IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 01141

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: Tristan Edmond COSGRIFF

Delivered On:	22 February 2013
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	14 August 2012
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	Mr James Donald COSGRIFF, the deceased's brother, attended the inquest on behalf of the COSGRIFF family.
Police Coronial Support Unit:	Leading Senior Constable Kelley RAMSEY, assisting the Coroner

I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of TRISTAN EDMOND COSGRIFF
and having held an inquest in relation to this death
on 14 August 2012 at Melbourne
find that the identity of the deceased was TRISTAN EDMOND COSGRIFF
born on 20 April 1991
and that the death occurred on 25 March 2010
at Plenty Road, Mill Park, Victoria 3082
from:

1 (a) MULTIPLE INJURIES
1 (b) MOTOR VEHICLE ACCIDENT

in the following circumstances:

BACKGROUND & PERSONAL CIRCUMSTANCES[1]

1. Tristan Cosgriff was a young man of eighteen years who resided with his family in Mill Park, had a casual job and was studying Accounting at Northern Metropolitan Institute of TAFE (NMIT) after completing his secondary schooling at Parade College, Bundoora. According to his family, Tristan had been a successful junior footballer, played basketball successfully at competition level and was a popular and well-regarded young man who maintained a healthy lifestyle and had never given them cause for concern regarding his behaviour. According to his medical records, Tristan enjoyed good physical health, and had not presented with any history of depression or any other mental illness.

THE MOTOR VEHICLE COLLISION

2. On 25 March 2010, Tristan attended one of his regular classes at NMIT finishing at about 1230 hours. His movements thereafter are unknown until about 1355 hours when he was parked on the western roadside reserve of Plenty Road, Mill Park, some 100 metres north of Childs Road. The vehicle was a Ford sedan registered in his father's name, and Tristan was parked near the scene of a multi-victim motor vehicle collision that occurred two months

[1] Paragraphs 1 & 2 are a summary of facts that were uncontentious, and provide a context for those circumstances which were contentious and will be discussed in some detail from paragraph 14 onwards.

earlier and had achieved a level of notoriety, not only locally but more broadly due to media reporting.[2]

3. From this parked position, Tristan pulled out into Plenty Road behind another motorist, Ms Hatzis, and began travelling north behind her. Plenty Road has a posted maximum speed limit of 80kph at this location. Tristan did not appear to the motorist to be travelling at an excessive speed, nor in a concerning or erratic manner. However, he did appear to be distracted and was looking down inside his vehicle, and moving around in a way that suggested he was not wearing a seatbelt.[3]

4. Near Rivergum Drive, Tristan's vehicle veered left, leaving the roadway, travelling over the gravel shoulder onto the grassed roadside reserve, and colliding head-on with a large tree. The impact caused his vehicle to spin clockwise, roll and come to rest on its roof, against a paling fence. Despite the immediate assistance of Ms Hatzis, and Jeanine Benton, an off-duty police officer who lives nearby and helped pull Tristan from the vehicle, and the attendance of ambulance paramedics and other emergency services responders a short time later, Tristan sustained fatal injuries and died at the scene.

THE CORONIAL INVESTIGATION & THE DECISION TO HOLD AN INQUEST

5. The coronial investigation of Tristan's death was constrained by the absence of other witnesses to the collision proper. The only additional evidence relevant to the collision was the physical evidence at the scene, and the expert evidence of Sergeant Peter Bellion from the Specialist Collision Services Unit of the Major Collision Investigation Group of Victoria Police. Some of the circumstances raised the possibility that Tristan had intentionally taken his own life.

6. The Cosgriff family requested an inquest, in part so that rumours of suicide, which they found hurtful, could be addressed openly in a public hearing. They also raised concerns about aspects of road infrastructure, and the degree of uncertainty around the circumstances in

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[2] See Coroner Spooner's findings regarding the death of Steven Johnstone and Ors delivered on 21 December 2012 (CCoV case refs 2010 255, 256, 257, 258 & 259) accessible on the Court's website- see http://www.coronerscourt.vic.gov.au/home/case+findings.

[3] Statement of Ms Anna Hatzis dated 19 May 2010, Exhibit "A". Her evidence will be canvassed in more detail below.

which the collision occurred.[4] My decision to proceed to inquest was very much in response to the family's request.[5] As a general proposition, a death in such circumstances would not necessarily otherwise warrant an inquest, as part of the coronial investigation, even if some of the circumstances remained unclear.

7. This finding draws on the totality of the material the product of the coronial investigation of Tristan's death. That is, the investigation and inquest brief compiled by Senior Constable Jaclyn Cushen from the Epping Traffic Management Unit of Victoria Police, the statements/reports and testimony of those witnesses who testified at inquest, and any documents tendered through them. All this material, together with the inquest transcript, will remain on the coronial file.[6] In writing this finding, I do not purport to summarise all the material/evidence, but will refer to it only in such detail as appears to me to be warranted by its forensic significance and the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

8. The purpose of a coronial investigation of a *reportable death*[7] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[8] The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances, but is

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[4] Letter from Mr Brendan Cosgriff dated 16 September 2011. R v Hemsworth *[2009] NIQB 33 at [35]- [36]* and Re Ramsbottom *[2009] NIQB 55 at [17]- While a coroner cannot investigate every rumour or suspiciou, the coroner must not prematurely conclude that rumours or suspiciouns cannot hope to be confirmed. Instead, the coroner must assess whether there is a reasonable evidentiary basis to warrant investigation and, if so, call relevant evidence to investigate the rumour or suspicion.*

[5] See section 52(1) of the ***Coroners Act 2008,*** *hereinafter referred to as the Act.*

[6] From the commencement of the *Coroners Act 2008* (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

[7] The *Coroners Act 2008,* like its predecessor the *Coroners Act 1985*, requires certain deaths to be reported to the coroner for investigation. Apart from a jurisdictional nexus with the State of Victoria the definition of a reportable death in section 4 includes deaths that appear *"to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury"* and the *death of a person who immediately before death was a patient within the meaning of the Mental Health Act 1986".*

[8] Section 67(1) of the *Coroners Act 2008.* All references which follow are to the provisions of this Act, unless otherwise stipulated.

confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death.[9]

9. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[10] Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[11] These are effectively the vehicles by which the prevention role may be advanced.[12]

FINDINGS AS TO UNCONTENTIOUS MATTERS

10. In relation to Tristan's death, most of the matters I am required to ascertain, if possible, were uncontentious. His identity, the date, place and medical cause of death were never at issue. I find, as a matter of formality, that Tristan Edmond Cosgriff, born on 20 April 1991, aged 18, late of 61 McLaughlin Crescent, Mill Park, Victoria 3064, died at Plenty Road, Mill Park at about 1400 hours on 25 March 2010.

THE MEDICAL CAUSE OF DEATH

11. Nor was the medical cause of death contentious. Although no autopsy was performed, in response to the family's objection to autopsy, Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (VIFM), performed a preliminary examination (including a full external examination), reviewed the circumstances as reported by the police to the coroner and post-mortem CT scanning of the whole body (PMCT). Having done so, he advised that Tristan's death could be reasonably attributed to *multiple injuries secondary to a*

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[9] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[10] The "prevention" role is now explicitly articulated in the Preamble and purposes of the Act of the *Coroners Act 1985* where this role was generally accepted as "implicit".

[11] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.

[12] See also sections 73(1) and 72(5) of the Act which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

motor vehicle accident. In terms of the nature and extent of the injuries, Dr Bedford advised that PMCT showed fractures of the right distal humerus, radius and ulna (the main bones of the right arm), right femur (right thigh bone), a fracture dislocation of the right ankle and, significantly, skull fractures.[13]

12. Toxicological analysis of a post-mortem blood sample, also undertaken at VIFM, detected no ethanol (alcohol) or other common drugs or poisons. There is thus no evidence to suggest that Tristan's ability to drive a motor vehicle, or his cognition, were impaired by substances to any extent. In light of the main focus of the coronial investigation of Tristan's death which was to understand what may have caused or contributed to the motor vehicle accident (or more properly "collision"), this is a significant "negative" finding.[14]

13. I find that the medical cause of Tristan's death was multiple injuries secondary to a motor vehicle accident.

FOCUS OF THE CORONIAL INVESTIGATION & INQUEST

14. The focus of the coronial investigation of Tristan's death was on the motor vehicle accident itself - the role played by any other driver or vehicle, the contribution of prevailing weather conditions or any aspects of road infrastructure, and whether or not the accident was in fact *not* accidental but intentional. These issues were either explicitly raised by the family in correspondence with the Court and/or in their request for an inquest, or were implicit in the circumstances.

15. The family raised the possibility of another driver being involved in the collision, specifically a driver turning right from Rivergum Drive into Plenty Road to join vehicles travelling north, that is in the same direction as Tristan and Ms Hatzis.[15] The inference was that someone could have done so unsafely causing Tristan to veer left and lose control of his vehicle. Senior Constable Cushen verified that such a turn would be legal, as the intersection had been configured to allow for a right turn from Rivergum Drive into Plenty Road. [16] However, Ms Hatzis, who was travelling in the left lane immediately ahead of Tristan, did not recall seeing

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[13] Dr Bedford's "Medical Examination Report" is part of Exhibit "T" the balance of the brief.

[14] See paragraph XX and following below where the circumstances of the collision are discussed in some detail.

[15] Transcript page 3.

[16] Transcript page 11.

any vehicles in the lane to her right, nor could she recall seeing any vehicles entering Plenty Road from Rivergum Drive.[17] Police found no physical evidence at the scene to suggest that any other vehicle was involved in the collision, and no witnesses came forward to say that another vehicle was involved.[18]

16. In terms of overall driving conditions at the time of the collision, traffic was light and visibility was excellent. It was broad daylight on a fine day, when the sun was high and to the west, posing no hindrance to the visibility of drivers travelling north. There was no suggestion of any physical obstacle to visibility, or that the collision occurred in other than perfect driving conditions.[19]

17. In terms of road infrastructure and the physical environment at this location, Plenty Road is an divided arterial road constructed of a bitumen spray and aggregate seal, with provision for two marked traffic lanes in either direction, separated by a wide, raised media strip bordered by concrete kerbing. The northern carriageway has a straight north-south alignment and a slight downhill grade. Immediately to the west of the marked northbound lanes is a two metre wide sealed bitumen shoulder, further west is a gravel shoulder, followed by a downward sloping grassed verge, tree plantings, further grass, an open drain, a concrete path, more grass and residential fencing.[20]

18. At inquest, a number of witnesses thought that the gravel shoulder posed a driving hazard and raised the possibility of a loss of traction/control. Witnesses also expressed concerns that the downward slope of the grass verge was steeper than it looked from the photographs in the brief, and may have contributed some momentum to Tristan's vehicle after it left the roadway and thus contributed to the collision.[21]

19. Apart from these hypotheses of lay witnesses, there was the expert evidence of Acting Senior Sergeant Peter Bellion from the Specialist Collision Services Unit of the Major Collision

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[17] Exhibit "A" and transcript pages 4-5.

[18] Transcript page 20, where it is clear that the "scene" for these purposes encompasses the intersection of Rivergum Drive and Plenty Road

[19] Exhibit "A", transcript page 6, statement of Leading Senior Constable David Mair and the photos he took about one and a half hours after the collision which are part of Exhibit "I" the balance of the inquest brief.

[20] Exhibit "C" and LSC Mair's statement and photos in Exhibit "I".

[21] Transcript pages

Investigation Group who undertook a collision reconstruction drawing on his training, study, experience and specialised knowledge.[22] The conclusions in his statement were that –

- the physical evidence indicates that the vehicle was travelling faster than the speed limit;
- there appeared to be no attempt to brake prior to impact with the tree;
- there appeared to be no attempt to steer the vehicle once it left the roadway to try to avoid impact with the tree;
- the principle impact force was aligned with the driver's seat; and
- the driver was not wearing a seat belt.

20. Acting Senior Sergeant Bellion expanded on his statement and conclusions at inquest.[23] On my reading of his evidence, he did not materially modify his conclusions. Referring to the 40.9 metre distance between the point where the vehicle entered the gravel shoulder and the impact with the tree,[24] he reiterated the view that, even at speed, there was enough opportunity for Tristan to manoeuvre around the tree, so as to avoid impact altogether. While he testified that Tristan appeared to have taken a line between a bus shelter and a pole situated on the roadside reserve, apparently steering towards the tree, he conceded that as a relatively inexperienced young driver, Tristan may not have been well-equipped to take sudden evasive action, and/or may have panicked. By reference to Ms Hatzis evidence, he conceded that the initial manoeuvre whereby the vehicle left the roadway *may* have resulted from the distraction associated with leaning down towards the left unrestrained, succumbing to the tendency to steer to the left. The apparent absence of braking or steering input from the driver, also raises the possibility of a blackout or other natural disease process, which he also conceded was a possibility consistent with the physical evidence found at the scene. [25]

21. Tristan's family provided details of his general good character and relied on the absence of any prior mental illness or noted changes in behaviour or demeanour, relevant to both the

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[22] Details of his formal qualifications and extensive experience are contained in his statement, Exhibit "C".

[23] See transcript from pages 20 and following.

[24] I note that the tree was located 8.25 metres west of the left edge of the left northbound traffic lane and 6.25 metres west of the western bitumen edge - Exhibit "C". That is well outside the desirable "clear zone" for an 80kph speed limit – transcript page 31. See also statement of Nial Finegan, Regional Director, VicRoads dated 7 February 2012 and attachments in Exhibit "I" and evidence of Patricia Liew, VicRoads, at transcript page 57.

[25] Transcript pages 27-28.

unlikelihood that he would have been driving in an unsafe manner, and the unlikelihood that he intentionally caused the collision in order taken his own life.

22. A number of Tristan's friends provided statements and attended the inquest to testify. Although somewhat nuanced, their evidence supports a finding that Tristan was a popular well-adjusted young man who had a lot going for him. They saw nothing in his behaviour to suggest suicidality or to raise concerns for his safety, and were not aware of any significant issues in his life that might be troubling him. They thought Tristan may have had some family issues, but nothing out of the ordinary.[26] They were familiar with his driving habits and considered him to be a safe driver, probably the best of the group, who was not known to speed or to be a "hoon" on the road.[27]

23. In light of the suggestion that something in the front passenger side of the vehicle was distracting Tristan shortly before he left the roadway, Senior Constable checked his mobile phone and found no evidence of incoming or outgoing calls or text messages for some hours before the collision.[28] Two of Tristan's friends, Liam Hunt and Matt Cerni, thought that he could be distracted by the CD player or might try to change CDs whilst driving.[29] James Cosgriff, Tristan's older brother also gave evidence about this at inquest. He testified that the vehicle had a six CD stacker and there was no need to change CDs while driving. Moreover, as the spare CDs were kept in a storage place under the front passenger seat, whilst it was possible, it would be *too dangerous* to reach for them while driving, and he couldn't imagine Tristan would do so.[30]

24. For completeness, I note that although a relatively inexperienced driver, Tristan was familiar with the vehicle he was driving and familiar with the general vicinity of the collision. I also

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[26] Statement of Mitchell Oliver, Exhibit "D" – "besides the family stuff that always happens in every family, there was nothing too major." Statement of Matt Cerni, Exhibit "F" – "In relation to any problems he might be having, he was sort of wanting to move out of home because his mum and dad were very strict…But that was probably about it." Statement of Hirsi Twomey, Exhibit "G" – "before we turned 18 and stuff, like his parents sometimes wouldn't' let him come out with us. I don't know if he had troubles with them or his parents were overprotective, like I don't blame them, my parents are the same." Statement of Christopher Nave, Exhibit "H" – "I wasn't aware if he had any issues at home…His parents were very nice, they wanted the best out of him. They pushed him a little, but what parent doesn't." Transcript pages 35, 41-42.

[27] See statements referred to above and statement of Liam Hunt, Exhibit "E". Also transcript pages 33-34, 37, 41, 44.

[28] Note that the vehicle ended on its roof and sustained significant crush damage/cabin intrusion. The mobile phone was handed to Sen Const Cushen by someone at the scene, so its precise location in the vehicle, prior to the collision, is unknown. Transcript page 8.

[29] Exhibits "E' and "F", transcript pages 37, 39-40.

[30] Transcript pages 48-49.

note that mechanical inspection of the vehicle after the collision revealed no mechanical faults or problems with could have caused or contributed to the collision.[31]

CONCLUSION

25. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities with the *Briginshaw* gloss or explication.[32] I have applied that standard to the totality of the evidence available to me.

26. Having done so, I find that there is insufficient evidence to support a positive coronial finding that any other vehicle was involved in the collision, although the possibility cannot be sensible excluded altogether. Nor does the weight of the evidence support a finding that any aspect of road infrastructure or prevailing weather conditions caused or contributed to the collision, in any meaningful sense.

27. I further find that there is insufficient evidence to support a positive coronial finding that Tristan intentionally causes the collision in furtherance of a plan or intention to take his own life. Whilst I accept Acting Senior Sergeant Bellion's analysis of the physical evidence, and the inferences which can be drawn from that evidence, in my view, it is at least equally plausible that Tristan veered to the left and left the roadway whilst distracted, and thereafter simply lost control of his vehicle, in circumstances which would have challenged even more experienced drivers.

COMMENTS

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

1. In the concluding paragraph of his statement, Acting Senior Sergeant Bellion called for VicRoads to investigate the installation of wire rope safety fencing along this stretch of Plenty Road as a priority.[33]

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[31] Transcript pages 47 and following. Statement of

[32] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 esp at 362-363 - "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences..."*

2. On the assumption for present purposes, that this was an accidental and not intentional collision, wire rope fencing at this location would improve safety by washing off a vehicle's momentum and minimising the extent of injury and, of lesser concern, property damage.[34]

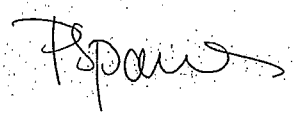
3. At inquest, Ms Patricia Liew, VicRoads advised that the Traffic Accident Commission (TAC) had agreed to fund a VicRoads' proposal for improvements on a 2.5 kilometre stretch of Plenty Road, between McKimmies Road and Centenary Drive, encompassing the collision site.[35] The road safety treatments included in the proposal involve the removal of roadside hazards (such as trees), the construction of sealed shoulders (on the median side) and the installation of roadside barriers, both wire rope and fixed metal barriers.[36]

4. VicRoads and the TAC are to be commended for developing and funding the proposal respectively, thereby improving the safety of all road users at this arterial road location.

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

The family of Mr Cosgriff
Senior Constable Jaclyn Cushen (#35316) c/o Epping Traffic Management Unit
VicRoads
Traffic Accident Commission
Shire of Whittlesea

Signature:



PARESA ANTONIADIS SPANOS
CORONER
Date: 22 February 2013

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[33] "From a preventative measure in lieu [sic] of this being the sixth death associated with cars striking trees off the left hand side of Plenty Road, Mill Park this year, I recommend that VicRoads investigate the installation of wire rope safety fencing along this stretch of road as a priority." Exhibit "C".

[34] Transcript page 59 and RTA Road Environment Safety Update No 24 issued March 2004, in Exhibit "I".

[35] Statement of Nial Finegan, Regional Director, VicRoads dated 7 February 2012 in Exhibit "I". This stretch of Plenty Road also encompasses the collision site where the earlier multiple fatality collision occurred. See footnote 2 above.

[36] Transcript pages 56 and following where Ms Liew describes the proposed improvements.