IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2016 5554

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

I, AUDREY JAMIESON, Coroner having investigated the death of PAMELA LOUISE ELSDON

without holding an inquest:
find that the identity of the deceased was PAMELA LOUISE ELSDON
born 24 August 1931
and the death occurred on 22 November 2016
at the Royal Melbourne Hospital, 300 Grattan Street, Parkville Victoria 3050
from:

1 (a) MULTIPLE INJURIES AS PASSENGER IN MOTOR VEHICLE ACCIDENT

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

1. Pamela Louise Elsdon was 85 years of age at the time of her death. She lived in Pascoe Vale South with her husband Raymond ('Mick'); together they had two adult children. Mrs Elsdon's medical history included type II diabetes mellitus, aortic valve replacement, a posterior communicating cerebral aneurysm and previous stroke.

2. On the morning of Tuesday 22 November 2016, Mrs Elsdon was the front seat passenger in a 2003 Holden Astra sedan driven by her husband, travelling west along Moreland Road. At

approximately 11.40am, witnesses observed the vehicle pass between two stationary vehicles on Moreland Road, and fail to turn at the T-intersection with Pascoe Vale Road in Essendon, at a speed of approximately 60km/h. The vehicle instead travelled straight through the intersection and collided with a tree on the western nature strip on Pascoe Vale Road. No other vehicle was involved in the collision.

3. Bystanders contacted emergency services; police, ambulance paramedics and Metropolitan Fire Brigade (MFB) members attended shortly afterwards. Mrs Elsdon was conscious at this time and still wearing her seatbelt; MFB members worked to extract her from the vehicle. Mr Elsdon underwent a preliminary breath test for alcohol, which was negative. He sustained survivable injuries and was transported by ambulance to the Royal Melbourne Hospital (RMH).

4. Mrs Elsdon was also conveyed by ambulance to the RMH Emergency Department (ED); upon arrival, her Glasgow Coma Scale (GCS) score was 14.[1] Mrs Elsdon acutely deteriorated while in the ED and her GCS score dropped to 8. It was established that she had sustained multiple injuries, including haemorrhagic contusions to the left frontal lobe. In light of Mrs Elsdon's frailty and co-morbidities, members of the trauma, neurosurgical, orthopaedic and emergency teams, together with Mrs Elsdon's family, determined to withdraw active treatment. Mrs Elsdon was declared deceased at 6.20pm on 22 November 2016.

INVESTIGATIONS

Forensic pathology investigation

5. Professor Stephen Cordner, Professor of Forensic Pathology at the Victorian Institute of Forensic Medicine, performed an external examination upon the body of Mrs Elsdon, reviewed a post mortem computed tomography (CT) scan and e-Medical Deposition Form, and referred to the Victoria Police Report of Death, Form 83. Anatomical findings were consistent with the known mechanism of injury. Toxicological analysis of Mrs Elsdon's post mortem blood detected medications that were mostly related to emergency or hospital treatment. Professor

[1] The Glascow coma scale is a neurological scale that aims to give a reliable, objective way of recording the conscious state of a person for initial as well as subsequent assessment. A patient is assessed against the criteria of the scale, and the resulting points give a patient score between 3 (indicating deep unconsciousness) and either 14 (original scale) or 15 (the more widely used modified or revised scale). The GCS is a widely used score of a level of unconsciousness, with a score of less than 8 being universally accepted as the level of coma in which a person is likely to be unable to protect their airway from saliva and other secretions and is at risk of obstructing their airway. There is also agreement that at a level of GCS less than 8, a patient should be intubated to protect the airway and ensure adequate oxygenation.

Cordner ascribed the cause of Mrs Elsdon's death to multiple injuries as a passenger in a motor vehicle accident.

Police investigation

6. Sergeant Kelvin Cannon the nominated coroner's investigator,[2] conducted an investigation of the circumstances surrounding Mrs Elsdon's death, at my direction, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by Mrs Elsdon's son Russell Elsdon and two witnesses to the collision.

7. Upon attending the scene of the collision, police observed that the weather was overcast and visibility was fair; the road was wet, there was light rain and it had been raining consistently throughout the day. There was medium traffic. Police identified that Moreland Road travels east / west, with two marked lanes of traffic in both directions. Moreland Road terminates in a T-intersection at Pascoe Vale Road in Essendon, which is controlled by traffic lights. Traffic signals were operational upon police arrival. Police observed that Pascoe Vale Road is a major arterial road that travels north / south. The speed limit for both Moreland and Pascoe Vale Roads was 60km/h. Based on the damage to the Elsdons' Holden Astra, police could not estimate a speed upon impact, however, it appeared that the speed limit had not been exceeded to a high degree.

8. Police were unable to definitively determine what traffic control signal applied to the Holden Astra at the time the vehicle travelled through the intersection. Neither of the two witnesses to the collision were able to specifically recall the signal. However, the witness who was stopped in the right turn lane, on Moreland Road, stated that just prior to the collision, a vehicle was stopped next to him in the left hand lane, waiting for a left turn signal. Mr Elsdon's Holden Astra subsequently drove between the witness' car and the other vehicle, before travelling straight through the intersection. Sergeant Cannon stated that it was believed a red light was displayed for all Moreland Road traffic at the time of the collision.

9. Mechanical Investigator Dale Woodland, of the Mechanical Investigation Unit, inspected the 2003 Holden Astra on 6 January 2017. Mr Woodland stated that the level and type of damage observed indicates the vehicle had major damage to its front passenger side. The inspection did not reveal any mechanical faults that may have caused or contributed to the collision.

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

10. Russell Elsdon stated that his parents both enjoyed good health for most of their lives, and were fiercely independent. However, he observed that his father, Raymond Elsdon, had experienced cognitive problems that had slowly worsened. Russell stated that Mr Elsdon's ability to get around locally continued, but if he was out of his routine, he would become confused. He added that Mrs Elsdon would not usually let Mr Elsdon drive alone, in case he was somewhere different and became lost or confused. Police ascertained that as of 22 November 2016, Mr Elsdon was licensed under the *Road Safety Act 1986* (Vic) to drive a motor vehicle.

11. In the course of the investigation, police learned that the cognitive condition of Mr Elsdon may have been significantly impaired at the time of the collision. Sergeant Cannon obtained medical records from General Practitioner Dr Ross Jeffery at the Melville Medical Group and Associate Professor Wong at the John Fawkner Hospital Cardiac Centre. Progress notes were also obtained from Consultant Psychiatrist Dr Patrick Lavoipierre.

12. It was established that in 2010, following coronary bypass surgery, Mr Elsdon presented with cognitive decline. In January 2012, Mr Elsdon was reviewed at the Cognitive, Dementia & Memory Service at RMH. A letter from Professor David Ames to Dr Lavoipierre, dated 31 January 2012, indicated that Mr Elsdon had a history of slow cognitive decline, which he felt had been gradually getting worse over the last ten years. While he was forgetful of recent events, he was still functioning at quite a high level. Professor Ames assessed that Mr Elsdon may have had mild, early Alzheimer's disease at this time.

13. A note by Dr Lavoipierre on 6 January 2015, indicated that Mr Elsdon was showing progressive cognitive decline and his short term memory was quite diminished – *'he seems to get lost in places which are not familiar'*. Following the January 2015 visit, Dr Lavoipierre's notes over the multiple subsequent appointments and up until the date of the collision, indicate that Mr Elsdon's cognitive condition remained static and did not deteriorate dramatically during this period. However, notes from an appointment on 27 March 2015, indicated that Mr Elsdon's activities of daily living were very curtailed at this time and he had very poor short term memory.

14. Dr Jeffery compiled a GP Management Plan on 25 September 2015; Alzheimer's disease was listed as part of the plan. Mr Elsdon was said to be taking prescribed medications for this condition, which was being managed by Dr Lavoipierre. Dr Jeffery's clinic notes for the 25 September 2015 visit include: *'needs new GPMP as dementia not on last one and is the major*

issue now'. A note by Dr Jeffery on 9 February 2016, indicated Mr Elsdon was seen that day with his wife *'re dementia'*.

15. In a 'My Aged Care' support plan for the Commonwealth Department of Health, generated on 16 August 2016, Mr Elsdon was noted to have a diagnosis of Alzheimer's disease. His care needs were listed as 'low level'. In a note on 27 September 2016, Dr Lavoipierre recorded that Mr Elsdon had maintained progress.

16. Sergeant Cannon observed that medical notes failed to indicate that any action had been taken by clinicians to notify VicRoads about Mr Elsdon's declining cognitive function. Sergeant Cannon suggested that like deaths might be prevented, should medical professionals be required to report any cognitive impairment of patients to VicRoads, so that their suitability to retain a Driver's Licence is assessed.

17. Russell stated that his father was now in full time aged care at Craigcare in Pascoe Vale. Sergeant Cannon spoke with Dr Mohamed Marzook, Mr Elsdon's current treating physician. Dr Mazook provided a statement to the effect that Mr Elsdon was cognitively impaired and unsuitable to be formally interviewed.

Further investigations

18. Following the investigation into Mr Elsdon's death, I directed that further information be sought from Dr Lavoipierre and Dr Jeffery as to whether they had ever turned their minds to Mr Elsdon's ability to continue driving.

19. By way of letter dated 12 July 2017, Dr Lavoipierre advised the Court that it had never entered his mind, at Mr Elsdon's time of life and his illness, that he would be driving a car. Dr Lavoipierre said that he never asked Mr Elsdon whether he was still driving, and none of the other doctors involved in his care mentioned the question of him driving a car.

20. By way of statement dated 7 August 2017, Dr Jeffery provided further information to the Court. Dr Jeffery advised that while Mr Elsdon had been a patient at the Melville Medical Group since 1987, it was only from June 2015 that he became his main treating doctor. Dr Jeffery stated that Mr Elsdon's dementia manifested mainly with short term memory loss and he did not have reason to believe it impacted on his ability to drive in 2015 and early 2016. Dr Jeffery added that while Mr Elsdon had a single episode of dizziness in 2015, this settled almost immediately and his cardiac condition was also managed well. He said he therefore had

no reason to be concerned about his ability to drive from a medical, rather than cognitive perspective at that time.

21. Dr Jeffery stated that he saw Mrs Elsdon on 10 occasions between February and August 2016. In light of Mrs Elsdon's heart condition, the couple's daughter had come down from Queensland to provide support. Dr Jeffery said that Mr Elsdon did not attend these appointments and he assumed Mr Elsdon was not driving. Dr Jeffery assessed Mrs Elsdon's fitness to drive on 28 June 2016, and deemed her unfit to drive as she was having cognitive problems after a surgery and had also experienced seizures.

22. Dr Jeffery stated that the Elsdons' daughter returned to Queensland in late August 2016. When Mr Elsdon attended appointments in September and October 2016, Dr Jeffery did not ask how the couple had arrived. Dr Jeffery said he was under the impression that Mr Elsdon had not been driving when his family was staying with him, so it did not occur to him that he might have been driving during this period. He added that there was no mention from the family that Mr Elsdon was either driving or was driving unsafely.

COMMENTS

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

1. In the Finding without Inquest into the death of Nicholas Carr[3] delivered on 28 November 2016, I observed that Section 17A of the *Road Safety Act 1986* (Vic) provides that a person who drives a motor vehicle on a highway must drive in safe manner having regard to all the relevant factors, which include the physical and mental condition of the driver or road user (s17A(1), (2A)(g)). I also note Regulation 67(2) of the *Road Safety (Drivers) Regulations 2009* (Vic), provides that 'if the holder of a driver licence… 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 [VicRoads] about it.'
2. These provisions appear to provide a 'self-reporting' model, which places the onus on the driver to notify VicRoads of any medical issues. However, VicRoads can also receive notifications from members of the public, including concerned family members or health clinicians. In circumstances where VicRoads is notified, or becomes aware, that a person may not be fit to drive, it is obliged to investigate potential safety concerns, which involves *inter alia* requesting medical opinions. Under Regulation 78(3) of the *Road Safety (Drivers) Regulations 2009*,

[3] COR 2015 4295.

VicRoads can suspend or vary a person's licence if it receives information that appears reasonable or credible, which suggests that a person is unfit to drive.

3. In South Australia and the Northern Territory, health practitioners are required to report if a patient is diagnosed with a medical condition that may affect their ability to drive. However in response to previous coronial recommendations,[4] VicRoads has consistently put forward a view that it does not support mandatory reporting of drivers by doctors or others.

4. It is concerning that there is no evidence Mr Elsdon's suitability to retain a valid driver's licence was reviewed or raised as an issue, given his long period of cognitive decline. However, as in Mr Carr's case, in light of the onus placed upon drivers to notify VicRoads of their own health conditions, I make no adverse comment against any individuals involved in Mr Elsdon's care. Doctors and health professionals play a crucial role in identifying fitness to drive issues and encouraging their patients to act on their reporting obligations. Ultimately, however, in Victoria, the duty to report currently rests on the individual operating the motor vehicle.

5. In the Finding relating to Mr Carr's death, I observed that given the history of coronial findings and responses relating to this issue, it appears that the self-reporting model is not entirely effective. The Victorian coronial cases identify significant limitations in a self-reporting framework, most obviously being that an individual would be reluctant to inform VicRoads of something that could affect their right to drive. The consequences of this status quo affect not only the safety of individuals, but other road users. Treating medical practitioners are best placed to objectively determine whether their patient is or is not fit to drive. The community is entitled to expect that if a medical practitioner is alert to such a risk, it should be mandatory that they make a report to VicRoads. With a view to reducing harms to others and preventing like deaths, I recommended that consideration be given by the Secretary of the Department of Economic Development, Jobs, Transport and Resources, and VicRoads, to adopting a framework requiring mandatory reporting to VicRoads when a medical practitioner forms an opinion that a person with a permanent or long-term injury or illness, is not medically fit to drive.

6. In response to this recommendation, the Court received a letter dated 31 January 2017, from Anita Curnow, Executive Director of Access and Operations at VicRoads. Ms Curnow stated that to date, there was no compelling body of evidence that demonstrates that mandatory reporting is more effective than self or community based referral into the VicRoads medical

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[4] See, in particular: Finding into the death of Scott Peoples with Inquest: COR 2006 4776; and Finding into the death of Petroula Krassos without Inquest: COR 2011 2908.

review system. She added that some sequelae of mandatory reporting might lead to negative consequences if a compulsory medical reporting system was mandated. In particular, it was noted that mandatory reporting may impact on doctor-patient relationships, resulting in potentially negative health, social and productivity outcomes. However, no empirical evidence was provided to support this proposition.

7. Ms Curnow stated that VicRoads would continue to apply, refine and enhance the self and community reporting system framework to identify and review medically impaired drivers. For example, VicRoads was requiring licence and learner permit application forms to include the completion of health information highlighting driver licensing obligations related to key risk-related medical conditions; granting and renewing licences to drivers aged 75 years and over for three year periods to encourage them to regularly assess their fitness to drive; encouraging health professionals and family members to have conversations with older and medically impaired people about their ability to drive through the VicRoads website, publication materials and community activities; and producing 'The Victorian Older Drivers' Handbook', which provides extensive information to help people assess their fitness to drive.

8. The Court also received a response from Gillian Miles, Lead Deputy Secretary, Transport, at the Department of Economic Development, Jobs, Transport and Resources. Dr Miles confirmed that the Department supported VicRoads' response. However, she also emphasised that across the transport portfolio, VicRoads, its road safety partners and the Department regularly review data, research and policy on fitness to drive. Dr Miles acknowledged that ensuring fitness to drive is an important policy area, given the aging profile of our population. She advised that this will remain a priority area for further policy consideration.

9. On 28 August 2017, I repeated the recommendation I made following Mr Carr's death, in the Finding following my investigation into the death of Frederick Hylla.[5] Mr Hylla died from multiple injuries in a motor vehicle incident; it was believed likely that a natural cardiac event had led to the collision. Mr Hylla had continued to drive despite the opinion of his General Practitioner and family members that he was not fit to do so.

10. Ms Elsdon's death and the danger caused to the wider community by other impaired drivers continuing to operate motor vehicles, serve as a compelling indication that VicRoads have an intransigent position on this issue. The existing policy measures are inadequate.

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[5] COR 2016 4011.

11. The circumstances of Mrs Elsdon's death reflect that in the absence of a mandatory reporting system for the medical profession, a significant opportunity is lost to protect drivers and other road users.

RECOMMENDATION

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

1. With a view to reducing harms to others and preventing like deaths, **I repeat my recommendation** that consideration be given by the Secretary of the Department of Economic Development, Jobs, Transport and Resources, and VicRoads, to adopting a framework requiring mandatory reporting to VicRoads when a medical practitioner forms an opinion that a person with a permanent or long-term injury or illness, is not or may not be medically fit to drive.

FINDINGS

The investigation has not identified the cause of the collision on 22 November 2016, other than driver error on the part of Mr Elsdon. The evidence indicates that Mr Elsdon drove between stationary vehicles on Moreland Road, and most probably passed straight through the intersection with Pascoe Vale Road, against red traffic lights.

In circumstances where Mr Elsdon's prolonged period of slow cognitive decline had meant that dementia was noted by Dr Jeffery as 'a major issue' on 25 September 2015, and where in January 2015, he was noted by Dr Lavoipierre to get *'lost in places which are not familiar'*, it is concerning that no assessment of his suitability to drive appears to have been suggested or performed.

I accept and adopt the medical cause of death as identified by Professor Stephen Cordner and find that Pamela Louise Elsdon died from multiple injuries sustained as a passenger in a motor vehicle collision in circumstances where the evidence supports a conclusion that Mr Elsdon caused the collision.

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

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

Mr Russell Elsdon

Ms Kellie Gumm, the Royal Melbourne Hospital

Transport Accident Commission

Mr Richard Bolt, the Secretary of the Department of Economic Development, Jobs, Transport and Resources

Ms Robyn Seymour, Director of Road User and Vehicle Access, VicRoads

Dr Ross Jeffery, General Practitioner

Dr Patrick Lavoipierre, Consultant Psychiatrist

Sergeant Kelvin Cannon

Signature:

AUDREY JAMIESON
CORONER
Date: **7 September 2017**