IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2016 006147

FINDING INTO DEATH OF JACKSON DAVID EALES

Form 37 Rule 63(1)

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

Findings of:	Jacqui Hawkins, Deputy State Coroner
Delivered on:	18 August 2023
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria, 3006
Inquest hearing dates:	1 – 8 February, 21 April 2023
Counsel Assisting the Coroner:	Ms Anna Martin of Counsel, instructed by Ms George Carrington, Coroners Solicitor, Coroners Court of Victoria
Ms Gerardine Eales:	Ms Phoebe Prosser of Counsel, instructed by Tom Burgoyne of Fortitude Legal Geelong

Mr Gerard Voss:	Ms Cara Foot of Counsel, instructed by Mel Cox of Geelong Law
Dr Stephen Fryman:	Mr Phillip Cadman of Counsel, instructed by Louise Williams and Isabella Van Schaik of Kennedys Law
Toll Holdings Ltd:	Ms Diana Manova of Counsel, instructed by Tim Coghlan of Collins Biggers and Paisley
Department of Transport:	Mr Richard Stanley of Counsel, instructed by Hannah Sowdon of Thomson Geer
WorkSafe:	Ms Gemma Cafarella of Counsel, instructed by Portia Makwanya and Kirsten Hughes of WorkSafe Victoria
National Heavy Vehicle Regulator:	Mr Iain Macdonald, instructed by Craig Tonks of the National Heavy Vehicle Regulator
Keywords:	FATAL COLLISION; OBSTRUCTIVE SLEEP APNOEA; CARDIAC EVENT; TRUCK DRIVER; DISCLOSURE OF MEDICAL CONDITIONS; CERTIFICATE OF MEDICAL AND PHYSICAL FITNESS TO DRIVE; HEAVY VEHICLE LICENCE; DANGEROUS GOODS LICENCE; VICROADS; WORKSAFE VICTORIA; TOLL HOLDINGS LIMITED; VICROADS, DEPARTMENT OF TRANSPORT

BACKGROUND

1. Jackson David Eales was 27 years old when he died on 26 December 2016. At the time of his death, Jackson lived with his partner, Melissa Goldsmith. Jackson was adored and deeply loved by his family and friends. He was the son of Gerardine, twin brother and soulmate to Leah, brother to Naomi, Darcy and McKenzie, and uncle to Lucy and Bonnie. He was described as being the backbone of his family, their rock and protector; keeping them strong and safe.

2. Jackson had a strong work ethic and a successful career as a leading hand scaffolder. He was kind, sensitive, had a brilliant sense of humour and a bellowing laugh.

3. At about 4:40pm on 26 December 2016, Jackson was driving his Ford Utility when it was hit by a Kenworth Prime Mover B Double tanker truck, driven by Gerard Voss. Ms Goldsmith was a passenger in the Ford Utility.

4. The accident occurred at the intersection of Broderick and Heales Road in Corio, Victoria. Jackson died as a result of the injuries sustained in the collision. Ms Goldsmith was taken to the Alfred Hospital with serious injuries requiring a blood transfusion upon arrival and surgery to stabilise fractures to her pelvis and humerus and to debride scalp and ankle wounds. She was discharged almost a week later.

CORONIAL INVESTIGATION

Jurisdiction

5. Jackson's death constituted a *'reportable death'* pursuant to section 4(2)(a) of the *Coroners Act 2008* (Vic) (**Coroners Act**), as his death occurred in Victoria and appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury.

6. The Coroners Court of Victoria (**Coroners Court**) is an inquisitorial court.[1][2] The purpose of a coronial investigation is to independently investigate a reportable death to

[1] Section 89(4) *Coroners Act 2008.*
[2] Section 89(4) *Coroners Act 2008.*

ascertain, if possible, the identity of the deceased person, the cause of death, and the circumstances in which the death occurred.

7. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

8. The circumstances in which the death occurred refers to the context or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally relevant to the death.

9. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the prevention role.

10. Coroners are empowered to:

    (a) report to the Attorney-General on a death;

    (b) comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

    (c) make recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.

11. Coroners are not empowered to determine civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including a finding or comment or any statement that a person is, or may be, guilty of an offence. [3] It is not the role of the coroner to lay or apportion blame, but to establish the facts.[4]

[3] Section 69(1). However, a Coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69(2) and 49(1) of the Act.

[4] *Keown v Khan* (1999) 1 VR 69.

Standard of Proof

12. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[5] The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[6]

13. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[7] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals or entities, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

14. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved.[8] Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences. Rather, such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[9]

Sources of Evidence

15. This Finding draws on the totality of the coronial investigation into Jackson's death. That is, the court records maintained during the coronial investigation, the Coronial Brief and any further material sought and obtained by the Coroners Court, the evidence adduced during the Inquest, and any submissions.

16. In writing this Finding, I do not purport to summarise all the evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of

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5 *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.

6 *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J (noting that His Honour was referring to the correct approach to the standard of proof in a civil proceeding in the Federal Court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-1 per Mason CJ, Brennan, Deane and Gaudron JJ.

7 (1938) 60 CLR 336.

8 *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.

9 *Briginshaw v Briginshaw* (1938) 60 CLR 336 at pp 362-3 per Dixon J.

narrative clarity. The absence of reference to any particular aspect of the evidence should not lead to the inference that it has not been considered.

CIRCUMSTANCES OF DEATH

17. Prior to the collision on 26 December 2016, Mr Eales and Ms Goldsmith had been shopping at the Boxing Day sales. They were on their way home at the time of the collision.

18. Gerard Voss was 67 years of age at the time and worked as a truck driver for Toll Liquid Distribution (**Toll**). Mr Voss had been employed by Toll since May 2009. He was an experienced heavy vehicle driver, specifically fuel tankers. At the time of the accident, Mr Voss was the holder of a full and current Victorian Driver's Licence issued by VicRoads, with a heavy vehicle endorsement, on condition that he wear prescribed corrective spectacles or contact lenses. He also held a Dangerous Goods Driver Licence issued by WorkSafe Victoria (**WorkSafe**).

19. Mr Voss started work at Toll's refinery in Geelong at 4:00pm and headed out in his vehicle at about 4:30pm. Prior to this shift, he had had a full two days of rest.

20. Witnesses who observed Mr Voss driving in the minutes prior to the accident observed that he did not appear to be concentrating,[10] and was driving across the lane.[11] The MT data system which records driving activity from Mr Voss' truck indicates he was still logging in as he commenced driving.

21. Mr Voss drove northbound on Broderick Road, which is a 60km/h road. A 'stop sign ahead' warning sign is located approximately 149 metres south of the intersection with Heales Road. The continuation of Broderick Road past Heales Road is a no through road.

22. At the same time Mr Voss was driving on Broderick Road, Jackson and Ms Goldsmith were travelling towards the intersection along Heales Road, which is an 80km/h road.

[10] Exhibit 1, Coronial Brief, pp 51-2.
[11] Exhibit 1, Coronial Brief, p 57.

23. The road was dry, and traffic was light. The weather was overcast but visibility was good.

24. At about 4:28pm Mr Voss' truck approached the intersection of Heales Road and failed to slow down or stop at the stop sign, and continued through colliding with Jackson's utility.

25. Evidence indicates the truck entered the intersection at a speed of approximately 62km/h. CCTV footage from the intersection reveals Mr Voss applied his brakes as he crossed the stop line. Victoria Police's Major Collision Investigation Unit's investigation indicated Jackson's vehicle was wholly in the eastbound lane of Heales Road travelling at approximately 71km/h at the time of the collision.

26. Jackson and Ms Goldsmith suffered significant injuries as a result of the collision. Witnesses contacted emergency services who attended the scene. Jackson and Ms Goldsmith were treated by Ambulance Victoria paramedics, however Jackson died at the scene. Ms Goldsmith was taken to the Alfred Hospital with serious injuries from which she later recovered.

27. Following the collision, Mr Voss initially said he did not know what happened, and that he must have gone through the stop sign. He was observed to be shaking, disoriented, anxious, and emotionally distressed. Mr Voss advised paramedics and police that he was driving approximately 50km/h along Broderick Road. He should have turned left but did not see the sign and went through the intersection.

28. Police conducted a preliminary breath test and oral fluid test on Mr Voss which did not indicate the presence of alcohol or illicit drugs. Mr Voss was arrested by police after refusing treatment from Ambulance Victoria. He was interviewed at Corio Police Station however was unable to remember or recollect what happened after driving past Richie Bros on Broderick Road. During the interview, Police became concerned about Mr Voss' fitness to be interviewed. He was later assessed by Dr Jason Schreiber, a

Forensic Physician at the Victorian Institute of Forensic Medicine, and was deemed medically unfit to be interviewed,[12] and was taken to Geelong Hospital.

29. Mr Voss returned to Corio Police Station again on 13 January 2017 for a further interview with police. This interview was terminated due to concerns for Mr Voss's mental and physical health.[13]

IDENTITY OF THE DECEASED

30. On 28 December 2016, Jackson David Eales, born 30 August 1989, was visually identified by his mother, Gerardine Eales, who signed a formal statement of identification to this effect.

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

MEDICAL CAUSE OF DEATH

32. On 27 December 2016, Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination and provided a written report of his findings. Dr Lynch also considered the Victorian Police Report of Death Form 83, the medical records, and the post-mortem computed tomography (**CT**) scan.

33. The post-mortem examination revealed multiple injuries. Dr Lynch reviewed the post-mortem CT scan which revealed a fractured mandible, subarachnoid, intraventricular and intraparenchymal cerebral haemorrhage, a small right pneumothorax and fractured left superior and inferior pubic rami. The craniocervical junction was intact.

34. Routine toxicological analysis of post-mortem samples identified a small amount of Ketamine, however this was likely administered as part of treatment by the attending medical staff. No alcohol was detected.

[12] Exhibit 1, Coronial Brief, pp 175-7.
[13] Exhibit 1, Coronial Brief, pp 1111-2.

35. Dr Lynch provided an opinion that the medical cause of death was 1 (a) injuries sustained in motor vehicle collision (driver). I accept Dr Lynch's opinion.

CRIMINAL TRIAL

36. Mr Voss was charged with negligent and culpable driving causing the death of Jackson, and negligent driving causing serious injury to Ms Goldsmith. Alternative charges of dangerous driving causing death and serious injury were also heard.

37. The matter was heard between 25 and 28 November 2019 before her Honour Judge Hampel at the Geelong County Court. On 28 November 2019, her Honour made a ruling for a permanent stay of the prosecution where her Honour considered the case was clearly *"*foredoomed to fail*".*[14]

CORONIAL INQUEST

38. After her Honour Judge Hampel's order to stay the prosecution, Jackson's mother, Gerardine Eales, submitted a Form 26 - Request for Inquest on 13 September 2022. Jackson's family raised concerns and submitted that they had a number of unanswered questions, particularly given the stay of the criminal prosecution. I considered these concerns and determined that it was appropriate in the circumstances to conduct an inquest.

39. The inquest was held between 1-8 February 2023 at the Coroners Court of Victoria, in Melbourne. An oral submissions hearing was held on 21 April 2023.

Witnesses

40. The following witnesses were called to give oral evidence at the Inquest:

    a) Gerard Voss[15]
    b) Dr Stephen Fryman, General Practitioner

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[14] *Director of Public Prosecutions v Gerard William Voss* (2019) VCC, Ruling of Her Honour Judge Hampel [24]; (*Clark v The Queen* [2016] VSCA 96, [13]).

[15] Mr Voss applied to be excused from giving evidence pursuant to section 57 of the Coroners Act and this was granted. A written ruling was provided in this regard 3 February 2023.

c) Associate Professor Neil Strathmore, Cardiologist

d) Associate Professor Jeremy Hammond, Cardiologist

e) Dr Yew Chung Chee, Occupational Medical Doctor

f) Professor Matthew Naughton, Respiratory and Sleep Physician

g) Dr Liam Hannan, Respiratory and Sleep Physician

h) Fiona Morris, Medical Case Manager, VicRoads

i) Aaron Louws, Manager of Health, Safety and Environment with Road Transport Safety, Toll Global Logistics

j) Tristan Gallus, Technical Quality Assurance Coordinator, WorkSafe Victoria

k) Phillip Rout, Operations Manager, Toll Global Logistics[16]

l) Associate Professor John Amerena, Cardiologist.

Scope of inquest

41. The following issues were examined at the Inquest:

a) The reasons Mr Voss may have failed to stop at the intersection of Broderick Road and Heales Road, Corio, including:

i. Medical reasons, including cardiac arrest, and microsleep associated with obstructive sleep apnoea; and

ii. Non-medical reasons, including inattention, fatigue, or distraction.

b) The requirements for a heavy vehicle endorsement on a driving licence and dangerous goods driving licence, and how these requirements were met by Mr Voss, including:

i. Medical disclosures made by Mr Voss to VicRoads and WorkSafe;

ii. Reports prepared by medical practitioners and submitted to VicRoads and WorkSafe;

iii. Consideration of medical assessments and/or reports by VicRoads and WorkSafe.

[16] At the time of the collision.

c) The requirements of Toll for employment of heavy vehicle drivers responsible for transporting dangerous goods, and how those requirements were met by Mr Voss, including:

   i. Medical disclosures made by Mr Voss to Toll;
   ii. Reports prepared by medical practitioners and submitted to Toll;
   iii. Medical assessments conducted by Toll; and
   iv. Consideration of medical assessments and/or reports by Toll.

d) Applicable training, policies, procedures, and practices in respect of obtaining, granting, and considering medical certificates or reports as they relate to the above requirements for VicRoads, WorkSafe and Toll.

Possible reasons Mr Voss failed to stop

42. Uncertainty exists as to why Mr Voss failed to stop at the intersection of Broderick and Heales Road, Corio on 26 December 2016. Mr Voss had travelled this exact route for many years and was familiar with the road and well aware that he had to make a left hand turn at Heales Road, as the continuation of Broderick Road is a no through road. After the accident he was unable to recall driving the distance of approximately 150-200 metres prior to the intersection.

43. The inquest examined potential reasons why Mr Voss may have failed to stop at the intersection on that day including medical and non-medical issues.

44. At inquest, the Court heard from Mr Voss' treating medical practitioners that he had at least two medical conditions which could have directly impacted or influenced his ability to drive safely; coronary artery disease and/or obstructive sleep apnoea.

45. Following the collision, and after being found unfit to be interviewed by police, Mr Voss was examined at the Geelong Private Hospital. At this time, he was found to have suffered a heart attack. The timing and extent of the heart attack was a focus of this inquest.

46. There was an initial suggestion that Mr Voss may have *"*blacked out*"* or temporarily lost consciousness. It was questioned whether this was related to his cardiac condition, or some other reason. Cardiologists Associate Professor Jeremy Hammond, and Associate Professor Neil Strathmore, concluded it was unlikely that any loss of consciousness occurred immediately prior to the collision was related to a cardiac event.

47. In 2018, Mr Voss was diagnosed with severe obstructive sleep apnoea. Knowledge of this diagnosis raised the question of whether symptoms of this condition could have potentially caused the collision.

48. There was also discussion at inquest and in submissions that Mr Voss drove through the stop sign not due to any medical condition, but rather due to inattention. Submissions were also made regarding the use of the MT data system inside the truck, and whether this may have caused Mr Voss to be distracted.

Did Mr Voss' cardiac arrest contribute to Jackson's death?

49. Mr Voss was diagnosed with coronary artery disease in April 2006 after experiencing chest pain. This was investigated with an ECG and coronary angiogram and Mr Voss was found to have *"*some narrowing*"* of his coronary arteries.[17]

50. A letter provided on 20 April 2006 from his Cardiologist, Associate Professor John Amerena to Mr Voss' General Practitioner (**GP**), Dr Stephen Fryman stated, "At this stage I can see no reason why he should not continue to drive heavy vehicles as he clearly meets the criteria outlined in the road traffic authority guidelines".[18]

51. Dr Fryman provided oral evidence at the inquest. I found him to be an impressive and forthcoming witness who is evidently a dedicated GP.

52. Dr Fryman's evidence was that following Mr Voss' diagnosis of minor coronary artery disease in 2006, he prescribed cholesterol lowering medication. Dr Fryman conducted medical assessments for Mr Voss consistent with the *Assessing Fitness to Drive for*

[17] Transcript of evidence, p 49.
[18] Exhibit 1, Coronial Brief, p 367; Transcript of evidence, p 764.

Commercial and Private Vehicle Drivers: Medical Standards of Licensing and Clinical Management Guidelines, published by the National Transport Commission and Austroads (**National Guidelines**).[19]

53. Dr Fryman had referred Mr Voss to a cardiologist and Mr Voss continued to be reviewed by Associate Professor Amerena every six months, reportedly at his own request.[20] Mr Voss did not report any angina, shortness of breath or impaired exercise tolerance when asked about completing the assessment of medical and physical fitness to drive. Dr Fryman noted that Mr Voss continued to be able to undertake heavy manual work on his five-acre property.[21] Mr Voss' lipid levels and hypertension were apparently well controlled by medication, and Dr Fryman did not consider that there was any reason to suspect progression of his cardiac disease.[22]

54. Mr Voss provided an additional statement to the Court in which he described experiencing 'twinges' when getting ready in the morning in the months prior to the collision. He considered this to be due to eating breakfast too fast but intended to raise it with Associate Professor Amerena at their next appointment.[23]

55. Mr Voss was then involved in the fatal collision on 26 December 2016.

56. Despite Mr Voss' diagnosis of coronary artery disease in 2006, Dr Fryman considered that his exercise tolerance had been excellent. He and Associate Professor Amerena considered that Mr Voss' coronary artery situation was stable.[24] Dr Fryman gave evidence that at no point prior to the collision in 2016, did he have any reason to be concerned with Mr Voss' ability to drive a heavy vehicle laden with dangerous goods due to his known cardiac condition.[25]

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[19] Exhibit 1, Coronial Brief, Annexure 2. These guidelines were applicable at the time Mr Voss renewed his driver licence in 2014 and underwent medical assessments for fitness to drive prior to the collision.
[20] Transcript of evidence, pp 761-2
[21] Exhibit 1, Coronial Brief, p 1028, Transcript of evidence, p 46.
[22] Exhibit 1, Coronial Brief, p 1029.
[23] Exhibit 1, Coronial Brief, Annexure 1, p 81.
[24] Transcript of evidence, pp 46, 765-6.
[25] I note that Dr Fryman noted he was initially concerned with the November 2016 correspondence from Dr Chee regarding the murmur, however this was appropriately investigated, and he did not consider that this would impair Mr Voss' ability to drive – Transcript of evidence, pp 51-2.

57. Following the collision, Mr Voss complained of chest pain and was taken to the Geelong Hospital. There he was found to have suffered a small myocardial infarction and was transferred to Geelong Private Hospital under the care of his cardiologist, Associate Professor Amerena.[26] Mr Voss was later discharged but returned to hospital for a repeat angiography which showed significant coronary artery disease and he required bypass surgery.[27]

58. In 2017, Associate Professor Amerena stated he was certain Mr Voss had suffered a heart attack around the time of the accident but could not say whether it was the cause of the accident or a consequence of it.[28] In oral evidence and with the benefit of the further investigations, he stated he now believed sleep apnoea was a more likely cause of the collision, though still believes Mr Voss suffered a heart attack.[29]

59. Associate Professor Amerena gave evidence that a person suffering a heart attack causing a temporary loss of consciousness would generally appear like a fainting attack, their head would slump, and they would become unconscious. They may grimace, and touch their chest.

60. I note that during his oral evidence it became clear that Associate Professor Amerena had recalled the in-cabin footage incorrectly. His recollection from viewing it many years before was that it showed Mr Voss' eyes closing and his head dropping prior to the accident.[30] It was not in dispute from any of the parties that the footage clearly did not show this behaviour from Mr Voss prior to the collision. Given this misunderstanding from Associate Professor Amerena, I have somewhat tempered the weight I have given to this aspect of his evidence regarding the possible cause of the collision.

61. Associate Professor Jeremy Hammond conducted an independent medical examination of Mr Voss after the collision at the request of his employer, Toll, on 14 February 2017.

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[26] Exhibit 1, Coronial Brief, p 174.
[27] Exhibit 1, Coronial Brief, p 174.
[28] Exhibit 1, Coronial Brief, p 174.
[29] Transcript of evidence, p 753.
[30] Transcript of evidence, p 758.

At the time of writing his report, Associate Professor Hammond was of the view that the "most likely cause of his episode of loss of consciousness, was that he suffered an episode of ventricular fibrillation…this occurred on a background of longstanding known underlying coronary artery disease".[31]

62. Associate Professor Hammond provided an additional report dated 24 January 2023, and oral evidence at inquest. Upon review of additional material including the in-cabin footage,[32] Associate Professor Hammond altered his initial opinion and stated that he now considers "it is less likely that an episode of myocardial ischaemia (associated with an episode of ventricular fibrillation) was the cause of his period of inattention/loss of memory/loss of concentration, prior to his accident".[33]

63. He stated that what struck him most of all about the in-cabin footage was that, in his view, Mr Voss did not lose consciousness, but rather seemed "distracted or lacking concentration".[34] In oral evidence, Associate Professor Hammond stated he considered it was "extremely unlikely" that the collision was caused by a cardiac condition.[35]

64. Associate Professor Hammond confirmed at inquest that he accepted that Mr Voss did have a myocardial infarct on 26 December 2016. He was of the view this most likely occurred following the collision either at the side of the road or whilst being interviewed by police.[36] Associate Professor Hammond detailed he would have expected to see specific symptoms of a cardiac event in the in-cabin footage if Mr Voss was having a myocardial infarct prior to the collision. He suggested it may have shown Mr Voss grabbing at his chest in pain or experiencing shortness of breath.[37]

65. Associate Professor Neil Strathmore was briefed by Counsel for Dr Fryman to provide an expert opinion as a cardiologist. Upon reviewing the in-cabin footage of Mr Voss

[31] Exhibit 1, Coronial Brief, p 202.
[32] Transcript, p 208.
[33] Exhibit 1, Coronial Brief, Annexure 1, p 15.
[34] Transcript of evidence, p 208.
[35] Transcript of evidence, p 211.
[36] Transcript of evidence, pp 231-2.
[37] Transcript of evidence, p 232.

immediately prior to the collision, Associate Professor Neil Strathmore was of the view that there was:

> no evidence of loss of consciousness that would be associated with a cardiac arrest due to ventricular fibrillation. If he had suffered a cardiac arrhythmia which would reduce blood flow to the brain enough to lose consciousness, I would have expected him to slump forward or to the side, and possibly convulse.[38]

66. Associate Professor Strathmore did note that Mr Voss' coronary artery disease had progressed between 2006 and 2017, though he did not consider it particularly severe. The troponin levels recorded at Geelong Hospital following the collision were "not particularly high troponins in the context of saying that he's had a myocardial infarct".[39]

67. Associate Professor Strathmore was of the view that if Mr Voss did have a myocardial infarct on the day of the accident, it was quite small.[40] He stated that the overwhelming likelihood is that a cardiac arrhythmia or cardiac event did not lead to any loss of consciousness for Mr Voss.[41]

68. The cardiologists were asked about the significance, if any, of Mr Voss' description of experiencing 'twinges' in the weeks prior to the collision. Associate Professor Strathmore was not concerned by this description and did not consider it to be a major warning sign for angina.[42] Similarly, Associate Professor Hammond was also not concerned by the reports of 'twinges'.[43] Associate Professor Amerena agreed. He stated that if the 'twinges' had only lasted a second or so, he would consider it highly unlikely to be a cardiac issue. Had Mr Voss been experiencing pain on exertion, this would have been more suggestive of a cardiac issue.[44]

69. Counsel Assisting submitted that it is unlikely that a myocardial infarct or other cardiac event related to Mr Voss' coronary artery disease contributed to his failure to stop at the

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38 Exhibit 1, Coronial Brief, Annexure 1, p7, Transcript of evidence, p 161.
39 Transcript of evidence, p 166.
40 Exhibit 1, Coronial Brief, Annexure 1, p 8.
41 Transcript of evidence, p 164.
42 Transcript of evidence, p 166.
43 Transcript of evidence, p 217.
44 Transcript of evidence, p 837.

intersection of Broderick and Heales Road.[45] The Eales family and other interested parties agreed with this submission.

Conclusions

70. I accept the evidence that Mr Voss suffered a heart attack at some point proximate to the collision on 26 December 2016. I am unable to determine whether the heart attack occurred before or after the collision in the circumstances. However, after reviewing the in cabin footage, the medical evidence strongly suggested there were no obvious signs of Mr Voss suffering a cardiac event prior to the accident and on that basis and on the balance of probabilities, I find it unlikely the collision was caused by a cardiac event.

Did Mr Voss' undiagnosed severe obstructive sleep apnoea potentially contribute to Jackson's death?

71. Mr Voss failed to slow down on his approach to the intersection and failed to brake until just prior to entering the intersection.[46] This failure to slow down or brake suggests Mr Voss was experiencing a prolonged lapse in concentration lasting approximately 20-30 seconds, better described as a cognitive impairment – not mere inattention.[47]

72. Significant new evidence came to light in this inquest regarding Mr Voss' undiagnosed obstructive sleep apnoea, and this resulted in several clinicians altering their opinions regarding the cause of the collision.

73. The evidence revealed that obstructive sleep apnoea had been suspected and considered by medical practitioners prior to and after the events of 26 December 2016.

December 2014

74. In a letter to Dr Fryman from Associate Professor Amerena dated 2 December 2014, Associate Professor Amerena made a note that Mrs Voss thought her husband had sleep

[45] Outline of Submissions of Counsel Assisting dated 15 March 2023, p 1.
[46] Exhibit 1, Coronial Brief, pp 147-50.
[47] Transcript of evidence, pp 401, 406.

apnoea, as he snored at night.[48] At inquest, Associate Professor Amerena stated he asked Mr Voss further questions about this and confirmed he had no other symptoms of sleep apnoea at the time.[49] In cross examination, he stated that he did not think an investigation for sleep apnoea was justified in 2014[50] as he was asymptomatic and did not present with the classic signs of the condition. Associate Professor Amerena stated he would have discussed the symptoms of sleep apnoea and what to look out for with Mr Voss. However, he emphasised he did not consider there was any need for further investigations for sleep apnoea at the time of this consultation.[51]

Alleged April 2015 incident

75. There is evidence before me that in April 2015 Mr Voss had a motor vehicle accident and reported having no clear memory of it afterwards. Correspondence from Respiratory Physician Dr Jeremy Cailes, to Dr Fryman on 11 April 2015 stated:

> …his wife is also concerned by the fact that he appeared to have had a motor vehicle accident around four days previously and he had no clear memory of this. It is difficult to work out the sequence of events. He showed no other features of confusion and no other central nervous system symptoms or signs. Given this however I arranged for a CT scan of the brain which reassuringly did not show any structural pathology.[52]

76. Tests were conducted however a cause for any memory loss was not found.[53] He was diagnosed with suspected bronchitis and treated with antibiotics.

77. In evidence, Dr Fryman emphasised that he had very little details of the accident in 2015. He didn't recall having any specific discussions with Mr Voss following the 2015 accident as to whether he should notify VicRoads that he may have a condition which

[48] Exhibit 1, Coronial Brief, p 1042.
[49] Transcript of evidence, p 775.
[50] Transcript of evidence, p 810.
[51] Transcript of evidence, p 812.
[52] Exhibit 1, Coronial Brief, p 408.
[53] Exhibit 1, Coronial Brief, p 408.

may impact his ability to drive.[54] He presumed the accident was a result of Mr Voss being unwell with a viral condition at the time.[55]

78. It was put to Dr Fryman that the National Guidelines state that a person is not fit to hold an unconditional licence if they have had a motor vehicle crash or crashes caused by inattention or sleepiness.[56] Dr Fryman stated he deferred to the expertise of Dr Jeremy Cailes, a sleep physician who saw Mr Voss following the 2015 crash. Dr Cailes assessed Mr Voss and conducted a brain scan which returned a normal result.[57]

79. I note that the Court did not hear oral evidence from either Mr Voss or Mrs Voss, or anyone else who was directly involved in this incident.[58] As such, I do not consider that I have sufficient cogent evidence on this incident to make a conclusive finding. This was a contentious issue at inquest.

After the collision

80. Mr Voss' wife, Mary Voss, provided a statement to the Court dated 2 December 2022,[59] detailing her concerns relating to two instances in 2017 and 2018 where she observed Mr Voss veer outside of his lane while driving. When she raised these concerns with her husband immediately after the incidents, Mr Voss was apparently oblivious to what had occurred and denied that they occurred.

81. Mrs Voss raised concerns about Mr Voss' driving to Dr Fryman and wondered whether there was something medically wrong with her husband. Dr Fryman's evidence was that Mr Voss did not appear to have any signs or symptoms of obstructive sleep apnoea.[60] However, after hearing these concerns, Dr Fryman and Mrs Voss encouraged Mr Voss to attend a sleep specialist.

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54 Transcript of evidence, pp 86-7.
55 Transcript of evidence, p 87; Coronial Brief, p 355.
56 Exhibit 1, Coronial Brief, Annexure 2, p 645.
57 Transcript of evidence, p 113.
58 Mr Voss was excused from giving evidence. Mrs Voss was not called to give evidence.
59 Exhibit 1, Coronial Brief, pp 1107-8.
60 Transcript of evidence, p 135.

82. Mr Voss was reviewed by Dr Liam Hannan, a Respiratory and Sleep Physician on 14 March 2018. Dr Hannan considered that Mr Voss's sleep history was relatively unremarkable. The physical examination indicated no overt features to suggest a high risk of significant obstructive sleep apnoea apart from his age and gender.[61]

83. A diagnostic polysomnogram (**sleep test**) was conducted on 4 April 2018.[62] Dr Hannan reviewed the data, which provided evidence of severe obstructive sleep apnoea, with an apnoea-hyopnoea index of 48.2 per hour.[63] Oxygen desaturations were observed frequently with levels falling below 80%. Dr Hannan considered this significant. Sleep architecture was also abnormal.[64]

84. A maintenance of wakefulness test was performed on 5 April 2018. The test yielded a mean sleep latency of 35.8 minutes which is within the normal range.[65] The report indicated multiple microsleeps.[66]

85. At inquest Dr Hannan described the initial assessment and consultation with Mr Voss prior to his diagnosis. Dr Hannan noted Mr Voss worked in a high-risk occupation and had been involved in a recent motor vehicle accident. Dr Hannan noted that regardless of the results of the clinical assessment, the only way to determine obstructive sleep apnoea was by conducting the overnight sleep test.[67]

86. Mr Voss did not score highly on the Epworth Sleepiness Scale and did not report any difficulties with alertness or daytime sleepiness.[68] Mrs Voss noted that he often snored loudly.[69]

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61 Exhibit 1, Coronial Brief, Annexure 1, p 2.
62 Exhibit 1, Coronial Brief, Annexure 1, p 2.
63 This index is a measure of the number of apnoeas (cessation of airflow) or hypopnoeas (reduction in airflow) per hour of sleep. Values greater than 30-40 per hour are considered severe.
64 Exhibit 1, Coronial Brief, Annexure 1, p 2.
65 Exhibit 1, Coronial Brief, Annexure 1, p 2.
66 Brief periods of sleep identified on electroencephalography lasting 3-15 seconds.
67 Transcript of evidence, p 419.
68 Transcript of evidence, p 445.
69 Exhibit 11, Correspondence from Mary Voss questions dated 6 February 2023.

87. The sleep study demonstrated evidence of severe obstructive sleep apnoea.[70] Prior to this, Mr Voss was oblivious to the symptoms of the disease. A lack of awareness of symptoms is reportedly a frequent occurrence and is often a barrier to diagnosis.[71] Following the diagnosis, Mr Voss started continuous positive airway pressure (**CPAP**) treatment with reportedly very good adherence and results.[72]

88. Mr Voss advised Dr Hannan at the initial consultation that he had minimal recollection of the collision in 2016 but recalled driving through the intersection.[73] Dr Hannan provided a report to VicRoads on 1 August 2018 and concluded "it seems very plausible that untreated [obstructive sleep apnoea] was the underlying factor in the motor vehicle accident he was involved in".[74]

89. Dr Hannan was cross-examined regarding Mr Voss' weight gain in the years between the collision and his diagnosis. Dr Hannan did not change his opinion that Mr Voss would have had obstructive sleep apnoea at the time of the collision because "we just don't see fluctuations in that diagnosis to that degree."[75]

90. Dr Hannan stated it is a fact that those with untreated severe obstructive sleep apnoea are at an increased risk of a motor vehicle accident when compared to those that do not have obstructive sleep apnoea. Individuals with untreated obstructive sleep apnoea frequently have impairments in reaction time, psychomotor vigilance and visual vigilance compared to those without. These impairments can be present even in the absence of overt sleepiness.[76]

91. Dr Hannan provided his professional opinion that "Mr Voss's untreated severe obstructive sleep apnoea increased his risk of a motor vehicle accident at the time the accident occurred".[77]

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70 Transcript of evidence, p 419.
71 Transcript of evidence, pp 481, 483.
72 Transcript of evidence, p 434; Coronial Brief, Annexure 2, p 377.
73 Exhibit 1, Coronial Brief, Annexure 2, p 1.
74 Exhibit 1, Coronial Brief, p 277.
75 Transcript of evidence, pp 439-40, 476.
76 Exhibit 1, Coronial Brief, Annexure 1, p 3.
77 Exhibit 1, Coronial Brief, Annexure 1, p 3.

92. In evidence, Dr Hannan was "convinced" obstructive sleep apnoea was an "underlying" factor in the collision.[78] However, he was unwilling to say that obstructive sleep apnoea directly caused the accident.[79]

Expert Opinion – Professor Matthew Naughton

93. Professor Matthew Naughton, a respiratory and sleep physician, provided an expert report for the purposes of the coronial investigation and gave evidence at inquest. Among other things, Professor Naughton was provided with the results of Mr Voss' sleep study, which he confirmed Mr Voss' diagnosis of severe obstructive sleep apnoea.[80] Professor Naughton explained that a person with obstructive sleep apnoea will have limited good quality sleep, which may in turn cause microsleeps.[81] Professor Naughton suggested about 50% of people will not be aware that they are experiencing a microsleep.[82] However it is possible to have a microsleep without an obstructive sleep apnoea diagnosis.[83]

94. Professor Naughton agreed with Dr Hannan's statement that individuals with untreated obstructive sleep apnoea frequently have impairments in reaction time, psychomotor vigilance and visual vigilance compared to those without.[84] He stated that a long-distance truck driver, such as Mr Voss, would undoubtedly be prone to fatigue due to the monotonous nature of the work.[85]

95. Professor Naughton was of the view that it was very likely Mr Voss suffered from obstructive sleep apnoea at the time of the crash in December 2016.[86] He stated that sleep apnoea is a condition which usually progresses over time. A 50-year-old person diagnosed with sleep apnoea will have likely had it for 10-15 years prior.[87]

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78 Transcript of evidence, pp 438, 440. Coronial Brief, p 277.
79 Transcript of evidence, p 440.
80 Transcript of evidence, p 343.
81 Transcript of evidence, p 357.
82 Transcript of evidence, p 361.
83 Transcript of evidence, p 358.
84 Transcript of evidence, p 366.
85 Transcript of evidence, p 372.
86 Transcript of evidence, p 348.
87 Transcript of evidence, p 377.

96. Professor Naughton considered the letter from Associate Professor Amerena in December 2014 which detailed Mrs Voss' descriptions of him snoring and considered it likely that Mr Voss had obstructive sleep apnoea at this time.[88] Dr Hannan agreed with this,[89] and noted that the level of severity of Mr Voss's obstructive sleep apnoea suggests it would not fluctuate much.[90]

97. Initially, Professor Naughton opined that the cause of the collision was likely cardiac-related due to the need for cardiac surgery after the accident.[91] However, upon being provided additional contextual material to the accident including Mr Voss' earlier driving history, list of medications, and witness accounts of Mr Voss' driving on the morning of the accident, Professor Naughton altered his opinion.

98. Professor Naughton stated that the witness accounts of Mr Voss swerving in the minutes prior to the crash,[92] and failing to respond to the green light,[93] were "very consistent with someone who's fallen asleep or is very sleepy whilst driving".[94] With the additional information, Professor Naughton considered the cause of the collision was "likely" sleep apnoea.[95] He stated the sleep apnoea was likely present at the time of the collision, and he believed it to be a contributing factor to the crash.[96] Further, the lack of braking prior to entering the intersection indicated "some sort of cognitive impairment at the time".[97]

99. Professor Naughton had reviewed the in-cabin footage and noted that whilst Mr Voss is not seen to have any head nodding or eyelids drooping, that doesn't necessarily mean the collision was not caused by fatigue.[98] Professor Naughton gave examples of how sleep apnoea may appear on a person to include a blank stare, appearing awake but not

88 Transcript of evidence, p 377.
89 Transcript of evidence, p 459.
90 Transcript of evidence, p 437.
91 Transcript of evidence, p 349.
92 Exhibit 1, Coronial Brief, p 57.
93 Exhibit 1, Coronial Brief, p 51.
94 Transcript of evidence, p 352.
95 Transcript of evidence, p 353.
96 Transcript of evidence, p 406.
97 Transcript of evidence, p 401.
98 Transcript of evidence, p 353.

responding to information, slow blinking, and an inability to remember a period of time.[99] It is possible to have a microsleep without these visible symptoms.[100] Professor Naughton described a type of "daydreaming" as a microsleep but with the eyes open.[101] When asked the difference between daydreaming and inattention, Professor Naughton described daydreaming as lost focus, and a "step towards sleep".[102]

100. Regarding Mr Voss' lack of memory in the period leading up to the collision, Professor Naughton opined that if he had been asleep, he very well may not recall what was happening immediately prior to impact.[103] Dr Hannan agreed with this statement, though noted that memory loss was not his area of expertise.[104]

101. Professor Naughton was of the view that the alleged prior crash is "crucial" and that Mr Voss being unable to recall such an incident would significantly concern him.[105] He considered a prior fatigue related crash would put an individual at higher risk of having further crashes.[106]

102. It was identified that the National Guidelines prescribe that if a driver experiences a blackout and a cause cannot be identified, then that person should not be issued with a licence for a period of five years.[107] I note that we have no clear evidence in this case as to whether Mr Voss did or did not suffer a blackout at the time of the 2015 incident. I acknowledge the condition in the National Guidelines, but I do not consider that the cause for Mr Voss' possible loss of consciousness or lack of memory in this incident is entirely uncertain. Dr Fryman was of the view that the likely cause of this loss of consciousness for the 2015 accident was due to the viral illness Mr Voss was experiencing at the time.

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[99] Transcript of evidence, p 377.
[100] Transcript of evidence, p 362.
[101] Transcript of evidence, p 363.
[102] Transcript of evidence, p 365.
[103] Transcript of evidence, p 369.
[104] Transcript of evidence, p 433.
[105] Transcript of evidence, p 352.
[106] Transcript of evidence, p 374.
[107] Exhibit 1, Coronial Brief, Annexure 2, p 572.

103. I note the concerns of the sleep experts that prior fatigue related accidents suggest Mr Voss had obstructive sleep apnoea at the time of the collision in 2016.

104. Dr Fryman suggested anyone who drives commercial vehicles should have a mandatory sleep apnoea test, though he acknowledged how difficult this may be, particularly for patients without any symptoms.[108] Dr Hannan noted sleep studies required to diagnose obstructive sleep apnoea do involve a significant cost.[109] Professor Naughton agreed with this concept and stated that he considers many of the fatigue related accidents he sees in his work to be preventable.[110]

105. I note the submissions of Counsel for the Eales Family that although sleep studies may be costly, the emotional costs to families who have lost loved ones in fatal road accidents is severe, visceral, and enduring.[111] Further, the economic cost to the community of road trauma has been estimated to be billions of dollars Australia wide.[112]

106. Professor Naughton believed there was a greater than 50% chance that obstructive sleep apnoea was the cause of the collision on 26 December 2016.[113] Dr Hannan agreed with this opinion.[114]

107. Counsel Assisting submitted that it is highly probable Mr Voss suffered from severe obstructive sleep apnoea in the years prior to his diagnosis, including at the time of the collision.[115] Further, that it is probable that symptoms relating to severe obstructive sleep apnoea contributed to Mr Voss' failure to stop at the intersection of Broderick and Heales Road.[116]

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[108] Transcript of evidence, pp 69-70.
[109] Transcript of evidence, p 468.
[110] Transcript of evidence, pp 378-9.
[111] Outline of Submissions on Behalf of the Eales Family dated 4 April 2023, p 10.
[112] *Cost of Road Trauma in Australia, Summary Report – September 2017,* Australian Automobile Association; *Social Cost of Road Crashes – Report for the Bureau of Infrastructure and Transport Research Economics Final Report, September 2022,* The Australian National University.
[113] Transcript of evidence, p 407.
[114] Transcript of evidence, p 440.
[115] Outline of Submissions of Counsel Assisting dated 15 March 2023, p 2.
[116] Outline of Submissions of Counsel Assisting dated 15 March 2023, p 2.

108. Counsel for the Eales Family disagreed.[117] It was submitted on their behalf that while it may be probable that he had obstructive sleep apnoea on the day of the accident, it is submitted that the evidence does not go as far as to indicate that symptoms relating to obstructive sleep apnoea contributed to Mr Voss' failure to stop at the intersection.[118]

109. Counsel for Dr Fryman warned against making a definitive finding.[119] It was submitted that "the evidence on sleep apnoea supports a presumption that it was a factor, and the most likely medical factor. But it does not provide sufficient cogent evidence …to prove the impact of sleep apnoea as a fact".[120]

110. Counsel for Mr Voss and Toll submitted that the weight of the evidence supported a finding that Mr Voss had a microsleep caused by undiagnosed and untreated severe obstructive sleep apnoea.[121]

111. It was submitted by Counsel for Toll that if Associate Professor Amerena had made a referral to an appropriate specialist and investigation had been undertaken, then Mr Voss' obstructive sleep apnoea may have been diagnosed at this early stage in 2014. Further, this would "have had an impact on Mr Voss's licence, necessitated treatment, and thereby prevented the accident".[122] Counsel for Toll submitted that the letter from Associate Professor Amerena in 2014 and the accident in 2015 should have been sufficient for Mr Voss' treating practitioners to identify the possibility that he was suffering from obstructive sleep apnoea and conduct appropriate tests.[123] Based on the available evidence I have before me, I do not agree with this submission.

Conclusions

112. I find it highly probable Mr Voss suffered from severe obstructive sleep apnoea in the years prior to his diagnosis, including at the time of the collision. He was unaware that

[117] Outline of Submissions on behalf of the Eales Family dated 4 April 2023, p 2.
[118] Outline of Submissions on behalf of the Eales Family dated 4 April 2023, p 2.
[119] Outline of Submissions on behalf of Dr Fryman dated 11 April 2023, p 3.
[120] Outline of Submissions on behalf of Dr Fryman dated 11 April 2023, p 3.
[121] Outline of Submissions on behalf of Mr Voss dated 4 April 2023, p 2. Outline of Submissions on Behalf of Toll dated 3 April 2023, p 2.
[122] Outline of Submissions on Behalf of Toll dated 3 April 2023, p 4.
[123] Outline of Submissions on Behalf of Toll dated 3 April 2023, pp 3-6.

he was suffering from severe obstructive sleep apnoea prior to his diagnosis in April 2018. I find it is probable that symptoms relating to severe obstructive sleep apnoea were present and may have contributed to Mr Voss' failure to stop at the intersection of Broderick Road.

113. I find that Mr Voss likely had obstructive sleep apnoea for a number of years prior to his diagnosis, including at the time of the collision on 26 December 2016. I further find that he was unaware that he was suffering from severe obstructive sleep apnoea prior to his diagnosis in April 2018.

114. Prior to the diagnosis, none of Mr Voss' treating doctors suspected he was suffering from severe obstructive sleep apnoea. With the benefit of hindsight, it is tempting to put together snippets of information received by Mr Voss or his treating clinicians over a period of years to illustrate there *were* signs of sleep apnoea earlier in time. However, no criticism can be made of Mr Voss' treating clinicians in the context of Mr Voss not presenting with the typical physical signs or symptoms of sleep apnoea.

Non-medical reasons – Did inattention, fatigue or distraction contribute to Jackson's death?

115. Inattention, fatigue or distraction were identified as potential non-medical causes for the collision and were examined as part of this investigation.

116. Fatigue related to obstructive sleep apnoea was discussed in the previous section. The evidence demonstrates that Mr Voss was well rested and had had two days of leave prior to the beginning of his shift. He stated that had had a good night's sleep the night prior, and felt ready, fit, and able to start work on 26 December 2016.[124] The evidence does not suggest that general fatigue was a potential cause in this case.

117. This inquest was assisted with in cabin footage which captured Mr Voss' driving in the seconds before the collision. The footage reveals that he does not close his eyes, he did not display any visible sign of pain or discomfort, and he was not distracted by a mobile

[124] Exhibit 1, Coronial Brief, Annexure 1, p 81.

phone or otherwise. His right hand is on the steering wheel and his left hand is either on his lap or on a gearstick, he appeared to be looking ahead, until the very last second, when he looked to his left and suddenly appeared alarmed just prior to the collision.

118. Counsel for the Eales Family submitted that the collision was caused by Mr Voss' failure to stop due to inattention or distraction. Weight was given to the evidence of witnesses who observed Mr Voss failing to respond to traffic lights and swerving on the Princes Highway prior to the collision. It was submitted that this may have been due to Mr Voss logging on to the MT data system while he was traveling northeast along the Princes Highway.[125]

119. The MT data system is a GPS tracking system used in the trucking and transport industry. It requires drivers to log in, and it displays speed and required break times.[126] Logging into the MT data system takes approximately 30 seconds to one minute.[127] It requires entering two sets of four-digit codes, and answering two login questions of, 'Are you fit for duty?' and 'Have you completed your pre-start inspection?'.[128]

120. Drivers leaving the Toll Refinery in Geelong were expected to pull over into a gravel area just outside the refinery, and log on to the system before driving away and beginning their journey.[129] Drivers are unable to log on to the system while within the refinery.[130] When questioned at inquest, Phillip Rout, who was the Operations Manager at Toll at the time of the collision, accepted that drivers may at times log in to the MT data system whilst driving, and that this could be dangerous to drivers and other road users.[131]

121. The investigation report commissioned by Toll and completed by their Senior Health Safety and Environment Manager, Sean Hepburn suggested that Mr Voss' failure to respond to the green traffic light (witnessed by Jeff Whatnall) was due to him logging

[125] Outline of Submissions on behalf of the Eales Family dated 4 April 2023, pp 4-5.
[126] Transcript of evidence, p 643.
[127] Transcript of evidence, pp 657, 659.
[128] Transcript of evidence, p 655.
[129] Transcript of evidence, p 654.
[130] Transcript of evidence, p 645.
[131] Transcript of evidence, p 682.

into the MT data system. The history shows that the MT unit was powering up at the geographical position of the traffic lights, and that Mr Voss logged in approximately 20-30 seconds after the intersection while travelling along the Princes Highway.[132]

122. Mr Rout gave evidence that the MT data system will omit audible alerts until a driver logs in. He could not say for certain whether this warning sound would have been present for Mr Voss prior to him logging in.[133]

123. Associate Professor Hammond stated in his report of 24 January 2023 that in his opinion, Mr Voss in the CCTV footage, "did appear distracted and seemed inattentive, seemingly not concentrating on the job at hand".[134] He was questioned about whether Mr Voss' driving in the minutes prior to the collision, including swerving and missing a green light, may have been attributable to inattention and attempting to log-in to the MT data system. Professor Naughton considered this was possible, but he qualified he was not familiar with the MT data system. He noted that inattention is a major issue and causes a significant number of vehicle accidents,[135] but he also later clarified that he didn't know why Mr Voss had the crash.[136]

124. Professor Naughton stated that the prolonged lapse of concentration which had to have occurred for Mr Voss to not even slow down in approaching the intersection on a stretch of road he knew well, indicated cognitive impairment rather than mere inattention.[137]

125. Counsel Assisting submitted that Mr Voss may have been distracted by the MT data system at some point that afternoon, but the in-cabin footage shows that immediately prior to the collision he is seen to be looking straight ahead. Therefore, the in-cabin footage suggests the MT data system was not distracting Mr Voss at the time of the collision.[138]

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[132] Transcript of evidence, p 664.
[133] Transcript of evidence, pp 668-9.
[134] Exhibit 1, Coronial Brief, Annexure 1, p 10.
[135] Transcript of evidence, p 400.
[136] Transcript of evidence, p 404.
[137] Transcript of evidence, p 401.
[138] Transcript – Submissions Hearing, p 10.

126. The in-cabin footage, which was viewed during inquest, does not show Mr Voss demonstrating any signs of sleepiness. Mr Voss is seen reacting as he crosses the intersection, and just prior to colliding with Jackson's vehicle. It was submitted by the Eales family that this footage is inconsistent with Mr Voss experiencing a microsleep.[139]

127. Counsel for the Eales Family urged me not to be "seduced into making a finding that there is a medical cause simply due to the sheer volume of medical evidence that's been heard".[140]

128. It was further submitted by Counsel for the Eales Family that should I find that inattention or distraction contributed to Mr Voss' failure to stop, it is open to me to form the belief that an indictable offence has occurred and refer the matter to the Director of Public Prosecutions, in accordance with s49(1) of the *Coroners Act 2008.*[141]

129. Counsel Assisting submitted that inattention, fatigue or distraction caused by non-medical reasons, are unlikely to be factors which contributed to Mr Voss's failure to stop at the intersection of Broderick and Heales Road.[142]

Conclusion

130. Having considered all of the evidence, I find that inattention, fatigue or distraction, caused by non-medical reasons, are unlikely to be factors which contributed to Mr Voss' failure to stop at the intersection of Broderick Road and Heales Road.

[139] Outline of Submissions on Behalf of the Eales Family dated 4 April 2023, p 6.
[140] Transcript of Submissions Hearing, p 88.
[141] Outline of Submissions on Behalf of the Eales Family dated 4 April 2023, p 6.
[142] Outline of Submissions of Counsel Assisting dated 15 March 2023, p 2.

Requirements for a heavy vehicle endorsement on a driving licence and dangerous goods driving licence and how these requirements were met by Mr Voss

VicRoads requirements for a heavy vehicle driving licence

131. All Victorian drivers have a legal obligation to inform VicRoads of any medical conditions that may impair their ability to drive. Regulation 68 of the *Road Safety (Driver) Regulations 2019* (Vic) provides that if a holder of a driver licence is:

> affected by any permanent or long-term illness, disability, medical condition or injury or because of the effects of the treatment for any of those things, that may impair the person's ability to drive safety, the person must, as soon as practicable after becoming aware of the injury or illness or commencing the treatment for any of those things, notify VicRoads about it. [143]

132. The process of applying for and renewing a heavy vehicle driver licence at VicRoads is also a process required by law[144] and is largely the same as in 2014, with some minor amendments.

133. There is no requirement for a person to undergo a medical assessment for their fitness to drive in order to obtain a heavy vehicle endorsement on their driver licence.[145] However, if the driver discloses to VicRoads (or if VicRoads otherwise becomes aware of) a medical condition that may impair their ability to drive, a referral to the VicRoads medical review team will occur, and a medical assessment may be required.[146]

134. At the time of renewing a driver licence in 2014, the driver was required to complete the health details questionnaire consisting of two questions:

    a) Have you ever suffered from bad eyesight or hearing, dizziness, blackouts, epilepsy, diabetes, psychiatric or mental illness, any medical condition or other disability which may affect your driving?

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[143] Regulation 68, *Road Safety (Driver) Regulations 2019* (Vic).
[144] The renewal period is between three and ten years: section 21A of the *Road Safety Act 1986* (Vic); Transcript of evidence, p 539.
[145] Transcript of evidence, p 539.
[146] Transcript, pp 501, 503, 534.

b) Are you taking any drugs or prescribed medication?[147]

135. If both questions were answered 'no' then the licence was processed and renewed. There was no further action taken on behalf of VicRoads in terms of medical review or assessment.[148]

136. If either of the answers were 'yes', then further details were required in the section below on the form. The operator dealing with the renewal would then have emailed the completed form to the Medical Review team for further action and added a note into the driver licensing system that this had been done. The licence would be renewed, and the medical review team would conduct the further investigation.[149]

137. Once the medical review team received a new referral, a medical report may be requested regarding the disclosed medical condition. The driver's fitness to drive is then assessed against the National Guidelines.[150] The commercial standards set out in the National Guidelines apply to heavy vehicle drivers.[151]

138. Upon receipt of the driver's medical reports, the Medical Review team may request further information or consult the Victorian Institute of Forensic Medicine. Ultimately, the Medical Review team decide whether a licence is issued, whether any conditions should apply to the licence, or whether a licence should be suspended based on the National Guidelines. That decision is reviewable internally at VicRoads and in the Magistrates Court.[152]

WorkSafe requirements for a Dangerous Goods Licence

139. The requirements for a Dangerous Goods Licence at the time of Mr Voss' application renewal on 11 February 2015 were set out at Regulation 194 of the *Dangerous Goods*

[147] Exhibit 1, Coronial Brief, p 550.
[148] Exhibit 1, Coronial Brief, pp 230, 550; Transcript, p 513.
[149] Exhibit 1, Coronial Brief, p 231; Transcript, p 540.
[150] Exhibit 1, Coronial Brief, Annexure 2. These guidelines were applicable at the time Mr Voss renewed his driver licence in 2014 and underwent medical assessments for fitness to drive prior to the collision.
[151] Exhibit 1, Coronial Brief, Annexure 2, p 548.
[152] Transcript, pp 534-7.

(Transport by Road or Rail) Regulations 2008.[153] Those requirements include: the person must hold a driver licence, provide evidence of medical fitness, and a declaration that the information contained in the application is, to the best of the applicant's knowledge true and correct.

140. The medical fitness evidence required must be issued by a registered medical practitioner who had examined the applicant not more than six months prior to the application and certified the applicant was fit to drive a vehicle in accordance with the National Guidelines.[154]

Medical disclosures made by Mr Voss and medical assessments completed

141. Dr Fryman confirmed he completed six certificates of medical and physical fitness to drive for Mr Voss between 2010 and 2015 for Toll, VicRoads, and WorkSafe.

142. Dr Fryman stated that each letter from Associate Professor Amerena in relation to these consultations stated that there were no symptoms to suggest progression of Mr Voss' coronary artery disease. Dr Fryman stated that he was aware of and relied on the cardiology reviews of Associate Professor Amerena.[155]

143. Associate Professor Amerena reportedly reviewed Mr Voss with respect to his coronary artery disease a month or two prior to each assessment, except for 2013 when he was reviewed approximately three months before the assessment.

144. On 2 February 2010 and 30 September 2010, Mr Voss attended Kensington Medical Clinic to obtain a certification of medical and physical fitness to renew his WorkSafe Dangerous Goods Driver Licence. This was signed, dated, and witnessed by Dr Fryman.[156]

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[153] The 2008 Regulations. The current requirements are contained in Regulation 197 of the *Dangerous Goods (Transport by Road or Rail) Regulations 2018* (The 2018 Regulations) and are identical.
[154] Regulation 198 of the 2008 Regulations; Regulation 200 of the 2018 Regulations.
[155] Exhibit 1, Coronial Brief, p 1029, Transcript of evidence, p 59.
[156] Exhibit 1, Coronial Brief, pp 376-7.

145. The questionnaire related to medical conditions including heart disease and chest pain. Mr Voss ticked 'no' on each of these sections. Dr Fryman signed the document indicating his familiarity with Mr Voss' medical history and that he met the relevant medical criteria and required no further assessment.[157]

146. On 12 September 2011, Mr Voss completed another medical assessment. On this questionnaire it is noted that Mr Voss had experienced chest pain and angina. There is a note (presumably from Dr Fryman) which indicates that Mr Voss has stable angina and lipids.[158]

147. On 4 September 2012 a Truck Safe Medical Certificate for Toll Group was conducted by Dr Fryman. All medical questions were answered with 'no' and Mr Voss was recorded as 'fit and healthy'.[159]

148. On 23 September 2012, Dr Fryman conducted a medical assessment for fitness to drive. It was determined that Mr Voss met the required medical criteria. Mr Voss was recorded as having high blood pressure.[160]

149. On 14 January 2015, Dr Fryman conducted a medical assessment for fitness to drive. It was determined that Mr Voss met the required medical criteria. Mr Voss was recorded as having high blood pressure.[161] Dr Fryman acknowledged he should have noted on this form that Mr Voss had a history of angina.[162] Dr Fryman explained that angina (or chest pain) is a symptom of narrowed arteries, although a person can have coronary artery disease without having any symptoms.[163] It was conceded that on the form dated 14 January 2015, Mr Voss should have answered yes to the questions regarding "heart disease" and "chest pain".[164]

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[157] Exhibit 1, Coronial Brief, p 374.
[158] Exhibit 1, Coronial Brief, p 386.
[159] Exhibit 1, Coronial Brief, pp 393-7.
[160] Exhibit 1, Coronial Brief, pp 400-3.
[161] Exhibit 1, Coronial Brief, pp 1032-3.
[162] Transcript of evidence, p 55.
[163] Transcript of evidence, p 55.
[164] Transcript of evidence, p 56.

150. When asked why he considered Mr Voss met the medical criteria for an unconditional licence, Dr Fryman stated that Mr Voss was "completely asymptomatic; in terms of angina, he didn't have any angina symptoms at all. The medical treatment appeared to have produced a good response … and that was Professor Amerena's opinion as well".[165]

151. The National Guidelines were discussed at length at inquest, including the edition in force at the time of the collision, and the current edition. At the time of the collision and Mr Voss' most recent assessment with Dr Fryman prior to 26 December 2016, the National Guidelines stated that, "A person is not fit to hold an unconditional licence: if the person is subject to angina pectoris".[166]

152. Dr Fryman noted that Mr Voss did not suffer from angina at the time of the 2015 assessment.[167] He clarified that although the historical diagnosis was considered, he was asymptomatic. As such, Dr Fryman did not consider Mr Voss to be "subject to angina pectoris".[168] Dr Fryman did not consider that Mr Voss had a physical problem.[169] He stated:

> my understanding…stable angina…according to the guidelines that I've read, stable angina, meaning no symptoms, asymptomatic, able to tolerate moderate exercise, then an unconditional licence is appropriate.[170]

153. There appears to be some confusion as to what "subject to" in the National Guidelines means – whether it is present or past tense.[171] Dr Fryman considered it to mean present tense, as Mr Voss was not experiencing angina at the time of the assessment in 2015.

154. Associate Professor Amerena considered it to be applicable to a person who has "ongoing angina and is having symptoms related to angina".[172] He considered that as Mr Voss had no chest pain, he was not "subject to" angina. Associate Professor

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165 Transcript of evidence, p 61.
166 Exhibit 1, Coronial Brief, Annexure 2, p 580.
167 Transcript of evidence, p 63.
168 Transcript of evidence, p 64.
169 Transcript of evidence, p 65.
170 Transcript of evidence, p 60.
171 Transcript of evidence, p 129.
172 Transcript of evidence, p 764.

Amerena suggested it would be clearer if the National Guidelines asked whether a patient has a background or history of angina, and if so, suggest they have further tests to determine their eligibility to drive.[173]

155. Ms Fiona Morris confirmed in her oral evidence that VicRoads considers the use of "subject to" in the National Guidelines to be a present tense question.[174] I have discussed Ms Morris' evidence in more detail below.

156. Dr Fryman provided some explanation for Mr Voss' repeated negative answers to these questions across the years of medical assessments. He suggested that Mr Voss likely considered that as he had no symptoms and he was being treated for his coronary artery disease, he wouldn't have thought of it as a problem.[175] He suggested that Mr Voss' understanding of his broader cardiac issues would have been limited to the fact he was on blood pressure medication. As such, his understanding would have been that he suffered from high blood pressure.[176] In that sense, Mr Voss' answers on the medical questionnaire throughout the years was accurate.

157. Dr Fryman conceded that he should have approved Mr Voss for a 'conditional' licence on the basis of his requirement to wear glasses while driving on the 2015 medical assessment.[177]

November 2016 Assessment by Dr Chee

158. On 10 November 2016, Mr Voss completed a driver medical assessment for Toll.[178] Mr Voss was examined by Dr Chung Chee at Sonic Health for Toll. Dr Chee gave oral evidence at inquest regarding conducting fitness to drive assessments for commercial drivers, and specifically about her examination of Mr Voss.

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[173] Transcript of evidence, p 773.
[174] Transcript of evidence, p 522.
[175] Transcript of evidence, p 56.
[176] It is worth noting that Dr Fryman confirmed that Mr Voss' blood pressure was acceptable under the Assessing Fitness to Drive Guidelines.
[177] Transcript of evidence, p 66.
[178] Exhibit 1, Coronial Brief, p 467.

159. Dr Chee stated that she encourages workers to be truthful in their declarations, but often they are concerned about their job security and may not declare all their conditions. She noted she is often able to discover these in the physical examination.[179] However, if they have not made a declaration and there is no physical evidence of pre-existing injuries, there is no way for medical practitioners to be aware of their conditions.[180]

160. Dr Chee was asked about the significance of asking a patient if they have suffered from angina in a fitness to drive examination. Dr Chee stated that experiencing angina would suggest to her an underlying ischaemic heart condition and would prompt her to assess a driver's heart condition and whether or not they are fit to drive.[181] In Mr Voss' case, he did not declare on the form that he suffered from angina, chest pain, or heart disease.[182]

161. Dr Chee advised that if she received this information in an examination, she would obtain further information about the condition from the patient and a treating cardiologist for a professional opinion as to his fitness to drive.[183] Dr Chee stated that she was unaware of Mr Voss' regular attendance at a cardiologist. She stated that had she known, she would have requested a letter from the cardiologist confirming his fitness to drive.[184] She would not have issued a fitness to drive certificate without receiving information from a treating cardiologist.[185]

162. I note that the Court heard evidence from Dr Fryman and Associate Professor Amerena that they considered Mr Voss fit to drive. I consider that Dr Fryman and Associate Professor Amerena had the most detailed understanding of Mr Voss' cardiac conditions at the time.

[179] Transcript of evidence, p 259.
[180] Transcript of evidence, p 259.
[181] Transcript of evidence, p 271.
[182] Exhibit 1, Coronial Brief, p 468.
[183] Transcript of evidence, p 272.
[184] Transcript of evidence, p 278.
[185] Transcript of evidence, p 278.

163. Dr Chee identified a systolic murmur during the examination of Mr Voss.[186] The records indicate Mr Voss denied any symptoms relating to the murmur. Dr Chee referred the findings to Dr Fryman to be investigated.[187]

164. An echocardiogram study was performed which confirmed aortic valve sclerosis with no evidence of stenosis or regurgitation and was considered functionally normal.[188] Associate Professor Strathmore confirmed in his evidence that knowing Mr Voss' history and upon review of the echocardiogram, he would not have recommended any further investigation or treatment, and would be happy with Mr Voss' cardiac function.[189]

165. Dr Chee stated there was nothing in the results of the echocardiogram to indicate an underlying diagnosis of ischaemic heart disease, or anything to cause any concern about Mr Voss's fitness to drive.[190]

166. Dr Chee stated that if the results of the further tests suggested something more serious, she would have reported this to Mr Voss' employer, in this case Toll, as it is a safety issue.[191]

167. It was submitted by Counsel for Toll that Mr Voss deliberately withheld information in his medical assessments. I do not entirely agree with that submission. Mr Voss was not required to disclose his diagnosis of coronary artery disease to VicRoads in circumstances where his treating cardiologist and GP both considered that condition to be well managed and would not impair his driving.

Conclusion

168. I note the evidence of Dr Chee that the National Guidelines require a driver with ischaemic heart disease to be reviewed by a cardiologist annually in order to be granted

[186] Exhibit 1, Coronial Brief, p 454.
[187] Transcript of evidence, p 276.
[188] Exhibit 1, Coronial Brief, p 418.
[189] Transcript of evidence, p 159.
[190] Transcript of evidence, p 291.
[191] Transcript of evidence, p 289.

a conditional licence.[192] The evidence before this Court was that Mr Voss attended a cardiologist, Associate Professor Amerena, every six months, and as such was, in effect, complying with the guidelines.

169. I find that Mr Voss did not disclose any medical conditions or current medications to VicRoads prior to the collision on 26 December 2016. Mr Voss should have disclosed the medication he was taking.

170. I find no fault in relation to Dr Fryman, Associate Professor Amerena, and Dr Chee's assessments that Mr Voss was fit to drive a heavy vehicle laden with dangerous goods at the time of the collision.

Reports prepared by medical practitioners and submitted to VicRoads and WorkSafe

171. Dr Chee was employed by Sonic Health who are contracted by Toll to complete medical assessments. The medical forms prepared by Dr Chee were provided to Toll. Dr Chee gave evidence that she does not provide the fitness to drive declarations to the licensing authorities.[193] She stated that she may only contact a licensing authority where a person has a medical condition which renders them unfit to drive, and the person advises they will not inform the licensing authority themselves.[194] Dr Chee gave evidence that she was unaware whether she was obliged to make the same notification to WorkSafe.[195]

172. I note the National Guidelines provide an obligation on health practitioners to advise drivers of "their responsibility to report their condition to the driver licensing authority if their long-term or permanent injury or illness may affect their ability to drive safely".[196]

173. Dr Fryman gave evidence that medical practitioners are not provided any training or information as to how to use and apply the National Guidelines. Rather, they must

[192] Transcript of evidence, p 334.
[193] Transcript of evidence, p 315.
[194] Transcript of evidence, p 315.
[195] Transcript of evidence, p 328.
[196] Exhibit 1, Coronial Brief, p 686.

familiarise themselves with the guidelines and look them up online.[197] He stated that additional training for GPs in conducting the assessments would be beneficial.[198] It was discussed at inquest that the National Guidelines are now accessible online. Dr Fryman considered the new process to be very useful.[199]

174. He noted that often patients don't book a long enough appointment to conduct a thorough medical assessment, which creates a time pressure for practitioners.[200] Dr Chee echoed this statement.[201]

175. Dr Chee's evidence was that she considers the potential for patients to provide inaccurate information to be a systemic and cultural issue. She noted employees can be afraid of their employer being informed of their full medical conditions, which leads to hesitancy to disclose.[202] She stated that some drivers may choose not to declare their conditions for the "simplicity" of getting their approval to drive.[203] She agreed it would be helpful to have access to driver's medical files to safeguard against this issue, though noted that there are some privacy concerns with this suggestion.[204]

176. Dr Fryman ultimately was of the view that independent medical examiners may be in the best position to conduct medical fitness to drive assessments.[205] Dr Hannan echoed this statement and said that an independent practitioner would be able to perform the assessments and apply the guidelines more consistently.[206]

177. I too see the benefit in this, as it appears that GPs are often placed in a difficult position with managing the therapeutic relationship with a patient, and their duty to truthfully disclose medical conditions to the licensing authorities. However, an independent

[197] Transcript of evidence, p 69.
[198] Transcript of evidence, p 69.
[199] Transcript of evidence, p 131.
[200] Transcript of evidence, p 69.
[201] Transcript of evidence, p 293.
[202] Transcript of evidence, p 307.
[203] Transcript of evidence, p 307.
[204] Transcript of evidence, p 308.
[205] Transcript of evidence, p 71.
[206] Transcript of evidence, p 487.

practitioner will be at somewhat of a disadvantage without the detailed clinical history a regular GP may have.

178. I recognise the systemic issues regarding drivers' unwillingness to disclose their medical conditions, and the real or perceived risks this may pose to their employment. However, I do not consider Mr Voss' case to be a case of intentional non-disclosure to protect his employment.

Medical disclosures made by Mr Voss to VicRoads and WorkSafe

179. Dr Hannan advised that upon his diagnosis of obstructive sleep apnoea in April 2018, he advised Mr Voss of the need to contact VicRoads and inform them.[207] Obstructive sleep apnoea is a reportable condition which places a personal obligation on a driver or patient to inform VicRoads.[208] Dr Hannan stated he believed Mr Voss contacted VicRoads and provided this information following the diagnosis.[209]

180. There was discussion of requiring mandatory reporting from health practitioners. VicRoads currently do not place a legal obligation on health professionals to report patient's health conditions which impact their driving ability. However, there is an ethical responsibility.[210] Consultation with health professionals has reportedly indicated they would not be willing to provide mandatory reports due to the impact this would have on the patient/doctor relationship.[211] VicRoads have found the community model of self-reporting is the best option.[212]

[207] Transcript of evidence, p 441.
[208] Transcript of evidence, p 442.
[209] Transcript of evidence, p 442.
[210] Transcript of evidence, p 548.
[211] Transcript of evidence, p 529.
[212] Transcript of evidence, p 529.

Consideration of medical assessments and/or reports by VicRoads and WorkSafe.

VicRoads

181. Ms Morris is the Medical Case Manager in the medical review department of VicRoads and is a registered nurse. She provided a written statement[213] and oral evidence at the inquest. I found Ms Morris to be a genuine and credible witness. I also note that she was the only witness to provide her condolences to Jackson's family.

182. Drivers have a legal requirement to notify VicRoads of relevant medical conditions. VicRoads also receives referrals from police, health professionals, and confidential notifications from third parties. These are then reviewed by Ms Morris and her colleagues.[214]

183. Following the collision on 26 December 2016, Mr Voss's vehicle licence was suspended by VicRoads as he was suspected to have suffered a blackout.[215] After providing reports as to his capacity to drive from Dr Fryman, Associate Professor Amerena, and Dr Hannan, Mr Voss' fitness to hold a car and heavy vehicle licence was confirmed.[216]

184. Prior to receiving notification after the December 2016 collision, the Medical Review unit at VicRoads did not receive any request or referral for review of Mr Voss' fitness to drive.[217]

185. Regarding reports of Mr Voss' angina, Ms Morris reported that VicRoads considers medical conditions from a risk perspective. That is, if someone is well-treated and has not experienced angina for approximately a decade, VicRoads would not consider that patient to have angina under the guidelines and therefore would not be at risk.[218] This was consistent with the beliefs of the clinicians involved in this inquest.

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[213] Exhibit 1, Coronial Brief, pp 232-6.
[214] Transcript of evidence, pp 502-3.
[215] Exhibit 1, Coronial Brief, p 232.
[216] Exhibit 1, Coronial Brief, p 235.
[217] Exhibit 1, Coronial Brief, p 236.
[218] Transcript of evidence, p 522.

186. In May 2018, VicRoads were notified of Mr Voss' obstructive sleep apnoea diagnosis.[219] Ms Morris requested a specialist report about treatment and compliance. Dr Hannan provided a report confirming Mr Voss was fit to drive according to the guidelines.[220] VicRoads approved Mr Voss' licence renewal, with the condition he be subject to ongoing review.[221]

187. Ms Morris confirmed that at the time of issuing a licence, VicRoads are not aware whether a driver also has a WorkSafe issued licence. Further, it is not routine practice to notify WorkSafe when VicRoads makes a determination someone is not fit to drive.[222] I consider this to be a concerning gap in the licensing process and discuss this in more detail later in the finding.

188. I note that both Counsel for VicRoads and WorkSafe indicated in the submissions hearing that they would agree to collaborate to develop a memorandum of understanding to allow for the sharing of information, specifically in relation to cancelled or suspended licences on medical grounds by either organisation. I strongly encourage both VicRoads and WorkSafe to collaborate on this issue.

189. Ms Morris gave evidence that the VicRoads website had been updated with documentation and fact sheets for patients and health practitioners on different medical conditions. In particular, one has been developed for sleep apnoea.[223] Information is provided for health professionals on having difficult conversations with patients, and a podcast has been developed in conjunction with the Royal College of Physicians on the medical review process.[224] I encourage VicRoads to continue educating GP's about their knowledge around medical impairments and their implications on licensing requirements.

190. Ms Morris indicated that VicRoads would like to do more by way of education for GPs in this area and have information for the public more readily available where drivers

[219] Transcript of evidence, p 508.
[220] Transcript of evidence, p 509.
[221] Transcript of evidence, p 510.
[222] Transcript of evidence, p 559.
[223] Transcript of evidence, p 531.
[224] Transcript of evidence, p 532.

have contact with health services.[225] She further stated they would like to involve allied health professionals.[226] This appears to be having an impact because from 2021 to 2022, there were 30,000 new referrals of drivers to Ms Morris's team.[227] She commented this is a very steep trajectory upwards.

191. Ms Morris gave evidence that there are only three medical case managers in the Medical Review team. Evidence was also heard about the significant number of cases required to be reviewed, and that this is growing. Ms Morris agreed that if people followed the rules to the letter – her office would be overwhelmed.[228]

192. I consider that increased education to GPs, allied health practitioners and the general public would likely contribute to a further rise in referrals to the Medical Review team at VicRoads. It is vital that Ms Morris and her colleagues receive resources commensurate with that increase. Counsel for VicRoads responded to this concern by confirming that VicRoads continues to monitor the workload of the Medical Review department and will allocate resources as required.

WorkSafe

193. Tristan Gallus, a Technical Quality Assurance Coordinator for the WorkSafe Licensing team provided a written statement[229] and oral evidence at inquest. He also spoke to a written statement provided by Dean Grow, from WorkSafe.[230]

194. There is an obligation on licence holders to notify WorkSafe of any changes to their circumstances which may impact their licence.[231] Licence holders are made aware of this by WorkSafe in the approval email. Mr Gallus commented this notation could be made clearer.[232] There is no obligation on an employer to notify WorkSafe of any

[225] Transcript of evidence, p 543.
[226] Transcript of evidence, p 533.
[227] Transcript of evidence, p 533.
[228] Transcript of evidence, p 556.
[229] Exhibit 1, Coronial Brief, p 1104.
[230] Exhibit 1, Coronial Brief, p 226.
[231] Transcript of evidence, p 724.
[232] Transcript of evidence, pp 727-8.

change.[233] In the period of 2015 to 2020, WorkSafe did not receive any notifications regarding Mr Voss's fitness to drive.[234]

195. Mr Gallus described the process of a driver filling in the relevant patient questionnaire before attending their medical professional. WorkSafe does not receive a copy of this questionnaire, though Mr Gallus noted they may occasionally receive one inadvertently. In that case, they have no regard to the information.[235] Mr Gallus emphasised that the only part of the form WorkSafe has regard to is the section where the doctor has declared whether a driver meets the requirements and is fit to drive.[236]

196. Mr Gallus confirmed WorkSafe will follow the recommendations of the medical professionals when determining fitness to drive.[237]

197. Regarding communication from VicRoads to WorkSafe about licensing, Mr Gallus stated "in my personal opinion…it would be extremely useful for VicRoads or the police to let us know of such matters that also relate to our licences".[238] I agree with this proposition and have referred to the benefits this above and in the comments section of this finding.

Requirements of Toll for employment of heavy vehicle drivers responsible for transporting dangerous goods, and how these requirements were met by Mr Voss

198. Aaron Louws, Manager of Health, Safety and Environment with Road Transport Safety at Toll Global Logistics, provided a written statement[239] and oral evidence at inquest. He provided evidence about Toll's employees and contract truck drivers various licensing requirements.

[233] Transcript of evidence, p 726.
[234] Transcript of evidence, p 725.
[235] Transcript of evidence, p 718.
[236] Transcript of evidence, p 719.
[237] Transcript of evidence, p 723.
[238] Transcript of evidence, p 735.
[239] Exhibit 1, Coronial Brief, Annexure 1, p 83.

199. Prior to being employed at Toll, full time drivers are required to undergo a medical assessment.[240] Drivers of dangerous goods vehicles, such as Mr Voss, must hold a Dangerous Goods Licence which requires a medical assessment on initial application for licence, and then every five years thereafter.[241]

200. Toll receives and maintains copies of its employees' dangerous goods licences and subsequent renewed licences. Toll does not receive copies of the medical questionnaire completed by a patient, and if they are inadvertently received, they are discarded.[242]

201. The National Law regulates drivers to operate under standard hours. However, some drivers are allowed to work additional hours in a 24-hour period under a Basic Fatigue Management (**BFM**) accreditation.

202. Toll requires any drivers who are operating under its BFM accreditation to complete the relevant training and undergo a medical assessment every year if over the age of 50 years (and every three years if 49 years or younger). This requirement is in place to ensure Toll continues to maintain and comply with their Fatigue Management accreditation under the National Heavy Vehicle Accreditation Scheme as well as comply with the Heavy Vehicle National Law.

203. The Heavy Vehicle National Law regulates for three different rest and work options, including standard hours, BFM and Advanced Fatigue Management. Drivers who operate under BFM conditions are able to work under more lenient work/rest rules, including additional working hours in a 24 hour period.

204. The training focuses on work and rest hours, information about fitness for duty, signs and symptoms of fatigue, the heightened risks of fatigue for heavy vehicle drivers, and informs drivers not to operate a vehicle if they identify any symptoms of fatigue or if they are not feeling well. Drivers are required to complete the training only once.[243]

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[240] Transcript of evidence, p 603.
[241] Exhibit 1, Coronial Brief, Annexure 1, p 83.
[242] Exhibit 1, Coronial Brief, Annexure 1, pp 83, 85.
[243] Exhibit 1, Coronial Brief, Annexure 1, p 84; Supplementary statement of Aaron Louws and Annexure B, Driver's Responsibilities (for training on induction to accreditation), p 1.

205. Mr Voss worked for Toll under a BFM accreditation.[244]

206. Prior to Mr Voss' employment with Toll in 2009, he underwent a pre-employment medical assessment. The assessment required Mr Voss to fill out a questionnaire which was signed by a Dr Richard Lunz. The questionnaire instructed that it was the patient's responsibility to make the doctor examining them aware of any health issues which may impact their fitness to drive. Mr Voss did not disclose his cardiac condition.[245] However, he did undergo regular medical assessments and provided consent for his employer to be informed of the outcome of those assessments.[246]

207. Mr Voss completed Toll's Fatigue Management Strategies on 8 July 2009, which remains valid.[247]

208. Mr Voss held a dangerous goods driver licence which was renewed on 11 March 2015.[248]

209. Mr Voss underwent medical assessments conducted by Dr Chee on 9 February 2015 and 10 November 2016. Dr Chee assessed him as satisfying the criteria for a conditional licence under the National Guidelines on both occasions. The condition was that Mr Voss wear glasses.[249]

210. On 26 December 2016 Mr Voss successfully logged into his vehicles MT Data system at the commencement of his driving shift, and confirmed he was fit for duty.[250]

211. Prior to the collision, the evidence does not reveal that Mr Voss made any medical disclosures directly to his employer. However, he did undergo regular medical assessments and provided consent for his employer to be informed of the outcome of those assessments.[251]

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[244] Exhibit 1, Coronial Brief, Annexure 1, p 83.
[245] Exhibit 1, Coronial Brief, pp 427-8.
[246] Exhibit 1, Coronial Brief, pp 385, 403, 1032.
[247] Exhibit 1, Coronial Brief, Annexure 1, p 84.
[248] Letter to Mr Voss from WorkSafe dated 11 March 2015 (provided after the inquest hearings).
[249] Exhibit 1, Coronial Brief, pp 462, 473.
[250] Exhibit 1, Coronial Brief, pp 224, 505, 655.
[251] Exhibit 1, Coronial Brief, pp 385, 403, 1032.

Conclusions

212. The evidence reveals that Mr Voss was diligent in his attendances on Associate Professor Amerena.

213. He had been assessed by Dr Chee on 10 November 2016 as being fit to drive (with the condition he wear glasses).[252]

214. At the time of the collision Mr Voss met the National Guidelines criteria for a commercial driver and satisfied his shift with Toll.

215. On the 26 December 2016, Mr Voss felt ready, fit and able to work and felt that he had a good night's sleep the night before. He had a sufficient break of about 60 hours between shifts.[253]

216. Neither of his treating doctors were aware of the likelihood that Mr Voss was suffering from severe obstructive sleep apnoea.[254]

Applicable training, policies, procedures, and practices in respect of obtaining, granting, and considering medical certificates or reports by VicRoads, WorkSafe, and Toll and any recent changes

VicRoads

217. VicRoads has also implemented an online renewal process which automatically triggers a referral to the Medical Review team if an applicant answers 'yes' to any of these questions.[255] A large proportion of medical assessments for fitness to drive are now received via the online system.[256] Evidence provided about the new system suggests the information provided is relevant, easily accessible, and current. I consider this to be an improvement on the paper form.

[252] Exhibit 1, Coronial Brief, p 473.
[253] Exhibit 1, Coronial Brief, p 508 and Annexure 1, p 1.
[254] Exhibit 1, Coronial Brief, p Annexure 1 p 2, Transcript of evidence, pp 76-79, 82, 88, 107-8, 123-4, 266-7, 418-9, 460, 471, 774-6, 781, 797-9, 801, 827-8, 1030,
[255] Transcript of evidence, p 516.
[256] Transcript of evidence, p 532.

218. There is scope for improved understanding by the public, including heavy vehicle drivers, of their ongoing duty to advise VicRoads of any medical conditions which may impair their ability to drive safely.

219. VicRoads has previously acknowledged to the Coroners Court that, at a consumer level, there is a lack of awareness of the medical review process, the impact of health conditions on driving, and a driver's legal obligations to report to VicRoads and refrain from driving if they are impaired.[257] That lack of awareness was reflected in some of the evidence in this Inquest.[258] The obligations on drivers is currently only communicated via the VicRoads website. I consider that improved understanding may be achieved by more direct communication with drivers when providing licences. this fact confirms the importance of a public awareness campaign for self-reporting and I have made a relevant recommendation.

National Guidelines

220. There have been no substantive changes to the National Guidelines' criteria for an unconditional or a conditional licence for commercial drivers as they relate to cardiac conditions relevant to this inquest. I note the reference to myocardial ischaemia in the 2022 version of the National Guidelines appears more clearly to be a sub-category of angina, rather than a standalone category.[259] I note the confusion detailed above regarding the requirements of someone diagnosed with ischaemic heart disease, this change may clarify some of this.

221. In relation to sleep apnoea, the 2022 National Guidelines now state explicitly that a treating doctor should not rely solely on subjective measures of sleepiness such as the Epworth Sleepiness Scale to rule it out.[260] This is a positive change since 2012 as the evidence suggests the ESS is not the most reliable measure of sleepiness.[261]

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[257] Exhibit 7, VicRoads Report to the Coroner, 4 November 2018, p 23.
[258] Exhibit 1, Coronial Brief, Annexure 1, p82; Transcript, pp 678, 531, 533.
[259] Exhibit 2, 2022 National Guidelines, p 73.
[260] Exhibit 2, NTC Guidelines, Assessing Fitness to drive for commercial & private vehicles dated 2022 pp 180-3, 185.
[261] Transcript of evidence, pp 373, 383, 416, 417, 466, 481; Exhibit 1, Coronial Brief, p 1025.

WorkSafe

222. The current application process for dangerous goods licences is largely the same, but now includes an updated form that can be completed via an online portal. Complex cases are now referred to an internal panel. Otherwise, the requirements and process for renewal are largely unchanged.[262]

223. The online portal requires an applicant to download and print the medical forms, and then upload the completed hard copy.[263] Counsel Assisting submitted that WorkSafe may wish to consider electronic forms as used by VicRoads.

224. Counsel for WorkSafe in reply submitted that transitioning to electronic forms would require significant resources, and that there are currently no plans to transition to electronic forms in the immediate future. It was further stated that the inquest has not produced evidence which supports a need to transition to electronic medical certificates.[264] I do not intend to make a specific recommendation on this point but encourage WorkSafe to continue to review their processes and practices to look for areas for improvement.

225. As discussed above, there is currently no communication between WorkSafe and VicRoads in relation to licensing. I consider that communication is likely to benefit both authorities and the parties have confirmed their willingness to do so. Counsel for VicRoads submitted that they would be open to engaging with WorkSafe to jointly review existing processes between the two organisations, with a view to introducing or enhancing processes to share information regarding drivers with a dangerous goods licence, subject to any legislative considerations. Counsel for WorkSafe submitted they were willing to explore a memorandum of understanding on information sharing with VicRoads[265] and I encourage them to do so.

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[262] Regulations 197 and 200 of the *Dangerous Goods (Transport by Road or Rail) Regulations 2018;* Transcript, pp 716-7, 722; Exhibit 13, WorkSafe Online Application for Dangerous Goods Drivers Licence including Driver Commercial Health Assessment – Medical Certificate application.

[263] Transcript of evidence, p 729.

[264] Outline of Submissions on Behalf of WorkSafe dated 4 April 2023, p 6.

[265] Outline of Submissions on Behalf of WorkSafe, p 7.

Toll

226. Evidence was provided at inquest of new safety technology developed by Toll, particularly the Fatigue Distraction Detection Technology System, which operates through driver facing cameras which detect eye and body movement. However, if the driver's eyes were on the road, their head was not moving, and their facial position did not change, the system would not necessarily pick up a microsleep with those features.[266] It is difficult to envisage technology that could do this.

227. No training, either in 2016 or currently, appears to address the importance of undergoing medical assessments, full disclosure in those assessments, and reporting obligations to licensing authorities as to any medical conditions which may impair a driver's ability to drive.[267]

228. Counsel Assisting submitted, that Toll should consider what they can do as an employer to raise awareness amongst its drivers about:

    a) Drivers' ongoing obligations to advise the licensing authorities of any medical conditions which may impair their ability to drive;
    b) The importance of understanding their own medical history, and providing a full and frank medical history to the medical assessor;
    c) The fact that medical information provided to assessors is not provided to Toll and remains confidential;
    d) Signs, symptoms, and dangers associated with untreated obstructive sleep apnoea; and
    e) How the Medical Review team at VicRoads assesses referrals and how conditional driver licences work.

229. Toll now uses independent contractors to conduct medical assessments. This means that specialists in conducting occupational specific medical assessments take the pressure

[266] Transcript, pp 593-5, 596.
[267] Transcript, pp 597-8, 678-9.

off busy GPs.[268] Toll can arrange the assessment during work hours, cover the costs, and make it as convenient and efficient for their drivers to attend.[269]

230. However, some disadvantages to this approach were identified during evidence. Namely, it relies on self-reporting of medical conditions. There may be concerns about job security and not wishing to declare a medical concern or condition due to a belief, rightly or wrongly, that it would result in them no longer being able to perform their duties.[270] There are also issues with a driver's lack of understanding or memory of their own medical conditions and medications, as in Mr Voss' case.

231. Dr Chee advised that the time allocated for medical assessments at Sonic HealthPlus was only ten minutes. I do not consider this to be a sufficient period of time for patients with extensive medical conditions and/or history.

232. Counsel Assisting submitted, and I agree, that consideration ought to be given as to how Toll intends to ensure contractors receive adequate time and information about an employee's medical history to conduct an assessment which does not solely rely on self-reporting. Access to a treating GP's medical file or MyHealth records is likely to be of significant assistance.[271]

FINDINGS

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

a) the identity of the deceased was Jackson David Eales, born 30 August 1989;

b) the death occurred on 26 December 2016 at Heales and Broderick Road, Corio, Victoria, 3214, from injuries sustained in motor vehicle collision (driver); and

c) the death occurred in the circumstances described above.

[268] Transcript, pp 253, 257.
[269] Transcript, pp 601, 637, 646, 648, 310.
[270] Transcript, pp 258, 259, 307, 315, 317, 373, 707-8.
[271] Transcript, p 308.

234. I find that on 26 December 2016, Jackson and his partner, Melissa Goldsmith were innocently driving in his Ford Utility, when Mr Voss failed to stop at a stop sign at the intersection of Heales and Broderick Roads, Corio and collided with Jackson's utility which caused Jackson's sudden death and serious injuries to Melissa Goldsmith.

235. I find that Mr Voss suffered a small myocardial infarct (heart attack) at some stage proximate to the collision on 26 December 2016. I am unable to determine whether the heart attack occurred before or after the collision. However, after reviewing the in cabin footage, the medical evidence strongly suggested there were no obvious signs of Mr Voss suffering a cardiac event prior to the accident and on that basis, I find it unlikely the collision was caused by a cardiac event.

236. I find it highly probable Mr Voss suffered from severe obstructive sleep apnoea in the years prior to his diagnosis, including at the time of the collision. He was unaware that he was suffering from severe obstructive sleep apnoea prior to his diagnosis in April 2018. I find it is probable that symptoms relating to severe obstructive sleep apnoea were present and may have contributed to Mr Voss' failure to stop at the intersection of Broderick Road and Heales Road, Corio.

237. Prior to diagnosis, none of Mr Voss' treating doctors suspected he was suffering from severe obstructive sleep apnoea. With the benefit of hindsight, it is tempting to put together snippets of information received by Mr Voss or his treating clinicians over a period of years to illustrate there *were* signs of sleep apnoea earlier in time. However, no criticism can be made of Mr Voss' treating clinicians in the context of Mr Voss not presenting with the typical physical signs or symptoms of sleep apnoea.

238. Having considered all of the evidence, I find that inattention, fatigue or distraction, caused by non-medical reasons, are unlikely to be factors which contributed to Mr Voss' failure to stop at the intersection of Broderick Road and Heales Road, Corio.

239. I find that at the time of the collision, and to the best of his and his treating practitioner's knowledge, Mr Voss satisfied the National Guidelines criteria for a commercial driver

(with the condition he wear glasses) and satisfied the criteria for commencing his shift with Toll.

240. Mr Voss was not required to disclose his diagnosis of coronary artery disease to VicRoads in circumstances where his treating cardiologist and GP both considered that condition to be well managed and would not impair his driving.

241. I find that Mr Voss did not disclose any medical conditions or current medications to VicRoads prior to the collision on 26 December 2016. Although, the evidence demonstrates that Mr Voss should have disclosed the medication he was taking.

242. I find no fault in relation to Dr Fryman, Associate Professor Amerena, and Dr Chee's assessments that Mr Voss was fit to drive a heavy vehicle laden with dangerous goods at the time of the collision.

COMMENTS

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

244. This inquest has highlighted the importance of road users understanding their individual medical conditions, and any prescribed medications they may take and how that may impair their driving and/or impact their licensing requirements. Whilst the evidence in this case has demonstrated that Mr Voss' obstructive sleep apnoea was undiagnosed, there is evidence that he did not fully understand his own medical condition and his requirement to notify VicRoads when answering questions and filling in renewal forms.

245. Drivers, especially heavy vehicle truck drivers need to understand the serious risks and implications associated with non-disclosure of medical conditions. Whilst I have not found this issue to be causal to Jackson's death, the issue was identified and is connected to the circumstances of this case.

246. VicRoads has previously acknowledged to the Coroners Court that at a consumer level, there is a lack of awareness of the medical review process, the impact of health conditions on driving and a driver's legal obligations to report to VicRoads and refrain

from driving if they are impaired. This inquest identified that there is an opportunity to improve awareness of driver's legal obligations to notify VicRoads when they have been deemed to be impaired due to a medical condition by a medical practitioner. Consequently, I have made a recommendation consistent with this.

RECOMMENDATION

247. Pursuant to section 72(2) of the Act, I make the following recommendation:

Recommendation one:

To: Paul Younis, Secretary of VicRoads and the Department of Transport

I RECOMMEND THAT the Secretary of VicRoads and the Department of Transport develop a public awareness campaign around the importance of understanding the fitness to drive guidelines and obligations of individuals to inform VicRoads of any medical conditions that may impair an individual's fitness to drive.

Final comments

248. Whilst the majority of the evidence at inquest focussed on Mr Voss' various medical conditions and potential reasons for the collision, it is important to emphasise that this Finding is about Jackson and the tragic circumstances of his death.

249. Jackson's death has had a profound and lasting impact on his family and his community. The coronial impact statements provided by his mother Gerardine, aunt Pauline, and sisters Leah and McKenzie, demonstrated to me the love this family has for Jackson. I also wish to acknowledge the attendance of Jackson's other siblings, Naomi and Darcy and other family members who attended the inquest. Their presence, strength, love and support to each other, each day, through very difficult and at times confronting evidence was most impressive.

250. It is clear to me that Jackson as a beloved son, adored brother, nephew, uncle, cousin, partner and great friend, and he will always be remembered as a loving, kind, beautiful, strong and protective person, who had a brilliant sense of humour and a bellowing laugh.

251. I wish to convey my sincere condolences to the Eales Family and Ms Goldsmith for the tragic loss of your beloved Jackson.

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

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

Mrs Gerardine Eales

Ms Melissa Goldsmith

Mr Gerard Voss

Dr Stephen Fryman

Associate Professor John Amerena

Toll Holdings Limited

Paul Younis, Secretary of VicRoads and the Department of Transport

WorkSafe Victoria

National Heavy Vehicle Regulator

Mr Jaime Slipais, Transport Accident Commission

Mr Iain Macdonald, National Heavy Vehicle Regulator

Detective Sergeant Mark Amos, Coroner's Investigator

Signature:

JACQUI HAWKINS

DEPUTY STATE CORONER

Date: 18 August 2023