IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2015 4295

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 NICHOLAS BARRY CARR

without holding an inquest:
find that the identity of the deceased was NICHOLAS BARRY CARR
born 10 October 1978
and the death occurred on 23 August 2015
at the Princes Highway in Heathmere Victoria 3305
from:

1 (a) INJURIES SUSTAINED IN MOTOR VEHICLE COLLISION (MOTORCYCLIST)

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

1. Nicholas Barry Carr was 36 years of age at the time of his death. He lived in Heywood with his partner Crystal Sanderson. Mr Carr had a teenage son from a previous relationship and a newborn daughter. He had recently been diagnosed with an arteriovenous malformation in his medial right temporal lobe. Mr Carr had a history of seizure-like episodes and had been prescribed carbamazepine (Tegretol). He was known to smoke marijuana.

2. At around lunch time on Sunday 23 August 2015, Mr Carr rode his 1997 Suzuki GSX750 motorcycle from his Heywood address to Portland District Hospital to see Ms Sanderson and their newborn daughter. At approximately 6.45pm, he departed and visited Ms Sanderson's nearby property to get some cigarettes. At 7.01pm, Mr Carr telephoned Ms Sanderson to advise her he was leaving shortly to return to Heywood.

3. Just prior to 8.00pm on 23 August 2015, Mr Carr was riding his motorcycle in a northerly direction along the Princes Highway in Heathmere, about 200 metres south of the Heathmere railway crossing. From a 100km/h zone he had entered an 80km/h zone and ridden around a slight left hand bend, before riding into a slight right hand bend. The motorcycle veered off the road to the left and collided with a wire barrier, striking four poles. The motorcycle subsequently collided with another pole in the wire barrier, approximately 36.7m away, before Mr Carr was thrown from the motorcycle and lay on the road 76.9m from the first point of the collision.

4. Nearby residents who heard the collision came to assist and care for Mr Carr, who was conscious and breathing. Emergency services were called and police and ambulance paramedics subsequently attended. Ambulance paramedics treated Mr Carr at the scene but his condition deteriorated rapidly, and he was declared deceased at 9.00pm.

INVESTIGATIONS

Forensic pathology investigation

5. Dr Matthew Lynch, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine performed a full post mortem examination upon the body of Mr Carr, reviewed a post mortem computed tomography (CT) scan and referred to the Victoria Police Report of Death, Form 83. At autopsy, Dr Lynch found evidence of multiple fractures, and significant chest and abdominal trauma. Dr Lynch noted the that the arteriovenous malformation in Mr Carr's right temporal lobe showed no evidence of recent or remote haemorrhage, in keeping with the result of a Magnetic Resonance Imaging (MRI) scan in May 2015. However, Dr Lynch could not exclude or confirm the possibility Mr Carr had suffered a seizure, and whether or not this was a factor in the collision. Toxicological analysis of post mortem specimens identified

methylamphetamine (0.03mg/L in blood) and amphetamine,[1] cannabinoids THC (>100ng/mL in blood) and THC-CCOH (>1000ng/mL in urine),[2] and carbamazepine.[3] Dr Lynch ascribed the cause of Mr Carr's death to injuries sustained in a motor vehicle collision as a motorcyclist.

Police investigation

6. First Constable Ken Matthews, the nominated coroner's investigator,[4] conducted an investigation of the circumstances surrounding Mr Carr's death, at my direction, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by Mr Carr's mother Janine Carr, partner Crystal Sanderson, sister Marisa Price, five witnesses and General Practitioner at Seaport Medical Clinic Dr Anna Hattingh. The Court also received a statement from Sergeant Leigh Booth of the Mechanical Investigation Unit, dated 3 May 2016.

7. Police identified that the section of Princes Highway near the collision scene is in excellent condition, with new asphalt, lots of grip, and divided by clearly marked white 'rumble strip' lines and reflectors. The weather on the night of 23 August 2015 was fine and the road was dry. Traffic was light and visibility was good. The road is bordered on each side by a wire barrier which comprises green metal poles holding three wires, approximately 2.5cm in diameter.

8. A preliminary inspection of the motorcycle at the site of the collision, indicated that it was in roadworthy condition. The headlight and tail light were operational, and the front and rear tyres were roadworthy. Mechanical Investigator Sergeant Booth inspected the motorcycle on 2 March 2016. The inspection did not reveal any mechanical fault which would have caused or contributed to the collision.

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[1] Amphetamines is a collective word to describe central nervous system (CNS) stimulants structurally related to dexamphetamine. One of these, methamphetamine, is often known as 'speed' or 'ice'. Methamphetamine is a strong stimulant drug that acts like the neurotransmitter noradrenaline and the hormone adrenaline. In drivers of motor vehicles amphetamines can produce aggressive and dangerous driving, and even produce rebound fatigue when the effects of amphetamines are waning.

[2] Delta-9-tetrahydrocannabinol (THC) is the active form of cannabis (marijuana). 11-nor-delta-9-carboxy-tetrahydrocannabinol (THC-COOH) is the carboxy metabolite of THC. Persons under the influence of cannabis will experience impaired cognition (reasoning and thought), poor vigilance and impaired reaction times and coordination.

[3] Carbamazepine is an anti-convulsant used in the treatment of epilepsy, some types of neuralgia and schizophrenia.

[4] 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.

9. In the course of the investigation, police learned that Mr Carr was an experienced motorcyclist and had not had a previous collision. Mr Carr held a current motorcycle licence; it had previously been suspended for three months after he was found to have driven a motorcycle while drug affected on 26 January 2015.

10. In relation to reported seizure activity, Mr Carr's sister Marisa Price reported that he would have episodes characterised by his mouth going watery and dropping, and his hands going limp. Ms Sanderson stated that Mr Carr would 'black out' for 15-20 minutes at a time; he would come to and not know what had happened. During these events, Mr Carr would sometimes talk inappropriately, making sexual remarks that were not of his usual nature. At one point, Mr Carr would have five to six of these episodes a day. Mrs Carr reported that her son had an episode at his home on 1 May 2015. After this event, he attended the Portland District Hospital and underwent a brain CT scan.

11. General Practitioner Dr Anna Hattingh saw Mr Carr from 2 May 2015. At an appointment on 4 May 2015, Dr Hattingh noted that the CT scan showed an arteriovenous malformation in his temporal lobe. Mr Carr subsequently underwent an MRI scan at Warrnambool Base Hospital, which confirmed the diagnosis. Dr Hattingh referred Mr Carr to a neurologist, who advised him to take Tegretol to control the seizures. Mr Carr attended two further appointments with Dr Hattingh to monitor the levels of Tegretol. Dr Hattingh noted that he was still having episodes twice per week.

12. Ms Sanderson reported that the medication helped to significantly reduce the number of episodes Mr Carr experienced. Ms Price noted that while Mr Carr was on medication he had no major fits, but had 'zone outs' about once every three days that would last two to three minutes. Ms Price believed her brother when he told her he was taking his medication as prescribed. However, Ms Sanderson noted that Mr Carr often forgot to take his medication and on 23 August 2015, she was aware that he had not had his tablets.

13. At an appointment on 30 June 2015, Mr Carr told Dr Hattingh that his licence had just been restored. She advised him that he should not drive a vehicle until he experienced six months seizure free, and reiterated this advice at their next consultation. Ms Price noted that Dr Hattingh had told Mr Carr not to drive, but was not aware of any subsequent alterations to his licence. She noted that their parents asked police to speak with Mr Carr with a view to removing his licence. Ms Price added that their father had approached Mr Carr's workplace to

inform them that he should not be operating machinery or a forklift, and when Mr Carr attempted to return to work, he was told that he would not be able to return for three months. Mr Carr was angry about this and did not speak to his parents for the last weeks of his life.

14. Dr Hattingh last saw Mr Carr on 31 July 2015. He was scheduled to return in a fortnight to check his Tegretol levels, but failed to attend. A letter to Dr Hattingh dated 14 August 2015, indicated that Mr Carr also failed to attend two consecutive outpatient appointments at the Barwon Health neurosurgery clinic.

15. Ms Sanderson reported that while Mr Carr smoked marijuana, she was pretty sure he did not smoke any on 23 August 2015, because he had commented that he had 'no smokes and no pot.'

16. One witness believed he observed Mr Carr riding his motorcycle at a speed of up to 150km/h, shortly prior to the collision. The witness was an experienced motorcyclist and was confident in his speed estimates. Another witness reported that she saw Mr Carr driving in the area, but described his driving as normal and that he was neither speeding nor erratic.

17. One of the witnesses who assisted Mr Carr after the collision, noted that he made sexually explicit comments to her and had become agitated, before calming down.

COMMENTS

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

1. The investigation has identified that on 30 June 2015, Mr Carr was advised not to drive a motor vehicle until he had been seizure free for six months. However, it does not appear that Mr Carr's licence was cancelled, and there was no evidence that VicRoads were notified about his condition.

2. I note that Section 17A of the *Road Safety Act 1986* 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*, 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.' These provisions appear to provide a 'self-reporting' model, which places the onus on the driver to notify VicRoads of any medical

issues. I do note, however, that VicRoads can also receive notifications 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.

3. 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, I note that in response to previous coronial recommendations,[5] VicRoads has put forward a view that it does not support mandatory reporting of drivers by doctors or others. The reasons cited for this position have been *inter alia* because it may reduce the trust between a doctor and their patients who may fear reporting; a lack of evidence that mandatory reporting has improved road safety outcomes; and that self-reporting requirements are appropriate.

4. It is concerning that Mr Carr retained a valid motorcycle licence despite his recent seizures and medical advice not to drive. However, 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 Carr'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.

5. Given the history of coronial findings and responses relating to this issue, it appears that the self-reporting model is not entirely effective. 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.

6. Excluding his use of illicit drugs, Mr Carr was at risk of having a seizure while in charge of a motor vehicle, with the potential of endangering others. The community is entitled to expect that

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[5] 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.

if a medical practitioner is alert to such a risk, it should be mandatory that they make a report to VicRoads.

FINDINGS

The investigation has not elucidated the definitive cause of the collision on the night of 23 August 2015. I note that post mortem toxicological analysis indicates Mr Carr had elevated concentrations of cannabis on board, a level which is consistent with recent use, as well as methylamphetamine, which independently, or in combination, most likely impeded his ability to safely control his motorcycle. It is possible that Mr Carr smoked cannabis after leaving the hospital that night. I also note that Mr Carr was still experiencing 'black out' episodes; had apparently not taken his Tegretol medication; had been advised by Dr Hattingh to not operate a motor vehicle; and made comments that were out of character following the collision. This evidence indicates that Mr Carr may have indeed suffered a seizure proximate to the incident.

I find that there is no evidence to indicate that Mr Carr suffered from mental illness or intentionally caused the collision. In circumstances where there were no issues of inexperience, environmental factors, mechanical failures or other drivers contributing to the collision, I find that Mr Carr's death, so proximate to his daughter's birth, is a tragic reminder of the inherent dangers of operating a motor vehicle contrary to both road laws and medical advice.

I accept and adopt the medical cause of death as identified by Dr Matthew Lynch and find that Nicholas Barry Carr died from injuries sustained in a motor vehicle collision as a motorcyclist.

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 Janine and Mr Barry Carr

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

Transport Accident Commission

Dr Anna Hattingh, General Practitioner

First Constable Ken Matthews

Signature:

AUDREY JAMIESON
CORONER
Date: **28 November 2016**