IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 001637

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Phyllis Alma Maud Brady
Date of birth:	18 April 1935
Date of death:	30 March 2021
Cause of death:	1(a) Multiple injuries sustained in a motor vehicle incident (driver)
Place of death:	Airly Road, Stratford, Victoria, 3862

INTRODUCTION

1. On 30 March 2021, Phyllis Alma Maud Brady was 85 years old when she died in a motor vehicle collision on Airly Road, Stratford. At the time of her death, Phyllis lived at unit 2 of 487 Raymond Street, Sale.

2. Phyllis' medical history included dementia, hypertension, hypercholesterolaemia, type II diabetes mellitus, osteoporosis, a cerebrovascular accident, hysterectomy, hemicolectomy, and cholecystectomy. At the time of her death, Phyllis was prescribed donepezil, denosumab, and telmisartan/amlodipine.[1]

3. Phyllis' son, John Brady, described his mother as being very fit for her age.[2] She held a current Victoria Driver's Licence with a clean driving record.[3] Phyllis had owned her vehicle for several years and had never experienced any mechanical issues with her car.[4]

4. On 5 March 2020, Phyllis attended a health assessment with her general practitioner, Dr Yousef Ahmed. Dr Ahmed performed a memory assessment and noted that Phyllis was suffering from mild cognitive decline. A follow up was performed over the following months which also assessed her driving ability and noted that she appeared to be coping well.[5]

5. On 1 February 2021, Dr Ahmed recommended a family meeting with Phyllis' son, John Brady, after noting that Phyllis was starting to struggle with her activities of daily life. John attended the meeting on 5 February and told Dr Ahmed that his mother was still driving, however she has begun to get lost on occasion.[6] Dr Ahmed suggested that he remove her access to the car, noting that she should not drive anymore, and could no longer live independently. A plan was made for Phyllis to move in with John or his sister in the future.[7]

6. John later suggested to Phyllis that she stop driving, offering to provide transport, and encouraging her to catch taxis, however his mother was not keen on the idea of losing her independence.[8]

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[1] Medical Examiner's Report dated 19 May 2021, page 2.
[2] Coronial Brief, statement of John Brady dated 29 June 2021, page 6.
[3] Coronial Brief, VicRoads Driving Certificate dated 29 July 2021, pages 40-41.
[4] Coronial Brief, statement of John Brady dated 29 June 2021, page 6.
[5] Coronial Brief, statement of Dr Yousef Ahmed dated 7 July 2021, page 42.
[6] Coronial Brief, statement of Dr Yousef Ahmed dated 7 July 2021, pages 43-44.
[7] Coronial Brief, statement of John Brady dated 29 June 2021, pages 6-7, statement of Dr Yousef Ahmed dated 7 July 2021, pages 43-44.
[8] Coronial Brief, statement of John Brady dated 29 June 2021, page 6.

THE CORONIAL INVESTIGATION

7. Phyllis' 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.

8. 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.

9. 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.

10. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Phyllis's death. The Coroner's 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.

11. This finding draws on the totality of the coronial investigation into the death of Phyllis Alma Maud Brady 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.[9]

12. In considering the issues associated with this finding, I have been mindful of Phyllis' basic human rights to dignity and wellbeing, as espoused in the Charter of Human Rights and Responsibilities Act 2006, in particular sections 8, 9 and 10.

[9] 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

Circumstances in which the death occurred

13. On 30 March 2021, Phyllis began driving to Stratford along Airly Road to attend a friend's funeral.[10] At approximately 11.45pm, her vehicle was observed driving towards the intersection of Airly Road and Princes Highway in a slightly erratic fashion, veering to the left and right within her own lane.[11]

14. Phyllis' vehicle was observed to enter the intersection at approximately 15km/hr without braking or stopping directly into the path of an oncoming log truck.[12] Witnesses stated the log truck flashed its lights and honked its horn several times however Phyllis' vehicle did not appear to take any evasive action.

15. The driver of the truck activated his brakes to avoid the collision with Phyllis' vehicle but was unable to stop in time, impacting Phyllis' car on its righthand side at approximately 80km/hr and pushing her vehicle 74 metres down the road before coming to a stop.[13]

16. The section of the road where the collision occurred was at the intersection of Airly Road and Princes Highway. Princes Highway has two sealed lanes travelling in a north-south direction with a single lane of traffic in each direction and a sealed shoulder that gives way to grass land. There is a continuous double white line separating the lanes. As the highway approaches the intersection, it has a posted speed limit of 80km/hr, and additional left- and right-turning lanes are added to allow traffic to enter the bordering roads.[14]

17. Airly Road is a two-lane bitumen road in an east-west direction with a dirt and grass shoulder, located on the eastern side of the Princes Highway. There is a single lane of traffic in each direction, with broken white line dividing the two lanes. It has a speed limit of 80km/hr, with a visible stop sign posted at the intersection.[15] Offset on the western side of the Princes Highway is Stratford Maffra Road.[16]

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[10] Coronial Brief, Victoria Police Traffic Incident Report dated 30 March 2021, page 23.
[11] Coronial Brief, statement of Eleanor Abel dated 29 June 2021, page 9; Victoria Police Traffic Incident Report dated 30 March 2021, page 23.
[12] Coronial Brief, statement of Eleanor Abel dated 29 June 2021, page 10.
[13] Coronial Brief, statement of Eleanor Abel dated 29 June 2021, page 10; statement of John Bell dated 10 July 2021, pages 12-13; Victoria Police Traffic Incident Report dated 30 March 2021, page 19.
[14] Victoria Police Traffic Incident Report dated 30 March 2021, pages 19-25.
[15] Victoria Police Traffic Incident Report dated 30 March 2021, pages 19-25.
[16] Victoria Police Traffic Incident Report dated 30 March 2021, pages 19-25.

18. To cross the Princes Highway from Airly Road into Stratford Maffra Road, traffic must proceed up a gentle slope before coming to a complete stop at the intersection before proceeding across the intersection. There is clear visibility of traffic approaching the intersection on the Princes Highway in a southerly direction. At the time of the collision, the weather was clear, and the road surface was dry.[17]

19. Witnesses contacted emergency services and attempted to render assistance to Phyllis who was in an unresponsive condition following the collision.[18] Emergency services attended the scene at 11.54pm however Phyllis was unable to be revived and was verified as deceased by Ambulance Victoria paramedics at 12.04pm.[19]

Identity of the deceased

20. On 7 April 2021, Phyllis Alma Maud Brady, born 18 April 1935, was visually identified by her son, John Brady.

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

Medical cause of death

22. Forensic Pathologist Dr Chong Zhou from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 1 April 2021 and provided a written report of her findings dated 19 May 2021.

23. The post-mortem examination revealed extensive traumatic injuries consistent with the history given.

24. The autopsy also revealed incidental findings including a focal area of replacement subendocardial fibrosis within the posterior left ventricle with patchy interstitial and perivascular fibrosis. There was moderate atherosclerosis within the coronary arteries, with severe atherosclerosis of the infrarenal aorta. Moderate steatosis of the liver was observed, as was reduplication of the internal elastic lamina of arcuate and interlobular arteries of the kidneys, consistent with chronic hypertensive changes, and bilateral pale kidneys.

[17] Victoria Police Traffic Incident Report dated 30 March 2021, pages 19-25.
[18] Coronial Brief, statement of Eleanor Abel dated 29 June 2021, page 10.
[19] Ambulance Victoria Verification of Death form dated 30 March 2021, page 27; VACIS e-PCR (Case #10612) dated 30 March 2021, page 47.

25. Dr Zhou noted that there was no significant natural disease of the internal organs which could have resulted in sudden incapacitation, change in her level of consciousness, or death.

26. Toxicological analysis of post-mortem samples identified the presence of amlodipine. Alcohol was not detected.

27. Dr Zhou provided an opinion that the medical cause of death was from 1 (a) multiple injuries sustained in a motor vehicle incident (driver).

28. I accept Dr Zhou's opinion.

CPU REVIEW

29. To assist with my investigation into the death of Phyllis, I directed the Coroners Prevention Unit[20] (**CPU**) to determine whether Dr Ahmed should have reported his concerns regarding the impact of Phyllis' dementia on her ability to safely drive directly to VicRoads following the identification of a deterioration in her cognitive state.

30. On review, the CPU advised that there is currently no mandatory requirement for health practitioners to report concerns regarding an individual's ability to drive to VicRoads (or any other state driving governing authority).[21]

31. The CPU noted that there is no good correlation between screening tests for dementia and the ability to drive.[22] Phyllis' memory assessment was indicative of mild dementia – according to the Australian and New Zealand Society for Geriatric Medicine, it would be 'unreasonable' to suspend her licence on that assessment alone.

32. The CPU concluded that the most accurate indicator of an individual's ability to drive is through familial observations. I note John's assessment of his mother's driving ability in his statement to Victoria Police in which he stated to Dr Ahmed that Phyllis' was "driving quite okay" but did eventually suggest that his mother stop driving, to which she refused.[23]

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[20] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[21] https://www.vicroads.vic.gov.au/licences/health-and-driving/information-for-health-professionals/know-your-responsibilities

[22] https://www.racgp.org.au/afp/2012/april/dementia-and-driving/

[23] Coronial Brief, statement of John Brady dated 29 June 2021, page 7.

33. Losing one's ability to drive represents a significant loss of independence for the affected individual and is a very difficult decision to make. The best method regarding concerns about a family member's driving ability is through the utilisation of a team approach involving the individual, their treating practitioner, and family members, however I acknowledge the inherent reluctance to give up one's independence, and the potential effects such a discussion may have on the relationship between the individual, their family, and/or their doctor.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Phyllis Alma Maud Brady, born 18 April 1935;

    b) the death occurred on 30 March 2021 at Airly Road, Stratford, Victoria, 3862, from multiple injuries sustained in a motor vehicle incident (driver); and

    c) the death occurred in the circumstances described above.

35. In consideration of the cause of Phyllis' death, I note the conclusions of the Victoria Police investigation in which the investigating officer concluded that whilst the collision was likely the result of driver error on Phyllis' part, the fact that she was sitting at a low level in a small vehicle may have restricted her view of oncoming traffic at the intersection.[24]

36. The investigator also highlighted the witnesses' observations of her erratic driving prior to the collision, noting that Phyllis was driving to a funeral at the time of the collision and may have been considerably upset.[25] This may have also been a contributing factor in the tragic collision which claimed her life.

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

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.

[24] Coronial Brief, Victoria Police Traffic Incident Report dated 30 March 2021, page 23.
[25] Coronial Brief, Victoria Police Traffic Incident Report dated 30 March 2021, page 23.

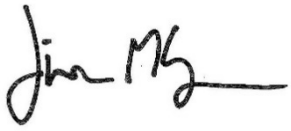
I direct that a copy of this finding be provided to the following:

John Brady, Senior Next of Kin

Traffic Accident Commission

First Constable Cam Lake, Victoria Police, Coroner's Investigator

Signature:



CORONER SIMON McGREGOR

CORONER

Date: 30 May 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.