Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 24/17

I, Sarah Helen Linton, Coroner, having investigated the death of ***Mamadou Hady DIALLO*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***15 June 2017*** *find that the identity of the deceased person was* ***Mamadou Hady DIALLO*** *and that death occurred on* ***22 May 2015*** *on* ***Great Eastern Highway, near the intersection of Chedaring Road, Wundowie*** *as a result of* ***multiple injuries*** *in the following circumstances:*

Counsel Appearing:

Ms A Sukoski assisting the Coroner.
Ms N Eagling (State Solicitors Office) appearing on behalf of Bentley Mental Health Service.
Mr D Brand (MDA National) appearing on behalf of Dr Atartis.
Mr E Panetta (Panetta McGrath acting on behalf of MDA National) appearing on behalf of Dr Connor.

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INTRODUCTION

1. Mamadou Hady Diallo (the deceased) died on 22 May 2015 at the scene of a traffic collision on the Great Eastern Highway in Wundowie.

2. At the time of his death the deceased was subject to a community treatment order made under sections 76 and 79 of the *Mental Health Act 1996* (WA) and accordingly, the deceased came within the definition of an involuntary patient pursuant to section 3 of that Act.

3. As the deceased was an involuntary patient at the time of his death, he was a 'person held in care' for the purposes of the *Coroners Act 1996* (WA). In such circumstances, a coronial inquest is mandatory.[1] I held an inquest at the Perth Coroner's Court on 15 June 2017. The inquest was held jointly with the inquest into the death of another person, Mr James Yung, who also died in a traffic collision in 2015 while subject to a community treatment order. Both deaths raised the issue of the system in place for assessing fitness to drive in patients with chronic psychiatric conditions.

4. The documentary evidence included a comprehensive report of the investigation into the death by the Western Australia Police.[2] The author of the report was called as a witness at the inquest. In addition, oral evidence was heard from Dr George Atartis and Dr Peter Connor, who were involved in the deceased's medical care, and Dr Murray Chapman, who reviewed the deceased's records and provided an expert report on the quality of the deceased's supervision, treatment and care while he was subject to a community treatment order.

5. The inquest focused primarily on the care provided to the deceased while on the community treatment order, as well as the circumstances of his death and his fitness to drive given his psychiatric disorder.

BACKGROUND

6. The deceased was born on 7 March 1976 in Conakry, the capital city of Guinea in West Africa. He was of African descent. The deceased came to Australia in 2005. At the time of his death the deceased was single and was living in shared accommodation in Victoria Park. He had initially gained work in factories and had also worked as a security guard. He was receiving a disability pension at the time of his death but was actively seeking new employment.

7. The deceased's main support in Perth was his cousin, Thierno Sadou Diallo, as his brother and sister lived overseas.

8. The deceased was not known to have suffered from any major mental illness in Africa, although there was a report of a brief psychotic episode some years

[1] Section 22(1) (a) *Coroners Act*.
[2] Exhibits 3 and 4.

before he migrated to Australia.[3] He had no history of self-harm or aggression towards others. He also had no history of substance abuse at this stage.[4]

EMERGENCE OF PSYCHIATRIC ILLNESS

9. On 18 November 2005 the deceased was admitted to Royal Perth Hospital with acute paranoid psychosis. He had reportedly been stressed by matters relating to his immigration status. The deceased was aroused, confused, anxious and perplexed and expressed paranoid ideas about the police. He required medication to tranquilise him and was stabilised on risperidone (an antipsychotic) and venlafaxine (an antidepressant). His symptoms improved on medication but he had residual psychotic symptoms some two weeks later. The deceased underwent a CT head scan while in hospital, which was unremarkable.[5]

10. After discharge the deceased was referred to Inner City Mental Health and was admitted into the Community Recovery Program. He was discharged from this program in April 2006. By that time he had a diagnosis of Acute Polymorphic Psychotic Disorder with symptoms of Schizophrenia.

11. The deceased's mental state deteriorated again when he received a negative outcome from the Refugee Review Tribunal and it is suggested he may have had transient self-harming thoughts.[6]

12. In December 2009 the deceased relapsed into florid psychosis with auditory hallucinations, paranoid delusions, passivity phenomena and thought disorder. He stabilised on increased doses of his medication and was discharged into the care of his general practitioner, Dr Peter Connor, at the Maylands Medical Centre.[7]

13. Dr Connor has been practising as a general practitioner for many years and has specialty training in the area of addiction medication.[8] Dr Connor had been seeing the deceased as a patient since February 2008 and came to know him quite well. Dr Connor felt that they established a very good rapport. The frequency of the deceased's appointments varied, depending upon his issues, with a lot of the visits to do with sexual health as the deceased was a single man and changed partners from time to time. The other recurring theme of his attendances was in relation to his psychiatric medications and mental health issues. The deceased often expressed a desire to reduce his medications as he was a physically fit young man and was keen to reduce his medication load, with an aim to be well without medications. In particular, the deceased often sought to reduce his antidepressant, Efexor (venlafaxine), as it at times caused him sexual dysfunction.[9]

[3] Exhibit 1, Tab 14 [5] and Tab 23, p. 3.
[4] Exhibit 1, Tab 23, pp. 3 – 4.
[5] Exhibit 1, Tab 23, p. 4.
[6] Exhibit 1, Tab 23, p. 4.
[7] Exhibit 1, Tab 23, p. 4.
[8] T 57.
[9] T 58 – 59.

14. Dr Connor gave evidence that he had worked cautiously with the deceased to reduce his Efexor, gradually reducing his dose and even stopping the medication entirely for periods. At other times the deceased would voluntarily come to see Dr Connor and report that he was feeling more anxious, at which time they would agree to a plan of restarting, or increasing, his Efexor dose. The deceased would usually respond quite rapidly to the medication change.[10]

15. On 11 October 2013 the deceased's cousin became concerned that the deceased was suicidal, although the deceased had not made any specific threats. Several psychosocial stressors were identified, including stress and working long hours. The deceased was referred to Bentley Mental Health Services (BMHS). The deceased was contacted but indicated he was well and did not require any assistance. The deceased's cousin remained concerned but asked that any assessment be deferred as he did not want to damage his relationship with the deceased.[11]

16. On 7 May 2014 the deceased presented to BMHS with his cousin, who was concerned that the deceased's mood was low and he was socially withdrawn. The deceased had reportedly just returned from a visit to his sister in the USA and had been suffering a worsening of his symptoms since his return. He had also been non-compliant with his medication.

17. The deceased was assessed by a medical officer and recommenced on his antidepressant and antipsychotic medications.

18. The deceased did not attend his next two appointments at the clinic. He was reviewed at home on 24 June 2014, when he reported feeling better. However, his cousin Sadou felt the deceased was still withdrawn.

19. On 13 July 2014 the deceased's cousin became concerned that the deceased was having suicidal thoughts after he had again stopped taking his medications. He had reportedly called his sister and stated that he wanted to die and his cousin had been required to physically restrain him to prevent him from harming himself. The deceased was taken by his cousin to Royal Perth Hospital. He was placed on forms and admitted as an involuntary patient into a locked ward. He was commenced on risperidone and venlafaxine, his original medications. The deceased was later transferred by ambulance to Rockingham Hospital on 16 July 2014, before being transferred to Bentley Hospital on 20 July 2014. The deceased was restarted on his antipsychotic medication and started on two new antidepressants, mirtazapine and Pristiq. His antipsychotic medication was later changed to depot paliperidone. The deceased's mental state improved on medication, although he remained reluctant to accept the depot medication. He was discharged on 13 August 2014 with follow up at BMHS.[12]

[10] T 59.
[11] Exhibit 1, Tab 23, p. 4.
[12] Exhibit 1, Tab 23, p. 5; Exhibit 2, Tab 1, RPH Discharge Summary 16/07/2014 and Bentley Hospital Discharge Summary 30/10/2014.

20. The deceased was readmitted to Bentley Hospital with a relapse of his paranoid schizophrenia on 28 August 2014. In the two weeks following his earlier discharge on 13 August 2014 the deceased had initially disappeared from his home and then returned home but spent several days in bed and was seen to be behaving erratically. He had shown poor engagement with the outpatient clinic and non-adherence with oral medications.[13]

21. During this next admission the deceased was not suicidal but was noted to have psychotic symptoms and to be sexually disinhibited on the ward. He spent time in both a locked and open ward. His medication was changed to zuclopenthixol depot and his symptoms and insight appeared to eventually improve. The deceased was discharged on a Community Treatment Order on 30 October 2014. The deceased thereafter begrudgingly accepted his depot medication in the community.[14]

22. He was reviewed by a psychiatrist on 4 December 2014, at which time he denied any symptoms and stated he believed he did not really need medication.

FITNESS TO DRIVE CERTIFICATION

23. Because the deceased had a chronic psychiatric condition (schizophrenia), he was required to satisfy the Department of Transport of his fitness to drive before he could be granted a licence, or have his licence renewed/extended. In order to satisfy that requirement, the deceased was required to undergo a medical assessment by a health professional.[15]

24. The examination must be conducted in accordance with the national medical standards described in the publication, "Assessing Fitness to Drive for commercial and private vehicle drivers" which is published by Austroads and is available online at www.austroads.com.au.[16]

25. The Department of Transport also provides some Medical Assessment Instructions (M106A) as well as a Medical Assessment Certificate: Fitness to Drive (M107A) that is to be completed by the patient and health professional. The same form is used for assessment of fitness to drive to commercial vehicle standards and private vehicle standards.[17]

APPOINTMENT WITH DR ATARTIS RE COMMERCIAL LICENCE

26. By the beginning of 2015 the deceased had a diagnosis of Chronic Paranoid Schizophrenia and had been on a Community Treatment Order for some time due to poor insight into his condition resulting in non-compliance with his treatment.[18]

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[13] Exhibit 1, Tab 23, p. 5;Exhibit 2, Tab 1, Bentley Hospital Discharge Summary 30/10/2014.
[14] Exhibit 1, Tab 23, p. 5;Exhibit 2, Tab 1, Bentley Hospital Discharge Summary 30/10/2014.
[15] http://www.transport.wa.gov.au/licensing/fitness-to-drive.asp
[16] Exhibit 1, Tab 26; http://www.transport.wa.gov.au/licensing/fitness-to-drive.asp.
[17] Exhibit 2, Tab 1; http://www.transport.wa.gov.au/licensing/fitness-to-drive.asp.
[18] Exhibit 1, Tab 24.

27. On 9 January 2015 the deceased was reviewed by Consultant Psychiatrist Dr George Atartis at BMHS. Dr Atartis was a locum psychiatrist at the Bentley Hospital at the time. Dr Atartis had become the deceased's supervising psychiatrist for the deceased's Community Treatment Order at that time, and was aware of his history, but this was his first contact with the deceased. The deceased's first scheduled appointment with Dr Atartis was not until late January 2015, and the deceased did not have an appointment at the clinic that day, but he insisted on being seen so Dr Atartis arranged a brief impromptu meeting with him.[19] The deceased was accompanied to the appointment by his brother, who was visiting from overseas at the time.

28. During the appointment the deceased presented Dr Atartis with some forms he had filled out seeking a commercial driver's licence. He told Dr Atartis that he wanted to become a bus driver or delivery driver, and needed the licence for that purpose. Dr Atartis performed a brief mental state assessment of the deceased and noted the deceased appeared to be quite settled in his presentation and there was no evidence of psychotic symptoms. However, Dr Atartis did note that the deceased's insight remained quite poor.[20]

29. Although the deceased presented as settled, Dr Atartis was aware that the decease had only recently come out of hospital and he was not convinced there was any stability in terms of his condition. Dr Atartis was also concerned that the deceased was expressing an interest in being a bus driver, which would make him responsible for multiple passengers. This raised an issue of community safety. Dr Atartis therefore declined to take the forms off the deceased or fill in any paperwork, but gave him some general advice that the application was premature and at that stage he was unable to approve the application as the deceased did not meet the relevant standards. As an alternative, Dr Atartis offered to put the deceased in contact with work rehabilitation services, given he was keen to seek employment.[21]

30. The deceased apparently already had a private vehicle licence at this stage, although there is little evidence available as to any fitness to drive assessments in this regard.

APPOINTMENT WITH DR CONNOR RE COMMERCIAL LICENCE

31. On 27 January 2015, a bit less than three weeks after seeing Dr Atartis, the deceased saw his general practitioner Dr Connor. As he had done with Dr Atartis, the deceased requested Dr Connor to complete his certification for fitness to drive a commercial vehicle.

[19] Exhibit 1, Tab 24.
[20] Exhibit 1, Tab 24.
[21] T 47 – 49; Exhibit 1, Tab 24.

32. At the time Dr Connor came to assess the deceased's fitness to drive on a commercial basis, there were a number of gaps in his knowledge, which had a material effect upon the assessment process.

33. Dr Connor gave frank evidence at the inquest that at the time he saw the deceased in January 2015, he was not aware that there was a requirement that a psychiatrist had to do the assessment for a commercial licence for chronic psychiatric patients. Although he acknowledged that the requirement for a psychiatrist's certification is set out in the guidelines, Dr Connor gave evidence that while he was familiar with the guidelines in a general sense, he did not routinely refer to them each time he did an assessment. Dr Connor noted that the form was the same for both private licences and commercial licences and there was no indication on the form itself that the commercial licence process was different and required a psychiatrist's approval. Dr Connor also queried the responsibility of the Department of Transport to ensure that the assessment was completed by an appropriately qualified professional as Dr Connor explained that he had completed similar assessments for commercial licences in the past and had never been advised by the Department of Transport that he did not have the appropriate qualifications to do so.[22]

34. The deceased also did not inform Dr Connor of his earlier conversation with Dr Atartis about his desire to obtain a commercial licence.[23]

35. Further, Dr Connor explained that he was not aware of some of the issues with the deceased's non-compliance with his psychiatric medication regime. Dr Connor was under the mistaken impression that the deceased was vigilant about compliance with his medical treatment as he wanted to be well for work and from a romantic relationship perspective. Dr Connor described the deceased as "a young man with ambitions"[24] who appeared motivated and in remission in terms of any mental health concerns. Dr Connor indicated that if he had been privy to the deceased's mental health treatment issues at that time, his assessment on the deceased's commercial fitness to drive would have been different.[25] Although there was a copy of the deceased's most recent discharge summary from Bentley Hospital on the deceased's file, Dr Connor did not recall seeing that summary until after the deceased's death. When he saw it as part of a review of the file after being notified of the death, he reported being disturbed by its contents.[26]

36. Working on the background knowledge that was available to him at the time, Dr Connor went on to consider the deceased's fitness to drive a commercial vehicle.

37. Unlike when the deceased spoke to Dr Atartis and mentioned hoping to be a bus driver, when the deceased saw Dr Connor he spoke about wanting a commercial driver's licence so he could get work as a delivery truck driver. Dr Connor always tried to support the deceased's work and he thought that

[22] T 60 – 62.
[23] Exhibit 1, Tab 23, p. 14.
[24] T 64.
[25] T 65.
[26] T 70 – 71.

becoming a truck driver was a good idea as a change of career for the deceased. Dr Connor was aware that the deceased had previously worked as a security guard doing night shift at a warehouse and the deceased had found that stressful. Further, Dr Connor was under the impression he would need to do lessons in that regard, with somebody else supervising him and having to make an assessment before he would be granted a truck licence, which would be a safeguard in the short term.[27] The application assessment certificate that the deceased presented to Dr Connor had been pre-prepared, and that did indeed indicate that the deceased would be applying for a learners permit.[28]

38. Dr Connor gave evidence that he thought that he might have taken a different view, and been less supportive of the application, if the deceased had mentioned he wanted to become a bus driver.[29]

39. At the time of the appointment the deceased presented as well and motivated. He had a plan for a career change that seemed reasonable to Dr Connor. Dr Connor had never known the deceased to be suicidal and he had never got the impression that the deceased was a self-harm risk.[30] He was also aware that the deceased was on regular monthly depot injections and he believed the deceased's mental illness was in remission. Noting that he understood the deceased was going to be seeking a learners permit for a truck driving licence, Dr Connor formed the view that the deceased was fit to get a learners permit for that purpose and therefore ticked the category indicating that the deceased met the relevant criteria and was fit to drive without conditions.[31] There was nothing about the deceased's presentation that suggested to Dr Connor that he might need specialist assessment per se.[32]

40. In retrospect, Dr Connor conceded that under the guidelines:

    i. he did not have the appropriate qualifications as a psychiatrist to make a fitness to drive assessment for a commercial vehicle; and

    ii. given the deceased had a chronic psychiatric condition that was likely to impair his capacity for safe driving, a conditional licence would have been more appropriate, to ensure that he was compliant with his treatment.[33]

41. Dr Connor saw the deceased for the last time on 7 and 14 April 2015. He was unaware that the deceased had not been compliant with his depot medication in the previous period. At these two consultations the deceased reported he was on his fortnightly depot medication (which, as noted below, he had resumed in mid-March) and he complained the medication was causing him erectile dysfunction. Dr Connor referred the issue to the

[27] T 63 – 64.
[28] Exhibit 2, Tab 1.
[29] T 63.
[30] T 72.
[31] T 71 – 72.
[32] Exhibit 1, Tab 25, Statement [41].
[33] T 72 – 73.

deceased's psychiatrist, Dr Atartis by way of a letter dated 14 April 2015.[34] Dr Connor recalled that at one of these last two appointments the deceased mentioned that he was doing truck driving lessons and they were going well.[35]

NEXT APPOINTMENT WITH DR ATARTIS

42. Dr Atartis had been expecting to next see the deceased for a formal review on 20 January 2015, after which he was intending to make a decision about whether the deceased's Community Treatment Order should be extended and then prepare a report for the Mental Health Review Tribunal.[36] The deceased telephoned the clinic and cancelled the appointment scheduled for 20 January 2015, but he still had an original appointment scheduled for 27 January 2015, which remained in place. However, the deceased did not attend that appointment.[37] The deceased also began refusing his depot medications around this time.

43. Based on his lack of engagement with the psychiatric team, Dr Atartis made an application to the Mental Health Review Tribunal to extend the deceased's Community Treatment Order.

44. The deceased was issued with notices under the *Mental Health Act*, including a notice of breach of the Community Treatment Order on 13 March 2015 due to his refusal to accept his depot medications and efforts were made to re-engage him in treatment. He recommenced his depot medications on 15 March 2015 and was eventually seen by Dr Atartis on 1 May 2015.[38]

45. During the appointment the deceased appeared quite settled in his mental state and was bright and reactive, with no evidence of florid psychosis. Dr Atartis' impression was that the deceased's main issue was longstanding compliance issues complicated by poor insight.[39] The deceased informed Dr Atartis that he was unhappy with his current medication (the monthly antipsychotic depot injection) and claimed that it resulted in significant sexual dysfunction. Dr Atartis had also received Dr Connor's letter raising this issue. The deceased asked whether he could change his depot medication to one that would not cause sexual dysfunction.[40]

46. Dr Atartis saw this discussion as an opportunity to re-engage the deceased in treatment and a potential therapeutic tool. Dr Atartis therefore acquiesced to the request and changed the deceased's medication to Abilify, which is a depot medication with (ostensibly) reduced side-effects of sexual dysfunction and less sedative effects as well. The deceased was reportedly happy with the treatment change and it was seen as a positive outcome by the treating team.[41]

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[34] Exhibit 2, Tab 1.
[35] T 74.
[36] T 49.
[37] T 50.
[38] T 50; Exhibit 1, Tab 24.
[39] T 50 – 51; Exhibit 1, Tab 24.
[40] Exhibit 1, Tab 24.
[41] T 51; Exhibit 1, Tab 24.

47. Dr Atartis also took the opportunity to enquire about the deceased's employment situation, and was told that he was looking for work and was open to a referral to the hospital based work rehabilitation service provider.[42]

48. On 11 May 2015 a home visit was attempted but the deceased was not at home. A message was left on the deceased's mobile telephone and he returned the call later that day and reported that he felt mentally stable and denied any psychotic symptoms. He indicated he had been out looking for jobs and requested a referral to the work rehabilitation IPS program, which was agreed.[43]

49. On 12 May 2015 Dr Atartis signed a further Community Treatment Order in relation to the deceased, which was co-signed by another psychiatrist. Dr Atartis saw the extension of the order as a pathway forward to try to engage the deceased voluntarily in treatment.[44] Dr Atartis did not see the deceased again prior to his death.[45]

CIRCUMSTANCES OF THE CRASH

50. The deceased saw his cousin about a week before his death and at that time he seemed fine and his cousin had no concerns about his welfare. The deceased was talking of getting another job at a car wash in Victoria Park. The deceased has also been speaking of his desire to find a wife and settle down.[46]

51. On the evening before his death the deceased went for a walk along the South Perth foreshore, returning home at about 10.00 pm. He told his housemate that he would drop his housemate at the airport the following morning.[47]

52. At 5.00 am on the morning of 22 May 2015 the deceased and his housemate drove to the International Airport Terminal. The deceased appeared fine during the drive and after saying a short goodbye the deceased stated he was returning home and left. Before leaving the deceased had agreed that he would collect his housemate from the airport when he returned. The deceased's housemate sent the deceased a text message when he landed in Malaysia at about noon, but received no reply.[48]

53. The deceased visited a Cash Converters store in Victoria Park later that morning. The deceased conducted a transaction at the store at 9.49 am. He sold his camera, lenses and shaver for $110. The receipt was found in his wallet after his death.[49]

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[42] Exhibit 1, Tab 24.
[43] Exhibit 1, Tab 23, p. 7.
[44] T 51; Exhibit 1, Tab 1 and Tab 23, p. 7; Exhibit 2, Tab 1.
[45] Exhibit 1, Tab 24.
[46] Exhibit 1, Tab 14.
[47] Exhibit 1, Tab 21.
[48] Exhibit 1, Tab 21.
[49] Exhibit 1, Tab 21 and Tab 22.

54. At 11.18 am the deceased was alone and driving his red Suzuki hatchback east on Great Eastern Highway in Wundowie. It is a single lane highway along that stretch of road with two solid white lines separating the lanes. The vision in the area at the time was said to be good and the road was dry and in good condition. At the same time the deceased was travelling east, a Kenworth truck fitted with a bullbar and towing a trailer was travelling west along Great Eastern Highway at that location. As the vehicles approached each other the deceased's car suddenly swerved onto the incorrect side of the road and into the path of the oncoming truck. The two vehicles collided head on.[50]

55. The deceased's vehicle, which was much smaller than the truck, was destroyed and the deceased sustained multiple, non-survivable injuries and died at the crash scene. The driver of the truck was shocked but physically unharmed. He was breathalysed at the scene and returned a negative result.[51]

56. Major Crash investigators, Sergeant Magorian, Senior Constable Wright and Senior Constable Mawdesley attended the scene along with officers from the local police station and traffic enforcement. Sergeant Magorian, who is an expert in crash reconstruction, noted the deceased was not wearing a seat belt at the time of impact and there was no evidence at the scene that the deceased applied the brakes.[52] No evidence was found at the scene to suggest any obvious reason why the deceased would have suddenly swerved.

57. The deceased's car was later examined by a mechanical expert and there was no evidence found of any mechanical cause or fault with the vehicle that would have caused it to swerve suddenly.[53]

58. The truck driver had remained at the scene of the crash and was questioned by police. He indicated that he seen nothing out of the ordinary when the deceased had suddenly swerved into his path without warning and did not appear to brake. The vehicles were only metres apart when this occurred and the truck driver had no time to brake or take some evasive action before they collided head on.[54]

59. Two witnesses who were in another car travelling behind the truck were also spoken to by police. They stated that both their car and the truck had been travelling at about 100 km/hr, which is 10 km/hr below the posted speed limit at the time of the collision. Consistent with the account of the truck driver, they told police they saw the red Suzuki suddenly veer directly into the path of the truck without warning.

[50] Exhibit 1, Tab 8.
[51] Exhibit 1, Tab 8 and Tab 15.
[52] Exhibit 1, Tab 8.
[53] Exhibit 1, Tab 8 and Tab 9.
[54] Exhibit 1, Tab 8.

CAUSE OF DEATH

60. On 29 May 2015 a Forensic Pathologist, Dr Judith McCreath, conducted a post mortem examination on the body of the deceased. The post mortem examination showed extensive, non-survivable injuries. Toxicological analysis of the deceased's blood showed the presence of his depot medication, aripiprazole. Analysis of urine was negative for alcohol and common basic drugs. At the conclusion of the examination Dr McCreath formed the opinion that the cause of death was multiple injuries.[55]

61. I accept and adopt the conclusion of Dr McCreath as to the cause of death.

MANNER OF DEATH

62. The circumstances of the crash support the conclusion that there was no mechanical or external contributing factor. The evidence indicates the deceased's car swerved into the path of the oncoming truck when they were only metres apart and the deceased did not try to brake.

63. Dr Chapman was asked whether, following his review of the materials, he was able to form a view as to whether the deceased may have had an intention to take his life at the time of his death. Noting the evidence suggested that the deceased had steered the car into the path of the oncoming vehicle, Dr Chapman indicated that the deceased's conduct had the feeling of an impulsive action. He accepted there was a possibility that the deceased may have been reacting to an auditory command, but also thought there was a possibility that he could have been impulsively reacting to an altercation with a member of the public or some other social interaction that was a trigger.

64. Dr Chapman considered it was unlikely that sedation from his medication was a factor, as the deceased's new depot medication had a less sedating effect than his previous medication.[56]

65. I also asked Dr Atartis whether he had formed any view as to the deceased having suicidal thoughts at the time of his death. Dr Atartis had only recently found out the circumstances of the death and expressed concern about the information that the deceased had swerved rather than simply drifted into traffic.[57]

66. Dr Atartis observed that we were missing information about the deceased's mental state in the last three weeks of his life following his last mental state examination, which had occurred on 1 May 2015 and at which time he was not floridly mentally ill. During a telephone conversation with his case manager on 11 May 2015 the deceased had sounded well and Dr Atartis noted that the witness statements suggested that the deceased was seen by family members on or about the day of his death and there was no evidence

[55] Exhibit 1, Tabs 4 -6.
[56] T 43.
[57] T 51 – 52.

that he was floridly unwell. Dr Atartis also explained that usually a person becoming psychotic is not an acute instantaneous type condition, but takes weeks of being off medication to develop. He would, therefore, have expected the deceased's housemate to have seen some signs that something was not quite right in the days leading up to his death, if the deceased had been psychotic.[58]

67. Based on that information, Dr Atartis agreed with Dr Chapman that the case was perplexing and the deceased's driving conduct was more explicable as an impulsive act or reckless act, rather than an act that he had been planning. If it was an impulsive act, Dr Atartis explained it was most likely triggered by a psychosocial event, such as a relationship breakup or other significant personal event, although it was pure conjecture as to what had occurred in the lead up to his death.[59] Dr Atartis also noted that despite some episodes of depression, the deceased had no history of actual suicide attempts.[60]

68. Dr Connor, who had a longstanding treating relationship with the deceased, confirmed at the inquest that the deceased had never disclosed experiencing suicidal thoughts although Dr Connor would routinely ask him. The deceased had generally been well during his patient visits, although sometimes he would be anxious and becoming vexed and on one occasion was experiencing paranoid, persecutory type ideation. All of these issues were corrected with medication. When Dr Connor saw the deceased in April 2015, the deceased was not depressed and was not suicidal. With that history in mind, Dr Connor was inclined to agree with the opinions of Dr Chapman and Dr Atartis that if the deceased had deliberately steered his car into the path of another vehicle, it was an impulsive act. However, Dr Connor also queried whether the act might have been the result of distraction or pure accident.[61]

69. Given the deceased had appeared to be well and settled in the lead-up to his death, with no signs of developing psychosis, none of the doctors seemed to think his conduct was likely to be explained by a reaction to auditory hallucinations, although it could not be ruled out entirely.[62]

70. The deceased's housemate and cousin could provide no explanation as to why the deceased would have been driving along Great Eastern Highway in Wundowie. They did not know anyone the deceased might have been intending to visit in that area, or any other reason for him to go there. They also asked other members of their community, who could not offer an explanation as to where the deceased might have been going.[63]

71. The deceased's cousin described the deceased as "a meticulous driver, very careful and law abiding."[64] He always wore his seat belt and was unlikely to have answered his phone while driving. The deceased's cousin said he had

[58] T 52 – 53.
[59] T 52.
[60] T 53.
[6161] T 74.
[62] T 42, 52.
[63] Exhibit 1, Tab 14 and Tab 21.
[64] Exhibit 1, Tab 14 [15].

always felt safe when the deceased was driving.[65] The deceased's cousin did not believe the deceased would have had the courage to deliberately drive into the path of a truck, even if he had wanted to, and for this reason he believed the crash was more likely to have been an accident.[66]

72. The fact that, contrary to his usual habit, the deceased was not wearing a seat belt, is one factor that points towards the deceased having an intention to take his life at the time of the crash. The sudden steering input by the deceased and lack of attempt to brake, is also supportive of this conclusion. Weighed against that objective evidence is the absence of any clear history of suicidal ideation in the past, as well as his generally stable presentation to doctors and family and friends in the time leading up to his death. He was also talking positively about plans for the future.

73. The three doctors who gave evidence at the inquest were in agreeance that, if the deceased did deliberately drive his car into the path of the truck, it was more likely to be an impulsive act rather than the result of deliberate planning over any length of time. It was also unlikely to be due to any symptom of psychosis or sedative effect of his medication.

74. The police investigation noted that fatigue and falling asleep cannot be discounted as a cause of the crash, although the police investigator was working off incorrect information that the deceased had just finished working a night shift at the airport.[67]

75. Taking into account all of the evidence before me, I am satisfied that the evidence supports the conclusion that the deceased had an intention to take his life at the time he steered his car into the path of the oncoming truck. It was likely to have been an impulsive act, without much preplanning, although I do note that he must have taken time to release his seatbelt, which he was otherwise known to be vigilant about wearing. I find that the death occurred by way of suicide.

QUALITY OF SUPERVISION, TREATMENT AND CARE

76. Under s 25(3) of the *Coroners Act 1996*, where a death investigated by a coroner is of a person held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care.

77. Having reviewed the medical notes and police report, Dr Chapman expressed the opinion that the deceased received an appropriate and high level of treatment and care over the months that he was under a Community Treatment Order.[68] Indeed, Dr Chapman stated that he was "quite impressed" when he looked at the crescendo of attempts to see the deceased at his home and the utilisation of the more assertive treatment service to get him back onto his depot medication.[69]

[65] Exhibit 1, Tab 14 [15].
[66] Exhibit 1, Tab 154.
[67] Exhibit 1, Tab 8.
[68] T 35.
[69] T 35.

78. Dr Chapman also indicated that he considered it was reasonable for the deceased to continue to be treated under the terms of a Community Treatment Order, as this would have been the least restrictive option available given his potential to be non-adherent to medications in the community.[70]

Communication

79. I queried with Dr Chapman how general practitioners and mental health practitioners usually interact to ensure that there is an adequate overlap of care. Dr Chapman explained that in general that communication is done in written form, as is evidence by the correspondence between Dr Connor and Dr Atartis in April 2015.

80. Dr Chapman indicated that there is no expectation that after each consultation with a practitioner that an update will be provided to the other. He explained that there is usually no particular change in the treatment or care that is being offered, so it would not be a good utilisation of resources to do so. The exchange of information is more focused around changes in treatment and/or significant changes in presentation that might require coordination of care.[71] Of course, if a patient is hospitalised, it would be standard for the hospital discharge summary to be provided to all of the relevant practitioners.[72]

81. The relevance of communication between psychiatrist and general practitioner in this case is that if Dr Atartis had informed Dr Connor about his discussion with the deceased about a commercial driver's licence, it would have prompted Dr Connor to consider more carefully the deceased's request.[73] Dr Chapman agreed that, in retrospect, that information might have been useful to Dr Connor, but he did not think there was a general expectation that communication should have occurred in the ordinary course of things.[74] When put into the context that the guidelines state that only a psychiatrist can make such an assessment, it is also more understandable that Dr Atartis would not think he needed to pass on that information to Dr Connor.

82. In submissions, counsel for the Metropolitan Health Service, Dr Atartis and Dr Connor all agreed that there was a communication gap in this case between Dr Connor and Dr Atartis about the fitness to drive assessment, but all counsel also agreed that it was not an easy issue to resolve in a more general sense.

83. In relation to commercial licence applications, the problem is not in fact so great, as the reality is that the guidelines require a psychiatrist to complete the assessment. However, in relation to private vehicle licence assessments, it was suggested that it might be better for the general practitioner to take

[70] Exhibit 1, Tab 23, p. 11.
[71] T 37.
[72] T 37.
[73] T 37.
[74] T 37.

the initiative and make enquiry with the treating psychiatric team, if they are aware the patient has a treating specialist, since the general practitioner is the person who will be asked to perform the assessment. Certainly that is the practice now adopted by Dr Connor after he has reflected on these events, as set out below. Without making a formal recommendation, I would certainly encourage other general practitioners to learn from the experience of Dr Connor in this case and adopt a similar practice in such cases.

Was the deceased fit to drive?

84. The question of whether the deceased was, indeed, fit to drive at the time of his death was raised at the inquest, as well as attention given to how it came to be that he was certified by Dr Conner.

85. Dr Atartis explained that he had "felt really uncomfortable"[75] at the idea of the deceased driving a bus, but did not have significant concerns about the deceased being a solo driver.[76] There had been no suggestion from his treating team, prior to Dr Atartis' involvement, that he should have his private driver's licence revoked, and from the time Dr Atartis saw him he remained quite settled so there was no apparent need to review that position or pass that information to his general practitioner.[77]

86. As for his desire to get a commercial driver's licence, Dr Atartis' first impression was that he was impressed by the deceased, who appeared quite likeable and held a genuine desire to get work, which was difficult given his limited skill set. In that sense, his desire to get a commercial licence and perform delivery work or as a bus driver seemed rational.[78] It was more a case of wanting to ensure the deceased's condition was more stable before further consideration could be given to such an application, given the safety of potential passengers was involved.

87. Acknowledging that he was unaware that the deceased had been non-compliant with his medication regime and relapsed prior to his appointment in January, Dr Connor's evidence was still that at the time he assessed the deceased in January 2015, and again in April 2015, there was nothing in his presentation that gave him concern about the deceased's fitness to drive a vehicle.

88. Given my finding that the deceased's driving that caused his death was an impulsive act, and the general evidence of his cousin that he was usually a safe driver, I do not find that there was any error on the part of the doctors in allowing the deceased to continue to hold a private driver's licence.

Fitness to drive assessment guidelines

89. In relation to any guidelines on fitness to drive that might assist general practitioners or psychiatrists, Dr Atartis accepted that the current guidelines are quite nebulous and it is left to an individual clinician's decision as to

[75] T 54.
[76] T 54.
[77] T 54.
[78] T 54.

whether to support it, sometimes based upon only a snapshot of the patient's presentation at a particular time.[79] However, Dr Atartis felt that a better path would be to emphasise education of the people involved as to their responsibilities as a driver, perhaps with a requirement that the person applying should have to make a declaration that their condition is stable or giving the doctor or psychiatrist the option of ticking a box requiring further information to be obtained, such as blood tests or a longitudinal patient history to be obtained.[80]

90. Dr Connor gave evidence that he had "done a lot of soul-searching" following the deceased's death and had read the fitness to drive guidelines and attended a special seminar on assessing fitness to drive as part of an international medicine and addiction conference. The participants in the conference, who were comprised of addiction specialists and addiction psychiatrists, all agreed that the fitness to drive assessments can be a very vexed and troubled issue.[81] Dr Connor expressed his view that the fitness to drive assessments are a vexed issue as it could be said that the Department of Transport has outsourced the risk to doctors, although the Department does of course still have to make the final assessment.[82]

91. Dr Connor has resolved since the death of the deceased to always refer a patient to a relevant medical specialist where a patient requires a fitness to drive assessment and is undergoing specialist treatment. He has started implementing that resolve in his practice. However, there are practical difficulties with this process. For example, Dr Connor spoke of a recent case where a patient had been discharged from Inner City Mental Health and then sought a fitness to drive assessment for a commercial vehicle, including heavy haulage. Dr Connor was aware that he could not assist with the assessment, so he called Inner City Mental Health to ask if a psychiatrist at that service who had been treating the patient could complete the assessment. Dr Connor was told that as the patient had been discharged, he would have to go to a new psychiatric service for the assessment, which would take a long time to arrange. In the end, Dr Connor managed to find a psychiatrist who had previously treated the patient who could assist, but Dr Connor cited the case as an example of some of the difficulties with referral to a specialist.[83]

92. In terms of guidelines, Dr Connor did not necessarily support a need for more detailed guidelines, and suggested that it was more a case of people being reminded to look more carefully at the existing guidelines and be cautious in their application.[84]

[79] T 55.
[80] T 55.
[81] T 66 – 67.
[82] T 61.
[83] T 66 – 68; Exhibit 1, Tab 25, Statement [52].
[84] T 75.

93. Dr Chapman was also asked his opinion about the appropriateness of the level of guidance currently available to doctors in making such assessments. While Dr Chapman agreed that he could not find much in the way of guidelines or guidance, other than the Department of Transport guidelines, like the other witnesses, Dr Chapman also thought there were huge limitations on what assistance guidelines can give. He expressed the opinion that in attempting to cover all situations, guidelines can become meaningless for the individual. However, Dr Chapman did think there might be some benefit in the Royal Australian College of General Practitioners (RACGP) providing some guidance about the need for a specialist opinion in relation to commercial driver's licence applications.[85]

94. I also raised the possibility that it might be advisable for the Department of Transport to alter the form to make the requirement for a psychiatrist to certify a commercial application more clear. Certainly, the Department of Transport needs to be informed of the fact that the evidence suggests that the Department is on occasion accepting medical assessment certificates that have not been certified by an appropriately qualified professional as specified in the guidelines upon which they rely. Accordingly, I will arrange for a copy of this finding to be provided to the Department of Transport, with their attention drawn specifically to this issue.

95. Similarly, I will arrange for a copy of this finding to be provided to the RACGP, to alert them to this issue and encourage them to draw it to the attention of their members, as they see fit.

CONCLUSION

96. The deceased had a history of severe mental illness that had been managed intermittently by in-patient hospital admissions and community treatment orders for many years. His psychiatric condition was generally managed well on medication, but he was not always compliant with his medication regime, hence the need for him to remain on a Community Treatment Order. His treatment while on the order was appropriate and of a generally high standard.

97. At the time of his death the deceased had appeared to be generally well and making plans for the future, including trying to obtain a commercial truck driver's licence to create new job opportunities. Although the process by which he was found fit to obtain a learners permit for commercial truck driving was flawed, in that his general practitioner mistakenly performed the assessment when he was not in fact qualified to do so, this error did not play any role in the deceased's death. The deceased was not driving a truck at the time he died, and there was no evidence prior to the crash to suggest that he was not fit to drive a private vehicle at that time.

[85] T 39.

98. On the day of his death the deceased had appeared well in the morning but then something unknown occurred that prompted him to drive outside his usual area and while driving along Great Eastern Highway he made the impulsive decision to take his life by driving into the path of an oncoming vehicle. His death was unexpected and the manner of his death could not have been easily predicted or prevented.

S H Linton
Coroner
6 September 2017