

CORONERS COURT OF SOUTH AUSTRALIA

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INQUEST INTO THE DEATH OF ROBERT LLOYD HALL

[2025] SACC 25

Inquest Findings of his Honour State Coroner Whittle

17 October 2025

CORONIAL INQUEST

Examination of the cause and circumstances of the death of a man who was hit by a four-wheel drive vehicle while riding a bicycle along the side of the Horrocks Highway. The inquest explored the circumstances surrounding the driver of the vehicle being unconditionally licensed to drive, notwithstanding suffering from an acquired permanent visual field defect which created a risk to pedestrians and road users.

Held:

1. Robert Lloyd Hall, aged 66 years of Quorn, died at Quorn on 14 May 2018 as a result of multiple injuries.
2. Circumstances of death as set out in these findings.

Recommendations made.

Counsel Assisting: MR P LONGSON

**Interested Party: DEPARTMENT FOR INFRASTRUCTURE AND TRANSPORT, SOUTHERN ADELAIDE
LOCAL HEALTH NETWORK & FLINDERS AND UPPER NORTH LOCAL HEALTH NETWORK**

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Witness: MR S GILBERT, MS K ROBERTS & DR P ANASTASSIADIS

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Witness: MS N HAYBALL

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Introduction

- 1 At about 8:20am on 14 May 2018, Robert Lloyd Hall, a resident of the town of Quorn, South Australia, was riding his bicycle on the Horrocks Highway towards the town when he was struck from behind by a Toyota Landcruiser, driven by John Charles Robertson, who was travelling the 40 kilometres from Wilmington to Quorn for a medical appointment. The weather was fine. Mr Hall was wearing a hi-vis vest, had a flashing rear taillight and was riding on the white edge line of the roadway when Mr Robertson collided with him. Mr Hall died at the scene of multiple injuries. He was 66 years of age.
- 2 Mr Hall's widow, Helen, has provided the Court with some illuminating information about her husband Robert. Mr Hall was an ambulance volunteer for 27 years and was '*all about safety*'. In that capacity he attended the scenes of many vehicle accidents, and assisted many injured patients, some of whom did not survive. In 1998, Mr Hall was diagnosed with throat cancer and advised that he had a 5% chance of survival. After many surgeries and three months in hospital, he was unable to drive for about 12 months and Mrs Hall became his eyes and his chauffeur until, after months of physiotherapy, he regained enough movement to be able to drive again. Mr Hall was very much a family man, was a wonderful husband, great father and grandfather and very proud of their children Megan, Rebecca, Tracy and Ben, and his 13 grandchildren. Against this background, Mrs Hall notes poignantly that he was alone when he was killed. Mrs Hall described her husband Robert as her best friend, her soulmate and her lifelong partner until he was tragically taken from her.
- 3 As a result of an ischaemic stroke in 2013, Mr Robertson suffered from a visual field defect known as left absolute homonymous hemianopia, in which the left field of vision of each eye is lost. A person with this condition, who is looking straight ahead, has no vision to the left of the centreline of where they are looking and loses the ability to detect movement to the left-hand side. In other words, if looking straight ahead, Mr Robertson had no capacity to see a cyclist lawfully riding on the road. As was heard in this inquest, vision to the left-hand side and the ability to detect movement can only be established by a left homonymous hemianope by what is known as scanning, that is, repeatedly and constantly turning the eyes to the left, usually aided by turning the head. This is a fatigue inducing activity.
- 4 It is reasonable for me to conclude that at the time he struck Mr Hall with his vehicle, Mr Robertson was not scanning to the left to compensate for his serious visual defect and therefore did not have Mr Hall within his field of vision and could not see him at all. It is also clear that a left homonymous hemianope who is driving a motor vehicle, and is not scanning to compensate for this defect, presents a particular danger to cyclists. According to Emeritus Professor Stephen Dain, who gave independent expert evidence during the inquest, absolute homonymous hemianopia (which can affect the right or the left hemifield) is the worst visual field defect that can be present in any person seeking a licence to drive.

- 5 By way of brief background, after his stroke Mr Robertson's driver's licence had been cancelled. As a result of the nationally adopted rules relating to licensing of drivers, a person with the condition of left homonymous hemianopia is not entitled to have an unconditional driver's licence. Following a series of medical examinations and practical tests Mr Robertson had been reissued with a driver's licence, with conditions. By the time he struck and killed Mr Hall, he was subject to only one condition,¹ that he undergo an annual medical assessment.
- 6 Following the collision in which Mr Hall was killed, Mr Robertson was charged with and convicted of the offence of aggravated causing death by dangerous driving and was sentenced to a period of imprisonment to be served on home detention.

Cause of death

- 7 Dr Cheryl Charlwood, a forensic pathologist, performed a postmortem examination of Mr Hall on 16 May 201823. Dr Charlwood determined the cause of Mr Hall's death to be multiple injuries.²
- 8 Mr Hall's postmortem toxicology demonstrated the presence of prescribed antihypertensive medication only. No alcohol was detected.³
- 9 A sample of blood taken from Mr Robertson was found to contain levels of prescription medications tapentadol and citalopram, consistent with use as prescribed by Dr Lian-Lloyd, Mr Robertson's general practitioner. Expert evidence from Professor Jason White,⁴ pharmacologist, was to the effect that the concentrations of these drugs were consistent with normal therapeutic use, with only mild effects and very little or no impairment of Mr Robertson's driving ability, either individually or in combination.
- 10 Also found in Mr Robertson's blood was 2µg delta-9 tetrahydrocannabinol (THC) per L.⁵ This is the major psychoactive component of cannabis and may be detected in low quantities up to a day after consumption of cannabis. The presence of this chemical in Mr Robertson's blood while driving constituted an aggravating feature of the offence of which he was convicted. However, Professor White's opinion was that the level present was consistent with what Mr Robertson said after the fatal collision, namely that he had used cannabis not less than 24 hours earlier and that it would have had no adverse effect on his capacity to drive.
- 11 I have approached this inquiry on the assumption that Mr Robertson's use of cannabis and prescription medications did not causally contribute to the collision which caused the death of Mr Hall. For the sake of clarity, and to address concerns of Mr Hall's loved ones, I shall elaborate upon this conclusion and the basis for it.

¹ Whether it is properly referred to as a condition will be discussed later

² Exhibit C2a

³ Exhibit C3a

⁴ Exhibit 16a, Annexure JST1; Exhibit C34, evidence at Mr Robertson's criminal trial

⁵ Exhibit C4a

Did adverse effects of Mr Robertson's prescription medication or other drugs contribute to the collision?

- 12 Toxicological analysis of a sample of Mr Robertson's blood taken shortly after the collision revealed the presence of:
- 0.19mg tapentadol per L
 - 0.17mg citalopram per L
 - 2µg of delta-9 tetrahydrocannabinol per L
- 13 Dr Lian-Lloyd gave evidence at Mr Robertson's criminal trial that, to assist with chronic pain from discogenic low back pain and sciatica complicated by repeated surgeries, Mr Robertson had an embedded intrathecal morphine pump allowing an infusion of a consistent amount of morphine of 5mg per day into the intrathecal space [the space around the spinal cord].⁶ His pump had been in place for two or three years. When he collided with Mr Hall, Mr Robertson was on his way to an appointment with Dr Lian-Lloyd to have the intrathecal morphine pump refilled, but it was not yet empty.
- 14 Professor Jason White, a pharmacologist, gave evidence⁷ at the criminal trial that the reason morphine was not detected in the blood is that in that circumstance morphine is delivered directly into the spinal cord and very little of it actually ever reaches the blood, which is partly because the amount of morphine that needs to be delivered directly in the spinal cord is very, very small compared to the amount you would take if you swallow a tablet, for example.
- 15 Dr Lian-Lloyd also stated⁸ that Mr Robertson was prescribed tapentadol, which was not initially prescribed by him, but by a pain specialist. Dr Lian-Lloyd would adjust Mr Robertson's dose from time to time, always trying to keep his medication doses as low as possible whilst controlling his pain. At the time of the collision, he was prescribed 250mg twice a day and he had been prescribed that for at least three years.
- 16 Dr Lian-Lloyd had advised Mr Robertson that he would develop a tolerance to the opioid medications and could reach a point where, due to hyperalgesia, the chronic use of opiates could in fact make his pain worse, so it was desirable in his view to try to get Mr Robertson off opiates to the extent possible. However, Dr Lian-Lloyd said that Mr Robertson was being treated by three or four doctors and the common denominator amongst all the specialists, and himself, was that these were drugs which were needed.⁹
- 17 Dr Lian-Lloyd further stated¹⁰ that Mr Robertson had told him on a number of occasions that he was using cannabis and felt it helped his pain. Dr Lian-Lloyd told Mr Robertson, in response, that he was not an advocate of the use of THC for medicinal purposes.
- 18 As I have mentioned, Professor Jason White gave expert opinion evidence as to the likely effect of the drugs being taken by Mr Robertson at the time of the collision.

⁶ Exhibit C34, page 177

⁷ Exhibit C34, page 203

⁸ Exhibit C34, page 180

⁹ Exhibit C34, pages 182-183

¹⁰ Exhibit C34, pages 181-182

- 19 As to delta-9 tetrahydrocannabinol, Professor White said that the quantity of 2µg found in the blood taken about an hour after the collision would indicate that Mr Robertson had not smoked cannabis within the few hours leading up to the collision. It was an amount of THC in the blood which was consistent with what Mr Robertson said to police, namely that he had last smoked cannabis '*A day or two before probably*', '*Yeah it was at least, at least 24 hours before*'.¹¹ Professor White's evidence was that the level of THC found would not have had a very significant effect on the brain and body, only possibly very subtle effects which are not readily detectable. Professor White expressed the opinion that he did not expect there to be any impairment of Mr Robertson's brain or body functions, including impairment of his vision and the need to scan to the left, at the time of the collision.¹²
- 20 I find that Mr Robertson's prior consumption of cannabis had either no, or no significant, effect causing any impairment of his brain or body functions, including impairment of his vision and the need to scan to the left, at the time of the collision. I note that this was the position taken by the prosecution at Mr Robertson's criminal trial.
- 21 Professor White gave evidence that the concentration of tapentadol in Mr Robertson's blood of 0.19mg/L was consistent with normal therapeutic use and, in a person who had been taking it for several years such as Mr Robertson, in terms of driving ability there would be very little or no impairment.¹³ In light of that evidence I cannot conclude, on the balance of probabilities, that there was any causal link between tapentadol and the collision. I find that Mr Robertson's consumption of tapentadol did not, or did not significantly, impair his driving ability at the time he collided with Mr Hall and was not a contributing factor to the cause of that collision.
- 22 As to morphine, Professor White gave evidence that, when administered in Mr Robertson by an intrathecal pump, it would be unlikely to be found in the blood but, if it was possible to detect morphine by taking fluid from the brain, it would have been found there. However, the dose of 5mg per day was not a very high dose for someone who has been using it for years and a lot of such people would be using twice that amount. Professor White expressed the opinion that the morphine delivered to Mr Robertson's spinal cord by the intrathecal morphine pump would not have had any significant adverse effect on his ability to drive at the time of the collision,¹⁴ and I so find.
- 23 Professor White was also asked at Mr Robertson's criminal trial about the likely effect of tapentadol and morphine taken in combination. He said that adverse effects, such as the degree of sedation and impaired ability to concentrate, become more likely if you combine two drugs compared to either drug alone. Again, much would depend on the level of tolerance built up from taking them together. Professor White expressed the opinion that if he had a high degree of tolerance, it is likely that he would be able to scan in the normal manner and that it would not be affected. If he had been taking those drugs throughout the time when he was told to scan, and taught to scan and assessed for scanning, Professor White's view was that this would probably decrease the likelihood that scanning would be affected by the drugs because he would have essentially learned

¹¹ Exhibit C15, Annexure KP1, record of interview, page 24

¹² Exhibit C34, pages 197-198

¹³ Exhibit C34, page 201

¹⁴ Exhibit C34, page 204

how to do it whilst affected by the drugs, therefore probably minimising any likelihood of the effects of the drugs on his scanning ability.¹⁵

- 24 Having regard to the pattern and duration of Mr Robertson's use of tapentadol and morphine in the process of learning to scan, and scanning during the several years prior to the fatal collision with Mr Hall, I cannot find, on the balance of probabilities, that the combined use of morphine and tapentadol had any, or any significant, adverse effect on Mr Robertson's driving or scanning ability.
- 25 As to citalopram, a prescription antidepressant used in the treatment of major depression, Professor White gave evidence that its adverse effects are only mild and usually only within the first week or two of taking the drug. Having regard to Mr Robertson's history of having been prescribed this drug since about 2012, Professor White's expert opinion was that the concentration of 0.17mg/L of citalopram was, firstly, consistent with normal therapeutic use and, secondly, in combination with tapentadol and morphine, he would not expect there to have been any adverse effects on Mr Robertson's driving ability.
- 26 In conclusion on this point, the evidence establishes on the balance of probabilities that neither prescription drugs nor illegal drugs, either individually or in combination, were factors which contributed to Mr Robertson's fatal collision with Mr Hall.

Evidence at Inquest

- 27 Three witnesses were called to give evidence at the inquest and also provided affidavits:
 - Emeritus Professor Stephen Dain – Professor Dain was engaged by the Court as an independent expert witness. He is a faculty member of the School of Optometry and Vision Science at the University of New South Wales, with more than 40 years of combined clinical, research and teaching experience. He is a widely published authority within the field of optometry and has simultaneously maintained a career as an expert witness for the past two decades;
 - Mr Stuart Gilbert – Mr Gilbert is the Director of Regulation for the Department of Infrastructure and Transport (DIT). He has been employed by DIT and its predecessors for some 40 years;
 - Ms Nicola Hayball – Ms Hayball is an occupational therapist who, in July 2015 when she conducted an occupational therapy (OT) driving assessment for Mr Robertson, was providing OT services to the Southern Adelaide Local Health Network Occupational Therapist Driving Assessment and Rehabilitation Clinic located at the Repatriation General Hospital. In addition to her formal qualifications in OT obtained in 1993, Ms Hayball undertook a course in advanced training and driver assessment and rehabilitation at the University of Sydney in 2003 and she established her own private business as an occupational therapist driver assessor in 2013.
- 28 Affidavits from the following people were also received into evidence:
 - Ms Tracey Toune, Mr Hall's daughter

¹⁵ Exhibit C34, pages 206-207

- Dr Cheryl Charlwood, Specialist Forensic Pathologist, Forensic Science SA (FSSA)
 - Heather Lindsay, Senior Forensic Scientist, FSSA
 - Dr Danielle Butzbach, Forensic Scientist, FSSA
 - Paul Rodgers, civilian witness, first on scene
 - Jean Phillips, License Regulation Manager, Road & Marine Services Division, DIT
 - Professor John Crompton, ophthalmologist
 - Dr Peter Anastassiadis, rehabilitation physician
 - Dr Tony Lian-Lloyd, general practitioner, Quorn
 - Senior Constable Timothy Schoemaker, SAPOL
 - Probationary Constable Rachel Bagshaw, SAPOL
 - Constable Frank Scrimshaw, SAPOL
 - Senior Sergeant David Kuchenmeister, Reconstruction and Technical Examination Unit, Major Crash Investigation Section, SAPOL
 - Elliot McDonald, Vehicle Examiner, Major Crash Investigation Section, SAPOL
 - Brevet Sergeant Kylie Peters, SAPOL
 - Brevet Sergeant Jason Thiele, SAPOL
 - Kathleen Roberts, Licence Examiner/Accreditation Audit Assessment Officer, DIT
- 29 Numerous documentary exhibits were also received. These included the SAPOL Major Crash Investigation Unit fatal collision report, dashcam footage from Mr Robertson's vehicle, various medical and hospital notes of Mr Robertson, DIT records, academic research papers referred to by Professor Dain, Assessing Fitness to Drive - Medical Standards for Licensing and Clinical Management Guidelines, 2012, 2016 and 2022 versions, Occupational Therapy Driving Test Assessment Manual (Vic) (2018), and a transcript of evidence in the criminal trial of Mr Robertson.
- 30 In Mr Robertson's criminal trial in the District Court at Port Augusta, which commenced on 3 May 2021, oral evidence was given by Brevet Sergeant Thiele, Senior Constable Schoemaker, Senior Sergeant Kuchenmeister, Dr Anastassiadis, Dr Lian-Lloyd, Professor Crompton, Brevet Sergeant Peters, and Professor Jason White. I have read and had regard to all of that evidence.¹⁶
- 31 I shall only refer to evidence received and heard at the inquest to the extent that its forensic significance requires, and in the interests of narrative clarity. All of the evidence has been considered whether or not it is referred to.
- 32 The civil standard of proof, the balance of probabilities, applies to the making of coronial findings. If findings which imply or express criticism of individuals are to be considered,

¹⁶ Exhibit C34

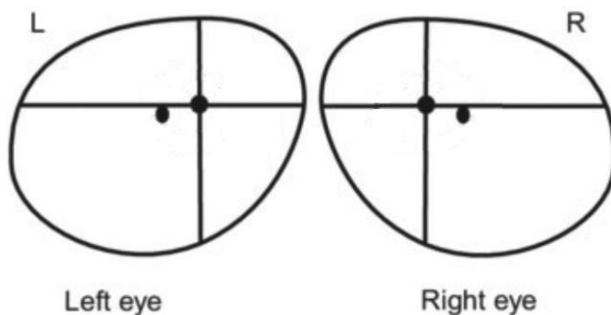
I shall not make such a finding unless the evidence leads me to a comfortable level of satisfaction that the finding should be made.

Mr Robertson's relevant medical history and loss of licence

- 33 After a minor motorcycle accident in October 2013 Mr Robertson underwent a CT scan of his brain which led to the discovery and confirmation of a right internal carotid artery aneurysm. In January 2014 he underwent an elective craniotomy with clipping of the aneurysm. The procedure was complicated by a right sub-cortical ischaemic stroke, resulting in left-sided limb weakness and complete left visual field loss, known as left homonymous hemianopia.
- 34 On 20 January 2014 Mr Robertson commenced rehabilitation at the Memorial Hospital which included physiotherapy, OT, speech pathology and referral to the Guide Dogs visual scanning training service. Dr Peter Anastassiadis, rehabilitation consultant, informed Mr Robertson that he was not permitted to drive until medically cleared and a notification was made to DIT (as it later became known) that Mr Robertson was not medically fit to drive.¹⁷
- 35 On 23 January 2014 Mr Robertson was formally diagnosed with left absolute homonymous hemianopia (AHH) by Professor John Crompton, neuro-ophthalmologist.

Professor Dain explains the effect of left absolute homonymous hemianopia

- 36 Professor Dain described AHH, in the context of driving, as *'the greatest visual field defect that you are likely to come across; it is a worst-case scenario'*.¹⁸
- 37 Visual field was explained as including everything that we can see around, both vertical and horizontal. A person's best detailed vision, or visual acuity, is at the centre of vision, but vision can extend to things in the periphery. The normal total visual field of each eye extends to about 50° up, 70° down, 60° towards the nose and about 90° laterally, as represented by the figure below.¹⁹



Schematic of the extent of the normal monocular visual fields. The vertical oval is the blind spot in each eye.

- 38 Professor Dain explained that in a person with two eyes, vision is mainly measured one eye at a time, but some of the functional assessments, particularly in visual assessments for driving, take the natural situation of two eyes. In central vision we have our most detailed vision and our best colour vision. These both deteriorate as you go out to the

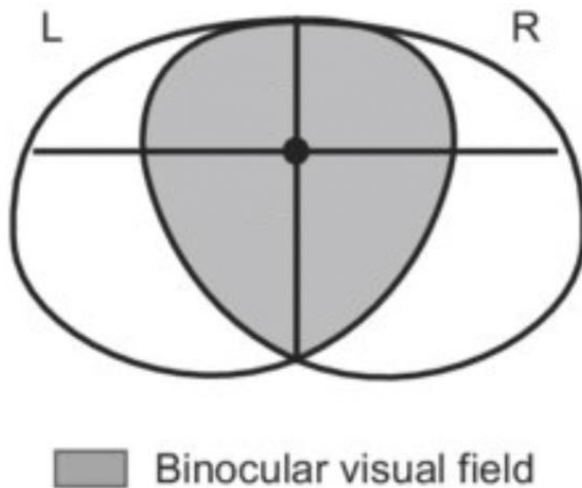
¹⁷ Exhibit C8 at [16]

¹⁸ T89

¹⁹ Exhibit C17, Expert report of Emeritus Professor Dain, page 9

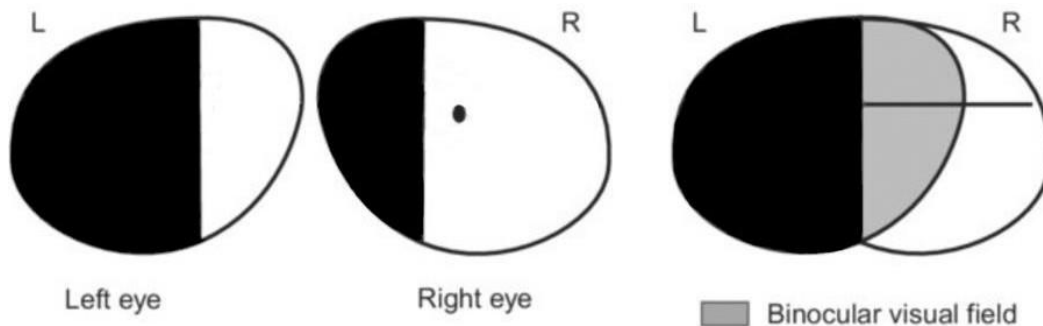
periphery, but what is maintained much better in the periphery is, firstly, blue-yellow colour vision but, more importantly, a kind of non-colour vision, in particular, the ability to detect change and the ability to detect movement.²⁰

- 39 The field of vision seen by both eyes normally extends 50° up, 70° down and about 60° laterally each side (120° in all) and then an area extending to each side which is seen by one eye only, as represented by the figure below.²¹



Schematic of the extent of the normal monocular and binocular visual fields.

- 40 Mr Robertson's condition known as left absolute homonymous hemianopia, in which the left field of vision of each eye is lost, is represented in the following figure.²²



Schematic of the extent of the monocular and binocular visual fields when there is a left absolute homonymous hemianopia

Scanning

- 41 As a person with this condition, who is looking straight ahead, has no vision to the left of the centreline of the direction in which they are looking, they also have no ability to see and to detect movement to the left-hand side. Without the ability to detect movement in the peripheral vision, there is no cue to then turn one's eyes to examine in detail anything to which you have been alerted in your peripheral vision. As was heard in this inquest, vision to the left-hand side, and the ability to detect movement, can only be established

²⁰ T35

²¹ Exhibit C17, page 9

²² Exhibit C17, page 10

by a left homonymous hemianope by what is known as scanning, that is, repeatedly and constantly turning the eyes to the left, either with or without turning the head.

- 42 Professor Dain explained that a person with normal vision is reliant on peripheral vision for a sense of speed and to detect movement of things to which detailed attention is then paid.²³

Rehabilitation and medical consultations

- 43 During the initial round of consultations at the Memorial Hospital in January 2014, Mr Robertson had an assessment with Guide Dogs who implemented a plan for a structured scanning training program.²⁴
- 44 Upon examination of Mr Robertson on 23 January 2014, Professor Crompton found good visual acuity unaided (6/6) in each eye with good colour vision. However, there was no field of vision to the left half of centre in each eye. From Professor Crompton's letter to rehabilitation consultant Dr Anastassiadis, it may be seen that there was quickly a focus on providing Mr Robertson with an opportunity, with rehabilitation, to regain his driving licence, which was clearly what Mr Robertson wanted. Professor Crompton wrote:

'Unfortunately I think it is unlikely that he will get much recovery but he is having visual rehabilitation to learn to scan to his blind hemifield. I will review him in six months' time and if he is doing well I will consider referring him for occupational therapy-assisted driver assessment. Of course, if he does pass that he will only get a licence with a waiver. He knows he is able to drive on private property unrestricted. His wife will watch him however!'²⁵

Suspension of licence

- 45 It is recorded in hospital records that Mr Robertson underwent a craniotomy for elective clipping of his right internal carotid artery aneurysm on 7 January 2014 and was advised by his neurosurgeon that he was not to drive for a period of six months following the craniotomy.²⁶ This was quickly followed up by formal advice required to be given to the Registrar of Motor Vehicles.
- 46 The *Motor Vehicles Act 1959* (SA) relevantly provides:

'148 – Duty of health professionals

- (1) Where a health professional has reason to believe that –
- (a) a person whom the health professional 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, the person would be likely to endanger the public,
- the health professional 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.'

²³ T36

²⁴ Exhibit C19, page 228

²⁵ Exhibit C22, page 18

²⁶ Exhibit C18, page 16

- 47 On 28 January 2014 Dr Anastassiadis, Mr Robertson's rehabilitation physician, completed a Certificate of Fitness – Light Vehicle Drivers and forwarded it to the Registrar, advising the Registrar that Mr Robertson had undergone intracranial surgery complicated by suffering an ischaemic stroke, resulting in left-side limb weakness and a '*persisting*' left hemianopia.²⁷
- 48 The Certificate was received soon afterwards by the DIT Customer Operations Group, but was apparently incomplete and sent back to Dr Anastassiadis, who reviewed Mr Robertson again on 3 April 2014 and added further detail to the Certificate. In that further detail Dr Anastassiadis advised that Mr Robertson was not considered medically fit to drive, that he could be assessed in a further three months for readiness to undergo a practical driving assessment (PDA), and that his licence should be suspended until medically improved and/or he was ophthalmologically assessed as fit for such an assessment.²⁸
- 49 During that review, Dr Anastassiadis noted that Mr Robertson was suffering from decreased cognition, tiredness and sleep apnoea. He recommended a sleep study for Mr Robertson to confirm whether he had sleep apnoea. Mr Robertson reported that he was driving on private property and his wife reported that Mr Robertson needed prompting with scanning. Mr Robertson was reminded that he could not drive on public roads. Dr Anastassiadis referred Mr Robertson to an OT pre-driving assessment at the Repatriation General Hospital and scheduled him for clinical review in three months.
- 50 The amended Certificate was received by the DIT Customer Operations Group and recorded in the TRUMPS database²⁹ on 17 April 2014.
- 51 Ms Jean Phillips, Delegate of the Registrar of Motor Vehicles, advised Mr Robertson by letter dated 22 April 2014, that his licence was suspended, effective 28 April 2014, as he did not meet the medical standards required to drive a motor vehicle.³⁰
- 52 On 23 April 2014 the Certificate of Fitness was stamped by DIT Licence Services, a team for which Mr Stuart Gilbert is responsible, which deals with matters of greater complexity than the Customer Operations Group.

Process to regain conditional licence

Reviews and first OT assessment – June 2014 to June 2015

- 53 On 3 June 2014 Mr Robertson underwent a pre-drive assessment with Mr Bradley Williams, occupational therapist. That test was undertaken at the Repatriation General Hospital (RGH). The assessor noted that Mr Robertson '*... tends to lead scanning with head movements and not his eyes with reduced compensation strategies*'. His reaction time for scanning was more than twice the '*sound reaction speed*'.³¹ Mr Robertson undertook the DriveSafe test, an off-road test, and missed three objects (a truck and two pedestrians), all on his left.

²⁷ Exhibit C22, pages 97-100; Exhibit C8 at [17]

²⁸ Exhibit C22, page 99

²⁹ Transport Regulation User Management Processing System – the IT system containing the register of driver licenses and motor vehicles as required to be maintained under the Motor Vehicles Act

³⁰ Exhibit C22, page 101

³¹ Exhibit C22, page 94

- 54 The occupational therapist recorded in his report to Dr Anastassiadis, the following:
- ‘... Mr Robertson is not at the compensatory function stage to drive. He does not consistently compensate for his visual field loss to meet the safety levels required to move towards a practical assessment.
- ...
- Significant issues with fatigue were evident.
- ...
- Review will be required if there is a significant change in Mr Robertson’s symptoms and scanning abilities.’³²
- 55 I observe that Mr Robertson’s address at the time was noted as Bulloo Creek Station via Cockburn SA, which Google Maps shows is in outback South Australia, 428 kilometres from Adelaide. Under the heading ‘*Future driving needs*’ Mr Williams noted:
- ‘Mr Robertson lives in a rural location with limited access to alternative transport options. He would drive to and from Adelaide and other long-distance driving on regular occasions.’
- 56 Also on 3 June 2014, Mr Robertson was reviewed by Professor Crompton.³³ Professor Crompton wrote to Dr Anastassiadis on 4 June 2014. I am unaware which occurred first between the OT assessment and the appointment with Professor Crompton, however it is clear that there is no reference in Professor Crompton’s letter to the OT assessment or its outcome. Professor Crompton wrote:
- ‘Thank you for asking me to review this chap with the left absolute homonymous hemianopia. His vision is 6/5 in each eye. He is learning to scan to his blind side and is driving around the property he manages outside Olary without any great difficulties. I am happy to see if he can get re-licensed in the first instance with a waiver restricting him to a 50 km radius from Olary. He is now living in the town itself so needs to drive the 24kms to get to the property he is working on and others if he helps out with fencing etc. He is very sensible and his wife is helping him in the rehabilitation process. Of course, he needs to pass the driver assessment test. I have asked him to contact me in three months time and let me know how he is getting on.’
- 57 Mr Robertson saw Dr Anastassiadis at the Neuro-Rehab Clinic at the RGH on 5 June 2014. Dr Anastassiadis wrote to Professor Crompton that upon the assessment of Mr Williams, the occupational therapist, Mr Robertson was not yet safe for a PDA. Dr Anastassiadis referred to Professor Crompton supporting a limited licence within a 50 kilometre radius of Olary, subject to satisfactory driving assessment, and said that Mr Robertson was ‘*not ready for driving assessment as has untreated sleep disorder and poor scanning*’.³⁴ Plans made at the appointment included Mr Robertson continuing with Guide Dogs visual impairment training and a rehab review in three months.
- 58 On 4 September 2014 Mr Robertson was again reviewed by Dr Anastassiadis, who noted that his hemianopia was likely to be permanent, and also that he wanted to return to driving eventually if he could. Dr Anastassiadis recorded that he needed to await adequate treatment of sleep apnoea for which he had a follow-up with Dr Chia.

³² Exhibit C22, page 96 - This report was forwarded to DPTI

³³ Exhibit C34, page 240

³⁴ Exhibit C21, pages 21-22

Dr Anastassiadis scheduled a review in six months and noted ‘*Consider OT practical driving assessment*’. The following was also noted:

‘Left visual field loss persists. Drives close to right side and misses left-hand turns when driving with wife. Currently wife not permitting him to drive.’³⁵

59 Mr Robertson next saw Dr Anastassiadis on 5 February 2015. On this occasion, according to the doctor’s statement,³⁶ several matters were noted. Mr Robertson was staying at Wilmington,³⁷ but visiting both Broken Hill and Mildura to see his children. I mention this because it makes plain that the nature of Mr Robertson’s driving tasks still included, and would likely continue to include, driving on country roads, for long distances, whether he lived in Wilmington or further into the outback. Dr Anastassiadis also noted that Mr Robertson was very keen to return to driving and reported that his sleep apnoea had been treated and fatigue levels were much reduced. Dr Anastassiadis also noted that Mr Robertson had attended the New South Wales Guide Dogs for visual scanning training, but this had subsequently ceased.

60 Dr Anastassiadis completed and forwarded to the Registrar a Certificate of Fitness,³⁸ in which the question ‘*Does your patient meet the eyesight standards in the Assessing Fitness to drive 2012?*’ was not answered ‘*No*’ or ‘*Yes*’ but with the comment:

‘To be assessed by OT (the name of Professor Crompton was also inserted here) cleared for practical driving assessment.’

61 Later in section 5 of the form, there is a Medical Practitioners Declaration in which the medical practitioner is asked whether in their opinion the person the subject of the report, ‘*Meets the relevant medical standard. If no, please provide details below*’. Dr Anastassiadis appears to have ticked the box ‘*No*’ and then crossed that out. He then wrote:

‘– special case for assessment. But depends on performance in OT pre-driving and practical.’

The question ‘*Requires a practical driving test*’ is answered ‘*Yes*’. The question ‘*Should a licence be issued subject to conditions?*’ is answered, ‘*to be assessed subject to OT pre-driving and practical driving assessments*’.

62 On 31 March 2015 Professor Crompton reviewed Mr Robertson and wrote to neurosurgeon Dr Molloy,³⁹ with copies sent to Dr Anastassiadis and Dr Lian-Lloyd, advising Mr Robertson was ‘*ready for driver assessment*’ and that:

‘if successful he will then need to be relicensed for a license (sic) with a waiver because of his absolute right (sic⁴⁰) hemianopia.’

³⁵ Exhibit C19, pages 128-129

³⁶ Exhibit C8

³⁷ The reader is reminded that this is where he was driving from when he struck Mr Hall

³⁸ Exhibit C22, pages 86-89

³⁹ Exhibit C22, page 80

⁴⁰ The hemianopia was left-sided

Professor Crompton reported that Mr Robertson:

‘Does admit to bumping into people occasionally in the crowded supermarket but never has problems outdoors and has no trouble driving vehicles on private property and backing his caravan into a crowded caravan park lot!’

Professor Dain explained that Mr Robertson’s visual field test results on that day⁴¹ demonstrated a field of peripheral vision of around 80° – 85°, which is well short of the required field of 110° to obtain an unconditional licence.⁴² I note, as confirmed by Professor Dain, that a person with absolute homonymous hemianopia could never demonstrate a field of vision of 110°.⁴³

63 Following receipt of the Certificate of Fitness dated 5 February 2015, DIT made enquiries with SA Health in relation to the provision of visual field reports from Professor Crompton, which were forwarded, together with documentary records of the testing.⁴⁴ DIT sought an independent medical adviser opinion in relation to whether Mr Robertson ought to be granted a permit to undertake an OT assessment.⁴⁵ A report was provided by Dr Thang Vuong, a specialist in occupational medicine, supporting the granting of a permit for an OT assessment.⁴⁶ Dr Vuong’s conclusions were stated:

- ‘1. I note the reports of a CVA in 2013 resulting in a R (sic⁴⁷) homonymous hemianopia but retained independence with physical tasks.
2. I note Professor Crompton’s support for a practical driver assessment based on driving performance on private property.
3. I would support the granting of a permit to allow for OT driver assessment, with the provision of a conditional car class license (sic) subject to the results of the driver assessment. I would not support the granting of a conditional or unconditional HR class driver’s license.’

64 In evidence Mr Gilbert explained that DIT may seek out independent medical advice, but that they were reliant on clinical assessments about someone’s ability to scan in order to compensate for visual field issues.⁴⁸

65 On 9 June 2015 DIT issued Mr Robertson a temporary driving permit, which was restricted to driving only while accompanied by a Motor Driving Instructor.⁴⁹ There is no basis upon which to criticise this decision.

OT driving assessment - 14 July 2015

66 Mr Robertson underwent an OT driver assessment at the Southern Adelaide Local Health Network Driving Assessment and Rehabilitation Clinic, a public system clinic based at

⁴¹ By reference to Medmont plots for each eye, with fixation. A roving binocular Esterman test taken on the same day was not relevant to determining the horizontal extent of the binocular field of vision (see Exhibit C17 at [80]-[81]).

⁴² T74

⁴³ T78

⁴⁴ Exhibit C22, page 85

⁴⁵ Exhibit C22, page 79

⁴⁶ Exhibit C22, page 77

⁴⁷ The error in Professor Crompton’s documentation provided to Dr Vuong is repeated

⁴⁸ T288

⁴⁹ Exhibit C22, page 69

the RGH, on 14 July 2014. This clinic assesses people with a broad range of medical conditions, disabilities, injuries or age-related functional impairments.⁵⁰

67 The OT driver assessment was conducted by Ms Nicola Hayball, who was providing casual OT services for the Driving Assessment and Rehabilitation Clinic.

68 Ms Hayball's qualifications include a Bachelor of Applied Science and Occupational Therapy, University of South Australia, 1993; advanced training in Driver Assessment and Rehabilitation, University of Sydney, 2003; advanced training in Heavy Vehicle Driver Assessment and Rehabilitation, Flinders University, 2018; Certificate IV Transport & Logistics: Road Transport Car Driving Instruction, Adelaide, 2018.

69 Part A section 4 of the Assessing Fitness to Drive guidelines is titled '*General Considerations for Assessing Fitness to Drive*'.⁵¹ Section 4.9 discusses practical driver assessments (PDAs).⁵² This section states that a PDA is to be distinguished from the tests of competency to drive that are conducted for licensing purposes. The section states:

'A practical driver assessment is designed to assess the impact of injury, illness or the ageing process on driving skills including judgement, decision making skills observation and vehicle handling. The assessment may also be helpful in determining the need for vehicle modification to assist drivers with musculoskeletal and other disabilities.'

70 This assessment comprised a series of clinic-based screening tests for functional vision, cognition and physical skills necessary for driving.⁵³ If the results of the screening tests permit, a practical on-road assessment follows.⁵⁴

71 Ms Hayball's evidence was that testing of Mr Robertson was based upon the Victorian Occupational Therapy Driving Test: Assessment Manual (the Manual),⁵⁵ which is considered to represent '*best practice guidelines*' in driver assessment.⁵⁶ There is no corresponding manual written in South Australia. I note the evidence of Ms Hayball that in Victoria an occupational therapist, if having dual qualifications (as Ms Hayball does), can perform a dual function of conducting an OT assessment and the PDA for licensing purposes. In South Australia, DIT conducts its own PDAs for licensing purposes.

72 Ms Hayball described a number of techniques she looks for in a person with homonymous hemianopia to determine whether they can compensate for the vision loss, including: scanning; driving a few kilometres below the speed limit to allow extra scanning and reaction time; maintaining at least three seconds from the vehicle in front; braking early and slowing down to walking speed when approaching intersections; completing a full visual check at intersections before proceeding; double scanning left and right before proceeding into an intersection; performing over shoulder blind spot checks or using compensatory blind spot mirrors; subject to laws requiring a vehicle to move to the left of travelling at or above 80 km/h, travelling in the central or right lane to reduce the need to pass parked vehicles or vehicles turning left; placing the right foot over the brake pedal

⁵⁰ Exhibit C33 at [6]

⁵¹ Exhibit C25, page 16

⁵² Exhibit C25, page 22

⁵³ Exhibit C33, page 14

⁵⁴ Exhibit C33, page 15

⁵⁵ Exhibit C33a

⁵⁶ T310.13-T310.17

to enable quick reaction if required when approaching an intersection or road hazard; always scanning for pedestrians on the affected side when stationary; and looking far ahead and remaining conscious of potential hazards on the affected side.

73 As stated by Professor Dain, the primary consideration in assessing a person with absolute homonymous hemianopia in a driving scenario is to ascertain their degree of compensatory scanning to make up for the loss of visual field. Ms Hayball agreed with this proposition.

74 Part 3 of the Manual sets out the requirements for a standard route for use in open area licence tests. The guidelines state:

‘The use of standard routes including a specified set of road environments and driving tasks will help OTs to conduct valid, reliable on road tests for clients.’⁵⁷

75 Appendix C of the Manual lists the standard driving tasks and location requirements to be included in open area test routes.⁵⁸ Ms Hayball acknowledged that tasks involving high-speed driving were not necessarily incorporated into the common tasks undertaken. This could not be accommodated in a one-hour assessment⁵⁹ conducted from the suburban clinic. She said that if an evaluation of high-speed driving is required, recommendations to that effect are made and that such recommendations were common for drivers who live in the country and encounter high-speed driving frequently.⁶⁰ In making this observation, Ms Hayball distinguished between a further referral to a private occupational therapist driver assessor to cover such issue more specifically, with a significant cost to the client, and the other option, if the cost is of concern, of conducting the DIT test in a country area.⁶¹

76 In relation to those two options, I observe that the first option, although probably involving a significant cost to the client, is the only one of the two options which is conducted by an occupational therapist as a ‘*practical driver assessment*’, ‘*designed to assess the impact of injury, illness or the ageing process on driving skills including judgement, decision making skills observation and vehicle handling*’.⁶² The second option is, as stated in *Assessing Fitness to Drive*, a test of competency for licensing purposes. In my opinion, it became apparent in this inquest that a test of competency for licensing purposes is unlikely to lead to a proper assessment of the ability or likelihood of a person with left homonymous hemianopia to be able to constantly scan to compensate for lack of vision to the left-hand side of centre whilst driving for long distances on country roads which, by their nature, tend to be relatively featureless on the left-hand side compared to driving in a city or suburban setting. One of the reasons is that such a test will not normally involve driving for long distances on country roads. Indeed, I heard no evidence that this ever occurs. Other reasons are that in South Australia the PDA for licensing purposes is always undertaken by a suitably qualified DIT employee, who is not an occupational therapist. Additionally, the examiner might or might not know the nature or extent of the unexamined driver’s disability.

⁵⁷ Exhibit C33a, page 21

⁵⁸ Exhibit C33a, page 6

⁵⁹ The practical component - the whole assessment was two hours

⁶⁰ T312

⁶¹ T313

⁶² Exhibit C28, page 21

77 Ms Hayball told the Court that a PDA undertaken by an occupational therapist was ‘one of the gold standard assessments for determining people’s ability to drive with a medical condition’. She said that doctors will use an OT report including any recommendations to guide their decisions about licensing.⁶³

78 Ms Hayball was mindful of Part A section 10.3 of the Assessing Fitness to Drive guidelines which describes the medical standards for licensing. In respect to the drivers of cars, the standard concerning visual fields states:

‘A person is not fit to hold an unconditional licence:

if the binocular visual field does not have a horizontal extent of at least 110 degrees above and below the horizontal midline, **or**

if there is any significant visual field loss (scotoma) within a central radius of 20 degrees of the foveal fixation or other scotoma likely to impede driving performance

A **conditional licence** may be considered by the driver licensing authority subject to **annual review** taking into account the nature of the driving task and information provided by the **treating optometrist or ophthalmologist**’⁶⁴

79 Ms Hayball said that when conducting Mr Robertson’s assessment, she was not aware of the extent of his hemianopia but assumed it was extensive.⁶⁵ In her statement, Ms Hayball stated she noted, following the pre-drive screening tests:

‘that Mr Robertson demonstrated sound visual scanning techniques and was aware of the implications of his visual field loss on his driving. I did note that I felt that Mr Robertson did not necessarily correlate his visual field loss with potential difficulty in driving.’⁶⁶

80 It is pertinent to repeat from Ms Hayball’s statement the following opinions and information about the pre-drive screening and her impressions of Mr Robertson:

‘Insight into driving risks is important. Insight influences driving behaviours. It is not medical fitness. From my recollection, Mr Robertson was of the attitude “I know I have got a vision impairment, but I’ve been driving for years and I’ll be fine”. He was compliant with the OT assessment, driving lessons and the DIT practical driving assessment. I wrote that I ‘felt’ there was some discrepancy in Mr Robertson correlating his experience of vision impairment with what he acknowledged could be risk for driving. It was not a definite demonstration of poor insight, rather ‘hunch’ or ‘gut instinct’. Signs of poor insight would more likely be a refusal to adjust driving behaviours, derogatory comments, or refusal to complete components of the driving assessment/training.’⁶⁷

81 The on-road assessment was conducted with a driving instructor seated in the front passenger seat, with dual foot controls. There was also an additional rear-view mirror to allow Ms Hayball, who was seated in the left rear passenger seat towards the centre, to observe Mr Robertson’s scanning and head movements.⁶⁸ The route undertaken was a standard (suburban-based) route, incorporating a specific range of driving tasks.⁶⁹

⁶³ T317

⁶⁴ Exhibit C25, page 120

⁶⁵ T329.11-T329.27

⁶⁶ Exhibit C33 at [52]

⁶⁷ Exhibit C33 at [62]

⁶⁸ Exhibit C33 at [62]

⁶⁹ Exhibit C33 at [60]; Exhibit C33a, page 21

- 82 The on-road driving assessment went for 60 minutes. Ms Hayball maintained a contemporaneous log during the subsequent on-road assessment.⁷⁰ Overall, minimal issues with Mr Robertson's driving were noted.
- 83 Ms Hayball noted that on one occasion Mr Robertson made a wide left-hand turn.⁷¹ Ms Hayball did not attribute that episode to Mr Robertson's homonymous hemianopia.⁷²
- 84 She noted that Mr Robertson hit a kerb when pulling in.⁷³ Ms Hayball did not consider this occurrence to be a cause for concern in the early stages of the assessment.⁷⁴
- 85 Ms Hayball noted one occasion when the driving instructor assisted steering when Mr Robertson drove close to a parked car on the left side.⁷⁵ Ms Hayball said that she did not think Mr Robertson was missing visual information. Rather, it was probably reflective of his previous driving style.⁷⁶ Ms Hayball agreed that such an episode would be consistent with inadequate scanning but, when giving evidence, she said she was able to say that she did not consider Mr Robertson was dangerously close to the parked vehicle as she did not mark the log with a big cross, which she would have done if she thought it was dangerously close.⁷⁷
- 86 Ms Hayball noted that Mr Robertson needed to give himself extra time to scan by slowing down his approach to, and exit from, intersections.⁷⁸
- 87 Ms Hayball noted that Mr Robertson did not perform an over the shoulder blind spot check when changing lanes and that he relied on his rearview mirrors.⁷⁹ Ms Hayball attributed this occurrence to Mr Robertson's previous driving experience which included driving heavy vehicles.⁸⁰
- 88 Ms Hayball noted that Mr Robertson needed to allow more gap behind cars in front of his vehicle at traffic lights.⁸¹
- 89 Ms Hayball summarised her assessment on page 9 of her report.⁸² The summary included the following statements:

'The pre-driving screening assessment identified that Mr Robertson was employing sound visual scanning techniques. It was noted however, that he was fairly dismissive of his vision loss and the likely impact this could have on driving.

On-road Mr Robertson's skills in observation, planning and judgement, vehicle positioning, speed control and fiscal control were assessed and compared to the results of the pre-drive screen.

⁷⁰ Exhibit C20a, pages 45-48

⁷¹ Exhibit C20a, page 45

⁷² T342.13

⁷³ Exhibit C20a, page 45

⁷⁴ T342.34

⁷⁵ Exhibit C20a, page 46

⁷⁶ T344.15

⁷⁷ T344.29

⁷⁸ Exhibit C20a, page 46; T345.2

⁷⁹ Exhibit C20a, pages 47-48; T345.22

⁸⁰ T345.22

⁸¹ Exhibit C20a, page 48; T346.1

⁸² Exhibit C20a, page 31

Overall, it was apparent that Mr Robertson's medical condition does impact on his driving performance. On-road performance issues that are related to his medical condition are:

1. Speed control approaching/exiting intersections - while considered safe and legal for people with normal vision - was too fast for accommodating the extra time required for visual scanning to overcome a complete visual field loss. This is considered the necessary precautionary technique. Mr Robertson was able to apply the feedback to slow down, but his general conversation indicated that he felt it unnecessary as he was driving safely and competently.⁸³

90 Counsel Assisting suggested to Ms Hayball that these were signs that Mr Robertson was not listening to Ms Hayball and the driving instructor.⁸⁴ Ms Hayball answered:

'They were probably the signs that made me want to have him perform again, and to be checked further. His driving seemed to be of a reasonable standard considering, but probably that behaviour which is depicted there, I wanted to be checked again, yes.'⁸⁵

91 Ms Hayball later explained in evidence:

'So obviously there was no at-risk driving for Mr Robertson. If somebody has a hemianopia and it is significantly impacting on their awareness of the visual environment, you will know it straightaway. It will be very consistent. It will be consistently driving up very close to cars, missing information, missing road signs, missing a lot of information. It's clear and we terminate the assessment at that point. For Mr Robertson, he did well for him to be able to get to this point. There is only a small percentage of people with this medical condition that will get to this point, in my opinion, in what I've assessed, I should say that, clarify it.'⁸⁶

92 Ms Hayball was quite aware and open about the possibility that a person under assessment will put their best foot forward, as passing the OT PDA is an essential hurdle to jump to have their licence reissued, as applied to Mr Robertson.⁸⁷ Mr Robertson expressed his frustration with the delay in returning to drive.⁸⁸ Following his pre-driving screen, Ms Hayball felt that Mr Robertson had, or appeared to have, '*good insight*'⁸⁹ even though Ms Hayball had made the following note, '*fairly dismissive of vision loss/possible impact on driving*'.⁹⁰ When asked if this raised a red flag, Ms Hayball responded that the assessments she undertakes are '*very deficit focused*' and it was something that raised her awareness, but it was not conclusive.⁹¹

93 Ms Hayball noted that when she provided feedback about entering and exiting intersections too quickly, not allowing sufficient time to scan, he felt it was unnecessary to slow down, as he was driving '*safely and competently*'.⁹² When giving evidence

⁸³ Exhibit C20a, page 31

⁸⁴ T366.25

⁸⁵ T366.27

⁸⁶ T380.6

⁸⁷ T340.30-T340.34; T358.11-T358.31

⁸⁸ Exhibit C20a, page 25

⁸⁹ T340.4-T341.9

⁹⁰ Exhibit C20a, page 43

⁹¹ T341.14-T341.24

⁹² Exhibit C20a, page 31

Ms Hayball was asked if Mr Robertson was being ‘*dismissive*’ of her feedback and gave the following evidence:

‘A. I suppose that’s how you could interpret it, but it seemed to be that he required more persistent coaching. Dismissive I suppose is a strong word. We needed to encourage him to get to that point. I suppose, of being able to adjust his technique. It is my opinion that he was fairly confident about his driving ability despite the vision impairment.

Q. Again, is that an observation that could be considered a red flag?

A. Yes, which is why I think why I’ve noted it here because there were people who knew Mr Robertson a lot better than I did at that point in time who’ve had consistent dealings with him over that time who could read that and made opinion about whether that was accurate or not.’⁹³

94 Ms Hayball was at some pains to emphasise that the attitude she perceived from Mr Robertson was common in persons that she assessed.⁹⁴ This highlights an inherent difficulty in assessing the attitude of the person being tested, acknowledging that some persons will put their best foot forward in order to achieve the result they desire, when the assessor has no prior knowledge of them. Ms Hayball made four recommendations:

‘With approval from his treating medical practitioner, Mr Robertson is recommended to return to a Class C licence once he completes 2 x driving lessons with a qualified Driving Instructor to reinforce the technique of slowing down at intersections to allow for adequate visual scanning and reaction time.

Recommended conditions for Mr Robertson's licence are - no night driving, no towing vehicles;

Recommend Department of Transport practical test in local area following lessons;

Further medical review is required if Mr Robertson wishes to upgrade these conditions following a three-month period of successful return to daytime car driving.’⁹⁵

95 In relation to the first recommendation, Ms Hayball arranged for Mr Robertson to have two driving lessons with the driving instructor who was in the vehicle for the PDA.⁹⁶

96 Ms Hayball explained in oral evidence her reasons for the third recommendation. She said:

‘That I wanted them to have a test in their local conditions to test the driving that they would be doing. The two options would be an OT on-road assessment which was going to be a ridiculous cost for Mr Robertson, or the other option was the Department of Transport test of competency in his local area. The doctors have the capacity on their form to write, you know, want to test this or that. And I’m sure that the Department of Transport comply as well as they can. I am aware that the Department of Transport have set criteria that they need to include in their routes as well, so I suppose the test was the best possible option for us testing Mr Robertson in his area to see whether he could actually incorporate all of the things that we’d been teaching him in the preceding time.’⁹⁷

⁹³ T349; T372

⁹⁴ T364.6

⁹⁵ Exhibit C20a, page 31

⁹⁶ Exhibit C33 at [72]

⁹⁷ T377.3

- 97 Although Ms Hayball expected that this test would involve driving on high-speed roads,⁹⁸ in my opinion her recommendation, ‘*Department of Transport practical test in local area*⁹⁹ following lessons’ did not adequately identify precisely what she was recommending, and why, and whether Mr Robertson’s nearest standard DIT testing arrangement at Port Augusta would satisfy that description from her perspective. As will be seen, the doctor who then saw Mr Robertson did not specify that the test should occur in his local area.
- 98 I conclude that if Ms Hayball had in mind that Mr Robertson’s ability to scan to compensate for his visual field loss during high-speed, long-distance country driving needed to be assessed, then she would have known that a standard Port Augusta based DIT licensing test would not adequately assess that, and that she should specifically recommend a further OT PDA, no matter the cost to the client. My sense, although she was not asked the question directly, is that Ms Hayball’s preference would have been to recommend a further OT assessment, conducted in a significant part on country roads, but that the likely high cost of that exercise led her not to make that recommendation.
- 99 I should mention at this stage that foundational to the recommendations I intend to make is that in the case of homonymous hemianopia, practical testing should be extended to clearly test and demonstrate competency in all conditions in which a driver might intend to drive and that, where not so demonstrated, conditions should be imposed to limit the nature of driving which may be undertaken.
- 100 Ms Hayball wrote¹⁰⁰ to Dr Anastassiadis on 14 July 2015 attaching a copy of her OT driver assessment report for Mr Robertson.
- 101 Ms Hayball was mindful of her role, and well aware that the task of assessing medical fitness to drive and making licensing recommendations, pursuant to the governing scheme, was not hers, and rested with Dr Anastassiadis, as she made clear in her letter to the rehabilitation specialist:

‘...’

As the treating medical officer who completed the Medical Fitness to Drive a Light Vehicle – MR712 form for Mr Robertson, please review the attached assessment results and recommendations to assist your decision making regarding the clients current and future drivers licence status. **Your consideration and action is required to notify the Department of Planning Transport and Infrastructure (DPTI) of your licensing recommendations following review of this report.** It would be appreciated if you would notify the Repatriation General Hospital Occupational Therapy Driver Assessment and Rehabilitation Clinic of your decisions following review of this report.’¹⁰¹

Follow-up rehabilitation specialist appointment

- 102 On the same day, Mr Robertson had an appointment with Dr Vaqas Farooqi, a different rehabilitation medicine specialist at the RGH Occupational Therapy Services Driver Assessment and Rehabilitation Clinic. This is a public clinic, and it is reasonable for me

⁹⁸ T378.8

⁹⁹ My emphasis

¹⁰⁰ Exhibit C20a, page 58

¹⁰¹ Exhibit C20a, page 23

to assume that Dr Farooqi was available on that day, and Dr Anastassiadis was not. It is clear that Dr Farooqi had the documentation sent by Ms Hayball.

- 103 Dr Farooqi wrote to the Registrar of Motor Vehicles by letter¹⁰² dated 10 August 2015 advising that he reviewed Mr Robertson after the OT driving assessment. The letter was presumably not sent for a couple of days after it was dated because, enclosed with the letter, was a fresh Certificate of Fitness with section 4, the Eyesight Certificate, completed on 14 July 2015 by Dr Farooqi and Mr Robertson's declaration dated 12 August 2015. I note that the DIT file, produced for the purpose of the inquest, did not contain the last page of the Certificate of Fitness, Section 5: Medical Practitioner's Declaration, and the first page of that document had a handwritten note on it, '*Awaiting Section 5 from Dr/Repat*'.¹⁰³ Accordingly, from the documents produced, it is not clear to me whether and, if so, when, DIT received a fully completed Certificate of Fitness from Dr Farooqi.
- 104 The Certificate of Fitness included in '*Additional Notes*' some detail relevant to Mr Robertson's stroke on 14 January 2014 and to assessment of his fitness to drive:

'Stroke following surgical clipping of aneurysm causing L Homonymous Hemianopia which is unlikely to improve. He has since adapted with good scanning techniques and has been cleared by Professor Crompton (neuro-ophthalmologist at RAH) to drive w/i 50 km radius of Olary. He has been assessed by OT driving clinic for driving.

RECOMMENDATION FOR RESTRICTED DRIVING

- (1) 2 Driving lessons to reinforce slowing at intersections to allow adequate scanning and reaction times.
- (2) Dept of Transport practical test following lessons.
- (3) No night driving, no towing.¹⁰⁴

- 105 Dr Farooqi's covering letter stated:

'I have reviewed John who underwent occupational therapy driving assessment. As per the recommendations from this assessment, the medical Fitness to Drive form was completed with following conditions:

- a) One to two lessons with driving instructor to work on slowing at intersections to scan and to allow adequate reaction times.
- b) Once the lessons completed, driving assessment to be conducted by transport department.
- c) On completing these assessment he can have license restricted to no driving at night and no driving while towing.

I will appreciate your assistance in organizing temporary permit for this gentleman to facilitate the driving lessons. Please do not hesitate to contact me if you have any concerns.¹⁰⁵

- 106 Dr Farooqi was not called to give evidence in the inquest. The doctor did not mention in the letter to the Registrar that Ms Hayball noted, about the results of the pre-drive

¹⁰² Exhibit C20a, page 57

¹⁰³ Exhibit C22, page 56

¹⁰⁴ Exhibit C22, page 58

¹⁰⁵ Exhibit C22, page 53

screening, that Mr Robertson was fairly dismissive of his vision loss and the likely impact this could have on driving. However, Ms Hayball's report appears in the DIT file in the same location as Dr Farooqi's letter and the Certificate of Fitness to Drive. So, for present purposes it appears likely that Ms Hayball's report, which includes that reference, was forwarded to DIT with those documents and was available to the Registrar for consideration. Professor Dain expressed the view that more attention should have been paid to the concerns of the on-road driving assessor.¹⁰⁶

- 107 I have noted that in purported transcription from the Certificate of Fitness, which referred to two driving lessons, the letter referred to 'one to two' lessons. Ms Hayball's evidence was that she arranged for Mr Robertson to have the two further recommended lessons with the driving instructor, Mr Whiteside.¹⁰⁷ Ms Hayball elaborated in oral evidence that it was common for her to ask these experienced driving instructors to undertake lessons and give them information about exactly what she was looking for. Although she did not have a specific recollection, she was confident Mr Whiteside gave her feedback after those lessons. In the circumstances, I conclude it is likely that both of the recommended lessons occurred.
- 108 Ms Hayball was at pains to inform the Court that she, as an occupational therapist can only make recommendations, not licensing decisions.¹⁰⁸ It is in that context she wrote her report addressed to the medical referrer, Dr Anastasiadis.

Mr Robertson is issued with a temporary permit to allow a practical driving assessment for licensing purposes

- 109 On 17 August 2015, in accordance with the advice given by Dr Farooqi, Mr Robertson was issued with a section 80 permit (temporary licence)¹⁰⁹ valid from 17 August 2015 until 17 October 2015 with conditions including to drive only while accompanied by a motor driving instructor and to drive only during daylight hours.
- 110 The permit was sent to Mr Robertson with a covering letter which unfortunately referred to Dr Farooqi's recommendation that he undertake '1-2 sessions with a Motor Driving Instructor prior to undertaking a practical driving assessment'. As I have noted, this was different from the recommendation made by Ms Hayball, which I have observed was correctly recited by Dr Farooqi in the Certificate of Fitness. However, for reasons I have mentioned, I am not concerned that only one lesson may have occurred as opposed to the two lessons recommended by Ms Hayball. If I am wrong in concluding that two lessons occurred, I have no doubt that two lessons, as opposed to one, would not have prevented Mr Hall's death.
- 111 I am, however, concerned that there had by this stage been no assessment by an occupational therapist of Mr Robertson's ability to scan constantly and consistently during long-distance country driving. Furthermore, neither the report of Ms Hayball, nor the Certificate of Fitness, or the covering letter from Dr Farooqi drew specific attention to the fact that this had not occurred. Neither was there any specific suggestion that it ought to occur before Mr Robertson should be issued a licence which would, by necessary

¹⁰⁶ Exhibit C17 at [110]

¹⁰⁷ Exhibit C33 at [72]

¹⁰⁸ T315.20; T371.38-T372.31

¹⁰⁹ Exhibit C22, page 52

implication unless restricted by conditions, permit him to drive in all the circumstances covered by that licence, including long-distance country driving, which was clearly something Mr Robertson intended to do. To be clear, I include in my description for present purposes of ‘*long-distance country driving*’ a drive such as that being undertaken by Mr Robertson when he collided with Mr Hall, namely a half hour drive of some 40 kilometres on country roads. For practical purposes, and in the circumstances under consideration, such a drive should be considered as a subset of long-distance country driving.

- 112 In the context of this observation, I mention the evidence of Professor Dain, with which I agree, referring to the OT assessment and what should be made of it by the licensing authority:

‘In my opinion, the further investigation and scope of and performance in the on-road assessment should determine what is and is not permitted.’¹¹⁰

Practical driving assessment – Port Augusta 10 September 2015

- 113 On 10 September 2015 Kathleen Roberts, a Licence Examiner and Accreditation Audit Assessment Officer with DIT, conducted a PDA with Mr Robertson in Port Augusta. According to Google Maps, this is about half an hour’s drive from Wilmington where Mr Robertson was living. The test was mainly within the city of Port Augusta but included a quite brief component of driving in 80 km/h and 100 km/h zones on the outskirts. This PDA was of the standardised licensing variety, intended to assess a person’s ability to safely operate in a motor vehicle and comply with the road rules. It is broadly consistent with the test administered to a learner driver seeking a probationary licence, but without all of the elements, such as reverse parallel parking, intended to test a new driver.¹¹¹
- 114 Ms Roberts was not called to give evidence during the inquest but provided an affidavit,¹¹² in which she stated that she undertook this PDA, and a subsequent one during which Mr Robertson towed a caravan, without knowing on either occasion that Mr Robertson had an eye defect. Neither was she provided with a copy of Ms Hayball’s report to Dr Anastassiadis, or even a summary of the report.¹¹³
- 115 Mr Gilbert gave some pertinent evidence about the nature of the PDA, which was undertaken, having regard to Ms Roberts’ PDA report,¹¹⁴ which formed part of the DIT licensing file. Mr Gilbert explained that Ms Roberts would not have had the OT assessment or a summary of information of that assessment, as the general view at the time was that each PDA should be a standalone assessment of a person’s ability to drive safely and to meet all road rule requirements, which should not be influenced by external information. This was the standard practice of the DIT at the time, and the assessor would be blind to ‘*any specific issues*’ of the person being assessed.
- 116 That practice has now changed following a previous coronial recommendation, in the sense that the assessor, while not being informed of any detail, would know ‘*there was a*

¹¹⁰ Exhibit C17 at [93]

¹¹¹ T232-T233

¹¹² Exhibit C29

¹¹³ T274.3

¹¹⁴ Exhibit C22, page 41

visual field issue,¹¹⁵ but the assessor would not receive a copy of the occupational therapist's report.¹¹⁶

- 117 Ms Hayball gave evidence that the DIT advised in 2023 that it was no longer necessary to provide the DIT with the OT's report, so it only gets to DIT if the doctor completing the Certificate of Fitness provides it together with that certificate.¹¹⁷ I express my disapproval of this approach. In my opinion, in the case of a homonymous hemianope seeking authority to drive, it is essential that DIT receives and takes into account the report of an occupational therapist to assist in, or at least operate as, a crosscheck in making a final determination whether a conditional licence should be issued and, if so, upon what conditions. In my opinion, it is unwise, and potentially unsafe for the DIT driving assessor, not to be clearly informed that the driver must constantly scan to the left to see the full field of view. Without doing so, the driver will fail to see the left-hand side of the road.
- 118 The PDA involved a 20-point demerit-based scoring system, accumulation of which would lead to a fail. Some errors were prescribed certain points, as set out on the PDA form. Some, including breaches of road rules, anything that put the PDA assessor in danger, or any instances where the assessor had to intervene, for example, making a turn onto the wrong side of the road, would lead to an automatic fail.
- 119 Mr Robertson passed the PDA with minor errors, only scoring four points. His errors were:
- Fail to keep safe distance from parked cars;
 - Fail to check traffic behind (blind spot);
 - Lacked forward judgement; and
 - Made incorrect turn (cut right corner).¹¹⁸
- 120 According to the rules of the test and having regard to Ms Roberts' lack of knowledge of Mr Robertson's left absolute homonymous hemianopia, she was entirely unable to consider these errors in the context of his visual disability. By reference to design of the test and the scoring system, Mr Robertson clearly passed without Ms Roberts being in any position to consider whether his visual field defect had a bearing on the way he drove. Even if she had, Mr Robertson would have passed the test by reference to the criteria for doing so. In any event, in my opinion, it cannot be said that the quite short period of driving in 80 km/h and 100 km/h speed limits could specifically test a homonymous hemianope's capacity to constantly and consistently scan during long-distance country driving, even if the assessor was aware of the issue.
- 121 I observe that if Mr Robertson had been tested on a specifically designed extended route for the purpose of assessing his ability to constantly and consistently scan during long-distance country driving, there is no way of knowing whether he would have passed. If he had been so tested and had not demonstrated an ability to maintain scanning for extended durations, a condition could have been considered limiting his driving to lower

¹¹⁵ T274.17

¹¹⁶ T274.22-T275.12

¹¹⁷ T316.31-T317.16, ability of a homonymous hemianope

¹¹⁸ Exhibit C6 at [3]; Exhibit C22, pages 40-46

speed limit roads unless and until such time as he could demonstrate such ability. If he had been tested and did demonstrate that ability, then assuming the nature of the testing was adequate and appropriate for the purpose, the mere requirement of that testing and its administration might have served to impress upon him the necessity to maintain constant and effective scanning even in conditions which might suggest to him that there was minimal risk if he failed to do so.

Conditional licence issued

- 122 On 30 September 2015 Ms Phillips wrote to Mr Robertson informing him that he may hold a car class driver's licence with conditions 'to drive only during daylight hours' and 'not valid for towing'.¹¹⁹ These conditions were as recommended by Ms Hayball and, in turn, Dr Farooqi who, I assume, took into account Ms Hayball's recommendations. Mr Gilbert explained that doctors' recommendations are 'very influential' in the decision-making of DIT, and that they would not typically challenge those recommendations.¹²⁰ However, Mr Gilbert said that if the recommendations of one doctor appear inconsistent with the recommendations of another doctor, this may prompt follow-up questions as to whether the doctor deliberately decided to recommend something different.¹²¹
- 123 The licence was also subject to annual review, which DIT asserted met the minimum requirement for a conditional licence in Assessing Fitness to Drive. During the inquest there arose a question, which was the subject of contested submissions, whether it was intended in Part A section 10.3 of the Assessing Fitness to Drive guidelines that 'annual review' could be the one and only condition of a conditional licence. In my opinion this is, and remains, unclear. It is an ambiguity in the publication which, in my opinion, should be corrected. It is my opinion that the nature of the condition of absolute homonymous hemianopia, and the level of risk created by a driver with that condition who does not at all times adequately scan to their blind side, should mean that a licence with no condition other than annual medical review should never be considered as adequately addressing that risk.

Process which led to towing and night time driving restrictions being lifted

Medical and visual assessments

- 124 On 4 November 2015 Mr Robertson was reviewed by Dr Anastassiadis, who noted that Mr Robertson was disappointed by the driving restrictions and had asked him to review them. Dr Anastassiadis wrote¹²² to Dr Lian-Lloyd, with copies to various practitioners including Professor Crompton and Dr Farooqi, mentioning that Mr Robertson was outside the normally permitted clearance guidelines for recreational and commercial driving, but had demonstrated sufficient scanning and passed OT and DOT¹²³ PDAs. Also mentioned was that Mr Robertson had sleep apnoea, which was not currently satisfactorily controlled with BPAP, although he was under medical management for this, and his morphine intrathecal pump had been reduced by 20% to determine if this might improve his sleep pattern. Dr Anastassiadis stated in conclusion that in his opinion Mr Robertson had

¹¹⁹ Exhibit C22, page 37

¹²⁰ T249-T250

¹²¹ T261.26

¹²² Exhibit C19, page 131; Exhibit C21, page 30

¹²³ Plainly, Dr Anastassiadis is referring to DIT (previously DPTI)

performed to a satisfactory and competent level on the driving assessments. Nevertheless, he advised Dr Lian-Lloyd:

‘I have advised that the restrictions of no night time driving and no towing of vehicles should remain in place. It is advisable to be cautious and observe his progress over the next eight – nine months, particularly while his OSA management and morphine doses are optimized.

...

‘I will review John’s progress in mid-2016 and have reinforced that he should be happy with his current driving clearance and driving permissions, given that he is strictly outside the return to driving visual clearances/guidelines.’

125 On 9 November 2015 Dr Lian-Lloyd wrote to Professor Crompton. He said:

‘He has undergone driving assessment and review by yourself in the past. I understand there is some attempt to change his licence restrictions, which would be more restrictive for this gentleman. He is very sensible and he has a number of other co-morbidities and he does really need to be able to drive. He is aware of his blind spot, he allows for this accordingly and moves his head more readily to check his visual field. I would appreciate your assessment and recommendation with regard to the above.’¹²⁴

126 On 12 April 2016 Dr Lian-Lloyd wrote to Dr Anastassiadis requesting he review Mr Robertson, stating that he was due for review, and requesting ongoing care and management.¹²⁵

127 On 1 June 2016, presumably as a result of Dr Lian-Lloyd’s correspondence with Dr Anastassiadis, Mr Robertson was reviewed by Dr Mei-Fen Sung (Rehabilitation Registrar) at the Whyalla Hospital and Health Service Rehabilitation Clinic. Dr Sung spoke to Dr Lydia Huang, the Rehabilitation Medicine Consultant who was on call. Dr Huang advised that Mr Robertson’s conditions could not be removed given his persistent left hemianopia. Dr Huang advised that if Mr Robertson wanted to pursue the issue further, he would require ophthalmologist review and either a driving clinic review or a review with Dr Anastassiadis.¹²⁶

128 On 3 June 2016 Dr Lian-Lloyd wrote to Professor Crompton advising that Mr Robertson was due for his annual review and referring him for Professor Crompton’s assessment and recommendation.

129 On 14 June 2016 Professor Crompton reviewed Mr Robertson. He performed an Esterman test, without fixation, which he described¹²⁷ as showing further great improvement over the test conducted on 31 March 2015. Professor Crompton wrote to Dr Lian-Lloyd:

‘He has adapted very well and scans perfectly well and never bumps into people. Even now in supermarkets he is very careful not to collide with anyone. He has been driving happily by day and has not had any [scares] at all. I see no reason why he cannot upgrade his driver’s licence and remove the restrictions about no night driving and not towing a

¹²⁴ Exhibit C19, page 187

¹²⁵ Exhibit C19, page 184

¹²⁶ Exhibit C8 at [66]-[70]; Exhibit C19, page 126

¹²⁷ Exhibit C7, page 2

caravan. It is a waste of time testing his fields on computerised perimetry because he is scanning so well that he moves his midline well to his left. His unaided acuity is 6/6 in each eye and the rest of the neuro-ophthalmic examination was unremarkable.

I will write to the rehabilitation doctors to help facilitate the upgrading of his licence.’¹²⁸

130 The next day, Professor Crompton wrote to Dr Anastassiadis:

‘I have just reviewed John Robertson who will always have the left absolute homonymous hemianopia. However, he has adapted very well and it is a waste of time doing computerized perimetry because he scans so well that he shifts the midline well to his left. Because of his scanning ability he has not had any difficulties driving by day and I support his application to have the restrictions, i.e. allow him now to drive at night and also to tow a caravan. He is very sensible and will not take risks, I am sure.

His acuities are 6/6 unaided in each eye and the rest of the neuro-ophthalmic examination is unremarkable.

I would be most grateful if you could help facilitate the relaxation of his restrictions.’¹²⁹

131 On 17 July 2016 Professor Crompton completed section 4 (Eyesight Certificate) of a Certificate of Fitness describing Mr Robertson’s visual acuity as 6/6 in each eye and writing an additional note referring to his left absolute homonymous hemianopia, stating:

‘He has adapted very well and scans properly and has been driving his 4WD without problems (with a waiver to licence).

I consider that he is now fit to drive his car at night and to be able to tow his caravan as well.

I recommend that he have a driving test with caravan in tow every three years.’

Professor Dain in relation to the June assessment and July recommendation

132 Professor Dain’s evidence in relation to the Esterman test administered by Professor Crompton on that day was that the number of points not seen does, indeed, reduce (from the previous test administered on 31 March 2015) and is indicative of more efficient scanning, at least for the duration of the test.¹³⁰ Professor Dain points out that the improvements in the tests (including in a subsequent test in 2017) could be due to improvements in Mr Robertson’s condition, improved insight into how to get the best result from the test, or greater skills at scanning the test area or a combination of both.¹³¹ Professor Dain also pointed out that the results of this test show Mr Robertson to be fixating a little further to the left and, consequently, a point to the far right then fell outside his right temporal field.¹³²

133 Professor Dain also gave evidence that he knows of no evidence that the binocular Esterman tests undertaken without fixation, which are stated by Professor Crompton to demonstrate an ability to scan, translate into adequate scanning for the driving task. Later in this finding I shall refer to an academic article referred to by Professor Dain which

¹²⁸ Exhibit C21, pages 8, 35; Exhibit C7, pages 2-3

¹²⁹ Exhibit C21, page 36

¹³⁰ My emphasis

¹³¹ Exhibit C17 at [47]

¹³² Exhibit C17 at [88]

examines the relationship between Esterman tests without fixation and performance in an on-road driving test.

- 134 In a statement taken to provide Professor Crompton with an opportunity to answer observations by Professor Dain, Professor Crompton agrees with Professor Dain that there is no evidence that the Esterman tests translate into adequate scanning for the driving task and adds that he also relied upon history from Mr Robertson and his wife. For these reasons, Professor Crompton stated he relied on extra assessments by rehabilitation doctors (Dr Anastassiadis) and the Guide Dog driving assessors, etc.¹³³

Review by Dr Anastassiadis - 3 August 2016

- 135 Mr Robertson then saw Dr Anastassiadis for review on 3 August 2016, following which Dr Anastassiadis completed the remainder of the Certificate of Fitness, referring to Mr Robertson being cleared for driving after passing the OT driving test and the PDA in in 2015, and currently having restrictions on night driving and towing. Dr Anastassiadis stated that Mr Robertson required a practical assessment for night driving and towing a caravan/trailer, followed by medical clearance by his general practitioner every year. He referred to Professor Crompton's recommendation of a practical driving test with caravan every three years.¹³⁴ He stated in a letter to Dr Lian-Lloyd:

'I have cleared John to undertake practical driving assessments while towing (trailer/caravan) and night time driving.'¹³⁵

- 136 On 24 August 2016 a DIT client action sheet records:

'Dr Anastassiadis confirms that if client passes test towing a caravan we can remove both conditions. Not valid for towing and daylight hours.'¹³⁶

This note suggests that Dr Anastassiadis was contacted on or about that day by the DIT employee who made the note. It does not record any reason for which Dr Anastassiadis said, if he did, that it was not necessary for the test to occur at night. On the same day, Ms Phillips wrote to Mr Robertson saying that she had recently received information from Dr Anastassiadis who recommended that he undertake a PDA to remove the towing and daylight driving conditions from his licence. Ms Phillips stated, '*Dr Anastassiadis has advised that you must undertake this assessment whilst towing a caravan.*'¹³⁷ There was no specific evidence received at inquest to confirm, or otherwise, that Dr Anastassiadis advised that the test need not occur at night, so I can only speculate why that requirement was not imposed. One possibility is that Dr Anastassiadis was informed by someone at DIT that they do not usually undertake night time driving tests. I might guess that the DIT PDA staff are usually expected to work during regular daylight hours.

Practical Driving Assessment – Port Augusta 13 September 2016

- 137 Ms Roberts conducted a PDA with Mr Robertson towing a caravan within and on the fringe of the township of Port Augusta.¹³⁸ It appears to have followed a route quite similar

¹³³ Exhibit C7b at [9]

¹³⁴ Exhibit C22, page 34

¹³⁵ Exhibit C19; Exhibit C21, pages 37-38

¹³⁶ Exhibit C22, page 2

¹³⁷ Exhibit C22, pages 26-27

¹³⁸ Exhibit C22, pages 18-24

to the previous test, including a limited time driving on roads with 80 km/h and 100 km/h speed limits. The assessment was undertaken during daylight hours.¹³⁹ Mr Robertson incurred no penalty points and drove according to road traffic and weather conditions. It was raining during the assessment and there was poor visibility at times.¹⁴⁰

138 On the evidence, I conclude that if Dr Anastassiadis had specifically advised that the test should occur at night, DIT could have arranged for that to occur, unusual as it was.¹⁴¹ I also observe that it would seem logical for a test to assess the suitability of removing conditions of no towing and no night time driving, to include driving whilst towing and driving at night.

139 I am not able to say whether Mr Robertson would have been likely to demonstrate any difficulty in driving at night during a test conducted by DIT. Having regard to the previously discussed criteria for passing DIT PDAs for licensing purposes, and what I regard as Mr Robertson's demonstrated general competence for matters practical and his apparent adaptability, there is no particular reason to think that Mr Robertson would not have passed such a test.

140 In any event, there is no evidence to suggest that failing to conduct this test at night was a factor which contributed to the death of Mr Hall. Even if, by the time of Mr Hall's death, the original conditions were still in place, Mr Robertson was driving in daylight and would still have been driving to Quorn on the morning of 14 May 2018 and, in all likelihood, still would have collided with Mr Hall. He would not have been driving in breach of any condition.

141 However, what cannot be known is whether, if the conditions were still in place, they might have operated upon Mr Robertson as a permanent reminder of the seriousness of his condition and in this sense operated as an effective reminder to constantly scan to the left.

Issue of 'unrestricted' driver's licence

142 On 28 September 2016 Ms Jean Phillips wrote to Mr Robertson stating:

'As you are aware, the report recommended that the current conditions endorsed on your driver's licence is no longer required it will be necessary [sic]. It will therefore be necessary to issue you with an unrestricted driver's license endorsed with class C only.'¹⁴²

143 Ms Phillips wrote to Dr Anastassiadis on the same day advising that Mr Robertson had undertaken a PDA which he passed and that he, '*may hold unrestricted car drivers licence only*'.

Condition of annual medical review

144 In the DIT Licensing File¹⁴³ produced to this Court for the purpose of the inquest, there is no other document, including a copy of the driver's licence then issued, or a copy of a covering letter sent with his licence, which specifically records that a new licence then

¹³⁹ Exhibit C22, page18

¹⁴⁰ Exhibit C22, pages 18-24

¹⁴¹ T281.10 and T281.29

¹⁴² Exhibit C22, page 15

¹⁴³ Exhibit C22

issued to Mr Robertson was subject to annual review. Accordingly, I do not know whether this was stated as a condition. I note that the letter sent by Ms Phillips refers to an ‘*unrestricted*’ driver’s licence. So, despite the submission on behalf of DIT that a licence subject to annual review is a conditional licence, I should think that Mr Robertson’s impression would have been that the conditions previously attaching to the licence had been lifted and he would have seen it, as Ms Phillips had described it, as an unrestricted licence.

145 It is the case that the electronic database of DIT, TRUMPS, has an entry dated 24 September 2017 entitled ‘*Print Medical Reminder [transaction name] – Overdue Licence Medical [description]*’. So, it is clear that at least within the internal records of DIT, it was recorded that there was a requirement for annual medical review.¹⁴⁴ There are also references in screenshots from TRUMPS to ‘*Medical Certificate Due Dates*’ of ‘*10/8/2016, 3/8/2017 and 3/8/2018*’.¹⁴⁵

146 Regardless of whether annual review was imposed as a condition of issue of the licence, and how or if this was conveyed to Mr Robertson, it is nevertheless clear that Mr Robertson’s doctors, at the very least, understood that an annual review was required and that this was a requirement of the issuing authority. This is clear as on 10 July 2017 Dr Lian-Lloyd wrote to Professor Crompton advising Mr Robertson was due for annual review and requesting his assessment and recommendation.¹⁴⁶ Dr Lian-Lloyd also wrote to Dr Anastassiadis on 13 July 2017 advising Mr Robertson was due for review and requesting ongoing care and management.¹⁴⁷ Dr Lian-Lloyd’s medical notes relating to Mr Robertson also disclose that in the same period Dr Lian-Lloyd was carefully managing the prescription to Mr Robertson of medications for ongoing pain management.¹⁴⁸

Professor Crompton’s review - 14 July 2017

147 Professor Crompton reviewed Mr Robertson on 14 July 2017 and completed Section 4: Eyesight Certificate of a Certificate of Fitness to Drive, dated 14 July 2017,¹⁴⁹ as follows:

- The question ‘*Does your patient meet the eyesight standards in the Assessing Fitness to Drive 2016?*’ was answered ‘*Yes – see below*’.
- The question, ‘*Should a condition be placed on the licence? (e.g. daylight hours only)*’ was answered ‘*No*’.
- Under the heading ‘*Additional Notes*’ was written:

‘He passed his driving test and now drives at night and tows a caravan with no problem. I recommend relicensing with a waiver with no need for van towing test and no need for three yearly driving tests.’

¹⁴⁴ Exhibit C32; T237

¹⁴⁵ see also T237

¹⁴⁶ Exhibit C19, page 165

¹⁴⁷ Exhibit C19, page 159

¹⁴⁸ Exhibit C19

¹⁴⁹ Exhibit C22

148 Professor Crompton also completed Section 5: Medical Practitioners Declaration expressing his opinions as follows:

- As to whether Mr Robertson ‘*meets the relevant medical standard*’, Professor Crompton ticked the box ‘*No*’.
- Asked to provide details in relation to that answer, Professor Crompton wrote ‘*But should be relicensed with a waiver as he has adapted so well from his left homonymous hemianopia*’.
- Professor Crompton stated Mr Robertson did not require a practical driving test as ‘*he has already passed one see above and overleaf*’.
- In answer to the question ‘*Should a licence be issued subject to conditions?*’ Professor Crompton ticked the box ‘*Yes*’ and provided details:
 - ‘Needs a waiver
 - Has been towing a caravan without problems
 - Should be retested (eye) annually.’

149 I observe that during his evidence in Mr Robertson’s criminal trial, Professor Crompton explained that by ‘*waiver*’ he meant the types of limitations that might be incorporated as conditions.¹⁵⁰ I infer that Professor Crompton regarded a requirement for annual (eye) retesting to be the waiver, or condition, which Mr Robertson needed. Professor Crompton’s assertion of the need for a waiver was presumably to propose a conditional licence in light of Mr Robertson’s unfitness, according to Part A section 10.3 of the Assessing Fitness to Drive, for an unconditional licence.

150 Professor Crompton wrote to Dr Lian-Lloyd on 17 July 2017:

‘It was nice to review this chap who tells me he is not having any troubles driving, towing his van etc. I have recommended, on renewing his licence, that he no longer needs to have driving tests. Of course, he has adapted particularly well and scans very well to his blind left side.’¹⁵¹

151 Professor Crompton conducted an Esterman binocular test without fixation which, as pointed out by Professor Dain, showed an improved scanning ability over the previous tests.¹⁵² Professor Dain’s previously highlighted comments apply, namely that the improvements in the tests could be due to improvements in Mr Robertson’s condition, improved insight into how to get the best result from the test, or greater skills at scanning the test area or a combination of both,¹⁵³ and also that he knows of no evidence that scanning demonstrated in an Esterman test translates into adequate scanning for the driving task, a proposition with which Professor Crompton agrees.

¹⁵⁰ Exhibit C34, page 246

¹⁵¹ Exhibit C21, page 42

¹⁵² Exhibit C7, page 3; Exhibit C21, page 7; Exhibit C22, pages 11-14

¹⁵³ Exhibit C17 at [47]

152 I also refer here to a recent article to which the Court was referred by Professor Dain, ‘*Predictive Value of the Esterman Visual Field Test on the Outcome of the On-Road Driving Test*’¹⁵⁴ in which the authors, in conclusion, state:

‘The results of the study confirm the relation between visual field damage and impaired driving performance. When more points are seen, the likelihood of passing the on-road driving test increases. However, in our group, the Esterman visual field test shows no discriminative ability to predict driving performance on an individual level.’¹⁵⁵

153 The authors also refer to an assumption made in the conduct of the study:

‘We assume the on-road driving test is the gold standard for driving performance. Although this is generally accepted, it may be debated. The expert on practical fitness to drive who administered the on-road driving test was not blinded to the candidate’s diagnoses and visual field defects; otherwise, planning a suitable on-road driving test is not possible. This could have biased the outcome of the on-road driving test.’¹⁵⁶

154 This was the subject of questions in evidence to Professor Dain, who discussed and noted the possibility for bias, but agreed with the authors that without knowing of the candidate’s diagnoses and visual field defects, planning of a specific on-road driving test would not be possible. The impact of planning specific tests upon an otherwise desirable outcome of standardising tests between the various jurisdictions in Australia was then discussed. Pros and cons of different approaches towards tailoring or standardising tests were discussed.¹⁵⁷ In my opinion, regardless of possibilities of bias which might arise from the planning of specific tests and lack of standardisation, the primary aim of individual licensing authorities in Australia should be to ensure that, in assessing fitness to drive of people with conditions such as homonymous hemianopia which lead to such an elevated risk, tests are fashioned which ensure that all necessary aspects of a person’s driving performance are appropriately tested.

Dr Anastassiadis’ review - 16 August 2017

155 Dr Anastassiadis saw Mr Robertson on 16 August 2017.¹⁵⁸

156 Mr Robertson advised Dr Anastassiadis that Professor Crompton had cleared him to drive without any ongoing restrictions (which I observe is not strictly correct) and Dr Anastassiadis understood that the restrictions of no night time driving and no towing had been removed.

157 Mr Robertson told Dr Anastassiadis of an incident two weeks prior to the appointment when he had scraped the side of a parked car with the left-hand side of his vehicle whilst driving at night into a narrow space between two cars.

¹⁵⁴ Exhibit C31; Faraji and Others Transl Vis Sci Technol. 2022 Mar;11(3):20

¹⁵⁵ Exhibit C31, page 9

¹⁵⁶ Exhibit C31, page 9

¹⁵⁷ T127-T131

¹⁵⁸ Exhibit C20a, page 5; Exhibit C8 at [85]; Evidence at Mr Robertson's criminal trial, Exhibit C34, pages 152-154

- 158 Dr Anastassiadis wrote to Dr Lian-Lloyd about this and Professor Crompton received a copy. Dr Anastassiadis referred to Mr Robertson having been reviewed by Professor Crompton and cleared for driving without ongoing restrictions, and then advised:

‘2 weeks ago, however, John reported that he entered a driveway to park his car in a space between 2 cars. He was driving at night and the space was narrow. He reports that he collided with the right-hand side of the vehicle to his left. The damage was apparently small. He reported no other vehicle accidents. He reports that he has had no seizures and no transient ischaemic attacks.’¹⁵⁹

He continued:

‘Close monitoring of his vehicle driving and accident profile is appropriate. I have not made any alteration to his driving status, but I would appreciate if Dr Lian-Lloyd could monitor any further driving incidents or concerns. He may need to be restricted to daytime driving or a company driving, if there are further night time vehicle accidents.’

- 159 At Mr Robertson’s criminal trial, Dr Anastassiadis explained that he advised Mr Robertson that he would be making that recommendation to Dr Lian-Lloyd.¹⁶⁰ It indicates a degree of caution on the part of Dr Anastassiadis.

- 160 Dr Lian-Lloyd gave evidence that Mr Robertson did not report to him any further incidents or concerns.¹⁶¹

The fatal collision on Monday, 14 May 2018

- 161 On 14 May 2018 Mr Robertson got up at about 7:15am, after sleeping from about 8pm the previous evening, and left home at approximately 8am to travel the 40 kilometres from his home in Wilmington to an appointment with Dr Lian-Lloyd in Quorn. He was familiar with the road, having ‘lost count’ of how many times he had travelled along that road in the many years he had lived in the area. He travelled it on average once per week.¹⁶²

- 162 For a description of what happened then I adopt a portion of the sentencing remarks of his Honour Judge Stretton, delivered on 28 May 2021, after Mr Robertson was found guilty in the District Court sitting at Port Augusta of the offence of aggravated causing death by dangerous driving:

‘At about 8:20am on 14 May 2018 Robert Hall, a 66-year-old member of the local community, was riding his bicycle along Horrocks Highway. The weather was fine and clear and the road was in perfect condition. Mr Hall was wearing a hi-vis vest and riding to the extreme left of the carriageway. In other words, he was doing everything right. You were driving your Toyota Landcruiser in the same direction along Horrocks Highway at about 108 km/h. The dash cam in your vehicle captured the events that followed.

From over 200 m away, Mr Hall was plainly visible, cycling to the very left of the road and, indeed, brightly illuminated by the morning sun. The road curved gently left and then straightened for a short period before beginning a gentle right-hand turn. As you completed the gentle left-hand curve, Mr Hall was clearly visible about 50 or so meters ahead of you.

¹⁵⁹ Exhibit C19, page 69; Exhibit C21, page 43

¹⁶⁰ Exhibit C34, page 153

¹⁶¹ Exhibit C34, page 186

¹⁶² Record of interview with Brevet Sergeant Peters - Exhibit C15, Annexure KP1

Your vehicle continued, however, to veer to the left, took no evasive action and struck Mr Hall. Mr Hall was mortally injured. You stopped your vehicle, flagged down a passerby, called 000 and rendered assistance including performing CPR until medical assistance arrived. Unfortunately, Mr Hall was pronounced dead.’¹⁶³

163 I should comment upon and explain – so that it is understood that I agree with it – Judge Stretton’s statement in the sentencing remarks that Mr Robertson’s vehicle ‘*continued... to veer to the left*’. During the evidence at Mr Robertson’s criminal trial, there were some seven images tendered which were captured from the dash cam footage covering the last 15 seconds or so of the passage of the vehicle toward striking Mr Hall. The trial Judge identified to Senior Sergeant Kuchenmeister, an accredited forensic specialist in the field of motor vehicle collision, investigation and reconstruction, that in images six and seven of exhibit P5 at the trial,¹⁶⁴ it could be seen from the position of the vertical aerial relative to the left-hand line on the road, that as Mr Robertson’s vehicle got close to Mr Hall the car seemed to be veering towards the left, towards Mr Hall, because the aerial could be seen to be closer to the left-hand line. Senior Sergeant Kuchenmeister agreed, answering as follows:

‘Yes, I agree. If we go to image 1 – 3, because the road is bending, I’m not sure that that method or that vision is, we can say how, if it’s going to be closer to the line or not. So I discount images 1 – 3 when discussing what your Honour has raised. However, from image 4 through to image 7, when the road is straight and because the camera is fixed, it is apparent that the vehicle or that fixed aerial has got closer to the left-hand side of the road. So if the aerial has moved towards the left of the road and because it’s fixed to the front of the vehicle, then the vehicle must have moved to the left side of the road, over those frames. So I agree with your Honour.’¹⁶⁵

164 There was discussion during the trial of possibilities that this slight veering may have been because, either: Mr Robertson having negotiated a left-hand bend, after the road straightened up, just kept turning left; or at the moment of impact the road had been straight for not very long before being about to go into an uphill right-hand bend and Mr Robertson was preparing to negotiate that right-hand bend, being aware of the possibility of any traffic, especially trucks, which might have been coming towards him from the opposite direction. In other words, he was focussing on the centreline in order to give it a wide berth to be well clear of any oncoming traffic whilst negotiating the right-hand bend.

165 I regard each of these as a possible explanation.

Conclusions to be drawn from police interviews with Mr Robertson as to whether he saw Mr Hall

166 Following the collision, at about 9:50am on 14 May 2018 Mr Robertson was interviewed at the Quorn Hospital by Probationary Constable Bagshaw,¹⁶⁶ whose questions included:

‘Q. So what can you tell me about what happened today.

¹⁶³ Annexed to Exhibit C16

¹⁶⁴ Exhibit C34, evidence at criminal trial, pages 117-118

In the Inquest brief, these images appear at pages 13-19 of Exhibit C16, the affidavit of Brevet Sergeant Thiele

¹⁶⁵ Exhibit C34, page 117

¹⁶⁶ Exhibit C11

A. I just saw the push biker up in the distance, and as I went past him the next thing it was bang, then I just stopped and turned around.'

167 On 15 May 2018 Mr Robertson was interviewed by Brevet Sergeant Kylie Peters.¹⁶⁷ The transcript of the record of interview relevantly provides:

I said: Ok, so John I'm just gonna ask you, umm can you please tell me your version of events?

He said: There's not a lot to tell, I saw the guy in the distance, I'd driven through a lot of fog on the way and I was having problem with the sun shining, there wasn't any fog on the scene, but the sun was shining through fog on the right hand side and I believe that may have distracted me and then the next thing I know, I hit the gentleman.

...

I said: **And you said that you saw the cyclist?**

He said: **Well I, I think I saw him in the distance**

...

I said: **Yep umm so you do recall seeing the cyclist at a distance?**

He said: **Yep**

I said: But you don't recall seeing the cyclist getting closer?

He said: No

I said: Ok

He said: No and I'm sure there's, I was having trouble with the sun coming through, I had the sun visor on, over the driver's passenger window

I said: Right

He said: Cos the sun was coming in from the east and it was in my eye and it was actually coming around the end of the visor and I'm move the visor and I'm not sure if that's exactly when it happened or.'

168 Mr Robertson was then informed by Brevet Sergeant Peters that he would be arrested for Causing Death by Dangerous Driving.

Was Mr Robertson distracted by the sun shining through fog?

169 As to Mr Robertson's assertion about having been distracted by the sun shining through the fog, it may be seen from the shadows on the road¹⁶⁸ that having completed the gentle left-hand bend, that the sun was quite low in the sky and shining from behind, over Mr Robertson's right shoulder from the rear right-hand quarter. I note also that during the U-turn undertaken by Mr Robertson after striking Mr Hall, the dashcam footage shows the sun in the eastern sky, and I conclude any assertion that the sun was shining through fog is not supported. Further, I note Professor Dain's opinion, while acknowledging that photographic and video evidence does not replicate the view of the same subject from the human eye, that nevertheless having regard to his expertise in human vision and experience in giving expert evidence, including having

¹⁶⁷ Exhibit C15

¹⁶⁸ Exhibit C16b, Dashcam Footage

photographically documented accident scenes, he was not concerned that this dashcam footage demonstrated an issue suggesting the footage was likely to mislead.¹⁶⁹

Did Mr Robertson see Mr Hall at any time prior to colliding with him?

- 170 Having reviewed all of the evidence I have noted that the trial Judge sentenced Mr Robertson – clearly on the basis he was satisfied having regard to the verdict of the jury – on the basis that he saw Mr Hall ahead before, then failing to scan to his left in order to continue to see him on his blind side. It was also the prosecution case at trial, based on the police interviews, that Mr Robertson initially saw Mr Hall and then failed to continue to see him before colliding with him. Interestingly however, at his criminal trial, at which Mr Robertson did not give evidence, Mr Robertson’s counsel suggested in submissions to the jury that Mr Robertson might not in fact have seen Mr Hall at all. In all of the circumstances, it is clear to me, that if the jury accepted that suggestion or regarded it as reasonably possible, this could not have saved Mr Robertson from the finding of guilt upon the most serious charge he faced, that of aggravated causing death by dangerous driving.
- 171 For myself, I regard with caution Mr Robertson’s assertion that he initially saw Mr Hall, noting that the second time he was asked about it by Brevet Sergeant Peters, he said ‘*Well, I think I saw him in the distance*’.¹⁷⁰ The apparent uncertainty was addressed by Brevet Sergeant Peters asking, ‘*Yep, umm, so you do recall seeing the cyclist in the distance?*’, and Mr Robertson replied ‘*yep*’. This was apparently accepted at face value with a question which inherently assumed that there was no uncertainty, ‘*OK so when you saw him in the distance can you give me an approximate?*’, and was answered by Mr Robertson, ‘*Well as I came around the left-hand bend you’re talking about, he was up in the distance on the left, to my knowledge*’. Even then, the use of the words ‘*to my knowledge*’ seem odd if he was certain that he did see him.
- 172 As I mentioned, Mr Robertson did not give evidence at his criminal trial, and he was not required to give evidence at this inquest. On my own assessment of all of the evidence, including that received at Mr Robertson’s criminal trial, I do not regard it as established, either beyond reasonable doubt, or on the balance of probabilities, that Mr Robertson saw Mr Hall before colliding with him.
- 173 Further, I should explain that in my judgment it was not necessary to call Mr Robertson at this inquest in order to attempt to establish the correct position because it is in any event clear that at the time he struck Mr Hall, Mr Robertson was not scanning to his left and did not have Mr Hall within his field of vision. In a man who is blind in his left hemifield, and has no vision to the left of the centreline of the direction in which he is looking, and who knows that unless he scans constantly to the left he cannot see any hazard which may be present at the left-hand side of the road, it was open for the jury to find that he was driving in a manner dangerous, whether or not it was proved beyond reasonable doubt that he saw Mr Hall prior to the fatal collision. I note also in this regard the opinion of Professor Dain that there is no reasonable explanation for what occurred other than that Mr Hall occupied on his bicycle a portion of Mr Robertson’s vision which was occluded by his left absolute hemianopia and that Mr Robertson did not sufficiently scan.¹⁷¹

¹⁶⁹ T222-T224

¹⁷⁰ My emphasis

¹⁷¹ T219-T222

Ms Hayball also gave evidence, having observed the dashcam footage, that Mr Robertson failed to adequately scan, to compensate for his absolute homonymous hemianopia, and at the time of the collision failed to see Mr Hall.¹⁷²

- 174 Counsel for DIT and the Department for Health and Wellbeing submitted¹⁷³ that the fact that Mr Robertson saw Mr Hall in the distance demonstrates that his visual field defect did not prevent him from seeing Mr Hall in advance of the crash. For the reasons I have just explained, I do not accept this submission.
- 175 Professor Dain also addressed, by reference to the dashcam footage, whether Mr Robertson might have been able to see Mr Hall prior to the collision if, as he was driving, he was looking generally straight ahead, in the direction of the front of his vehicle, rather than scanning to his left. The effect of the evidence was that as Mr Robertson came around the last left-hand bend there was a moment where Mr Hall might just have been in the edge of Mr Robertson's field of vision, allowing for macular sparing and that thereafter, Mr Hall would have been moving further into his blind area as he approached.¹⁷⁴
- 176 Professor Dain also took into account that as Mr Robertson rounded the left-hand bend, logic would indicate that he would be using the double white line in the centre of the road as his guide¹⁷⁵ and probably paying quite a bit of attention to that. In that context, Professor Dain also agreed that a person with left homonymous hemianopia could satisfactorily drive on a road during a test by keeping a view of the middle of the road, or the white line in the middle of the road and whilst doing that, would tend to concentrate on the right¹⁷⁶ and that, in this way, a (left hemianopic) driver could be seen to demonstrate an ability to drive on the correct part of the road by actually hugging the white line in the centre of the road.
- 177 I find that at the time of the collision Mr Robertson could not see Mr Hall because he was not within his field of vision, which was defective because of his left absolute homonymous hemianopia and Mr Robertson was not scanning sufficiently, if at all. I also find that Mr Robertson's left absolute homonymous hemianopia and failing to adequately scan to his left to compensate for it, was the cause of the collision which killed Mr Hall.
- 178 The exact reason for which Mr Robertson was not adequately scanning to the left at the time of the collision is not known. It might be that he was momentarily distracted by something. If so, as I have stated, I find there was no reason for the sun to have distracted him at that moment.
- 179 It might be, as discussed above, that Mr Robertson was focussing on negotiating the left-hand bend he had just passed and the right-hand bend just ahead of him by using the white line in the centre of the road as his guide in order to keep his position in his lane.

¹⁷² T370.1

¹⁷³ Written submissions at [96]

¹⁷⁴ T134-T138

¹⁷⁵ T138

¹⁷⁶ T151

- 180 It might be that Mr Robertson had become complacent about scanning to the left when on country roads, particularly ones he knew very well, on the basis of his experience that country roads are relatively featureless, compared to city and suburban roads, and there is no particular reason to expect to meet hazards on the left.
- 181 These possibilities take into account the clear evidence of Professor Dain and Ms Hayball that scanning, involving as it does constant eye, head and neck movements, is fatiguing. It was also observed by Professor Dain that if driving on country roads, the longer the duration of the driving task, the more fatiguing the scanning exercise is.¹⁷⁷
- 182 It does not require an expert to understand that when driving on country roads a (left) homonymous hemianope might be tempted to avoid the fatigue of scanning or might be lulled by complacency into not doing so adequately or often enough, simply because he does not expect hazards on the left and he can keep in his lane perfectly well without constantly looking at the left-hand side of the road, by using as a reference point the centre, or the centreline, of the road. In the case of Mr Robertson, it could have been an added comfort to him to know that he was driving a large four-wheel-drive vehicle with a bull bar which would deal with something unexpected like a kangaroo.
- 183 It is also reasonable to think that Mr Robertson may well not have been expecting or advertent to the possibility of meeting a cyclist on this open speed limit country road, even relatively close to Quorn.
- 184 I acknowledge that in the absence of the evidence of Mr Robertson, these potential reasons for failing to scan amount to speculation, but they are logical and educated speculation as to a range of possibilities. It is simply not necessary, for the purposes of this inquest, to identify exactly which, or which combination, was operating in this instance.

Statutory provisions governing medical assessment

- 185 In South Australia fitness to hold a licence or a permit is governed by section 80 of the Motor Vehicles Act 1959 (the Act). Sub-section (2) requires that medical tests must be conducted in accordance with guidelines published or adopted by the Minister by notice in the Gazette.
- 186 A notice published in the Gazette dated 1 March 2012 adopted for the purpose of section 80(2) of the Act *‘the guidelines and policies contained within the publication entitled Assessing Fitness to Drive published by Austroads Incorporated in 2012’* (AFTD 2012).¹⁷⁸
- 187 A notice published in the Gazette dated 22 September 2016, adopting for the purpose of section 80(2) of the Act *‘the guidelines and policies contained within the publication entitled Assessing Fitness to Drive published by Austroads Incorporated in 2016’* (AFTD 2016).¹⁷⁹ The notice further advised that the guidelines and policies in Assessing Fitness to Drive published by Austroads Incorporated in 2012 are adopted for use until the 31 December 2016.

¹⁷⁷ T152

¹⁷⁸ Exhibit C25

¹⁷⁹ Exhibit C26; An addendum to the 2016 AFTD guidelines was issued in 2017, see Exhibit C27

- 188 A notice published in the Gazette dated 30 June 2022, adopted for the purpose of section 80(2) of the Act ‘*the guidelines and policies contained within the publication entitled Assessing Fitness to Drive published by Austroads Incorporated in 2022*’ (AFTD 2022).¹⁸⁰ The notice further advised that the guidelines and policies in Assessing Fitness to Drive published by Austroads Incorporated in 2016 are adopted for use until 30 September 2022.
- 189 Each of the other Australian States’ and Territories’ licencing authorities likewise refer to the medical standards in the AFTD, in assessing drivers with a medical condition.¹⁸¹
- 190 It is a cooperative scheme, and it is noted that if one state imposes greater restrictions in relation to particular conditions than others, a driver might seek a licence in a state with lesser restrictions. This is a matter which counsel for DIT quite properly asks me to bear in mind when considering recommendations. I shall do so, but I must observe that even where there is a cooperative scheme, properly based reforms in one state need not be held up just because an agreement for such a reform cannot be reached among all the parties to the cooperative scheme.

Assessing Fitness to Drive guidelines and their application to a person suffering (left or right) homonymous hemianopia

- 191 The AFTD guidelines, published by Austroads Incorporated (Austroads), contain the medical standards for licensing and clinical management guidelines. Austroads is governed by a board consisting of senior executive representatives from each of its member organisations, including each State and Territory in Australia, the Commonwealth and New Zealand. The AFTD is accepted and followed in all Australian states and territories. The National Transport Commission (NTC) undertakes reviews of the AFTD periodically.¹⁸²
- 192 The AFTD in force at all relevant times, except at the time of his annual review in 2017, was the AFTD 2012 (V4, March 2012). In relation to visual and eye disorders the AFTD 2012 relevantly provides:

‘A person is **not** fit to hold an **unconditional licence**:

- if the binocular visual field does not have a horizontal extent of at least 110 degrees within 10 degrees above and below the horizontal midline,¹⁸³ **or**
- if there is any significant visual field loss (scotoma) within a central radius of 20 degrees of the foveal fixation or other scotoma likely to impede driving performance.¹⁸⁴

¹⁸⁰ Exhibit C28

¹⁸¹ [Assessing fitness to drive \(for medical professionals\) | NSW Government; Information for health professionals : VicRoads; A45690 State Growth Medical Letters updated June 2022.indd \(transport.tas.gov.au\); Information for health professionals | Transport and motoring | Queensland Government \(www.qld.gov.au\); Fitness to drive \(transport.wa.gov.au\); Driver Licence Medical \(act.gov.au\); Drivers: medical assessment for fitness to drive | NT.GOV.AU](#)

¹⁸² Exhibit C23, page 3

¹⁸³ Mr Robertson’s disqualifying condition

¹⁸⁴ Not relevant to Mr Robertson

A **conditional licence** may be considered by the driver licensing authority subject to **annual review**, taking into account the nature of the driving task and information provided by the **treating optometrist or ophthalmologist**.¹⁸⁵

193 As I have stated, in my opinion wording of this part of the provision suggests that a requirement for annual review should be regarded as mandatory and separate from, and additional to, ‘*conditions*’ attaching to a ‘*conditional licence*’.

194 The AFTD 2012 states, in relation to a ‘*conditional licence*’:

‘A conditional licence provides a mechanism for optimising driver and public safety while maintaining driver independence when a driver has a long-term or progressive health condition or injury that may impact on their ability to drive safely. A conditional licence identifies the need for medical treatments, vehicle modifications and/or driving restrictions that would enable the person to drive safely. It may also specify a review period, after which the person is required to submit for medical review to establish the status of their condition and their continued fitness to drive. A conditional licence therefore offers an alternative to withdrawal of a licence and enables individual case-based decision making.’¹⁸⁶

195 This definition refers, unsurprisingly, to identifying the ‘*need for medical treatments, vehicle modifications and/or driving restrictions that would enable the person to drive safely*’. These would clearly be ‘*conditions*’ attaching to a ‘*conditional licence*’.

196 This definition also seems to include as a potential condition of a conditional licence the ability to specify a review period after which a person is required to submit for medical review ‘*to establish the status of their condition and their continued fitness to drive*’. In the provision enabling a conditional licence to be considered by the licensing authority for a person whose binocular field of vision does not have a horizontal extent of at least 110 degrees, (which includes each and every person with absolute homonymous hemianopia), the frequency of ‘*review*’ is specified as ‘*annual*’.

197 So, in my opinion, the combined effects of the provisions recited above are that the AFTD are ambiguous as to whether a ‘*requirement for annual review*’ was intended in those guidelines to be, if standing alone, a sufficient restriction to render a licence to drive a ‘*conditional licence*’.

198 In any event, in my opinion the ambiguity should be addressed to make clear whether a licence which is unrestricted, except for a requirement for ‘*annual review*’, is a permissible ‘*conditional licence*’ for a person who, because of a field of vision deficit, is stated to be ineligible for an unconditional licence.

The nature of the driving task required to be taken into account

199 The term ‘*nature of the driving task*’ appears as a matter to which regard is to be had in relation to the issue of a conditional licence to a person otherwise unfit to hold an unconditional licence and appears many times in each edition of the AFTD, but is not specifically defined. On a number of occasions where the term appears, there are examples given which make clear that the ‘*nature of the driving task*’ is not merely a

¹⁸⁵ Exhibit C25, page 120

¹⁸⁶ Exhibit C25, page 13

reference to the class of licence proposed to be issued, encompassing all the permissions which a licence of a particular class grants, but is a reference to all of the circumstances in which the individual driver may be expected to drive.

200 Mr Robertson did not and could not qualify for an unconditional licence. As I have already observed, it was known to all concerned in Mr Robertson's medical and OT assessments and treatments, and was either known or ought to have been known, by all concerned within DIT who were assessing or contributing to the assessment of whether any conditional licence was to be granted, that he lived in a remote area and could be expected to be driving in all circumstances, including driving in and between cities and towns and driving long distances, regularly and often, in the country. It must have been clear to all those individuals that Mr Robertson should have been treated as a man for whom the '*nature of the driving task*' included all those aspects of driving. He could not reasonably have been regarded as a person likely to restrict his driving to short distances from his home, or within towns, or in any way whatsoever. Accordingly, it was incumbent upon the licensing authority, in considering whether to issue a **conditional** licence, to consider whether any conditions were appropriate to impose in order to optimise '*driver and public safety while maintaining driver independence when a driver has a long-term or progressive health condition or injury that may impact on their ability to drive safely*'.

201 This is because it should at all times be understood by any person involved in medical or licensing assessment of a left (or right) homonymous hemianope that if at any time, for any reason, such a person fails to scan, that person immediately presents a danger to other road users because he or she cannot see the half of the road which is on their blind side.

The danger, or risk, presented by a licensed left homonymous hemianope who at any time fails to scan

202 This was specifically addressed in evidence by Professor Dain. The circumstances of this case demonstrate that a left homonymous hemianope, if licensed to drive, presents a particular danger to cyclists. The reason is obvious: even if a person is considered to have shown an ability to scan and has passed a PDA for licensing purposes, if for any reason at any time the driver fails to scan, any road user or hazard situated to the left of a centre line drawn straight ahead of the subject driver will not be seen and is at risk of being struck, without any chance of being avoided.

203 It must be presumed that any homonymous hemianope is at risk, at some undefined time or other, of failing to adequately scan.

204 Professor Dain summarised it thus in his expert report:

'The primary risk arises from the inability to see objects in the left hemifield. The secondary risk is that, in adopting the compensatory gaze scanning to observe the objects to the left will result in less attention being paid to the other driving tasks.¹⁸⁷

¹⁸⁷ Exhibit C17 at [66]

There are no reports of the factors in the accidents of drivers with left absolute homonymous hemianopia but there are some published observations from on-road and simulator driving. The risks identified in these studies may be summarised as;¹⁸⁸

- Lane crossing
- Station keeping in lane
- Missing traffic signals
- Negotiation of curves
- Turns/intersections
- Steering steadiness
- Gap judgement
- Vehicle control
- Speed control
- Reaction time to unexpected events or change
- Pedestrian and vehicle detection

It has also been reported that performance is poorer in rural situations rather than city. The self-reported difficulties are the reliance on peripheral vision and driving in low visibility.¹⁸⁹

205 Professor Dain agreed¹⁹⁰ with the proposition that a cyclist is in a unique position of danger from a left homonymous hemianope. If the chances of there being a cyclist on a particular road might be expected by the driver to be relatively low, it is not something you would routinely look for. The cyclist is a road user who will tend to assume that the driver behind has seen them, particularly if, as Mr Hall did, they are wearing a hi-vis vest and displaying a flashing red light. In this sense, the cyclist is in much greater danger from the hemianope than is, for example, a pedestrian, who can watch the approach of an oncoming driver and make a decision to give way. An animal of course, as I have observed, cannot be expected to exercise any judgement, but in the case of Mr Robertson his vehicle is equipped with a bull bar which reduces the risk to him and his vehicle and might affect Mr Robertson's perception of the need for attention.

206 A particular scenario was posed to Professor Dain,¹⁹¹ namely driving up a steep winding hills road with serial blind bends and, immediately after negotiating a blind left-hand bend, coming across a cyclist climbing slowly up that road. Professor Dain agreed that unless a driver with a left homonymous hemianopia was scanning frequently and intensively as they were negotiating that bend, there would be every chance that the cyclist just would not be seen. He said that this was the accident scenario which really stands out as the risk associated with hemianopia and demonstrates the most extreme danger that a cyclist could find themselves in, from a left homonymous hemianope.

207 Professor Dain agreed that unless there is a test that can adequately judge the likelihood of such a driver dealing with that situation, then the fate of the cyclist is simply left to chance.¹⁹²

¹⁸⁸ Exhibit C17 at [67]

¹⁸⁹ Exhibit C17 at [68]

¹⁹⁰ T143

¹⁹¹ T147-T148

¹⁹² T150

- 208 As I have previously mentioned in the context of speculating about what Mr Robertson might have been doing when he hit Mr Hall, Professor Dain agreed that there was logically a tendency on the part of a left homonymous hemianope to focus on the centreline of the road if assistance was required with lane keeping. Going back to the example of a left homonymous hemianope coming across a slow-moving cyclist after rounding a steep blind left-hand uphill bend, it stands to reason that the hemianope would be concerned when negotiating that bend to ensure that any oncoming downhill traffic is avoided, and so would be looking out for oncoming traffic as they rounded the bend and ensuring that they did not cross to the wrong side of the road. This would, by the very nature of the task, likely lead the hemianope to focus on the centreline, at the expense of scanning, involving a loss of focus on the left-hand side of the road. This will increase the chance of not seeing the cyclist.
- 209 I find, as agreed with by Professor Dain, that a cyclist is a road user to whom a left homonymous hemianope coming from behind potentially presents an extreme danger. In the absence of scrupulous compensation by scanning there is little which can be done for any hapless cyclist who happens to be present during this moment of the progress of a left (in Australia) homonymous hemianope. Even if it is just a momentary lapse in concentration, in this circumstance the hemianope is to be starkly distinguished from a normally-sighted person who is not paying close attention, because the normally-sighted person, assuming they are looking in the general direction of the road ahead, will often or usually nevertheless have the cyclist in their peripheral field of vision and has a chance of being thereby prompted to react appropriately to the cyclist, whereas a left hemianope who is not scanning simply cannot see a cyclist on the left at all.
- 210 In my opinion, every person involved in assessing those who wish to drive with homonymous hemianopia should at all times keep at the forefront of their mind the real and greatly heightened danger that a hemianope presents to other road users in the event of any failure to constantly and adequately scan.

Absolute homonymous hemianopia and driving – international context

- 211 Whereas in Australia, having regard to Assessing Fitness to Drive, the presence of a homonymous hemianopia precludes the issuing of an unrestricted licence to drive, but does not preclude issuing a licence with conditions. Professor Dain gave evidence that there are quite a number of states in the USA which have a blanket prohibition on issuing a licence to drive to a person with a homonymous hemianopia. It also emerged that there are countries in Europe where there is a blanket prohibition.
- 212 By reference to several reported studies in the academic literature, Professor Dain explained that there is evidence that those with a homonymous hemianopia who are permitted to drive tend to drive less and so, statistically, are involved in accidents no more often than somebody with full visual fields. However, given that they are exposing themselves less to the risk by not driving as much, if an adjustment is made by the distance driven, they are on average about two and a half times more likely to be involved in an accident and even more likely to be involved in an accident which was their fault.
- 213 A person diagnosed with a homonymous hemianopia is required to have that condition reported by their medical practitioners to the Registrar of Motor Vehicles, resulting in a suspension of licence to drive. Professor Dain was asked what percentage of those might then be able to develop the compensatory mechanisms to enable them to drive better, with

a risk acceptable to the community. He advised it would depend on other factors, particularly the person's comorbidities. Examples would be a condition which impairs their ability to make new compensatory body movements, their attitudes to driving, how much they choose to drive and the time of day. In addition, there are the major things normally related to accidents, namely that they happen more at night and that alcohol and speed are a major factor.¹⁹³

Accident statistics and studies

- 214 Professor Dain presented in his report a summary¹⁹⁴ of some reported studies bearing upon accident rates amongst those with visual field loss.
- 215 As any recommendations in this finding may have Australia-wide implications, given the cooperative regulatory scheme which operates, I consider it more useful in this instance to set out that summary from Professor Dain's report rather than attempt to further summarise it:

'Johnson and Keltner¹⁹⁵ studied 20,000 drivers to identify any relationship between visual field loss and accident record for a three-year period from the licensing authority. Hemianopias were not specifically analysed but identified as being a severe binocular loss (0.3% of the population). Monocular field defects were not related to driving record. The accident rate (per 160,000 km) was 2.25 higher and the conviction rate (per 160,000 km) 6.0 times higher in those with visual field losses in both eyes ($p < .005$ and $< .001$ respectively). The authors do point out that earlier studies, mainly by Burg and his co-workers, failed to identify differences but cast doubt on the quality of those studies. The data presented are not in the form of an Odds Ratio and confidence limits that could be used to calculate the proportion of drivers with homonymous hemianopia that perform with the range of drivers with intact visual field, as I have done in the next paragraph. From their Figure 4, it may be calculated that for drivers with both eyes involved, the Odds Ratio for accidents/person/160,000km is 2.16 and for convictions/person/160,000km is 3.86, which is of the same order as the findings of the following, more specific, study.

Owsley et al¹⁹⁶ looked at the relationship between a reduction in the Useful Field of View (UFoV) and a 3-year incidence of crashes in subjects with normal visual fields. When a subject is given a loading task to do while having their visual field examined, compared with simply looking at the fixation point in the visual field, the measured field of view reduces. The resulting visual field is known as the UFoV. The phenomenon shows marked individual differences. The authors showed that drivers whose UFoV reduced by 40% or more were 2.21 times more likely to have had a crash in the following 3 years.

While this is not about hemianopsia, it does indicate the importance of visual fields and it should be seen in the context of a loss of more than 50% of Mr Robertson's field of view.

Huisingh et al¹⁹⁷ showed that drivers with severe binocular visual field impairment, especially in the lower or left region of the driving visual field have a 40% increased rate

¹⁹³ T49

¹⁹⁴ Exhibit C17, pages 19-20

¹⁹⁵ Johnson Exhibit CA, Keltner JL. Incidence of Visual Field Loss in 20,000 Eyes and Its Relationship to Driving Performance. *Arch Ophthalmol* 1983;101:371-5

¹⁹⁶ Owsley Exhibit C, Ball K, McGwin G, et al. Visual Processing Impairment and Risk of Motor Vehicle Exhibit Crash among Older Adults. *JAMA* 1998;279:1083-8

¹⁹⁷ Huisingh Exhibit C, McGwin G, Wood J, Owsley Exhibit C. The Driving Visual Field and a History of Motor Vehicle Exhibit Collision Involvement in Older Drivers: A Population-Based Examination. *Invest Ophthalmol Vis Sci* 2015;56:132-8

of at-fault collision involvement (RR, 1.4; 1.07-1.83). This was, however, carried out in drivers 70 years of age and above, which is an older age group than Mr Robertson.

Rubin et al¹⁹⁸ also showed that greater binocular visual field loss was a significant predictor of motor vehicle collisions.

McGwin et al¹⁹⁹ evaluated motor vehicle collisions (MVCs) of 20 subjects with hemianopia and 7 with quadrantanopia in a retrospective study. Co-morbidities were excluded. The accident records from the licensing authority for a 2-year nine-month period were analysed. Expressed as MVCs per person-year there was no statistically significant difference between those with hemianopsia and drivers with normal fields. However, when analysed in terms of MVCs per person-mile, those with hemianopsia were 2.45 times more likely to be involved in an MVC and 2.64 times more likely to be involved in an accident in which they were at fault. These are statistically significant findings. This odds ratio for accident involvement of 2.64 (confidence limits 1.03-6.80):1 indicates that 15% of drivers have reduced their risk to less than 1 and could be considered safe to drive.⁷

Drivers with absolute homonymous hemianopia in South Australia

216 The Court has been advised by DIT in a letter dated 9 May 2023²⁰⁰ that, at that date, 84 drivers with homonymous hemianopia held a valid driver's licence in South Australia. DIT advised that all held a conditional licence. I have no information about what conditions were imposed and how many of those conditions were limited to a requirement for annual review. I have no information about the processes to which those licensees were subjected. I was also advised that there are 1.3 million drivers in South Australia so it is clear that homonymous hemianopes represent only a small proportion.

217 I note in this context the evidence of Mr Gilbert on behalf of DIT who explained his understanding that around one third of individuals who undertake a PDA for licensing purposes, after a certification of medical unfitness, fail that test. I do not have the information about the various processes which were applied in those cases which could enable any useful comparison with Professor Dain's suggested rate of suitability for driving by reduction of risk to that of the normal population, of 15% of those suffering from homonymous hemianopia.

Should those with homonymous hemianopia be excluded from driving?

218 During his oral evidence at inquest, Professor Dain elaborated,²⁰¹ particularly on his interpretation of the last-mentioned study by McGwin et al, which he regarded as the most pertinent and best available academic study on the particular condition of absolute homonymous hemianopia, despite its relatively small sample (of drivers who had been through the ophthalmology clinic at the University of Alabama in Birmingham, Alabama). Professor Dain noted that in this study the estimated weekly mileage of a driver with hemianopia was 177 miles per week and for those with normal visual fields, it was 296 miles per week, so the hemianopes in the study were only driving about 60% of the distance that the people with normal visual fields were driving. Professor Dain explained, by reference to the expressed confidence limits, that the 15% or thereabouts

¹⁹⁸ Rubin GS, Ng ESW, Bandeen-Roche K, et al. A Prospective, Population- Based Study of the Role of Visual Impairment in Motor Vehicle Exhibit Crashes among Older Drivers: The See Study. *Invest Ophthalmol Vis Sci* 2007;2004:1483-91

¹⁹⁹ McGwin G, Wood J, Huisingh Exhibit C, Owsley Exhibit C. Motor Vehicle Exhibit Collision Involvement among Persons with Hemianopia and Quadrantanopia. *Geriatrics* 2016;3:1-8

²⁰⁰ Exhibit C35

²⁰¹ T93-T102

who have reduced their risk to less than one would have to be accepted as performing better than the worst of the unaffected group, that is they belong within driving ability distribution of the normal population. It is for this reason that Professor Dain expressed the opinion, with which I agree, that this proportion of homonymous hemianopes should not be excluded from driving.²⁰² Conversely, the remainder of 85%, opined Professor Dain, should be considered not capable of presenting only an ‘*acceptable risk*’, which he defines as the ‘*risk of the normally-sighted population*’.²⁰³

- 219 Nevertheless, opined Professor Dain, the safe approach is to allow people identified as presenting an acceptable risk to drive only with conditions. He explained that even if it is thought to be demonstrated that they are within the 15%, it will always be somewhat uncertain. He expressed the opinion, which I accept, that it will be less uncertain if you also prudently place restrictions on them, if only to remind them that they are more at risk than everybody else. He explained (with appropriate simplicity) when asked, that they are more at risk because hemianopia makes them more at risk, and what has happened with those who are within the 15% is they have coped with all the things that put them at risk and minimised them, so it has brought them within the normal distribution.²⁰⁴
- 220 The extreme nature of their risk is clear: even if they satisfy medical practitioners, occupational therapists, licensing assessors and the licensing authority that they have demonstrated a capability of driving as safely as the normal population, the risk is that in any moment when they might fail, for whatever reason, to continuously scan to their blind side, it is a fact that they cannot see one half of the road. What will then occur, if any cyclist or other road user or hazard is unfortunately on the road at that moment, is tragically demonstrated by the death of Mr Hall.
- 221 In my opinion, it is fanciful to think that no hemianope with a driver’s licence will ever fail to adequately scan whilst driving. I observe that it would be equally fanciful to think that no normally sighted driver will ever fail to drive at all times with due care and attention, and no collisions will eventuate. However, it is the nature of the heightened risk, well above that of the normal population, which exists when a hemianope fails to adequately scan, which in my view makes it appropriate to impose conditions, beyond annual eye tests, upon all licensed drivers with this condition.

How may the increased risks be ameliorated?

- 222 I return to the evidence of Professor Dain and his expert report,²⁰⁵ which, in my view, should be read by regulators considering this finding for the purpose of the next review of AFTD. Professor Dain referred to the general argument that compensatory behaviours will modify those risks and can, in some drivers, reduce the risk to be within the range of risks for drivers with full fields. He observed, as I have stated, that some reduction can be achieved by driving less. As another strategy to reduce modifiable risks, both from the frequency and severity of accidents, he referred to the initial restriction against towing and night driving serving that purpose in the case of Mr Robertson, as these are more accident-prone conditions. He also referred to the conditions such as those imposed upon

²⁰² See T96.3-T97.26

²⁰³ T97

²⁰⁴ T100-T101

²⁰⁵ Exhibit C17

young, inexperienced drivers, such as zero blood alcohol level, a speed limit and a passenger limit.

223 Professor Dain expresses the view that the risks are able to be adequately ameliorated in some drivers²⁰⁶ and that the elements in any amelioration include:

- the driver understands the consequence on driving of their visual field loss;
- the driver accepts that compensations need to be made;
- the driver is given help to understand the consequences and the necessary compensations;
- the driver makes the necessary compensations;
- the driver accepts that there will be conditions on the driving licence in areas where their driving has not been evaluated as adequate and/or cannot, in practice, be appropriately evaluated.

224 I have noted that Professor Crompton agrees with these propositions.

225 Professor Dain stated,²⁰⁷ and I agree, that it follows that there needs to be appropriate, evidence-based education, training and assessment and methods followed by validated acceptance criteria. As a guideline, having regard to the academic literature, he advocates that the acceptance criteria would pass less than 15% of people with absolute homonymous hemianopias.

226 I also note in this context the opinion, to which I shall return, of Ms Hayball, expressed in her statement,²⁰⁸ that any person with homonymous hemianopia who is granted a licence should have permanent conditions on their licence similar to the mandatory conditions for Provisional licences:

- not to drive or attempt to put a motor vehicle in motion when there is any concentration of alcohol in the blood or the presence of THC, methylamphetamine or MDMA in the blood or oral fluid;
- not to exceed the speed limit by 10 km/h or more;
- not to drive over 100 km/h even if the local speed limit exceeds 100 km/h;
- not to use any mobile phone function while driving, including hands-free mode, Bluetooth technology and loudspeaker operation.

How to appropriately assess drivers with absolute homonymous hemianopia

227 I have mentioned Professor Dain's opinion that reliance on clinical observation and clinical tests is based upon methods which are often *ad hoc* and without evidence-based pass/fail criteria. He states that observation in the consulting room and gaining a clinical impression does not have an evidence base. Professor Dain refers in his report to the Esterman test not having been proposed as applicable to driving but to personal mobility,

²⁰⁶ Exhibit C17 at [77]-[78]

²⁰⁷ Exhibit C17 at [79]

²⁰⁸ Exhibit C33 at [83]

and its applicability to the driving task has been questioned, as have clinical tests in general.²⁰⁹

228 Obviously, clinical assessment is appropriate for identifying the condition of homonymous hemianopia and the extent of the remaining visual field. ‘*Section 10.2.2 Visual fields*’,²¹⁰ within ‘*Section 10.2. General assessment and management guidelines*’²¹¹ of the 2022 version of AFTD states appropriate assessment methods for visual field defects, which include defects of the horizontal extent of the visual field, which include homonymous hemianopias. Esterman tests without fixation are not included in those methods. Neither should it be thought that a binocular Esterman test **without** fixation should be regarded as capable of demonstrating to a licensing authority the extent of a person’s ability to scan whilst driving to adequately compensate for a loss of one side of a person’s visual field. More on that shortly.

229 Professor Dain stated in his expert report:

‘It is my opinion that, in a general sense, it is appropriate to issue a conditional licence to a person whose visual field deficit is outside of the normally permitted clearance guidelines for recreational and commercial driving provided that there is evidence that:

- i) the driver is deemed to have demonstrated sufficient scanning ability for all the driving conditions permitted in the conditions of the licence;
- ii) the driver has no significant co-morbidities, including cognitive impairment;
- iii) the driver has demonstrated a thorough knowledge of the road rules;
- iv) the driver has demonstrated an understanding of the consequences of their visual field loss;
- v) the driver has successfully completed validated driving assessment(s) covering the conditions in which they are permitted to drive;
- vi) the driver accepts the limitations placed on their licence for driving situations in which they have not been assessed or have not successfully completed assessment;
- vii) the driver has the conditions to their licence that are imposed to mitigate the risk in a more general way given that there is sufficient evidence that they contribute to risks of motor vehicle accidents (*eg* permitted blood alcohol levels, time or distance limits, night time driving limits, speed limits).’²¹²

230 In the opinion of Professor Dain, an appropriate driving test is the appropriate method of assessing the ability of an absolute homonymous hemianope to compensate for their field of vision defect. Upon the evidence I have heard in this inquest, I agree. The question then is what is an appropriate driving test for that purpose. It is certainly Professor Dain’s opinion that the usual licensing authority driving test is not specifically directed to that purpose. With this I also agree.

231 In my opinion, the starting point in answering the question, what is an appropriate driving test for that purpose, is a PDA conducted by an occupational therapist, as contemplated in ‘*Section 2.3.1. Practical driver assessments*’ under the heading ‘*2.3. Assessing and*

²⁰⁹ Exhibit C17 at [76] – references are cited in Professor Dain’s report

²¹⁰ Exhibit C28, page 204

²¹¹ Exhibit C28, page 202

²¹² Exhibit C17 at [121]

supporting functional driving capacity' in the 2022 version of AFTD. To meet the requirements of Professor Dain's list above, the driving in the test would need not only to demonstrate sufficient scanning ability but do so for all the driving conditions permitted in the conditions of the licence. It follows logically that an occupational therapist driving test, conducted to inform a medical expert of matters which that doctor cannot assess in a clinical setting, must be conducted in all the conditions and circumstances in which the homonymous hemianope is to be permitted to drive which, unless there are to be limiting conditions placed upon the licence, are all the circumstances in which that licence ordinarily permits any person to drive. Having regard to this, it is my opinion that in South Australia, it is appropriate that dual qualified occupational therapist driver assessors may undertake PDAs for licensing purposes in cases, such as homonymous hemianopias, where a person's ability to compensate for the condition is regarded as the primary matter needing assessment and this has led to the referral by a medical practitioner for of an OT PDA as described in Section 2.3. of AFTD (2022).

232 When asked what he meant by 'appropriate driving test' Professor Dain answered:

'Well, it means it's got to be of sufficient length to assess their compensatory behaviour over a period of time. I mean, there's no point in testing them for half an hour, and then letting them go out onto the road and drive for four hours. So, it's got to be of a realistic length, it's got to be of a form that reflects the different kinds of driving conditions, and because – generally these tests, it's like a driving test it's taken within a built up area, and you've got clues, like other cars to follow, you've got a kind of a heightened attention too, because things are happening – whereas you go out into, you know, the uninterrupted country road, it's a different problem. Keeping the car on the road in the right place is a relatively straightforward thing to do, but unexpected events become – responding to unexpected events and emergencies becomes more important. So, that driving test has got to reflect the range of situations that people are going to be driving in, and also, I think to be linked with whatever restrictions you may place on them. If you've only tested them for half an hour, my logic says they need to take a break every half hour.'²¹³

233 In this answer, Professor Dain was talking about the test for licensing purposes but was also assuming that that test would be capable of assessing the capacity to sufficiently scan so, clearly, the answer encompasses both types of '*practical driving assessment*' (that related to assessing and supporting functional driver capacity and that related to licensing) contemplated in AFTD. It is fair to say that in referring to PDAs, the fact that the term is used in AFTD to describe OT driver assessments and licensing assessments can generate confusion. It did so during the evidence in this inquest of Mr Gilbert from DIT.

234 The potential for confusion is most evident, however, in '*Section 10.2.9. Practical driver assessments*' in AFTD (2022) which states:

'A practical driver assessment is not considered to be a safe or reliable method of assessing the effects of disorders of vision on driving, especially the visual fields, because the driver's response to emergency situations or various environmental conditions cannot be determined. Information about adaptation to visual field defects can be gained from visual field tests such as the Esterman.

²¹³ T104

A practical driver assessment may be helpful in assessing the ability to process visual information (refer to Part A section 2.3.1. Practical driver assessments).'²¹⁴

235 The assertion in the first sentence of the passage above appears to be repeated as an assumption²¹⁵ in the Department for Infrastructure and Transport - Submission to Review the Australian Fitness to Drive - June 2021, which the National Transport Commission has advised DIT will be considered in the next AFTD review (early 2026), pending the issue of the next version of AFTD expected later in 2026.

236 In relevant part, the submission states:

'DIT would also welcome some further clarification for visual fields on when a person would qualify for a conditional licence, where their visual fields are outside of the criteria for the issue of an unconditional licence.

Presently the guidelines indicate a conditional licence may be considered taking into account information provided by an optometrist or ophthalmologist but this could be very subjective with no definitive visual parameters or criteria for how far out of the guidelines a person can be before a conditional licence should be refused.

DIT finds that a lot of optometrists or ophthalmologists will advise the person doesn't meet the visual field standards but recommend the person undertake a practical driving assessment to determine if they can qualify for a conditional licence.

As practical assessments are not a good method of determining whether a person with a visual field defect can safely drive,²¹⁶ this will usually be refused and the person will be refused an unconditional or conditional licence.

Given the above, DIT would appreciate the standards addressing the conditional licence aspect more definitively if possible and providing clear guidance on what allowance there can be to consider a conditional licence where the visual field readings are outside of the allowable readings for an unconditional licence.

For example, if a person has significant visual field loss with more than four contiguous spots within a 20° radius from fixation, would there be a particular number of spots beyond four where a person would reasonably qualify for a conditional licence?'²¹⁷

237 This part of the submission was prepared by DIT having regard to DIT's knowledge of the tragic death of Mr Hall after Mr Robertson was granted a licence.

238 As to the second paragraph of the submission reproduced above, I would agree, except to say that apart from the test results which establish the field of vision with fixation, the '*information provided by an optometrist or ophthalmologist*' in support of proceeding to (OT) testing for a conditional licence would almost inevitably be subjective, heavily reliant upon self-reporting and, as Professor Dain stated and Professor Crompton agreed with, without an evidence base. However, if OT testing is the only or the only appropriate way to assess a person's ability to compensate for a medical condition while driving, there must be a means of assessing whether to proceed to such testing. What is important is that subjective assessments heavily reliant upon self-reporting are not relied upon by a

²¹⁴ Exhibit C28, page 208

²¹⁵ See the emphasised passage referred to by the next footnote

²¹⁶ My emphasis

²¹⁷ Exhibit C23, Annexure SBG-2

licensing authority as final evidence of the sufficiency of a person's compensation for their medical condition.

- 239 The information conveyed by DIT in the third paragraph does not surprise me. Optometrists and ophthalmologists have been referred to in identical terms, to the exclusion of rehabilitation specialists and occupational therapists conducting PDAs, in each of the additions of AFTD since 2012, in the permissive provision for consideration of conditional licences to those with defined visual field defects:

‘A **conditional licence** may be considered by the driver licensing authority subject to **annual review**, taking into account the nature of the driving task and information provided by the **treating optometrist or ophthalmologist**.’

- 240 Making plain that I have not heard evidence to this effect, I expect that DIT's experience is that such recommendations have been made by optometrists and ophthalmologists stating their views about a hemianope's ability to scan, about which I have commented with respect to the second paragraph above. On this point, I should mention that in relation to Professor Dain's opinion expressed in paragraph 79 of his expert report:

‘It follows that there needs to be appropriate, evidence-based education, training and assessment and methods followed by validated acceptance criteria. As a guideline, the acceptance criteria would pass less than 15% of people with absolute homonymous hemianopias.’

Professor Crompton responded, not unreasonably:

‘With respect to paragraph 79 I can only act under present rules and recommend available therapy/tests.’²¹⁸

- 241 The last paragraph of the passage of the submission reproduced above refers to conditions under the heading ‘*Central Field Loss*’ which is not the condition suffered by Mr Robertson and which has not been addressed in this inquest. However, it was given as the foundation for an example of the sort of guidance DIT would seek – something that would relate to a test conducted by an ophthalmologist or optometrist.
- 242 In the case of a person with good visual acuity but with a homonymous hemianopia which is likely to be permanent, the guidelines might be made more specific about exactly how a person's visual field is to be measured and what the cut-off is for consideration of a conditional licence, but the real question will remain whether a person can demonstrate an ability when driving to constantly and adequately scan to compensate for that defect, in order to bring themselves within the driving ability distribution of the normal population, and what conditions should be imposed on the licence.
- 243 I agree with Professor Dain's opinion that the judgement of the adequacy of the compensation really can only be in the driving task itself.²¹⁹

²¹⁸ Exhibit C7b at [8]

²¹⁹ T109

244 AFTD (2022) quite properly states in ‘*Section 10.2.2. Visual fields*’ (although whether it is intended to be under the heading ‘*Central Field Loss*’ is not clear to me):

‘Methods of measuring visual fields are limited in their ability to resemble the demands of the real-world driving environment where drivers are free to move their eyes as required and must sustain their visual function in variable conditions.

Additional factors to be considered by the driver licensing authority in assessing patients with defects in visual fields therefore include, **but are not limited**²²⁰ to, the following:

- kinetic fields conducted on a Goldman
- binocular Esterman visual fields conducted without fixation monitoring, often referred to as a roving Esterman (two consecutive tests must be performed with no more than one false-positive allowed) – the test should be in the numeric field format when it is printed out or sent for an opinion
- contrast sensitivity and glare susceptibility
- medical history; duration and prognosis; if the condition is progressive; rate of progression/deterioration; effectiveness of treatment/management
- driving record before and since the occurrence of the defect
- the nature of the driving task – for example, type of vehicle (truck, bus, etc.), roads and distances to be travelled concomitant medical conditions such as cognitive impairment or impaired rotation of the neck.’²²¹

245 As to the first dot point, I have heard no evidence and can make no comment.

246 As to the second, the binocular Esterman test without fixation, it appears on the basis of the evidence I have heard that these tests may properly be regarded as giving an indication of an ability to scan, but for reasons I have discussed should not be regarded as evidence that a person should be deemed able to adequately scan whilst driving. Professor Dain also pointed out that as an indicator of scanning, this might be contaminated by the ability to fixate somewhere else (into the blind hemifield).²²² I accept that a binocular Esterman test without fixation might, in an appropriate case, be one factor favouring a decision to recommend a PDA (undertaken by an occupational therapist).

247 As to the third dot point, I have heard no evidence and can make no comment, although it stands to reason that a person assessed with high sensitivity to contrast and/or susceptibility to glare should be treated with even greater caution.

248 As to the other three dot points, they appear to be entirely appropriate considerations.

249 Professor Dain referred to ‘*the million-dollar question*’ as the question of how to determine which people with absolute homonymous hemianopia should be granted a licence and with what conditions. He referred to the Esterman test, a clinical test carried out in the consulting room, which is referred to in AFTD. As to practical tests of driving which Professor Dain said might be on-road tests and might be a simulated test, Professor Dain said there is no consistency around the world and he understood there to be a different appetite in different states of Australia for the undertaking of practical tests, as

²²⁰ My emphasis

²²¹ Exhibit C28, page 205

²²² T126

opposed to accepting the certification of an ophthalmologist or optometrist. As I have made plain, it is my view that, where homonymous hemianopes are concerned, a medical certification by an ophthalmologist or optometrist should certainly not be accepted without a practical test, which should include, as a minimum, an OT driving assessment.

The potential value of simulators

- 250 In preparing his report and for giving evidence, Professor Dain was not specifically asked about simulators and so had not tabulated any academic literature in relation to them, either generally or in relation to homonymous hemianopia. However, he did inform the Court when asked that a significant body of research work has been done in relation to simulators and there are published academic studies.
- 251 In general terms though, he stated that people with homonymous hemianopia could very easily be subject to assessment within a simulator to determine what they are actually doing and not doing, what they are seeing and not seeing. I observe that simulator testing could include extended duration driving on country roads.
- 252 Professor Dain was also asked about cars which have cameras to observe the driver and their eyes, and what they are doing with their eyes, being used to test people with visual field defects. Professor Dain referred to research undertaken in Queensland and, although he had not personally worked with simulators set up with cameras which monitor the eye and head movements of the driver, he said it would be very easy to do that.
- 253 I observe from my own experience that some modern vehicles have a camera in the dashboard which detects, either from the direction of the eyes, or perhaps from the position of the head, when a driver is not being attentive to the road ahead, and delivers a warning.
- 254 On the basis of what I have heard, I assume it would be technologically feasible to set up extended duration country driving simulator testing which would not only present occasional random hazards to be appropriately negotiated by the subject being tested, but could separately monitor, with cameras, the extent and consistency of scanning in a person with a hemianopia.

Collision avoidance systems

- 255 Although I did not during the inquest hear evidence about these systems, and their potential suitability for use in reducing the heightened risk to road users such as cyclists and pedestrians presented by some (or most) persons suffering from homonymous hemianopia, it occurs to me that a licensing authority could consider imposing as a condition of a licence a requirement that such a driver only drive in a vehicle equipped with such a system. This suggestion assumes that there is some evidence that the incidence or severity of injury to pedestrians or cyclists is reduced in collisions involving vehicles deploying technology which detects the presence of cyclists or pedestrians vulnerable to an impending collision and automatically applies the vehicle's brakes. Whether Mr Hall might have survived the collision due to automatic braking applied after the vehicle's detection of him ahead, or whether the collision might have been avoided entirely, is a question I cannot answer. However, for present purposes I can only speculate that if Mr Robertson had been subject to such a condition, rather than driving a Toyota Landcruiser with a bull bar, Mr Hall's chances of survival might have been increased.

Some further observations about Mr Robertson's attitude

- 256 Mr Robertson cannot be criticised for wanting to resume his life following his surgery and subsequent stroke by obtaining his driver's licence, and therefore his independence.
- 257 Mr Robertson self-reported to Professor Crompton, Dr Anastassiadis and Ms Hayball, about his scanning ability in everyday life. Professor Crompton appeared to place some weight upon Mr Robertson's self-reporting.²²³ In a general sense, medical practitioners use self-reporting as a tool for history taking and understanding the presenting complaint, so there is a very real degree of reliance put on self-reporting as a tool in everyday clinical use. However, Ms Hayball did not place any weight on self-reporting as to how well Mr Robertson was compensating for the absolute homonymous hemianopia, a position with which Professor Dain concurred.²²⁴
- 258 Counsel assisting submitted that Mr Robertson never appeared to fully grasp the nature of the absolute homonymous hemianopia and the fact it did, and would continue to, impact on his ability to drive.²²⁵ It is difficult to draw with certainty a conclusion about this but I agree with Professor Dain, who expressed the view that Mr Robertson's reported lack of insight should sound an alarm, and that more attention should have been paid to the concerns of the on-road driving assessor.²²⁶ Those concerns were recorded in Ms Hayball's report and represented reason for any subsequently involved doctor or licensing authority representative to question whether Ms Hayball's recommendations for driving lessons were sufficient to deal with those concerns, rather than requiring further OT assessment.
- 259 In my opinion, any indication during the whole assessment process that a person with homonymous hemianopia does not fully grasp the nature and impact upon them of their condition, and their ability to drive, should lead the licensing authority to carefully consider referral for further OT assessment, in addition to and after any further lessons which may be recommended.

Findings

- 260 In the course of this finding I have made many comments and observations which fall short of being specific findings as to fault or failure to which Mr Hall's death might be attributable, directly or indirectly.
- 261 It is undeniable in this tragic case that Mr Hall in no way contributed by his conduct to the collision which caused his death. Mr Hall was doing everything right and he could not have anticipated that approaching him from behind was a man who was blind on his left-hand side and, if he was not scanning to compensate for that, would not see him at all.
- 262 The converse of that is that Mr Robertson was a driver on this road who knew that he was blind on his left-hand side, that the only way he could remedy that condition and drive safely was to constantly and consistently scan to the left-hand side, and failed to do so. The fault was entirely Mr Robertson's and the fault amounted to criminal conduct of

²²³ Exhibit C21, pages 20, 29 and 35

²²⁴ T160.37-T161.23; T374.15-T374.21; Exhibit C17 at [100]

²²⁵ Exhibit C20a, page 29

²²⁶ Exhibit C17 at [110] and [112]

which he was found guilty and for which he was penalised. It is not for me in the coronial process to review or comment upon the penalty.

263 It is also true, as pointed out by Professor Dain as being obvious, that the death of Mr Hall could have been prevented by Mr Robertson being refused a driving licence.

264 Otherwise, I cannot find that Mr Hall's death was preventable.

265 The evidence I have heard does not lead me to conclude that a homonymous hemianope should in every case be refused a driving licence or, specifically, that Mr Robertson should have been refused a licence.

266 I cannot conclude that Mr Robertson was issued an unconditional licence which the licensing authority was not entitled to issue. Whether it was a '*conditional*' licence for the purposes of AFTD is open to debate and that debatability should be foreclosed by amendment of the relevant provisions.

267 I conclude that an '*unrestricted*' C class license was issued to Mr Robertson by the licensing authority without sufficient assessment of his ability to demonstrate adequate compensatory scanning on country roads, with open speed limits, for extended periods of time.

268 This occurred despite the fact that it was known to the licensing authority that the nature of Mr Robertson's driving task would always involve driving on country roads, with open speed limits, for extended periods of time.

269 The lack of sufficient assessment of Mr Robertson's ability to adequately scan to compensate for his absolute homonymous hemianopia, while driving on country roads with open speed limits for extended periods of time, cannot be shown to have led to the fatal collision or contributed to its cause.

270 The issuing of Mr Robertson's licence also occurred despite the licensing authority being aware of concerns expressed by an occupational therapist which should have led to doubts as to whether Mr Robertson had sufficient insight into the impact of his condition upon his ability to safely drive.

271 A lack of sufficient insight into the impact Mr Robertson's condition may have had upon his ability to safely drive may have been a contributing factor to Mr Robertson's failure to scan at the time he struck Mr Hall, in the sense that sufficient insight into that potential impact may have operated to avert complacency, if that was a contributor to the cause.

272 Several conditions which could have been proposed or imposed upon Mr Robertson to attempt to reduce the risk which would plainly arise in the event that he should fail to constantly and consistently scan were neither proposed nor imposed. These included the conditions mandatorily imposed upon provisional drivers and limiting driving in conditions for which he had not been appropriately assessed, including for extended durations on open speed limit country roads. A further condition which could be considered, which was probably not available at the time Mr Robertson was issued with his licence but is now probably available, is a condition requiring Mr Robertson to drive a vehicle equipped with an automatic emergency braking system of some commercially available kind.

- 273 I conclude that the AFTD guidelines require greater detail and clarity in order to guide medical practitioners, occupational therapists and licensing authorities as to the minimum standards below which a person suffering a visual field defect should never be granted a conditional licence. However, in relation to most cases of homonymous hemianopia, absent other comorbidities, in-principle concerns about automatically disqualifying people based on a clinical finding rather than a PDA are justified and lead me to doubt whether such minimum standards may properly be formulated. On the evidence I have heard, automatic disqualification of Mr Robertson, for example, would not be appropriate on the basis of any minimum standard applied by clinical finding.
- 274 There was no failure in or of the whole process of relicensing Mr Robertson which can specifically be found to have led to the collision which caused Mr Hall's death or have contributed to its cause.
- 275 The condition of absolute homonymous hemianopia is the worst eyesight defect which might present to the driver licensing authority.
- 276 Even a person who is appropriately assessed as having the ability to adequately scan to compensate for his disability should be regarded as presenting a high potential for putting other road users in danger whenever they have moments of inattention leading to a failure to scan, as the result is that they cannot see the side of the road in which they have lost their vision.
- 277 A cyclist is the type of road user facing the greatest potential danger presented by an absolute homonymous hemianope at any time when they might fail to adequately scan.
- 278 Without being able to identify this in any particular individual whether a doctor, occupational therapist, driving instructor/assessor or member of staff of the licensing authority, in my opinion during the process which eventually led to Mr Robertson being issued an unrestricted driving licence after his stroke, there was a general under-appreciation of the gravity of the risk potentially presented to a road user, particularly a road user such as a cyclist, by an absolute homonymous hemianope who should at any time fail to adequately scan. A proper appreciation of that risk informed by greater awareness as a result of the tragic fate of Mr Hall should lead those involved, in the future in such assessments and decisions, to have greater regard to the nature and extent of the potential risk which I have identified, when making recommendations and decisions in relation to a conditional licence sought by a person suffering absolute homonymous hemianopia.

Was Mr Hall's death preventable?

- 279 As stated by Professor Dain, it is obvious that Mr Hall's death could have been prevented if Mr Robertson was not granted a licence.
- 280 Even if conditions had been imposed and even if they were more extensive than those which were originally imposed, it is doubtful that they would have had any influence. The road was open, generally straight, with some curves but undulating, and the road and vehicle were familiar to Mr Robertson. It was clear daylight and there was little other traffic. Mr Robertson had been driving for a relatively short time and for a relatively short distance.

- 281 I agree with Professor Dain that in those circumstances, the typical provisions on a conditional licence e.g. daytime only, limited distance from home, would have had little influence.
- 282 Neither, probably, would conditions such as those imposed upon provisional drivers. In the particular circumstances of this case, a condition prohibiting Mr Robertson from driving if THC was present in his blood or oral fluid might have persuaded him not to drive on this occasion, although this seems unlikely, as driving in such circumstances is, and was, prohibited in any event.

Recommendations

- 283 Pursuant to [section 25\(2\)](#) of the [Coroners Act 2003](#) I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of events similar to the events which were the subject of the inquest.
- 284 To the Minister for Infrastructure and Transport I recommend:
- 1) That the National Transport Commission and Austroads Incorporated (Austroads) be requested to amend the next version of Assessing Fitness to Drive:
 - a) to require that a person assessed pursuant to the Assessment Method stated in ‘Section 10.2.2. Visual fields’, who demonstrates in accordance with the Assessment Method a horizontal extension of the visual field of less than 110° but greater or equal to 90° and is hemianopic, may only be supported by an optometrist or ophthalmologist for the granting of a conditional licence by the licensing authority when the person has undertaken a practical driver assessment by an occupational therapist in accordance with ‘Section 2.3. Assessing and supporting functional driver capacity’, and only if the support and certification by the optometrist or ophthalmologist considers the occupational therapist’s conclusions and recommendations;
 - b) to require in ‘Section 2.3. Assessing and supporting functional driver capacity’, or another suitable section, that occupational therapy practical driver assessments of absolute homonymous hemianopes are designed to ensure that the driver pays sufficient attention to scanning at all times. This would mean assessing them on-road for longer periods and in a greater variety of driving conditions, including rural roads and recommending any appropriate conditions, including rest breaks, to ensure heightened vigilance;
 - c) to recognise and reflect in ‘Section 10.2.9. Practical driver assessments’ that an occupational therapy practical driver assessment is the gold standard for assessing the ability of a person who has been clinically assessed to be suffering an absolute homonymous hemianopia to adequately and appropriately compensate for that visual field defect during driving by scanning to the blind side and should determine what is permitted pursuant to any licence; and

- d) as to '10.3. Medical standards for licensing – vision and eye disorders – Private standards':
- i) to clarify whether there is a minimum horizontal extent of the visual field below which an absolute homonymous hemianope is to be considered unfit to hold any licence, conditional or unconditional;
 - ii) to extend the range of providers of information to which the licensing authority is to have regard when considering whether to issue a conditional licence and, if so, appropriate conditions to attach to a licence for an absolute homonymous hemianope, extending that range of providers to include rehabilitation specialists and occupational therapists (where an occupational therapy practical driving assessment has been undertaken);
 - iii) to require the licensing authority to consider imposing upon a conditional licence, conditions which address the high potential for risk to other road users presented by an absolute homonymous hemianope at any time during which they may fail to adequately scan to compensate during driving for their visual field defect;
 - iv) to require the licensing authority to impose conditions attaching to a licence issued to an absolute homonymous hemianope, in addition to the requirement for annual review:
 - (1) similar to those imposed upon a driver with a Provisional licence, in particular:
 - (a) not to drive a motor vehicle or attempt to put a motor vehicle in motion whilst there is any concentration of alcohol in the blood or the presence of THC, methyl amphetamine, or MDMA in the blood or oral fluid;
 - (b) not to exceed the speed limit by 10 km/h or more;
 - (c) not to drive over 100 km/h even if the local speed limit exceeds 100 km/h;
 - (d) not to use any mobile phone function while driving, including hands-free mode, Bluetooth technology and loudspeaker operation;
 - (2) initially, no night driving or towing; and
 - (3) that the driver shall not drive except in a vehicle with an Automatic Emergency Braking system or equivalent; and
 - (4) in the case of an absolute homonymous hemianope, to specify the nature and extent of the requirement for annual review to include medical, vision and occupational therapy on-road reviews.

- 2) That the National Transport Commission and Austroads Incorporated (Austroads) be requested to investigate, or commission, initiate or encourage research, into:
 - a) the assessment of persons with absolute homonymous hemianopia and their ability to scan to adequately compensate for their visual field loss, including in extended duration, high-speed country driving; and
 - b) the potential for the use of driving simulators which include cameras monitoring head and eye movements for the purpose of undertaking such assessments.
- 3) That the National Transport Commission and Austroads Incorporated (Austroads) be requested to consider making representations to the Australian Government for the inclusion of the cost of complex vision/medical driving assessment by occupational therapists on the Medicare rebate table.
- 4) That in the event that any of the foregoing recommendations are not adopted into the next edition of Assessing Fitness to Drive, DIT internal policies and practices be reconsidered with a view to incorporating and giving effect to these recommendations within South Australia in relation to conditional licences being considered by the licensing authority for persons who do not qualify for the issue of an unconditional licence as a result of absolute homonymous hemianopia.
- 5) That in South Australia, changes (if required) to legislation and DIT internal procedures and policies be considered to enable occupational therapy driver assessors to formally make licence recommendations alongside medical practitioners.
- 6) That any report prepared by an occupational therapist following an occupational therapy practical driving assessment be required to be forwarded to DIT for consideration by the licensing authority in determining the appropriateness of issuing a conditional licence to a person who does not qualify for the issue of an unconditional licence due to absolute homonymous hemianopia and any conditions to be attached to the licence. The report should also assist the licensing authority to understand and consider in the decision-making process whether the driver has demonstrated an understanding of the consequences of their visual field loss and accepts limitations placed on the licence for driving situations in which they have not been assessed or have not successfully completed assessment.

Keywords: Driving Licence, Fitness to Drive; Homonymous Hemianopia