IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 005449

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, CORONER
Deceased:	Steven John Parlby
Date of birth:	25 January 1950
Date of death:	30 September 2023
Cause of death:	1a : COMPLICATIONS OF MULTIPLE INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT (CAR VS. CAR, DRIVER) 2 : CHRONIC OBSTRUCTIVE PULMONARY DISEASE, CONGESTIVE CARDIAC FAILURE, HYPERTENSION, OBSTRUCTIVE SLEEP APNOEA SYNDROME
Place of death:	The Royal Melbourne Hospital 300 Grattan Street Parkville Victoria 3052
Keywords:	Fitness to drive, driving assessments, motor vehicle incident, driver licence suitability

INTRODUCTION

1. On 30 September 2023, Steven John Parlby (**Steven**) was 73 years old when he died nine days after a motor vehicle collision. At the time of his death, he resided at Millgrove with his brother, Richard Parlby.

2. At the time of his death, Steven held a full driver licence. According to his son, Danny Parlby (**Mr Parlby**), Steven *'wouldn't drive that far, he knew his limits'*.

Medical History

3. Steven had an extensive medical history and visited a general medical practitioner, Dr Gamini Colombage (**Dr Colombage**) in Yarra Junction. He had multiple diagnoses including sleep apnoea, hypertension and prediabetes. Steven was a patient of Eastern Health's *'Hospital in the Home'* program and received medical treatment at home from clinicians and nurses.

4. Between 24 July and 1 August 2023, Steven was admitted to Maroondah Hospital and was diagnosed with severe biventricular heart failure with mild mitral valve regurgitation[1] and moderate pulmonary hypertension.

5. During an examination on 24 August 2023, Steven was recorded as *'frail', 'tachypnoeic'* – quick and shallow breathing – and *'look[ing] like an end stage [chronic obstructive pulmonary disorder] patient'.* The clinician wrote *'putting him in touch with palliative care would be beneficial'.*

6. From August to September 2023, Steven participated in the Yarra Ranges Health Community Rehabilitation Program. In a letter dated 7 September 2023, clinicians from the program stated that Steven *'declined ongoing physiotherapy'* and he was discharged from their service.

THE CORONIAL INVESTIGATION

7. Steven's 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.

8. 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

[1] A heart valve condition in which the flaps of the mitral valve do not close properly, causing a backward flow of blood back to the heart/

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.

9. 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.

10. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Steven's 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.

11. This finding draws on the totality of the coronial investigation into the death of Steven John Parlby 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.[2]

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

Circumstances in which the death occurred

12. On 21 September 2023, Steven left home and drove to an appointment in Yarra Junction, approximately 10 minutes away.

13. As Steven drove along Warburton Highway, the motorist immediately behind him noticed he *'started to accelerate quickly for no reason and cross onto the wrong side of the road'.* A motorist travelling in the opposite direction similarly recalled *'a car coming towards [them] starting to cross onto the wrong side of the road, it seemed to be travelling at around 80 kph and was accelerating'*.

[2] 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. An oncoming motorist took evasive action to avoid Steven's vehicle. However, as she did so, *'[Steven] seemed to realise what was happening and turned sharply back to his left'.* The two vehicles collided *'almost head on in the middle of the road'.*

15. Following the collision, the motorist, and her son, were able to extricate themselves from their vehicle. They sustained minor injuries and have since recovered.

16. Witnesses contacted emergency services, and at 3:58pm, Ambulance Victoria paramedics arrived at the scene and approached Steven. According to paramedics, *'his skin appeared grey in colour & was tachypnoeic'*. He eventually told paramedics *'he ha[d] been short of breath for a number of months'.*

17. Steven was transported to the Maroondah Hospital, then transferred to the Royal Melbourne Hospital. Investigations revealed he sustained multiple rib fractures, a right chest wall subcutaneous haematoma and liver laceration.

18. Over the following days, Steven developed complications including pneumonia and worsening congestive heart failure. His condition did not improve, on 30 September 2023, Steven was declared deceased.

Identity of the deceased

19. On 5 October 2023, Steven John Parlby, born 25 January 1950, was visually identified by his daughter, Jacqueline Gauci, who completed a formal Statement of Identification.

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

Medical cause of death

21. Forensic Pathologist Dr Hans De Boer (**Dr De Boer**) of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on the body of Steven Parlby on 2 October 2023. Dr De Boer considered materials including the Victoria Police Report of Death for the Coroner (**Form 83**), post-mortem computed tomography (**CT**) scan and e-Medical Deposition Form completed by Royal Melbourne Hospital and provided a written report of his findings dated 3 October 2023.

22. The post-mortem examination revealed bilateral pleural effusions, a large haematoma in the chest and abdominal wall, emphysematous lungs, coronary artery calcification and peripheral artery calcification. Also identified were fractures to several ribs.

23. Toxicological analysis of ante-mortem plasma samples collected by the Royal Melbourne Hospital on 22 September 2023 identified the presence of the following compounds:

Acetone	~ 40 mg/L
Valsartan	~ 0.2 mg/L
Ondansetron	~ 0.09 mg/L
Paracetamol	~ 6 mg/L

24. Dr De Boer stated: *'considering the comorbidities of the deceased, a medical episode as precipitating the motor vehicle incident cannot be excluded'.*

25. Dr De Boer provided an opinion that the medical cause of death was 1(a) COMPLICATIONS OF MULTIPLE INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT (CAR VS. CAR, DRIVER) and 2 CHRONIC OBSTRUCTIVE PULMONARY DISEASE, CONGESTIVE CARDIAC FAILURE, HYPERTENSION, OBSTRUCTIVE SLEEP APNOEA SYNDROME.

CAUSE OF THE COLLISION

26. Warburton Highway is a sealed bitumen road and at the time of the collision, it was daylight, visibility was good, the road was dry, and the traffic was described as average.

27. Witnesses did not see anything that would have required Steven to cross into the oncoming lane: *'there were no animals or children or any obstructions on the road'.*

28. Leading Senior Constable Brett McCormick (**LSC McCormick**), provided the Court with his opinion regarding the cause of the collision:

> *'[Steven] has either fallen asleep due to his obstructive sleep apnoea, suffered a heart attack or similar medical condition which has caused him to lose cognitive and physical function, causing his vehicle to veer to the right while accelerating*'.

29. Mr Parlby visited his father in hospital and recalls:

> *'I went to the hospital that evening [of the collision] and Dad said to me that he didn't have a heart attack but had fallen asleep at the wheel and woke up just before the impact'.*

30. Accordingly, evidence indicates that Steven experienced a natural medical episode while driving. However, the precise cause of that event – including whether it was related to his sleep apnoea or his heart failure – remains unclear. I note that there are several types of acute natural medical episodes which do not exhibit physiological signs at post-mortem examination.

FAMILY CONCERNS

31. During my investigation, Mr Parlby expressed concerns that Steven's driver licence was not revoked or suspended by Maroondah Hospital during his most recent admission. He wrote:

> *'I* [sic] *and my sister believe that he should have had his licence revoked by [Maroondah] hospital as he was only in hospital for a month prior for sever* [sic] *heart failure, we believe the hospital system didn't act in accordance with protocol and provide the duty of care he needed and deserved'.*

FITNESS TO DRIVE ASSESSMENTS AND REPORTING

32. Australians' fitness to drive is governed by the *'Assessing Fitness to Drive for Commercial and Private Vehicle Drivers: medical standards for licensing and clinical management guidelines'* (**the Guideline**) published by Austroads. [3]

33. In Victoria, medical practitioners are not under an obligation to report their patients' medical conditions to VicRoads. Rather, the individual is responsible to, amongst other things, enquire whether their medical diagnoses may impact their ability to drive and report their diagnoses to Transport Victoria.

34. However, evidence makes clear that Steven did not self-report his medical conditions to VicRoads as required under the *Road Safety (Drivers) Regulations 2009* (Vic), as he was concerned that he would lose his licence and by extension, his independence. Unfortunately, this concern is common amongst elderly road users, and a strong deterrent against self-reporting. In this instance, it is evident that Steven was reluctant to disclose his driving status. Mr Parlby recalls that *'Richard mentioned to the nurse during one of [the Hospital in the Home] sessions that [Steven] still had his [driver] licence. [Steven] was concerned that he*

[3] '*Assessing Fitness to Drive for Commercial and Private Vehicle Drivers: medical standards for licensing and clinical management guidelines'* effective from 22 June 2022, published by Austroads. Accessible at: https://austroads.gov.au/__data/assets/pdf_file/0037/498691/AP-G56-22_Assessing_Fitness_Drive.pdf.

might have his licence taken off him and told Richard to stay quiet'. On 24 August 2023, Steven told the Hospital in the Home clinicians that he did not drive.

35. The issue of fitness to drive and its self-reporting model, is one that has been analysed by many Victorian coroners, including myself, in previous years. In 2016, I handed down my findings into the death of Mr Nicholas Carr and commented:

> *'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'.*

36. Indeed, as I said in 2016, medical practitioners are best placed to identify, advise and report that a patient's declining health impacts their ability to drive. Where the patient, and their family member, are partial and disinclined to report, medical practitioners are independent and can objectively assess their patients capabilities. By way of comparison, medical practitioners in South Australia and the Northern Territory are subject to mandatory reporting requirements.

37. In the finding relating to Mr Carr, I recommended that the *'Secretary of the Department of Economic Development, Jobs, Transport and Resources, and VicRoads consider a framework under which it is mandatory of medical practitioners to report to VicRoads when they believe a patient is no longer fit to drive'*. In the Department's response, the then-Executive Director of Access and Operations at VicRoads stated that there was no compelling body of evidence that demonstrates that mandatory reporting is more effective than self or community-based referral to the VicRoads review system. The then-Executive Director did not provide any empirical evidence to support this position.

38. In 2017, I repeated my recommendation to the Department in the finding into the death of Frederick Hyalla. Again, I received a response from the then-Executive Director Access and Operations at VicRoads who declined to consider the framework and instead, outlined improvements that VicRoads were making to their existing system.

39. In response to recommendations made by other coroners, VicRoads has put forward a view that it does not support mandatory reporting of drivers by doctors or others. They suggest it may, amongst other things, reduce the trust between a doctor and their patients who fear reporting. I note that in Victoria, there are legislative protections provided to medical practitioners who report.

40. When I re-considered the issue in 2018, in relation to the death of Stanislaw Czubryj, I decided against repeating my recommendation. However, now, as I investigated Steven's death, it is apparent that the issue persists. A statement I made in 2017 remains relevant today:

> *'[This] death and the danger caused to the wider community by impaired drivers continuing to operate motor vehicles, serve as a compelling indication that VicRoads' existing policy measure and intransigence on this issue are inadequate'.*

41. It has been some nine years since I first made my recommendation to the Department of Economic Development, Jobs, Transport and Resources, and VicRoads, however, the self-reporting framework remains in force. In 2019, the Department was split in two divisions and VicRoads is now managed by the Department of Transport and Planning.

42. Given that deaths associated with unfit drivers continue to occur, I consider it is an opportune time to repeat my recommendation.

RECOMMENDATION

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

1. In the interests of promoting public health and safety and with the aim of preventing like deaths, I recommend that the **Secretary of the Department of Transport and Planning** consider adopting a framework which required medical practitioners to submit a report to VicRoads when they form the belief that a person is not medically fit to drive.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was Steven John Parlby, born 25 January 1950;

   b) the death occurred on 30 September 2023 at The Royal Melbourne Hospital 300 Grattan Street, Parkville Victoria 3052; and,

c) I accept and adopt the opinion of Dr de Boer and find that Steven John Parlby died due to complications he sustained as a result of a motor vehicle collision on the background of multiple diagnoses including chronic obstructive pulmonary disease, congestive cardiac failure, hypertension and obstructive sleep apnoea syndrome.

2. AND having considered the available evidence, I find that Steven John Parlby experienced a medical episode which caused him to lose consciousness while driving, causing the motor vehicle collision. The weight of the evidence before me does not enable me to make a finding regarding the precise cause of the medical episode.

3. AND I find that Steven John Parlby did not report his medical diagnoses to the relevant authority, as was required.

I convey my sincere condolences to Steven's family for their loss.

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.

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

Jacqueline Gauci, Senior Next of Kin

Mr Jeroen Weimar, Secretary of the Department of Transport and Planning

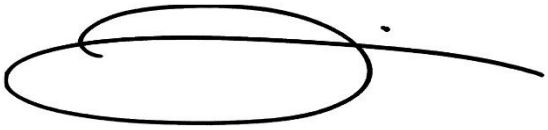
VicRoads

Royal Melbourne Hospital

Eastern Health

Leading Senior Constable Brett McCormick, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 27 February 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.