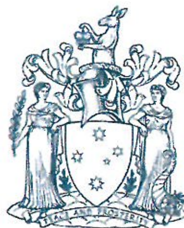

IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2016 4011

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 60(2)*

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

I, AUDREY JAMIESON, Coroner having investigated the death of FREDERICK HYLLA

without holding an inquest:
find that the identity of the deceased was FREDERICK HYLLA
born 22 July 1929
and the death occurred on 24 August 2016
at the Alfred Hospital, 55 Commercial Road, Melbourne Victoria 3004
**from:**

1 (a) MULTIPLE INJURIES IN A MOTOR VEHICLE INCIDENT

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

1. Frederick Hylla was 87 years of age at the time of his death. Mr Hylla was born in Germany and migrated to Australia in 1950. He lived in Mansfield with his wife Selma. Mr Hylla suffered from a number of co-morbidities. He had recently been discharged from Mansfield Hospital, after receiving treatment for an acute myocardial infarction.

2. On Wednesday 24 August 2016, at approximately 10.15am, Mr Hylla and his wife departed their home; they planned to visit a café in Jamieson. Mr Hylla drove their Ford station wagon

south along Mansfield-Woods Point Road; Mrs Hylla was seated in the front passenger seat of the vehicle. In Macs Cove, the Ford station wagon veered to the left, before leaving the road and entering adjacent vegetation, colliding with trees and rolling onto its side. A passer-by contacted emergency services at approximately 12.42pm; ambulance paramedics, police and Country Fire Authority (CFA) members attended shortly afterwards. State Emergency Service (SES) members were called to assist, and after approximately one hour were able to extract Mr and Mrs Hylla, who were both conscious, from the vehicle.

3. Mrs Hylla sustained multiple survivable injuries. Mr Hylla's Glasgow Coma Scale score was initially measured to be 15, but decreased to 13.[1] He was found to be hypotensive and was consequently intubated. Ambulance paramedics performed a focussed assessment with sonography with trauma (FAST) scan, which was positive. Mr Hylla was transfused and infused with inotropes to maintain his blood pressure.

4. Mr Hylla was subsequently airlifted to the Alfred Hospital, and upon arrival had an unrecordable blood pressure and suffered a cardiac arrest. Chest tubes were inserted which drained a large volume of blood. Mr Hylla progressed to cardiac arrest at 4.29pm. Cardiopulmonary resuscitation (CPR) was commenced, but Mr Hylla was unable to be revived. At 4.55pm on 24 August 2016, Mr Hylla was declared to be deceased.

## INVESTIGATIONS

### *Forensic pathology investigation*

5. Dr Michael Burke, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed a full post mortem examination upon the body of Mr Hylla, reviewed a post mortem computed tomography (CT) scan and e-Medical Deposition Form from the Alfred Hospital, and referred to the Victoria Police Report of Death, Form 83.

6. At autopsy, Dr Burke identified *inter alia* ischaemic heart disease with prior coronary artery bypass grafts and coronary artery disease; cardiac amyloidosis; and an organising thromboembolism within the right main pulmonary artery. Upon microscopic examination of

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[1] The Glascow coma scale is a neurological scale that aims to give a reliable, objective way of recording the conscious state of a person for initial as well as subsequent assessment. A patient is assessed against the criteria of the scale, and the resulting points give a patient score between 3 (indicating deep unconsciousness) and either 14 (original scale) or 15 (the more widely used modified or revised scale). The GCS is a widely used score of a level of unconsciousness, with a score of less than 8 being universally accepted as the level of coma in which a person is likely to be unable to protect their airway from saliva and other secretions and is at risk of obstructing their airway. There is also agreement that at a level of GCS less than 8, a patient should be intubated to protect the airway and ensure adequate oxygenation.

Mr Hylla's heart, Dr Burke observed contraction bands in keeping with a sudden cardiac ischaemic event. Dr Burke reported that the degree of heart disease detected would be consistent with causing a sudden cardiac arrhythmia which could have led to a change in conscious state and the subsequent motor vehicle incident. Toxicological analysis of Mr Hylla's post mortem blood detected morphine,[2] midazolam[3] and ketamine,[4] which were likely administered by emergency services and hospital staff. Dr Burke ascribed the cause of Mr Hylla's death to multiple injuries in a motor vehicle incident.

7. In correspondence dated 7 September 2016, Dr Burke elaborated that the identification of a thrombus occluding an artery meant it was quite likely – although not conclusive – that a natural event caused the collision. Dr Burke observed that Mr Hylla had significant cardiac disease. Noting the lack of evidence of evasive action, Dr Burke believed it more likely than not that Mr Hylla's natural disease caused the collision.

*Police investigation*

8. Leading Senior Constable (LSC) Paul Gillard the nominated coroner's investigator,[5] conducted an investigation of the circumstances surrounding Mr Hylla's death, at my direction, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by Mr Hylla's wife Selma Hylla, stepdaughter Karin Adams, Rhett Smith, Laura Buye and Helen Stergiou.

9. Selma Hylla stated that her husband underwent a triple bypass operation in 1999, and his general good health declined over the years. She added that Mr Hylla's driving was generally really good; she did not recall him ever speaking with doctors about undergoing a medical review in relation to his ability to drive.

10. On 7 July 2016, Mr Hylla was admitted to Mansfield Hospital, after experiencing shortness of breath, swollen legs and general poor health. Mrs Hylla said that the family were advised that her husband would not recover, but he was discharged home on 1 August 2016. She said he was feeling a lot better when he returned home from hospital.

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[2] Morphine is a narcotic analgesic used to treat moderate to severe pain.

[3] Midazolam is a short acting benzodiazepine used intravenously in intensive care patients.

[4] Ketamine is an anaesthetic.

[5] A coroner's investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator takes instructions direction from a coroner and carries out the role subject to the direction of a corner.

11. Karin Adams stated that when her stepfather was discharged from hospital, she asked him not to drive the car, because she was worried he would have an accident. Ms Adams added that the family discussed Mr Hylla's driving and she subsequently contacted his doctor and requested that a conversation be had about his driving. Ms Adams said she asked not to be named as the one who called the doctor, because she did not want to be *'the bad guy'*. She said that when Mr Hylla returned from seeing the doctor, she asked Mrs Hylla how it went. Ms Adams reported that Mrs Hylla said the doctor advised Mr Hylla he could drive, as long as his legs were not too swollen. *'That was all we could do as they have to take responsibility for their lives.'*

12. Mrs Hylla stated that on the morning of Wednesday 24 August 2016, her husband alighted from bed at approximately 8.40am. They ate breakfast together, and Mr Hylla appeared especially well. He suggested that they go out for scones and jam in Jamieson, and they left home at approximately 10.15am. Mrs Hylla said that her husband's driving on this day was good; *'I was never scared when he was driving'*. She said that just prior to the collision, Mr Hylla was driving into a right hand curve, when he instead drove straight ahead, over an embankment and into a tree.

13. Upon attending the scene of the collision, police observed that the roads were dry, weather was fine, visibility was good and traffic was light. It was identified that the Mansfield-Woods Point Road runs from Mansfield to the north and Jamieson to the south. The speed limit for the road was 100km/h. The location of the collision was approximately four kilometres south of an intersection with Goughs Bay Road. The road was a sealed surface in good condition, and the north and south bound lanes were separated by two solid white lines. The road had a single solid edge line on each side of the road, and a gravel shoulder on both sides. Enquiries revealed that there were no witnesses to the collision.

14. After examining the scene of the collision, LSC Gillard reported that there were no tyre skid marks on the sealed surface of the road, prior to where the vehicle left the road. LSC Gillard opined that it appeared Mr Hylla had been travelling at unknown speed in a southerly direction, approaching a sweeping right hand bend. There were rolling tyre marks identified on the gravel shoulder of the road, which commenced approximately 67.5 metres prior to where the vehicle collided with two medium sized trees. LSC Gillard suggested that Mr Hylla had driven in a straight line through the right hand bend. No dead wildlife or other objects, natural or manmade, were identified which may have contributed to the collision.

15. Police inspected Mr Hylla's vehicle on 25 August 2016, and observed that it appeared to be well maintained and in good condition. It was ascertained that Mr Hylla had a full and current Victorian driver's licence at the time of the collision. He had no previously recorded collision history.

*Further investigations*

16. Following the receipt of the coronial brief, I directed that further information be sought from Mr Hylla's General Practitioner at Mansfield Medical Clinic, Dr Andrew Wettenhall. In his statement, Dr Wettenhall advised that he saw Mr Hylla during his recent admission to Mansfield District Hospital, on 13 July, 20 July, 21 July, 26 July, 27 July and 28 July 2016.

17. Dr Wettenhall stated that following Mr Hylla's discharge from hospital on 1 August 2016, he reviewed him at the Mansfield Medical Clinic on 10 August 2016. Dr Wettenhall said that he documented that he advised Mr Hylla he was not fit to drive, because of his heart condition and the effect this appeared to be having on his cognition. He did not recall what Mr Hylla's response to this was.

**COMMENTS**

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

1. It is concerning that despite the evidence of both Dr Wettenhall and Ms Adams that they viewed Mr Hylla to be unfit to drive, he was able to continue driving and seemingly place both himself and other road users in danger.
2. In the Finding without Inquest into the death of Nicholas Carr[6] delivered on 28 November 2016, I observed that Section 17A of the *Road Safety Act 1986* (Vic) provides that a person who drives a motor vehicle on a highway must drive in safe manner having regard to all the relevant factors, which include the physical and mental condition of the driver or road user (s17A(1), (2A)(g)). I also note Regulation 67(2) of the *Road Safety (Drivers) Regulations 2009* (Vic), provides that 'if the holder of a driver licence... is affected by a permanent or long-term injury or illness that may impair the person's ability to drive safely, the person must as soon as practicable after becoming aware of the injury or illness notify [VicRoads] about it.'
3. These provisions appear to provide a 'self-reporting' model, which places the onus on the driver to notify VicRoads of any medical issues. However, VicRoads can also receive notifications

[6] COR 2015 4295.

from members of the public, including concerned family members or health clinicians. In circumstances where VicRoads is notified, or becomes aware, that a person may not be fit to drive, it is obliged to investigate potential safety concerns, which involves *inter alia* requesting medical opinions. Under Regulation 78(3) of the *Road Safety (Drivers) Regulations 2009*, VicRoads can suspend or vary a person's licence if it receives information that appears reasonable or credible, which suggests that a person is unfit to drive.

4. In South Australia and the Northern Territory, health practitioners are required to report if a patient is diagnosed with a medical condition that may affect their ability to drive. However in response to previous coronial recommendations,[7] VicRoads has consistently put forward a view that it does not support mandatory reporting of drivers by doctors or others.

5. It is concerning that following Mr Hylla's appointment with Dr Wettenhall on 10 August 2016, he continued to drive. However, as in Mr Carr's case, in light of the onus placed upon drivers to notify VicRoads of their own health conditions, I make no adverse comment against any individuals involved in Mr Hylla's care. Doctors and health professionals play a crucial role in identifying fitness to drive issues and encouraging their patients to act on their reporting obligations. Ultimately, however, in Victoria, the duty to report currently rests on the individual operating the motor vehicle.

6. In the Finding relating to Mr Carr's death, I observed that given the history of coronial findings and responses relating to this issue, it appears that the self-reporting model is not entirely effective. I noted the Victorian coronial cases identify significant limitations in a self-reporting framework, most obviously being that an individual would be reluctant to inform VicRoads of something that could affect their right to drive. The consequences of this status quo affect not only the safety of individuals, but other road users. Treating medical practitioners are best placed to determine whether their patient is or is not fit to drive. The community is entitled to expect that if a medical practitioner is alert to such a risk, it should be mandatory that they make a report to VicRoads. I made a recommendation in the following terms: with a view to reducing harms to others and preventing like deaths, that consideration be given by the Secretary of the Department of Economic Development, Jobs, Transport and Resources, and VicRoads, to adopting a framework requiring mandatory reporting to VicRoads when a medical practitioner forms an opinion that a person with a permanent or long-term injury or illness, is not medically fit to drive.

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[7] See, in particular: Finding into the death of Scott Peoples with Inquest: COR 2006 4776; and Finding into the death of Petroula Krassos without Inquest: COR 2011 2908.

7. In response to this recommendation, the Court received a letter dated 31 January 2017, from Anita Curnow, Executive Director of Access and Operations at VicRoads. Ms Curnow stated that to date, there was no compelling body of evidence that demonstrates that mandatory reporting is more effective than self or community based referral into the VicRoads medical review system. She added that some sequelae of mandatory reporting might lead to negative consequences if a compulsory medical reporting system was mandated. In particular, it was noted that mandatory reporting may impact on doctor-patient relationships, resulting in potentially negative health, social and productivity outcomes. However, no empirical evidence was provided to support this proposition.

8. Ms Curnow stated that VicRoads would continue to apply, refine and enhance the self and community reporting system framework to identify and review medically impaired drivers. For example, VicRoads was requiring licence and learner permit application forms to include the completion of health information highlighting driver licensing obligations related to key risk-related medical conditions; granting and renewing licences to drivers aged 75 years and over for three year periods to encourage them to regularly assess their fitness to drive; encouraging health professionals and family members to have conversations with older and medically impaired people about their ability to drive through the VicRoads website, publication materials and community activities; and producing 'The Victorian Older Drivers' Handbook', which provides extensive information to help people assess their fitness to drive.

9. The Court also received a response from Gillian Miles, Lead Deputy Secretary, Transport, at the Department of Economic Development, Jobs, Transport and Resources. Dr Miles confirmed that the Department supported VicRoads' response. However, she also emphasised that across the transport portfolio, VicRoads, its road safety partners and the Department regularly review data, research and policy on fitness to drive. Dr Miles acknowledged that ensuring fitness to drive is an important policy area, given the aging profile of our population. She advised that this will remain a priority area for further policy consideration.

10. Mr Hylla's death and the danger caused to the wider community by impaired drivers continuing to operate motor vehicles, serve as a compelling indication that VicRoads' existing policy measures and intransigence on this issue are inadequate.

## FINDINGS

The investigation has not identified the cause of the collision on 24 August 2016, other than driver error on the part of Mr Hylla. The weight of the evidence indicates that Mr Hylla, who had a number of co-morbidities and had recently been discharged from Mansfield Hospital, suffered some form of cardiac event, which caused him to fail to negotiate a sweeping right turn on Mansfield-Woods Point Road.

I accept and adopt the medical cause of death as identified by Dr Michael Burke and find that Frederick Hylla died from multiple injuries in a motor vehicle incident, in circumstances where I find that he was not medically fit to be driving.

## RECOMMENDATION

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

1. With a view to reducing harms to others and preventing like deaths, **I recommend** that consideration be given by the Secretary of the Department of Economic Development, Jobs, Transport and Resources, and VicRoads, to adopting a framework requiring mandatory reporting to VicRoads when a medical practitioner forms an opinion that a person with a permanent or long-term injury or illness, is not medically fit to drive.

Pursuant to section 73(1A) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

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

Mrs Selma Hylla

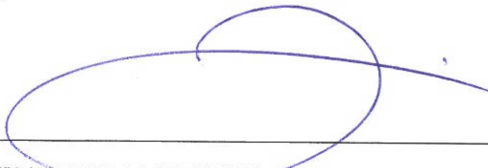
Transport Accident Commission

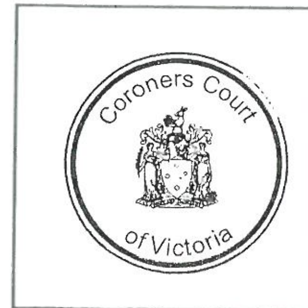
Mr Richard Bolt, the Secretary of the Department of Economic Development, Jobs, Transport and Resources

Ms Robyn Seymour, Director of Road User and Vehicle Access, VicRoads

Leading Senior Constable Paul Gillard

Signature:






AUDREY JAMIESON
CORONER
Date: **28 August 2017**