IN THE CORONERS COURT)
AT CANBERRA IN THE)
AUSTRALIAN CAPITAL TERRITORY) CD 32/03 and CD 39/03

INQUEST INTO THE DEATH OF STACEY AND COURTNEY MEAS

FINDINGS

Delivered on Tuesday, 28 April 2009 by Chief Coroner R J Cahill

1. In regard to this inquest, I did indicate my views in the hearing. I am now taking the opportunity to hand down my formal findings and reasons therefor, in writing.

PART 1 – THE LEGISLATIVE SCHEME

2. By virtue of section 13(1)(h) of the *Coroners Act 1997* (the Act), I am required as the Coroner to hold an inquest into the manner and cause of the death of Courtney and Stacey Meas. Section 13(1)(h) provides that a coroner must hold an inquest into the manner and cause of death of a person who dies after an accident where the cause of death appears to be directly attributable to the accident.

3. The matters on which the Coroner holding an inquest must make findings, if possible, are set out in section 52(1) of the Act as follows:

> "(a) identity of the deceased; and
> (b) when and where the death happened; and
> (c) the manner and cause of death; and
> (d) in the case of the suspected death of a person—that the person has died."

4. Section 52(3) of the Act provides that "At the conclusion of an inquest…., the Coroner must record his or her findings in writing". Section 52(4) provides for the discretion of a Coroner to comment "on any matter connected with the

death…….including public health or safety or the administration of justice".

5. Section 55 of the Act sets out the procedure that a Coroner must follow if he or she is to make an adverse comment in relation to a person:

> "**55 Adverse comment in findings or reports**
>
> (1) A coroner must not include in a finding or report under this Act (including an annual report) a comment adverse to a person identifiable from the finding or report unless he or she has, making the finding or report, taken all reasonable steps to give to the person a copy of the proposed comment and a written notice advising the person that, within a specified period (being not more than 28 days and not less than 14 days after the date of the notice), the person may—
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> (a) make a submission to the coroner in relation to the proposed comment; or
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> (b) give to the coroner a written statement in relation to it.
>
> (2) The coroner may extend, by not more than 28 days, the period of time specified in a notice under subsection (1).
>
> (3) If the person so requests, the coroner must include in the report the statement given under subsection (1) (b) or a fair summary of it."

6. A Coroner may make recommendations to the Attorney-General on any matter connected with an inquest, pursuant to section 57(3) of the Act, which provides as follows:

> " **57 Report after inquest or inquiry**
>
> …….
>
> (3) A coroner may make recommendations to the Attorney-General on any matter connected with an inquest or inquiry, including matters relating to public health or safety or the administration of justice."

7. Section 58 of the Act directs a Coroner with regard to processes that must be followed where the Coroner has reasonable grounds for believing that a person has committed an indictable offence.

8. I will be making recommendations to the Attorney-General with respect to assessing motor vehicle drivers who are insulin-dependent diabetics as to their fitness to drive.

Formal findings under section 52

9. As required by section 52 of the Act, I make the following findings:

   - Stacey Louise Meas died at the Canberra Hospital on Monday, 10 February 2003.

   - The manner of her death was a severe closed head injury.

   - The cause of Stacey Louise Meas' injury was that at about 4:30 pm on10 February 2003, a car crashed into the back of the car in which she was a passenger, when her car stopped behind two other cars at the red light at the intersection between Canberra Avenue and Newcastle Street.

   - Courtney Stacey Meas died at Canberra Hospital on 18 February 2003.

   - The manner of Courtney Stacey Meas' death was severe brain injury.

   - The cause of her brain injury was the lack of oxygen and blood supply due to the death of her mother, Stacey Louise Meas. Her mother was fatally injured in the above motor vehicle collision and Courtney Stacey Meas was born by Caesarean section following collision.

   - I am not proposing to refer the matter to the Director of Public Prosecutions for consideration of charges against Mr Michael John Tipping (for the reasons specified below).

PART 2 – FACTUAL FINDINGS

The accident

10. Around 4:30pm on 10 February 2003 Mr Tipping was driving east along Canberra Avenue approaching the intersection with Hindmarsh Drive. He had picked up his son from school after earlier attending a job interview at the Canberra Institute of Technology.

11. The traffic lights were red as he approached the intersection. Three cars were waiting in the left hand lane. The last of

these cars was a green Mitsubishi Lancer sedan driven by Mr Veasna Meas. Also in the car were his pregnant wife Stacey and their 10 month old son, who was in the back seat. Mr Tipping's car crashed into the back of Mr Meas' car forcing the rear luggage area pushed into the passenger compartment.

12. The day after the accident, Mr Tipping told investigating police "I don't remember the squealing of brakes, tooting a horn, I don't remember crunching of metal or breaking of glass, just nothing. My first memory of the accident is looking at my son and pumping the brakes thinking when is the car going to stop because we were slewed all across the road, that's the only memory I've got of the accident."

13. Mr Tipping's car collided with Mr Meas' car, forcing it forward so that it collided with the car in front before spinning round to collide with the rear of Mr Tipping's car. Ms Stacey Meas suffered serious injuries and was taken to Canberra Hospital. An emergency Caesarean section was performed and Courtney Meas was born on that day, but with severe brain damage. She was placed on life support. Stacey Meas never recovered and died that day. Courtney's life support was switched off on 16 February and she died on 18 February 2003.

14. Mr Tipping's car hardly slowed before the collision. It is likely that he had a hypoglycaemic blackout while driving. At the time he seemed to show some awareness of that possibility, telling a police officer "if you think that my diabetes caused an accident you're barking up the wrong tree". When tested at the scene by an ambulance officer, Mr Tipping returned a blood-glucose level (BGL) of 1.4 mmoL/L, a very low reading. At the hearing Mr Tipping explained his statement to the police by saying he was not feeling the symptoms of hypoglycaemia, therefore he did not consider he was hypoglycaemic. He did not know that he had a low BGL reading until after being interviewed by police. He told the court he would have reconsidered his view had he known about the reading.

Mr Tipping's diabetes management

15. The nature of this accident raises the issue of Mr Tipping's diabetes and his management of it.

16. Mr Tipping was diagnosed with diabetes in March 1997 while living in Queensland. On 2 November 2000 he was admitted to a Brisbane hospital with ketoacidosis. In January 2001 his wife, a Royal Australian Air Force officer, was posted to

Kuala Lumpur, Malaysia. He moved with her. Mr Tipping gave evidence that while in Kuala Lumpur he rarely tested his BGL, only doing so whenever his GP, Dr Malkit Singh, requested it. He said that his diabetes was discussed whenever he visited Dr Singh, even if the reason for the visit was not related to his diabetes. Mr Tipping did not drive while in Kuala Lumpur, and thus considered regular testing to be unnecessary. He came to Canberra approximately a month before the accident.

17. In Queensland, Mr Tipping was testing his BGL 3 or 4 times a week. He told the court that he had resumed testing 4 times a week since the accident. At the time of the accident, however, he had not tested at all in the last 4 weeks. This was because his meter was still in storage, waiting for the Defence Housing Authority to find a house for his family. Despite not testing his BGL, Mr Tipping commenced driving during that 4-week period.

18. After a home had been found, and the family's belongings had been delivered, Mr Tipping discovered that the batteries in his meter had run down. It was necessary for him to order new ones, which needed to be shipped to him. This further delayed the resumption of his testing.

19. On the day of the accident, Mr Tipping said he would have had his usual breakfast: 4 Weet-Bix, a couple of slices of toast and a cup of black tea. He had lunch at about midday, consisting of 2 or 3 toasted sandwiches. At around 2pm he had a cup of coffee and some fruit cake.

20. Dr Sonia Stanton, an endocrinologist, gave expert evidence and wrote a report that was admitted as Exhibit B. In her evidence she said that a slice of fruitcake was not an unreasonable expectation for afternoon tea; however, the fact that he recorded a low level at the time of the accident, combined with the presence of moderate ketones in his urine when it was tested at the hospital, suggested an inadequate carbohydrate intake during the day.

21. The most significant point in Dr Stanton's view was the fact that Mr Tipping's BGL could have fallen to the level it did at the time of the accident without him becoming aware that his BGL was getting dangerously low. This suggested to her that he had developed hypoglycaemic unawareness. Hypoglycaemic unawareness is a condition that gradually develops over weeks or months; theoretically, a person can develop unawareness if his or her BGL goes low once every 72 hours, in practice it usually occurs when a person has 1 or 2 periods of low BGL per day for a sustained period.

22. A complicating factor in diabetes management is hypothyroidism. Mr Tipping was apparently diagnosed with this condition some time after the accident. Dr Stanton says that hypothyroidism reduces glucose levels and increases the body's sensitivity to insulin. Mr Tipping's insulin dose had apparently not been adjusted in the two years prior to the accident. Dr Stanton believes that if his hypothyroidism had developed in that time his insulin level would be too high and he would be at increased risk of his glucose falling too low.

23. It is likely that Mr Tipping, at the time of the accident, had developed hypoglycaemic unawareness due to inadequate monitoring of his diabetes, particularly while he was in Malaysia.

PART 3 - ISSUES

Mr Tipping's criminal liability

24. Counsel for the family submitted that I should recommend that charges be laid against Mr Tipping. I do not consider that I should recommend charges.

25. Mr Tipping gave his evidence under a certificate granted pursuant to section 128 of the *Evidence Act 1995* (Cth). This evidence would thus be unavailable in any subsequent prosecution. Without it, a prosecution would have insufficient prospects of success. Furthermore, in his submission, Counsel assisting the Coroner indicated that, were the matter to be referred to the Director of Public Prosecutions under section 58 of the Coroners Act, the prosecution would not be proceeded with.

26. In any event, a prosecution would likely be barred under double jeopardy rules. Charges were in fact laid against Mr Tipping in the Magistrates Court for negligent driving causing death[1] and for failing to stop at a red light.[2] Both charges were dismissed after the prosecution offered no evidence. This dismissal would be likely to enliven the autrefois acquit plea.[3] Nevertheless, this could be debatable due to the fact that Mr Tipping was not exposed to the risk of a valid conviction because no evidence against Mr Tipping was offered by the prosecution. In any event, under the *Crimes Act 1900* as it stood at the time of the accident, a charge of culpable driving might have been barred under

[1] *Road Transport (Safety and Traffic Management) Act 1999* (ACT) s 6(1)(a).
[2] *Australian Road Rules* s 56(1)(a).
[3] *R v Middlesex Quarter Sessions (Chairman); ex parte Director of Public Prosecutions* [1952] 2 QB 758 at 769.

section 29(10) owing to the dismissal of the charges before the Magistrates Court.

27. For these reasons, I do not propose to refer this matter to the Director of Public Prosecutions or recommend Mr Tipping be charged with an offence.

28. I would like to comment on the issue of Mr Tipping's criminal liability in relation to Courtney Meas' death. Ms Courtney Meas was born alive and died after 8 days. The brain injury she sustained was because of the lack of oxygen and blood supply due to her mother dying as a result of the accident injuries.

29. The provision that applies in a similar situation, if it arises now, is section 48A of the Crimes Act, which provides for aggravated offences against pregnant women. This section was inserted in the Crimes Act by the *Crimes (Offences Against Pregnant Women) Amendment Act 2006*.

30. Under section 48A(2), the offence of culpable driving under section 29 of the Crimes Act is an aggravated offence if it was committed against a pregnant woman, and caused the loss of, or serious harm to, the pregnancy, or the death of, or serious harm to, a child born alive as a result of the pregnancy. However, the defendant would not be liable if the defendant proves, on the balance of probabilities, that he or she did not know, or could not reasonably have known, that the woman was pregnant (see, section 48A(3), Crimes Act).

31. Section 48A did not exist during the time the fatal accident that is the subject of this inquest happened in 2003. An offence provision will not have a retrospective effect. Section 25 of *the Human Rights Act 2004* enshrines the right of a person not to be held guilty of a criminal offence because of conduct that was not a criminal offence under Territory law when it was engaged in. I also note that section 84A(1) of the *Legislation Act 2001* clarifies that a law creating an offence operates prospectively only. Even though the aggravated offence provision does not apply in relation to the events that that led to this inquest, I have considered its effect for the reason that it would become relevant if a similar incident arises in the future.

Diabetic drivers

32. The accident that resulted in the death of Ms Stacey Meas and Ms Courtney Meas highlights the dangers diabetes poses for drivers, and raises the issue of how best to reduce those risks.

33. The greatest risk, as illustrated by this case, is that a driver may develop hypoglycaemic unawareness and thus drive with a dangerously low BGL. It is important that drivers with diabetes have proper control of their condition so as not to develop hypoglycaemic unawareness. It is also important for drivers to be educated about the risks associated with diabetes and about how to properly manage their condition. There may be a need for greater awareness of the impact of conditions such as hypothyroidism on diabetes. Another concern is how licensing authorities can ensure that drivers have adequate control of their diabetes.

34. In her evidence, Dr Stanton stated that maintaining appropriate glucose levels is a balancing act involving insulin dosage, food intake and activity level. To ensure adequate monitoring of glucose levels, patients would ideally test their BGL 3 times a day. She advises her patients to test before a meal and again 2 hours after the meal, varying daily which meal the tests are conducted around.

35. In her report, Dr Stanton made some recommendations concerning Mr Tipping's fitness to drive:

> "To satisfy me that he would be a low risk [of] future accidents he would need to regain this [hypoglycaemic] awareness and attend diabetes education preferably at the Canberra Hospital to ensure there are no other gaps in his knowledge of self management of diabetes … In addition I would expect Mr Tipping to test his BGL before driving on all occasions for at least a six month period. He would need to eat extra before driving if his BGL was between 4.0 and 5.0 mmol/L. If his BGL was less than 4.00 mmol/L he would need to agree to eat but not drive and have a further review with Dr Schmidli. He would need to agree to a minimum of three reviews with Dr Schmidli per year with appropriate home testing and pathology testing monitored by Dr Schmidli."

PART 4 – VICTORIAN CORONER'S RECOMMENDATIONS

36. Counsel assisting has drawn my attention to the recommendations made by the Victorian Coroner in the inquest into the death of a Mr Sheriff, who was killed by a truck driven by a diabetic during an episode of hypoglycaemia. In that inquest (2005) the coroner made the following recommendations:

> "1. It is recommended that the guidelines for medical examiners in relation to Commercial Vehicle Drivers be reviewed and the criteria for driving in respect of

Type 1 diabetes ought to be more stringent such that applicants who require insulin therapy shall not be entitled to hold commercial or passenger carrying vehicle licences unless the following criteria are satisfied:

a) the patient retains an appropriate specialist that he/she is required to attend four times per year (or with such other regularity as the specialist certifies as appropriate);

b) the patient submits to regular Hb Alc testing as the specialist deems appropriate;

c) the patient provides regular proof to the specialist of blood sugar level testing (ideally a downloaded log from a memory equipped blood glucose meter) as regularly as the specialist deems appropriate;

d) the specialist certifies to VicRoads on a yearly basis that the patient's diabetes is under control;

e) the patient adhere to an appropriate diet and regime of medication that may be established by the specialist;

f) in the event of the patient suffering any hypoglcaemic episode involving loss of consciousness or loss of control of motor ability, the specialist, or any other medical practitioner, or the police, should formally report the matter to VicRoads and the person's commercial vehicle licence should be suspended; and

g) in the event of a hypoglycaemic episode as above, the licence should not be reinstated unless the specialist certifies that:

    i) a period of 12 months has elapsed during which there has been no further hypoglycaemic episodes;

    (ii) the specialist is satisfied as to the cause of the previous hypoglycaemic event; and

    (iii) the specialist is satisfied no further hypoglycaemic event will occur without

there being some forewarning to the patient.

2. That VicRoads clearly communicate the above criteria to the diabetic driver so that he/she is aware that the commercial vehicle drivers licence is conditional upon meeting and abiding by the criteria, and that any breach will result in a suspension of the licence."[4]

37. Counsel assisting submits that I should make these recommendations in respect of any driver, irrespective of licence class, who has a history of hypoglycaemic episodes.

PART 5 – MY RECOMMENDATIONS

38. The accident which caused the death of Ms Stacey Meas and her child, Ms Courtney Meas, might have been avoidable. Being an insulin-dependent driver, Mr Tipping would have discharged his responsibility to drive safely, had he maintained a regime of appropriate and regular care about his diabetic condition. Evidence suggests that Mr Tipping was unaware of the onset of hypoglycaemic attack he had and did not, in previous years, have perception about the symptoms preceding hypoglycaemia.

39. Even though a reasonable adult driver of a vehicle takes precautions about road safety measures, there may be instances where the driver's mind might assign a low priority to how the driver manages his or her own medical condition that impacts on the driving ability. This may be because of a belief the driver may entertain that the matter is personal to him or her. What should always be remembered is that it really is not a personal matter but that impacts on the driver's ability to drive safely and calls for a high level of responsibility from a driver towards the safety of others, mainly, other road users. The seriousness of the driver's responsibility to take care of his or her medical condition will need to be conveyed strongly to the community. This will be achieved only if it is supported by an enforceable regulatory regime of reviewable driver licence conditions and changes to law.

40. In formulating my recommendations, I have been helped by the standards developed by the National Transport Commission (NTC) and Austroads and included in their publication *Assessing Fitness to Drive*[5], in relation to

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[4] Submission of Mr Lawton, Counsel assisting the Coroner, .
[5] *Assessing Fitness to Drive* (Austroads, 2003, Reprint, October 2006).

licensing drivers with insulin-requiring diabetes; the opinion and evidence of Dr Sonia Stanton, endocrinologist; and the Victorian Coroner's recommendations in the inquest into the death of Sheriff. In the circumstances of the current inquest, my recommendations will need to be with regard to the licensing of private vehicle drivers.

41. In relation to private vehicle drivers with insulin-requiring diabetes mellitus (both Types 1 and 2), the NTC recommends that a "conditional licence may be granted, taking into account the opinion of the treating doctor/GP, and the nature of the driving task, and **subject to at least 2 yearly review**
    - If the condition is well controlled; **and**
    - There is an absence of defined hypoglycaemic episodes and there is awareness of hypoglycaemia sufficient to stop driving a vehicle; **and**
    - There is an absence of end organ effects which may affect driving……"[6]

    End organ effects are "on relevant functions, including effects on vision, the heart, the peripheral nerves and vasculature of the extremities, particularly the feet".[7]

42. A defined hypoglycaemic event "is one of sufficient severity to cause impairment of perception or motor skills, abnormal behaviour or impairment of consciousness."[8]I understand that defined hypoglycaemia is where a person needs the help of another to get out of it. "It is to be distinguished from mild hypoglycaemic symptoms such as sweating, tremulousness, hunger, tingling around the mouth, etc which are common occurrences in the life of a person with diabetes treated with insulin and some hypoglycaemic agents".[9]

43. Where a **defined hypoglycaemic episode** occurs "in a previously well controlled person" the NTC recommends that " they generally should not drive for **6 weeks** depending on identification of the reason for the episode, and a specialist opinion. In the event of a defined hypoglycaemic episode being associated with a motor vehicle crash the Driver Licensing Authority must be notified".[10]

44. Dr Stanton in her evidence at the inquest said that persons with Type 1 diabetes should be seen by a specialist, and

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[6] Ibid, p.49.
[7] Ibid, p.48.
[8] Ibid, p.48.
[9] Ibid, p.48.
[10] Ibid, p.50.

there are "some general practitioners who are happy to manage Type 1 diabetes and have taken aboard extra training and that is fine". She also said that that drivers with Type 1 diabetes "should be seen at an absolute minimum twice a year if things are well controlled. But I advise three to four times a year, usually each four months".

45. I now turn to the *Road Transport (Driver Licensing) Regulation 2000* which sets out the requirements for driver licences, including conditional driver licences. Regulation 15 provides that the required medical standards for driver licence purposes are "are the medical standards set out in the publication *Assessing Fitness to Drive*, as amended from time to time, published by Austroads Incorporated, that apply to the person".

46. Regulation 69(6)(d) – (g) enables the road transport authority to require an applicant for the issue or variation of a driver licence to undergo a medical examination; provide a report of the examination or other evidence of compliance with the required medical standards; provide information about an illness, injury or incapacity suffered by the person or the effects of treatment for any illness, injury or incapacity; and to provide any documents relevant to the person's medical fitness to hold a driver licence. Whether to ask a person to comply with any of these requirements seems to be at the discretion of the authority.

47. Regulation 77(1) prohibits a driver licence holder to drive a vehicle on a road or road related area if his or her ability to drive safely is impaired by an illness, injury or incapacity or the effects of treatment for any illness, injury or incapacity. Regulation 77(2) makes it an offence if a driver licence holder does not tell the road transport authority within 7 days of suffering any permanent or long-term illness, injury or incapacity that may impair his or her ability to drive safely.

48. The authority may refuse to issue a driver licence if satisfied on reasonable grounds that the person does not meet the required medical standards (Regulation 70). It may require a driver licence holder to undergo medical examination (Regulation 78) and also vary, suspend or cancel a licence if the person does not comply with the required medical standards (Regulation 87).

49. It appears that the only provision in the Regulation that obliges a person to disclose to the road transport authority about illness that impairs the ability to drive safely is

regulation 77(2). I note that the obligation is a general one and does not specify insulin-requiring diabetes as an illness to be disclosed. I also note that the obligation does apply to driver licence holders but not to applicants for a driver licence. Nevertheless, the current forms for application for, and renewal of, driver licence specifically ask the question whether the applicant has diabetes. While I welcome this feature, I also think the high importance of the duty to disclose insulin-requiring diabetes to the road transport authority will be given due recognition only if there is an explicit statutory provision.

50. Arguably, regulation 77(2) would not appear to address the situation where, for example, a driver licence holder believes his or her diabetes does not impair the ability to drive safely because the person has taken care to regularly test his or her BGL, have a medical review periodically, and follow proper food and insulin intake. On the other hand, it could be argued that the reality is that it is an illness that impairs the ability to drive safely irrespective of the fact that with a control regime, the driver could drive 'safely'. These interpretations mean that the provision must be made explicit enough, as I mentioned in paragraph 49 above, for making it clear that it is compulsory to disclose insulin-requiring diabetes.

51. I understand that in managing driver licences for persons with insulin-requiring diabetes

- the road transport authority will, on receiving information that an applicant has insulin-requiring diabetes, require the person to submit the relevant medical reports and may ask him or her to undergo medical examination, before deciding on what conditions to apply to the driver licence;
- the authority implements the standards in the *Assessing Fitness to Drive* publication in relation to insulin-requiring diabetic drivers;
- the standards in the *Assessing Fitness to Drive* publication are not conditions on a licence but conditions to hold a licence in the sense that they are available in the authority's database;
- it is the policy of the road transport authority that drivers with a medical condition, including insulin-requiring diabetes, are required to submit subsequent medical reports at the frequency set out in the *Assessing Fitness to Drive* publication, unless different medical advice is received for the individual; and

- the authority's database will automatically print a medical form to be sent to licence holders at the required frequency, and if the form is not completed and submitted by the due date, the database will automatically produce a warning of licence suspension and the licence will be suspended automatically if the medical information is not received.

52. The tragic events in the context of this inquest seriously warrant that driving by a person diagnosed with insulin-requiring diabetes should be controlled not only by self-management of medical condition but also by regulatory measures that deal with this illness explicitly. A measure that the road transport authority may consider in the interest of the road safety would be to convert the conditions for an insulin-requiring driver to hold a licence into licence conditions. Licence conditions would ensure that drivers know those conditions, in particular, without waiting to be notified by the authority. Observing licence conditions would be an exercise of diligence expected of a driver, while its effect would be to limit the opportunity a negligent or reckless driver has to escape liability by pleading ignorance of the conditions.

53. I note that the recommendations in the Sheriff inquest were made in relation to commercial vehicle driver licensing but they are also relevant to consider, in the context of our inquest, in relation to private vehicle driver licensing.

54. In view of what I have said above, and in the interest of the road safety, I recommend that the government strongly consider:

- making important conditions for an insulin-requiring diabetic driver to hold a licence into licence conditions, as I have mentioned in paragraph 52, subject, of course, to modifications the conditions may require in light of my other recommendations below;

- providing for a specific obligation of an applicant for a private vehicle driver licence to inform the road transport authority if he or she was diagnosed with insulin-requiring diabetes, and to furnish a medical report from a specialist setting out the current treatment regime and any comments the specialist has about the applicant's driving ability, including the limitations to driving that the applicant will need to observe;

- providing for a specific obligation of a private vehicle driver licence holder to inform the road transport authority as soon as he or she is diagnosed with insulin-requiring diabetes, and to furnish a medical report from a specialist setting out the current treatment regime and any comments the specialist has about the applicant's driving ability, including the limitations to driving that the applicant will need to observe;

- providing that a licence issued to a private vehicle driver licence holder who is diagnosed with insulin-requiring diabetes should be subject to the following conditions:

  (1) that the licence holder retain a specialist, or a doctor who has training in relation to managing such diabetes, and at least attend three times a year (or with such other regularity as the specialist or the doctor certifies as appropriate); and
  (2) that the licence holder provide a certificate annually from the specialist or the doctor that his or her diabetes is under control and would not impair his or her ability to drive for a stated period of time;

- requiring a medical professional, a specialist or a doctor, who treats a person who is a private vehicle driver licence holder, or the police, to report to the road transport authority if the person suffers any hypoglycaemic episode, and to provide for the authority to immediately suspend the driver licence;

- not reinstating the driver licence in the event of a hypoglycaemic episode as above, unless the specialist (not a doctor with training in managing insulin-requiring diabetes) certifies that:

  a) a period of 12 months has elapsed during which there has been no further hypoglycaemic episodes;

  b) the specialist is satisfied as to the cause of the previous hypoglycaemic event; and

  c) the specialist is satisfied no further hypoglycaemic event will occur without there being some forewarning to the patient; and

- requiring that the road transport authority clearly communicate the above conditions to a diabetic driver so that he or she is aware that the private vehicle driver licence is subject to his or her meeting and abiding by the conditions and that non-compliance will result in a suspension of the licence or not reinstating the suspended licence, as the case may be.

55. I would like to point out that the recommendation not to reinstate without a specialist certificate the driver licence of person who suffered a hypoglycaemic attack, which is an adaptation of the recommendation in the Sheriff inquest, is more stringent than the standard set out in the *Assessing Fitness to Drive* report for dealing with drivers who had an episode of hypoglycaemia. The standard in the report states that generally a person should not drive for 6 weeks after a defined hypoglycaemic episode depending on the identification of the reason for the episode, and a specialist opinion.[11] I think this standard is inadequate as a measure to avert the horrific circumstances of the type that we have now found in this inquest that hypoglycaemia in a driver could bring about.

56. In my recommendations any reference to hypoglycaemic episode is "one of sufficient severity to cause impairment of perception or motor skills, abnormal behaviour or impairment of consciousness", as defined in the *Assessing Fitness to Drive* publication.[12]

57. I have approached this case with a particular interest because I myself am a diabetic. The evaluation of my recommendations should be done in consultation with relevant stakeholders, including health professionals and authorities, with due regard being paid to the views of Diabetes ACT and organisations that represent the interests of diabetics in the Territory.

58. There needs to be a balance between the interests of public safety and the need to ensure that there is no undue abrogation of the rights of people who may suffer diabetes and reasonably expect to drive.

59. My recommendations here are restricted to situations of diabetic drivers. However, the principles may also apply to other medical conditions such as heart condition and epilepsy.

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[11] Ibid, p.50.
[12] Ibid, p.48 (see, paragraph 42 of these findings.)

60. Finally, I express my personal sympathy to Mr Veasna Meas and the relatives of Ms Stacey Meas and Ms Courtney Meas.