MAGISTRATES COURT
TASMANIA

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified by the direction of the Coroner pursuant to s 57(1)(c) of the Coroners Act 1995)

I, Simon Cooper, Coroner, having investigated the death of Deborah Renee Griffiths

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is Deborah Renee Griffiths;

b) Mrs Griffiths died as a result of multiple injuries sustained as a passenger in a two vehicle collision;

c) The cause of Mrs Griffiths' death was multiple injuries; and

d) Mrs Griffiths died on 3 October 2020 on the Arthur Highway near Copping, Tasmania.

In making the above findings, I have had regard to the evidence gained in the comprehensive investigation into Mrs Griffiths' death. The evidence includes:

- The Police Report of Death;
- Affidavits establishing identity and life extinct;
- An opinion of the forensic pathologist who conducted the autopsy;
- Results of toxicological analysis of samples taken at autopsy;
- Records – Ambulance Tasmania;
- Report – Mr Jason Hardy, Transport Inspector;
- Affidavit – Mr Scott Griffiths, sworn 14 October 2020;
- Affidavit – Miss Sophie Griffiths, sworn 13 October 2020;

- Affidavit – Ms Sarah Perkins, sworn 6 October 2020;
- Affidavit – Ms Belinda Webster, sworn 6 October 2020;
- Affidavit – Constable Michael Boucher, sworn 2 March 2021;
- Affidavit – Constable Matthew Watton, sworn 4 October 2020;
- Affidavit – Sergeant Adrian Leary, sworn 2 January 2021;
- Affidavit – Senior Constable Arthur Alforte, sworn 21 February 2021;
- Affidavit – Constable Ian Bellette, sworn 6 October 2020 (and scene photographs);
- Affidavit – Senior Constable Adam Hall, sworn 10 October 2021, with scene notes, calculations and sketch plans;
- Results – Blood Analysis – Sophie Griffiths;
- Results – Blood Analysis –VF;
- Motor Registry System licensing and registration details;
- Police Record of Interview - VF; and
- Medical Records – Dodges Ferry Medical Centre.

Introduction

1. In the early evening of Saturday 3 October 2020, Mrs Deborah Griffiths, wife of Scott and mother of Sophie, Alyssa, Jack and Lochie, died in a car crash near Copping in southern Tasmania. This finding will examine the circumstances of her death.

The role of the coroner

2. A coroner in Tasmania has jurisdiction to investigate any death that "appears to have resulted directly from an accident." Self-evidently, Mrs Griffiths' death meets this definition. When conducting an investigation a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. The coroner's job is to try to find out how, why, in what circumstances and where an unexpected death occurred.

3. When conducting such an investigation, a coroner is required to thoroughly investigate the death and answer the questions (if possible) that section 28(1) of the *Coroners Act* 1995 asks. These questions include who the deceased was, how they died, the cause of the person's death and where and when the person died. This process requires the making of various findings, but without apportioning legal or moral blame

for the death.[1] The job of the coroner is to make findings of fact about the death from which others may draw conclusions. A coroner may, if she or he thinks fit, make comments about the death or, in appropriate circumstances, recommendations to prevent similar deaths in the future.[2]

4. It is important to recognise that a coroner does not punish or award compensation to anyone. Punishment and compensation are for other proceedings in other courts, if appropriate. Nor does a coroner charge people with crimes or offences arising out of a death that is the subject of investigation. I note that by the time I received the completed investigative file it had been reviewed by the Director of Public Prosecutions. The Director of Public Prosecutions, Mr Coates SC determined that there was no evidence of negligence on the part of the other driver involved in the crash that claimed Mrs Griffiths' life. It is not any part of my role to review Mr Coates SC's decision, whether I agree with it or not.

5. As was noted above, one matter that the *Coroners Act* 1995 requires, is a finding (if possible) as to how the death occurred.[3] 'How' has been determined to mean "by what means and in what circumstances",[4] a phrase which involves the application of the ordinary concepts of legal causation.[5] Any coronial inquest necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.

6. The standard of proof at an inquest is the civil standard. This means that where findings of fact are made, a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an inquest reaches a stage where findings being made may reflect adversely upon an individual, it is well-settled that the standard applicable is that expressed in *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation against anyone is proved should be approached with a good deal of caution.[6]

Circumstances surrounding the death

7. Mrs Griffiths spent the last day of her life at home with her family in Dunalley. At approximately 5.00pm, Mrs Griffiths suggested to her daughter, Sophie Griffiths that

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[1] *R v Tennent; Ex Parte Jager* [2000] TASSC 64.
[2] This function is important in Australia and overseas. As to the latter see 'Coroners' Courts- A Guide To Law And Practice', Third Edition, Dorries, at paragraph 10.13.
[3] Section 28(1)(b).
[4] See *Atkinson v Morrow* [2005] QCA 353.
[5] See *March v E. & M.H. Stramare Pty. Limited and Another* [1990 – 1991] 171 CLR 506.
[6] (1938) 60 CLR 336 (see in particular Dixon J at page 362).

they travel to Sorell and pick up takeaway food for dinner. Mrs Griffiths asked Sophie to drive as she was having a headache. They left their home in Dunalley at about 5.30pm. Mrs Griffiths was the front seat passenger in her daughter's Hyundai i20. They travelled north on the Arthur Highway from Dunalley towards Sorell. Both were wearing the seat belts available to them.

8. At the same time, VF was driving her husband's Volkswagen station wagon south from Sorell towards Dunalley. Her 2-year-old son was in the rear passenger seat, restrained in an approved child restraint.

9. The road conditions were wet, as it had been raining intermittently the whole day.

10. As VF approached a left-hand curve on the road, she lost control of her car. The rear of her vehicle slid on the wet road surface. VF tried to counter-steer and apply the brakes but her vehicle continued to slide across to the incorrect side of the road before colliding with the vehicle Miss Griffiths was driving.

11. At the moment of impact Miss Griffiths' car was in the westernmost of two northbound lanes.

12. The Volkswagen driven by VF then came to rest in the western northbound lane facing east, while Miss Griffiths' Hyundai stopped in the southbound lane facing a southerly direction. Numerous airbags deployed in both vehicles.

13. Mrs Griffiths was still breathing shortly after the collision but was not conscious. Despite the efforts of members of the public who stopped and assisted before the arrival of paramedics, and the efforts of paramedics at the scene, Mrs Griffiths was unable to be saved. She was declared dead at the scene by paramedics.

14. Police and Fire Service personnel also attended the crash. Police – including specialist Crash Investigators and Forensic Officers – commenced an investigation at the scene. I will return to the results of that investigation shortly.

15. Mrs Griffiths' body was formally identified and then taken by mortuary ambulance to the Royal Hobart Hospital (RHH).

Investigation

16. At the RHH, Forensic Pathologist, Dr Christopher Lawrence, performed an autopsy. The autopsy revealed that Mrs Griffiths had suffered multiple traumatic injuries to the left side of her body, mainly being the chest or abdomen, arm and leg. She had

multiple fractures to her ribs, pelvis, left forearm and left femur. She also suffered from a diaphragm rupture, a collapse of the right lung, bruising of the lung and a shift in her body organs.

17. Dr Lawrence expressed the opinion that the cause of Mrs Griffiths' death was multiple injuries she sustained in the motor vehicle crash. I accept Dr Lawrence's opinion.

18. Investigations carried out at the scene by Tasmania Police Crash Investigators found that the collision occurred approximately 6 kilometres north of Copping on the Arthur Highway, which is known locally as "Red Hill." There are two northbound lanes and one southbound lane at the area of the collision. More specifically, the collision occurred at the exit of a sweeping left-hand curve for southbound traffic and at the commencement of a right-hand curve for northbound traffic. At the time of inspection, both sides of the highway were vegetated, and the surface of the highway was in good condition.

19. Because of the wet road conditions, Crash Investigators could not find any evidence on the road surface such as skid or scuff marks. However, gouging on the road surface indicated that the impact likely occurred in the western northbound lane. It is evident from the position of the gouge marks and the positions of the two vehicles after the crash, that both must have rotated anti-clockwise after the impact before coming to rest.

20. As part of the investigation, police formally interviewed VF. During that interview, she told them said that she had driven on the Arthur Highway regularly, but not in wet conditions. VF said she was aware that the speed limit on the highway is 100km/h and thought that immediately prior to the crash that prior to the collision, she was travelling at about 80-90km/h. There seems to be no reason to not accept this as the truth. Relevantly, the speedometer of her vehicle was found to be stuck on 70 km/h. This does not necessarily indicate that was the speed of her vehicle of the time of the collision, but does provide some support for her account.

21. Due to poor weather conditions at the time of collision, crash investigators were unable to carry out any form of reliable speed determination for either vehicle prior to the collision.

22. There is no evidence that VF was using her mobile phone at the time of the crash. Nor was Miss Griffiths.

23. There is no evidence at all of the involvement of a third party in the crash.

24. Blood tests conducted on both Miss Griffiths and VF carried out after the crash showed that neither driver was effected by alcohol or illicit drugs.

25. The report of the Transport Inspector satisfies me that both vehicles were in roadworthy conditions at the time of the crash.

26. And, as I have already said, Mrs Griffiths was wearing her seatbelt.

Conclusion

27. I am satisfied to the requisite legal degree that speed on the part of VF *must* have contributed to the happening of the crash. While I accept she was not exceeding the legal limit in the area where the crash occurred, there can be no other reason, other than driving too fast in the prevailing conditions, for her to have lost control of a roadworthy vehicle on a road the surface of which was in good repair.

28. Certainly, nothing that Miss Griffiths did caused or contributed to the happening of the crash in which her mother died. It is very clear that she was driving carefully and to the conditions. She did not lose control of her vehicle. The crash happened in her lane.

Comments and Recommendations

29. I extend my appreciation to investigating officer, Senior Constable Adam Hall, for his investigation and report.

30. The circumstances of Mrs Griffiths' death are such that I consider it is necessary to **comment** that it is essential all drivers drive to the prevailing weather conditions.

31. I convey my sincere condolences to the family and loved ones of Mrs Griffiths.

Dated: 1 February 2022 at Hobart in the State of Tasmania.

Simon Cooper
Coroner