MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

# Record of Investigation into Death (Without Inquest)

*Coroners Act* 1995
*Coroners Rules 2006*
*Rule* 11

I, Simon Cooper, Coroner, having investigated the death of James Raymond Nichols

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

a) The identity of the deceased is James Raymond Nichols;
b) Mr Nichols died as a result of injuries sustained in a single motor vehicle crash;
c) The cause of Mr Nichols' death was a traumatic closed head injury; and
d) Mr Nichols died on 16 May 2018 in the Royal Hobart Hospital, Hobart, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Nichols' death. The evidence comprises an opinion of the forensic pathologist who conducted the autopsy; relevant police and witness affidavits; medical records and reports; and forensic and photographic evidence.

On 4 May 2018 whilst speeding, not wearing a seatbelt, and significantly affected by alcohol, Mr Nichols lost control of the vehicle he was driving on the Bass Highway between Prospect and Hadspen, crashed the vehicle and was ejected from it, suffering massive injuries.

He was transported from the scene of the crash by ambulance to the Launceston General Hospital where he was admitted to the Intensive Care Unit and then transferred the next day to the Royal Hobart Hospital Intensive Care Unit for further neurological management. His condition did not improve and

after discussion with his parents several of his organs were donated, all treatment was ceased and he died at the Hospital just after 1.30pm on 16 May 2018.

After formal identification an autopsy was carried out upon his body by experienced forensic pathologist Dr Donald Ritchey. Dr Ritchey expressed the opinion, which I accept, that the cause of Mr Nichols' death was a traumatic closed head injury, specifically a diffuse axonal injury, a type of severe brain injury caused by shearing forces during trauma.

The evidence satisfies me that Mr Nichols had a blood alcohol reading of 0.157g of alcohol per 100mL of blood at the time of the crash, was travelling at, at least, 142 km/h an hour (the speed limit being 110 km/h on the section of road where the crash occurred) and was not wearing a seatbelt.

I am satisfied that no other person or vehicle was involved in the happening of the crash.

**Comments and Recommendations**

I extend my appreciation to investigating officer Constable Kelly Hindle for her investigation and report.

The circumstances of Mr Nichols' death are not such as to require me to make any recommendations pursuant to Section 28 of the *Coroners Act* 1995. I do however **comment** that this is yet another completely avoidable road death caused by a fatal combination of excessive speed, alcohol and the failure to wear a seatbelt.

I convey my sincere condolences to the family and loved ones of Mr Nichols.

**Dated** 17 May 2019 at Hobart , Tasmania.

**Simon Cooper**
**Coroner**