T R A N S C R I P T

LEGISLATIVE ASSEMBLY ECONOMY AND INFRASTRUCTURE COMMITTEE

Inquiry into the impact of road safety behaviours on vulnerable road users

Melbourne—Thursday 24 August 2023

(via videoconference)

MEMBERS

Alison Marchant—Chair
Kim O'Keeffe—Deputy Chair
Anthony Cianflone
Wayne Farnham
John Mullahy
Dylan Wight
Jess Wilson

WITNESS

Dr Natasha Cook.

The CHAIR: Welcome to the public hearings for the Legislative Assembly Economy and Infrastructure Committee's Inquiry into the impact of road safety behaviours on vulnerable road users. All mobile telephones should now be turned to silent.

All evidence today given today is being recorded by Hansard and broadcast live on the Parliament's website.

While all evidence taken by the Committee is protected by parliamentary privilege, comments repeated outside of this hearing, including on social media, may not be protected by this privilege.

Witnesses will be provided with a proof version of the transcript to check. Verified transcripts and other documents provided to the Committee during the hearing will be published on the Committee's website.

I will just remind Members to mute their microphones when not speaking to minimise that interference.

Thank you so much, Dr Natasha Cook, for joining us today. What we might do is allow you to maybe have an opening statement, or talk about your submission or add anything further, and then we will ask Committee members to ask some questions of you just to unpick that a little bit further. I might hand it over to you.

Dr Natasha COOK: Sure. Thank you again. I will just start by means of a brief introduction—where I come from and what I am hoping to contribute. My name is Natasha Cook. I am a nephrologist and general physician at Austin Health, and I am also the wife of a man, a former Vietnamese refugee and multilingual general practitioner, who became severely brain injured when he was struck while marathon training in June 2016 by an intoxicated person chasing a heroin hit. I suppose the start of my advocacy from there was sitting in court listening to the sentencing transcript and hearing for the first time that that person had a 20-year history of polysubstance misuse and would almost certainly have been chronically brain injured as well as intoxicated at the time that Louis was struck. My advocacy has been partly in speaking at road trauma seminars with the Amber Community to offenders sent by courts or by their lawyers pre court about our story and the ripple impact of road trauma that evolves over years. Seven years later, we still have a lot of impacts.

Also, a little more complex and harder to address is how we address system failures for dealing with medically unfit drivers. Really what I hope you will understand from today is that there are a huge number of medically and mentally unfit drivers on the road that we would not even be aware of day to day. If we thought about it, we would not get it in our cars. Unfortunately they have to be dealt with by three different departments, namely transport, justice (for criminal matters) and health, and there are huge disconnects and inefficiencies, despite everybody's best intentions, in those processes.

The CHAIR: Thank you so much for that. To have lived experience and to have you present today is really important for this Committee to understand and, going forward, to have really strong recommendations. I really appreciate your time in sharing your story with us as well. I will give it to a couple of Committee members to ask some questions first. I might ask Dylan. Thank you.

Dylan WIGHT: Thank you, Chair. And thank you so much, Dr Cook, for your submission and for giving evidence today. You spoke just then about fitness to drive and the fact that there are a large cohort of people on our roads who are driving who are not fit to drive. What are the specific medical conditions that will impact your capacity to drive or your fitness to drive, and how do doctors report these conditions to authorities at the moment and how can that be improved?

Dr Natasha COOK: Well, VicRoads's procedures have improved markedly with an online medical reporting form which makes it a lot easier, but doctors need to identify their patients or think of their patients as drivers to start with and ask whether they would want their own family member in the car with them. We are instinctively, as doctors, advocates for our patients, and there are documented poor outcomes from removing driving privileges. But conditions that are problematic are problems that affect physical strength and also cognition. There are a lot of complex higher functions needed to drive safely. I am a nephrologist, so I look after patients on dialysis. Forty per cent of end-stage kidney disease is due to diabetes, and there are a plethora of impacts of diabetes on driving fitness. Of dialysis patients alone, 75% of over 55-year-olds have cognitive impairment. Substance abuse is hugely common in the community, unfortunately. Every cardiac, neurological and psychiatric condition as well as lots of physical impairments that require prescription drugs have the potential to severely impact on driving fitness.

The CHAIR: Thanks. Doctor, could you just elaborate a little bit more about the reporting of those?

Dr Natasha COOK: Right. So, yes. Under the *Road Safety Act*, VicRoads are obliged to act on any report they receive from any member of the community, be it a member of the police or doctors or just a concerned family member or any other person in the community. They have a lot of personnel that are not medically trained that respond to the more simple inquiries. When it is more complex there is a very experienced nurse who processes the information that has been received and then informs the patient by letter that their licence and driving fitness is questioned and that they need a medical report, be it from their GP or other relevant specialist that that nurse considers relevant. She will make a decision, and they do have a special committee for the very complex cases in the Department of Transport too. But the problem is GPs are time-poor and they have a long-term relationship with their patients. It is a very difficult thing for them to do. The online form makes it a lot easier. It has things they have to fill in like visual acuity and details of the patient; they need the patient's licence number; and there is space to write a paragraph or two about why they think the person has impaired driving fitness. So getting doctors to use that process and actually put some detail in that form is what is needed. They do get those forms without doctors actually writing anything in, so it is very difficult. But I think what we need to do is more at the hospital end to take some of the load off the GPs where we have more time and ready access to a lot of different specialists, the multidisciplinary assessments, and not necessarily the ongoing relationship with the patient. So that is what I try to advocate within my own hospital, the RACP and training junior doctors to make them aware of this process. Sorry, does that answer—

The CHAIR: Yes, it does. That is great. Thank you very much for that. I might go to Jess to ask the next question.

Jess WILSON: Thanks so much, Chair. And thank you, Natasha, so much for your submission, for sharing what I am sure is a deeply personal story with us today and for your time. I think you have covered a lot of what we are seeking to understand—that process around how we can potentially put greater linkages between doctors and hospitals and the road authorities.

What do you think, though, could be an ongoing process if someone presents in hospital or presents to a GP—they might have an acute condition—or this sort of ongoing assessment in this space? We have also heard from other witnesses over the past couple of weeks around whether or not people need to be retested for their fitness to drive over the course of their licence. You know, you have different perspectives on that, particularly when it comes to ageing and the elderly. Do you have a position on whether we should look at retesting down the track?

Dr Natasha COOK: I do, but we need the resources and the capacity to act on what is found really. I know there is a lot of emphasis put on the specialist Ots who make driving assessments, and they have a really important role, but there is a lot of what I would term low-hanging fruit out there. You do not even need to be a doctor to know they should not be driving. So you will end up with queues of people waiting for such assessments, and it is great that they are there and available, but we do need some simpler processes.

I think a lot of that comes with giving people options for retiring from driving, which is the language they like to use in the Department of Transport. I mean, there is no simple fix for infrastructure, but there is stuff we can do easily around family education. Often when I talk to family members, they are really appreciative that the message their loved one is not fit to drive is coming from me, not them, because they have wanted to take away the keys. I mean, I would welcome more driving assessments for elderly people, but it goes back to just, you know, health professionals having the conversation with patients and carers. Also, the OT, just to point out—it is probably obvious to people here: the driving assessment is not an easy or cheaply available thing. You have to pay for the OT and the driving instructor. The patient bears the cost. It is hundreds of dollars. It just does not happen mostly. There was a clinic that was run by a former close associate of mine, Morris Odell from the Institute of Forensic Medicine. They did have a specialist driving assessment clinic running at St Vincent's, but yes, capacity was an issue. It is a complex assessment. They might have seen three or four people in a session every two weeks. When he retired, it folded. But that is the kind of thing GPs would love, because they would like to have somewhere to send the person to without having to be the ones that make the decision.

The CHAIR: That is an interesting point. Kim, I might head to you next. Thanks.

Kim O'KEEFFE: Thank you, Natasha, for sharing your experience. It is a really powerful one. And having that lived life experience, you know—it is so connectable, I am sure, to so many people that you deal with. And all my best to Louis as well.

Dr Natasha COOK: Thank you.

Kim O'KEEFFE: Look, I think you have answered some of the things I was asking, but I was really interested in the families too, how they manage and how they navigate. Trying to make these decisions I would assume would be hard for the patient a lot of the time, and that could be really challenging. So how can patients' families be more supported as they go through the process?

Dr Natasha COOK: Usually the people that bring the elderly person—or not necessarily elderly person but the person that is not driving that needs support—are very kind and very caring. So it is usually a very respectful conversation explaining to them that under the *Road Safety Act* there is onus on the driver to self-report but there is not mandatory reporting by health professionals. And if there was an incident that led to loss of life or serious injury or property damage, if their medical records had documented that they have one of these conditions and there is potential liability. I try to say that in a not threatening or intimidating manner—for example, I may say, 'You've got these medical problems that are documented, so that could potentially put your person in a difficult position,' and then it does support them and seem to trigger a lot of family effort around keeping the person out of the car. We do not have to make it a lot of punitive processes. The geriatricians tell me the families will do things like say, 'Oh, this grandchild needs to borrow your car for a while,' and then in that way remove the car from the person's home. There are a lot of nuances in preserving the dignity of older people. I will say things to them like, 'I know you've driven for years and you've got an impeccable driving record, but gee, Melbourne's population is about three times the size of what it was, and there are a lot of drunk people, you know, or people not driving well out there, and I worry about your reaction time.' There are no easy solutions.

The CHAIR: Thank you. Delicate conversations have to happen.

Dr Natasha COOK: Very much.

The CHAIR: Yes. I am just mindful of time, so I am going to squeeze in one last question to you, which I would really appreciate.

Dr Natasha COOK: Sure.

The CHAIR: This inquiry has been looking at behaviours through COVID as well and whether our risky behaviours are staying from the COVID years, and I just wanted to know a little bit about our mental health. Have mental health issues maybe presented through COVID and continued through COVID which then reduce our ability to make decisions on the road or things like that? Can you talk a little bit about that?

Dr Natasha COOK: Absolutely. And look, I am not apportioning blame for any past decisions. It is a fact that in the case of 95% of lives lost on Victorian roads, the underlying factors are human—speed, fatigue, drugs, alcohol and distraction. It is about 3% just random environmental factors and 2% car maintenance issues. We know mental health is poor at the moment. We know alcohol consumption went up in the community by a third during the pandemic. I have been sitting on some of the advisory committees for a while. Before we saw the lives lost on Victorian roads increase there was a big concern that mental health was going to play out this way, I am sure there are other factors on the road as well, like maintaining the roads, but I do just wonder about the contribution of—us being physically and mentally not well as a community, and that bears out in our physical driving fitness and our mental driving fitness. So yes, people make poor decisions when their mental health is poor—and it is all about choices and road safety, and that is what we teach in the Amber Community. It is not so much about judgement, but the choices you make can have terrible consequences. They impact on other people's lives and obviously your own too.

There is actually a fairly new VicRoads document that is meant to be a guide for mental health clinicians highlighting the impact of medications and mental illness and also some of the chronic brain injury aspects of addiction as well. So yes, I think it was not good for us, a lot of the things arose from the pandemic that we are dealing with now, including worse road statistics. I suppose motivation and driving. Restrictions meant less driving hours for learner drivers. People got out of practice, maybe, to some extent, so driving was their outlet.

The CHAIR: Yes. We are sort of learning that there is not a lot of solid data yet about all this. I am sure we will be able to capture that at some stage, but we are still seeing the effects of COVID.

Dr Natasha COOK: Yes. Absolutely not—not a causal link that has been proven, but we do have those truths about what the main underlying factors of lives lost are and a few markers of community physical and mental health. Even just such things as diabetes not being monitored as well, so people have hypos or increased obesity, and there is a huge amount of obstructive sleep apnoea. Anyone who is not compliant with the CPAP mask with sleep apnoea is really medically unfit to drive, but I do not think we have any conditions on licences about CPAP compliance, and that is a very common condition.

The CHAIR: Yes. I am sorry that we have to wrap it up today, because I think there would be lots of questions that we would have for you. If there is something that you would like to provide further to the Committee, though, you are more than welcome to write to us if there is anything further or something might have been sparked today from our conversation.

Dr Natasha COOK: Thank you.

The CHAIR: Thank you so much for your time, your advocacy and all your work that you do in this space. It is muchly appreciated by this Committee, so thank you.

Dr Natasha COOK: Thank you, Alison, for having me. Thank you, everyone. It is a pleasure to talk with you all.

Committee adjourned.