IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 0634

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)
Section 67 of the Coroners Act 2008

Deceased:	Durdica SERBEC (also known as Georgina)
Delivered on:	24 November 2022
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	21 & 22 March 2022
Findings of:	Coroner Sarah Gebert
Counsel assisting the Coroner:	N. Hodgson instructed by Coroners Court of Victoria
Counsel for Mrs Serbec's family	P. Bourke
Counsel for the Department of Transport:	D. Oldfield instructed by Maddocks Lawyers
Counsel for The Driver[1]	J. Munster instructed by Victoria Legal Aid

[1] The identity of this person is subject to a suppression order and is referred to in my Finding as 'The Driver'.

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INTRODUCTION

1. Durdica Serbec (also known as **Georgina**) was born on 18 May 1950 and was aged 65 years at the time of her passing.

2. Georgina moved to Australia from Croatia in 1969 and had three children Tania, Peter and Katherine with her former husband Leo who she divorced in 1984. She subsequently met Ibro who had been her partner for over 30 years.

3. Tragically, Georgina passed away at the Royal Melbourne Hospital (**RMH**) on 12 February 2016 following being struck by a motor vehicle driven by The Driver earlier that day.

THE CORONIAL INVESTIGATION

4. Georgina's passing was reported to the Coroners Court as it fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) because her death appeared to have been unexpected, unnatural or violent or to have resulted from accident or injury.[2]

5. The coronial investigation was suspended pending the resolution of criminal proceedings. The Driver was charged with Dangerous Driving Causing Death, Drive in a Manner Dangerous, and Drive without an experienced driver sitting beside her as required by her Learners Permit.

6. On 31 January 2019, the County Court found the offence of Drive in a Manner Dangerous Causing Death proven and The Driver received a non-custodial supervision order.

7. Following completion of the criminal proceedings, the coronial investigation resumed under the Act.

The coronial role

8. Coroners independently investigate reportable deaths to find, if possible, identity, cause of death and the surrounding circumstances of the death. Cause of death in this context is accepted to mean the medical cause or mechanism of death. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death.

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[2] Deputy State Coroner Caitlin English (as she then was) initially had carriage of this investigation.

9. Under the Act, coroners have an additional role to reduce the number of preventable deaths and promote public health and safety by their findings and by making comments and or recommendations about any matter connected to the death they are investigating.

10. When a coroner examines the circumstances in which a person died, it is to determine causal factors and identify any systemic failures with a view to preventing, if possible, deaths from occurring in similar circumstances in the future.

11. In the coronial jurisdiction, the standard of proof applicable to findings is the balance of probabilities.[3]

Discretionary inquest

12. As Georgina's death was the result of a homicide and a person was charged with an indictable offence with respect to her death, an inquest was not mandatory pursuant to the Act.

13. Georgina's family made an application for an inquest to be conducted. The family's primary concerns were the legitimacy of the driver related tests recorded to have been passed by The Driver, the possibility of weaknesses in Victoria's licensing system, and the potential for future harm in the community.

14. Relevant to the application was the sentencing Judge's remarks with respect to The Driver:

One of the very troubling aspects of this case, is that you ever held a learner's permit. As I have said, it is not my role to investigate how that occurred. Given your lack of English and low IQ, in my view someone must have assisted you to get that learner's permit. They should never have done so. You should never have held a learner's permit .

You should not be in a position where you have access to a motor vehicle, the keys to a motor vehicle, or anything that could place you behind the wheel.

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[3] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.
"The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences ...". (pages 362-363)

15. I subsequently determined that an inquest would be held as part of the investigation.[4] A central issue at inquest was the basis upon which the Department of Transport (**DOT**) could be satisfied that The Driver undertook certain driving related tests.

16. The inquest scope was determined as follows[5]:

    a. The basis upon which DOT states it is satisfied, having considered the reports of Dr Michael King, Dr Nina Zimmerman, Mr Martin Jackson and Professor James Ogloff, that The Driver took the tests noted in paragraph (b) below (noting that she passed each of those tests.)

    b. Clarification from DOT regarding the circumstances in which The Driver passed;

        i. an eyesight test on 9 September 2010;

        ii. a Road Law Knowledge Test on 9 September 2010; and

        iii. a Hazard Perception Test on 6 October 2015.

    c. Whether there are any prevention opportunities arising from Georgina's death.

Sources of evidence

17. As part of the coronial investigation, Sergeant[6] David England prepared a coronial brief. The brief comprises statements from witnesses including those present at the scene of the accident, the forensic pathologist who examined Georgina, an ambulance paramedic, investigating officers, a representative of DOT as well as other documentation such as photographs. The brief also contained the transcript of an interview conducted between police and The Driver, utilising Tigrinya interpreter Ghebremedihin Atsebaha, at the Keilor Downs Police Station on 19 February 2016 (**the Record of Interview**).

18. Following receipt of the coronial brief, the Court also obtained Georgina's medical records from the RMH, a further statement from DOT as well as statements from interpreters who had assisted The Driver whilst undertaking driver related tests.

19. The inquest ran for two days and heard evidence from three witnesses. They were:

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[4] A directions hearing was convened on 25 February 2021.

[5] I made a determination regarding the scope of the investigation dated 2 July 2021 following an application by DOT.

[6] Formally Leading Senior Constable.

(a) Mohammed Mahmoud, interpreter;

(b) Jacqueline Sampson, Director of Registration and Licensing Services, DOT; and

(c) Sergeant David England, Coroner's Investigator.

20. Following the inquest, DOT also provided the Court with additional material and the Court obtained the video recording of the Record of Interview.

21. In addition, I received written submissions from Counsel Assisting and Counsel for Georgina's family, DOT and The Driver. Reply submissions were also received on behalf of the family and The Driver.

22. This finding is based on the entirety of the investigation material comprising of the coronial brief of evidence including material obtained after the provision of the brief, the statements and testimony of those witnesses who gave evidence at the inquest and any documents tendered through them, any documents tendered through counsel (including Counsel Assisting), written submissions of counsel and their replies following the conclusion of the inquest. All this material, together with the inquest transcript, will remain on the coronial file and comprises my investigation into Georgina's death. I do not purport to summarise all the material and evidence in this finding, but will refer to it only in such detail as is relevant to comply with my statutory obligations and necessary for narrative clarity.

RELEVANT BACKGROUND

Driving related tests undertaken by The Driver

23. According to records held by DOT, on 9 September 2010 The Driver passed an eyesight test (whether this was with the assistance of an interpreter is discussed later) and a Road Law Knowledge Test (with the assistance of a Tigrinya interpreter) for her Victorian Learners Permit.

24. On 6 October 2015 The Driver passed a Hazard Perception Test (with the assistance of a Tigrinya interpreter) which is required to be completed successfully before sitting a driving test to obtain a Probationary Drivers Licence.

25. On 2 February 2016 The Driver failed a Probationary Drivers Licence test (with the assistance of a Tigrinya interpreter).

CIRCUMSTANCES OF DEATH

26. At approximately 10.30am on Friday 12 February 2016, Georgina was standing at a bus shelter on Billingham Road, Deer Park, less than 500 metres from her home.

27. At the same time, The Driver was driving a Toyota Corolla and attempting to do a U-turn at the intersection of Winnington Street and Billingham Road.

28. The Driver said that she commenced a U-Turn with the intention of performing a right hand U-turn to travel back down Winnington Street but did not steer the vehicle to the right and instead mounted the left hand kerb towards the bus stop following which her vehicle collided with Georgina. Georgina sustained life threatening injuries and was transported to the RMH, where she was later pronounced deceased.

29. The Driver was drug tested, with negative results and there were no mechanical issues or environmental conditions relevant to the cause of the collision.

30. The Driver was interviewed by police on 19 February 2016 and admitted that she had been driving without a licenced driver present and was aware that she was prohibited from doing so. She said that she had been attempting to make a U-turn to move the position of the vehicle she was driving to an alternative park. The Driver said through the interpreter at the recorded interview,

    What happened is when I was turning right, I sort of – I patted on the brake but unfortunately I patted on the accelerator.

31. The transcript of the Record of Interview recorded The Driver say through the interpreter, amongst other things, her date of birth, that she was an Australian Citizen, that she was a permanent resident of Australia, that she had a passport, where she was from, when she arrived in Australia (Christmas day 2005), the time of the accident, that she held a Learner's Permit, that she paid $40 every fortnight for an hour long driving lesson when she received her payment, as well medications she was taking.

IDENTITY OF THE DECEASED

32. On 15 February 2016, Darren McKeown identified his mother in law, Durdica Serbec (also known as Georgina), born on 18 May 1950.

33. Identity is not in issue and required no further investigation.

CAUSE OF DEATH

34. On 15 February 2016, Dr Matthew Lynch, specialist forensic pathologist at the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination and prepared a written report dated 16 February 2016.

35. Dr Lynch formulated the cause of death as "*1(a) Injuries Sustained in Motor Vehicle Collision (Pedestrian)"*.

36. I accept Dr Lynch's opinion.

Criminal Investigation

37. As part of the criminal trial, a number of medical reports were prepared regarding The Driver for the purpose of determining whether she was fit to stand trial.

38. The reports formed a similar view in relation to The Driver as her having a profound cognitive impairment and an inability to understand trial proceedings.

39. Clinical Psychologist, Dr Michael King[7] noted that The Driver is *below the level of intellectual development required for entry to Australian Primary Schools*, and

    The results of assessment build a strong base for the interpretation that this client at present profoundly diminished intellectual ability. The best interpretation of her functional level in age related terms would be that she is somewhat below the standard of the average 5 year old and may perform at the cognitive level of a 3 year old.

40. Forensic psychiatrist Dr N Zimmerman[8] was advised by The Driver's daughter during an assessment that "*her mother always needed guidance and help and that she does not feel that she is worse now in this regard than she has been in the past"*. Dr Zimmerman noted that The Driver "*speaks no English, has no education, is illiterate in all languages"* and that

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[7] Report dated 29 April 2017. *The results a level of cognitive functionality which is far below the standard deemed as "Intellectual Deficit'. In terms which are easier to understand to a broader audience, this lady is consistently rated as being among (or well below) the poorest 1% of the adult population of her age…, this would necessarily place her a great deal below any standard of cognitive functioning that is expected and required of a functioning healthy normal adult in our society.*
More than this relative ranking (far below the poorest 1% of her age), she is consistently shown to be far below the level of the average 6 year old and on some tests at least (those where such ranking is possible) there is an indicative age as low as a 3 year old, and never an indicative age above 5 years old.

[8] Report dated 8 September 2017.

she "*is not currently functioning independently in the community, depending on her daughter for handling money, shopping and orienting her to tasks and times".*

41. Consultant Clinical Neuropsychologist, Mr M. Jackson[9] noted in relation to specific tests that The Driver "*could not even see that a nose was missing on the face"* (Picture Completion Subtest) and "*was unable to copy a square or a triangle".* Mr Jackson noted that The Driver "*obtained a Full-Scale IQ of 41, which is Extremely Low range and the lowest, but one, score a person can achieve".* And further, "*Overall, the results of the current neuropsychological assessment indicate that* [The Driver] *has generalised profound cognitive impairment in all areas of cognitive function (language, perception, processing speed, working memory, new learning and memory and executive skills)".* Mr Jackson said, "*There is absolutely no doubt that* [The Driver] *has profound generalised cognitive impairment consistent with a moderate, if not severe, intellectual disability".*

42. In addition, I noted the following observations with respect to the experience of interpreters during two of the cognitive function assessments conducted as part of the criminal process:

The interpreter at times told me that her answers 'did not make sense'. The concepts and words she used throughout were very limited and concrete and I attempted to put all questions to her in a similar vein. She would frequently shrug, or state she did not know or could not remember.[10]

She struggled to understand even basic questions and instructions given to her by the interpreter as evidenced by the interpreter trying to re-explain things to her in as simple terms as possible constantly throughout the interview and assessment. On many occasions, he would turn to me and say that she just didn't understand what he was saying or asking.[11]

43. After a jury found The Driver unfit to stand trial on the basis of her cognitive impairment the matter proceeded under the *Crimes (Mental Impairment) Act* and a second jury was empanelled and after a special hearing determined the charge of Drive in a Manner Dangerous Causing Death was proven.

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[9] Report dated 23 November 2017.
[10] Dr Zimmerman.
[11] Mr Jackson.

44. A judge of the County Court then determined to make The Driver subject to a non-custodial supervision order which required that she receive both supervision and treatment as directed by the Secretary of the Department of Health and Human Services (as it then was).

EXAMINATION OF ISSUES

45. No CCTV was available to the Court in relation to any tests undertaken by The Driver. The Sunshine VicRoads office where the various tests took place has subsequently moved location[12].

46. For clarity, I considered that there was no basis to conclude that the interpreters who assisted The Driver during the driving related tests acted outside their professional role or boundaries.

Further Details of Tests undertaken

Eyesight Test

47. On 9 September 2010 DOT records show that an Eyesight Test was conducted and passed by The Driver (without glasses/contact lenses) at Sunshine VicRoads. VicRoads standard processes require that an eyesight test is always conducted on the same day as the Road Law Knowledge Test. VicRoads Work Instructions require that a candidate stand three metres directly in front of the Snellen eye chart[13]. The staff member points to a line on the chart which contains certain letters of the English alphabet and the candidate is asked to read out specific lines. Only one error is permitted.

Road Law Knowledge Test

48. On 9 September 2010 a Road Law Knowledge Test (Computerised Car Learner Test) was conducted and passed by The Driver at Sunshine VicRoads, with the assistance of Tigrinya Interpreter, Saba Tesfamariam, where The Driver scored 25 out of 32 correct (representing 78% which is the minimum pass rate) from randomly generated questions (often accompanied by pictures) from the 'Road to Solo Driving Handbook'.

49. A digital portrait was taken on The Driver with her signature on 9 September 2010.

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[12] From Ballarat Road to Clarke Street.
[13] A Snellen chart is an eye chart that can be used to measure visual acuity.

50. Ms Tesfamariam had no recollection of any of the tests conducted with The Driver on 9 September 2010.

The Hazard Perception Test

51. On 15 July 2015, The Driver failed the Hazard Perception Test without an interpreter.

52. On 6 October 2015, the Hazard Perception Test was conducted and passed by The Driver at Sunshine VicRoads, with the assistance of Tigrinya Interpreter, Mohammed Mahmoud, where The Driver scored 17 out of 28 correct responses.

53. The Hazard Perception Test is comprised of short video scenarios of 28 traffic hazard scenes where the candidate is asked to click on the computer mouse when it is safe to take certain actions such as turn or brake for each particular video scenario with a minimum pass of 54%. The Hazard Perception Test must be successfully completed before the candidate is permitted to undertake a driver test.

54. Mr Mahmoud gave evidence at the inquest and, following been shown a photograph of The Driver (as appeared on her learner's permit), told the Court that he recognised The Driver as the person he had interpreted for on 6 October 2015. Given that nearly five and half years had elapsed since the test was conducted and the giving of his evidence, he was asked why he remembered The Driver. He confirmed that there was nothing specific about The Driver that he remembered and he had not seen her prior or subsequent to that time. He recalled that she was alone at the time the test took place.

Driver Test

55. On 2 February 2016, The Driver failed a Driver Test conducted by a Sunshine VicRoads Licence Testing Officer with the assistance of Tigrinya Interpreter Ghebremedihin Atsebaha.

56. Katrina Sinbandhit[14] who was the licence tester on 2 February 2016 stated the following,

> *I observed during the pre drive check that* [The Driver] *was very slow in understanding what was required. All instructions and directions were given through the interpreter.*[15]

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[14] Statement dated 28 July 2016.
[15] Tigrinya Interpreter Ghebremedhin Atsebaha.

….

When we were in the car park at VicRoads and commenced to leave the car park [The Driver] *drove against car road marking arrow. As there were no cars coming and no pedestrians I recorded this as a Critical Error. We then excited the car park into Harvester Rd. We were required to turn right into Ballarat Road from the right turn lane. When we commence this right turn we cut off the vehicle off that was in the lane to out left, also turning right. During that move* [The Driver] *did not indicate. I marked her down as another Critical Error for this manoeuvre.*

I wanted her to perform a U-turn and come back to VicRoads but she would not follow my instruction. We continued on Ballarat Rd towards Duke St. I was scared. I had my right hand on the handbrake. The errors [The Driver] *made during this drive were, steering was shaking, not using her mirrors,, poor observation of other road users, no head checks, poor judging of gaps in traffic and her speed choice for traffic conditions were poor. I was that scared with her driving that I had to raise my voice to get her to listen*.

57. She further stated that in her opinion,

[The Driver] *is a very bad driver. She has no awareness of her surroundings, that being people or cars. She is a very erratic driver. She had no understanding [of] road markings or road signs.*

Evidence of Practice - Interpreters

58. Ms Tesfamariam[16] who interpreted on 9 September 2010 said,

The sequence of my involvement with VicRoads was, when I arrived at reception at VicRoads I would tell them my name and what language I would be interpreting. I would then get asked to sit down and wait until they call me. When reception call my they would tell me to go to the computer. Usually the client would arrive early. When a computer became free someone from VicRoads would tell the client and myself which computer to go to.

59. She also confirmed that she would be called upon to assist with the conduct of eyesight tests.

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[16] Statement dated 22 October 2020.

60. Mr Mahmoud[17] who interpreted on 6 October 2015 said,

If the client is at VicRoads before me or I arrive at VicRoads before the client, we are both called up to the reception counter when we are both at VicRoads. The reception worker then tells us which computer to go to.

61. Mr Mahmoud also said that he would interpret where necessary for an eyesight test, but this was rarely needed, and if the candidate couldn't read English letters, they would fail. He suggested there were other versions of the Snellen test including a version which would use numbers (for example, a clock).

62. Ghebremedihin Atsebaha[18] who interpreted on 2 February 2016 said,

As an approved interpreter, I interpret for VicRoads during the Knowledge Test for Learners, the Hazard Perception Test for Probationary Drivers and the Driving Test for Probationary Drivers.

….

When I assist with these tests, there is only the applicant and myself at the computer. No one else is present during this testing. When the test is ready to commence, the VicRoads staff member calls me and the applicant to the counter. VicRoads introduces the applicant to me and informs the applicant that I am their interpreter. VicRoads staff then direct us to the computer to be used.

Evidence of DOT

63. Prior to the commencement of the inquest additional information was sought from DOT to help understand the circumstances in which The Driver obtained the Learner's Permit she held at the time of the accident and how she passed the Hazard Perception Test. Following consideration of the evidence in the coronial brief and in particular the reports regarding The Driver prepared for the criminal trial, I asked whether DOT was satisfied that The Driver passed the relevant tests and the basis for that conclusion.

64. DOT provided two statements in response to this request.

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[17] Statement dated 6 March 2021.
[18] Statement dated 15 May 2020.

65. In the first response, Executive Director, Registration and Licencing, Dean Tillotson stated[19], amongst other things, that he was satisfied that The Driver undertook all the tests which were queried, and the basis for his conclusion was DOT's *business records*. Having considered the reports which formed part of the evidentiary material, Mr Tillotson expressed no doubt that The Driver undertook the tests.

66. Mr Tillotson indicated that DOT records suggest that an interpreter was not used by The Driver during the eyesight test on 9 September 2010 but that an interpreter assisted The Driver complete the Road Law Knowledge Test on that date. He noted that interpreters can assist with interpreting the eye chart and that where the candidate has reading difficulties or is unable to comprehend the language available, an interpreter can be used.

67. Mr Tillotson noted that whilst The Driver's medical condition documented as 'diabetic' was identified in her application for a learner's permit on 9 September 2010, that due to an error a copy of the Driver's learner permit application was not forwarded to DOT's Medical Review Team in accordance with their relevant business rules for an assessment of her fitness to drive.

68. Mr Tillotson also stated that that if a licence tester wanted to report concerns in addition to the test results, they could submit an incident report on the DOT Health and Safety database.

69. In the second response[20] provided by DOT, Director, Registration and Licensing, Jacqueline Sampson agreed with the conclusions of Mr Tillotson but provided further details in support, including the manner in which tests are conducted making it impossible for a replacement candidate to *sit* a test. In addition, she noted that it is not intended that a low IQ be a barrier to a person obtaining a learner permit or driver licence in Victoria.

70. Ms Sampson noted that the VicRoads computerised licence/permit test (**CLT**) database of questions has been translated into most of the commonly encountered foreign languages in Victoria. However, there are still many languages that are not as prevalent and are not currently included in the pool of questions. Therefore, many candidates still require interpreting assistance when sitting a CLT and generally with navigating the processes when they attend a VicRoads office. In The Driver's case, she required a Tigrinya interpreter as this language was not included in the translated database of test questions at the time.

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[19] Dated 24 March 2020.
[20] Dated 8 April 2021.

71. Ms Sampson noted that once the candidate's identity is confirmed, the candidate (and interpreter where relevant) is assigned a computer terminal in the open plan CLT area. The CLT area is always clearly visible by VicRoads staff. At least one licensing supervisor, usually multiple staff members, have direct line of site over this open plan area and responsibility for supervising candidate's sitting tests. If, for example, a candidate tried to get someone else to enter the CLT area after confirmation of identification and assignment of the testing terminal has occurred, it was her understanding and expectation that this would be observed by VicRoads staff and they would take action.

72. Ms Sampson said that at the conclusion of the test, the candidate, and interpreter where relevant, reattend the service counter area and if the candidate passed the test, both proceed to the eye-testing station. The interpreter translates from English to the required language and upon successful completion of the eyesight test, both the candidate and interpreter return to the service counter together to complete the process.

73. Ms Sampson said that at every stage during the above process, the candidate's identity is confirmed by VicRoads staff and any concerns about the veracity of a person's identification must be reported and investigated. Ms Sampson was not aware of any concerns having ever been raised about a person's identity after it had been confirmed upon initial presentation at the service area and then questioned during that visit to the VicRoads office (e.g. between being assigned a CLT terminal and returning to have their photograph taken).

74. She stated that at the successful completion of the Learner Permit Test process[21], the candidate reattends the service counter to have their photograph taken and they sign the keypad. This photograph and signature are then used to populate the physical Learner Permit card which is sent to the candidate by post once produced.

75. Ms Sampson said that while knowledge tests cannot *screen out drivers who will be unsafe or whether they will put safe driving behaviours into practice once licensed,* they *can screen out the unacceptably incompetent and as such keep these people out of the licensing system until they demonstrate an acceptable level of road law and safe driving knowledge.*

It is important to note that a low IQ is not, and should not be a barrier to a person obtaining a learner permit or driver licence in Victoria. AusRoads and the National Transport

[21] The Learner Permit Test is now a six hour online test.

Commission, endorse this position concluding that people with an intellectual disability should not be prevented from obtaining a driver licence by virtue of their disability, and instead, the impact of other neurological conditions including developmental and intellectual disability should be assessed individually. The main safeguard and barrier to people that may be incapable of having safe control of a motor vehicle by not allowing them to be issued with a driver licence remains the practical driving test. [The Driver] *failed her only attempt at a practical driving test and was therefore never issued a Probationary Driver Licence that would have permitted her to drive by herself.*

The [Hazard Perception Test] *is different from and not intended to be a substitute for any part of the practical driving test required to obtain a driver licence in Victoria. The driving test focuses on car handling skills and the applicant's ability to demonstrate safe driving on the road, whereas the hazard perception test is computer based, and assesses how you would react to hazards such as other vehicles, pedestrians and cyclists. In other words, a test of responsiveness.*

76. I note that Ms Sampson had firsthand experience regarding how the Sunshine VicRoads office operated having held the position of Director of Customer Service, and had *spent days physically* in the customer service centre. She had worked in VicRoads for more than 20 years.

77. Ms Sampson gave evidence at the inquest and outlined the following matters with respect to general licensing process,

    a. The layout of the licence testing area is specifically designed so there is full visibility in terms of the waiting, testing and customer service areas, and there are mirrors on blind spots and at no time is the customer desk unstaffed;

    b. At all steps of the licensing process there is validation of the person's identification, including after a candidate has used the restroom;

    c. There are standard procedures in relation to identification documentation to verify the identity of a candidate;

    d. A candidate would deal with only one customer service officer throughout the licensing process, as each staff member has their own list of candidates. The only exception being test results, which may be given by a different staff member;

e. Candidates are told where to sit and are not generally permitted to leave the area;

f. There is overt CCTV operating in the computer licencing testing area which can be seen in real time by managers behind the office;

g. Part of staff training is to *maintain observational vigilance* and the need for authentication of the identity of a candidate;

h. Testing times are staggered in order that there are never too many applicants being processed at one time;

i. The eyesight test is completed prior to the learner driver test and again prior to the driver test;

j. The eye chart uses the alphabet and no other symbols. It is possible that a candidate could write down what letter they saw on a piece of paper if they could not respond in English (described as an active practice to meet the needs of different clientele demographics);

k. Excluding a candidate who is *unacceptably incompetent* would include someone with a severe cognitive impairment with functioning between the ages of three and five;

l. For a candidate with a mild intellectual disability there is a different pathway within the system which may result in conditions on a licence; and

m. The licensing system is graduated with the final control as the practical driver test which is the most important road safety control.

78. Ms Sampson outlined the following matters with respect to The Driver and the tests she was documented to have undertaken,

a. Diabetes is not a medical condition that would have prevented The Driver from being able to hold a learner permit, even if the condition was not well managed. However, prior to issuing such a permit, there would have been a request to The Driver's general practitioner to provide a medical fitness to drive assessment, which would include medical conditions that are likely to place a driver at risk from a driving perspective, including any cognitive issues;

b. Ms Sampson was not able to conclude *absolutely* that there was not an interpreter used during The Driver's eyesight test on 9 September 2010, but it appears from DOT's records that The Driver *didn't have support during her eye test*;

c. It is apparent that The Driver passed an eyesight test (vision test) prior to her driver test on 2 February 2016, but as she failed the driver test the details of the eyesight test were not kept in the system;

d. That if the conclusions reached by the medical practitioners with respect to The Driver's capabilities were accurate, *there is no way that someone of that functioning would've been able to pass the assessments;*

e. Based on Ms Sampson's knowledge of the licensing process, the evidence of identity and photo requirements as well as the logistics of the Sunshine Office (*in terms of the immediate oversight over the testing procedures*) it was impossible for someone else to have switched places with The Driver in 2010 and 2015; and

f. Ms Sampson did acknowledge that there are instances where individuals set about to deceive VicRoads in relation to their processes (*I'm not gonna say that that doesn't happen*).

The record of interview with The Driver

79. Coroner's Investigator Sergeant England gave evidence at the inquest and said with respect to the conduct of the Record of Interview that: The Driver could follow the questions that he put to her through the interpreter and responses were provided; she could identify the car she was driving from a photograph; she could point to the registration plate but didn't know the letters and numbers; she didn't know her address and pointed to her Victorian health care card for her name. Sergeant England was familiar with the process where an independent person is required for the purpose of an interview in cases where he formed the opinion that the person had a cognitive impairment and this process was not utilised for the Record of Interview.

Video record of the interview with The Driver

80. Following the conclusion of the inquest the Court obtained a copy of the video Record of Interview (in addition to the transcript which was part of the Coronial Brief). The interview

took place a week after the incident and approximately four months after The Driver undertook the Hazard Perception Test.

81. As noted by Counsel Assisting, the transcript does not record the words spoken by The Driver or the interpreter in Tigrinya, nor does it capture The Driver's gestures or the photographic and documentary material she is shown by police in the interview. It was Counsel Assisting's view that the video captured a number of matters which are at odds with the psychological and intelligence testing and conclusions reached in some of the reports, in particular, the assessments related to visual pattern matching, spatial orientation, visuospatial and perceptual abilities.

82. I note that the assessment dates for the medical reports prepared for the criminal trial occurred well after the driving related tests (2010 and October 2015); the accident (12 February 2016) and the Record of Interview (19 February 2016), being 28 April 2017[22], 6 April 2017[23], 15 November 2017[24] and 14 February 2018.[25]

83. I made the following observations in relation to the Record of Interview,

    a. The Driver produced an earlier learner's permit card from her bag which she said had been lost as part of her response to when she first got her learner's permit;

    b. The Driver produced a document from VicRoads in relation to her driver test conducted on 2 February 2016 as part of her response to whether she had been to VicRoads to undertake a probationary licence test;

    c. When asked what the colour of the car she was driving on the day of the accident, The Driver pointed to a piece of paper to indicate the colour white and, when asked to describe the colour of her daughter's vehicle pointed to an item that was green in a photo; and

    d. The Driver made the shape of a circle with her finger (with reference to a satellite street map being used by police) as part of her answer to describe the movement she made with her vehicle before approaching Billingham Road to attempt the U turn before the accident.

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[22] Dr King.
[23] Dr Zimmerman
[24] Mr Jackson
[25] Professor Ogloff.

Conclusions

84. The scope of the inquest was confined to examining the basis upon which DOT was satisfied that The Driver passed certain driver related tests given the conclusions of a number of medical assessments of The Driver for the purpose of the criminal trial; clarification of the circumstances in which The Driver passed those tests; and whether there were any prevention opportunities arising from Georgina's death.

85. The scope of the inquest was necessarily limited as a criminal charge had been found proven and The Driver acknowledged that she drove against the terms of her licence (by not having an experienced driver sitting beside her as required by her Learners Permit) at the time of the accident.

86. It was apparent that Ms Sampson on behalf of DOT was a well-informed witness with firsthand knowledge of the operations of the relevant Sunshine VicRoads office and its security measures at the time The Driver was documented to have undertaken driver related tests in 2010, 2015 and 2016.

87. Ms Sampson said at inquest that a person with the abilities described in the relevant medical reports would not have been able to pass the driving related tests documented to have been undertaken by The Driver in 2010 and 2015.

88. Ms Sampson noted with respect to the relevance of those medical reports: the timing of the assessments; The Driver's circumstances at the time of the assessments (following the accident); and their purpose (to determine fitness for trial).

89. It was also Ms Sampson's evidence that it was not possible for another person to have switched places with The Driver to undertake those tests in 2010 and 2015, given her knowledge of the security measures in place at the time. In fact, I heard no (feasible) theory of how it could have occurred, either in the context of the security measures that were in place at time , and on two separate occasions. There was no suggestion that The Driver did not attempt the practical driving test on 2 February 2016.

90. Whilst Ms Sampson was unable to definitively say whether an interpreter assisted The Driver with the eyesight test conducted on 9 September 2010, she outlined different ways a person with language difficulties could undertake the test, and was satisfied that The Driver had undertaken and passed the eyesight test herself.

91. I note that the question of the validity of the expert evidence prepared for the purpose of criminal trial was not under scrutiny by this Court and is beyond the scope of the inquest. As such, the observations I have made about the Record of Interview are not intended to and do *not displace* the expert evidence contained in those reports. Nevertheless, amongst all of the evidence considered in this matter, the Record of Interview does not in my opinion give rise to any concern related to the tests documented as successfully completed in 2010 and 2015.

92. In addition, whilst it is difficult to assess what weight should be given to the identification evidence of Mr Mahmoud given the passage of time, it is also not evidence which raises any concern related to the test said to be completed by The Driver in 2015.

93. I now consider that there is no proper basis within the scope of this investigation to further examine the conclusions reached by DOT regarding the tests documented to have been passed by The Driver in 2010 and 2015, and in particular the robustness of the security measures in place at the relevant times. Counsel Assisting noted that whilst no system is impenetrable, Ms Sampson's evidence was credible and founded on her significant, and directly relevant experience working for DOT.

94. In these circumstances, having considered the available evidence as well as noting the possible limitations of the medical reports in the context of their timing, circumstance and purpose, I am satisfied that there is a proper basis for the conclusions reached by DOT in relation to the tests documented as successfully completed by The Driver in 2010 and 2015.

95. I was unable to find any systemic issues related to the death, and in those circumstances, there is no basis upon which to formulate any prevention recommendations in this matter.

FINDINGS

96. Pursuant to section 67(1) of the Act I find as follows:

(a) the identity of the deceased was Durdica Serbec (as known as Georgina) born on 18 May 1950;

(b) Durdica Serbec died on 12 February 2016 at Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, from 1(a) *Injuries Sustained in Motor Vehicle Collision (Pedestrian)*; and

(c) the death occurred in the circumstances described above.

97. I convey my sincere condolences to Georgina's family for their loss and acknowledge the heartbreaking circumstances in which her death occurred.

98. Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Katherine McKeown, Senior Next of Kin

Paul Bourke on behalf of the family

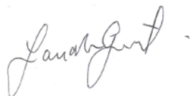
Department of Transport

Maddocks Lawyers on behalf of the Department of Transport

Victoria Legal Aid on behalf of The Driver

Sergeant David England, Coroner's Investigator, Victoria Police

Signature:



Coroner Sarah Gebert

Date: 24 November 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.