CITATION: *Inquest into the death of Benjamin Leigh Wilton* [2014] NTMC 09

TITLE OF COURT:	Coroners Court
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FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Motor Vehicle Death; Fitness to drive of elderly drivers**

REPRESENTATION:

Counsel Assisting:	Mr Mark Thomas
Counsel for Dr Goodhand:	Mr Miles Crawley
Department of Health:	Mr Rob Jobson
Department of Transport:	Mr Kelvin Currie

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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0081/2014

In the matter of an Inquest into the death of

BENJAMIN LEIGH WILTON

ON 8 May 2012

ON THE STUART HIGHWAY, 50 METERS WEST OF THE INTERSECTION OF AMY JOHNSON AVE, MARRARA, DARWIN

FINDINGS

Mr Greg Cavanagh SM:

Introduction

1. On Tuesday, 8 May 2012 at just before 1.45pm Mr Benjamin Wilton was the driver and sole occupant of a Suzuki Swift motor vehicle that was either stationary or very close to stationary in an outbound lane of the Stuart Highway, Marrara, some 50 metres west of a set of traffic lights at the intersection of the Stuart Highway and Amy Johnson Avenue.

2. At that point a Ford Falcon utility motor vehicle driven by the then 67 year old Robert Frank Spencer, was travelling east along the outbound section of the Stuart Highway, which was a divided carriageway at this point. Mr Spencer's motor vehicle had been noticed by a number of other motorists as it travelled along the highway, who observed it to be swerving across the road, and being driven in an erratic fashion. Several motorists thought that the driver was either drunk or under the influence of drugs.

3. Mr Spencer's motor vehicle did not brake or slow down as it approached the intersection of Amy Johnson Avenue. The traffic lights at this intersection had been red for vehicles heading east along the Stuart highway a short time before Mr Spencer's vehicle approached. Several vehicles had stopped at the lights, which changed to green shortly prior to the approach of Mr Wilton's vehicle. Mr Spencer's vehicle probably swerved sharply to its right seconds before it struck the rear of Mr Wilton's motor vehicle.[1] At the point of impact, Mr Spencer's vehicle was travelling at a speed estimated by police as between 50 and 80 kph. Mr Wilton's vehicle was either stationary at the point of impact or moving very slowly. Police determined that Mr Wilton's brake lights were activated when it was struck. When it was struck, the impact caused Mr Wilton's vehicle to be thrust forward in a diagonal fashion into the left hand of the two outbound lanes. Mr Wilton's vehicle moved about 17 metres along the road and spun around as it did so a full 180 degrees. Mr Wilton's vehicle's fuel tank ruptured causing petrol to leak from it. Very shortly afterwards, the fuel tank exploded probably as a result of sparks that were emitted by the vehicle as it was propelled along the road as a result of the impact. Mr Wilton was probably knocked unconscious shortly after his vehicle was struck with the result that he could not get out of it himself. Some courageous motorists attempted to help him but the doors of the Suzuki were jammed shut due to the extensive crush damage sustained to them as a result of being struck by Mr Spencer's vehicle. When the fire took hold the intensity of it drove back those motorists who were endeavouring to help Mr Wilton. Mr Wilton died as a consequence of severe

[1] There were two outbound lanes of the Stuart highway at the crash location that were for vehicles proceeding straight ahead in an outbound direction. There were also two additional lanes at the crash location, one for vehicles turning left and the other for vehicles turning right. At the point that it was struck the Suzuki was located in one of the two outbound lanes, which was for vehicles proceeding straight ahead.

burns received in the fire that engulfed his motor vehicle. His death was horrific. He was 29 years old.

4. After Mr Spencer's vehicle struck Mr Wilton's vehicle, Mr Spencer's vehicle proceeded ahead and struck the rear of a Toyota Hilux. The Hilux was then propelled forward and struck the rear of a Toyota Landcruiser. When the Hilux was struck it rotated in a clockwise fashion about 30 degrees. This caused Mr Spencer's vehicle to veer off across the median strip to the inbound section of the Stuart highway. Mr Spencer's vehicle struck the rear of a passing Mitsubishi flat bed truck as it travelled across the inbound section of the Stuart highway, before Mr Spencer's vehicle struck a fifth vehicle, which was an Isuzu truck, causing minor damage to it. Mr Spencer's vehicle finally stopped at a point near to the stop line at the southern end of the intersection of Amy Johnson Avenue and the Stuart highway. Mr Spencer's vehicle very nearly struck a sixth vehicle that was located at the southern point of the intersection, specifically on Amy Johnson Ave, which rapidly reversed back to avoid a collision with Mr Spencer's vehicle.

5. Mr Spencer's vehicle was the cause of five other vehicles being collided with. Sole responsibility for it rests with Mr Spencer. His vehicle suffered extensive damage to the front and to the right hand side of it. Mr Spencer was uninjured. Weather conditions were fine and the road conditions were good. Motor vehicle mechanical problems were ruled out as a contributing factor to the crash. Mr Spencer tested negative to the presence of alcohol and illegal drugs when police tested him at the scene.

6. The speed limit at the point of impact was 90kph. Some motorists estimated that Mr Spencer's vehicle had been driving at about 90kph shortly before the crash.

7. Mr Spencer held a license to drive a motor vehicle as at 8 May 2012. This was despite the fact that he had, in the 18 months prior to 8 May 2012 caused two multi-vehicle crashes and had, in addition, run off the road into a ditch.

8. The reality was that as at 8 May 2012, Mr Spencer constituted a lethal danger to all other road users in the Northern Territory. He was an accident waiting to happen due to the health problems that he suffered from at the time, which will be examined in detail. He should never have held a driver's license that permitted him to legally drive on 8 May 2012. Mr Wilton was utterly blameless and his death a tragedy.

9. The point of the Inquest was twofold: firstly, to examine how it came to be that Mr Spencer was granted a driver's license that permitted him to drive on 8 May 2012. The second matter was to examine what steps ought to be taken to prevent this sort of tragedy from happening again. There was no issue regarding the facts of the collision that killed Mr Wilton and hence no need to call any witnesses in that regard.

10. It is vital to note at this point that all key actors in this matter were agreed upon the importance of the full exchange of all relevant information – both medical and from the police, to aid the Registrar of Motor vehicles, whose job it is grant driver's licenses, to grant driver's licenses only to those who do not constitute a danger to other road users. Secondly, all key actors[2] were

[2] Those who supported the establishment of a Review Panel in this area who gave evidence or spoke at the Inquest included Mr Paul Rajan, who is the Registrar of Motor Vehicles; the Department of Health; key doctors such as Dr Burrow, a very experienced neurologist, Dr Daniel of the Department of Health and Dr Goodhand, who made the assessment in January 2012 of Mr Spencer that led to his driver's license being granted to him at that time. The Commissioner of the NT Police did not formally state his position on this matter. I would expect that the Commissioner would be cooperative.

agreed upon the formation of some form of a Review Panel to be set up to deal, at the very least, with complex cases involving the assessment of applicants for driver's licenses who suffer from health problems.

11. NT Police laid criminal charges against Mr Spencer, the principal one of which was drive in a manner dangerous occasioning the death of Mr Wilton. The Office of the Director of Public Prosecutions prosecuted the matter. However, in February 2014 the Crown accepted, on the basis of medical evidence, the merit of the defence raised by Mr Spencer's lawyer, Mr Ian Read SC, that Mr Spencer had a lawful defence of mental impairment. The prosecution was then terminated. However, a non-custodial supervision order was issued out of the Supreme Court on 25 February 2014 which imposed certain conditions upon Mr Spencer, the terms of which will be examined in these findings.

12. Mr Mark Thomas appeared at the Inquest as Counsel Assisting. Mr Miles Crawley appeared for Dr Goodhand. Mr Rob Jobson appeared for the NT Department of Health. Mr Kelvin Currie appeared for the NT Department of Transport. Mr Wilton's family and extended family attended each day of the Inquest. They were his mother, brother, fiancée and her parents.

13. I received into evidence the investigation brief, which was prepared by Sergeant Mark Casey who gave evidence as did Dr Burrow, a neurologist. Dr Sinton, who conducted the autopsy, gave evidence as well as Dr Daniel of the Department of Health, Mr Paul Rajan the Registrar of Motor Vehicles, and finally, Dr Goodhand. Mr Spencer did not give evidence at the Inquest. Mr Ian Read SC appeared for him. I decided that I would not require Mr Spencer to give evidence as I viewed any evidence that he might give as not being likely to be reliable, given his significant health problems that

included, in particular, early onset dementia, which caused significant memory problems.

14. The brief of evidence was supplemented by a bundle of material marked "additional documents" that included a medical advisory committee report, a folio marked legal services response, a letter from Dr Burrow, a report of Dr Woods, a court report, a transcript of the committal proceedings dated 9 November 2012, and a statement from the Registrar of Motor Vehicles. In addition, three volumes of material that comprised medical records pertaining to Mr Spencer, were tendered. Two of these volumes were from Royal Darwin Hospital while the third was from Farrar medical clinic.

15. Pursuant to section 34 of the *Coroners Act* ("the Act"), I am required to make the following findings:

> "(1) A coroner investigating –
>
> (a) a death shall, if possible, find –
>
> (i) the identity of the deceased person;
>
> (ii) the time and place of death;
>
> (iii) the cause of death;
>
> (iv) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act;

16. Section 34(2) of the Act operates to extend my function as follows:

> "A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated."

17. Additionally, I may make recommendations pursuant to section 35(1), (2) & (3):

"(1) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner.

(2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner.

(3) A coroner shall report to the Commissioner of Police and Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the coroner believes that a crime may have been committed in connection with a death or disaster investigated by the coroner."

18. Where there has been a death in custody, pursuant to section 26 (1) and (2) of the Act a coroner:

"(1) Must investigate and report on the care, supervision, and treatment of the person being held in custody; and

(2) May investigate or report on a matter connected with public health or safety or the administration of justice that is relevant to the death.

19. This was not a death in custody.

Reported when and by whom

20. Mr Phillip Hatty reported this crash to police at 1.45 pm on 8 May 2012. Mr Wilton died in his motor vehicle very shortly after the impact. No medical assistance was provided or required at the time due to the circumstances of almost immediate, certain death. No medical practitioners formally certified that the deceased was dead at the time of the incident. Mr Wilton was identified by Constable Michael Whiting for the purpose of the autopsy that was conducted by Dr Sinton on 10 May 2012. The deceased was formally

identified on 11 May 2012 by Dr Mark Leedham, a forensic odontologist, using dental records.

RELEVANT CIRCUMSTANCES SURROUNDING THE DEATH

Background of Mr Wilton

21. Mr Wilton was born at the Royal Darwin Hospital on 7 April 1983 to Mark Leonard and Sandra Marotzek. He had five siblings. His formative years were spent in NSW where he attended Bega Primary and High School. He was the father of two children born to him and a long term relationship that he had with his ex-partner Kylie Schloeffel. The children both to this relationship lived with their mother in Victoria but continued to see their father whilst he was alive. Mr Wilton's relationship with Ms Kylie Schloeffel terminated in 2010. Mr Wilton commenced a relationship with Ms Rachael Timson and they were due to be married on 19 July 2012.

22. Mr Wilton had been driving for approximately seven years after acquiring his provisional license on 31 May, 2005. He gained his C class driver's license on 8 June 2007.

23. Mr Wilton had a diverse work history, having commenced working at the cheese factory in Bega as well as in the motor vehicle industry. At the time of his death he was employed at Arnos Tyres in Winnellie where he was held in very high regard by his employer and colleagues.

The crash that caused Mr Wilton's death

24. There was no issue at the inquest regarding the factual circumstances of the collision that caused Mr Wilton's death.

The cause of death

25. Dr Sinton, who conducted the autopsy, stated that the cause of death was severe burns. Dr Sinton noted the presence of fractured ribs on both sides of the chest as well as a fractured pelvis. These injuries were consistent with a sudden impact by Mr Wilton with the steering wheel. This, Dr Sinton said was likely to mean that Mr Wilton was immobilised. He did add that these injuries indicated that it was highly likely that Mr Wilton was knocked unconscious shortly after the collision and hence, that this reduced his level of suffering prior to his death.

The relevant traffic history of Mr Spencer

THE MOTOR VEHICLE ACCIDENT – 25 NOVEMBER 2010 (THREE VEHICLE CRASH)

26. Time: 12.21 pm. Location: intersection of Roystonea Ave and Temple Terrace. Mr Robert Spencer drove his motor vehicle into the back of one motor vehicle that was stopped at this intersection, causing it to smash into the rear of another vehicle. One driver was injured but not badly. Mr Spencer was not injured and tested negative to alcohol. He was issued with an infringement notice regarding this crash.

SECOND MOTOR VEHICLE ACCIDENT – 10 OCTOBER 2011 (FIVE VEHICLE CRASH)

27. Time: 12.21 pm. Location: intersection of Roystonea Ave and the Boulevard, and subsequently Temple Terrace. Mr Spencer was travelling southbound on Roystonea Avenue. He approached the intersection of Roystonea Ave and the Boulevard and without stopping smashed into the

rear of one motor vehicle, causing it to be propelled forward and to the side before accelerating into the next intersection where the traffic lights were red for Mr Spencer's vehicle. Three vehicles were stopped at the lights. Mr Spencer then sideswiped the third vehicle that was stopped at this intersection before striking a fourth vehicle, which was forced into the fifth vehicle. Four of the five vehicles involved in this crash were required to be towed away. All drivers were assessed by St Johns Ambulance and two, including Mr Spencer were taken to hospital by St Johns Ambulance. No brake lights were used by Mr Spencer according to eyewitnesses. Nobody was seriously injured. Mr Spencer was charged with drive in a manner dangerous and drive in a speed dangerous. At least one of the motor vehicles that was the subject of this collision was a complete write off. It is important to observe that the intersection of Temple Terrace and Roystonea Ave is a major intersection. It is remarkable that nobody was killed or seriously injured in this incident.

THIRD MOTOR VEHICLE ACCIDENT – 3 NOVEMBER 2011 (RAN OFF ROAD)

28. Time: 12.30 pm. Location: Corner of Tilston Ave and Bonson Terrace, Moulden. Mr Spencer drove off the road going around the corner. He tested negative to a roadside breath test. Police noted that he was confused; he struggled to answer simple questions, such as his name and where he lived. Police observed that one of his pupils was fully dilated and the other very small. The policeman, Constable Johnson-Bailey suspected a mental disorder and suspected, in addition, that he had a stroke. He was conveyed by ambulance to Royal Darin Hospital. The ambulance report from this incident reveals that Mr Spencer told the ambulance personnel that he had "driven up the rear of another car whilst driving two weeks ago (for loss of

concentration)". This report and Constable Johnson-Bailey's salient observations did not make their way to those who subsequently were called upon to make an assessment regarding Mr Spencer's fitness to drive.

Relevant medical and driving history of Mr Spencer

29. 11 June 2008 stroke. Royal Darwin Hospital (hereafter RDH) advised the NT Motor Vehicle Registry (MVR) that Mr Spencer unfit to drive. Dr Tomlinson, in this letter specified that he currently had a medical condition that impeded his ability to drive a motor vehicle safely.

30. 18 June 2008. Mr Spencer's license to drive a motor vehicle suspended.

31. 24 July 2008. Medical Notification form from Rehabilitation Specialist due to "recent right CVA [3] with left-sided inattention. Needs OT driving assessment[4].

32. 2 September 2008. OT on-road assessment by Julia Bailey[5]: "Mild left-sided sensory changes which are no longer evident". Ms Bailey recommended that his license be re-instated.

33. 8 September 2008. Conditional license to drive motor vehicle granted. This was conditional upon a medical review and report every two years.

34. 19 October, 2010. Report from Mr Spencer's treating GP Dr Goodhand. He assesses Mr Spencer as being fit to drive and states "a number of medical conditions are well controlled".

35. 28 October 2010. MVR in a letter to Mr Spencer acknowledges receipt of Dr Goodhand's report dated 19 October 2010. MVR advises Mr Spencer that

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[3] Cerebrovascular accident ie a stroke
[4] assessment
[5]Ms Bailey was an occupational therapist

from this point annual medical reviews by a medical practitioner that is preferably aware of his personal medical history.

36. 25 November 2010. First Motor vehicle accident. See above.

37. THIS WAS NOT KNOWN TO THE MVR at the time.

38. 10 October 2011 Second Motor vehicle accident. See above.

39. THIS WAS NOT KNOWN TO THE MVR at the time.

40. Note: Summonses were issued for Drive manner dangerous and drive without due care. These charges were terminated together with the charges arising directly out the crash that killed Mr Wilton, in February 2014.

41. 3 November 2011. Third Motor vehicle accident. See above.

42. 4 November 2011. RDH notified the MVR that the 3 November 2011 incident involved a "syncope[6] of unknown cause. Now two x episodes while driving." The RDH doctor specified that Mr Spencer does not meet the conditional or unconditional criteria in the Assessing Fitness to drive guidelines.

43. 16 November 2011. MVR suspends Mr Spencer's driver's license. On the same date Dr Goodhand conducted a medical assessment of Mr Spencer's fitness to drive. He was declared fit to drive but informed that he must wait for two months before he was permitted to be granted a license to drive.

44. 12 January 2012. Dr Goodhand sent a report to the MVR in which he assessed Mr Spencer as fit to drive. He added that Mr Spencer had an

[6] Technically a loss of consciousness or faint.

unexplained syncopal episode whilst driving on 5 November 2011[7] and that extensive investigations conducted by RDH showed no cause for the event. He said that in order to regain his license it was necessary that he have no further syncopal episodes in the following three months.[8] Dr Goodhand said that he had not had any further syncopal episode and has passed the medical examination for fitness to drive.

45. 18 January 2012. MVR grants Mr Spencer a conditional license to drive a motor vehicle, which was conditional upon a medical review being conducted on an annual basis.

46. 8 May 2012. Date of death of Mr Wilton.

47. 25 February 2014. After the termination of the criminal prosecution of Mr Spencer in the Supreme Court, Mr Spencer entered into a non -custodial supervision order that required periodic annual review pursuant to s 43 ZK. It prohibited him from driving a motor vehicle in any circumstances and prohibited him from applying for a driver's license or a permit to drive without the prior consent of the Court.

THE RELEVANT LAW AND GUIDELINES FOR GRANTING MOTOR VEHICLE LICENSES TO PERSONS WHO SUFFER FROM A MEDICAL CONDITION (AS AT 8 MAY, 2012).

48. Section 10 of the Motor Vehicles Act NT (hereafter "the Act") provides that the Registrar of Motor Vehicles may, on the application by a person, grant a person a license to drive a motor vehicle (other than a commercial passenger vehicle or AIL vehicle) of the class specified in the license if the person has

[7] This was an error. It was actually 3 November
[8] This was an error. Two months was required.

previously held in the Territory or elsewhere a license to drive that class of vehicle, or the person is the holder of a learner license and the person satisfies the Registrar that the person is capable of driving a motor vehicle of that class with safety to the public and the person satisfies the Registrar that he is able to understand the notices, signs and devices in use from time to time for the regulation of motor vehicle traffic.

49. Pursuant to section 102 (2)(b)of the Act the Registrar may, subject to the direction of the Minister, cancel or suspend or restrict the use of a license (for such a period as the Registrar thinks fit) where in the opinion of the Registrar the person is unfit to hold a license or a license unconditionally having regard to:

    (i) the person's finding of guilt for an offence in the Territory or in a State/another Territory, or

    (ii) the person's age, or

    (iii) any mental or physical condition, disorder or disability of the person.

50. Under section 102 (5A) of the Act, the Registrar may, subject to any direction of the Minister, grant or renew a license under section 10 subject to any conditions as are prescribed or as the Registrar thinks fit.

51. Two key National bodies are of importance in this area. They are:

    (i) Austroads. This is the association of Australian and New Zealand road transport and traffic authorities. All Australian road transport and traffic authorities are members of this body.

(ii) The National Transport Commission. This was established in 2003 pursuant to the National Transport Commission Act 2003 (Cth). One of its functions is to set out model legislation. It is the body that formulated the Australian Road Rules, which establish rules for driving and driving behaviour offences in all Australian States and Territories. It endeavours to achieve uniformity in this regard.

52. In the Northern Territory fitness to drive a motor vehicle was, as at 8 May 2012 (and presently), significantly affected by a set of Guidelines for Assessing Fitness to Drive that are the joint production of Austroads and the National Transport Commission. The Guidelines are called "medical standards for licensing and clinical management guidelines" and are published under a heading entitled "Assessing Fitness to Drive for Commercial and Private Vehicle Drivers". These Guidelines are employed on a National basis and are used by medical practitioners throughout Australia. In the specific area of the fitness to drive a motor vehicle of a person who is suffering from health problems, the Guidelines place a very significant responsibility upon medical practitioners to assess fitness to drive. The ultimate decision as to whether to grant a driver's license is always the responsibility of the Registrar of Motor Vehicles.

53. The Guidelines have been updated on a regular basis since 1998. The most recent amendments were published on 1 March, 2012 and came into force on that date.

54. In relation to private as opposed to commercial drivers the NT MVR did not, as at 8 May 2012, have direct access to criminal histories of persons or police information in relation to motor vehicle crashes. This remains the current situation. The Registrar of Motor Vehicles, Mr Rajan, confirmed

this. He added that where the MVR considers that a criminal history report is required, the applicant for a license is required to sign an authority permitting the MVR to obtain a criminal history check.

55. The most recent Guidelines, dated 1 March 2012, at page six, do specify that the Driver Licensing Authority[9] does have the responsibility to "make all decisions regarding the licensing of drivers. The driver licensing authority will consider reports provided by health professionals, police and members of the public as well as crash involvement and criminal histories". As the Registrar of Motor Vehicles has noted in his statement and evidence at the Inquest, the reference to "crash involvement and criminal histories" is a new amendment that was introduced in the most recent edition of the Guidelines.

DR GOODHAND's DECISION TO CERTIFY MR SPENCER AS FIT TO DRIVE

The 16 November 2011 assessment

56. On 4 November 2011 Dr Sarah Hurley of RDH stated in a medical condition notification form that there had been a "syncope of unknown cause. Now two x episode while driving." She sent this report to the MVR at about this time but it does not appear to have made its way to Dr Goodhand.

57. Mr Spencer was an inpatient at RDH from 3 November until his discharge on 5 November. Dr Goodhand stated in evidence that he was aware that Mr Spencer had been dealt with in cardiology as well as the emergency departments at this time and that cardiology had not found any cause for the blackout on 3 November 2011.[10] Nor did it appear that Neurology had found

[9] In the Northern Territory the Driver Licensing Authority is the MVR
[10] p 106, inquest transcript, dated 9 April 2014

a cause although it was still investigating the matter. Therefore Dr Goodhand was of the view that Mr Spencer had suffered from potentially or possibly a single syncope but the cause was unknown. Dr Goodhand testified at the Inquest that this did not concern him. He said that at this point the most likely cause of the problem was excessive heat.

58. Dr Goodhand noted that after Mr Spencer's release from hospital on 5 November 2011 there was to be a Myoview (a cardiac scan using a dye), an INR to determine the status of the blood thinning effect and general cardiac monitoring. There was also to be an EEG[11] but this never actually happened until after the fatal crash. When an EEG was conducted well after Mr Wilton's death the results revealed that Mr Spencer had a form of partial epilepsy. Dr Goodhand was not aware that there may be a problem with epilepsy when he examined Mr Spencer in November 2011 and January 2012. Mr Spencer's health deteriorated after the death of Mr Wilton: in May of 2013 Dr Goodhand noted that Dr Burrows observed that there was some indication of a dementing illness, which had not been present in January 2012.

59. Dr Goodhand assessed Mr Spencer as fit to drive as at 16 November 2011 but specified that Mr Spencer could not do so because of the mandatory requirement that he be off the road for two months (following an unexplained black out).

60. The 16 November assessment was made after Dr Goodhand had received from RDH a CT scan of Mr Spencer's head, which Dr Goodhand said in his

[11]Electroencephalogram. A test or record of brain activity utilizing electroencephalography

testimony revealed nothing new, as well as an x-ray of Mr Spencer's chest, which Dr Goodhand said was normal.

61. When Dr Goodhand made his assessment on 16 November Dr Goodhand was aware of the discharge summary from Royal Darwin Hospital, dated 5 November 2011. In it there was a reference to Mr Spencer having had no recollection of events of the 3 November incident in which he drove off the road. Dr Goodhand testified that this suggested some form of blackout. This summary also referred to the following: "He had a similar episode in October of this year currently being investigated with an outpatient ECG later in November followed by a cardiology review". Dr Goodhand agreed with the proposition put to him in evidence that if the reference to similar episode meant a reference to blackout there should have been a request made by the relevant doctor for his license to be withdrawn. Given that there had been no such request Dr Goodhand said that he was unable to form any idea as to what had happened in the October incident. He added that he did address the matter at the time in a patient questionnaire. Mr Spencer said in the questionnaire that it was a no fault tail gate. Dr Goodhand testified that he asked Mr Spencer about this incident and that Mr Spencer had merely said that he had hit a trailer. Later, Dr Goodhand said that he didn't recall what Mr Spencer said that he had hit. Dr Goodhand's counsel asked him at the Inquest "But there was no suggestion of a blackout or syncope?" Dr Goodhand repied "no".[12]

62. On 9 November 2011, Dr Peter Chan, the Emergency Department Registrar of RDH sent to Dr Goodhand a report, which included, under the heading of "Clinical notes", a reference to there being a "similar episode in October

[12] p 105 Inquest transcript dated 9 April 2014.

this year[13] currently being investigated with an outpatient echocardiogram later in November followed by a cardiology review. CT brain in October revealed an old infarct. On examination there was no focal neurology".

63. Dr Goodhand was shown the discharge summary of the 10 October incident for the first time when it was shown to him during the Inquest.

64. Dr Goodhand was shown the discharge summary from 5 November 2011 and testified that the cardiac inquiries that were conducted appeared to rule out a cardiac cause. Further, the neurology department had investigated it and notwithstanding that further tests were to be conducted it did not appear that there was a neurological cause for the blackout.

65. The discharge summary did not specify the cause of the November 2011 syncopal episode but did note under the discharge Care Plan that "Neurology have booked an outpatient EEG"

The 12 January 2012 assessment

66. On12 January 2012 Dr Goodhand made an assessment, in which he determined that Mr Spencer was fit to drive a motor vehicle. At this time, the old 2003/2006 Guidelines applied. Dr Goodhand did not know, at the date that he made his assessment, of the two prior motor vehicle crashes that Mr Spencer had caused, one of which was only three weeks prior to the 3 November 2011 incident. Of course, he knew of the 3 November 2011 incident, where Mr Spencer had driven off the road. Dr Goodhand was aware that Mr Spencer had suffered a syncope or blackout at that time. Further, he was of the view that there was no medical explanation for it.

[13] 2011

67. The Guidelines 14 as at January 2012 merely specified that a “person should not drive for two months following unexplained syncope/blackouts” (or six months for a commercial driver). It is important to observe that the 2003/2006 Guidelines did not specify that if a person had two or more unexplained syncope episodes that the person should be off the road for more than two months. In any event Dr Goodhand was aware of just the one blackout at the time that he made the assessment.

68. Dr Goodhand stated in his written assessment dated 12 January 2012 that extensive investigations at RDH showed no cause for this event (unexplained syncope episode of 3 November 2011) and that Mr Spencer “has had no further episodes of syncope and passed the medical examination for fitness to drive.”

69. As at 12 January 2012, Dr Goodhand was aware that Mr Spencer had a heart condition which had necessitated an aortic valve replacement. He was also aware that he was on anti-coagulent medication.

70. Dr Goodhand, in evidence, defined a syncope as a faint or a transcient loss of consciousness, which in about 90% of cases could be caused by (in descending order of prominence) heat exhaustion or dehydration, cardiac causes or cerebella episodes.

71. On 18 January 2012 the MVR wrote to Mr Spencer and advised him that based on Dr Goodhand’s fitness to drive report, his license to drive was re-instated on the basis that he provide annual fitness to drive reports.

72. In summary, at 12 January 2012 Dr Goodhand had a very limited knowledge of the full medical history and traffic history pertaining to Mr Spencer. He did not know of the two previous motor vehicle crashes, he knew of only one blackout episode (on 3 November 2011); he had no knowledge that Mr Spencer might suffer from a problem with epilepsy, (the EEG having not been conducted). In making these observations no criticism is made of Dr Goodhand. The problem was a systemic one as will be discussed. The applicable guidelines were then limited in their scopes as was the transfer of medical information between medical discipline and also the transfer of information from the police. In addition, RDH had yet to engage in detailed neurological analysis of Mr Spencer.

IF THE 1 MARCH 2012 GUIDELINES APPLIED AT THE TIME OF DR GOODHAND'S ASSESSMENT

73. The most recent Guidelines, which came into force on 1 March 2012, did not apply to the January 2012 assessment by Dr Goodhand. Nevertheless it is relevant to examine them. They contain[15] a reference to the condition defined as "Blackouts (episodes of impaired consciousness) of uncertain nature" that "if there have been two or more blackouts separated by at least 24 hours, a conditional license may be considered by the driver licensing authority subject to at least an annual review, taking into account information provided by the treating doctor as to whether the following treatment is met: "There have been no further blackouts for at least 12 months"

74. Mr Rahjan testified at the Inquest that if the 1 March 2012 Guidelines would have been in force when Dr Goodhand made his assessment in January 2012,

[15] Page 33

it would require that Mr Spencer would have had to be free from blackouts for 12 months from January 2012. This is because Mr Rajan assumed that two blackouts would have been identified by the doctors. Thus, Mr Rajan concluded that he would not have had a driver's license granted to him in January 2012. However, if Dr Goodhand's evidence is accepted, only one blackout would have been identified, which would mean the 12 month period off the road would not be activated. However, under the 1 May 2012 Guidelines, if they had been in force, he would still be not able to drive, in this case for a period of six months commencing on 16 November 2012, which was when his license was suspended. This would mean that Mr Spencer would not have been able to drive as at 8 May 2012.

FURTHER MEDICAL EVIDENCE

Dr Burrow

75. Dr Burrow is a Neurologist. He reviewed the medical files after the death of Mr Wilton. He said that Mr Spencer suffered from complex partial epileptic seizures in which the patient loses awareness but does not necessarily fall to the ground. He said that these types of seizures are particularly dangerous for a driver as the patient may be not aware that they are occurring. Dr Burrow added that he was of the opinion that all of the accidents were caused by these seizures.

76. Dr Burrow added that when he saw Mr Spencer on 16 May 2013 he was of the opinion that in addition to the diagnosis of epilepsy Mr Spencer was suffering from a dementing illness. He added that on both these grounds he ought not to be driving a motor vehicle.

77. Dr Burrow also testified about a medical panel and conflict of interest. He said that a client may withhold vital information about their health if he

knows that he or she may be penalised by the doctor as to driving. Further, considerable antipathy can be generated between doctor and patient when an adverse assessment is made by a doctor giving a negative assessment regarding fitness to drive.

78. Dr Burrow recommended that a Medical Driving Assessment Panel be set up, which would comprise medical specialists, the MVR, the NT Police as well as members of the public. The panel would make recommendations to the MVR. It would eliminate the antagonistic conflict of interest situation referred to above. Dr Burrow noted that a similar system had been operating for years in Victoria. Dr Burrow noted that in 2007 he had raised this matter with the Chief Medical officer and key parties were all in favour of such a panel. They included NT Police, the Registrar of Motor Vehicles, and the Chief Medical Officer. The Panel however was not put into effect. Dr Burrow regretted this and said that this continues to be a major source of concern to his colleague physicians.

79. He added that if the panel was in place as at 8 May 2012, Mr Wilton would be alive.

Dr Daniel

80. Dr Vinod Daniel testified at the Inquest that he worked on a rotation in the office of the Chief Health Officer between March 2007 and November 2007. He said that he was asked to look into the issue referred to above that was raised by Dr Burrow. He said that the primary concern of doctors was that they were sent referrals by the Registrar to independently assess complicated medical cases and certify their fitness to driver without offering any indemnity to the specialist. The second issue was the mandatory obligation imposed upon private medical practitioners to notify the MVR of

any medical conditions identified in patients that might affect their fitness to drive without any indemnity being offered.

81. Dr Daniel noted that only South Australia and the NT imposed mandatory obligations upon medical practitioners in this regard. However, South Australia did offer indemnity protection.

82. A proposal of an Independent expert panel to be set up under the Motor Vehicles Act and funded by the Department of Transport was initiated. Much discussion and paper work happened. All relevant parties agreed upon it. There was no dissent. Then extraordinarily, the proposal faded away into thin air. There was not even a briefing paper to summarise what became of it. Nobody knew. Certainly, Dr Daniel did not. There was no paper trail indeed no explanation given as to what became of it.

Dr Lowe

83. Dr Michael Lowe is a Community Geriatrician for the Department of Health. He was a court appointed expert who was required to examine Mr Spencer for the purpose of the Supreme Court case that concerned the criminal charges that were laid against Mr Spencer in relation to the death of Mr Wilton.[16]

84. Dr Lowe examined Mr Spencer on 20 September 2013. He was fully aware of Mr Spencer's traffic and medical history and examined it in detail.

85. Dr Lowe stated that the discharge summary of 5 November 2011 included a reference to "Neurology have booked an outpatient EEG. He was of the view

[16] This report also had an impact upon criminal charges laid in respect to the previous incidents, which were terminated in consequence of the medical material of Dr Lowe and the other doctors, which the Crown accepted constituted a defence that could not be met by the Crown.

that Dr Burrow implied at the time that Mr Spencer would not have his license reinstated until after his EEG.

86. Dr Lowe came to the view that Mr Spencer was mentally impaired at the time he decided to drive his motor vehicle on 8 May 2012 because he was not able to control his actions, when colliding into the rear of a car.

87. Dr Lowe added that the metallic replacement aortic valve that was inserted in 2003 placed him at greater risk of having a stroke since clots can form on these valves, break off and go to the brain and obstruct cerebral circulation.

88. Dr Lowe observed that in 2003 Mr Spencer suffered a stroke of his right occipital-parietal region. Dr Lowe was of the opinion that Mr Spencer has likely inherited three complications from this stroke which were:

- Anosognosia
- Left sided visual neglect
- Complex partial seizures

89. Dr Lowe said that Anosognosia is a phenomenon commonly found in people with strokes on the right hand side of the brain, which means that these people have no insight or understanding that anything is wrong. This can be extreme (such as someone with a paralysed side who denies that anything is wrong) or can be more subtle. Dr Lowe noted that we can see this repeatedly in Mr Spencer's history. For example he ignored a major burn on the left side of his body, showed no insight into the fact that he was causing multi-car pile ups and wanted to leave hospital promptly after suffering a major stroke.

90. Left sided visual neglect meant that the patient's visual fields are normal when tested individually but when both sides are tested simultaneously the patient sees only stimuli on his or her right. This, Dr Lowe, said would have had a direct effect on his driving and his collision history.

91. Regarding complex partial seizures, Dr Lowe differed with Dr Burrow and thought that the two multi vehicle smashes at Roystonea and Temple Tce were unlikely to have occurred as a result of seizures. Dr Lowe thought that as the intersection required a driver to move from the left to the right side there was likely to have been a case of left sided visual neglect with Mr Spencer missing what was in his left side visual field.

92. Dr Lowe thought that the incident where he ran off the road might have been caused by either a seizure of left field visual neglect but it is not possible to say with certainty what occurred. Dr Lowe was of the same opinion in relation to the fatal crash.

93. Dr Lowe also opined that Mr Spencer was developing the beginning of a dementing process that would make it more difficult for him to understand his other disabilities.

Summary of medical position

94. On 12 January 2012, when Dr Goodhand assessed Mr Spencer as being fit to drive there had been:

    1) No EEG testing to determine if Mr Spencer had epilepsy, as has subsequently being revealed.

2) No knowledge of the operation of what Dr Lowe identified as being anosognosia (caused by the stroke to the right hand side of his brain)

3) No knowledge of the phenomenon of left side visual neglect (caused by the same stroke)

4) No knowledge of the two prior multi-vehicle crashes, let alone the detail of them.

95. Thus, Dr Goodhand had only a small part of the overall picture available to him when he made the assessment that Mr Spencer was fit to drive.

96. It should be noted that the early onset dementia would not appear to have been in existence at the time and hence is not relevant to the matter under consideration here.

97. What is relevant is that the system failed. Mr Wilton's death can be directly attributed to that failure as Dr Burrow accurately put it.

Improvements in MVR information systems since the death of Mr Wilton

98. The Registrar of Motor Vehicles stated that there were three areas that were targeted for improvement, which were:

- The information applicants are required to provide to medical practitioners has been improved. Forms have been amended to capture medical and traffic offences including any crash history

- The information that medical practitioners are required to provide the Registrar has been improved.

- Applicants as part of their declarations to the Registrar will be required to authorise the Registrar to obtain details of their health and driving records including not only convictions but crash involvement. A copy of Form L2 which was amended on 31 March 2014 was provided to the inquest. The Driver Health Questionaire has been revised to include consent of the applicant to permit the examining health professional contacting other health professionals.

Information provided by the Police to the MVR

99. The Registrar stated that NT Police automatically notify the MVR of driver offences that result in convictions or court orders generally or the loss of demerit points.

100. However, the Registrar stated that the Police do not routinely advise the MVR of at risk drivers of where no convictions/court orders/demerit points arise as in the first two motor vehicle crashes that Mr Spencer caused.

101. The Registrar has power under s 11AA of the Act to request, in respect to applicants for Commercial passenger vehicle licenses any evidence in relation to the character of a person. There is no equivalent power in respect of non-commercial drivers.

The Registrar of Motor Vehicle's view of a medical panel or expert panel

102. The Registrar of Motor Vehicles accepted that Mr Spencer should never have been granted a license to drive in January 2012.

103. The Registrar was of the view that a Review Panel would provide the "proper protection of the process and proper scrutiny of those complex cases

without building unnecessary administrative complexity that might attend the Victorian model in the NT context". By Review Panel he meant that that would include representatives of the police, the medical profession, the Dept of Health and the MVR.

104. The Registrar was of the view the Panel employed in Victoria might delay that processing of simple cases. He thought that the numbers in the NT compared to Victoria did not justify the use of what has been termed this "bells and whistles approach".

Findings

105. Mr Spencer should never have been granted a license to drive a motor vehicle in January, 2012. He should never have been on the road at the time of Mr Wilton's death. His presence on the road at that time represented a lethal danger to all other road users. Dr Lowe's report, in particular, presents the most detailed and most convincing analysis of Mr Spencer's problems. The chilling reality that follows from Dr Lowe's report is that, in effect, Mr Spencer was an accident waiting to happen.

106. The fact that the MVR did not know of the two multi-vehicle pile ups that Mr Spencer caused at the time of the granting of Mr Spencer's driver's license in January 2012, in itself represents a remarkable failure of the system that operated at the time.

107. Dr Goodhand only knew a small amount of Mr Spencer's medical situation at the time that he approved Mr Spencer as fit to drive in January 2012. I do not criticize Dr Goodhand. He was doing his best to apply the Guidelines as they existed at that time. Dr Goodhand did not know of the two multi-

vehicle pile ups. I find that that represented a fundamental failure of the system as the time.

108. The failure of the Department of Health to not merely pursue the reforms in this area, that Dr Daniels spoke about, but to let them vanish into the ether represents an egregious failure and must not be repeated.

109. Fundamentally, what is required is that in cases of this nature the MVR ought to have all to it all available medical and police information in order for it to make an informed decision as to whether a person in the position of Mr Spencer ought to be granted a license to drive. Specifically, this must have included access to all motor vehicle crash history records, including matters where there has been no conviction. A hypothetical example that was referred to in this inquest of an elderly driver who police know is dangerous and who has caused problems but has not been convicted or even charged, must be reported to the MVR. The present informal situation of notification must not continue. I note that the police who stopped Mr Spencer after his third incident (on 3 November 2011) made observations of him that were consistent with him having suffered a serious mental health incident. This information ought to have made its way to the MVR. It did not. This must not be repeated.

110. It is utterly remarkable that Dr Goodhand did not have available to him when he assessed Mr Spencer as fit to drive (in January 2012) that the medical note that said “syncope of unknown cause. Now two x episode while driving”.

111. I have listened carefully to Dr Burrow’s evidence regarding the question of a conflict of interest in this area. The crucial matter is that mandatory reporting must continue. However, in my view difficult cases must go to a

Review Panel for review-including cases where there is a real problem with a conflict of interest.

112. I acknowledge that the Registrar has been open and forthright with me in acknowledging his Department's shortfalls at the time of this incident. The frankness of his evidence is important and I accept that he is genuine in seeking to implement long-lasting reforms in this area.

113. I acknowledge that there has been important reforms in this area both in terms of the implementation of fresh Guidelines and also new forms that have been referred to in the evidence of the Registrar. Specifically, applicants are required to supply full details of their medical incidents and their crash history. In addition, Applicants are required to authorise the Registrar to obtain details of their health and driving records. This is most helpful.

114. Nevertheless, this does not cover the situation of a driver who has caused a crash, yet has not been found guilty or not been subject to a demerit point loss. This must be attended to.

115. It is important that the amendment to the forms includes (regarding the L2 form) that the driver's questionnaire includes the applicant providing consent for the examining health professional to contact other health professionals.

116. I do not find that it is acceptable that an occupational therapist or a physiotherapist should be making an assessment of a person's fitness to hold a driver's license. This should be the province only of medical doctors, preferably with a detailed knowledge of the applicant's history. To that end a detailed medical knowledge is required. Accordingly, occupational therapists and physiotherapists do not qualify.

117. I support Dr Daniels evidence in relation to an indemnity being provided as it is to medical professionals in the only other jurisdiction in Australia in which there is mandatory reporting by a medical practitioner of a person who in the view of the medical professional is not able, due to physical or mental problems, to either hold a driver's license with safety to the public or is unfit to be licensed- South Australia. This reform simply seeks that the words of s 148 (3) of the SA Motor Vehicles Act, 1959 (which state that a person incurs no civil or criminal liability in carrying out his or her duty under the act) be inserted in s 11 of the NT Motor Vehicle Act. This is a sensible reform and should be carried out.

118. I accept that the problem of aged drivers and motor vehicle licenses is not going away. It will only increase as the population of Australia increasingly ages and the proportion of the population that is both aged and drives motor vehicles increases.

119. I accept the evidence of the Registrar of Motor Vehicle that a practical, administratively streamlined system for dealing with non-commercial license applications for people with medical problems is required. I do not think, because of the reduced numbers in the NT, that a 'bells and whistles' model of a Medical Review Panel such as is presently used in Victoria is required. But I am of the view that a Review Panel is required. It would certainly not be required in every case of, for example, an elderly driver with medical problems as there would be many cases where the problem is straightforward and the assessment of a single medical practitioner would be appropriate. I should add that I am of the view that medical practitioners still must determine most of the medical assessments in this area. However, there ought to be a process of review by a Review Panel that compromise representatives from the MVR, the Department of Health, the medical

profession and the NT Police. I should add that I am of the view that Medical practitioners must still determine most of the medical assessments in this area. However, there ought to be a process of review by a Review Panel that comprises of representatives from the MVR, the Department of Health, the medical profession and the NT Police. It is not necessary to say now when precisely this would be required but the obvious cases are those where the medical problem is simply too complex for an individual medical practitioner to make an assessment. Another example is where the medical practitioner fears that there will be significant and deleterious consequences of his/her relationship with his client by assessing the patient as unfit to drive. A further example is where the medical practitioner is of the view that his/her client is not being honest with him/her in frankly divulging his/her medical history. In such cases, a Review Panel is a sensible and appropriate means to deal with these problems. The practical experience of Dr Burrow in particular, is of vital importance and provides very significant guidance in this area. A trial Review Panel, in my view must commence as soon as possible, with the relevant legislative reform. In my view this Review Panel ought to provide, as the Registrar said, proper protection and scrutiny of those complex cases. At the same time, this must be attended to with a minimum of administrative complexity.

Formal Findings

120. Pursuant to section 34 of the Coroner's Act, I find as a result of evidence adduced at the public Inquest, as follows:

(i) The identity of the deceased was Benjamin Leigh Wilton born on 7 April 1983. He last resided in Darwin.

(iii) The time and place of death was 1.45pm on 8 May 2012 at the Stuart Highway, 50 meters west of the intersection of Amy Johnson Ave, Marrara, Darwin.

(iv) The cause of death was severe burns.

(v) Particulars required to register the death:

(1) the deceased adult was Benjamin Leigh Wilton

(2) Benjamin Leigh Wilton was a tyre fitter

(3) The cause of death was reported to the Coroner

(4) The cause of death was confirmed by post mortem examination carried out by Dr Sinton on 10 May 2012

(5) Mr Wilton's parents were Sandra Marotzek and Mark Leonard.

Recommendations

121. That a Review Panel be set up for the purpose of rendering expert advice to the Registrar of Motor Vehicle regarding the fitness to drive of applicants for a driver's license who suffer from health problems.

122. A legislative system be put in place that fully supports the operation of such a Review Panel.

123. That the Review Panel be comprised of members of the MVR, the NT Police, the Department of Health and the medical profession. The proposed categories of medical specialists available to sit on the panel ought to

include neurologists, cardiologists, rehabilitation specialists, geriatric specialists, alcohol and drug specialists, ophthalmologists and endocrionologists.

124. That the decision making power of the Review Panel be determined by a process of referrals.

125. That such a Review Panel be for the purpose of complex cases involving fitness to drive issues and that it not be for all such decisions that are made in this area.

126. That the present system of mandatory reporting by health professionals of health issues pertaining to fitness to drive a motor vehicle continue and be run in tandem with the Review Panel.

127. That a system be put in place whereby such a Review Panel would have available to it all medical and police information relevant to the assessment of an applicant for a driver's license.

128. That the Review Panel be initially trialled with a view to it being a permanent body.

129. That all efforts be made to ensure that such a Review Panel be a practical and efficient body that is subject to a minimum of administrative complexity.

130. That a system be put in place whereby any NT police officer must draw to the attention of the Registrar of Motor Vehicles any person who that officer believes, on reasonable grounds, to be a serious danger to other road users (as a consequence of physical health/mental health issues suffered by that

person), if that person is granted a driver's license, or that person continues to hold a driver's license.

131. That when a medical practitioner who notifies the Registrar of Motor Vehicles that a person is physically or mentally incapable of driving a motor vehicle with safety to the public, or is physically or mentally unfit to be licensed (pursuant to section 11 of the NT Motor Vehicle Act), section 11 of the NT Motor Vehicle Act be amended by adding words to the effect that any health professional who makes such a notification, incurs no civil or criminal liability in carrying out his or her duty under the Act. This is intended to be consistent with Section 148 (3) of the South Australian Motor Vehicles Act 1959.

132. That occupational therapists/physiotherapists no longer be a registered person capable of making an assessment pursuant to s 11 of the NT Motor Vehicle Act that a person is not mentally or physically capable of driving a motor vehicle safely or is physically or mentally unfit to be licensed.

133. It is of the utmost importance that action be taken to ensure that a tragedy of the type that occurred to Mr Wilton not occur again.

134. I am conscious of the family and extended family of Mr Wilton. He had two young children. I extend my sympathy to all of his family. His death was utterly tragic. A death in similar circumstances ought not occur again.

Dated this 27th day of May 2014.

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GREG CAVANAGH

TERRITORY CORONER