

IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

Court Reference: COR 2011 002908

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 60(2)*

*Section 67 of the Coroners Act 2008*

I, ROSEMARY CARLIN, Coroner having investigated the death of PETROULA KRASSOS without holding an inquest:  
find that the identity of the deceased was PETROULA KRASSOS  
born on 15 February 1936  
and the death occurred on 6 August 2011  
at Merri Creek near Westgarth Street and Merri Parade intersection, Northcote, Victoria, 3070  
**from:**

1a. MECHANICAL ASPHYXIA

**Pursuant to Section 67(2) of the *Coroners Act 2008*, I make these findings with respect to the following circumstances:**

1. Mrs Petroula Krassos was born on 15 February 1936. She lived with her husband and her daughter, Mary in Thomastown, Victoria. On 6 August 2011, she died when a car driven by Mary ran off the road into Merri Creek. Mrs Krassos was a passenger in that car. She was 75 years old. She is survived by her husband, children and grandchildren.
2. A brief prepared by Victoria Police for the Coroner includes statements obtained from Mrs Krassos' family and friends, witnesses to events, attending police and emergency services officers and police investigators, including the Major Collision Investigation Unit (MCIU). I have drawn on all of this material as to the factual matters in this finding.

**BACKGROUND AND CIRCUMSTANCES**

3. Prior to her death Mrs Krassos visited Crown casino around two to three times a week, spending several hours playing the poker machines and having a coffee. Her daughter, Mary would drive on each occasion, as Mrs Krassos did not hold a drivers licence.
4. Mary first obtained her driver licence in August 1995. She was diagnosed with suspected epilepsy in about 1997. Commencing in 1997 she was prescribed 200 mg Carbamazepine twice daily, first by the Austin Hospital and then by the Gilbirch Clinic in Preston. Medical records indicate that her medication remained the same from 1997 to the date of the accident and that she last attended the Gilbirch Clinic on 26 July 2011. Following the accident, her dosage of Carbamazepine was increased and she was also prescribed Clonazepam.
5. On 6 August 2011, Mrs Krassos and Mary left their home around 4.00 p.m. to travel to the casino. Mary drove her Audi sedan down her usual route being St Georges Road, Westgarth Street, Heidelberg Road and Hoddle Street. They arrived at the casino around 4.25 p.m. and spent some time in the complex.
6. At around 7.07 p.m., CCTV footage at the casino shows Mrs Krassos and Mary leaving the casino. Mary did not appear affected by any medical event, nor was there anything observed in the footage that would suggest disharmony or disagreement between Mrs Krassos and Mary.
7. Mary drove back along their usual route but near the point where Westgarth Street turns into Merri Parade, the car ran off the road and ended up on its roof in the banks of the Merri Creek.
8. Witness Sonia Fullerton, who lived nearby, heard a loud noise some time between 8.00 p.m. and 10.37 p.m., which may have been the accident, however Ms Fullerton did not report the noise to the police, as she believed that if it was an accident, it would have been reported by a passer-by.
9. At 12.52 a.m. on 7 August 2011, whilst still trapped in the car Mary phoned 000 using her mobile phone. She told the operator she thought she had run off the road into Merri Creek and believed that she had been in the car since 7.30 p.m. She said her mother was beside her and was unresponsive and she believed she was deceased. She said she thought she must have had a seizure.

10. Numerous emergency services personnel attended the scene between 00.57 a.m. and 1.10 a.m. but initially had difficulty finding the overturned car. The emergency operator remained on the phone to Mary the whole time and repeatedly instructed her to scream out until the car was found. It was upside down, partly in shallow water on the western bank of the creek. It had sustained severe frontal impact damage. Mrs Krassos was determined to be deceased by the attending emergency personnel. Mary was transported to the Royal Melbourne Hospital for treatment for a fractured spine and other injuries. Whilst at the hospital she had a number of epileptic seizures resulting in loss of consciousness.
11. An autopsy of Mrs Krassos' body was undertaken by Dr Michael Burke, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine. Dr Burke reported that his examination revealed significant heart disease with coronary artery atherosclerosis and cardiomegaly. Toxicological analysis of post-mortem samples detected codeine (0.07mg/L), gliclazide (1.6mg/L) and trace paracetamol in blood. Based on the significant compression of the car roof, Dr Burke reported the medical cause of death as 1(a) Mechanical Asphyxia.

## **COLLISION RECONSTRUCTION**

12. The MCIU investigated and reconstructed the collision. Westgarth Street is a highway located in a built up residential area with a 60kph speed limit. Westgarth Street lies in a general east to west direction before curving to travel in a north to south direction and becoming Merri Parade. It is constructed of a bituminous substance that was in good condition. At the curve, Westgarth Street extends in a straight line towards the Merri Creek, but it becomes a narrow concrete road terminating at a bicycle path. Beyond the bicycle path is scrub and a sheer drop of 30 metres to the creek bed. There were no barriers or fences erected at this point.
13. Detective Sergeant Christopher Carnie conducted an extensive inspection of the scene and formed the opinion that Mary's car had been travelling in a westerly direction along Westgarth Street and failed to take the right hand curve into Merri Parade. The passenger side rear wheel struck the kerb as it entered the Westgarth Street Extension.
14. The car then travelled along the Westgarth Street Extension without any evasive action or emergency braking. It then crossed the eastern bicycle path onto the eastern embankment of Merri Creek and became airborne when it left the cliff face. The car then travelled through

the air across Merri Creek before its front impacted with the eastern side of the Merri Creek bed before coming to rest on its roof.

15. Acting Sergeant Leigh Booth examined the car and concluded that it would have been classed as being in an unroadworthy condition due to insufficient tread depth on both front tyres. However, the insufficient tread depth would have no consequence unless the road surface was considerably wet at the time. It had been raining earlier in the night, but was not raining at around 7.30 p.m. The inspection did not reveal any mechanical fault with the car that would have caused or contributed to the collision.
16. Detective Leading Senior Constable Glen Urquhart calculated that the car would have been travelling about 70kph when it launched off the cliff. Based on his investigations, the car could have travelled in a straight line until the point where it launched.

#### **POLICE INVESTIGATION**

17. Mary was formally interviewed by the police on 19 September 2011. She said she did not remember anything from leaving the Casino until her father called her mobile phone. At that stage she woke up, but didn't realise where she was. She missed the call but found the phone and called him back. She said she didn't think he understood her so she then called 000. She said she had been having seizures for about 13 years and had a minor seizure about once every two months. She couldn't say how often she had more serious seizures, but thought she had probably lost consciousness twice in the last 12 months. She said she had told her doctor she still gets minor seizures, but her medication had never been changed. She said her doctor had never spoken to her about notifying VicRoads of her condition and she was unaware that she had an obligation to do so. She had never had a seizure whilst driving before. She thinks she probably had a seizure prior to the car leaving the road. She did not recall having any seizures whilst at the Royal Melbourne Hospital.
18. Upon reviewing the evidence the investigating police officers decided not to charge Mary with any offences.

#### **FITNESS TO DRIVE**

19. Although suffering from epilepsy and having a seizure at least once every couple of months, neither Mary nor her treating clinicians notified VicRoads of her condition. VicRoads was unaware that there were any medical issues affecting her safety to drive until Victoria Police raised concerns in writing on 17 October 2011. After receiving a medical report indicating she was not fit to drive, Mary's licence was suspended by VicRoads on 1 February 2012.
20. Since 1999 the *Road Safety (Drivers) Regulations 2009* have made it compulsory for drivers to report "permanent or long-term injury or illness that may impair the person's ability to drive safely" to the licensing authorities, being VicRoads in this case.<sup>1</sup> There is a fine of three penalty units for failing to comply with this rule. There is no obligation on medical or other health practitioners to notify VicRoads if they entertain a concern about a patient, although they are free to do so.
21. If a health practitioner or member of the public does wish to notify VicRoads of a concern about a person's fitness to drive, they must do so in writing. They are assured of anonymity, unless they consent to disclosure. VicRoads then follows a procedure, which includes the obtaining of medical reports to determine the person's fitness to drive.
22. VicRoads has a number of internal policy documents to assist its officers in giving advice or making assessments about a person's fitness to drive. In addition VicRoads has adopted national guidelines published by Austroads entitled 'Assessing Fitness to Drive: For Commercial and Private Vehicle Drivers'.<sup>2</sup> These guidelines are used by VicRoads staff and health professionals and are available on the web. They cover medical standards for licensing including setting out conditions for drivers suffering from seizures. The period that an individual must be free from seizures before driving depends on the type of seizure, the circumstances surrounding it and whether the individual holds a private or commercial licence.
23. Tina Vasiliadis, Manager of Medical and Driver Review at VicRoads provided a Statement for the purpose of the Coroner's investigation. She advised that when an individual is applying for a learner permit, probationary licence or heavy vehicle category licence, the application form requires them to answer questions about their health. Ms Vasiliadis noted

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<sup>1</sup> *Road Safety (Drivers) Regulations 2009*, r.67(2).

<sup>2</sup> The current guidelines were published in March 2012, however the guidelines in force at the time of the accident were published in 2003.

that in her experience, many people do not realise that after obtaining their licence, they have an ongoing obligation to inform VicRoads of a medical condition or medications that may affect their fitness to drive.<sup>3</sup>

24. Expert Senior Forensic Physician, Dr Morris Odell provided a report to the Coroner. He noted that Mary had given a history to various medical practitioners whilst in Royal Melbourne Hospital of more frequent and serious epileptic episodes than disclosed in her record of interview. He also noted that whilst two past blood test results were at the low end of the therapeutic range, if she was having episodes as frequently as reported to the hospital, this indicated poorly controlled epilepsy warranting an increase in her medication. Further, she should have been advised not to drive.
25. Dr Odell noted that Mary's lack of memory of the incident could be due to a seizure at the time or secondary to a head injury or concussion. However, he was of the opinion that the mechanism of the collision was very suggestive of Mary being unresponsive when her car left the road. The probable cause of this lack of response was a seizure.
26. Dr Odell suggested that although there is no compulsion for treating clinicians to report patients unfit for driving, doctors should inform their patients that the patient has a responsibility in this regard. He was of the view that many doctors would be unaware of this. Dr Manjit Dhillon, Mary's general practitioner provided a statement in which he said he had verbally requested Mary not to drive, however she would "just smile" and "kept going to work and driving her parents everywhere".<sup>4</sup>

## **FINDING**

27. I am satisfied having considered all of the evidence before me that no further investigation is required. There are no suspicious circumstances.
28. I am satisfied the collision which led to Mrs Krassos' death was caused by Mary experiencing an epileptic seizure.

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<sup>3</sup> Statement of Tina Vasiliadis dated 14 December 2014.

<sup>4</sup> Statement of Dr Manjit Dhillon dated 26 June 2012.

29. I find that Mrs Petroula Krassos died on 6 August 2011 as a result of mechanical asphyxia arising from a motor car collision in which she was a passenger.

## COMMENTS

**Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comments connected with the death:**

1. There is an abundance of literature concerning medical conditions and fitness for driving. Several findings of this court serve as reference points for this case. These findings relate to drivers involved in fatal collisions who have not reported their medical conditions to VicRoads. Whilst VicRoads' policies and procedures following notification of a possible medical impairment appear adequate, the real issue lies in the seemingly unknown obligation of drivers to report relevant medical conditions to the licensing authority.
2. When drivers renew their licence they are not required to fill in another medical health form and therefore may be unaware of this continuing obligation. Ms Vasiliadis noted that in cases of renewal of heavy vehicle licences, drivers are requested to provide information regarding their medical condition and medication.<sup>5</sup> If this was also the case with renewal of other classes of licences, it would require drivers to turn their minds to including updated medical information on their licence renewal form.
3. Mary's general medical practitioner recognised that Mary should not drive in light of her epilepsy and was aware that Mary potentially acted against his advice. If he had been legally obliged to report to VicRoads either the fact of Mary's epilepsy, or the fact she appeared to be ignoring his advice not to drive, it may have prevented Mrs Krassos' death. In the absence of a legal requirement to report, it is likely that any medical practitioner would feel constrained by their duty of confidentiality and relationship of trust with their patient.
4. Mandatory reporting by medical practitioners is a controversial policy, which is not supported by VicRoads, or other relevant experts. The competing arguments have been canvassed

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<sup>5</sup> Email from Tina Vasiliadis dated 17 March 2014.

extensively in another coronial finding of this court<sup>6</sup>. It was recommended by the Coroner in that finding that medical practitioners who are aware that patients are ignoring their advice not to drive should be obliged to report this to VicRoads.

5. That case concerned a driver who suffered from a medical condition, which was not epilepsy. VicRoads did not support that recommendation “based on current evidence”. In its published response (date stamped 24 March 2011), it indicated that available evidence suggests mandatory reporting does not lead to an increase in the number of at risk drivers being reported to licensing authorities. It stated: “Consistent with overseas research typically only drivers with epilepsy are reported”.<sup>7</sup> VicRoads further suggested that mandatory reporting may be counterproductive as it can lead to patients hiding their conditions and then not receiving appropriate treatment, which in turn can lead to an increased risk on the road.
6. In my view, epilepsy can and should be distinguished from other medical conditions which may affect a person’s fitness to drive. That is because epilepsy has such an obvious bearing on a person’s fitness to drive, whereas many other conditions are more degenerative in nature and the question of fitness to drive is more obscure and subjective. In the case of epilepsy, the possible downsides to mandatory reporting are outweighed by the clear risk to the public of the condition not being disclosed. The patient is not necessarily the best person to assess the risk of their condition, as is evidenced by the fact Mary was unaware she had seizures in the hospital after the collision. Further, they have a vested interest in not reporting.
7. If the doctor’s obligation to report arose upon making an initial diagnosis of epilepsy, this could not have a detrimental affect on the relationship of trust between doctor and patient, as the doctor would have no discretion. At that stage there could be no question of the patient concealing the illness from his or her doctor. From then on proper monitoring of the patient’s fitness to drive by VicRoads could occur. Mandatory reporting at the time of diagnosis, rather than upon learning that the patient was driving against advice, would also have the advantage of not requiring the medical practitioner to be an investigator or reporter of behaviour.

## **RECOMMENDATIONS**

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<sup>6</sup> Finding in the death of Scott Peoples (case 4776/06), found on the Coroners Court of Victoria website: <http://www.coronerscourt.vic.gov.au/home/coroners+written+findings/477606+scott+peoples>.

<sup>7</sup> VicRoads Response to Recommendations in the Finding in the death of Scott Peoples (case 4776/06), found on the Coroners Court of Victoria website: <http://www.coronerscourt.vic.gov.au/home/coroners+written+findings/response+-+inquest+into+the+death+of+scott+peoples>.

**Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendations connected with the death:**

1. That the Secretary, Department of Transport, Planning and Local Infrastructure amend the *Road Safety (Drivers) Regulations 2009* to include a statutory obligation for reporting by medical practitioners of patients immediately upon diagnosis with epilepsy.
2. That the Secretary, Department of Transport, Planning and Local Infrastructure consider further amending the *Road Safety (Drivers) Regulations 2009* to include a statutory obligation for reporting by medical practitioners of patients previously diagnosed with epilepsy.
3. That VicRoads and the Royal Australian College of General Practitioners educate and encourage medical practitioners to inform patients of the patients' legal obligations to report relevant medical conditions to VicRoads.
4. That VicRoads and the Royal Australian College of General Practitioners educate medical practitioners as to their rights and obligations to report patients' relevant medical conditions to VicRoads.
5. That VicRoads conduct a campaign educating drivers and medical practitioners about drivers' continuing obligation to report possible medical conditions and/or changes to their medical conditions, including on renewal of all classes of licences. This campaign should also emphasise road safety implications of driving with certain medical conditions.
6. That VicRoads include a section in all licence renewal forms requesting drivers to provide information of any medical conditions they have or medications they are taking which may affect their driving.
7. That the Secretary, Department of Transport, Planning and Local Infrastructure give consideration given to increasing the penalty for drivers who breach their legal obligation under the *Road Safety (Drivers) Regulations 2009* by failing to report to VicRoads any injury or illness which may impair their driving, including possible licence suspension.

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

The family of Mrs Petroula Krassos;

The Secretary, Department of Transport, Planning and Local Infrastructure;

Minister for Roads, Department of Transport, Planning and Local Infrastructure;

VicRoads;

President, Royal Australian College of General Practitioners;

Dr Manjit Dhillon;

Investigating Member, Victoria Police; and

Interested Parties.

Signature:



ROSEMARY CARLIN

CORONER

Date: 6 May 2014

