IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2020 000256

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	Robin Albert Banks
Date of birth:	6 July 1929
Date of death:	15 January 2020
Cause of death:	1(a) Pneumonia complicating injuries sustained in a motor vehicle incident Contributing factors Plasma cell dyscrasia
Place of death:	Caulfield Hospital, 260 Kooyong Road, Caulfield, Victoria
Key words:	Fitness to drive, elderly driver

INTRODUCTION

1. On 15 January 2020, Robin Albert Banks was 90 years old when he died in hospital from complications of injuries sustained in a motor vehicle collision. At the time, Mr Banks lived alone in Elsternwick.

2. Mr Banks' medical history included atrial fibrillation, chronic kidney disease, and dyslipidaemia.

3. Mr Banks' granddaughter, Kirsten Bradbury, noted that Mr Banks' health had been declining for about two years. He had undergone eye surgery and radiation for throat cancer. His family had asked him not to drive following these procedures, but Mr Banks continued to do so as he had a current driver's licence, which had been renewed about four years prior to his passing. Mr Banks valued his independence and did not want to be driven around.

4. Ms Bradbury noted that in the months leading to the motor vehicle incident, Mr Banks had experienced multiple 'black out' events which had caused falls and injuries. She said that despite medical investigations, no cause for the black outs was identified. Ms Bradbury also noted that she and her mother (Mr Banks' daughter) had tried to speak to Mr Banks' general practitioner about his driving. The family remained concerned about Mr Banks' continued desire to drive himself around and believed he was unsafe when doing so but did not know what to do in this situation.

THE CORONIAL INVESTIGATION

5. Mr Banks' death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury.

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. The Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Mr Banks' death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into Mr Banks' death, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased

10. On 15 January 2020, Robin Albert Banks, born 6 July 1929, was visually identified by his granddaughter, Kirsten Bradbury.

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

Medical cause of death

12. Forensic Pathologist, Dr Heinrich Bouwer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 16 January 2020 and provided a written report of his findings dated 21 January 2020.

13. The post-mortem CT scan showed sternal wires, multiple fractures including a right clavicle, sternal, right rib fractures (2-4), left sided rib fractures (3, 4,7,8), and a T11 vertebral body compression fracture. In additional there was evidence of aortic valve replacement, mitral valve calcifications, bi-basal lung changes, gallstones, mild hydronephrosis, and possible small bladder diverticulum. There was no intracranial haemorrhage or skull fracture.

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

14. Dr Bouwer provided an opinion that the medical cause of death was *"1(a) Pneumonia complicating injuries sustained in a motor vehicle incident"*. Plasma cell dyscrasia was noted to be an indirect contributing factor.

15. I accept Dr Bouwer's opinion.

Circumstances in which the death occurred

16. At about 9.30am on the morning of 20 December 2019, Mr Banks drove his 2005 Hyundai Elantra sedan east along Orrong Road in Elsternwick, toward Glen Huntly Road. At about the same time, a 2003 Toyota Rav4 wagon (**the Toyota**) travelled west along the same road.

17. As the two vehicles approached each other on Orrong Road, Mr Banks' vehicle veered onto the other side of the road and into the path of the Toyota. This resulted in a head on collision at slow speed. Mr Banks informed police and paramedics that he did not remember the circumstances of the collision and that had been feeling unwell prior to the accident.

18. Mr Banks was subsequently transported by ambulance to The Alfred Hospital. Investigations there revealed he had sustained a right mid-shaft clavicle fracture, sternal body fractur with retrosternal haematoma, right 2nd to 4th and left 3rd to 4th, and 7th to 8th rib fractures, T1 and T3 superior end plate and T11 vertebral fractures, and right T7 pedicle lesion and vertebral fracture (the latter being old injuries seen on CT).

19. All the injuries were managed conservatively, and Mr Banks was required to wear a brace to manage the vertebral fractures, however, he was generally not compliant with wearing the brace during his admission.

20. On 25 December 2019, Mr Banks developed right-sided pneumonia, which was treated with antibiotics. This was subsequently complicated by delirium and acute kidney injury.

21. On 31 December 2019, Mr Banks was transferred to Caulfield Hospital for geriatric assessment and management, which included ongoing management of renal failure and delirium, and cognition investigations. Dr Amelia Crabtree, consultant geriatrician, noted:

> *Collateral history provided by Mr Banks' daughters indicated that there had been at least six months of decline in terms of his cognition prior to the accident, worsening over the previous three-four months. They indicated that Mr Banks had been forgetful of medications, and that he had been struggling at home with his daily routine. He had not been formally diagnosed [with] any dementia.*

22. In early January 2020, Mr Banks experienced two unwitnessed falls in hospital without further injury. At about the same time, Mr Banks was diagnosed with plasma cell dyscrasia, likely myeloma.

23. A few days later, Mr Banks' family engaged in a 'Goals of Care' discussion with the treating clinicians, and it was determined there would not be any further investigation of the haematological malignancy. It was further determined that if Mr Banks developed a potentially treatable condition, such as pneumonia, he would not have wanted this treated in the context of his overall condition.

24. Mr Banks remained intermittently confused during his admission. On 10 January 2020, he was diagnosed with pneumonia again and developed respiratory distress. He was transitioned to comfort care and kept comfortable until he passed away and was verified deceased at 12.45am on 15 January 2020.

FURTHER INVESTIGATION

25. In light of the concerns raised about Mr Banks' ability to continue driving after experiencing 'black outs', issues reportedly raised with his general practitioner, I made further enquiries about Mr Banks' health prior to the collision and how this affected his ability to drive.

Alfred Health

26. On 2 October 2019, Mr Banks presented to The Alfred Hospital after his general practitioner had detected an irregular heartbeat. According to Dr Nicole Hancock, Deputy Director of General Medicine, Mr Banks presented with a complaint of two days of dizziness, had not experienced any syncopal (loss of consciousness) episodes, and had had some near falls. Mr Banks had been otherwise well. His daughter reported a decline in memory and an increase in confusion over the previous six months.

27. Mr Banks was examined, and the main finding was a rapid heartrate. There were no findings with his neurological examination to suggest a neurological or ear-related cause for his dizziness. Investigations revealed that Mr Banks had a heart rhythm called atrial flutter. He also had evidence of reduced kidney function.

28. It was noted that Mr Banks had a history of atrial flutter. Further information was sourced from Mr Banks' general practitioner which revealed he was first prescribed heart rhythm medication in 2006 and was reviewed by a heart specialist in 2010, when the irregular heart

rate was also noted. It was agreed the current presentation was most likely a result of medication non-compliance in a setting of a gentleman with long-standing atrial arrhythmia. This theory was supported by his daughter's observations in the home setting. It was noted that his daughter had concerns regarding his cognition and how he was managing at home.

29. In hospital, Mr Banks was prescribed two medications to reduce his heart rate. He was observed in hospital until his heart rate dropped to a satisfactory level. He was also prescribed electrolytes to optimise his magnesium and potassium levels.

30. During his admission, Mr Banks was assessed by physiotherapy and occupational therapy in light of the concerns expressed by family.

31. Occupational therapy had no concerns regarding Mr Banks' level of function to manage activities of daily living in the community. He performed well when tested with the Rowland Universal Dementia Assessment Scale (**RUDAS**) which is a short screening instrument to assess cognitive performance. He had "*mild difficulty with visuoconstructional drawing – not negatively impacting patient's daily function requirements".* He demonstrated insight and problem solving with safety in mind. It was noted the importance of his hearing aid in optimising his performance in this setting. No further assessments in the acute hospital setting were recommended.

32. During the occupational therapy assessment it was noted Mr Banks was driving independently. There was no record of other discussions regarding Mr Banks' private driver's licencing status nor eligibility to drive during the admission from 2 to 5 October 2019.

33. Mr Banks was discharged on 5 October 2019 with suggested follow up with his general practitioner in one week's time. A referral to attend the General Medicine Specialist clinic was arranged to follow up his heart tests and review the response to the medication prescribed during this admission. No appointment was scheduled.

34. In relation to whether Mr Banks' medical condition would have affected his fitness or ability to operate a vehicle at the time, Dr Hancock responded:

    (a) cardiac rhythm disorder: in the absence of syncope or pre-syncope, Mr Banks' fitness to drive was not impacted; and

    (b) mild cognitive impairment: it is likely Mr Banks had mild cognitive impairment in October 2019. His daughters' observations, RUDAS assessment, and agitation at the

end of his admission would fit with this diagnosis. Further assessment would have been required to determine the impact of Mr Banks' mild cognitive impairment on his ability to operate a vehicle safely.

35. Dr Hancock did not find any evidence that concerns were raised about Mr Banks' ability to drive during his admission. Similarly, there was no evidence in the records regarding whether advice was provided to Mr Banks regarding his fitness to drive and obligation to report his medical condition(s) to VicRoads.

36. Dr Philippa Hawkings, Director of Medical Services, noted that Alfred Health utilises the publication, 'Assessing fitness to drive for commercial and private vehicle drivers' 2022 edition (Austroads). In accordance with the Austroads advice, Alfred Health clinicians clarify with the patient that they (the patient) have an obligation to inform VicRoads of their situation. Dr Hawkings also noted that if a patient were to present to Alfred Health today with a similar condition to Mr Banks (and started on similar treatment) it would be expected a discussion would take place regarding driving, with reference to the Austroads guide.

Mr Banks' general practitioner – Dr Vana Tran at Medical One

37. On 4 September 2019, Dr Tran took over Mr Banks' care following the retirement of his usual general practitioner.

Family concerns reported to Dr Tran

38. According to Dr Tran, he met with Mr Banks' children (Cheryl and Michael) on 8 October 2019. During their meeting, they expressed concerns that their father had self-discharged from Alfred Hospital and was noncompliant with his medications. His children were also concerned about Mr Banks' ability to manage at home alone, their ability to care for their father, and wanted to discuss instituting additional support to allow Mr Banks to remain at home.

39. In addition, Dr Tran stated Mr Banks' children raised the possibility of revoking his driver's licence but did not express any specific concerns regarding his driving ability. Dr Tran noted that whilst some concerns were raised regarding Mr Banks' driving ability, these were non-specific and were raised more in the context of his children's broader concerns regarding to his ability to self-manage and continue living at home.

40. Dr Tran advised that he needed to discuss the issues raised directly with Mr Banks himself, as Mr Banks retained capacity to make his own decisions.

Consultations following discharge from hospital

41. Dr Tran then reviewed Mr Banks on 15 October 2019. Dr Tran noted that Mr Banks booked his own appointment and drove himself to the clinic and walked into the clinic without any difficulty. Dr Tran stated, *"He appeared well".* Mr Banks denied self-discharging from the Alfred Hospital or being non-compliant with his new medications. Dr Tran noted that the Alfred Hospital discharge summary did not mention Mr Banks self-discharging but did plan for a review by his doctor in a fortnight to monitor his medication compliance.

42. Dr Tran stated that by the time of this review, Mr Banks had been symptom-free and compliant with his medications for 10 days since his discharge.

43. Mr Banks acknowledged the general concerns for his age-related mobility rather than any specific concerns and noted that he was managing independently without any support services. However, Mr Banks was amenable to an Aged Care Assessment to access additional support that would allow him to remain independently at home for as long as possible.

44. During the review, Dr Tran did not find any physical co-ordination impairment or weakness, or cognitive or visual issues that would have impacted on Mr Banks' ability to drive. Dr Tran advised Mr Banks to report his new diagnosis of atrial fibrillation to VicRoads, and Mr Banks assured Dr Tran he would.

45. Dr Tran subsequently saw Mr Banks again on 21 October and 4 November 2019 for repeat scripts for digoxin, apixaban, and metoprolol. On assessment, Dr Tran found his vital signs to be within normal ranges, which led him to conclude that Mr Banks was compliant with his medication as agreed.

46. Dr Tran also stated that he was under the impression that Mr Banks had followed advice and commenced the process of referring himself for a driving assessment as agreed during their previous consultation, noting that there can often be a significant delay between self-referrals and further action by VicRoads.

47. Mr Banks then attended on 9 and 19 December 2019 regarding scripts for his other medications. Given that Mr Banks appeared to be compliant with his medication, was doing well at home, and was making plans to visit his family for Christmas, Dr Tran did not believe that any further referrals were necessary at that time.

Whether Dr Tran thought Mr Banks should not be driving

48. Dr Tran stated Mr Banks did not present with any indicators that would have caused him to doubt Mr Banks' ongoing medication compliance in their consultations following his hospital admission. Mr Banks presented as well, independent, with vital signs within normal limits, and was compliant with his medication, requesting repeat scripts for his prescriptions.

49. Dr Tran noted that well-managed atrial fibrillation should not affect someone's ability to drive and that, whilst rapid atrial fibrillation can cause issues with dizziness and loss of consciousness, Mr Banks did not exhibit any adverse signs or symptoms that would lead Dr Tran to hold any immediate concerns for his ability to drive. However, he did advise Mr Banks to self-refer to VicRoads for an assessment which Mr Banks assured Dr Tran that he would. Dr Tran also emphasised to Mr Banks that, if he ever became symptomatic, he needed to stop driving immediately.

50. In addition, given Mr Banks' functional independence and willingness to co-operate with assessments, medication, and self-refer to VicRoads, Dr Tran did not believe it was necessary to report him to VicRoads at that time, preferring instead to encourage Mr Banks' agency and independence and allow him to self-refer as agreed. Dr Tran stated that had Mr Banks been resistive to his advice or had there been any doubt in his mind that he would refer himself as agreed, Dr Tran would have commenced the referral himself. In addition, Dr Tran stated that had Mr Banks complained of any symptoms of pre-syncope or syncope, or had been noncompliant with his treatment, Dr Tran would have advised him to cease driving and would have notified VicRoads of the need for a medical review.

51. Dr Tran stated that the ability to drive is often a significant point of conflict between elderly patients and their families. He noted:

> *Advanced age, in and of itself, is not a sufficient reason to exclude someone from driving, and a delicate balance must be observed in preserving a patient's independence and responding to concerns for their safety and the safety of other road users. This necessitates a holistic assessment of the patient, considering their functional capacity, ability to drive, and specific diagnosed conditions, which may prompt further assessment and/or referral to VicRoads.*

52. In conclusion, Dr Tran stated that faced with a similar situation again he would request proof of the patient's self-report to VicRoads as another way of ensuring that the patient has followed through with his recommendation. Since Mr Banks' death, Dr Tran has taken the

opportunity to review the VicRoads 'Information resources to support conversations with patients' to ensure he is following current recommendations.

Expert opinion – Dr Doorendranath Sanjeev Gaya

53. As part of my investigation, I obtained am expert report from Dr Doorendranath Sanjeev Gaya,[2] Senior Forensic Physician at VIFM, regarding fitness to drive generally and his assessment of whether Mr Banks was fit to drive.

Fitness to drive requirements and considerations

54. Dr Gaya explained that for licensing purposes, conditions affecting fitness to drive can be divided into two main groups:

    (a) conditions that cause sudden incapacity (e.g., stroke, myocardial infarction, seizure, hypoglycaemia, sleep); and
    (b) chronic conditions (e.g., cognitive decline, diabetes and its secondary end-organ effect, vision)

55. The Assessing Fitness to Drive (**AFTD**)[3] provides national guidelines on a variety of medical conditions. While the AFTD gives advice to doctors, they are not legally binding.

56. Dr Gaya explained that it is compulsory for drivers to report medical conditions in all Australian states. These include temporary, progressive, or permanent conditions that may impact driving. However, he noted that there are several recurrent issues with self-reporting:

    (a) many drivers are not aware of the legal obligation to self-report;

    (b) some drivers view their condition as not relevant to report;

    (c) some drivers assert that their doctors did not advise of the need to report;

    (d) others genuinely believe that it is the role of the doctors to report; and

    (e) some drivers do not have insight as a direct consequence of their medical condition.

[2] Dr Gaya is also an external medical advisor to VicRoads on licencing issues regarding fitness to drive, Chair of the VIFM/VicRoads Consultative Committee on complex licensing issues regarding fitness to drive, and Member of the Advisory Group to Austroads and National Transport Commission on Assessing Fitness to Drive for commercial and private vehicle drivers, 2022 Edition.
[3] Austroads, Assessing Fitness to Drive (2022), https://austroads.gov.au/publications/assessing-fitness-to-drive/ap-g56, accessed 25 February 2025.

57. Concerns about a person's fitness to drive may come from a range of sources, such as:

(a) the driver;

(b) family or the community;

(c) health professions; and

(d) police.

58. Dr Gaya noted that community members and worried family members often provide the first and only clues that something is wrong. This source of information is valuable and may provide clues about functioning, near misses, or minor bumps and scrapes on vehicles that would have gone unnoticed by doctors or police. Transport Victoria provides advice and contact details for reporting friends and family.[4]

59. Police will generally issue a License Review Request to VicRoads when a medical condition is suspected of having been a factor in a collision or if there has been impaired driving behaviour.

60. Dr Gaya noted that medical reporting to licensing authorities is discretionary in all states except South Australia and Northern Territory, where it is compulsory.

61. The ultimate decision regarding fitness to drive lies with the licensing authorities. If there is insufficient or conflicting information from the treating clinician, VicRoads may either make their own determination, request further information, or seek an independent review from a third party. These can be referred to as so-called 'fitness to drive' reviews.

62. A driver's treating clinician is generally responsible for a first-line medical review. VicRoads and Safe Transport Victoria assess the reviews undertaken by these clinicians and consider the information provided to determine licensing.

63. Dr Gaya explained that when assessing their patient's fitness to drive, doctors are often torn between their duty to advocate for their patients and their duty to protect public safety. Other factors include a detrimental effect on the doctor-patient relationship and patients hiding symptoms from their doctor, which may negatively impact on continuity of care. As Dr Gaya

[4] Transport Victoria, Medical conditions, https://transport.vic.gov.au/registration-and-licensing/licences/medical-conditions-and-reviews/medical-conditions, accessed 25 February 2025. See also, Transport Victoria, How to report concerns about other drivers, https://transport.vic.gov.au/registration-and-licensing/licences/medical-conditions-and-reviews/how-to-report-concerns-about-other-drivers, accessed 25 February 2025.

identified, it is axiomatic that many conditions rely on patients being honest with their doctors regarding symptoms.

64. Similarly, doctors may be reluctant to get involved in notification and medico-legal issues related to fitness to drive due to several factors, including extra paperwork, lack of familiarity with the process, and concerns about patient confidentiality. Touching on his professional experiences, Dr Gaya noted:

> *As an external medical adviser to VicRoads, I find that doctors generally report drivers who are blatantly unfit to drive. However, medical opinions have been known to change after the patient objects. Additionally, there is the issue of misplaced advocacy, where doctors ask for consideration under exceptional circumstances even in the face of conditions that cause egregious driving risk.*

Mr Banks's medical history

65. Dr Gaya noted Mr Banks' medical history included atrial fibrillation, coronary artery disease requiring bypass grafting, hearing impairment, chronic kidney disease, and there were concerns about falls and his general safety at home. The medical records also included a reference to a one-minute 'blackout' on 12 December 2018 which was not investigated because Mr Banks left Monash Hospital before being seen.

66. Dr Gaya noted that at the time of Mr Banks' collision, the 2016 edition of the AFTD was in place.

67. Dr Gaya explained that atrial fibrillation is a heart condition in which the upper chambers of the heart (atria) beat irregularly and out of sync with the lower chambers (ventricles). This can cause blood to pool in the atria, increasing the risk of blood clots. It can be a chronic condition, meaning it can last for a long time.

68. Atrial fibrillation can affect driving safety in several ways. People with atrial fibrillation are more likely to experience dizziness, fainting, and other symptoms that can make it difficult to drive safely. It can also increase the risk of a stroke, which can also impair driving ability

69. The AFTD (2016) recommended that:

    (a) if a person has experienced an episode of atrial fibrillation that results in syncope or incapacitating symptoms, that person is not fit to hold an unconditional licence;

(b) a conditional licence may be considered if there is satisfactory response to treatment AND there are minimal symptoms relevant to driving (chest pain, palpitations, breathlessness);

(c) the recommended non-driving period is at least one week following initiation of successful medical treatment.

70. Where a person has undergone coronary artery bypass grafting (**CABG**), the AFTD recommended that a person should not drive for at least four weeks after a CABG and that a person is not fit to hold an unconditional licence if the person requires or has had a CABG. A conditional licence may be considered, subject to periodic review, if there is satisfactory response to treatment, and there are minimal symptoms relevant to driving (chest pain, palpitations, breathlessness), and there is minimal residual musculoskeletal pain after the chest surgery.

71. There are no standards for private vehicle drivers with hearing loss or chronic kidney disease. When no specific standards exist for a condition, the AFTD recommends assessing the patient under the general principles, whose key considerations are the driving task, the potential impact of the medical condition including the interaction of multiple medical conditions, and the driver's functional abilities in relation to driving including their capacity to compensate and the need for rehabilitation.

72. In terms of the reported 'black out' episode, Dr Gaya noted that the AFTD defines a 'blackout' as a transient impairment or loss of consciousness and that there are many causes for a blackout. The AFTD (2016) recommended that:

(a) if the cause is identified, the licensing review will follow the guidelines for the identified condition;

(b) if a cause is not found and there has been a single blackout, a conditional licence may be considered if the driver has not experienced further blackouts for at least six months;

(c) if the cause is not found and the driver has experienced two or more blackouts separated by 24 hours, a conditional licence may be considered if the driver has not experienced further blackouts for at least 12 months.

73. Where a driver has *multiple* conditions or a condition that affects multiple body systems, there may be an additive or a compounding detrimental effect on driving abilities, for example in

ageing-related changes in motor (including joint movements, strength and coordination), cognitive (including attention, concentration, insight, judgement, memory, problem-solving skills, thought processing and visuospatial skills), and sensory abilities (in particular visual acuity, visual fields, and muscle and joint sensation).

74. Dr Gaya noted that advanced age is not a barrier to driving, and functional ability rather than chronological age is a criterion used in assessing fitness to drive of older people.

75. A history of recurrent falls in an elderly person may be an indication for a referral for an assessment by a general occupational therapist for an evaluation of overall functioning (personal, mobility, community, and work activities) and general capacity for driving. For those seeking to maintain a vehicle licence, a referral to a Driver Assessor Occupational Therapist (**DAOT**) may be required for a comprehensive driving assessment and determination of suitability for vehicle modifications and/or driving rehabilitation/retraining.

Whether Mr Banks' medical conditions should have been reported to VicRoads

76. Dr Gaya advised that Mr Banks' diagnosis of atrial fibrillation in October 2019 was a condition that was reportable to VicRoads. If he had reported it to VicRoads, as advised to him by his doctor, his licence would have been subject to a medical review.

77. The review would have then established whether there had been satisfactory response to treatment, whether he was compliant with medication, and whether there were minimal symptoms (chest pain, palpitations, breathlessness) relevant to driving. If these conditions were met, he would be issued with a conditional licence with a recommended non-driving period of at least one week following initiation of successful medical treatment.

78. Dr Gaya advised that Mr Banks' alleged 'black out' episode in December 2018 was also a condition that was reportable to VicRoads. If he had reported this to the licensing authorities and a cause not found, his licence would have been subject to a non-driving period of at least six months until there had been no further black outs. If a cause was discovered, his licence would be subject to the relevant guidelines for the condition that caused the blackout.

79. Additionally, Mr Banks' history of coronary artery disease and chronic kidney disease were conditions that were reportable to VicRoads. Had he reported those conditions, his licence would have been subject to a medical review and any driving restrictions commensurate with the guidelines in the AFTD.

80. Finally, a history of recurrent falls in an elderly driver with multiple conditions also warranted a report to VicRoads.

Department of Transport and Planning

81. In addition to the above information, I asked the then Department of Transport (now the Department of Transport and Planning) (**the Department**) regarding whether Mr Banks' fitness to drive was ever formally reviewed.

82. The Department informed me that Mr Banks had never been notified to the Department as having a medical condition that could impact his ability to drive safely, and the Department had never been advised that there were concerns about his driving skills prior to the December 2019 collision.

83. Mr Banks first came to the attention of the Medical Review team on 23 December 2019 when Victoria Police submitted a licence review request as a result of the motor vehicle collision. On 30 December 2019, the Department sent Mr Banks a notice of suspension requiring him to provide a medical report by 13 January 2020, failing which his driver's licence would be suspended from 14 January 2020. On 21 January 2020, the Department was notified by the multi-agency Victoria Police Road Fatality Review Committee that Mr Banks was deceased. The Medical Review team then closed Mr Banks' case.

84. As noted by Dr Gaya, the Department stated that Victoria's medical review system is based on a self or community-based referral model. All drivers are obligated under law to report to Medical Review any long term medical/disability conditions that could adversely impact fitness to drive.

85. Victoria Police, doctors, community members, family and friends, can also notify the Medical Review team of their concerns about a person's medical condition or disability, and its effect on their ability to drive safely. They can notify anonymously. People making a report in good faith are protected from legal action and the Medical Review team will not divulge the identity of people who make a report without their consent (unless it is required by law).

86. Under the *Road Safety Act 1986*, the Medical Review team has an obligation to ensure that all licence holders meet the national medical standards for licensing and are medically fit to drive. When information is received that raises concerns about a driver's health and fitness to drive, the Medical Review team will request the relevant medical report(s) to assess the driver's fitness to drive, in relation to their underlying medical condition and driving task.

87. The Department noted that it regularly reviews research, driver/trauma data, and world's best practice in relation to fitness to drive and medically impaired drivers. The Department noted that at this point in time, there is no compelling body of evidence to suggest an age-related population testing regime would provide any additional road safety benefit over and above the current community-based referral model and customised medical review process.

Mandatory reporting and licence renewal requirements

88. While all Australian health professionals have an obligation to protect public safety and they may notify the driver licensing authority directly if they feel their patient's condition poses a significant threat to public safety, only in South Australia and the Northern Territory is this obligation mandatory.

89. In South Australia and the Northern Territory, reporting to the driver licensing authority is mandatory for certain health professionals if they assess a person to be unfit to drive. In South Australia this applies to medical practitioners, physiotherapists, and opticians. In the Northern Territory this applies to medical practitioners, optometrists, occupational therapists and physiotherapists.[5]

90. Whilst the Australian Capital Territory currently has no mandatory reporting requirements, we understand that from 21 June 2024, a scheme will require health practitioners to report on a person's fitness to drive if the relevant health practitioner:

    (a) carries out an examination or assessment of a person; and

    (b) reasonably believes the person holds, or is applying for, a heavy vehicle licence; and

    (c) forms an opinion that the person has a permanent or long-term illness, injury or incapacity that may impair the person's fitness to drive a heavy vehicle safely.[6]

91. This change was following a coronial recommendation and does not apply to people who do not have a heavy vehicle licence.

[5] Austroads, Driving and health: Your questions answered (July 2022), https://austroads.gov.au/__data/assets/pdf_file/0033/499731/AFTD2022_Driver_patient_fact_sheet.pdf, accessed 25 February 2025.

[6] ACT Government City Services, Reporting fitness to drive (undated), https://www.cityservices.act.gov.au/roads-and-paths/road-safety/reporting-fitness-to-drive, accessed 25 Febraury 2025.

92. The following table outlines the licence renewal requirements in each of the states and territories in Australia. The information in the table is taken from *Assessing Fitness to Drive for commercial and private vehicle drivers* published by Austroads on 22 June 2022.[7]

93. The below table is applicable to private vehicle drivers.

State/Territory	Vision test	Medical assessment	Road test
Australian Capital Territory	Vision test for all drivers on initial licence; on renewal at ages 50, 60, 65, 70 and 75, and annually thereafter.	Medical assessment for all licence classes at age 75 years and annually thereafter.	No prescribed period or age.
New South Wales	Vision test for all drivers on initial application. All car and rider licence holders under 45 years of age have an eyesight test every 10 years. All car and rider licence holders 45 years of age or older have an eyesight test every 5 years. Drivers 75 years and over require an annual eyesight test.	Medical assessment for all licence classes at age 75 years and annually thereafter.	Road test required every two years for all car drivers (class C) and drivers of motorcycles (class R) from 85 years of age. Annual driving test for heavy vehicle drivers with a light rigid (LR) to heavy combination (HC) from 80 years of age. A road test may be required as a result of a doctor's or police recommendations.
Northern Territory	Vision test for all drivers on initial application.	Medical assessment only when condition notified by a health professional or driver.	Road test only when recommended by a health professional.
Queensland	A vision test, performed by a health professional, and a medical certificate verifying the outcome of the test is required if the applicant	A person must obtain, carry and drive in accordance with a current medical certificate if:	Road test required on application.

[7] Austroads, Assessing Fitness to Drive for commercial and private vehicle drivers, Appendix 1 Regulatory requirements for driver testing (22 June 2022), online edition accessed via https://austroads.gov.au/publications/assessing-fitness-to-drive/ap-g56/regulatory-requirements-for-driver-testing, accessed 25 February 2025.

State/Territory	Vision test	Medical assessment	Road test
	declares a vision or eye disorder or if required by the chief executive. Vision tests are not performed by departmental staff.	• They have a mental or physical incapacity that may affect their ability to driver safely, or • They are 75 years of age or older. Currency of the medical certification is determined by the health professional. Medical certificates issued to drivers 75 years or older have a maximum validity of one year.	
South Australia	Vision test yearly from 70 years of age for holders of licence classes other than C[8] or if declared or reported.	Medical assessment required yearly from 70 years of age for holders of licence classes other than C.	Road test annually from age 85 for licence classes other than C.
Tasmania	Vision test required on initial application.	No prescribed period or age but may occur if a medical condition and/or concern is declared or reported.	No prescribed period or age but may occur if a medical condition and/or concern is declared or reported.
Victoria	Vision test for all drivers on initial application and subsequently if a concern is declared or reported.	No prescribed period or age but many occur if a concern is declared or reported.	No prescribed period or age but many occur if a concern is declared or reported.
Western Australia	Vision test required on initial application then yearly from 80 years of age (as part of required medical assessment), or as required dependent on	Annually from 80 years of age, unless a medical condition requires earlier assessment.	Road test annually from age 85 for licence classes other than C unless a medical condition

[8] Authorised motor vehicles with a gross vehicle mass not greater than 4.5 tone, but not including a bus designed to carry more than 12 seated persons or a motor bike or motor trike. See Government of South Australia, Licence classes (1 December 2024), https://www.sa.gov.au/topics/driving-and-transport/licences/licence-details/driver-s-licence-classes, accessed 25 February 2025.

State/Territory	Vision test	Medical assessment	Road test
	condition declared or reported.		requires earlier assessment.

Recent Victorian coronial recommendations

94. In August 2023, Deputy State Coroner Jacqui Hawkins handed down her Finding into death of Jackson David Eales[9] following inquest. Mr Eales died on 26 December 2016 when he was struck by a heavy vehicle driven by Gerard Voss who failed to stop at an intersection.

95. In addition to other medical issues, Mr Voss was diagnosed with severe obstructive sleep apnoea in 2018. Deputy State Coroner Hawkins found that it was highly probable that 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. She found it probable that symptoms relating to severe obstructive sleep apnoea were present and may have contributed to Mr Voss' failure to stop at the relevant intersection.

96. This inquest 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.

97. Whilst the evidence in this case demonstrated that Mr Voss' obstructive sleep apnoea was undiagnosed at the time of the collision, there was evidence that he did not fully understand his own medical conditions and his requirement to notify VicRoads when answering questions and filling in renewal forms nor implications associated with non-disclosure of medical conditions.

98. Her Honour noted that there was a general lack of awareness amongst the community about 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. Her Honour identified that there was an opportunity to improve awareness and recommended that:

> *... the Secretary of VicRoads and the Department of Transport develop a public awareness campaign around the importance of understanding the fitness to drive*

[9] The Finding into death of Jackson David Eales is available at: https://www.coronerscourt.vic.gov.au/sites/default/files/Inquest%20Finding%20into%20death%20of%20Jackson%20Eales_Signed.pdf.

guidelines and obligations of individuals to inform VicRoads of any medical conditions that may impair an individual's fitness to drive.

99. On 16 November 2023, William Tieppo, Deputy Secretary at the Department of Transport and Planning responded to the above recommendation. The Department acknowledged that, despite the development of a range of driver and health professional resources over previous years, at a consumer level the challenge remains to improve awareness of the existing fitness to drive medical review process, the impact of health conditions on driving, and a driver's legal obligations to report to the Department / VicRoads and refrain from driving if they are impaired. The Department advised that the coronial recommendation would be partially implemented:[10]

> *The Department is investigating additional communication methods for drivers to be directed to their health professional, for increased awareness about their medical condition's potential to impact their driving performance, the importance of fitness to drive, and their obligations as a driver to report to the Department / VicRoads.*

100. The Department advised that further opportunities for communication would be explored over coming months, including:

(a) development of communications focused on highlighting for drivers the importance of engaging with their trusted health professional to understand the potential impact of a medical condition on driving performance, and obligations for reporting to the Department / VicRoads' Medical Review team. This will include supporting communications directed to health professionals, to improve understanding about the AFTD guidelines and obligations of individuals to inform the Department / VicRoads of any medical conditions that may impair their fitness to drive;

(b) there was potential for a staged communication approach, using the existing resources, and focusing targeted public and health practitioner awareness communications;

(c) targeted communication options to be explored may be: (a) Electronic direct mail to registered medical practitioners via their professional associations; and (b) Review and enhance information on both the on-line and paper Medical Report forms;

[10] The Departments full response is published is available at: https://www.coronerscourt.vic.gov.au/sites/default/files/2023-11/2016%206147%20Response%20to%20recommendations%20from%20Department%20of%20Transport%20and%20Planning%20%28DTP%29_EALES.pdf.

(d) public awareness campaigns encouraging drivers to speak to their trusted health professional may also be explored, including the use of existing Department / VicRoads points of connection with the community such as social media channels and other available media.

FINDINGS AND CONCLUSION

101. Pursuant to section 67(1) of the Act I make the following findings:

(a) the identity of the deceased was Robin Albert Banks, born 6 July 1929;

(b) the death occurred on 15 January 2020 at Caulfield Hospital, 260 Kooyong Road, Caulfield, Victoria;

(c) the cause of Mr Banks' death was pneumonia complicating injuries sustained in a motor vehicle incident with plasma cell dyscrasia as a contributing factor; and

(d) the death occurred in the circumstances described above.

102. I wish to convey my sincere condolences to Mr Banks' family for their loss.

COMMENTS

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

103. Mr Banks was a 90-year-old male when he was involved in a motor vehicle collision on 20 December 2019. He was taken to hospital where he later died on 15 January 2020.

104. Mr Banks had a current unrestricted driver's licence at the time of his collision. He obtained this 10-year licence, four years prior to his death. Despite concerns from his family, Mr Banks was adamant that he would continue driving since he had a licence.

105. Mr Banks had a number of medical conditions. The expert opinion from Dr Gaya outlined at least four occasions where Mr Banks should have reported his medical conditions to VicRoads. Records reveal that his general practitioner[11] advised him to report his most recent

[11] I note that Mr Banks's medical history included several conditions, including a reported 'black out' in 2018 (which, according to the available records, had not been repeated since). Most of these conditions were diagnosed prior to Dr Tran's time as Mr Banks' practitioner. Mr Banks had not presented any new concerns, including any further instances of black outs, following Dr Tran's adoption of his care in 2019.

medical issue – that of atrial fibrillation – to VicRoads. It appears that Mr Banks did not do so.

106. Driving a motor vehicle is a complex task involving perception, appropriate judgement, adequate response time, and appropriate physical capability. A range of medical conditions, disabilities and treatments may influence these driving prerequisites. Such impairment may adversely affect driving ability, possibly resulting in a collision causing death or injury.[12] For this reason, it is compulsory for drivers to report medical conditions.

107. However, as Dr Gaya explains, there are a number of reasons this does not happen. The inquest into the death Jackson Eales also highlighted some of these reasons.

108. In other Australian states, the responsibility of reporting a medical condition does not fall solely on the driver. Some states have mandatory reporting rules for health professions; others have mandatory medical assessments once a person reaches a certain age with regular assessments thereafter. In Victoria, there are no such requirements.

109. I note the Department's submission there is no compelling body of evidence to suggest an age-related population testing regime would provide any additional road safety benefit beyond that provided by the current community-based referral model and customised medical review process.

110. Victorian coroners have made previous recommendations regarding mandatory reporting for health professionals.[13] VicRoads did not implement those recommendations. However, they have previously responded by increasing education and improving the existing reporting system. Given these previous indications, I will not repeat these recommendations.

111. Mr Banks' case highlights that more education may be needed about the importance of fitness to drive both from the perspective of individual driver and the general community, including the processes for reporting concerns about a driver's fitness to drive.

[12] Austroads, Assessing Fitness to Drive – purpose, in *Assessing Fitness to Drive for commercial and private vehicle drivers*, 22 June 2022, online edition accessed via https://austroads.gov.au/publications/assessing-fitness-to-drive/ap-g56, accessed 25 February 2025.

[13] See for example coronial matter COR 2015 4992, unpublished; Finding into death without inquest regarding Stanislaw Edward Czubryj COR 2017 001790; Finding into death without inquest regarding Frederick Hylla COR 2016 004011; and Finding into death without inquest regarding Pamela Louise Elsdon COR 2016 005554,

RECOMMENDATIONS

Pursuant to section 72(3) of the Act, I make the following recommendations:

112. That the Secretary, Department of Transport and Planning develop a public education and awareness campaign about the importance of understanding the fitness to drive guidelines and obligations on individuals to inform VicRoads of any medical conditions that may impair their fitness to drive.

113. That the public education and awareness campaign also addresses the need to ensure the general community is aware of the process for reporting concerns about a person's fitness to drive to VicRoads, including information that such reports can be made anonymously.

PUBLICATION OF FINDING

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

DISTRIBUTION OF FINDING

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

Amanda Bradbury, senior next of kin
Alfred Health
Dr Vana Tran (care of Avant Law)
Secretary, Department of Transport and Planning
Senior Constable Joshua Hoopes, Victoria Police, Coronial Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date: 12 March 2025

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.