SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 4th, 5th, 6th, 7th days of April, 2001 and the 5th day of October, 2001, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Shantel Lisa Bednarek.

I, the said Coroner, find that, Shantel Lisa Bednarek aged 7 years, late of 32 Eugene Crescent, Parafield Gardens, South Australia, died at Parafield Gardens on the 9th day of February, 1999 as a result of multiple abdominal injuries including traumatic rupture of the liver and stomach. I find that the circumstances of the death were as follows:

1. Introduction

1.1. On 9 February 1999 a vehicular accident occurred when a Mitsubishi Lancer sedan being driven by Gregory Howard Johnson left the Salisbury Highway and collided with the kerb at the corner of that road and Lavender Drive at Parafield Gardens. Having hit the kerb, the car reared up onto the footpath, then collided with a stobie pole. This caused the car to spin in a clockwise direction, and collide with a group of pedestrians who had been walking along the footpath on the western side of the carriageway.

1.2. As a result of the collision, Shantel Lisa Bednarek, aged 7, suffered massive internal injuries, and died instantly. A number of the other pedestrians, including Shantel's mother, Mrs Christine Bednarek, Ms Pauline Pollard, and children including Jimmy Magro (aged 14) and John Magro (aged 4) suffered injuries. Mr Johnson also suffered injuries.

1.3. Cause of death

A post-mortem examination of the body of the deceased was performed by Dr R A James, Chief Forensic Pathologist, on 10 February 1999. Dr James concluded that the cause of death was 'multiple abdominal injuries including traumatic rupture of the liver and stomach'. He described these injuries as 'untreatable' (exhibit C3a, p4).

1.4. Criminal charges

As a result of these events, Mr Johnson was charged with causing death by culpable driving and other charges. However, on 15 March 2000 the Director of Public Prosecutions tendered no evidence to the Elizabeth Magistrates Court, and the charges were dismissed for want of prosecution.

2. The Investigation

2.1. The circumstances of the accident were investigated by the Major Crash Investigation Section of the South Australia Police ('SAPOL').

2.2. When interviewed by Senior Constable Wasley on 8 June 1999, after receiving legal advice, Mr Johnson declined to answer questions apart from acknowledging that he was the driver of the car in question, as he was obliged to do by law.

2.3. At about 7.10pm on 9 February 1999, Mr Tony Ashby was driving his car behind Mr Johnson's car, north along the Salisbury Highway at about 60 kilometres per hour in the left of two lanes. A 'B-Double' car carrier was overtaking them both at the time. He said that without warning, Mr Johnson's car veered to the left. He said:

> 'I was about 30 metres from the junction when I noticed this blue car suddenly go to the left. It appeared to me as thought it was suddenly turning left into Lavender Drive. There was no indication and it didn't slow down. It just suddenly turned left. It came close to the kerb on the south western corner of the junction but missed it. As it just missed this kerb the car suddenly flicked out to the right as though the driver tried to correct his turn. The right side of the car went down a bit and he put himself on an angle as though he wanted to come back out onto Salisbury Highway.
>
> …The car mounted the kerb on the north western corner and I believe the back section on the left hand side collided with the fence of the house on the north western corner. The front right collided with a stobie pole on Salisbury Highway just north of the junction. It then seemed to bounce up and stop.
>
> At the time this car went left, the B-Double, which was still in the right hand lane, was overtaking this car. It would have been blocking the junction. The prime mover section was ahead of this car and the car would have been half way along it as it turned left.

> Both vehicles were in their correct lanes and although the B-Double was overtaking it they were both in the centre of their lanes. You could have easily safely put a motor bike between them. There was no movement from the B-Double which even suggested it was moving to its left to have caused concern to the blue car.'
>
> (Exhibit C11a, p2-3)

2.4. Matthew Deller was also driving his car north on Salisbury Highway at the time. He was in the parking lane, intending to turn left into Lavender Drive, travelling at less than 30 kilometres per hour. He said:

> 'At this time my attention was suddenly drawn to a blue coloured Lancer GLI. I had been looking to my left in preparation to make my left turn into Lavender Drive when suddenly this car was just there, on my right hand side. It must have overtaken me on the right hand side but I didn't see it come from behind me and my attention was only drawn to it then because of the sounds like the skidding of tyres.
>
> A split second after I first saw the car I realised it was facing at a slight angle to the direction of the road so that the front of it was pointing straight at the stobie pole that is on the north-western corner of the junction.
>
> It seemed to me to have still been travelling quite quickly because this sound like tyres skidding lasted only about one (1) to one and a half (1½) seconds. It was a very short period of time but I believe the car was still travelling at a speed possibly as high as 60-70 km/h, the speed limit.
>
> I began to turn left but looked to my right in time to see the front of the Lancer lift into the air in the area of the kerbing on the opposite side of the junction to me. The front of the Lancer then hit the stobie pole while it was airborne. It may have been as much as half (½) a metre off the ground. It was hard to tell because it was so quick.
>
> The car then rotated clockwise around the pole and I saw it crash into the front fence of the house on the corner and stop with the back of it hanging on the fence.'
>
> (Exhibit C12a, p2)

2.5. Mr Deller's evidence of the sound of tyres skidding seems consistent with Mr Ashby's evidence that there was an apparent attempt to correct the car's direction of travel before the impact, suggesting that if Mr Johnson's conscious state was impaired, the impairment was not total.

2.6. The driver of the B-Double, Peter Grillett, said that he was still south of the Lavender Drive corner when he saw the car after the crash (Exhibit C14a, p2). Implicit in his evidence was that there had been no contact between Mr Johnson's car and his truck prior to the accident.

2.7. James Price was driving a Bull's Transport semi-trailer north on Salisbury Highway, in front of the B-Double. He saw in his mirrors that the B-Double had pulled over, so he did the same. He said he did not see Mr Johnson's car prior to the accident (Exhibit C15a, p3).

2.8. Mr Grillett mentioned in his statement that both he and Mr Price checked Price's truck for signs of damage but there were none. He said the police also checked his truck, and there were no signs of damage on it either (Exhibit C14a, p3).

2.9. Susan Magro said that Mr Johnson's car did not brake before the accident, and that its engine was on 'maximum revs' as it came across the junction at an angle (C9a, p3).

2.10. None of the other pedestrians were able to provide any more information about the movement of the car prior to the accident. Of course, the car was badly damaged, but Vehicle Examiner Elliot McDonald was unable to detect any mechanical defects in it which would have caused or contributed to the accident. He said that the vehicle appeared to have been in good condition prior to the collision (Exhibit C25a, p4).

2.11. Mr Johnson's condition at the scene

One of the paramedics who attended the scene was Mr Christopher Paton. He said that it was suspected that Mr Johnson had suffered a right pneumothorax (punctured lung), abdominal injury and leg injuries. He was trapped in the car.

2.12. On examination, Mr Johnson was conscious, alert, had a fast pulse (118) and a blood sugar level ("BSL") of 3.0 minimoles per litre (Exhibit C17a, p2). Mr Paton said that he knew Mr Johnson was an insulin-dependent diabetic.

He said he was pale, clammy and sweating, which was consistent with either hypoglycaemia (low blood/sugar level) or shock (Exhibit C17a, p3).

2.13. Mr Johnson was conveyed to the Royal Adelaide Hospital where the casenotes (Exhibit C36) record that he had suffered lacerations to his right elbow, left knee and right thigh which were treated and sutured. He told staff there that he had no recollection of the accident. On admission, his BSL had risen to 6.5 mmol/Litre (he had received intravenous glucose en route), and was 8.6 mmol/Litre by 10.30pm that night.

2.14. Mr Johnson was reviewed by a Registered Medical Officer from Endocrinology on 12 February 1999, who conducted a limited examination and suggested certain follow-up action in relation to his diabetes.

2.15. A letter dated 11 February 1999 from Dr C Trewin, Trauma Registrar, to Dr L Trbovic, Mr Johnson's general practitioner, advised him of the accident, gave details of his physical injuries and treatment. No mention was made of his diabetes or whether it was considered relevant to the accident.

2.16. Blood taken from Mr Johnson after the accident did not contain alcohol (Exhibit C5a).

2.17. Mr Johnson gave evidence at the Inquest that he is unable to recall the accident at all. He said:

> A: 'The last thing I remember before the accident I had, as I recall, I was in the right hand lane and decided that because I was going to continue on straight I would move to the left hand land to get out of the way of those people who wished to turn, and also I didn't wan to hold traffic up.
>
> Q: This is on Salisbury Highway.
>
> A: This is on Salisbury Highway, sorry, yes, so I made the decision that I would get into the left hand lane and that's basically the last thing I can remember.
>
> Q: At the time you made that decision do you remember how you felt.
>
> A: I felt perfectly normal, perfectly lucid.
>
> Q: And what's your next recollection after that.
>
> A: My next recollection after that is of an emergency worker of some sort coming to me and saying it's okay we'll get you out of the car shortly, you'll be fine.' (T20)

2.18. Mr Johnson told Mr McRae, Counsel for Mrs Magro and her children, that on all previous occasions when he had suffered an attack of hypoglycaemia, he had been aware of warning signs. He said:

> '… in my waking hours… there's never been a time when I haven't been aware that it's (hypoglycaemia) going to happen." (T21)

2.19. This stance was modified somewhat when he was asked the cause of the accident. He said:

> 'Can I preface this by saying I didn't think it was my diabetes because, as I've already stated, unless I was asleep, which I wasn't, I was always aware that something was going to happen. On this particular occasion, if it did happen, then it must have been a complete blackout because I recall absolutely nothing about any of those type of feelings that I'd associate with going into hypoglycaemia. Secondly, I do recall there being a truck in the left lane. Now, obviously I don't know, and I can't prove anything, but I have my suspicions that we actually crossed lanes – that he was moving into the right as I was moving into the left. I can only go by – and understand I don't have any memory of the accident whatsoever, so it's impossible for me to say for sure – but on reading subsequent reports, I believe a truck driver stopped another truck driver and said I think I've just collided with that car. He didn't say that he hit me or I hit him, he just said that he'd had a collision. Now to me a small car that I was driving hitting a truck, it would have been a fair sort of a thump for him to think that in the first place.' (T92, 93)

2.20. For the reasons that I have already outlined, particularly that of Mr Ashby, I reject the suggestion that the accident was caused by a collision with one of the two trucks in the area, or that any of the vehicles were changing lanes at the time.

2.21. It seem to me that the only plausible explanation for what happened is that Mr Johnson lost control of his vehicle, either through inattention, which seems implausible, or because his consciousness became impaired. Although there is some evidence of evasive or corrective action in the description given by Mr Ashby quoted above, this does not exclude impaired consciousness, since the action was far too late to be effective, suggesting a very delayed response. The impairment of consciousness could have arisen from a number of factors – tiredness and hypoglycaemia being the most likely in Mr Johnson's case. Since it was not late, and he was not tired (T93), hypoglycaemia seems the most plausible explanation. In order to examine this possibility more fully, it is necessary to examine in some detail the history of Mr Johnson's diabetes.

3. History of Diabetes

3.1 Insulin dependent diabetes mellitus (IDDM) is a condition in which the concentration of glucose in the blood is raised due to a deficiency in the production of the pancreatic hormone, insulin. Treatment involves the administration of insulin by injection. It is an increasingly common disease. Dr Wilton Braund, a consultant endocrinologist who gave evidence at the Inquest, told me that the incidence of the disease has increased to the extent that it has become "pandemic". The incidence has risen from 2% to 7.6% of the population during his career (T311).

3.2 One of the complications of the disease is hypoglycaemia, or low blood glucose (sugar) levels, which can result from too much insulin. Symptoms include confusion, hunger, sweating, pallor and , in severe cases, loss of consciousness, coma, epileptic convulsion and even death.

3.3 Mr Johnson was first diagnosed with diabetes in January 1995. He went to his general practitioner, Dr Luban Trbovic, complaining of weight loss, excessive thirst and frequent urination. Tests suggested diabetes. Dr Trbovic referred Mr Johnson to Dr Charles Wong, a specialist physician. (T227).

3.4 Dr Wong confirmed the diagnosis of IDDM, and commenced insulin therapy. He advised Dr Trbovic by letter dated 18 July 1995 that Mr Johnson's diabetes was not "well controlled" and suggested review (presumably meaning re-referral) in a year's time. This did not occur.

3.5 In compliance with the Motor Vehicles Act, Mr Johnson reported his condition to the Department of Transport ("DOT") and his drivers licence was duly endorsed. This meant that he was required to provide an annual medical certificate of his fitness to drive.

3.6 On 6 June 1996 Dr Trbovic provided the first of several such certificates (the bundle is marked Exhibit C32a). To the question whether Mr Johnson had diabetes, Dr Trbovic ticked "yes". To the question whether he had ever suffered hypoglycaemic reactions, he ticked "no".

Dr Trbovic told me that he asked Mr Johnson whether he was having any "hypos", and relied upon his answer, when filling out the form (T234). Mr Johnson denied that, saying:

> 'He never asked me did I suffer from hypoglycaemia or anything else, ….Dr Trbovic filled the form out and handed it back to me' (T78).

3.7 Without informing Dr Trbovic, Mr Johnson also went to see Dr Christopher Bollen at Ingle Farm in relation to his diabetes, the first occasion being 16 September 1996. Dr Trbovic told me that he had no idea that Mr Johnson was also seeing Dr Bollen until this year (T234). Equally, Dr Bollen told me that Mr Johnson did not tell him that he was still consulting Dr Trbovic (T124-5).

3.8 Mr Johnson denied he was "doctor shopping". He explained that he went to the two doctors because:

> 'Dr Trbovic because he lived not far from me and it was handy if I needed to see a doctor in a hurry, I could do that. Dr Bollen because he had a special interest in diabetes and so therefore without wanting to sound like a smart alec, he probably had a little more expertise in the area in my opinion' (T25).

In fact, Dr Bollen had a special interest in Type 2 diabetes, that is non-insulin dependent diabetes, which is a completely different disorder (T104).

3.9 On 16 September 1996, Mr Johnson complained to Dr Bollen of "some episodes of blurred vision" (T105). He referred Mr Johnson to an eye specialist, Dr K C Perks, but he found no abnormality, and, in particular no diabetic retinopathy (part of Dr Bollen's casenotes, Exhibit 30).

3.10 Dr Bollen did not see Mr Johnson again until 20 May 1997. In the meantime, Mr Johnson had seen Dr Trbovic again on 4 April 1997 for another medical certificate for his driving licence, which Dr Trbovic filled out in the same way as he did in 1996. The fact that Mr Johnson went back to Dr Trbovic for the certificate, but continued to consult Dr Bollen because he thought he had superior expertise in treating diabetes, and did not tell either doctor about the other, gives rise to the strong suspicion that Mr Johnson was 'doctor shopping'.

3.11 In fact, Mr Johnson told Dr Bollen on 20 May 1997 that he had suffered "several hypos recently". Dr Bollen's note goes on to read:

> 'has been steadily increasing insulin without monitoring blood sugar levels' (T130)

Dr Bollen told me that Mr Johnson's actions in increasing his insulin dose would have tended to reduce the blood/sugar level, thereby increasing the risk of "hypos" (T109). Clearly, Mr Johnson did not know what he was doing when trying to self-medicate. Additionally, he was failing to monitor his BSL's, which he should have been doing at least once a day, using a glucometer. Mr Johnson denied this evidence, suggesting that Dr Bollen had made a mistake (T95).

3.12 It was at this point that Dr Bollen might have considered his responsibilities under Section 148 of the Motor Vehicles Act. He knew that Mr Johnson was having "hypos", that his BSL's were unstable, and that they were not being monitored adequately. I will deal with this issue again later.

3.13 Dr Bollen saw Mr Johnson again three days later on 23 May 1997. His BSL, after fasting, was 10.7 which was "higher than you'd want but not terrible" (T112).

3.14 From that time until 6 June 1997, Mr Johnson kept a diary of his BSL's, which varied between 1.9 and 8.0. Dr Bollen decided to reduce the insulin over the next two weeks. In fact, as I will presently discuss, a level of 1.9 is alarmingly low, and Mr Johnson was, by definition, hypoglycaemic at that time. Again, Dr Bollen took no action in relation to Mr Johnson's driving licence.

3.15 Mr Johnson saw Dr Bollen again on 11 July 1997 when it was noted that he was "very good" on the current medication, and that he was "more motivated" (T113). Dr Bollen asked to check Mr Johnson again in October, but Mr Johnson did not return.

3.16 Mr Johnson went back to Dr Trbovic in September and October 1997, a prescription for insulin being given on the latter occasion. Dr Trbovic did not discuss with Mr Johnson the fact that he had not been back since 4 April.

3.17 On 9 March 1998 Dr Trbovic signed another medical certificate, again certifying that Mr Johnson had not suffered hypoglycaemic reactions. He took a blood sample on 14 March 1998, apparently for the first time.

3.18 In early May 1998 Mr Johnson started work as a car salesman with Adrian Brien Ford at St Mary's. He disclosed his diabetes to his new employer.

3.19 <u>Major hypoglycaemic episode</u>

On 15 September 1999, Mr Johnson's manager, Mr Martin Humpel, noticed that he appeared 'flustered" while talking to customers. He said he approached Mr Johnson and asked him if he was alright and that Mr Johnson told him he was "aware" of what was happening and that he would "fix" it.

3.20 About 15 minutes later, Mr Humpel was called back to the showroom. He said:

> 'On returning I entered the showroom and found Greg in his office at his desk and he appeared very distressed. He appeared very emotional and I asked if he was alright.'
>
> (Mr Humpel then called an ambulance).
>
> 'While I was making these phone calls Greg was still carrying on yelling, banging his head and thumping his desk. On returning to Greg's office Julie Randall and another person Craig Bugden, who was also a First Aider, arrived and Greg by this time was on the floor carrying on.

We removed the desks and furniture to get them out of Greg's way as he was flinging himself about hitting things as he was violent in his movements. We tried to hold him down and about the same time the ambulance arrived and took over.

I saw the ambulance personnel put a drip in him and injected him with something, after which he calmed down fairly quickly. They were with him for some 40 to 45 minutes before taking him off to hospital.'

(Exhibit C29a, p2-3)

3.21 Mr Johnson was taken to Flinders Medical Centre ("FMC"), and was treated initially in the Accident and Emergency Department. He was later admitted to the Diabetes Unit, which was described by Dr Amanda Terry, a consultant endocrinologist, as consisting of a "variety of subspecialties all involved with the management of diabetes" (T149).

3.22 FMC staff were told that Mr Johnson had been given intravenous dextrose by the ambulance officers at the scene, and that the seizure stopped soon afterwards. That, combined with the low BSL found by the ambulance officer, the nature of his collapse, and Mr Johnson's diabetic history, all led to the conclusion that Mr Johnson had suffered a severe hypoglycaemic episode at work (T151).

3.23 Dr Terry described the symptoms of a "hypo" as follows:

"A Normally if somebody's sugar level was falling they would initially start – it varies from person to person, but the standard sort of symptoms that are described are that of feeling shaky, feeling hungry, clammy, sick, and those symptoms will last for a variable time but usually anywhere from five minutes up to 20 minutes or so and that would be the time when normally a diabetic would realise that their sugar was going low and would treat that. Following those symptoms, the symptoms will become more severe as the sugar gets lower, and that's when behaviour changes start to develop, the person becomes less aware that they're suffering from a low sugar level, they become confused, they behave differently, and eventually they can become unconscious and even fit.

Q: Is it the case that every patient will have that sequence of symptoms or do some patients move from being quite well to being quite ill quite quickly?

A: The duration of the symptoms depends on how quickly the sugar level is falling, so the slower the fall of the blood sugar level the longer the symptoms will last. All diabetics when they first develop diabetes, when they develop a low sugar, will get basically those symptoms. Some diabetics, a minority fortunately, after they've had diabetes for some time, will lose some of those early symptoms, so they develop what we call hypoglycaemia unawareness, so they don't get those early warning signs that enables them to treat their sugar appropriately and they go straight into the sort of confused behaviour change stage.' (T152)."

3.24 It was concluded that Mr Johnson was one of those small numbers of people who had "hypoglycaemia unawareness" because:

- "he had no recall of any hypoglycaemic symptoms prior to the seizure (this is confirmed in a note made by the Registrar, Dr George, in the casenotes for 15/9/98 at 1630 hours);
- an unidentified "co worker" told Dr George on 16 September 1998 that Mr Johnson had been having "funny turns" for some time, regularly for the past 4-5 weeks, around two times a week, and that these turns had stopped if he had a sweet drink or a chocolate bar;
- On 16 September, Mr Johnson's BSL was as low as 2.6 without symptoms, although he was observed to appear "drunk" after a walk.'

After this last episode, the Registrar, Dr Amanda George, commented in the casenotes:

'Definite hypoglycaemia unawareness'

Unfortunately Dr George was not available to give oral evidence, since she has returned to the Bahamas, but this evidence was give by Dr Terry from the casenotes (T153).

3.25 Because of Mr Johnson's unawareness, Dr Terry said that the aim was to keep his BSL between 8.0 and 9.0, to avoid hypoglycaemia. With an aware patient, the levels are kept between 6.0 and 7.0 where possible (T153).

3.26 Another concern was that Mr Johnson was not monitoring his BSL's adequately. He told FMC staff that he was only testing himself two or three times a week, whereas he should have been testing himself two to four times daily, and on <u>every</u> occasion before driving and he should not have driven unless his level was above 5.0 (T156). Mr Johnson denied this evidence saying that he tested himself two or three times a day (T94). I reject this evidence in favour of the admission he made to Flinders Medical Centre staff.

3.27 <u>Driving Instructions</u>

Dr Terry saw Mr Johnson for the first time on 16 September 1990. The note made by the intern reads:

'He cannot drive for some time"

Although she was unable to recall the conversation, Dr Terry said that she would have advised Mr Johnson as follows:

> 'What I would have said to him was that because he had had a seizure he was not able to drive until that had been sorted out. So first of all to exclude any other cause for it. And secondly because of the diabetes that he could not drive until –well, because of the hypoglycaemia unawareness, that he could not drive until that was sorted out as well. And by sorted out I would have said that he was not having episodes of hypoglycaemia and that he was clearly documenting his blood glucose levels, that he was measuring them frequently and that he was measuring them prior to driving.' (T157-158)

One issue which needed to be "sorted out" was whether there was a neurological cause for his seizure.

3.28 In another note, dated 17 September 1998, Dr George wrote:

> 'Not to drive until EEG result known. See me in OP after EEG.'

Mr Johnson was discharged on that day.

The EEG results did not become available until 29 September 1998. The results were normal. There is no record of whether Mr Johnson was given any further advice about whether or not he should drive.

3.29 When Mr Johnson was discharged from FMC on 17 September 1998 a Discharge Summary was prepared, both in handwritten and typed form. The typed version is signed by Dr Terry. The handwritten version is signed by Dr George. It states that Mr Johnson was given instruction to monitor his glucose five times daily. The opening paragraph of the Summary is the following statement:

> 'Information to Patient and Relatives
> Diabetes education. Education re hypoglycaemia.
> Driving restrictions for three months of documentation of being free from hypoglycaemia.'
>
> (Exhibit C31a)

3.30 Ms Andrea Morrison, the Occupational Health and Safety Coordinator at Adrian Brien Ford at that time, said that Mr Johnson returned to work on 23 September 1998, with a certificate that he was fit to return to work. The certificate (part of Exhibit 37) does not refer to his fitness to drive. Ms Morrison said:

> 'On returning to work I recall speaking to him and asking him how he felt and if he was okay to continue work. I recall asking him about his driver's licence and he stated that the Flinders Medical Centre had discussed that issue and they had considered he was still fit to drive. I believe the doctors had allowed Greg to return to normal duties, which included driving.'
>
> (Exhibit C28a, p3)

3.31 Mr Johnson said he did not recall being given any advice that he was not to drive for any period of time(T17, 87), I reject this evidence. I accept Dr Terry's evidence about what she told him, that he was not to drive until things were "sorted out", but she was regrettably vague about the period.

3.32 Mr Johnson was seen by Dr Trbovic on 19 September 1998, two days after discharge. Dr Trbovic said that he told him about the hypoglycaemic episode leading to his admission. (T239). He said that he was unsure whether he discussed driving with Mr Johnson, but he had noted the Discharge Summary and presumed that he was not driving (T240).

3.33 On 28 September 1998, Mr Johnson telephoned the Diabetic Educator at FMC. The note records that he told her that he was still concerned about asymptomatic hypoglycaemic episodes. He was monitoring his BSL's and was getting readings as low as 1.2 and 1.8. It was remarkable that he was not getting hypoglycaemic symptoms at that level. He must have been aware that these readings were too low.

3.34 Mr Johnson telephoned Dr George on 1 October 1998 and 7 October 1998, and was clearly still unstable. He came in and saw Dr George on 26 October 1998 and she changed his dose again because his levels were so erratic. The note reads that he was asked to call back in four days, but he failed to do so.

3.35 Dr Terry said that Mr Johnson was clearly unfit to drive, since his BSL's were so erratic and the dose and type of insulin were still being changed. Although she was sure that Dr George would not have told Mr Johnson he could drive (T69), there is no note of any discussion about that.

3.36 The appointment with Dr George on 26 October 1998 was the last time Mr Johnson saw the people at FMC before the accident on 9 February 1999. He broke appointments on 11 November 1998 and 11 December 1998. He was written to on 13 January 1999 reminding him, and further appointments were made with the dietician on 10 February 1999 and with Dr Terry on 14 April 1999.

3.37 Notwithstanding this, when Dr Trbovic saw Mr Johnson on 24 March 1999, only a month after the accident, he certified him fit to drive because, he said, he had received no information since September 1998 that Mr Johnson had suffered a hypoglycaemic attack (T246). He said he asked Mr Johnson how the accident in February had occurred, and he told him he didn't know. He did not associate the accident with diabetes, because the Royal Adelaide Hospital Discharge Summary did not mention the topic (T245). He acknowledged that hypoglycaemia was "one of many possibilities", but certified him fit to drive in any event, without any further investigation of whether Mr Johnson had proper control of his condition at that time. Dr Trbovic said that he relied on Mr Johnson's statements, an assertion that Mr Johnson denies. Mr Johnson's unawareness rendered him a poor historian in any event. I find that Dr Trbovic has displayed a less than professionally appropriate degree of vigilance on this issue.

3.38 Dr Terry wrote to Mr Johnson on 17 June 1999, in ignorance of the accident having occurred, and said:

> 'I note that you have not attended any follow-up appointments made since your admission to hospital in September 1998. I am concerned about the circumstances surrounding that admission, eg your working as a car salesman, little monitoring of blood sugar levels and very little awareness of hypoglycaemia.
>
> I am sure that you are aware that this puts many people, other than yourself, at risk if you were to hypo while driving. It is now law that diabetics under these circumstances should not be allowed to drive unless they are under regular review and have demonstrated that they are safe. I have therefore, enclosed another appointment for you to attend the Diabetes clinic. If you are already having your diabetes managed by another doctor, please let me know who they are. If you wish to see any other doctor than me, please let me know.
>
> If I do not hear from you, I will have to assume that the situation is the same as previously and unfortunately, I will have to let the Registrar of Motor Vehicles know of my concerns.'
>
> (Exhibit C31a – FMC Casenotes)

3.39 It was only after Dr Terry's letter that Mr Johnson appears to have taken a more responsible attitude to his diabetes. This may have been due to the fact that she was threatening to report him to the Registrar at that time.

3.40 It was not until 15 October 1999 that any action was taken in relation to Mr Johnson's drivers licence. That action was taken by the police when they became aware of the details of Mr Johnson's diabetes and the role it may have played in the collision.

4. Issues Arising at Inquest

4.1 Causation of the accident

Having regard to the evidence that, when Mr Johnson's diabetes was last professionally reviewed by Dr George on 26 October 1998, and his BSL's were found to have still been erratic since his discharge in September, and that Mr Johnson had not sought any treatment between that time and the date of the collision, I accept Dr Terry's evidence that it was likely that his diabetes remained out of control until that time. She said:

> "Q: Could you then make these assumptions; assume that from late October until the happening of the accident in early February 1999 Mr Johnson did not seek medical attention at all save for once ordering a prescription, but not seeing a doctor for that purpose, simply ringing up for a prescription.
>
> A: The only assumption I can make is that he didn't see anyone at Flinders Medical Centre diabetes unit.
>
> Q: But I want you to make the further assumption that he didn't see anybody in that period between late October and early February. What would be your comment if that in fact was the case.
>
> A: If that was the case I don't believe from the couple of weeks of monitoring that we have in the notes here that Mr Johnson had sufficient understanding of his own diabetes to have been able to eliminate the hypoglycaemia and therefore I would imagine that his blood glucose levels would continue to have been very erratic and unstable in this man.
>
> Q: And also he would have continued to have had grave difficulty in ascertaining what his true condition was.
>
> A: You mean he would have continued to perhaps have hypoglycaemia unawareness assuming he had that.
>
> Q: Without being aware of it.
>
> A: Yes.
>
> Q: Whereas if he had attended at the hospital as he was told to do you might have been able to do something about it.

A: We were aiming to try and eliminate hypoglycaemia altogether, or reduce the risk, yes.

Q: There were two things that could have been done; one, it could have been eliminated altogether, or alternatively at least he could have been made more aware of defensive practices.

A: That's right, yes.

Q: So that is to say medically on balance he was failing to take proper care of himself on the assumptions that I've put to you.

A: On the assumption he wasn't seeking medical care, yes.

Q: And of everyone else around him for that matter.

A: It depends on what he was doing I guess.

Q: Driving a car for example.

A: It he was driving a car, then yes."

(T184-185)

4.2 Dr Braund said that in his opinion the following factors were significant:

- Mr Johnson had suffered multiple previous episodes of unrecognised hypoglycaemia (two at least were the attack in September 1998 at work, and the witnessed episode while he was an inpatient at Flinders Medical Centre);
- He had a history of persisting with tasks even when hypoglycaemic;
- Mr Paton, the ambulance officer recorded a BSL of 3.0, which could have been as low as 2.0 or as high as 4.0;
- Mr Paton's observations of paleness, sweating, etc which were consistent with both hypoglycaemia and shock;
- Normal CAT scans and EEG's taken at Flinders Medical Centre exclude a spontaneous epileptic seizure;
- The general circumstances of the accident;

All these factors led him to believe, on the balance of probabilities, that Mr Johnson was hypoglycaemic at the time of the accident (exhibit C33,p4 and T278)

4.3 Taking the combined effect of the evidence of the two experts, I find, on the balance of probabilities, that Mr Johnson was hypoglycaemic on 9 February 1999, and that the resultant impairment of consciousness caused him to lose control of his car and collide with Shantel Bednarek causing her fatal injuries.

4.4 Warning regarding driving

Mr Johnson received a number of instructions, both during and after his admission to FMC in September 1998, that he should not drive a motor vehicle. I accept Dr Terry's evidence that she told him he should not drive until his condition was "sorted out".

4.5 Dr George wrote in the Discharge Summary on 17 September 1998 that he should not drive "for three months of documentation of being free of hypoglycaemia". Confusingly, on the same day Dr George also wrote "not to drive until EEG result known." This result did not become known until 29 September 1998 and it was normal. The is no suggestion that driving was discussed with Mr Johnson after that.

4.6 Mr Hanus, counsel for Mr Johnson, pointed out that the "patient's copy" of the discharge summary was still on the hospital file (exhibit C31a), so there is no evidence that Mr Johnson ever saw it. Additionally, Dr Trbovic did not discuss driving with him even though he had seen the discharge summary. Mr Hanus submitted that the only two instructions his client received were not to drive until things were 'sorted out' (Dr Terry) and not to drive until the results of the EEG were known (Dr George). Once the EEG result was normal, he argued that it was reasonable for his client to have resumed driving.

The problem with this submission is that Mr Johnson did not claim to have been confused by conflicting instructions whether to drive or not. He said he received no instructions at all (T17,87). I find that this is not true.

4.7 Mr Harms, counsel for the Bednarek family, submitted that Mr Johnson was not a truthful witness, that he was a 'doctor shopper", and was prepared to indulge in dishonest behaviour to keep his drivers licence. I accept that there is some force in these submissions, but the evidence that Mr Johnson received a clear instruction not to drive is lacking.

4.8 The overwhelming impression I have from the totality of the evidence is that Mr Johnson suffered not only from "hypo-unawareness" as defined by Dr's Terry and Braund, but also from a good deal of wilful blindness about his condition. His failure to obtain proper treatment between October 1998 and February 1999 was irresponsible. He chose to ignore the risks he was presenting to himself and others by continuing to drive, and the only plausible explanation for that choice is that he found the prospect of losing his licence unpalatable. However, I am unable to find that he drove in contravention of a clear instruction from the Doctors at FMC to the contrary.

4.9 Role of Medical Practitioners

Section 148 of the Motor Vehicles Act provides:

> "(1) Where a legally qualified medical practitioner, a registered optician, or a registered physiotherapist has reasonable cause to believe that-
>
> (a) a person whom he or she has examined holds a driver's licence or a learner's permit; and
>
> (b) that person is suffering from a physical or mental illness, disability or deficiency such that, if the person drove a motor vehicle, he or she would be likely to endanger the public,
>
> the medical practitioner, registered optician or registered physiotherapist is under a duty to inform the Registrar in writing of the name and address of that person, and of the nature of the illness, disability or deficiency from which the person is believed to be suffering.
>
> (2) Where a medical practitioner, registered optician or registered physiotherapist furnishes information to the Registrar in pursuance of subsection (1), he or she must notify the person to whom the information relates of the fact and of the nature of the information furnished.
>
> (3) A person incurs no civil or criminal liability in carrying out his or her duty under subsection (1).

None of the medical practitioners who gave evidence had read that section before.

4.10 Instead, they relied on a booklet issued by the Department of Transport entitled "Assessing Fitness to Drive", 1998 edition (Exhibit C30a). I understand that all medical practitioners were issued with a copy.

4.11 Chapter 5 is concerned with diabetes, and includes the following statements:

> "If there is poor management of a diabetic condition, or poor compliance by a patient to their specified treatment, then the patient with diabetes should be advised not to drive."

4.12 A table on page 15 includes the following:

CONDITION	DRIVERS OF CARS and LIGHT TRUCKS, MOTORCYCLE RIDERS
Insulin Dependent Diabetes Mellitus	**Should not drive**. Normally Driver Licensing Authority will issue conditional licence on certificate of physician caring for the condition that condition is stable and all other criteria in this table have been met. Review of condition required at maximum periods or 2 years.
Insulin Dependent Diabetes Mellitus: Major Hypo-glycaemic Episodes	**Should not drive after a major hypoglycaemic episode**. Driver Licensing Authority may issue conditional licence upon receipt of satisfactory report from the treating doctor stating that treatment has been reviewed, patient has been educated on how to avoid hypoglycaemic reactions and patient complaint. If the hypoglycaemic episode occurred while driving, the same report is required but it must be issued by a consultant physician. Periodic reviews of driver licence status may be required by the Driver Licensing Authority.

4.13 At the foot of the table are the following two statements:

> "* All criteria in bold type should be notified to the Driver Licencing Authority.
>
> * Practitioners may consider reporting to the Driver Licencing Authority patients who are unwilling to comply with driving restrictions that the practitioner recommends". (My underlining).

4.14 Dr Braund was particularly scathing of the handbook (T293). He was more approving of the 2001 edition (Exhibit C30c) which is less restrictive. However, it carries the following explanatory note:

> "Patients should be made aware about the effects of their condition on driving and advised of their legal obligation to notify the driver licensing authority where driving is likely to be affected. As a last resort, practitioners may themselves advise the driver licensing authority." (My underlining).

4.15 In my opinion, the suggestion that doctors "may consider" using Section 148, or that its use can be a "last resort" is inconsistent with Section 148. The section creates a legal duty to report, not an option to do so.

4.16 To further complicate matters, the booklet, in a section entitled "Ethics and Legal Issues" refers to the dilemma faced by doctors between the duty to preserve confidentiality and the duty to preserve public safety. It states:

> "3.2.1 A fundamental ethical issue for medical and other health professionals is the requirement to maintain confidentiality. Patient confidentiality is an acknowledgement of the patients autonomy in maintaining control over information that relates to his or her medical condition.

Health professionals are therefore not at liberty, in the majority of cases, to disclose to third parties, including driver licensing authorities, any patient details revealed within the professional relationship. Doctors and all health professionals do, however, have a duty or care to the public that, in most cases, is secondary to their primary duty of care to the patient. Where the public duty of care assumes more importance, it will include taking reasonable action to minimise the risk of harm resulting from the actions of a patient whose condition or behaviour is likely to be dangerous.

A difficult ethical question arises if a health professional believes that there is an over-riding public interest in the disclosure of confidential information. The health professional must then decide if the public interest is sufficient to justify breaching patient confidentiality and jeopardising, perhaps irretrievably, the professional relationship held with the patient.

3.2.2 There is evidence from some places where reporting by health professionals to the driver licensing authority is required by law that the process becomes counter productive. It is found that patients may withhold information from their health care professionals and, as a consequence, their condition is less effectively managed. As a result the health and safety of the patient and of other road users may be jeopardised.

3.2.3 It follows from the argument above that health professionals have an obligation towards public safety, but it is equally clear that action taken in the interests of public safety should be taken with the consent of the patient wherever possible.

3.2.4 A health professional might be liable in any jurisdiction if a court found that he or she had failed to take reasonable steps to prevent an impaired patient from driving in circumstances that would result in a substantial foreseeable increase in risk to members of the public or to the patient him or herself.

3.2.5 Common Law may offer some clarification of the requirements for a health professional before disclosing information to a responsible authority. In W v. Edgell, weighing up whether disclosure in the public interest should outweigh the duty of confidentiality. It must be shown that:

1. there is a real, immediate and serious risk for public safety;
2. the risk will be substantially reduced by disclosure;
3. the disclosure is no greater than is reasonably necessary to minimise the risk; and
4. the public interest protected by the duty of confidentiality is outweighed by the public interest in minimising the risk."

(Exhibit C30c, p5-6)

4.17 Both Dr Braund and Dr Terry told me that their basic approach to this dilemma is to comply with Section 148 only when they consider that the patient is non-compliant with treatment. Dr Terry said that after Mr Johnson's discharge in September 1998 he was not fit to drive, because his BSL's were still unstable (T169).

However, as far as she knew, he was compliant with their advice, and she was not aware of whether he was driving or not (T170). She said:

> "My normal practice would be to notify the department of people who are unable to or won't comply with safe driving practices."

4.18 Dr Terry further explained the ethical dilemma faced by a medical practitioner:

> "Diabetes is one of these chronic disorders that requires management for a lifetime really. I think it is important that someone with diabetes, particularly complicated diabetes, is followed regularly by a particular medical practitioner, and usually management is better if it is with one person over time, rather than chopping and changing. I think that taking somebody's driving licence away the first time you meet them would seriously endanger you developing any sort of relationship with that person."

4.19 Dr Braund agreed, admitting that he does not follow the law "to the letter". He said

> "In an attempt to maintain a constructive relationship with most of my patients, I do not follow that law to the letter. It is, potentially, counter-productive. We know from several sources of information that, eventually, patients cease to tell us the truth. There are circumstances in which I absolutely follow that law to the letter. Those are circumstances in which I believe that the patient's personality or brain injury, or brain disease, or psychiatric disturbance, means that they won't co-operate, or have no insight into their disorder; no recognition that they could do harm. So there are patients who I have immediately notified to the Registrar of Motor Vehicles as being unfit to drive. So it's a very formal duty and there are that group of patients I've just described in which there is priority of my ethical duty to observe that law over my ethical duty to maintain patient confidentiality."

4.20 It would seem that this is an easier regime to follow in the private rather than the public health system. Dr Braund said that he would see private patients every three weeks, and could get a proper view of whether they are compliant, or not. This is to be compared with the delay of more than four months before the next appointment with Dr Terry, after Mr Johnson missed the appointment in December 1998.

4.21 If medical practitioners are to undertake the duty of monitoring compliance, rather than making an immediate notification under Section 148, then they will need to do a much better job of monitoring than was done by the FMC staff here. I appreciate that the public system placed great obstacles in their way, but they needed a much better system of monitoring than they had. It was not until June 1999, four months after the accident and eight months since they'd last seen him, that Dr Terry threatened to notify, and Mr Johnson then complied. His failure to keep successive appointments in November and December 1998 should have set the alarm bells ringing much earlier.

Mr Johnson's BSL readings were erratic in October, so the missed appointment in November, should have been enough to trigger that response, and failing that, the missed appointment in December should have put the issue beyond doubt.

4.22 I have already mentioned that when Mr Johnson returned to work as a car salesman on 23 September 1998 following his discharge from FMC on 17 September, he produced a Certificate that he was fit to resume work. On the basis of that, his employer allowed him to resume driving (Exhibit C28a, p3). As I have already observed, Dr Terry was of the view that he was clearly not safe to drive then. It is customary for doctors to enclose on such certificates any limitations on the workers' fitness. In retrospect, Dr Terry conceded that it would have been preferable if Mr Johnson's Certificate had been so endorsed (T220).

4.23 When asked what circumstances would allow Mr Johnson to drive again, Dr Braund said, in a letter dated 1 March 2000:

> "(a) That he should be unable to obtain his Drivers Licence for a minimum of two years.
>
> (b) That he should contract to visit a Specialist Endocrinologist every month during those two years.
>
> (c) That he should contract to provide a detailed set of home blood glucose records as requested by that Specialist Endocrinologist.
>
> (d) That by these means, and by attending to the advice of that Specialist Endocrinologist, he should be able to demonstrate a two year track record of having been virtually free of hypoglycaemia; of having been entirely free of unrecognised hypoglycaemia; of having been entirely free of any hypoglycaemia that was sufficiently severe that he required bystander, ambulance or doctor assistance.
>
> (e) There should also be evidence that, if he does indeed have hypoglycaemia of a milder degree during this time, he was able to recognise it easily.
>
> (f) The targets for his management should not include tight control of diabetes. While the ideal for diabetes is tight control in order to avoid long term complications, the short term complication of hypoglycaemia with unawareness and severe hypos, is simply unacceptable, particularly with the series of events that have happened to this man.
>
> (g) The decision on whether he could return to driving, and the date on which he could return to driving would ultimately be determined by his treating Endocrinologist.

(h) His Driver's Licence renewal form, issued annually to all diabetic drivers, should only be endorsed by his treating Endocrine Specialist. It should never be endorsed by any other treating Specialist, nor by any non specialised Medical Practitioner.

(Exhibit C33a, p1-2)

4.24 It is a great pity that such a clear regime was not spelled out to Mr Johnson in the clearest terms once his "hypoglycaemic unawareness" was diagnosed at FMC in September 1998. If it had been, his behaviour in driving on 9 February 1999 leading to Shantel Bendarek's death would have been deserving of the strongest condemnation. As it is, having regard to the vague and contradictory advice he was given, he is not in that position.

5. Recommendations

5.1 Section 25(2) of the Coroners Act 1975 empowers me to make recommendations if in my opinion, to do so may "prevent, or reduce the likelihood of" the recurrence of a similar event to Shantel Bednarek's death. Having regard to Dr Braund's evidence that here is a "pandemic" of diabetes in our community, it is especially important to consider the implications of Mr Johnson's driving in this case.

5.2 Having regard to the ethical dilemma faced by doctors treating patients such as Mr Johnson, particularly in the public hospital system where there is a reduced ability to monitor compliance, a very clear system of monitoring and reporting patients who are not safe to drive is required.

5.3 At present, the reporting system provided by Section 148, as interpreted by the doctors here, and the process of annual review of patients, as exemplified by Dr Trbovic's efforts in this matter, are clearly unsatisfactory.

5.4 Mr Boylan, Counsel for Dr's Trbovic and Bollen, suggested that the forms which doctors fill out in the annual review should request much more specific information about the patients condition. I agree. Mr Harms agreed, and suggested that the forms should have a section for both patient and doctor to fill in. The patient could be required, for example to report how many doctors he or she had consulted during the year, how many hypoglycaemic attacks he or she had suffered, and could be required to produce records of BSL's taken over a particular period. The doctor could also be asked to provide details of consultations, and be required to state whether he or she had viewed the patients records, etc. I agree with those suggestions.

Such information would give a much better understanding of the patients condition which the Registrar could make use of when considering whether to renew the licence or not. Notification under Section 148 might become less important.

5.5 Finally, I do not agree with the idea of putting a gloss on legislation in handbooks which is inaccurate. The booklet has obviously been prepared to cover all Australian jurisdictions, and may represent the lowest common denominator between them. If Section 148 was reproduced in the handbook, I am sure that most doctors could read and understand it.

5.6 Having regard to Dr Braund's remarks, it would seem that a much more consultative approach is called for in designing a system which fulfils the government's public policy objectives, and with which the medical profession can feel comfortable.

5.7 I therefore **recommend** that the Minister of Transport reviews the legislative scheme for reporting and reviewing the medical fitness of holders of drivers licences, having regard to the suggestions made by counsel in this case. Such a review should be conducted with the participation of representatives of the medical, optician and physiotherapy professions.

Key Words: Motor Vehicle Accident; Diabetes; Medical Treatment; Drivers Licensing

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 5th day of October, 2001.

……..……
Coroner

Inq.No. 12/01 (0325/1999)