IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 005436

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge Liberty Sanger, State Coroner
Deceased:	Linette Ann Hawkins
Date of birth:	5 May 1944
Date of death:	13 September 2024
Cause of death:	1a: Injuries sustained in a motor vehicle collision (driver)
Place of death:	The Alfred Hospital 55 Commercial Road Melbourne Victoria 3004

INTRODUCTION

1. On 13 September 2024, Linette Ann Hawkins was 80 years old when she passed away at The Alfred Hospital ('**The Afred**') from injuries sustained in a motor vehicle collision. At the time of her death, Linette lived at unit in Malvern, Victoria.

2. Linette was in a long-term relationship with Noel Lamont, until his passing in 2005. The pair were together for about 25 years and lived in Prahran. For about 18 years, Linette continued to live at the Prahran address she once shared with Noel. About one and a half years before her passing, Linette moved to her Malvern unit.

3. Linette previously worked as a social worker and an academic where she lectured at universities. Her brother, Anthony Hawkins described her as highly intelligent.

Medical History

4. In 1972, Linette was involved in a motor vehicle collision as a pedestrian in The Hague, Netherlands and sustained a traumatic brain injury (**TBI**) as a result. It is reported that she experienced a seizure following presentation to hospital and experienced seizure-like episode about five months after the incident.

5. In or about 2000, Linette sought a neuropsychiatry review due to concern about her declining memory. Although she reported her worries about episodes of blackout characterised by episodes of non-responsive and speech arrest, the neuropsychiatric assessment was unremarkable.

6. Since June 2020, Linette attended general practitioner, Dr Disha Lyer, at Next Practice Prahran Medical Centre on average of about six times per year for management of her chronic conditions. These included, type 2 diabetes, hypercholesterolaemia, osteoarthritis and hypothyroidism. There is no evidence that Linette suffered mental ill health or disclosed thoughts of suicidal ideation to Dr Lyer.

7. Most recently, on 16 February 2023, Linette attended an appointment with neurologist, Dr Christopher Dwyer at Malvern Neurology. Dr Lyer referred Linette to Dr Dwyer after she disclosed concerns about her declining memory.

8. During the consultation, Linette stated one time in December 2022 she became non-responsive whilst she drove her vehicle home. Consequently, she became involved in a minor motor vehicle incident due to confusion between the accelerator and brake pedal. She also

mentioned that she was not aware of any further events before December 2022 and she had been maintaining her usual medication regime (levothyrocine, perindopril and rosuvastatin).

9. In the specialist consultation report to Dr Lyer, Dr Dwyer noted his clinical impression of Linette's behaviour in December 2022 was "*suggestive a period of post-ictal*". Dr Dwyer also reviewed her computed tomography (**CT**) scan, which demonstrated left frontal and temporal encephalomalacia and taking in account the behavioural arrest episode, further reinforced his opinion that her behaviour was most consistent with seizure activity.

10. In the same report, Dr Dwyer recorded that he advised Linette she was not permitted to drive for 12 months in accordance with the *Austroads Assessing Fitness to Drive* guidelines[1] (**Austroads Guidelines**). He further cautioned that, should she disregard this advice, she could face legal consequences if she caused a motor vehicle collision. It is unclear from Dr Dwyer's report whether he contacted VicRoads or directed Linette to report to VicRoads as to her fitness to drive. Victoria Police contacted the VicRoads Medical Review Team who confirmed there was no record of any medical review or suspension with respect to Linette's licence. [2]

11. In about September 2023, Dr Dwyer referred Linette for a magnetic resonance imaging (**MRI**) and electroencephalogram (**EEG**). The MRI result revealed no other significant abnormality. The appearance of her brain was otherwise normal apart from the findings of mild supratentorial small vessel disease and a healed injury in the front of the brain. The EEG result similarly revealed a normal EEG reading with no evidence of epileptiform or abnormalities.

12. According to Dr Lyer, Linnette did not attend a follow up appointment with Dr Dwyer afterwards given her MRI and EEG results. Dr Lyer noted that Linette resumed driving in about December 2023, Linette resumed driving and reported no further "*unconscious collapses or episodes*" to Dr Lyer.

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[1] Austroads, *Assessing fitness to drive for commercial and private vehicle drivers - Medical standards for licensing and clinical management guidelines*, Sixth Edition, 2022 ('**Austroads Guidelines 2022**').

[2] There are no mandatory reporting requirements in Victoria for health professionals to report. However, health professionals have a duty to inform their patient about the way in which their medical condition can affect their ability to drive safely, and whether they have an obligation to self-report. A health professional, however, should consider their duty to notify Medical Review if they believe their patient lacks insight/judgement and isn't following advice to cease driving or self-report. According to Dr Dwyer, Linette took "*copious notes during her review"* and "*assured [Dr Dwyer] that she understood her obligations"* and would not drive for 12 months. < *https://transport.vic.gov.au/registration-and-licensing/licences/medical-conditions-and-reviews/health-professionals-completing-medical-reviews*>.

THE CORONIAL INVESTIGATION

13. Linette's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

14. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

15. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

16. State Coroner, Judge John Cain (as his Honour then was) originally held carriage of this matter, prior to this retirement in August 2025. I assumed carriage of this investigation on 1 September 2025.

17. Victoria Police assigned Senior Constable Christina Reay (**SC Reay**) to be the Coronial Investigator for the investigation of Linette's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

18. This finding draws on the totality of the coronial investigation into the death of Linette Ann Hawkins including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[3]

[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.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased

19. On 13 September 2024, Linette Ann Hawkins, born 5 May 1944, was visually identified by her brother, Anthony Hawkins.

20. Identity is not in dispute and requires no further investigation.

Medical cause of death

21. Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 17 September 2024 and provided a written report of her findings dated 18 September 2024.

22. The post-mortem examination and CT scan revealed a subdural haemorrhage and extensive subcutaneous emphysema, which were consistent with The Afred's clinical findings and the prescribed circumstances.

23. Toxicological analysis of ante-mortem samples identified the presence of midazolam, rocuronium, ketamine and lignocaine, consistent with medications administered during an emergency and intensive treatment and care setting.

24. Dr Francis provided an opinion that the medical cause of death was *injuries sustained in a motor vehicle collision (driver)*.

25. I accept Dr Francis' opinion as to the medical cause of death.

Circumstances in which the death occurred

26. At 12.15pm on 12 September 2024, Linette drove her black 2013 Nissan Sedan ('**the Sedan'**) north along Blackburn Road. According to Anthony, Linette had plans to meet up with a friend for lunch.

27. As Linette approached the intersection of Blackburn Road and Waverly Road, the traffic light changed red. However, Linette disobeyed the red traffic light and continued to drive at high speed through the intersection in the left lane.

28. Across the intersection, the left lane on Blackburn Road begins to end and this required Linette to merge lanes. However, Linette continued to drive the Sedan at a high speed in the left lane.

As a result, the Sedan "*clipped the curb*" when the left lane ended, then collided with the rear of a white 2017 Nissan wagon ('**the Wagon'**) in the middle lane of Blackburn Road. After impacting with the Wagon, the Sedan continued to veer left and collided with a bus stop and concrete barrier outside Waverley Private Hospital. According to members of the public, the Sedan then appeared to 'ricochet' off a wooden power pole and came to a stop across the northbound lanes of Blackburn Road.

29. Simultaneously, the Wagon was pushed to the right of Blackburn Road into oncoming lanes from the Sedan's rear impact. The Wagon then struck a white 2019 Ford Ranger utility ('**the Ford'**) in the right lane which was driving south down Blackburn Road at the time of the incident. The impact with the Ford resulted in the Wagon being "*spun out of control*".

30. According to fellow motorist, Graeme Meer, the Wagon "*looked like it had been rear ended and was in pieces all over the road*." The Wagon then came to a 'backwards stop' in the gutter of Blackburn Road, whilst Graeme recalled the Ford was "*completely caved in from the front*" and came to a stop opposite Waverley Private Hospital in the right-hand lane which headed south towards the intersection.

31. Witnesses immediately came to the aid of Linette and called triple zero.

32. Members of the public, including Darryn Hill, attempted to pry open the Sedan driver's side door with crowbars, in an attempt to extract Linette from the vehicle. However, after he assessed the damage to the Sedan, Darryn stopped the individuals trying to assist, as Linette was pinned inside the Sedan and the driver's side door held her in position. Darryn is a trained volunteer firefighter with about 30 years' experience and considered Linette would suffer further serious injuries if the door moved.

33. A member of the public assisted Darryn to smash the Sedan driver's side window which allowed him to get inside the Sedan and administer first aid. Darryn recalled Linette "*continued to go in and out of consciousness*" and he attempted to communicate with her before emergency services arrived.

34. Fire Rescue Victoria (**FRV**) and Ambulance Victoria (**AV**) paramedics were first to respond to the scene. Victoria Police arrived at about 12.30pm.

35. FRV safely extracted Linette from the Sedan a Mobile Intensive Care Ambulance arrived later assessed Linette as unconscious, with a large haematoma to the right of her forehead, clavicle and neck, as well as lacerations to her arms. FRV members also noted that Linette was

confused when they extracted her from the Sedan. Paramedics intubated Linette at the scene and transported her to The Alfred.

36. Paramedics also assessed the drivers of the Ford and Wagon and a passenger in the Wagon. All individuals survived the collision:

    a) The driver of the Wagon suffered multiple bruises over her body. Her son seated in the passenger seat of the Wagon at the time of the collision and suffered lacerations to his face and head, injury to his tongue and a minor fracture to his left shoulder. The pair were transport to The Alfred for treatment.

    b) The driver of the Ford suffered no injuries from the collision.

37. At 1.48pm, Linette arrived at The Alfred and was admitted under the Trauma Team. She was noted to sustain multiple injuries including a right frontal subdural haematoma, left temporal subarachnoid haemorrhage, fractures across her body and pneumothorax. A blood sample were taken Linette upon her arrival to the Alfred and subsequent testing returned negative results for drugs and alcohol.

38. A multidisciplinary meeting was held with Alfred Health Neurosurgery, Trauma and Emergency Medicine and Linette's family. According to Dr Michael Noonan, the "*early consensus medical decision was that active traumatic brain injury management was futile*."

39. Following discussions, Linette was transferred to the palliative care unit for comfort care.

40. At 5.55pm on 13 September 2024, Linette was declared deceased.

VICTORIA POLICE INVESTIGATIONS

41. Highway Patrol Unit of Victoria Police conducted a preliminary inspection the Ford and Wagon. Police concluded that both vehicles did not appear to have pre-impact mechanical faults that would have contributed to the collision.

42. Senior Constable David Giulieri (**SC Giuelieri**) of Victoria Police Collision Reconstruction and Mechanical Investigation Unit completed a mechanical examination of the Sedan. SC Giuelieri concluded that there were no "*faults, failures or conditions that could have caused or contributed to the collision*."

43. A review of the CCTV footage from Waverley Private Hospital revealed that Linette drove at a high speed, above the 60km/h limit on Blackburn Road. Witnesses also reported to police that they did not see the Sedan brake prior to the collision.

44. Having considered all factors that may cause and/or contribute to the collision, SC Reay formed the opinion that Linette likely suffered a medical episode similar to her December 2022 collision, given the "*lack of braking and evasive driving*".

FINDINGS AND CONCLUSION

45. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Linette Ann Hawkins, born 5 May 1944;

    b) the death occurred on 13 September 2024 at The Alfred Hospital, 55 Commercial Road, Melbourne, Victoria 3004, from injuries sustained in a motor vehicle collision (driver); and

    c) the death occurred in the circumstances described above.

46. Having considered all the evidence, I find that Linette most likely experienced a medical episode while approaching the intersection, which caused her to disobey the red light and proceed through it at high speed. The weight of the evidence before me does not enable me to make a finding regarding the precise cause of the medical episode. One possibility is a relapse of her seizure, given her medical history.

47. I convey my sincere condolences to Linette's family for their loss.

COMMENTS

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

Fitness to drive

1. Driving is a complex task that depends on a person's vision, problem solving, perception and physical coordination. Many health conditions as well as medications or intervention used in the management of health may adversely affect these functions and thereby compromise a person's capacity to drive safely.

2. Assessment of an individual's fitness to drive is therefore an important consideration in prompting road safety and community mobility. The Austroads Guidelines provide several conditions with the potential to cause significant impairment and/or sudden incapacity include blackouts, cardiovascular conditions, diabetes, hearing loss and deafness, musculoskeletal conditions, neurological conditions, psychiatric conditions, substance misuse/dependency, sleep disorders, and vision problems.[4]

Reporting requirements in Victoria

3. There are no mandatory reporting requirements for health professionals in Victoria. Reporting is only mandatory in South Australia and the Northen Territory. There is also no requirement of mandatory medical assessment in Victoria once a person reaches a certain age with regular assessments thereafter.[5]

4. Nonetheless, Victorian health practitioners have an ethical and public health duty of care to support patient and public safety by informing their patient about the way in which their medical condition can affect their ability to drive safely, and that they have an obligation to self-report. Health professionals should also consider their duty to notify Medical Review, Department of Transport and Planning (**DTP**), if they believe their patients lack insight/judgement and are not following advice to cease driving or self-report.

5. This self-reporting model relies heavily on a patient's insight and willingness to comply with medical advice. Previous coronial investigations have identified cases in which health practitioners recognised significant risks to driving safety but did not notify authorities.

Pertinent coronial recommendations

6. Considering these concerns, Victorian coroners have since 2014 made coronial recommendations and commented on the importance of mandatory reporting for health

[4] Austroads Guidelines 2022 – Part 2.2 Impact od medical conditions on driving, page 10.
[5] Ibid, Appendix 3 Legislation relating to reporting, page 227-228.

practitioner to compel them to notify VicRoads when a patient's medical condition is likely to adversely affect their fitness to drive.[6] [7]

7. In response to these recommendations, DTP advised that it does not support introducing a mandatory reporting obligation. The Department noted that the current self-reporting model aligns with the appropriate balance between public safety, patient confidentiality and the therapeutic relationship between health practitioners and their patients.

8. Instead of legislative reform, the Department advised that it continues to promote awareness among health practitioners about their existing obligations and the use of the Austroads Guidelines to support decision making. The Department outlined a series of recent initiatives, notably, the release of new sources – the Medicinal Cannabis and Driving Decision Support Resources, accompanied by the Driving Needs Checklist and Medicinal Cannabis and Driving Fact Sheet to assist health practitioners in assessing fitness to drive and understand driving impairment risks associated with medicinal cannabis. These strategies were reported to have been successful with strong growth in notification from both health practitioners and drivers to the DTP Medical Review Team.

9. I acknowledge DTP's continuing efforts to strengthen voluntary reporting mechanisms and note the positive trend in health practitioners' referrals following the introduction of new sources. Nevertheless, it remains apparent from the circumstances of numerous coronial investigations into fatal motor vehicle incidents in Victoria that reliance on voluntary and self-reporting present the risks of leaving gaps identifying drivers whose medical conditions may pose a risk to themselves and others.

[6] In the Finding into Death of Petroula Krassos (COR 2011 2908) delivered on 6 May 2014, then-Coroner Rosemary Carlin made groundbreaking recommendations including a recommendation to the Department of Transport, Planning and Local Infrastructure to amend the *Road Safety (Drivers) Regulations 2009* to include a statutory obligation for reporting by medical practitioner of patients immediately upon diagnosis with epilepsy. Subsequently in the Finding of into Death of Nicholas Carr (COR 2015 4295) delivered on 28 November 2016, Coroner Audrey Jamieson expanded the scope of mandatory reporting where she 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*".

[7] See also Findings into Deaths of Frederick Hylla (COR 2016 4011) delivered on 28 August 2017; Pamela Elsdon (COR 2016 55554) delivered on 7 September 2017; Stanislaw Czubryj (COR 2017 1790) delivered on 22 February 2018; Jackson Easles (COR 2016 6147) delivered on 18 August 2023; Robert Banks (COR 2020 0256) delivered on 12 March 2025.

10. In this context, I endorse and support the recommendations made in previous coronial investigations by Victorian coroners calling for the introduction of a mandatory reporting requirement for health practitioners in Victoria.

PUBLICATION OF FINDING

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

DISTRIBUTION OF FINDING

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

Lewis Hawkins, Senior Next of Kin

The Alfred Hospital, Alfred Health

Carmel Laragy

Transport Accident Commission

Secretary of the Department of Transport and Planning

VicRoads

Senior Constable Christina Reay, Coronial Investigator

Signature:

Judge Liberty Sanger
State Coroner
Date: 8 January 2026

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.