect and had lost his vision on the left hand side up to the mid line.[40]

39. In lay terms as I understood the evidence of Dr O'Dell[41], an expert witness called in this inquest, ordinarily people have a field of vision of 180 degrees from left to right. This field of vision is made up of a combination of vision from both eyes which are combined in the brain to provide the field of view. Each eye has one half that provides peripheral vision to the left and one half of each eye provides peripheral vision to the right.

40. The left hand side of each eye is wired to a particular part of the brain and conversely so is the right side of each eye. In a stroke where there is damage to one particular half of the brain the corresponding sides of each eye suffer a loss of vision. As Dr O'Dell stated, *"So if a person has a stroke on one half of the brain at the back which is where the vision is then you very characteristically lose half the vision. So half the vision from the midline from one side to the other is gone. That usually is not that obvious to the person. They don't actually see a big black mark on one said. They can actually see, they have a blind spot".*[42]

41. In a letter from Dr Saines to a Dr Blomley dated 16 October 2003 which confirmed the visual defect on examination. The letter says, "I *assume the stroke is due to embolism from his arterial fibrillation and he will need to supervise his warfarin dose more closely...Unfortunately I doubt he will be able to return to driving in the future unless there is further improvement in his vision*".[43]

42. Blay was referred to Guide Dogs Victoria for an optometric examination on 10 December 2003.The testing which utilised the Goldman Chart test revealed that Blay's vision was more than 120 degrees along the horizontal. He could see the full field range in his left eye and had a defect in the upper part of the left side of the vision in his right eye.[44] Dr O'Dell reviewed the results and agreed that given the results, Blay would have had an acceptable field of vision for driving. If such a test had been presented to Vic Roads Blay would have been permitted to drive.[45]

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[39] T 691

[40] T 453 to 455 and exhibit P24

[41] Senior forensic physician with Victorian Institute of Forensic Medicine, medical advisor to Vic Roads for 10 years

[42] T 109

[43] T111

[44] See Exhibit P37

[45] T509 and see also p492 and 493

43. None of this information was disclosed to police by Blay following the first accident in January 2004 or the subsequent collision in December 2006.

THE ISSUES ARISING FROM THE FACTS

44. A number of issues can be distilled from the above facts which require consideration by the coroner in this inquest. They are:

A. The adequacy of the police investigation
B. The desirability of mandatory reporting and the efficacy of suspension procedures for impaired drivers
C. Cycling safety on rural and regional roads

A. The Adequacy of the police investigation

45. The family of Peoples have raised a number of concerns and criticisms of the police investigation for the consideration of the coroner. Those matters raise can be briefly summarised as follows:

a) Failure to compile an accurate Accident reconstruction diagram and provide photos of the crash scent to specialist police at MCIU resulting in errors being made in regard to the level of Blay's culpability.

b) Failure to inquire into other potential causal factors other than the roadworthiness of the vehicle.

c) Failing to properly investigate the circumstances of the collision to adequately reconcile the wide variance in accounts on the prevailing climatic conditions and field of vision provided by witnesses and Blay.

d) Failure to inquire further into the medical condition of Blay given the answers provided in his interview at the Yea hospital.

e) Failure to identify the 19 January 2004 collision before a decision was made to charge Blay with careless driving.

f) The Failure to disclose to the coroner relevant information in a timely manner.

The family of peoples also allege that certain members of the police delayed advising the coroner of the circumstances of the earlier collision involving Blay until after an earlier decision to conduct an inquest had been reversed. I will endeavour to address the concerns raised by the family in sequence.

a) Failure to compile accurate accident reconstruction diagram and provide photos of the crash to MCIU

46. The brief compiled by police in relation to both the criminal charges and the coronial inquest, was undertaken by Weidemann. The police brief was checked by her superior Sergeant Wittingslow the head of the BTMU. The brief in turn was approved by Acting Inspector Anthony Hill.[46]

47. Weidemann had been a police officer since 2002 and had been gazetted to the BTMU in August 2006.[47] She stated that she had investigated 20 to 30 traffic matters involving serious injuries but had not investigated a fatal traffic matter.[48]She conceded that she did not have any knowledge concerning accident reconstruction and accident depreciation.[49] She stated that she was aware that the MCIU have ways and means of establishing impact points.[50]

48. Weidemann was unable to explain how on a Vic Roads diagram[51] compiled by her, that the point of impact had the bicycle to the right of the white line dividing the carriageway from the shoulder.[52] Exhibit 47 titled Incident Report included a diagram drawn by Weidemann. The diagram identified the point of impact as being to the right of the white line dividing the shoulder and the lane Blay was travelling in. Weidemann understood that Bellion would rely heavily on an impact point in his calculations.[53] She conceded however that she did not know where the impact point was.[54]

49. Wittingslow accepted that he performed a supervisory role over Weidemann.[55]To what extent that supervision took is unclear, but there was no evidence of any direct intervention at any stage in the investigation process by him.

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[46] T p 27and T p 687

[47] T p 24

[48] T p 25

[49] T p 31

[50] T 34

[51] Exhibit P4

[52] T p38

[53] T p 40

[54] Ibid

[55] T p 693

50. We now know that after Bellion was provided with the photos, that he was able to determine the point of impact as being within the shoulder.[56] Bellion stated that this fact in the absence of knowing Blays medical condition would not have changed his view of Blays culpability.[57]

51. Weidemann on the other hand, gave evidence that if she had known that Peoples had been struck within the shoulder of the road, she would conclude that Blay was either in the shoulder or partially in the shoulder of the road.[58] As a consequence she stated that it would perhaps lead her to believe that he may have fallen asleep.[59]It follows that if fatigue had been a factor then the level and complexion of Blays criminal culpability would be greater.

Conclusion

52. The assumption made by Weidemann, and by necessary inference her supervisor Wittingslow, that Peoples was travelling to the right of the white line dividing the shoulder from the carriageway that Blays vehicle was travelling in had no basis in fact.

53. No reasonable or adequate explanation was offered by police for this error. The point of impact was determined without much difficulty once photos were provided to Bellion at the MCIU. This information was only provided to Bellion during the running of the inquest after Blay had been dealt with by the Courts for the charge of careless driving.

54. The suggestion that wind or inattention by Peoples because of the use of an iPod, may have contributed to the collision has no basis. There is no evidence that Peoples course deviated in any way. The suggestion by Counsel for Blay that Peoples may have been resting under the shade of a tree shortly prior to impact, has little credibility given Peoples elite status as a cyclist, nor would it be relevant given the known point of impact.

55. This error occurred because of Weidemann's lack of experience in accident reconstruction. It was compounded by her supervisor's failure to adequately check the facts upon which her conclusions were drawn.

56. By correctly identifying the point of impact, considerable doubts concerning the veracity of Blay's account should have been raised. It follows from the known evidence that Blay was travelling at 70 km/ph and given the location of the panel damage to his car along the left hand side,[60] that Blay's vehicle was straddling the dividing line. If Blay had been travelling in his lane no impact would have occurred.

57. These facts, combined with evidence that it was a bright clear day, with visibility on Weidemann's own account of 500 to 600 metres, with no visual impediments on the road, should have led to further inquiries being made. The start of those enquiries would be why Blay was

[56] T p 581

[57] T p554

[58] T p 73

[59] Ibid

[60] T p 551

travelling so slowly in a 100km/ph zone and why he was driving so far to the left of the carriageway.

58. The point of impact would not have been the sole determining factor leading to further questioning of Blay. It was however, an important and material fact that should have led to a chain of inquiry beyond the limited questioning of Blay at the Yea hospital.

b) Failure to inquire into other potential causal factors other than the roadworthiness of the vehicle

59. The evidence before the police before Blay was charged was never confined to the roadworthiness of Blay's motor vehicle. It is evident from the course of the police investigation that some consideration was given to other possible causes for the collision. This is evident from the type of questions asked of Blay during an interview at the Yea hospital.

60. Blay maintained at all times, both at the scene, and during the interview that he did not see Peoples prior to the impact. This explanation was never subject to any level of scrutiny, by reference to the objective evidence of what colour clothing Peoples was wearing and the clear visibility on the day.

61. No questioning in regard to the existence of previous accidents or his attitude to cyclists was considered, in order for them to be excluded as possible motivating considerations.

c) Failing to properly investigate the circumstances of the collision to adequately reconcile the wide variance in accounts on the prevailing climatic conditions and field of vision provided by witnesses and Blay.

62. Blay stated in his interview with Weidemann and Senior Constable Skerritt, that visibility was pretty low grade at the time of the collision, that he could only see 100 metres ahead.[61] He also stated that "you *had to be Johnny on the spot with all that smoke, there was a bit there because of the wind*".[62]

63. This evidence was directly at odds with the accounts provided by Borchardt, Hansen and Phillips, that visibility was good. Weidemann agreed that there was good visibility some 500 to 600 metres prior to the collision point. Skerritt gave evidence that on the day that you would expect to see a cyclist one kilometre ahead unless they were in the shadow of a tree.[63] He agreed that before he went to the Yea hospital that he knew that he had a cyclist being struck on a clear day on a straight stretch of road.[64]

[61] See Exhibit P1 page 11

[62] Ibid page 6

[63] T p 92

[64] T 93

64. Even allowing for a slight change in climatic circumstances from the time of the collision to the time Weidemann and Skerritt arrived, the objective evidence was that visibility was good and was not impaired by smoke.

Conclusion

65. It is generally acknowledged that it is undesirable to cross examine a suspect during a police interview, as it may give rise to concerns about fairness, and the voluntariness of answers given[65]. That is not to say however, that police do not frequently raise during questioning, a competing version of events and ask the suspect to comment on it. No such technique was used, nor was any puttage undertaken. No effort was made to confront Blay, and ask him to reconcile his version of the climatic conditions with their own, or from the information obtained at the scene from the various witnesses.

66. It may well have been seen as unsympathetic in the circumstances, given the tragedy that had just occurred. If that was the case, then a follow up interview should have been conducted at a more suitable time.

67. Simply accepting Blay's evidence at face value on this point, by not asking any further questions demonstrated a lack of basic police investigative skills. This error in methodology further compounded the erroneous assumption made by police at the time, as to the point of impact.

d) Failure to inquire further into the medical condition of Blay given the answers provided in his interview at the Yea hospital

68. The format of questions used in the interview of Blay followed a prepared format formulated by the MCIU. There was no apparent departure from the prepared questions, or attempt to clarify evasive or ambiguous answers.

69. By way of example Blay told police that he was in excellent health.[66]yet the answer to the question immediately before this question, revealed that for Blay it had been, "a *hell of a year. I've been in hospital in Wagga, hospital in Melbourne, hospital in Brisbane. Three to four times in previous years*".[67] No questions were asked as to why he was admitted, or how it was that he could maintain the assertion that he was in excellent health with a history of so many hospital admissions.

70. Later he is asked, *Do you attend a doctor for any illness or complaint*? His answer was *I'm supposed to go get Warfarin, it thins your blood. I only go when I have to.*"[68] No attempt was made to explore with Blay why he was receiving such medication.

71. Blay told police that his eyesight was all right, and that he had his eyesight checked about two and a half months ago.[69] Given what both Weidemann and Skerritt knew about the climatic

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[65] See *R v Amad* v[1962] VR 545 but see also *R v Clarke* (1997) 97 A Crim R 414 per Hunt CJ at 419

[66] See Exhibit P1 page 5

[67] Ibid

[68] Ibid page13

conditions, in the context of Blay's explanation that he did not see Peoples, it was surprising that he was was not asked any further questions concerning his visual health.

72. Weidemann was aware that Blay had undergone blood and eye tests and that the results were fine.[70]It is true that neither Weidemann or Skerritt had any medical training and could not be expected to know that the eye tests conducted by Yea hospital staff were deficient in that Blay was tested for acuity and not field of vision.[71]

73. This knowledge in regard to the eye testing, in the context of Blay's answers that he was in good or excellent health, was enough for the police not to take the matter any further that day by way of questioning or subsequent investigation.

Conclusion

74. In drawing any conclusions from these facts, it is useful to bear in mind that Blay's real state of health was not then known to police. It would be unfair to judge the quality of the police interview solely with the benefit of hindsight.

75. Taking into account that necessary concession, it must be said that the questioning of Blay was unnecessarily rigid and formalistic, and displayed a lack of basic intuition. The interviewing members at times were given answers that were in direct contradiction to previous answers or were evasive. Other answers were at odds with the independent facts, such as the prevailing climatic conditions. None of Blay's responses led to any questioning of a probing nature.

76. The questioning of Blay was inadequate and lacked any forensic purpose beyond the formula of pro forma questions prepared by the MCIU. If the members involved were too inexperienced to conduct such an interview, then it was the responsibility of their supervisors to rectify the obvious inadequacies. This was not done, nor was any concession made by the police that the questioning was flawed or inadequate. This in my view demonstrates a disturbing lack of professional judgment on the part of the police members..

e) Failure to identify the 19 January 2004 collision before a decision was made to charge Blay with careless driving.

77. The accident involving Blay and the cyclist Plummer was entered onto the TIS system by Gillard.

78. TIS was not developed as an investigative tool, although it could be used in that way. Weidemann undertook a search to ascertain if Blay had any convictions in other States or Territories.[72]She also conducted a search of the LEAP system on 16 December 2006.[73] She did not

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[69] Ibid page 15

[70] Ibid page 16

[71] See Dr O'Dell at T106,107,108 and 532

[72] T p 8

[73] T p p 37

interrogate the TIS system until 19 February 2008.Her supervisor Wittingslow has accessed the TIS on 15 August 2007.

79. Weidemann had not been trained in the use of TIS as an investigative tool at the time of the collision or at the time the brief recommending careless driving charges was compiled. TIS data cannot be accessed at a crash scene unlike LEAP.[74]

Conclusion

80. Given that Weidemann had not received any training in the use of TIS as an investigative tool at the relevant time of the collision and when compiling the police brief, it is not surprising that the details on the TIS were overlooked.

81. No criticism of the individual police members could be warranted in these circumstances. The problem was more systemic in nature and related more to the original intended application of TIS, and the role out of training of police members in it's use.

f) The Failure to disclose to the coroner relevant information in a timely manner

82. The responsibilities of the coroner were described in the case of *R v Coroner for North Humberside; ex parte Jamieson:*[75]

> It is the duty of the coroner as the public official for the conduct of inquests, whether he is sitting with a jury or without, to ensure that the relevant facts are fully, fairly and fearlessly investigated. He is bound to recognise the acute public concern rightly aroused where deaths occur in custody. He must ensure that the relevant facts are exposed to public scrutiny particularly if there is foul play, abuse or inhumanity. He fails in his duty if his investigation is superficial, slipshod or perfunctory. But the responsibility is his. He must set the bounds of the inquiry. He must rule on the procedures to be followed.

83. The coroner is by law an inquisitor, and the evidence produced and witnesses called should be based on the coroners decision on what is expedient to examine. It is a fact finding role, which in the phase before an inquest is held, requires the coroner to search out and become aware of relevant and irrelevant information.[76]

84. As a matter of practice, coroners are frequently assisted by police in their investigative role. Typically, members of the police force prepare an inquest brief for the coroner containing all relevant information to assist the coroner in the discharge of their functions under the *Coroner Act.*

85. This role is governed in part by s 18 A of the Police Regulation Act 1958 which provides:

> S18A The Chief Commissioner of Police shall direct that a sufficient number of members of the police force be present at any place at which an inquest may be held (whether or not an inquest is being held) whenever a coroner so requests.

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[74] T 396 674

[75] [1995] QB 1 ; (1994) 3 ALL ER 972

[76] *Maksimovich v Walsh* (1985) 4 NSWLR 318, 342

S 14(2) of the Coroners Act provides:

> A member of the police force who has information relevant to an investigation relating to a reportable death or a reviewable death must report it to the coroner investigating the death.

86. The role of police in this process is not a static one, and does not cease with the submission of the inquest brief. It is not uncommon for example, for a coroner once a brief is received, to issue directions for the gathering of further evidence as may be expedient in the circumstances of the case in question.

87. The task of assessing relevance or irrelevance of the evidence is the sole preserve of the coroner, and not investigating police or other agencies that may be called upon to assist with a coronial inquiry. The obligation to disclose relevant information as it comes to hand is an ongoing one and such information must be forwarded in a timely fashion. This is particularly the case where the provision of such information may have a direct bearing on the decision to hold an open inquest.

88. In this case we know that the existence of an earlier accident involving Blay and a cyclist came to light when the cyclist Plummer spoke to police following an article appearing in a local paper regarding the death of Peoples on or around August 2007.

89. It is not relevant whether the cyclist Plummer spoke to Gillard or a Sergeant Ross ("Ross") first. The reality is that Ross accessed TIS on 11 August 2007 and passed the information to Wittingslow, who in turn accessed the TIS on 15 August 2007. It is accepted that Weidemann was on maternity leave at this time. Wittingslow did visit Weidemann at her home and inform her of that information, he estimated that it would have been in August or September 2007.[77] He also stated that he had a conversation with her and explained to her what I'd found and, "*she in turn notified the coroners office at some point in time down the track*".[78]

90. Gillard gave evidence that he became aware of the connection between the death of Peoples and his own investigation into the collision between Blay and Plummer when told by Ross.[79]He did not make any special appointment to meet Plummer after this information was received, but ran into Plummer by coincidence.[80]

91. Gillard said in evidence that when he received the information from Ross, that he believed that it was just an unfortunate coincidence for Peoples and Blay, "*well, unfortunate certainly for Mr. Peoples, certainly, and unfortunate for Mr Blay being involved in two collisions*".[81]

92. Gillard was then asked to respond to the following proposition:[82]

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[77] T p 691

[78] T 688

[79] T p416

[80] ibid

[81] T 417

[82] ibid

> But did you think it was something that needed to be notified to the State Coroners Office or to the coroner?...In relation to my collision?..In relation to the coincidence of you having investigated an earlier collision involving the same driver in extremely similar circumstances?...Should I notify the coroner? No it didn't come to my mind.

93. Wittingslow accepted that he was Weidemann's supervisor, and during the time that she was on maternity leave, is taken to have assumed responsibility for the gathering of relevant information for the coronial investigation.[83]

94. It is important to bear in mind that as at 29 May 2007 a decision had been made by the State Coroners Office "SCO" not to hold an open inquest. A letter was sent by SCO to the solicitors acting on behalf of Peoples on 25 September 2007 informing them of that decision. In those circumstances, whilst an inquest would occur it would proceed as a chambers finding relying on the contents of the inquest brief.

95. Wittingslow agreed that from September to December 2007 he had not notified the Coroners Court of the information that he had about Blay's earlier accident.[84]

96. Wittingslow gave evidence that when he received information from the Mansfield police, he accessed the TIS entry and had a conversation with Gillard. He then stated in evidence before the inquest,

> In speaking with Senior Constable Gillard, ascertaining the exact circumstances as he had them, in relation to the accident, and knowing quite in depth, I guess the circumstances of surrounding the accident Senior Constable Weidemann was investigating, I formed no nexus between the two at all, and didn't feel the necessity, I guess, for Paul (Gillard) to do anything more than what he had done....

97. Wittingslow was then asked by the me this question, "*And you didn't think that there was anything that warranted any further investigation, or that there was any nexus which may give rise to a need to look at the matter in any further detail*". He responded;[85]

> No I didn't Your Honour, and the reason I didn't, I guess, is that in relation to the first accident that Senior Constable Gillard attended and investigated, he conveyed to me that the circumstances of that accident were that the rider of that pushbike was wearing dark clothing, had come out of a shadow of a tree into the bright sunlight, and it was at that point that Mr Blay had hit the rider from behind. And those circumstances certainly weren't evident at the accident that Senior Constable Weidemann attended. I'll grant it I was astounded by the coincidence. Don't get me wrong, I did find it extremely bizarre but in the cold hard of day, looking to the facts of each one, I really couldn't establish that there was any particular nexus between the two, just one of those very strange coincidences and bizarre coincidence. He further added... In the cold heart of day when you look at them individually I still couldn't form that the two – other than, yes they've both hit cyclists from behind, both within at a guess 30 kilometres apart, but it was a route that Mr Blay had travelled on many occasions...[86]

98. Wittingslow also agreed that he did not disclose the earlier accident to the Peoples family solicitors, despite agreeing that it was possible he had told then that he would not leave any stone

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[83] T 694

[84] T 694 pp13- 16

[85] T 689- 690

[86] T 690

unturned in the investigation of Scott Peoples death.[87] He also agreed that it was possible that the family may never have learned of this information had it not been for the submissions made on their behalf to the Coroners Court asking for the matter to be a matter of open inquest.[88]

99. Following on from the decision to hold an open inquest into the death of Peoples in December 2007, a directive was sent by the coroner to the then counsel assisting Sergeant Porter from Shepparton prosecutions to investigate Blay's past driving history and medical background.

Conclusion

100. The question of the relevance of the earlier incident to the coroners investigations in regard to the death of Peoples was not a decision that should have been made by Wittingslow or any other police member.

101. The process of reasoning employed to arrive at the conclusion that the two collisions were nothing more than *bizarre coincidences* was seriously flawed, and must call into question the professional judgment of Wittingslow as head of the BTMU.

102. As a matter of common sense, when the same motorist runs down from behind and seriously injures one cyclist, and kills another 23 months later on the same road 16 kilometres apart,[89] in bright sunshine, questions need to be asked. They were not.

103. The decision by Gillard not to take any steps to notify the SCO or the coroner was inexplicable, and in no way justified by his position in the investigative hierarchy. Whilst it is the case that Gillard had no role in the investigation of Peoples death, the obligation to disclose relevant information to the coroner in a timely manner is the duty of every police officer, not just the informant in charge of the inquest brief.

104. Wittingslow arrived at the conclusion that the two collisions were nothing more than "*very strange coincidences*", based on the information provided by Gillard and Weidemann. No effort was made to talk to Plummer or Blay about the circumstances of the collisions. Had Wittingslow talked to Plummer about the incident he would have been given a different version of the collision that must have given rise to questions about Blay's conduct.

105. Irrespective of the divergence on accounts provided by Plummer and the investigating officer Gillard, a basic enquiry of Plummer would have cast doubt on the version of events contained in the TIS, which stated that Plummer had emerged from the shadow of a tree, when he was hit by Blay. Plummer noted in his statement that was obtained by police on 13 March 2008, that, *"I had the sun directly behind me and it was a bright sunny day. There was no shade on that section of the road".*[90]

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[87] T 695

[88] T 696

[89] See Gillard evidence T 404 and Weidemann P1

[90] See Exhibit P28

106. Wittingslow took no steps to exclude other competing scenarios that arose from the two incidents. No enquiry was made of Blay as to his attitude toward cyclists, in order to exclude a malevolent motive. No further consideration was given to other possible explanations for the two collisions, the most obvious being medical impairment.

107. I therefore reject as entirely fanciful the assertion made by Wittingslow, that given the facts of the earlier incident, that there was anything that warranted any further investigation or that there was any nexus which may give rise to a need to look at the matter in any further detail. Indeed, Wittingslow's position appears even more difficult to reconcile, given the fact that ultimately the existence of the earlier collision was brought to the attention of the coroner. If it was just a "*bizarre coincidence*" why disclose it at all?

108. Wittingslow and Weidemann at the time that they became aware of the earlier incident in August or September 2007, must have also been aware that the coronial inquest had not concluded. Given the decision of SCO not to hold an open inquest was communicated to the parties on or about 25 September, it is a fair and reasonable inference, that both Wittingslow and Weidemann at that stage, were content for an inquest to be concluded in the absence of the information surrounding the earlier incident.

109. Wittingslow conceded as much in cross examination:

> And you gave every assurance the matter would be fully investigated?..well yes, I certainly would, yeah. And prior to December 2007 at no stage did you inform Mr Peoples or his solicitors about the information you had regarding Mr Plumber and the earlier accident?,..No I didn't And as far as they're concerned they may never have learned of that information had it not been for the submission that were made on their behalf to the Coroner's Court asking for the matter to be a matter of open inquest after all. They may never have learned of this information?..Well I guess that's a possibility.[91]

110. No rational explanation has been offered for the failure to disclose to the coroners office the existence of the earlier incident from the date Wittingslow became aware of it on 15 August 2007 to the date it was brought to the attention of the coroner at the first mention of the Inquest in Shepparton on 19 February 2008. A time when an open Inquest was forgone conclusion. Importantly, that information was not made available to the coroners court when a reconsideration of the decision not to hold an inquest was made on 21 December 2007.

111. The inescapable conclusion to be drawn therefore, is that Wittingslow as the office in charge, and Weidemann failed in their duty to the coroners court to disclose highly relevant information in a timely fashion. The motivation being, that the discovery of this information which was not known at the time Blay was charged with careless driving, would give rise to serious questions about the quality of the initial police investigation and the level of competence of the police members involved.

112. This was a lamentable course of action for the police to have adopted, given the conclusions reached earlier in this inquest. In particular, given the lack of training, and the lack of knowledge relating to the use of TIS as an investigative tool, there was no basis for criticism of the investigating police due to their failure to become aware of the earlier incident either at the time Blay was interviewed or charged.

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[91] T p 695 - 696

Mandatory reporting and the medical condition of Blay

113. In order for the this inquest to consider the issue of mandatory reporting of impaired drivers, it is necessary to find that at the relevant times that Blay was driving a motor vehicle that he was impaired, and that had that impairment been known to the authorities, that he would have been prohibited from driving.

114. I do not propose to repeat the facts outlined under the heading Blay's medical condition referred to earlier in this finding. The first question that must be asked is whether I am satisfied, applying the requisite standard of proof,[92] that Blay was visually impaired at the time that he hit both Plummer and Peoples.

115. That task involves in part, an endeavour to reconcile the various medical reports concerning Blay's visual health, with his age and lifestyle, and the manner in which he was driving his motor vehicle at the relevant times.

116. It is clear given the contents of the report from Dr Saines dated 16 October 2003 that Blay would not have been fit to drive at that time. The issue that arises is trying to reconcile that test result with the later test result using the Goldman chart test in December 2003 which indicated that Blay's field of vision had improved.

117. In assessing the outcome from this test it is useful to consider again Dr O'Dell's evidence and his interpretation of the results. Dr O'Dell explained that the two tests employed different methodology. The test conducted in October 2003, was called a threshold test. This test was described as being a more sensitive test, and focuses on the dimmest light a person can perceive.[93]

118. The Goldman chart test is performed using a bright target which moves. Dr O'Dell explained that with this testing, there is always the possibility of the subject not fixing their eyes on the target during the testing. This is particularly the case if the subject is not being closely observed by the clinician performing the testing.[94]

119. Dr O'Dell also made reference to two later tests performed in June 2007 and 2008 which tested Blay's field of vision and revealed a further deterioration in Blay's field of vision from the threshold test conducted in October 2003.

120. On 27 June 2007 in a letter from the Croydon Eye Clinic, the testing revealed that Blay had a left homonymous hemianopia, which means loss of vision on the left side of both eyes.[95] This test was the closest in time to the collision with peoples in December 2006.

121. In trying to reconcile the Goldman test result with the October 2003 results and the latter test results in 2007 and 2008, the Dr O'Dell had this to say:

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[92] See *Briginshaw v Briginshaw* (1938) 60 CLR 336;*Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1 ,19 per Hedigan J

[93] T p 461

[94] T T p 461- 462 and T p 485 and p 539

[95] T p 491

Well I think the only possibility might be that this gentleman wasn't fixing his eyes on a fixed target during the test. The Goldman's not as sensitive to people who don't fix properly, whereas the computerised test will detect that and in print it out. This one is a combination of a much brighter and moving target, and also you don't get quite as good a guarantee that the person's got his eyes fixed on the target all the time. When asked why some one may do that he replied: Well they may not understand the instructions. Some people find it hard...It's remarkable how many people have trouble staring at a fixed point, and then trying to perceive something in the periphery. So it's actually not easy to do, and it maybe that – you know, that the subject just found it hard to concentrate. If you see – or if you get a hint of something moving out in the periphery, the instinct is to go and look at it.

122. In a letter from the Blackburn South Eye Clinic in May 2005, where a Dr Campbell talked about cataract surgery. He says *"The patient has no idea what a cataract is, and has no understanding of the procedure or possible risks".*[96]

123. There was a suggestion by treating doctors of Blay in October 2006 that he may have suffered a further minor stroke in September 2006.[97]Notes from a general practitioner dated 21 September 2006 state, *"eyes very poor, right retinal hole fixed, known to have cataracts..cataracts right and left... refer Dr Conrad".*[98]

124. On 2 October 2006 in a further letter between doctors treating Blay it was noted, *"he has been told he has cataracts, and his vision has worsened recently. This is a major concern of his and he has an appointment to see Dr Conrad".*[99]

125. All of these reports opined Dr O'Dell, were consistent with a worsening eye problem.[100] He further observed, *"He wouldn't have been to see an eye doctor if he didn't think he had problems with his vision".*[101]He further added that he did not consider an improvement in December 2003 to be the most likely scenario.

126. We also know that Blay hit two cyclists, one in January 2004 and Peoples in December 2006, both cyclists were travelling to the left side of Blay's peripheral vision. In regard to the collision on 19 January 2004, the cyclist Plummer in his evidence said that following the accident, *"he (Blay) made comment that other passengers in his car had commented at times that he did drive too close to the left hand side of the road".*

127. Blay on the latter occasion was travelling at 70 km/ph in a 100 km/ph zone, and that the point of impact was to the right of the dividing line between the shoulder and the left lane his vehicle was travelling in.

128. Blay's representatives argued that the results of the Goldman chart test provide, clear, unqualified evidence of Blay's capacity to drive. They further argued Dr O'Dell's views were

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[96] T p 141

[97] T p 487

[98] T p 489

[99] T p488

[100] T p141

[101] T p 141

qualified, and lacking in any definite conclusions concerning his eyesight at the relevant time of the collision.

129. It is true that there are was no contemporaneous testing of Blay's peripheral vision at or close to the time of the collision, but this does not in my view prevent findings being made on the basis of necessary inference and the objective facts in this case.

Conclusion

130. I am satisfied that as a result of a stroke in September 2003 Blay suffered a profound defect resulting in the loss of peripheral vision on the left hand side up to the mid line of both eyes.

131. Blay would not have been aware of the loss of peripheral vision to the left. He would be able to see the road ahead but would not be aware that he could not see things off to the left.[102] It is unclear whether he appreciated the extent of his visual problems, as evidenced by his ignorance of cataracts and the procedures involved in their removal.

132. There exists a documented decline in his cognitive functioning, since the stroke. It is also apparent that Blay viewed his worsening eye problems as a major concern. It is evident given the sheer quantity of appointments with eye specialists since September 2003 that their concerns were explicitly made known to him.

133. Blay would have appreciated that a loss of licence would have resulted in a significant loss of independence for him. He resided in a remote rural location and was reliant on a motor vehicle for his mobility. He would have appreciated at the time the Goldman chart test was administered that failure of this test would result in all likelihood of his licence.

134. There is insufficient evidence to conclude that Blay wilfully cheated the Goldman chart test administered by Guide Dogs Victoria, by moving his eyes or head to pin point the moving bright light, thus producing false positive results. As Dr.O'Dell commented it may also be due to an inability to concentrate on an object or to follow instructions. The nature of the testing does allow for real questions about its reliability and accuracy to be raised.

135. The results from the Goldman chart testing are irreconcilable with previous and subsequent testing of his field of vision following the collision. Those tests are more rigid and allow for false positives and negatives. In short there is little room for subject error or operator inattention playing a part in the outcomes. The visual field impairment identified in September 2003 showing significant visual field defects detected by sensitive computerised testing, were still evident on testing by the opthamologist Dr Cheah in 2007.[103]

136. I am satisfied on the material and evidence before me in this inquest, that both Plummer and Peoples were struck by a motor vehicle driven by Blay because he could not see them due to the absence of left side peripheral vision. That condition had not improved since his stroke in September 2003.

[102] T p 118

[103] T p 478

137. Blay continued to drive knowing of medical concerns about the absence of left side peripheral vision and the gradual deterioration of his eyesight generally due to cataracts and a retinal tear.[104]

138. It follows, that I reject any suggestion that either Plummer or Peoples, or environmental conditions, contributed in any way to the collision with the motor vehicle driven by Blay.

Mandatory reporting

139. There is obviously a jurisdictional issue that arises from the facts in this case, given that Blay was licensed in the State of New South Wales. The initial advice that he received not to drive a motor vehicle came from a doctor in Queensland, and he was regularly driving to see relatives in the State of Victoria.

140. These issues may effect the practical application of any recommendations that may be made in this inquest, but they do not in my view, preclude a consideration of the issue of mandatory reporting.

141. There is scope for a great deal of speculation, on what may have occurred had there been mandatory reporting, which may have led to the suspension or cancellation of Blay's licence before December 2006.

142. On one view, if the collision involving Plummer had been investigated more thoroughly, police may have uncovered Blay's medical history and alerted NSW authorities to conduct a medical review.

143. If there had been a national mandatory requirement on doctors to report people unfit to drive, then Blay's condition would have come to the attention of the NSW Road Traffic Authority ("RTA") and in all likelihood his licence would have been cancelled, and he would not have been driving on Victorian roads in December 2006.

144. From a legal perpective this chain of reasoning is remote, but it is not difficult to sympathise with the family when they speculate on what could have happened had Blay taken himself off the road or had been forced to surrender his licence due to medical impairment.

The system in Victoria

145. Victoria does not at present have a mandatory requirement to report people who may be impaired to the extent that they are unsafe to drive a motor vehicle to the relevant licensing authority.

146. The current regime for reporting medical impairment is as follows:

Road Safety Act 1986

[104] T p 489

S17 A Obligation of road users

(1) A person who drives a motor vehicle on a highway must drive in a safe manner having regard to all the relevant factors, including (without limiting the generality)

(g) physical and mental condition of the driver

(3) A road user must – (a) have regard to the rights of others road users and take reasonable care to avoid any conduct that may endanger the safety or welfare of other road users

S 27 Power of Corporation to require tests to be undergone

(1) The Corporation may require a relevant person to undergo a test to determine-
(a) If the person is unfit to drive motor vehicles or a category of motor vehicles; or
(b) If it is dangerous for the person to drive motor vehicles or a category of motor vehicles; or
(c) Whether any driver licence or permit held by the person should be subject to conditions and, if conditions are to be imposed, the type of conditions to be imposed.

(2) For the purposes of subsection (1), the person may be required to under go-

(a) A test in relation to the person's fitness, including a test in relation to the person's health or medication the person is taking and it's effect on the person's ability to drive; or
(b) A test in relation to the person's competence; or
(c) Any test the corporation considers necessary and appropriate in the circumstances.

(3) If the Corporation requires a relevant person to undergo a test-

(a) The test must be carried out-

(1) By a person of the class prescribed in relation to that class of test; and
(2) In accordance with any relevant guidelines; and

(b) The use of results of the test by the Corporation to determine a matter referred to in subsection (1) must be in accordance with any relevant guidelines

(4) No action may be taken against a person who carries out a test under this section and who expresses to the Corporation an opinion formed by that person as a result of the test.

(5) No action may be taken against a person who, in good faith, reports to the Corporation any information which discloses or suggests that a person is unfit to drive or that it may be dangerous to allow that person to hold or be granted a driver licence, a driver variation or permit.

Road Safety (Drivers) Regulations 2009

Regulation 67 Change of personal particulars or condition

(1) A holder of a driver licence or a learner permit must notify the Corporation of any change to the person's personal particulars or the person's address for service of notices if this is different from the person's residential address within 14 days of the change

Penalty: 3 penalty units

(2) If a holder of a driver licence or learner permit, or a person who is exempt from holding a driver licence or learner permit under regulation 17, is affected by a permanent or long term injury or illness that may impair the person's ability to drive safely, the person must, as soon as practicable after becoming aware of the injury or illness, notify the Corporation about it.

Penalty: 3 penalty units

Vic Roads submissions

147. The Coroner has had the benefit of comprehensive submissions from Vic Roads and the Chief Commissioner of Police on the subject of mandatory reporting as it relates to medical practitioners and police.

148. The Vic roads submissions may be usefully summarised as follows;

(1) The current system employed in Victoria works well. It places on motorists a mandatory obligation on motorists when told by medical practitioners not to drive to notify Vic Roads.
(2) Reporting by medical practitioners is regular, and practitioners regularly contact Vic Roads and the Victorian Institute of Forensic Medicine ("VIFM") for advice.
(3) In States and Territories where there is mandatory reporting of impaired drivers there is no appreciable difference in crash rates.[105]
(4) Vic Roads has developed an education program for medical practitioners which reminds them of their obligation to report drivers who continue to drive against advice. Vic Roads also is involved in continuing education programs designed to educate and assist practitioners.[106]

Dr O'Dell's evidence

149. Dr Morris O'Dell gave evidence at this inquest on 27 August 2008 and 30 November 2009. He is a senior forensic physician with the VIFM, and frequently consults with Vic Roads and

[105] T p 515

[106] T p 115-116 and 510- 516

provides advice in relation to drivers who are under review. He opposed the introduction of mandatory reporting on the following basis:

(1) Cases such as the one before the inquest are rare.[107]
(2) Mandatory reporting encroaches on the trust developed in the doctor patient relationship.[108]
(3) Mandatory reporting may also impede the proper medical management of a patient if the patient refuses/neglects to inform a doctor of a relevant condition.[109]
(4) Mandatory reporting may encourage doctor swapping or shopping.[110]
(5) No medical organisation is in favour of compulsory reporting.[111]
(6) Victoria has an efficient system to identify people who may be impaired from driving.[112]
(7) Victoria has a lower death rate for older drivers despite not having mandatory reporting.[113]
(8) Mandatory reporting may encourage a large number of unnecessary referrals.[114]

Research on mandatory reporting

150. In 2003 the Victorian Parliament Road safety report into road safety for older road users. The view taken by the committee was that,

> *"The Committee does not support the introduction of mandatory reporting by health professionals of unsafe drivers in Victoria, but encourages the professions to adhere to public safety ethical principles".[115]*

151. These findings were supported by the Government of the day and peak medical bodies.[116]

152. The research and findings of the Monash University Research Centre,[117] into elderly drivers, fitness to drive and mandatory reporting[118] do not support the introduction of mandatory reporting.

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[107] T p 503 and see T 120 also

[108] Ibid

[109] T p 506

[110] T 504

[111] T p 524

[112] T 126 and 512

[113] T 126

[114] Tp 514

[115] See pp 84- 5 Victorian Road Safety Report into road safety for older drivers

[116] Australian Medical Association (vic), Optometrists Association of Australia (Vic) and the Royal College of Surgeons road trauma committee, RACV and Victoria Police

[117] T 511

[118] T 515 and 512

153. The National Transport Commission Interim review report looking at the issues of assessing fitness to drive and mandatory reporting raised concern that where mandatory reporting does exist in South Australia and the Northern Territory, that those governments review those requirements.[119]

The Coroners Prevention Unit report

154. In order to assist the inquest on this issue and the issue of cycling safety, a report was commissioned by the newly formed Coroners Prevention Unit ("CPU").

155. As the report notes, the challenge in considering any change to the current system is to accommodate acceptable risk while balancing the societal and individual need for driving mobility.[120]

156. In regard to self reporting, the Victorian Parliamentary Inquiry into road safety of older road users, self reporting by drivers was concluded as *"largely ineffective despite the legal requirements in place"*. (Parliament of Victoria 2003).[121] Drivers are often unable to judge their own level of impairment and have a vested interest in retaining their licence for mobility, independence, employment factors and social interaction.

157. The report states that no studies were identified which evaluated the efficacy of mandatory reporting systems through measuring the incidence of motor vehicles associated with medically unfit drivers. There was no indication that South Australia and the Northern territory experience fewer road crashes implicating medically unfit drivers under mandatory reporting arrangements, compared to other Australian jurisdictions.

158. The Victorian Ombudsman identified in 2007 that Vic Roads did not capture data on the number of licences suspended for medical conditions and the correlation between specific medical conditions and road crashes and thus could not identify or monitor trends.[122]This is due to insufficient collection and analysis of data to identify road crashes where medical conditions may have played a role.[123]

159. At present there is no publicly available documenting of the possible under reporting of individuals in South Australia and the Northern Territory.[124]

Submissions by the family of Scott Peoples

160. The family argue that the facts of this case demonstrate that without mandatory reporting, it is far from certain that seriously impaired drivers will ever come to the attention of licensing

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[119] See Coroners Prevention Unit Report dated 31 December 2009 annexed to this finding.

[120] Ibid p 5

[121] Ibid p 8

[122]Brouwer, G E (2007). Investigation into Vic Roads driver licensing arrangements: Ombudsman Victoria,

[123] CPU Report p 16 pp 2.5.1

[124] CPU Report p 15 pp 2.4.3

medical review bodies. A mandatory scheme, it was argued, would oblige police and health professionals to report drivers where they form a reasonable belief that a driver has impaired driving capacity.[125]

161. It was argued that if such a scheme existed in 2004, it is probable that Scott's death would not have occurred. Certainly, they argue that Blay's capacity to drive should have been assessed after the death of Scott Peoples.[126]

162. The family propose a three part medical review scheme:

a) **Mandatory reporting obligations on police and health care professionals** who form a reasonable belief that a driver suffers an impairment that renders them unsafe to drive

b) **A rebuttable presumption of unfitness to drive for specific high risk conditions**, where the onus shifts onto drivers to take steps to show that they are fit to drive; and

c) **An age based driver licence review scheme** that requires older drivers to have a medical assessment form completed by their regular general practitioner before renewal of their driving licence, at regular intervals after an agreed age, enabling the driver licensing authority to require further assessment of identified issues.

d) **Complementary statutory amendments,** such as the power to be given to police to suspend a driving licence, where police believe the driver is unfit to drive due to incapacity or impairment.[127]

Chief Commissioner of Police submissions

163. Police opposed mandatory reporting for medical practitioners and police of impaired drivers. The arguments against mandatory reporting mirrored those of Dr O'Dell, and reiterated the position that there was no evidence that the introduction of mandatory reporting would improve public safety, but rather it may diminish public safety.

164. Police argued that the current guidelines[128] for police and the legislative protections under s 27 of the Road Safety Act are sufficient to ensure that impaired drivers are not a danger to other road users.

165. It was also argued that there would be a real risk of overloading the system, if police, who are not medically trained, were mandated to report people involved in relatively minor collisions.

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[125] Peoples Family submissions p 13 pp 28 and 29

[126] Ibid p14

[127] Ibid p14 pp31

[128]Exhibit P18 - Police manual clause 5.2 from VPM 110-3- where a police member believes that the holder of a driver licence or permit may be unfit to hold that licence or permit, they may either; a) request the driver to surrender their licence or permit to Vic Roads for cancellation or ; b) complete a Licence Review Request [Form 195] Seek advice from VIFM regarding whether a person is medically unfit to hold a licence or permit

Conclusion

166. The issue of mandatory reporting does fairly arise in the circumstances of the facts in this inquest. The issue needs to be looked at from two perspectives, firstly the philosophical argument for and against, and secondly the practical implications of the implementation of any such requirement to report.

167. Philosophically, at the heart of the argument is a conflict between the individual rights of the motorist, and the confidential relationship they enjoy with their doctor, against the concerns for public safety of having impaired drivers on our roads.

168. There can be no argument that where a motorist is aware, or if informed that they should not drive, that they have a moral obligation to themselves and to other road users not to drive. The issue becomes complex when they either choose to continue driving, or are unaware of the danger they pose and continue to drive, *and* that fact is known by their treating doctor.

169. At present, there is no legal obligation placed on doctors to inform the relevant licensing authority of that fact. It is not sufficient in my view, to avoid this issue by responding that the doctor was unaware or did not ask if the patient was still driving. It follows that any advice from a doctor not to drive must be followed by a question, *are you still driving a motor vehicle*? Advice from a doctor not to drive cannot be given in a vacuum, devoid of context.

170. If the answer to the question posed above is yes, then in my view it should be mandatory for the doctor to report the patient to the relevant licensing authority. The greater good is best served by protecting the public from such drivers, and not by permitting such drivers to continue to drive, protected by the cloak of confidentiality.

171. This approach is not to be seen as mandating doctors to conduct their own investigations, to satisfy themselves that their patient is not driving, but rather shifting the moral responsibility to the patient to do what is inherently right. Can it be said that a doctor has discharged his/her responsibilities to society by simply informing a patient not to drive?

172. There will always be a portion of impaired drivers who will continue to drive against advice. They may achieve this by avoiding doctors or under reporting their condition, but this reality does not detract from the responsibility to report impaired drivers who continue to drive against advice.

173. In practical terms, in the circumstances of this case, it would mean that Blay's general practitioner upon receipt of specialist advice that he not drive, should be required to ask Blay if he was still driving. If he was, then it ought to be mandatory to report him to the relevant licensing authority. It should not be sufficient to say he was informed that he should not drive and no further enquiry made.

174. The question of fitness to drive at first instance is a matter for independent clinical judgment. There is no merit in identifying categories of impairment, where reporting should be mandatory. There exists within the scope of most medical conditions too much variance in the severity of a diagnosed impairment, to avoid unfairness and arbitrariness with such a rigid categorisation of impairment.

175. The argument, that mandatory reporting will adversely affect the doctor/ patient relationship, has less weight when the ultimate decision to cancel a licence is made not by the treating doctor, but by a panel of medical specialists employed by the relevant licensing authority to whom the patient is referred to. This process is already in place under the current non mandatory reporting regime in Victoria.

176. The fact that Blay's a diagnosis medical condition which led to his impairment was made in Queensland, in circumstances where he resided in and held a licence in NSW, but regularly drove in Victoria, underline the need for a national approach to the licensing of all motorists. Uniform legislation and guidelines to prevent impaired drivers from continuing to drive on our roads is a paramount priority.

177. A motorist deemed unfit to drive, should not be able to avoid their responsibilities, by moving across State borders, or by relying on poor information sharing amongst doctors or relevant licensing authorities.

178. Whilst research and common sense would indicate the older we get the more likely it is we are to suffer from medical conditions that impact on the ability to drive a motor vehicle, Blay's age was incidental not determinative of the myriad of medical complaints he was suffering from.

179. Just as we cannot always judge a person's maturity by their age, nor could it be said with any degree of certainty, that the attainment of a particular age should determine compulsory medical testing. Such a requirement would be discriminatory, and in practical terms would have to be the subject of a rigorous cost benefit analysis before it was considered for implementation.

180. The question of mandatory reporting by police members is a more vexed one, as they are not medically trained, nor do they have the experience to always identify a scenario where an accident may have occurred as a result of a drivers medical condition.

181. Experience and professional judgment are key elements in the decision making process. The knowledge and confidence of more junior police to call upon the expertise of staff from MCIU and VIFM should be promoted and encouraged. There is no utility in mandating police to report drivers they believe may be unfit to drive, in the absence strong proof of impairment, by reference to a disclosed medical history, or the objective circumstances of the collision warrant further enquiry.

182. I am of the view that mandatory reporting by police of impaired drivers requires the officer to speculate rather than further investigate, which ought to be the preferred course.

183. In circumstances where objectively there does not appear to be any rational reason why a motorist did not see a pedestrian, cyclist ,object or other motor vehicle before a collision this scenario should start to ring alarm bells. Where the existence of a medical condition that may have caused or contributed to the collision cannot be excluded, police ought to have the power to either cancel the licence of the driver pending medical review, or alternatively apply to a magistrate for cancellation as a matter of priority pending medical review.

184. The current legislation allows a motorist to continue to drive until a review has been conducted, which potentially could have fatal or tragic consequences. In the circumstances of this case *had* Blay disclosed his hemianopia, he would still have been permitted to drive from the Yea

hospital. This is an unconscionable situation and can only be remedied by extending the power to cancel a licence expeditiously where reasonable grounds are demonstrated, to either police or the courts.

Cycling safety

185. The circumstances of the injury sustained by Plummer and the untimely death of Scott Peoples, does give rise to consideration of cycling safety. The reality is that cyclists share the road with motor vehicles and motor cyclists. It is an unequal relationship, because in the event of a collision it is the cyclist that will be injured or killed. This is irrespective of whether the cyclist or the motorist was in the right.

186. Cyclists are far more vulnerable than motorists, because they do not have the protection afforded by a car. They are also more vulnerable because in many instances, such as the circumstances in this case, they are travelling with their back to approaching traffic and must rely on the motorist to give them sufficient space to be passed safely.

187. As the CPU report noted:

> Being hit from behind by a motor vehicle travelling in the same lane is the most common type of collision among bicyclist fatalities. Cyclists in rural areas are considered at a greater risk of fatalities, with 65% of total fatalities occurring on rural roads (ATSB -2006). The most frequently assigned major factor in fatal collisions concerns visibility- the failure of cyclists and other road users to observe each other on the road (ATSB,-2006); (Watson & Cameron 2006)[129]

188. The obligation to use our roads safely is a mutual one, shared by cyclists and motorists alike. The special vulnerability of cyclists however, does place on motorists a responsibility to drive in a manner that will not put the lives of cyclists at risk. The challenge however is to foster this appreciation of the risk for the cyclist, without being seen to favour cyclists or risk motorists feeling like they are being asked to give up any existing entitlement.

189. The question therefore is how best to develop a greater level of universal empathy amongst motorists and cyclists. It is evident that there exists a measure of antagonism between motorists and cyclists, and a great deal more can be done to foster tolerance between the two groups.

Signage

190. The question of signage has been extensively researched in the CPU report, and I will not repeat in detail much of the reports contents. Road signage is designed to warn or guide road users of potential hazards and to regulate their behaviour. Research has shown that the true measure of a warning sign's effectiveness is not recall or recognition of a sign- rather, the extent to which the sign affects drivers preparedness for and subsequent responsiveness to hazardous events.[130]

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[129] Coroners Prevention Unit report 31 December 2009 p24 pp3.1

[130] CPU p 25 pp 3.3.1 and 3.3.2

191. According to the CPU, researchers have concluded that there is still large scope for significant improvement in road sign comprehension.[131] A number of different road signs are employed on roads to alert drivers to the presence of cyclists.[132] The responsibility for erecting signs rests with Vic Roads for arterial roads and freeways, whilst Local Councils are responsible for municipal roads.

192. Importantly, as the CPU report points out:

> The effectiveness of signs warning of the presence of cyclists may depend on the numerous factors as previously described, including the frequency of signage erected along roads; symbol/icon design; and individual factors that may influence a drivers comprehension/ attention level. Sign familiarity is dependent on the frequency of signage use, frequency of driving by an individual and local driving experience.
>
> Victorian signage is pictorial in nature and does not include abstract icons, a key factor to signage comprehension.[133]

Amy Gillett Foundation and Shepparton cycling club submissions

193. The Amy Gillett Foundation ("AGF") were invited to make submissions on the topic of cycling safety together with the Shepparton cycling club. The AGF echoed the need for strategies to have motorists and cyclists respect each others rights on the road and in particular to make motorists more alert to the increasing presence of cyclists on all of our roads.[134]

194. The Shepparton cycling club of which Peoples was a member made a number of points in their submissions which can be summarised as follows:

a) The data collected by the Australian Transport Safety Bureau indicate that cyclists make up 2 to 3 % of total road deaths in Australia.
b) Vic Roads data from an inquiry into rural road safety and infrastructure noted cyclists are involved in 4% of all country fatalities and 6% of serious injuries, although the figure is probably understated due to under reporting.
c) The death of Peoples highlights the need for more information relating to travel activity patterns of rural residents to enable an accurate assessment of exposure to crash risk.
d) Education is necessary to increase awareness of road user relationships to reduce conflict and incidents occurring.
e) That Local council promote greater cycling safety by:

    1) Improving road conditions by widening and re surfacing
    2) Provide more prominent signage on known cycling routes, and replace current signage with more prominent signage
    3) Provide specific signage indicating times the road is likely to be used by cyclists

[131] ibid

[132] Ibid p27,28 and 29

[133] Ibid

[134] Amy Gillett Foundation submissions to inquest undated p 3

4) The council to provide signage promoting its commitment to local cyclists

Peoples family submissions

195. The family of People's made a number of submissions in relation to cycling safety and awareness:

1) Signage and cyclist awareness campaigns need to focus on the vulnerability of cyclists, and place an onus on drivers to pay greater attention;
2) TAC have a mandate to promote road safety and prevent accidents.[135] The TAC should be invited to share statistical information, concerning accidents involving impaired drivers and cyclists.

Blay's submission

196. In submissions filed on behalf of Kenneth Blay (now deceased) it was argued that:

1) There must also be a duty of care upon a cyclist to take all reasonable steps to ensure the metre of separation ie the cyclist should have been riding his bicycle on the left hand side of the shoulder rather than almost on the white line.

2) Cyclists and pedestrians must be made aware of the enormous traumatic impact that will come upon a driver if he/she has had a collision with a cyclist or a pedestrian who suffers fatal injuries when the cause of the collision and the fatality rests solely with the cyclist or the pedestrian.

Vic Roads submission

197. It was submitted that there was no evidence in the inquest in relation to signage having any impact on this accident.

Conclusion

Signage

198. I had earlier ruled in this inquest before its concluded that cycling safety and signage may be an issue that is inquired into during the course of this inquest.

199. I accept that the question of signage and cycling safety does not directly arise necessarily from the facts in this case. As I have found before the power to make comment or recommendation

[135] Transport Accident Act 1986 [Vic], s 8 (d), s 12 (2)

on matters connected with the death should be broadly construed. The power of a coroner to make comment or recommendation on matters of public health or safety may have general application and need not be limited to the death which is being investigated.[136]

200. The Maroondah Highway where both collisions occurred, was not a road that appeared to be used regularly by cyclists. In addition there were no signs warning motorists of the presence of cyclists to judge their adequacy in any event. Strictly speaking, given the level of visual impairment that I have found Blay suffered from at the time of the collision, it is unlikely that any type of signage would have made a difference. If anyone should have been alerted to the presence of cyclists on that road it was Blay, because he had hit and injured a cyclist 23 months beforehand on the same road 16 kilometres from where he struck Peoples.

201. Signs do however play an important role in advising motorists of their obligations and of potential hazards on the road. This is particularly the case for those road users who are unfamiliar with the road. The size, content and location of signage used are all relevant considerations for the relevant authorities.

202. There is a great deal of merit in Vic Roads and local government sitting down with local bicycle groups and identifying roads which are frequently used by cyclists, and the times of usage. The risk with generic signage with no temporal context, is that motorists will become conditioned to the signage in the absence of not encountering cyclists regularly and not alter their driving. A phenomenon not unlike the unmanned road work zones that so often raise the ire of the motoring public

203. Signs that promote mutual obligation of road users and the human impact of any collision are highly desirable tools in road safety. How to convey those messages in a graphic format that is readily intelligible to all road users is the challenge.

Road Safety Awareness

204. There would appear to be almost universal acknowledgement of the need for effective cycling awareness amongst road users. In some European countries as much as 40% of the population ride a bicycle, there appears to be a greater tolerance amongst motorists for cyclists. In Australia, where the numbers of cyclists are far less there appears to be a corresponding lack of awareness and tolerance.[137]Fostering and developing a more empathetic and aware cycling culture, will be a slow and ongoing process.

205. Short of actually separating cyclists from motorists on roads, building a culture of mutual tolerance and respect and insight into the tragic consequences of accidents involving cars and cyclists must be a central focus of any awareness campaign.

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[136] See Grace v Saines Unreported Supreme Court of Victoria, Williams J, 29 June 2004 and Doomagee v Deputy State Coroner [2006] 2 Qd R 352

[137] CPU p 31

FINDINGS

206. Scott Peoples was struck and killed by a motor vehicle driven by Kenneth Blay. Peoples did not in any way cause or contribute to his death. The death was caused by Blay not being able to see Peoples due to a diagnosed medical condition known as hemianopia.

207. Scott Peoples was travelling within the shoulder of the road when he was struck by Blay's motor vehicle. At the time of the collision the road was clear of other traffic, visibility was good and there were no environmental factors that contributed to the collision.

208. Blay did not see Peoples because he had lost half his peripheral vision to the left of both eyes as a result of a stroke in September 2003. As a consequence objects appearing within the affected field of vision are not 'seen' even though both eyes are functionally normally. His condition had not improved to any appreciable degree from that time onward.

209. Blay had been involved in an earlier collision with a cyclist in January 2004. That collision was caused by Blay's hemianopia, and not by any actions of the cyclist Plummer.

210. Blay knew as at September 2003 that he should not have been driving a motor vehicle. Notwithstanding the results from the Goldman Chart test in December 2003, Blay must have appreciated after he hit Plummer in January 2004 that his eyesight was impaired, and should have sought further medical advice concerning his ability to drive.

211. The investigation of the collision on 19 January 2004 by police lacked balance, in that the decision not to further investigate or charge Blay was made as a result of placing too much weight on Blay's account of the incident and not the objective facts present in the case.

212. It is too remote however, to conclude that had Blay's condition been discovered at this stage and his licence taken from him that Peoples may not have been killed.

213. Sergeant Wittingslow failed to adequately supervise and check the investigative work of Senior Constable Weidemann a junior officer under his command. The erroneous assumption that Peoples was travelling on the right hand side of the line dividing the shoulder from the road, should have been discovered and corrected.

214. This material oversight was further compounded by the rigid application of a formatted interview of Blay following the collision. The answers given by Blay should have alerted the interviewing officers to a number of other possible scenarios which may have explained the real cause for the collision.

215. Blay was less than forthright to police concerning the real state of his visual health. He failed to disclose material facts, namely that he had been told in September 2003 not to drive, and that he had hit a cyclist in 2004 in similar circumstances.

216. Police became aware of the earlier collision in August 2007. The explanation for not reporting the existence of the earlier collision to the coroner, because it was a "coincidence" is

fatuous.[138] The police officers Wittingslow, Weidemann and Gillard failed to properly discharge their duty to the coroner under s 14 (2) of the Coroners Act.

COMMENTS:

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death (including any notification to the Director of Public Prosecutions under Section 69(2) of that Act):

1. It is desirable that all police tasked with the investigation of serious injury or death on our roads, be given rigorous theoretical and practical training *before* they are permitted to assume responsibility for an investigation.

2. That the MCIU conduct further training on the use and application of their pro forma interview questionnaire to encourage lateral thinking in its application during interviews with motorists.

3. It should be noted that since this inquest commenced, that the Victoria Police Corporate Policy Unit have amended the Victoria Police Manual,("VPM") which came into force on 26 February 2010. A new section of the VPM reads:

   Past involvements

   Perform a search through TIS to identify the previous involvements for:

   All drivers, riders or pedestrians to identify any issues which may impact upon the investigation
   An owner of vehicles or objects (only if relevant to the circumstances)

4. This inquest has been advised that Victoria Police are continuing the training of police officers in the use of the TIS and have been since August 2009. The inquest has been informed that the training now includes using the search function as an investigative tool for road accidents, such change has been implemented as a result of the facts surrounding this inquest.

5. That the call out procedures for the MCIU be expanded to include a ground; *where the serious injury or death has occurred and no objective or rational explanation can be found or determined for the collision.*

[138] showing a lack of intelligence or thought combined with complacency

6. That disciplinary action be considered against Sergeant Wittingslow and Senior Constables Weidemann and Gillard over their failure to disclose to the coroner in a timely fashion the existence of the 19 January 2004 collision. These officers were aware of the earlier collision in August 2007 and chose not to bring relevant information to the attention of the coroner until nearly 6 months later on 19 February 2008.

7. That the Victoria Police Manual include a directive that where an officer has information relevant to an inquest it must be forwarded to the coroner in a reasonable period of time.

RECOMMENDATIONS:

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendation(s) connected with the death:

Recommendation 1:

That Vic Roads conduct more research into the link between impaired drivers and collisions in the context of mandatory and non mandatory reporting systems.

a) There is a need for research be undertaken to determine the relationship between impaired drivers and collisions caused by them, to improve data so that more informed policies and strategies can be considered to improve road safety. There is presently no evidence based research to substantiate the proposition that most impaired drivers do come to the attention of the authorities either from police or doctor notification.

Recommendation 2:

That it be mandatory for medical practitioners to report patients whom they know are unfit to drive, and are aware that they continue to drive against that advice.

a) It should be mandatory for doctors where they have formed a view that a person is unfit to drive by virtue of a medical condition, *and* where they are aware that the person is continuing to drive against that advice, to report them to the relevant licensing authority for a medical assessment.

b) This requirement ought to be national and I would encourage government and relevant agencies to consider a manner in which the limited form of mandatory reporting recommended in this inquest could be considered at a national level.

Recommendation 3:

Police should be given the power to immediately suspend a drivers licence where they hold a reasonable suspicion that a motorist is unfit to drive. Any exercise of this power should be reviewed by a magistrate within a short prescribed time period.

a) The relevant legislation should be amended to provide for the power to be given to police, where they reasonably suspect a collision has occurred as a result of a medical condition, to suspend that person's licence immediately. Following such suspension the police must summons the motorist before a court in a timely fashion to apply for an interim suspension of the motorist's licence pending a full medical review by Vic Roads. The system could operate in a similar way to the safety notice used by police in family violence situations. Under that system an alleged perpetrator is given a notice on the spot by police prohibiting them from specified behaviour. The notice also contains a summons requiring them to attend court within prescribed time. On a return to court, a magistrate then determines whether to grant an order. A magistrate under the proposed system for motorists, would have the power to hear submissions on whether a motorist should be allowed to drive pending a medical review.

Recommendation 4:

That Vic Roads no longer accept the results or use the Goldman chart test in determining whether a motorist has sufficient field of vision to drive.

a) Vic Roads should no longer accept the Goldman chart test as an indicator of a motorist's visual field in determining whether a motorist is fit to drive. In view of the shortcomings identified by Dr O'Dell, this test can no longer be considered as a reliable test. The potential for false positives during testing cannot be discounted, particularly where the subject may be cognitively impaired, or motivated by a fear of losing their licence.

Recommendation 5:

That Vic Roads include in licence application and renewal forms questions pertaining to visual health.

a) Vic Roads should include in a questionnaire on a licence application or renewal form requiring drivers to disclose whether they have had any eye problems including field of vision problems. If an answer is given in the affirmative this should trigger an immediate medical review.

Recommendation 6:

Safety awareness campaigns for medically impaired drivers and for cyclists and motorists.

a) That Vic Roads broaden its road safety awareness campaign to specifically target fitness to drive as issue across all age groups. Ensuring that drivers are fully aware of their obligations to report medical impairment and the tragic potential consequences if not done should be a priority.

b) A public safety awareness campaign focusing on mutual obligation between motorists and cyclists to take care on the roads should be considered given the ever increasing number of cyclists on our roads in rural and regional areas.

Recommendation 7:

That Vic Roads conduct a review of current signage that is research based to improve the effectiveness and purpose of road safety signs used by them.

a) If Vic Roads have not already done so, then Vic Roads needs to conduct further research and undertake a review of road safety signage used to warn motorists about cyclists, in view of the matters raised in the CPU report. It is a matter of concern that there is no publically available research that has investigated Victorian motorist's behaviour in response to signage.[139]

Recommendation 8:

Greater co-operation and collaboration with local road users should be undertaken by Vic Roads and local councils.

a) That Vic Roads, TAC and local government liaise with local cycling clubs to identify training routes and times to alert motorists to the presence of cyclists by the use of appropriate signage.

DISTRIBUTION:

I **direct** the distribution of this Finding together with the recommendations and comments to the following:

1. Vic Roads
2. Transport Accident Commission
3. Chief Commissioner of Police
4. Superintendent Peter De Santo Officer in charge NE Victoria
5. The Honourable Rob Hulls, Deputy Premier and Attorney General
6. The Honourable Tim Pallas MP, Minister for Roads and Ports
7. The Honourable Daniel Andrews MP, Minister for Health
8. Dr O'Dell Victorian Institute of Forensic Medicine
9. The family of Scott Peoples
10. Riordan Legal solicitors for the Peoples family
11. DLA Phillips Fox, Solicitors for Vic Roads
12. John Goetz, Counsel Assisting the Coroner
13. Leang Thai, Victorian Government Solicitors Office

[139] CPU p 28

14. John Barrett, Barretts Lawyers for the Blay family
15. The Amy Gillett Foundation
16. Cycling Victoria
17. Shepparton Cycling club

Signature:

Gerard Bryant
Coroner

Date: 11/10/10