IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2017 5171

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

Amended pursuant to section 77(2) of the Coroners Act 2008[1]

Findings of:	**AUDREY JAMIESON, CORONER**
Deceased:	**CAMERON ANDREW MACLELLAN**
Date of birth:	**21 November 1972**
Date of death:	**10 October 2017**
Cause of death:	**Multiple Injuries Sustained in a Motorcycle Incident**
Place of death:	**On Huntingdale Road in front of 231 Huntingdale Road, Huntingdale, Victoria 3166**

[1] The original Findings dated 30 October 2019 have been partially aside and amended to include new facts and circumstances, as delineated in paragraphs 24 to 28 of these Findings. The Comments and Findings sections have similarly been amended.

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

1. Cameron Andrew MacLellan was 44 years of age and resided alone in Huntingdale at the time of his death. Mr Maclellan had a girlfriend, Christina Kavvadias. He had been separated from his wife Danielle MacLellan for approximately six years; they had little to no contact during that time and never formally divorced. In 2004, they had a son Lachlan MacLellan.

2. Mr MacLellan had a complex psychiatric history. At various times, he had been diagnosed with Paranoid Schizophrenia, Depression, Post Traumatic Stress Disorder (**PTSD**) and Antisocial Personality Disorder (**ASPD**). He had been prescribed a number of psychiatric medications for these conditions. Mr MacLellan also had a history of substance abuse.

3. On 10 October 2017 at approximately 3.50pm, Mr MacLellan rode his motorcycle north on Huntingdale Road: a two-way street which allowed traffic to travel northbound and southbound, the lanes were divided by broken white lines. At the same time, 92-year-old Antonio Pupillo was driving southbound on Huntingdale Road. Mr Pupillo turned right across the northbound lane, into a driveway and across the path of Mr MacLellan. The vehicles collided and Mr MacLellan sustained fatal injuries. Multiple witness contacted '000' and emergency services attended; Mr MacLellan was pronounced deceased at the scene.

INVESTIGATIONS

Forensic pathology investigation

4. Dr Sarah Parsons, Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**), performed an external examination upon the body of Cameron Andrew MacLellan, reviewed a post mortem computed tomography (**CT**) scan and referred to the Victoria Police Report of Death, Form 83. Dr Parsons commented that the CT scan showed multiple fractures and other injuries consistent with the known mechanism of injury. Toxicological analysis of post mortem blood detected methylamphetamine

(~1.9 mg/L) and its metabolite amphetamine (~0.3 mg/L),[2] as well as citalopram (~0.05 mg/L).[3]

5. Dr Parsons formulated the medical cause of Mr MacLellan's death as multiple injuries sustained in a motorcycle incident.

Police investigation

6. Upon attending the site of the collision after Mr MacLellan's death, Victoria Police officers arrested Mr Pupillo and transported him to Oakleigh Police Station for the purposes of interviewing him and obtaining a blood sample pursuant to the *Road Safety Act 1986* (Vic). Clinical Forensic Registrar of VIFM Dr Vicky Kim assessed Mr Pupillo and conducted a mental status examination. She concluded that he was not fit to be interviewed. Mr Pupillo was released pending further enquiries. Victoria Police officers submitted a licence review to VicRoads and Mr Pupillo's driver's licence was suspended pending the outcome.

7. Victoria Police compiled a brief of evidence again Mr Pupillo for the criminal charge of Dangerous Driving Causing death and a summary charge of Careless Driving. The brief was submitted to the Office of Public Prosecutions, but a criminal prosecution was not authorised.

8. Detective Senior Constable (**DSC**) Caitlin Ryan was the nominated Coroner's investigator.[4] At my direction, DSC Ryan investigated the circumstances surrounding Mr MacLellan's death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by witness Eugene Pirie, witness Jordan Frew, witness Julian Torney, witness Malcolm Brown, Clinical Forensic Registrar Dr Vicky Kim, Detective Leading Senior Constable (**DLSC**) Jamie Mitchell of the Major Collision Investigation Unit in Glen Waverly, Detective Sergeant (**DS**) Robert Hay of the Forensic Services Department, Collision Reconstruction Unit, Leading Senior Constable (**LSC**) Mark Wood of the Mechanical Investigation Unit. DSC Ryan also

[2] Amphetamines is a collective word to describe central nervous system (CNS) stimulants structurally related to dexamphetamine. One of these, methylamphetamine, is often known as "speed" or "ice". Methylamphetamine is a strong stimulant drug that acts like the neurotransmitter noradrenaline and the hormone adrenaline.

[3] Citalopram or escitalopram are selective serotonin reuptake inhibitors with antidepressant activity.

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

obtained closed circuit television (**CCTV**) footage depicting Mr MacLellan riding northward on his motorcycle immediately prior to the collision.

9. During the investigation, police learned that the collision occurred at approximately 3.50pm, the road was dry, and the conditions were sunny with good visibility. The applicable speed limit was 60 km/h. At the location of the collision, Huntingdale Road was a two-way, two lane, bitumen road in good condition. The lanes of travel were approximately 5.6 metres wide and the relevant section of road was flat and straight.

10. On 10 October 2017 at approximately 9.30am, Mr Pupillo left his home in Carnegie to drive to an appointment in Oakleigh. He was diverted from his usual route due to a collision on Warrigal Road earlier that morning. Mr Pupillo drove around for many hours; he had become disoriented and was unable to find his way home.

11. At approximately 2.25pm, Mr Pupillo's daughter contacted Oakleigh Police Station and reported her father as a missing person.

12. CCTV footage obtained from 257 and 255 Huntingdale Road, Huntingdale, depicted Mr MacLellan driving a motorcycle northbound on Huntingdale road. DSC Ryan stated that Mr MacLellan appeared to be driving faster than other road users.

13. At approximately 3.40pm, Mr Pupillo stopped at some angled parking spaces in front of shops near the intersection of Huntingdale Road and Greville Street in Huntingdale. He spoke to Jordan Frew and Eugene Pirie, asking for directions to Carnegie. Mr Pirie stated that Mr Pupillo returned to his vehicle. Mr Pupillo turned out of the parking area and drove southbound onto Huntingdale Road. He then turned right into a driveway, in order to change course and drive northbound, as directed.

14. At approximately 3.50pm, CCTV footage obtained from 235 Huntingdale Road, Huntingdale, depicted Mr MacLellan overtaking a vehicle. At that time, Julian Torney was walking alongside the same section of Huntingdale Road. He commented that Mr MacLellan's '*motorbike was going pretty fast. He might have just been getting speed to go around the car.*'[5] Mr Torney then observed Mr MacLellan drive toward a maroon coloured car that appeared to have turned right into a driveway from the southbound side

[5] Coronial Brief, *Statement of Julian Torney*, dated 10 October 2017, p 47.

of Huntingdale Road: Mr Pupillo's vehicle. Mr Torney said that Mr MacLellan heavily applied his brakes but was unable to stop his motorcycle. The front of Mr MacLellan's motorcycle collided with the side of Mr Pupillo's car.

15. DLSC Jamie Mitchell of the Major Collision Investigation Unit and DS Robert Hay of the Collision Reconstruction Unit provided statements to the Court. These statements indicated that environmental factors did not cause nor contribute to the collision. When considering the site of the collision, DS Hay stated that there was a scuff mark on the road which, due to its position, he discounted as related to the incident. However, he said that there was a scuff mark on the rear tyre of the motorcycle. DSC Hay concluded that it was possible that Mr MacLellan applied his brakes prior to the collision.

16. Mechanical Investigator LSC Mark Wood provided a detailed report of the damage sustained by each vehicle. Mr MacLellan's motorcycle and Mr Pupillo's car did not have any damage or faults which LSC Wood considered contributory to the collision.

17. DSC Ryan produced section 84(1) certificates pursuant to the *Road Safety Act 1986* (Vic) [Road Safety Act]. The certificates indicated that Mr Pupillo was licenced at the time of the collision. However, Mr MacLellan was not licenced under the Road Safety Act; his previous licence had expired on 25 May 2015. A further certificate indicated that Mr MacLellan had committed a number of offences under the Road Safety Act between January 1992 and June 2015. On 10 October 2014, Mr MacLellan was convicted of *driving a motor vehicle whilst impaired by a drug.* His car and motorcycle licences were cancelled and disqualified for a period of three months from 25 May 2015. Mr MacLellan was not to be relicensed except by order of a magistrate.

Further Investigation

18. In light of the issues raised by the investigation, I requested that DSC Ryan obtain further documents. Specifically, I requested a statement from Mr Pupillo's treating General Practitioner (**GP**) to identify whether the doctor had cause to consider Mr Pupillo's fitness to hold a drivers licence. I also requested information about Mr McLellan's mental health and substance abuse.

Forensicare – Community Forensic Mental Health Service

19. Chief Psychologist Community Operations and Manager of the Problem Behaviour Program Dr Aleksandra Belofastov provided a statement to the Court. Dr Belofastov

stated that Community Correctional Services referred Mr MacLellan to the Problem Behaviour Program (**PBP**) in late 2015. He was serving a Community Corrections Order (**CCO**) for charges of threat to inflict serious injury and stalking, as well as a number of driving, theft and drug-related charges.

20. Dr Belofastov stated that Mr MacLellan presentation was characterised by personality disorder with mixed features (paranoid, schizoid, borderline and antisocial). Mr MacLellan described a difficult childhood and adolescence. On 21 December 2015, Consultant Psychiatrist at PBP Dr Adam Deacon reviewed Mr MacLellan. He agreed with the initial personality disorder diagnosis and also diagnosed Mr MacLellan with depression and post-traumatic stress disorder (**PTSD**). He found that Mr MacLellan's presentation was not indicative of a psychotic disorder.

21. Dr Belofastov stated that Mr MacLellan engaged with the service between October 2015 and January 2017; he continued to attend the PBP after the end of his CCO. On 16 January 2017, Mr MacLellan wrote to Senior Psychologist Dr Lauren Ducat. He indicated that, although he felt depressed after some of the sessions, he found offence-focussed treatment helpful and he had refrained from engaging in the criminal conduct which had led to the initial referral. Mr MacLellan was discharged from the PBP due to non-attendance.

General Practitioner Statement One – 14 May 2018

22. On 11 October 2017, Dr Mark Lipzker saw Mr Pupillo. He stated that he was aware Mr Pupillo had been involved in a motor vehicle collision the day before, but his patient was extremely unclear on the details. Dr Lipzker said that he was obviously confused and that he had swelling about his neck.

23. Dr Lipzker said that Mr Pupillo had been admitted to Caulfield Hospital after suffering a fall "in March". Whilst in hospital, Mr Pupillo's dementia was assessed and found to be *'moderately severe'*;[6] he scored 17 out of 30 in a mini-mental state examination (**MMSE**)[7] with an interpreter available. At the time Dr Lipzker made his statement,

[6] Coronial File, *Statement of Dr Mark Lipzker*, dated 14 May 2018, p 1.

[7] The Mini-Mental State Exam (MMSE) is a widely used test of cognitive function among the elderly; it includes tests of orientation, attention, memory, language and visual-spatial skills. In isolation, the test does not diagnose an individual with dementia.

Mr Pupillo had last consulted him on 27 April 2018. Mr Pupillo did not recollect any motor vehicle collision.

Findings and Closure 30 October 2019

24. On 30 October 2019, I closed the investigation on the evidence that was available to me at that time. On 2 December 2019, Dr Lipzker contacted the Court by letter to convey his displeasure at the representation of his statement. It came to light that Dr Lipzker's statement had been provided separately to the coronial brief but had been made during the time of its collation and that, despite my instructions, my investigator had not requested the doctor to specifically address fitness to drive issues prior to providing me with the statement.

25. In his letter dated 2 December 2019, Dr Lipzker stated that Mr Pupillo did not have a known medical condition affecting his fitness to drive at the time of his death. He clarified his previous statement in that the cognitive assessment conducted at Caulfield Hospital "in March" was March 2018, after the motor vehicle collision that ended Mr MacLellan's life.

26. On 22 January 2020, the Court initiated a Form 43 *Application to Set Aside Finding* pursuant to section 77 of the *Coroners Act 2008* (Vic). On the same date, a Form 44 *Determination Following Application to Set Aside Finding* was created to reopen the investigation into Mr MacLellan's death, as I found that there were:

    a. new facts and circumstances, and

    b. it was appropriate to reopen the investigation.

27. The original Findings of 30 October 2019 were partially set aside to include Dr Lipzker's statement dated 2 December 2019 and to include new formal Coronial Findings in an amended Form 38 *Finding into a Death without Inquest*. The Comment section was also amended at comment two (2), in order to correctly characterise the information that Dr Lipzker provided to the Court.

28. On 22 January 2020, the Court requested that Dr Lipzker provide a further statement to specifically address fitness to drive issues and clarify his initial statement. On 30 January 2020, Dr Lipzker provided his second statement to the Court.

General Practitioner Statement Two (Fitness to Drive) – 30 January 2020

Evidence of cognitive decline prior to the collision

29. Dr Lipzker characterised Mr Pupillo as a *'fit and health 92-year-old'* who was *'living independently with his wife…there was no evidence of cognitive decline'*. He informed me that Mr Pupillo had no illnesses and was only on medication for constipation at the time of the motor vehicle collision.

Further details on assessment post the collision

30. On 11 October 2017, Mrs Pupillo brought her husband to see his general practitioner due to changed behaviour. He could not recall the details of the motor vehicle incident at all. Dr Lipzker noted his patient's symptoms which were consistent with a seat belt injury, but it was Mr Pupillo's '*acute delirium*' and change in behaviour that were of chief concern.

31. Dr Lipzker noted swollen lymph nodes and ordered CT scanning, subsequently identifying malignant lymphadenopathy but no intracranial abnormality. He commented that Mr Pupillo was then subject to radical neck surgery, radiotherapy and a fractured pelvis as the result of a fall, resulting in an extended hospital stay. It was during this stay that Mr Pupillo had the MMSE and scored 17/30. The discharge summary notes also state that he was confused upon admission.

32. Dr Lipzker said that Mr Pupillo has never spoken of the motor vehicle collision which caused Mr MacLellan's death.

Other comments

33. Dr Lipzker stated that, upon receipt of the original finding dated 30 October 2019, he learnt of the circumstances of the of the collision for the first time. He said that it was '*not unusual for the elderly to become anxious or upset in unfamiliar surroundings.'* Dr Lipzker stated that a combination of this anxiousness at the diversion and being lost may have contributed to his judgement and error. He postulated that this, in conjunction with post traumatic shock, may explain Mr Pupillo's presentation with acute delirium and lost memory the following day.

COMMENTS

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

1. Mr MacLellan committed a number of drug-related and driving offences prior to his death. Mr MacLellan did appear to engage with a Forensicare program to curb his offending behaviours, including continued participation in the program after his Community Corrections Order was completed. Mr MacLellan also corresponded with program coordinators to indicate that he felt his behaviour had improved with participation. However, at the time of his death, Mr MacLellan no longer engaged with the program and was driving his motorcycle without a licence, under the influence of methylamphetamine.

2. The eye witness evidence and Detective Sergeant Hay's forensic reconstruction report support a conclusion that Mr MacLellan applied his brakes prior to the collision. A pertinent finding will follow.

3. The evidence available to me as at 30 October 2019, raised concerns about Mr Pupillo's fitness to drive and led me to complete the original Findings. The re-opening of the investigation has dispelled my original understanding that Dr Lipzker was aware of Mr Pupillo's cognitive decline. Dr Lipzker has clarified that, *inter alia*, he had no suspicion that Mr Pupillo suffered cognitive decline at the time of Mr MacLellan's death.

4. Dr Lipzker said that it is not unusual for elderly people to become anxious and upset in an unfamiliar situation. I accept that this probably occurred when Mr Pupillo encountered a diversion in his usual driving route on 10 October 2017. However, merely being anxious or upset cannot account for the hours in which Mr Pupillo was driving and lost, his delay so significant and unusual that his family reported him as a missing person.

5. Mr Pupillo's behaviour indicates an incapacity to overcome a fairly regular obstacle (a diversion) when driving a vehicle. His behaviour and actions on the date of Mr MacLellan's death are indicative of incapacity to appreciate and respond to all the nuances that driving a motor vehicle requires. Additionally, Clinical Forensic Registrar

Dr Kim's mental examination of Mr Pupillo identified that he was not fit to be interviewed immediately after the collision. As such, the discourse on fitness to drive remains relevant to this investigation.

6. In the past, I have made recommendations[8] to VicRoads in relation to Fitness to Drive and the inadequacies of the "self-reporting" model used in Victoria, whereby individuals are expected to report their own health conditions or other issues which may affect their ability to drive. There is no legislative requirement for a medical practitioner to report concerns about a patient's medical fitness to drive directly to VicRoads.

7. There is arguably an ethical obligation to notify VicRoads if a medical practitioner forms the view that a patient is unfit to drive and will continue to drive despite advice not to do so.[9] A medical practitioner making such a report is legally protected in doing so under Section 27(5) of the *Road Safety Act 1986* (Vic). I make no comment about whether there is such an ethical obligation. However, it is apparent that the current reporting system lacks clarity.

8. The loss of fitness to drive is often equal to loss of independence, especially for the elderly. A system that relies on an individual or their family members to report concerns about fitness to drive is fraught because it requires significant emotive detachment. Additionally, there is a vast difference between having a concern about a parent or loved one's fitness to drive and turning that concern into a report to a statutory body.

9. Over the past decade, Victorian coroners have investigated a number of motor vehicle collision deaths where medical practitioners expressed concern that a patient was not fit to drive, but neither they nor the patient notified VicRoads of this concern. Consequently, I have previously recommended legislative change to require a medical practitioner to notify VicRoads when he or she forms the view that a patient is or may not be medically fit to drive.

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[8] Please see: COR 2015 4295, COR 2016 5554, COR 2016 4001. Findings provided to VicRoads on basis of reviewing the model: COR 2016 5539, COR 2017 6004.

[9] According to VicRoads response to my Recommendations in the Investigation into the death of Pamela Elsdon COR 2016 5554 dated 24.11.17, referring to the AustRoads & National Transport Commission, 'Medical Standards for Licensing and Clinical Management Guidelines, *Assessing Fitness to Drive for commercial and private vehicle drivers*' (2016).

10. In this matter, Dr Lipzker has said that he did not recognise any cognitive decline in Mr Pupillo. Correspondingly, Mr Pupillo did not pursue any concerns in relation to the same by reporting himself for a fitness to drive test. It is not certain whether a clearer reporting model would have raised Dr Lipzker's suspicion of any cognitive decline that may have affected his 92-year-old patient's capacity to drive safely. Equally, it is not clear whether Mr Pupillo's decline occurred acutely or over a longer period of time. However, in the context of a mandatory reporting model, Dr Lipzker would have been required to scrutinise the issue.

11. On 24 November 2017, Executive Director Access and Operations Anita Curnow informed me that VicRoads would not adopt a mandatory reporting model for medical practitioners concerned about their patients' fitness to drive. However, she provided a detailed outline of activities that VicRoads would undertake in 2018 to improve the existing system within which concerns about fitness to drive are reported. The then Acting Secretary of the Department of Economic Development, Jobs, Transport and Resources, Gillian Miles,[10] similarly described a range of activities being undertaken by Transport for Victoria (the statutory office that as of April 2017 is responsible for road safety legislation and regulation) aimed at developing evidence to inform policy in this area.

12. I have provided a number of Findings to VicRoads with the intention of augmenting their review of the current model and any relevant policy. On that basis, I have not repeated my recommendations in other Findings since receiving the reports from Ms Curnow and Ms Miles. However, it has been almost two years since the provision of that material to this Court. As such, I consider it appropriate to repeat my previous recommendation.

[10] Gillian Miles is now the Chief Executive Officer and Commissioner for the National Transport Commission.

RECOMMENDATIONS

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

1. With the aim of promoting public health and safety, I repeat my recommendation that consideration be given by the Secretary of the Department of Transport[11] 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

1. The investigation has identified that Cameron Andrew MacLellan was driving without a licence and under the influence of methylamphetamine at the time of his death. His driving has been described as faster than other road users at the time of the collision.

2. I find that Cameron Andrew MacLellan applied his brakes prior to the collision.

3. The investigation also identified that Antonio Pupillo was confused and lost at the time of the collision: he had been lost for many hours, reported as a missing person and had turned his vehicle into the path of oncoming traffic, including Cameron Andrew MacLellan's motorcycle.

4. Victoria Police charged Antonio Pupillo with criminal offences associated with the incident, but the charges were not pursued by the Office of Public Prosecutions.

5. I accept and adopt the medical cause of death formulated by Dr Sarah Parsons and I find that Cameron Andrew MacLellan died from multiple injuries sustained in a motorcycle incident, in circumstances where he was driving without a licence and was under the influence of an illicit drug.

[11] On 1 July 2019 VicRoads, Public Transport Victoria and the Department of Transport were integrated under the umbrella of the Department of Transport.

6. I further find that Cameron Andrew MacLellan's offending behaviour was not the sole cause of the incident.

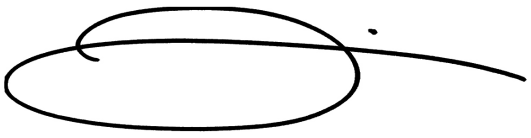
7. I find that Antonio Pupillo contributed to the motor vehicle collision which caused Cameron Andrew MacLellan's death, in circumstances where I find that Antonio Pupillo capacity to drive safely had been affected.

8. I further find that the question of Antonio Pupillo's fitness to hold a drivers licence was never reported to VicRoads and he continued to drive on Victorian roads.

To enable compliance with section 73(1) of the Coroners Act 2008 (Vic), I direct that the Findings will be published on the internet.

I direct that a copy of this finding be provided to the following:
Danielle MacLellan
Christina Kavvadias
Dr Mark Lipzker, Carnegie Medical Centre
Dr Aleksandra Belofastov, Forensicare
Office of the Chief Psychiatrist
VicRoads
Transport Accident Commission
Detective Senior Constable Caitlyn Ryan

Signature:



AUDREY JAMIESON
CORONER
Date**: 13 July 2020**