IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 000905

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

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

Inquest into the Death of: Keiran BAILEY

Delivered On:	25 August 2014
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank Victoria 3006
Hearing Date:	11 December 2013
Findings of:	Coroner Paresa Antoniadis SPANOS
Police Coronial Support Unit assisting the Coroner:	Senior Constable Kelly RAMSEY.

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of KEIRAN BAILEY

and having held an inquest in relation to this death at Melbourne on 11 December 2013

find that the identity of the deceased was KEIRAN BAILEY

born on 3 December 1966, aged 44

and that the death occurred on 10 March 2011

at The Alfred Hospital, 55 Commercial Road, Melbourne, Victoria 3004

from:

1 (a) COMPLICATIONS OF BLUNT HEAD INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT (CYCLIST).

in the following circumstances:

BACKGROUND AND PERSONAL CIRCUMSTANCES

1. Mr Bailey was a 44-year-old man who lived in Ringwood and was employed as a psychiatric nurse at Maroondah Hospital. He was in a long-term relationship with Ms Carolyn Jewell at the time of his death, and the couple had made plans to live together.

2. On Tuesday 8 March 2011, Mr Bailey had a day off work and left home on his bicycle after lunchtime to go shopping at Eastland, as was his usual routine. Mr Bailey rode his bike west on Mt Dandenong Road, in a designated bicycle lane. West of Dublin Road, the road reduces from three to two lanes for westbound traffic. Police advised that there is adequate sight distance to see this change.

3. At approximately 1.45pm, Mr Daniel Veerman was driving his grey Daewoo sedan on this section of the road in the far left lane, at least 10 km/hr above the posted speed limit. He failed to merge where the road reduced to two lanes, drove straight over the designated bicycle lane and struck Mr Bailey. The collision caused Mr Bailey to be thrown from his bike and onto the car bonnet, before landing on the road.

4. Although the collision itself was not witnessed, several witnesses observed the events that occurred shortly afterwards, and ran to help Mr Bailey. Witnesses observed Mr Veerman pull over, get out of his car and walk towards Mr Bailey, before turning back to his car and driving

away from the scene. Witnesses also noted Mr Veerman's car registration number and telephoned 000. Paramedics arrived and took Mr Bailey to The Alfred Hospital, however his injuries were not survivable and he died on 10 March 2011.

MR VEERMAN'S INVOLVEMENT AFTER THE COLLISION

5. Whilst ordinarily in a coronial finding, I would not present a lengthy summary of any events that might have occurred after a death and were unconnected with the death, I have detailed Mr Veerman's actions after Mr Bailey's death in this case, as they evidence behaviour that is particularly unusual, especially in the context of his having no prior criminal history.

6. After leaving the scene, Mr Veerman parked his car in a hotel car park about 600 metres away, and CCTV footage captured him setting the car on fire in the car park before running through an adjoining park. Police made significant efforts to locate Mr Veerman but were unable to do so immediately after the collision. At about 2.23pm, he entered the Eastland Shopping Centre where he withdrew $100 from an ATM before leaving.

7. At 2.15am on 9 March 2011, police located Mr Veerman walking between Tullamarine and Sunbury. Police stopped to speak to him, as they stated it was strange to see people walking this route (the police members were unaware that he was wanted by police regarding the collision with Mr Bailey). The police offered Mr Veerman a lift to his destination in Sunbury as he informed them that he had no car and that no other transport was available. Mr Veerman gave police a false name and date of birth.

8. At about 4.00am, Mr Veerman approached a man at an ATM in Sunbury, demanding his money and vehicle. The man refused, drove away and notified police. At about 4.15am, Mr Veerman approached a man who was driving a van and dropping off newspapers. He left the van open with the keys in the ignition whilst he made a quick drop-off, and Mr Veerman came towards him with what appeared to be a knife in his hand, entered the van and drove away.

9. At about 3.00pm, Mr Veerman was still in possession of the stolen van, when he stole petrol from a service station in Hamilton. At about 5.45pm, he attended another service station in Colac West and stole a packet of cigarettes. At 6.38pm, on the Princes Highway, Belmont, he was intercepted by police for driving a stolen vehicle. Again, Mr Veerman gave a false name, but he was arrested and taken to Geelong Police Station where his real identity was confirmed. He was assessed as unfit for interview by a Forensic Medical Officer on both 9 and 10 March 2011, was charged and remanded in custody.

10. A mechanical inspection of Mr Veerman's vehicle revealed that, despite it being considerably damaged by the fire, there was no mechanical fault which would have caused or contributed to the collision. A forensic assessment of the fire damage concluded that the fire started in the passenger compartment, probably on the driver's seat, by ignition of combustible material and was assisted by the presence of petrol spread on the interior.

11. Mr Veerman was charged with several criminal offences as a result of the collision and aftermath, and is currently serving a custodial sentence, is eligible for parole, but was charged in December 2013 with an unrelated murder offence that was alleged to have occurred on the day before the collision with Mr Bailey.[1]

MR VEERMAN'S HISTORY

12. Police provided the following information about Mr Veerman's background and personal circumstances. While it is unusual in a coronial finding to dwell on the personal history of anyone other than the deceased, these are not formal findings about these matters, but necessary in order to give context and sense to the discussion of Mr Veerman and the other drivers' fitness to hold a driver's licence at the material time.

13. Mr Veerman had a reasonably good, although varied work history. He graduated from university with a bachelor of environmental science in marine biology with distinction. He had two children with his former partner at the time. He started using illicit drugs from age 16 including marijuana, LSD, amphetamines, ecstasy and cocaine. He was unable to obtain employment after graduation, his relationship with his partner broke down, and Mr Veerman had been violent towards his partner and denied access to his children.

14. Mr Veerman's mother stated that he had received mental health treatment at the Maroondah Psychiatric hospital, that she had 'had many issues with him over 15 years', and she understood that he required medication for his condition. He was effectively homeless, and moved between his parents' and friends' homes and short-term share houses since early 2009. He was admitted to the Maroondah Hospital as a psychiatric patient on two occasions in 2010. At the first admission, Mr Veerman was reported to be paranoid and expressing suicidal ideation, and was diagnosed with schizophrenia with a significant mood component of depression and cannabis abuse.

---

[1] Evidence of Senior Constable Robert Cunningham, inquest transcript page 31.

15. Mr Veerman was discharged after one week, and admitted again about five moths later, following a siege at his mother's home. He was diagnosed with a drug-induced psychosis, and antisocial personality traits and polydrug abuse were noted. Mr Veerman was prescribed antipsychotic medication and referred to community management upon discharge. However, Mr Veerman did not maintain contact with the community mental health agency or his general practitioner, continued to abuse illicit drugs and did not take his antipsychotic medication. Mr Veerman's mother reported a decline in his mental state in the weeks before he caused Mr Bailey's death, but did not report anything unusual about his behaviour on the morning of 8 March 2011. At the time of the collision, Mr Veerman was a voluntary patient with the Maroondah Hospital, and engaged in some level of outpatient treatment.

16. On 21 June 2011, after Mr Veerman's arrest and transfer to Thomas Embling Hospital, a provisional diagnosis of affective psychosis was made, as well as a formal diagnosis of major depression – severe with psychotic features. He responded well to medication and was eventually assessed as well enough to be transferred back to prison. He was assessed again by consultant psychiatrist Dr Adam Deacon in December 2011, who concluded that Mr Veerman had experienced a marked deterioration in his mental health, with an associated significant decline in his psychological functioning over the two to three years before Mr Bailey's death.

17. At inquest, Senior Constable Cunningham explained that Mr Veerman did not have a significant history of driving offences. He had one prior conviction for exceeding the speed limit by 25km/hr or more, but less than 30km/hr in 2007, and his licence was suspended for one month. Senior Constable Cunningham considered that from his understanding of Mr Veerman's psychiatric history, and no doubt with the benefit of hindsight, that there were several periods where he was not what Senior Constable Cunningham considered 'a fit and proper person to be driving on the roads'. He considered that during the periods where Mr Veerman was receiving psychiatric treatment, a suspension of his drivers licence would have been prudent, at least until he could be deemed medically fit to drive again.[2]

INVESTIGATION – SOURCES OF EVIDENCE

18. This finding is based on the totality of the material the product of the coronial investigation of Mr Bailey's death. That is the brief of evidence compiled by Senior Constable Robert Cunningham, the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them; and the final submissions of Counsel. All of this

[2] Evidence of Senior Constable Robert Cunningham, inquest transcript pages 33-34.

material, together with the inquest transcript, will remain on the coronial file.[3] In writing this finding, I do not purport to summarise all the material and evidence, but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

19. The purpose of a coronial investigation of a *reportable death*[4] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[5] The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not merely all circumstances which might form part of a narrative culminating in death.[6]

20. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[7] Coroners are also empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[8] These are effectively the vehicles by which the prevention role may be advanced.[9]

---

[3] From the commencement of the *Coroners Act 2008* (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

[4] The *Coroners Act 2008,* like its predecessor the *Coroners Act 1985*, requires certain deaths to be reported to the Coroner for investigation. Apart from a jurisdictional nexus with the State of Victoria, the definition of a reportable death in section 4 includes deaths that appear *to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury* and the *death of a person who immediately before death was a patient within the meaning of the Mental Health Act 1986".*

[5] Section 67(1) of the *Coroners Act 2008*. All references which follow are to the provisions of this Act, unless otherwise stipulated.

[6] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[7] The "prevention" role is now explicitly articulated in the Preamble and purposes of the Act, cf: the *Coroners Act 1985* where this role was generally accepted as "implicit".

[8] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[9] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

21. It is important to stress that Coroners are not empowered to determine the guilt of any person, or the extent of any civil liability arising from a death.[10]

FINDINGS AS TO UNCONTENTIOUS MATTERS

22. In relation to Mr Bailey's death, most of the matters I am required to ascertain, if possible, were uncontentious from the outset. His identity, the date, place and medical cause of his death were never at issue. I find, as a matter of formality, that Keiran Bailey born on 3 December 1966, aged 44, late of 3A Charles Street, Ringwood Victoria 3134, died at The Alfred Hospital, 55 Commercial Road, Melbourne Victoria 3004 on 10 March 2011.

THE MEDICAL CAUSE OF DEATH

23. Nor was the medical cause of death controversial. On 15 March 2011, an autopsy was performed by Forensic Pathologist Dr Linda Iles of the Victorian Institute of Forensic Medicine (VIFM), who also reviewed the circumstances as reported by the police and post-mortem CT scanning of the whole body (PMCT). In her autopsy report, Dr Iles noted evidence of a blunt head injury, and concluded that the cause of Mr Bailey's death was *complications of blunt head injuries sustained in a motor vehicle incident (cyclist)*. Toxicological analysis revealed the presence of free morphine at 0.2mg/L in post mortem blood and 0.3mg/L in ante mortem plasma, midazolam at 0.3mg/L in blood and ~1.2mg/L in plasma, phenytoin at ~6mg/L in blood, as well as propofol and traces of paracetamol in blood. Dr Iles commented that these findings are consistent with therapeutic administration. Ethanol (alcohol) and other drugs or poisons were not detected.

FOCUS OF THE CORONIAL INVESTIGATION AND INQUEST

24. In common with many other coronial investigations, the primary focus of the coronial investigation and inquest into Mr Bailey's death was on the circumstances in which he died.

25. The inquest into Mr Bailey's death was held jointly with inquests into two other deaths,[11] as each death appeared to have resulted from a motor vehicle collision where there was a question about the driver's fitness to drive. Each of the three drivers who caused the deaths of Mr Bailey, Mr Slater and Mr Brindle were fully licensed at the time, were seriously impaired

---

[10] Section 69(1). A Coroner must not include in a finding or comment any statement that a person is, or may be, guilty of an offence. However, if a Coroner believes an indictable offence may have been committed in connection with a death, they must refer the matter to the Director of Public Prosecutions. Sections 49(1) and 69(2).

[11] William Slater COR 06 4917, Sean Brindle COR 08 5817.

in their ability to drive and their impairment caused or contributed to the death. Criminal proceedings in relation to each death have been completed, but the deaths are otherwise unrelated.

26. The Victorian licensing regime and the issue of fitness to drive has been the focus of several coronial investigations over a number of years.[12] There has been extensive consideration of the licensing regime in the past and, without underestimating the complexity of this issue, I considered that it was appropriate to hold an inquest into the circumstances in order to consider any possible regulatory changes that might prevent future deaths in similar circumstances.

27. The inquest also focused on the issue of reporting of a person's medical conditions to VicRoads by medical practitioners. In this regard, I invited the Royal Australian College of General Practitioners (RACGP) to make submissions. I must emphasise that the focus of the inquest was on the administration of justice and public health and safety, rather than the conduct of any individual medical practitioner.

VicRoads Medical Review

28. Under the current licensing regime for drivers in Victoria, there are no mandatory reporting laws. VicRoads advises drivers on its website that "[y]ou are required to notify VicRoads if you have, or develop, a medical condition that could affect your ability to drive safely." A driver may also be reported to VicRoads by any person, if they have genuine concerns about that person's ability to drive due to a medical condition or impairment, and VicRoads must investigate these reports.

29. Ms Tina Vasiliadis, the Manager of Driver and Medical Review at VicRoads gave evidence at inquest. She explained that she managed a team of staff who assessed fitness of drivers, and that these drivers would come to the attention of VicRoads through written notifications or

[12] Inquest into the death of Robin Sara Paul, COR 07 5233, Finding delivered on 20 December 2011 by Coroner Spanos; Inquest into the death of Benita Judd, COR 04 3397, Finding delivered on 16 December 2011 by Coroner Olle; Inquest into the death of Scott Peoples, COR 06 4776, Finding delivered on 11 December 2010 by Coroner Bryant; Investigation into the death of Margaret Digby, COR 10 1653, notification pursuant to Section 71 of the *Coroners Act* made by Coroner Jamieson on 29 June 2011; Investigation into the death of Anthony Rudzevecuis, COR 10 3695, Finding without inquest made on 1 August 2012 by Coroner Hayes.

reports by either the driver themselves, a family member or friend, any member of the community, a police member, a doctor or any other person.[13]

30. At my request, Ms Vasiliadis also provided data to the Court on the number of medical reviews conducted by VicRoads in the 2011-12 year. There were a total of 64,416 reviews conducted in that year, of which 31,942 (49.6 per cent) were reviews that related to notifications received during the year; and 32,474 (50.4 per cent) were periodical reviews.

31. VicRoads advised that of the 31,942 reviews received during the 2011-12 year:

- 53 per cent were notifications received by medical professionals
- 25 per cent were self-notifications received by the individual driver
- 10 per cent were notifications received by third parties
- 8 per cent were notifications received by Victoria Police
- 4 per cent were notifications received by occupational therapists.[14]

32. Ms Vasiliadis explained at inquest that she understood that the onus is on the driver to self-report to VicRoads if they have a medical condition or take medication that impairs their fitness to drive.[15] Ms Vasiliadis explained that when drivers apply for their license, they are asked on the VicRoads application form to indicate whether they have any medical conditions and, if they do disclose any conditions, the applications are referred to the Medical Review team to investigate. The driver would be notified and asked to submit a medical report in relation to their medical conditions.

33. Whilst VicRoads does not require that the practitioner who provides the report has treated the driver for any minimum amount of time, Ms Vasiliadis explained that when providing a medical report, practitioners must state for how long they have known the patient, and whether they are familiar with the patient's medical history. The various medical conditions considered relevant for assessing a person's fitness to drive are outlined in the Austroads guidelines.[16]

---

[13] Transcript page 55.

[14] Email from Ms Tina Vasiliadis dated 14 April 2014.

[15] Transcript page 57.

[16] *Assessing Fitness to Drive for Commercial and Private Vehicle Drivers: medical standards for licensing and clinical management guidelines*, March 2012 as amended up to 16 March 2013. Available at www.austroads.com.au/driver-licences/assessing-fitness-to-drive.

34. Ms Vasiliadis acknowledged that the conditions suffered by Mr Veerman and the drivers in the two other deaths, as well as the prescription and illicit substances they were using would be considered relevant for medical review. She explained that regarding prescription medication, VicRoads relied on the medical practitioner providing the report to assess their patient in accordance with the guidelines and that it is their responsibility to indicate whether there are any side effects in the medications taken by the driver, and/or if they have any concerns about the patient's fitness to drive.

35. Ms Vasiliadis agreed that, ultimately, her team is heavily reliant on the medical practitioner's familiarity with these guidelines, and added that practitioners must indicate on the relevant VicRoads form that they have assessed their patient in accordance with the guidelines, but were not provided with any additional information from VicRoads or a copy of the guidelines to indicate this. Ms Vasiliadis believed that most practitioners would be familiar with and aware of their obligations under the Austroads guidelines, that she rarely encountered a practitioner who was not familiar with them and stated *I would say it's common knowledge.*[17]

36. Ms Vasiliadis stated that Mr Veerman had not been reported to the Medical Review team for medical assessment.[18]

37. At inquest, I sought clarification of the way the review system operates in relation to drivers licences. Ms Vasiliadis explained that once a driver was identified to VicRoads as requiring review of their fitness to drive, they must provide a medical report. The report is then assessed by the Driver and Medical Review team. The team establishes whether further information is required in order to effectively assess the person's fitness to drive in accordance with their guidelines.

38. If further information is required, for example, a report from a medical specialist, and if the team is still unable to determine the person's fitness to drive, the matter is referred to a medical advisor from VIFM, who provides an expert opinion. Ms Vasiliadis confirmed that only a small percentage of matters would be referred to a VIFM expert.[19]

---

[17] Transcript page 60.

[18] Transcript page 61. The driver who caused Mr Slater's death, Mr Kane Miller, had been reported to VicRoads by police on one occasion in 2008. Mr Miller was asked to provide a medical report, and his father responded to VicRoads advising that his son could not do so as he was in custody at the Melbourne Assessment Prison. Mr Miller's licence was therefore suspended because of his failure to provide a medical report.

[19] Transcript page 63.

39. She explained that VicRoads did not have the power to direct a driver to attend a doctor of its choice. She was unsure as to whether it was theoretically possible and whether the relevant legislation allowed for such referrals.[20] However, she did explain that where further reports were required, VicRoads would ask the driver themselves for a report, usually from a specialist, and would stipulate as to the type of specialist depending on the driver's medical condition and the conditions of their licence.[21]

40. The VicRoads Medical Review team comprises two medical case managers who are both registered nurses (Ms Vasiliadis is herself a registered nurse), and work closely with VIFM. Whilst I understand that they have a reasonable understanding of medical conditions and how they impact a person's ability to drive, staff are heavily reliant on treating doctors providing medical information and conducting the assessment in accordance with the Austroads guidelines.[22]

41. At inquest, Ms Vasiliadis was asked how VicRoads encourages drivers to self-report. She explained that her team has undertaken community engagement exercises, which involved educating people about the medical review process. She also referred to discussions with medical and health professionals. Ms Vasiliadis stated that her personal view was that *VicRoads is doing as much as it can do, to make it public, the knowledge that drivers need to report if they have any medical conditions.*[23]

Victorian Institute of Forensic Medicine

42. Dr Sanjeev Gaya of the VIFM, specialist in clinical forensic medicine, traffic medicine and medical advisor to VicRoads, gave evidence at inquest. Dr Gaya has extensive experience in dealing with cases of drivers who are under the influence of drugs or alcohol and providing advice to VicRoads on these matters, as part of a team of five medical advisors. Dr Gaya also sits on the Neuro-Ophthalmology Committee expert panel to determine drivers' fitness, and runs a fitness to drive clinic at St Vincent's Hospital, where general practitioners (GPs) or any other medical practitioner can refer patients for assessment.[24]

---

[20] Transcript page 64.

[21] Transcript page 65.

[22] Transcript pages 65-66.

[23] Transcript page 66.

[24] Transcript pages 67-8.

43. Dr Gaya explained that in his role as medical advisor to VicRoads, his decision is usually based on the information made available in the VicRoads file, but that on some occasions he would directly telephone or contact the physicians who have made the medical report, to clarify matters. Dr Gaya found practitioners to be very forthcoming.[25]

44. On the issue of medical practitioners' understanding of the issue, Dr Gaya reiterated Ms Vasiliadis' advice that there is an expectation that any medical report assessing a person's fitness to drive has used the existing guidelines.[26]

45. Dr Gaya stated that instances where a driver's history is not well known to the practitioner making the report posed difficulties, as the GP is not in the best position to provide a report to VicRoads. As regards the drivers in the three cases at inquest for example, Dr Gaya testified that most had a psychiatric illness as well as a history of long-term drug use. Although it is the driver's responsibility to report a medical condition, Dr Gaya expressed the opinion that such drivers are the least likely to report, partly due to their mental illness, and lack of insight or judgement.[27]

46. Dr Gaya highlighted possible missed opportunities with such drivers, in that there were multiple contacts with agencies, evidence of poor attendance and non-compliance, drug-seeking behaviour and driving histories, and no central place to collate such information in order to make it available to the Medical Review team making decisions about their fitness to drive.[28]

47. Dr Gaya also commented on the difficult position of GPs who generally see themselves as advocates of sorts for their patients, in saying 'no'. He explained that it is difficult for a practitioner to tell a patient that they cannot drive, especially where they might have cared for that person and their family members for many years. Dr Gaya also referred to instances where a patient might attend a clinic in a threatening manner seeking a report, and a practitioner might simply refuse to prepare one.[29]

48. These concerns were then addressed by Dr Gaya in the context of evidence around mandatory reporting, and practitioners' concerns about this interfering with the therapeutic relationship

---

[25] Transcript page 68.

[26] Transcript page 70.

[27] Transcript pages 70-1.

[28] Transcript pages 71 and following.

[29] Transcript page 76.

with their patients, as well as concerns that some people might not access medical treatment or disclose symptoms for fear of losing their licence.[30] However, Dr Gaya did note that although it is not mandatory for doctors to report a driver, they have an ethical obligation to report if they sincerely believe that a patient is unlikely to report or does not have the capacity or insight to report.[31]

49. In Dr Gaya's view, an optimal model would be to assist medical reviewers by having as much information as possible available to them. He stated that *the basis of a good review will be when this happens from a variety of agencies, all of them have little bits of information about an individual, which when put together, may provide a better picture for someone to base a decision on.*[32]

RACGP Submission

50. The RACGP advised[33] that GPs are often required to assess a patient's fitness to drive, either at the request of a drivers licensing authority or in the general course of their patient management, and recognised the important role that GPs play in public health and safety when advising patients about their fitness to drive.

51. The RACGP advised that it does not have a formal position regarding mandatory reporting regarding a patient's fitness to drive. However, it raised concerns that mandatory reporting might dissuade patients from seeking medical assistance they require due to fear of being 'reported' by their doctor, that this could distort the patient-doctor relationship and might result in patients seeking to hide conditions from their GP.

52. The RACGP further submitted that if mandatory reporting of conditions were to be introduced, the possible impacts on a GP if they are not aware of or fail to identify and report a condition that affects a patient's ability to drive are unknown. The RACGP identified another challenge in defining the severity of a condition and its effects on behaviour that might change within a short period of time, which it submitted would make any form of reporting difficult to implement.

---

[30] Transcript page 77.

[31] Transcript page 79.

[32] Transcript page 78.

[33] Letter from Assoc Prof Morton Rawlin, Chair RACGP Victoria Faculty, dated 6 December 2013.

Victoria Police Policy Rules and Procedures & Guidelines

53. The Police Coronial Support Unit provided copies of the relevant Victoria Police Manual (VPM) Policy Rules (policy)[34] and Procedures and Guidelines (guidelines)[35] for road policing in order to assist me to understand what powers and in what circumstances, if any, police have to suspend drivers' licences immediately.

54. The guidelines refer to the VicRoads medical review power and ability to seek VIFM advice, and that police are permitted to report a driver to VicRoads.[36]

55. The policy refers to the police power under section 62 of the *Road Safety Act 1986*[37] to take action such as seizing keys, in order to forbid a person from driving a motor vehicle where it appears that they are incapable of doing so due to a physical or mental condition. The policy also refers to section 51 of the *Road Safety Act*, whereby a person may have their licence suspended immediately if they are charged with a drink-driving or drug-impaired driving offence.[38] Section 51 does not address any immediate suspension of a licence where a driver is impaired due to a physical or mental condition.[39]

---

[34] Victoria Police Manual Policy Rules, road policing, as at 3 March 2014.

[35] Victoria Police Manual Procedures & Guidelines, road policing, as at 3 March 2014.

[36] Victoria Police Manual guidelines, road policing, *1.3 Persons unfit to hold a driver licence.*

[37] Section 62(1) *Road Safety Act 1986* (Vic): *A police officer, or a protective services officer on duty at a designated place, who is of the opinion on reasonable grounds that a person, driving or about to drive a motor vehicle, is by reason of his or her physical or mental condition incapable of having proper control of the motor vehicle may do all or any of the following things, namely—*

(a) forbid that person to drive the motor vehicle while so incapable;

(b) require that person to deliver up forthwith all ignition or other keys of the motor vehicle in his or her actual possession;

(c) *take such other steps as may in the opinion of the police officer or protective services officer be necessary to render the motor vehicle immobile or to remove it to a place of safety.*

[38] Victoria Police Manual policy rules, road policing, *3. Enforcement action.*

[39] However, the policy roles do state that *where there is any doubt as to the sobriety/impairment of a driver and there is belief that their condition may be due to injury or illness, seek medical attention immediately.* Victoria Police Manual policy rules, road policing, *4.1 Driving under the influence of alcohol or drugs.*

CONCLUSIONS

56. The standard of proof for coronial findings of fact is the civil standard of proof, on the balance of probabilities, with the *Briginshaw* gloss or explication.[40] The effect of the authorities is that Coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

57. The criminal process has taken its course and a formal coronial finding that Mr Veerman caused Mr Bailey's death is unnecessary.[41] The inquest was held to elucidate the issue of his fitness to drive and the Victorian licensing regime, which falls outside the scope of the criminal jurisdiction. The inquest assisted in clarifying how the various organisations and agencies contribute to enforcement of the licensing regime as regards the fitness of drivers.

COMMENTS

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

1. It is trite to say that some people will continue to drive irrespective without a driver's licence, whether they have never been licensed, lost their licence through the demerits points register, as a result of a court order or due to a medical condition. However, these deaths were caused by drivers who held a valid driver's licence at the time of the collision, and I can understand how this fact compounds the grief of each family who has lost a loved one.

2. A better licensing regime would encompass the ability to test for drivers' fitness when they obtain their licence *and* would also ensure that driver's remain fit and capable of driving thereafter. The potential for improvements to public safety here are obvious enough. I am not in a position to say how this can be achieved, but it is worth the striving.

3. There is no system of mandatory reporting in Victoria. There is scope for a great deal of speculation about what may have occurred had these drivers been reported to VicRoads

---

[40] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 esp at 362-363.* "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences..."

[41] See section 71 of the Act.

pursuant to such a regime and assessed as unfit. Mandatory reporting by medical practitioners is not supported by VicRoads or the RACGP, and has been canvassed extensively in previous coronial findings.

4. The current regime relies heavily on the knowledge, capacity and integrity of the individual driver to disclose relevant medical conditions to VicRoads when applying for a licence, or when a medical condition arises thereafter. Moreover, drivers with a psychiatric condition, substance abuse issues and/or dual diagnoses are unlikely to self-report due to a lack of insight or judgement. By definition, self-reporting is against interest, and compliance is difficult to monitor, especially in the context of a dual diagnosis and its effects on driving. Where self-reporting fails, the system relies on a third party being in a position to notify VicRoads voluntarily.

5. Dr Gaya's opinion at inquest indicates a further complexity. That is, that fitness to drive turns not on the mere diagnosis of a medical condition or psychiatric illness as such, but on the impact of that diagnosis and/or symptoms on the person's level of functioning as it relates to driving.[42]

6. There are potential benefits in the notion of a central repository of information considered necessary by Dr Gaya, so that when drivers are subject to medical review, VicRoads and VIFM are able to access a fuller and more accurate medical history, including any history of driving-related offences.

7. At the very least, continued education of health professionals in *all* disciplines and specialties, by VicRoads in conjunction with the RACGP and other professional bodies, is clearly warranted, to ensure that fitness to drive is at the forefront of practitioners' minds when a patient presents with symptoms or is diagnosed with a condition that is likely to affect their ability drive safely.

---

[42] Transcript page 85.

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

The family of Mr Bailey

Dr Liz Marles, Royal Australian College of General Practitioners

Dr Sanjeev Gaya, Victorian Institute of Forensic Medicine

Ms Tina Vasiliadis, VicRoads

Ms Diana Battaglia, Legal Services, Alfred Health

Ms Margaret Angliss, Clinical Governance Unit, Alfred Health

Senior Constable Robert Cunningham.

Signature:

PARESA ANTONIADIS SPANOS
Coroner
Date: 25 August 2014