



*Western*

*Australia*

## RECORD OF INVESTIGATION INTO DEATH

*Ref No: 09/07*

*I, Evelyn Felicia Vicker SM, Deputy State Coroner, having investigated the death of Norman John HASLUCK, with an Inquest held at Perth Coroner's Court, Level 10, May Holman Centre, 32 St Georges Terrace, Perth on 13 March & 3 April 2007 find the identity of the deceased was Norman John HASLUCK and that death occurred on 9 January 2004 at the intersection of Guildford Road and Eighth Avenue, Maylands as a result of Compound Head Injury in the following circumstances:*

### **INTRODUCTION**

Norman John Hasluck (the deceased) was 69 years of age having been born on 3 July 1934. He was a Company Director and resided in Maylands.

At approximately 9:00am on 9 January 2004 the deceased was driving his Toyota Rav4 in a northerly direction on Eighth Avenue, Maylands. At the intersection with Guildford Road he had a green traffic control light giving him right of way into the intersection over traffic on Guildford Road facing red traffic control lights. The deceased entered the intersection and was

struck on the driver's side by a Mitsubishi Magna sedan which had entered the intersection from his right against the red traffic control light. The deceased's vehicle was turned over with the force of the impact and struck a traffic control light pole on the median island on Guildford Road before it came to rest on its roof 27metres west of the point of impact on Guildford Road.

The deceased died at the scene of injuries he sustained during the course of the crash.

The Mitsubishi sedan continued at an angle across the intersection and came to rest on the northern side of Guildford Road after striking a Mazda lift back which in turn impacted with a Ford utility

The driver of the Mitsubishi sedan also sustained injuries in the crash and was taken to Royal Perth Hospital (RPH) where she suffered a seizure in the Emergency Department.

The evidence of witnesses at the scene and medical opinion established the driver of the Mitsubishi sedan suffered an epileptic seizure as she travelled west along Guildford Road prior to and while entering the intersection at which the crash occurred.

I find death arose by way of Accident.

**COMMENTS WITH RESPECT TO THE ADMINISTRATION OF PUBLIC HEALTH AND THE ISSUE OF DRIVING LICENCES TO THOSE SUFFERING EPILEPSY.**

The Department for Planning and Infrastructure (DPI) are responsible for the issue of driving licences to would be motor vehicle drivers, and the renewal of licences for those already authorised to drive.

The inquest was provided with the "National Guidelines - Assessing Fitness to Drive 2003, Commercial and Private Vehicle Drivers". This is a joint National Road Transport Commission/Austrroads Publication which deals with medical standards for licensing, and provides clinical management guidelines with respect to epileptic persons and their fitness to drive.

Of note, the preface to the National Guidelines states there is a legal obligation upon persons to report to the DPI (or their equivalent) the fact of their diagnosis with epilepsy. There is a comment in parenthesis which indicates this does not apply within Western Australia. There is no legal obligation on drivers to advise DPI of the fact they have been diagnosed with epilepsy in this State. This makes the National Guidelines only applicable to those in Western Australia who choose, voluntarily, to inform the DPI they have a medical condition which may affect their ability to drive.

On the occasions when a person voluntarily provides that information the provisions of the National Guidelines then

apply and DPI request information from the treating medical practitioner. There is nothing in Western Australia, other than integrity, which requires a person to report the fact of their epilepsy to the relevant driving authority.

Similarly, there is no mandatory requirement under WA legislation, consultants or general practitioners report patients, whom they believe may have their ability to drive affected by reason of their medical condition of epilepsy.

Other States and territories differ but all require one or other to report. Evidence was heard at the inquest from treating medical doctors of the effect they believe obligatory/or mandatory reporting has had on their patient/doctor relationship. Their concern is patients will/do fail to report changes in their condition for fear it will compromise their driver's licence. As such physicians have become concerned their ability to adequately treat their patients, and consequently protect other members of the community from unintended harm, is compromised.

In Western Australia dispute between a patient's obligation to advise the DPI; and physicians' concern with mandatory reporting of their patients, has led to a situation where there is no legal obligation on anybody to do anything. This is not desirable. There must be a continuation in discussions in the community as a whole with respect to the necessity for persons with epilepsy wishing to obtain licences to drive, what

are potentially lethal weapons, and upon whom the responsibility for that decision should rest.

In the absence of agreement as to mandatory reporting by doctors, which would undoubtedly be the most efficient for the initial reporting aspect, I consider it essential provisions be adopted which place a legal obligation upon drivers wishing to obtain driving licences, or maintain driving licences once they have been confirmed as suffering epileptic seizures, to report their condition to the DPI which will then require information in accordance with the National Guidelines from the patient's treating doctors.

Relevant medical factors and treatments applicable for the issue of driving licences are covered by the National Guidelines but there is growing resistance from physicians as to their decision being the one to affect their patient's ability to obtain a licence. Physicians believe it more appropriate they are required to inform the patient they have a condition which the patient is legally obliged to report. The physicians then fill out appropriate forms, as supplied by the patient after reporting the condition to DPI, as to the condition and suitable treatment and the physician then returns the form to the DPI for them, and in difficult cases a suitably convened panel, to advise the patient as to whether or not they will be issued with a licence and the terms of that licence to drive relevant motor vehicles.

While there is no legal obligation on a prospective driver to advise the DPI of their medical condition, there is similarly no emphasis to those people that their condition is potentially life threatening to themselves and other road users. While a doctor may impress upon his patient the possibility of an adverse outcome for any road user from the driving of their patient, it lacks emphasis if a patient does not see there is also a legal obligation, to underscore, how importantly their actions may affect other people on the roads. A patient may understand they are at risk in a superficial manner but not really appreciate the extent of the danger.

In the current case the driver not only injured herself as the result of the seizure she experienced as she drove west along Guildford Road, she killed another person with a large and extensive family, and she potentially harmed, certainly damaged two other vehicles, and their occupants. The driver concerned is of the view there should be some form of mandatory reporting because she really failed to appreciate the terrifying outcome for herself with respect to the fact she had been involved in a crash where another person died.

She was also exposed to public scrutiny with respect to her form of epilepsy and whether or not she was compliant with medication. This prolonged examination of her very personal life would probably have been less stressful if she had been constrained by knowledge there was a legal requirement to report her condition to DPI and they had ultimately approved her to drive. Had that been done the issue of her medication

would have been on record without the speculation and controversy which then followed.

### **THE RELEVANT EVIDENCE FROM THE INQUEST**

The driver was a woman in her early 50's who had suffered an apparent seizure in late December 2002. She was unaware of the fact she had suffered a seizure and was taken to the Emergency Department at RPH following abnormal behaviour observed by her family. The driver herself had no recollection of anything untoward occurring and this appeared to be a consistent pattern with her later seizures. This meant unless she was observed in the lead up to a seizure or during a seizure it was often impossible to state with certainty a seizure or preliminary incident (aura) had or had not occurred. Evidence from a number of experts at the inquest indicated this was not abnormal with the type of epilepsy experienced by the driver.

The driver has right-temporal lobe epilepsy confirmed by EEG findings and consistent with MRI findings of probable right hippocampal/atrophy. Her epilepsy is termed focal epilepsy. This is a form of epilepsy which starts in a small area of the brain and may remain confined to that area without impairment awareness (simple partial seizure or aura). The seizure may progress so there is impairment of awareness (complex partial seizure), or it may secondarily generalise (generalised tonic clonic seizure or what used to be called a grand mal seizure). Dr Silbert, a Consultant Neurologist providing an expert overview, advised the inquest patients may

progress from an aura or simple partial seizure, to a complex partial seizure to a secondary generalise seizure or they may start at any point along the chain. Therefore patients may not have any warning they are about to have a seizure.

At the time of the driver's first seizure on 29 December 2002 she was referred to the Seizure Clinic for assessment by Dr Lawn, a Consultant Neurologist, specialising in epilepsy. Her first consultation was on 6 January 2003.

Dr Lawn took an extensive history from both the driver and her family because of the difficulty with her unawareness of her behavioural peculiarities. In addition an EEG had been taken in the emergency department which indicated the probability of an epileptic seizure.

On taking the history Dr Lawn discovered the driver, at two years of age, experienced a seizure during the course of a febrile fever. After that incident her mother noted her to suffer four or five seizures until the age of six from which point there were no further seizures, until possibly the one on the night of 29 December 2002. This was the basis for the provisional diagnosis of focal epilepsy, in that the seizure suffered in the setting of the fever may have caused a scar on the relevant part of the driver's brain. Later investigations carried out in hospital indicated this was likely to be on the right anterior temporal aspect of the brain. A CT scan was normal. In addition, the driver was left-handed.

History from the driver's husband and son indicated in the six weeks prior to the seizure the deceased had experienced some strange sensations. The difficulty for Dr Lawn was these peculiar sensations appeared to be in her right upper limb and un-associated with impaired consciousness; while on the day of the seizure she had been intermittently confused and possibly hallucinating with several episodes of unresponsiveness. The following seizure was a generalised tonic clonic seizure. The difficulty with the right limb peculiarities and the EEG report was there seemed to be an inconsistency. If the sensory sensations were related to the epilepsy they should have been on the left-hand side, not the right. This made a clear diagnosis for an unprovoked seizure very hard. On the day before her recognised seizure she had consumed, for her, a relatively significant amount of alcohol.

As a result of these anomalies it was decided the driver should not be medicated for epilepsy at that stage in case the seizure had been provoked by the alcohol and there were other explanations for the other symptoms which had been observed, possibly arising from or requiring other forms of medication. She was, however, told on Dr Lawn's review on 10 January 2003, she should not drive for a period of three months while the different investigations and her ongoing tendency for seizures were assessed.

The evidence at inquest was the driver did not drive during those three months. There was no requirement on either the driver or the treating doctor to report the advice not to drive to

the DPI. Obviously the driver held a licence at that stage which she had used for the purposes of getting to and from work.

The driver was reviewed on 15 May 2003 with no further witnessed symptoms and no further indication from herself she may have suffered a seizure. In addition her strange sensations had also disappeared. Dr Lawn believed the subtle right hippocampal changes seen on the MRI related to the febrile convulsions mentioned during childhood and were possibly not related to the potential for epilepsy. The driver had returned to driving, the three months having expired, and there having been no indication she was suffering any further seizures.

The driver was next reviewed on 30 May 2003 after attending the Emergency Department at RPH. She was taken by her work colleagues who had noticed acute behavioural symptoms. It later transpired this was a later episode of a series of events that day which were originally noted by her husband but, due to the driver's unawareness of her problem, denied by her. As a consequence of her disbelief of her husband's comments she had driven herself to work and there experienced further episodes noted by her work colleagues which resulted in her returning to hospital. In view of the fact these episodes were witnessed it was possible to say there was abnormal behaviour ("*behavioural arrests*") however, it begs the question as to whether or not there may have been other

episodes between January and May which were unwitnessed by anybody and consequently unknown.

On her presentation to the hospital she was taken to neurology and another EEG performed. This revealed a complex partial seizure of right temporal origin with behavioural arrest, staring, oral automatisms, and transient post-ictal confusion. This recorded seizure provides some evidence of how the driver would behave during one of her complex partial seizure.

Dr Lawn's letter to the driver's GP indicated, from the history given, he thought it possible events observed earlier by a friend suggested there had been other episodes. On that occasion one of the other medications she was taking, irrelevant to epilepsy, had been increased in dosage and it was suspected this may have contributed to her seizure. The medications in question are capable of predisposing to epileptic seizures. So while this may have been another provoked seizure, it was of considerable significance the driver was unaware of her difficulties unless they were observed by someone else. The seizure recorded during the EEG confirmed the potential for serious seizures.

As a result on 30 May 2003 Dr Lawn discussed the diagnosis of epilepsy with the driver and her husband and its relevance to the interaction of any medication for epilepsy and other potential interactions with other medications. She was commenced on Carbamazepine CR, an anti-epileptic

medication. She was advised as to the potential adverse effects and Dr Lawn recommended she not drive.

Dr Lawn advised the inquest in evidence he considers it a doctor's duty to emphasise to a patient diagnosed with epilepsy the dangers of their performing a number of activities alone and unsupervised. He emphasised this was not just in the patient's interest, but with respect to driving and the care of children, would place other members of the community at risk due to the condition. Dr Lawn was adamant a great deal of his time as a consultant neurologist was emphasising to patients their limitations and the dangers for themselves and other members of the community. While he advised the driver not to drive there was no legal obligation on the driver to notify DPI she had been advised not to drive, nor was there any requirement Dr Lawn mandatorily report her condition to DPI, nor would he do so without statutory obligation. The breach of a patient's confidentiality and resulting loss of trust which could severely affect the therapeutic benefits he could bring to his patient, and therefore the community, are significant considerations for a treating physician.

The plan for the driver's medication was communicated to her GP who then prescribed her medication as and when needed.

The driver described how the Carbamazepine had side effects with which she was uncomfortable. She was advised the side effects would probably be transient and if they weren't she was

to discuss matters with her doctors so the dosage and/or alternatives could be considered.

After 30 May 2003, the driver's prescriptions for medication were largely controlled by her GP taking into account the advice provided by Dr Lawn by way of his reports. The driver's GP from the beginning of 2003 was Dr Morrison. He first saw the driver on 11 February 2003 at which time he was informed she was possibly epileptic, but it had not been confirmed. She was being reviewed by RPH and the Seizure Clinic. Dr Morrison was not involved with her epilepsy directly until the events in May 2003. It was at Dr Morrison's behest the driver was taken to the Emergency Department at RPH on 30 May 2003. On that date she was started on medication and it was then Dr Morrison became involved with her medication regime. Apart from the letter from Dr Lawn, the driver advised Dr Morrison on 9 June 2003 of what had occurred at the consultation on 30 May 2003. On Dr Morrison's enquiry she advised him she was not experiencing any side effects from the medication.

Dr Morrison next consulted with the driver, with respect to her epilepsy, on 15 September 2003 when she was concerned she had experienced episodes of jumbled speech while talking to her family on the telephone. She also had gastroenteritis and Dr Morrison was not sure whether or not the symptoms she described were to do with her epilepsy, her flu like symptoms, or medication. As a result he had her blood Carbamazepine levels tested. The result came back with a level of "6" which

Dr Morrison viewed as within the optimal therapeutic range. He did not believe there to be a problem with her medication.

She advised Dr Morrison she was not driving, nor was she in danger at work of compromising herself or others. Dr Morrison agreed in evidence he relied upon information conveyed by the driver, as backed up by the medication levels he had checked. Dr Morrison sent the medication blood results to Dr Lawn. Dr Morrison was still prescribing a 200mg tablet in the morning and 2 x 200mg tablets in the evening (400mg) and the driver was still not complaining of any difficulty on the medication.

Dr Morrison next saw the driver on 10 October 2003 where she reported no problems. Dr Morrison was aware she was due for a review with Dr Lawn the following week and as a matter of assistance had her blood medication level checked because he thought it would be useful to Dr Lawn. When the blood results came back she had a Carbamazepine level of "5" on the same medication dose she had been taking since May. Dr Morrison considered that to be sub-therapeutic and as a result they discussed her options. She could either increase the dose or wait until Dr Lawn saw her the following week. She was not complaining of any abnormal symptoms or behaviours.

Dr Morrison's records indicate the driver decided she wished to increase her level of Carbamazepine to make sure her levels were appropriate. As a result Dr Morrison gave her oral advice

over the telephone she was to increase her Carbamazepine to 1.5 x 200mg tablets in the morning and remain on the 2 x 200mg tablets in the evening and discuss that situation with Dr Lawn when she next saw him.

The reason I have referred to the 1.5 tablets is because the driver's evidence, since the events of January 2004, has been confused with respect to her medication. I do not take this as her being deliberately misleading. She advised the police initially she was taking 200mg in the morning and 400mg at night. This was consistent with the instruction on her medication vials which she produced to the police. In view of the fact Dr Morrison's instruction to her had been with respect to the same prescription, and she had a clear recollection, in March 2007, of taking 1.5mg tablets at some point during the history of her medication I believe she is simply confused as to when this occurred.

If her medication at the time she and Dr Morrison decided to elevate one of the dosages was at 200mg and 400mg that is what her prescription vials would show. Her recall at some stage she was taking 1.5 tablets to give a 300mg dosage is entirely consistent with Dr Morrison's oral advice to her to increase the dose due to his perception her blood Carbamazepine level was sub-therapeutic.

Dr Morrison advised the last script he had written for the driver had been on 9 October 2003 at which stage she was still on the 200mg + 400mg. The advice with respect to

increasing it to 300mg and 400mg was over the telephone and therefore would not have appeared on the bottle provided to the driver by the chemist before she and Dr Morrison decided to increase the morning dosage. The tablets only come in a 200mg or 400mg size.

Dr Lawn then saw the driver on 23 October 2003. She advised Dr Lawn she and her GP had decided to increase her morning Carbamazepine CR to 300mg and remain with the 400mg in the evening. This was due to her trough blood level being 5mg/L (with the therapeutic range considered to be 6-12mg/L). There was extensive evidence at the inquest with respect to the efficacy of blood trough levels as a measure of reliability. It would also seem the driver explained to Dr Lawn the difficulty with her jumbled speech as experienced on the 15 September 2003.

Dr Silbert's assessment of Dr Lawn's notes of that consultation indicates the history is somewhat obscure. Having heard from Dr Morrison about the sequence of events I am satisfied we have the difficulty of a patient relating to her consultant events which have occurred and her interpretation of them.

It is clear from Dr Morrison's evidence the blood level at the time of the flu-like-symptoms and jumbled speech were within those he considered to be in the therapeutic range and he did not increase her dosage. The increase in dosage occurred a

week before the presentation to Dr Lawn as a result of Dr Morrison's view, her level at that time was sub-therapeutic.

In any event Dr Lawn advised the driver, and noted to Dr Morrison in his letter, he was in agreement with the increased dosage to 300mg and 400mg. He also advised if the driver experienced any difficulty with that dosage the morning dose should then again be increased to 400mg (2 x 200mg tablets). Thus the potential was for Dr Morrison to elevate the driver's Carbamazepine levels to 400mg in the morning and 400mg in the evening if she experienced difficulties with symptoms thought to relate to her epilepsy.

The driver also said she experienced drowsiness on the levels being elevated to 300mg and 400mg and Dr Lawn advised if her dosage was to be raised to 400mg + 400mg she was to commence the increased dosage at a weekend when there was no requirement to drive, because the side effect of drowsiness from the medication was potentially as dangerous as abnormal behaviour from her epilepsy.

Dr Morrison understood this to be the instruction, however, the difficulty appears to be the driver's interpretation of this advice. It seems the driver understood she was to remain with her 300mg and 400mg during the week when she was driving, but was to take 400mg and 400mg at the weekends only, if it was to be increased. The situation therefore was she was on a dosage of 300mg in the morning and 400mg at night as from approximately 17 October 2003.

Dr Morrison next saw the driver on 7 November 2003 when she confirmed with Dr Morrison the events described in Dr Lawn's letter. The driver advised Dr Morrison she was feeling better and that she was no longer experiencing side effects as she had when she commenced taking the increased dose of 300mg in the morning.

It is also relevant to mention at this point, in the reviews of the driver after the crash, there is reference by Dr Lawn to an episode he believes occurred in December 2003 with the flu-like symptoms. While the facts surrounding those symptoms are identical to Dr Morrison's description of the events of September 2003, the practice notes of Dr Morrison indicate he did not see her in December 2003. I have to assume there was an error in translation of events from the driver to Dr Lawn with respect to events prior to January 2004. She does have explicable difficulty with her memory due to the location of her lesion. Even without this I speculate it is some times very difficult to recall whether or not something which may be relevant occurred six or twelve weeks prior to a traumatic event.

In addition evidence was called at the inquest from Dr Frank Daly, a Consultant Clinical Toxicologist and Emergency Physician. The overall effect of Dr Daly's evidence was that Carbamazepine is a tricyclic anticonvulsant agent with a low therapeutic index which means the dose and concentration-dependent adverse effects may occur within or just above what

is regarded as the therapeutic range of serum concentrations. In addition there is the difficulty Carbamazepine acts as an auto-inductor to its metabolism. Therefore over a period of days the half-life of the drug may decrease by nearly 50% without any change in the dosage. There are other drugs which also fit this pattern which means the interaction of Carbamazepine with other commonly prescribed drugs for other conditions may also affect blood trough levels.

The reported therapeutic levels for Carbamazepine blood levels also vary between laboratories. In some laboratories a level of 4-8 mg/L is considered to be therapeutic while other reviews indicate levels of 5-10mg/L are therapeutic. In Western Australia RPH and St John of God Pathology Laboratories consider the therapeutic level to be between 6-12mg/L. Obviously that was the level influencing Dr Morrison when he checked the driver's blood levels and considered "5" to be to low, while "6" was what he considered to be in the therapeutic range. Dr Daly was of the view serum Carbamazepine levels are useful to check for compliance (ie that the patient is taking the medication) and for documenting levels associated with adverse affects, however, the dosage and actual serum levels do not correlate well with therapeutic efficacy.

In addition Dr Silbert, Dr Lawn and Dr Dunne, all Consultant Neurologists, were of the view while blood serum levels provide a guide, they are certainly not as important, when considering a patient's therapeutic levels as to it efficacy, as to whether or not there were break through seizures. Again this is difficult

where a patient is totally unaware of episodes, has no memory of them and they may merely have been unwitnessed. It is then impossible to determine accurately whether or not there is break through for that individual at particular levels or not.

Dr Daly also reviewed the driver's levels whilst in hospital after the crash. She was given a known dosage consistent with that showing on her medication bottles, (probably lower than the dose she was taking at the time of the accident if she was complying with Dr Morrison's instruction).

At a level of 200mg in the morning and 400mg at night, starting on the day after the crash the driver's serum carbamazepine level fluctuated from 6mg/L through 7, 5, 4 and 5. When her level was increased to the 300mg and 400mg as consistent with the dosage Dr Lawn believed she was taking, her level briefly rose and then again fell. At a later stage her dose was again raised and on 16 February 2004, at 400mg in the morning and 400mg in the evening, her level was 7mg/L, similar to those experienced immediately after the crash at 200mg and 400mg/L. This would seem to support the fact the driver was compliant with Carbamazepine medication at the time of the crash, however, it is impossible to tell from blood serum levels exactly what dosage she was taking. To quote Dr Daly

*"A level of 5mg/L is consistent with her taking a dose of 200mg morning and 400mg at night as this serum level is within the range seen on other occasions when serum levels were taken on that particular dose.*

*However, as demonstrated, a range of serum levels was seen in the driver while she was reported to be taking the dose 200mg morning and 400mg at night. In the documents provided, six levels in the range 4-7mg/L are documented.*

*While the driver was taking 400mg twice daily and up to 600mg twice daily serum levels were noted to be within the same range (7 and 6mg/L respectively).*

*This demonstrates that in the driver there was not a predictable linear relationship between the dose prescribed and the trough serum Carbamazepine level."*

The fact there are these ranges in serum level can be explained by many factors to do with the medication and individual involved. It is not indicative of a failure by the driver to take her medication as prescribed.

The driver could not recall, either on 9 January 2004, the date of the crash, or thereafter any indicators prior to her seizure that she may be at danger of experiencing a seizure and thereby in danger to herself or other road users. The fact she was experiencing a seizure is demonstrated by the evidence of other witnesses to her driving which appeared extremely erratic and the tests in the ED later that day.

Concern was initially expressed by the police due to the fact some of her driving appeared to be extremely deliberate. For example, a witness driving behind the driver observed her peculiar driving. She believed the driver may be experiencing some medical problem. There were fluctuations in speed and the placement of the vehicle on the road. At the intersection

in question the traffic lights were clearly red and there was traffic waiting at the lights for the lights to change. The driver "deliberately drove" into the right-hand turn lane, in which there were no stationary vehicles, and then swerved from that lane into the intersection to continue in a westerly direction.

Expert evidence at the inquest indicated this is not abnormal for the type of seizure experienced by the driver on that occasion. The brain in that type of partial seizure is quite capable of registering vehicles in front of the vehicle being "driven", but not capable of sorting out complex concepts such as why other vehicles may be stationary or, there was a necessity for the driver to stop. Rather the driver would automatically avoid items in front of the vehicle she was "driving" and continue in the path which appeared to be open. This appears to be precisely what the driver in these circumstances did although there is clearly no recollection in her mind of what occurred. Obviously the events once she was aware of what had occurred were very traumatic.

It can be seen from the above, and was confirmed by Dr Lawn the Consultant Neurologist treating the driver, the circumstances surrounding the driver's epilepsy and medication were such it is very unlikely the driver knew she was in danger and putting other people at danger at the time it occurred. All doctors also agree the specific crash would not have been avoided had the driver reported to DPI she was an epileptic and required medication.

As Dr Lawn pointed out, despite the fact she had not reported herself as an epileptic on the diagnosis on 30 May 2003, she still fitted within the guidelines of being able to drive as of January 2004. She was medicated, as supported by her Carbamazepine levels and there were no known precursor episodes or seizures which would indicate she was not seizure free. Consequently it is likely, even with obligatory reporting conditions, she would still have been driving.

Nevertheless having heard the evidence from the neurologists, the driver, the consultant toxicologist and the driver's GP I do consider obligatory reporting by a patient to the relevant driving authorities would emphasise to drivers, and reinforce the advice of their treating physicians, there is a real potential for harm with certain medical conditions, of which epilepsy is certainly an example.

I believe this legal reinforcement of the significant potential for harm to both the patient and other road users warrants the introduction in this State, consistent with other States, a legal requirement a driver inform the driving authorities of a difficulty which may affect their ability to drive and allow the driving authorities, with input from the relevant specialists as to the realistic potential for harm, to make a realistic determination.

I accept the fact deaths on the road resulting from epileptic seizure are rare. This is no doubt a reasonable matter for the driving authorities to take into account in individual cases,

with input from the treating physicians. But the fact there are fatalities in these circumstances indicates a legal requirement to report the condition is reasonable. It reinforces the very real fact there is danger and people need to ensure they are compliant with their medication and understand the risks posed to both themselves and others.

**I RECOMMEND:**

1. **Consistent with the "National Guidance - Assessing Fitness to Drive 2003, Commercial and Private Vehicle Drivers," there be a legal obligation on drivers suffering epilepsy to report that fact to the relevant driving authorities in Western Australia, that is The Department for Planning and Infrastructure. (DPI)**
2. **Treating doctors understand their duty to tell their patients they have a legal obligation to report the fact of their condition to the DPI.**
3. **On the patient informing the DPI of their diagnosis the patient is provided with a form to give to their treating doctor with respect to their medical condition.** There is currently a form in the National Guidelines which puts the obligation on the treating doctor as to the determination as to whether or not the person can drive. This form has caused the hiatus in this state with respect to whether or not there should be



**NOTE**

“mandatory reporting” by doctors or a legal “obligation” on patients to report and there needs to be proper negotiation about this point. I understand the various National and State Committees concerned with guidelines with respect to epilepsy have made recommendations before about the form and Dr John Dunne, head of the Western Australian Comprehensive Epilepsy Service has devised a form he believes would be more acceptable to consultant neurologists Australia wide and their patients.

**ATTACHMENT: MEDICAL ASSESSMENT RELATING TO FITNESS TO DRIVE**

**CONFIDENTIAL**

*Retain a copy for the patient's medical record*

*This form is not to be returned to the person subject of the report*

Post to: The Occupational Health Physician  
c/- Department for Planning and Infrastructure  
GPO Box R1290, PERTH WA 6844

**APPLICANT DETAILS**

FAMILY NAME
GIVEN NAMES
DATE OF BIRTH
RESIDENTIAL ADDRESS

**PATIENT CONSENT**

I consent to the medical practitioner named on this form providing medical information relevant to my fitness to drive to the Department for Planning and Infrastructure.

PATIENT SIGNATURE/VERBAL CONSENT:

DATE:

Were you familiar with the patient's medical history prior to this exam? **Yes/No (circle)**

The patient has attended this RPH clinic since: \_\_\_\_\_ (Month/Year)

1. VISUAL ACUITY	Without visual aids	With visual aids
(L) eye	6/ _____	6/ _____
(R) eye	6/ _____	6/ _____
both eyes	6/ _____	6/ _____

Peripheral vision of at least 45 degrees to each side of the midline **Yes/No (circle)**

**2. HEARING ADEQUATE?** **Yes/No (circle)**

**3. RELEVANT MEDICAL CONDITION/S**

Note: Only include information relevant to the patient's fitness to drive. (include diagnosis/cs; treatment and response, eligibility criteria relevant to unconditional or conditional licence and other relevant information to driving task.)

4. ASK PATIENT: Are you aware of any *other* medical conditions you have that may affect your ability to drive? (If yes, specify)

5. Are any vehicle modifications necessary? (e.g hand controls, left foot accelerator)  
*Requires specialist assessment unless already done and application is for current license continuation.*

6. Type of licence application:

Private vehicle

Commercial vehicle

*In my opinion the person who is the subject of this report:*

Requires referral to the Department for Planning and Infrastructure for recommendations. I am unable to make a determination this case.

Is eligible for an unconditional licence and requires no further assessment.

Is not fit to drive

May be suitable for a conditional licence based on the information above.

- Proposed restrictions to conditional licence and reasons if granted by Department for Planning and Infrastructure

- Suggestions for periodic review interval (if conditional licence granted)

Requires appropriate specialist assessment, practical driving test or Occupational Therapist assessment. *Specify type of assessment recommended. Required if vehicle modifications are necessary.*

Note:

The Department for Planning and Infrastructure (DPI) has a legal responsibility to ensure that all drivers have the appropriate skills and abilities, and are medically fit to hold a driver's licence. Currently no legal indemnity is provided to practitioners providing relevant information to the DPI.

Any queries regarding licensing may be directed to the Department for Planning and Infrastructure on (08) 9216 8166

**MEDICAL PRACTITIONER DETAILS (Please Print)**

NAME OF MEDICAL PRACTITIONER

QUALIFICATIONS

DATE OF ASSESSMENT

Department of Neurology, Royal Perth Hospital Ph: 08-92242593 Fax: 08-92247020  
*The above information is provided in accordance with the relevant National Medical Standards (private or commercial) as set out in Assessing Fitness to Drive, 2003.*

DOCTOR'S SIGNATURE

4. The forms, once completed by the treating physicians, are returned directly to the DPI and not provided to the patient to return. This provides some certainty the driving authorities obtain the correct and relevant information.
  
5. In the event a patient has complied with the obligation to report their medical condition and is driving in compliance with any determination then made by the DPI there be no issue with insurance companies with respect to accidents arising out of the condition.



EF VICKER SM.,  
**DEPUTY STATE CORONER**

2 May 2007