MAGISTRATES COURT
TASMANIA

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 Colin Jamie Oliver

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

a) The identity of the deceased is Colin Jamie Oliver;
b) Mr Oliver died as a result of injuries sustained by him in a mountain bike collision;
c) The cause of Mr Oliver's death was head injury, due to a single mountain bike crash; and
d) Mr Oliver died on 15 May 2018 at the Royal Hobart Hospital, Hobart, Tasmania.

1. In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Oliver's death. The evidence includes:

- Police Report of Death for the Coroner;
- Royal Hobart Hospital – Death Report to Coroner;
- Affidavit of Dr Jo Hudson sworn 22 May 2018 confirming life extinct;
- Declaration of Life Extinct made by Dr Jo Hudson on 15 May 2018;
- Affidavit of Christopher Robert Cheeseman, sworn 15 May 2018, confirming identification of Mr Oliver's body;
- Affidavit of Mr Anthony Cordwell of Southern and West Coast Mortuary Ambulance Service, sworn 15 May 2018;
- Affidavit of Dr Christopher Hamilton Lawrence, forensic pathologist, sworn 28 May 2018;
- Medical Records – Sandy Bay Clinic;
- Medical Records – Tasmanian Health Service;
- Ambulance Tasmania electronic Patient Care Report, dated 1 March 2018;
- Affidavit of Mr Nathan Burns – Safety Coordinator Maydena Bike Park, sworn 26 March 2018;
- Affidavit of Ms Amanda Noye, sworn 26 June 2018, Mr Oliver's partner;
- Affidavit of Mr Timothy Peter Johnson, sworn 28 June 2018;
- Affidavit of Mr Paul Morris Johnson sworn 3 July 2018;

- Affidavit of Mr Simon French, owner and managing director of Maydena Bike Park, sworn 13 September 2018;
- Affidavit of Senior Constable Adam John Hall, Tasmania Police Service – crash investigation services, sworn 4 October 2018 and collision analysis report;
- Affidavit of Mr Paul Ralph Wells, sworn 15 June 2018, a Transport Inspector who examined Mr Oliver's bike;
- Affidavit of Constable Perry Caulfield, Tasmania Police Service, sworn 20 August 2020; and
- Photographic evidence.

2. In addition, my findings were informed by my inspection of the scene of Mr Oliver's crash.

What a Coroner Does

3. A coroner in Tasmania has jurisdiction to investigate any death which appears to have been the result of an accident. Mr Oliver's death obviously meets this definition.

4. When investigating any death at an inquest, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. She or he is required to thoroughly investigate a death and answer the questions (if possible) that section 28(1) of the *Coroners Act 1995* (Tas) asks. These questions include: who the deceased was; the circumstances in which he or she 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. A coroner is required to make findings of fact from which others may draw conclusions. A coroner is also able, if she or he thinks fit, to make comments about the death or, in appropriate circumstances, recommendations to prevent similar deaths in the future.

5. A coroner does not punish or award compensation – that is 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. In fact, a coroner in Tasmania may not even say that he or she thinks someone is guilty of an offence.[1] I should make it very clear I do not think anyone committed any crime or offence in relation to Mr Oliver's death.

[1] Section 28(4).

6. As was noted above, one matter that the Act requires is finding how the death occurred.[2] It is well-settled that this phrase involves the application of the ordinary concepts of legal causation.[3] 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.

7. 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 articulated in *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation is proved should be approached with great caution.[4]

Background

8. Mr Oliver was a registered nurse, aged 48 and in a relationship with Ms Amanda Noye at the time of his death. He was extremely fit and an experienced mountain bike rider.

9. His medical history was unremarkable; it is completely consistent with his background as a highly talented athlete.

Circumstances of Death

10. On 1 March 2018 Mr Oliver went by himself to the Maydena Bike Park. He had with him his own mountain bike and bike helmet. The evidence suggests that the mountain bike was about 12 months old and appropriately maintained. Park records indicate that, upon arrival, Mr Oliver was checked in by staff who logged him in as intending to ride up the 'Climbing Trail'. The Climbing Trail contrasts with 'Uplift', whereby riders are transported by a park vehicle to the upper parts of the park, before riding down the various trails. It is a more expensive, but less strenuous, option than the Climbing Trail.

11. Records kept at the Park indicate that Mr Oliver was the first (and only) person intending to ride that trail at that time. Before being permitted to set out on the track, his equipment was inspected by staff and Mr Oliver read, and signed, the general terms and conditions of use.

---

[2] See section 28(1)(b).
[3] See *March v E. & M.H. Stramare Pty. Limited and Another* [1990 – 1991] 171 CLR 506.
[4] (1938) 60 CLR 336 (see in particular Dixon J at page 362).

12. The evidence indicates that this was the second occasion Mr Oliver had gone to the Maydena Bike Park. On the previous occasion, he rode the same trail as he was intending to ride on 1 March 2018.

13. Mr Oliver rode up the Climbing Trail to the start of the Tyenna Trail. He then set off down the Tyenna Trail for a distance of no more than 500 metres before coming off his mountain bike. His fall was not witnessed. The time of the fall is not known. At 11.04am he was found by Timothy and Paul Johnson. The 2 men immediately sought assistance and at 11.12am the Park safety coordinator and trained ambulance paramedic, Mr Nathan Burns, arrived at the scene to provide assistance to Mr Oliver.

14. Ambulance Officers were also called to the scene, arriving there at 11.47am. A Police Officer from New Norfolk also attended and assisted in the transfer of Mr Oliver to the rescue helicopter.

15. It was not until the local Maydena Police Officer, Senior Constable Bass, returned to work on 5 March (he was on leave when the crash occurred) that any investigation in relation to Mr Oliver's crash was commenced. By then, of course, four days had elapsed since Mr Oliver had crashed and the scene had not been secured. No physical evidence remained at the scene which might have assisted investigators (and ultimately me) to determine how and why the crash occurred. I will return to this issue later in these findings.

16. In any event, it was apparent that Mr Oliver was terribly injured. He was transferred to a helicopter and flown to Hobart where he was immediately taken to the Emergency Department of the Royal Hobart Hospital.

17. Mr Oliver was identified as having suffered multiple injuries, and significantly, critical head injuries. Despite the very best treatment, he did not recover from his injuries and died on 15 May 2018.

18. The fact of his death was reported in accordance with the requirements of the *Coroners Act* 1995 (it being the result of an accident).[5] Mr Oliver's body was formally identified and then taken to the hospital mortuary.

[5] See section 3.

Investigation

19. The investigation into Mr Oliver's death involved two aspects. The first was a medical review of the cause of his death. This was confirmed by the then State Forensic Pathologist, Dr Christopher Lawrence, as being due to a head injury sustained in the crash on 1 March 2018. It was not necessary for Dr Lawrence to perform a 'full' autopsy. Rather, he conducted an external examination of Mr Oliver's body and reviewed his extensive medical records before providing his report.[6]

20. In that report, Dr Lawrence said that Mr Oliver died as a consequence of the head injuries he sustained in the crash at Maydena on 1 March 2018. I accept Dr Lawrence's opinion.

21. The second aspect of the investigation – why the crash occurred – was hampered by the fact that, as has already been mentioned, the formal investigation did not commence until four days after Mr Oliver's accident.

22. Senior Constable Bass arranged for specialist crash investigators, Sergeant Rod Carrick (now retired) and Senior Constable Adam Hall, to inspect the scene of Mr Oliver's fall. They were accompanied by Mr Nathan Burns, the paramedic first on the scene. Mr Burns pointed out salient aspects of the track to Sergeant Carrick and Senior Constable Hall.

23. After visiting the scene, and conducting further enquiries, Senior Constable Hall authored a comprehensive report. I am quite satisfied he is qualified to express the opinions that he did in that report and I accept him as an expert in the area of crash investigation.

24. Senior Constable Hall's report was the subject of a peer review, conducted by another specialist crash investigator, in a different police district. I consider the report reliable and was greatly assisted by it.

25. Senior Constable Hall was unable to identify any evidence at the scene to enable a speed analysis to be carried out.

26. He said that the track where Mr Oliver crashed was approximately 3.5 metres wide, had a dirt surface and a grade which varied between 18 degrees and level. Nothing about the construction of the track, at least in the area where Mr Oliver crashed, appears to have played any particular role in the happening of the crash.

---

[6] Affidavit, Christopher Hamilton Lawrence, sworn 28 May 2018.

27. Both the helmet Mr Oliver was wearing, and the bike he was riding were examined by Senior Constable Hall as part of the investigation. He found both fit for purpose, and in particular the helmet, compliant with the relevant Australian Standard.[7] I accept that they were. In addition to Senior Constable Hall's inspection, the bicycle was also inspected by Mr Ralph Wells, a Transport Inspector. Mr Wells confirmed Senior Constable Hall's opinion that the bike was mechanically sound.[8]

28. I do note that the bike was not seized until 9 March 2018. This means that it was not a secure exhibit. However, there is nothing to suggest it had been altered or repaired following the crash and I do not think that that lack of security impacted upon the investigation in this case.

29. Senior Constable Hall said that the chin strap of the helmet was intact. What appeared to be dried blood was evident on the chin strap, suggesting that it was being worn, and was fastened, at the time of impact with the ground. This confirms the eye witness evidence of Mr Timothy Johnson (one of the men who found Mr Oliver) that Mr Oliver was wearing his helmet when found on the track.[9]

30. I do note however that the helmet was what might be described as a 'standard' bicycle helmet, rather than a specialised mountain bike helmet. It was certainly not a 'full face' helmet. Nonetheless, there is no evidence that had Mr Oliver been wearing a full face helmet, that the outcome of the accident would have been any different.

The Park

31. The Maydena Bike Park is a so-called 'gravity focussed' mountain bike park. It opened in early 2018, not long before Mr Oliver's crash. The trails in the Park are divided into different grades, identified by colours. Some are easy (green), some moderate (blue) and some hard (black, red). The colour code system is much the same as that used to identify the difficulty of snow ski runs.

32. The Tyenna Trail, on which Mr Oliver crashed, is a 'green circle' run. It is machine built and "offers a wider trail tread, smooth surface, and generally features larger bermed corners and flowing terrain".[10] Green circle runs are the least difficult trails in the park.

---

[7] AS/NZS 2063:2008
[8] Affidavit of Paul Ralph Wells, sworn 1 June 2018, page 1 of 3.
[9] Affidavit, Timothy Peter Johnson, sworn 28 June 2018, page 2 of 4.
[10] Report, Senior Constable Hall, page 4 of 15.

Conclusions

33. Mr Oliver died as a result of terrible injuries he sustained when he fell from his mountain bike. The bike was in a sound mechanical condition. He was wearing a helmet which complied with the applicable standard. The helmet was properly fitted and fastened.

34. The trail he was on was one of the easiest in the Maydena Bike Park. There is no evidence to suggest it was especially unsafe, or that it was of a standard inappropriate for a rider of Mr Oliver's experience.

35. There is no evidence to suggest the involvement of any other person in Mr Oliver's death.

36. There no evidence to suggest that weather played any particular role in his death.

37. The evidence does not allow me to find precisely why it was that Mr Oliver fell from his bike. I cannot determine how long it was before he was found by other Park users. I am satisfied that the response of the Park, and in particular of Mr Nathan Burns, was timely and professional, once notified of Mr Oliver's crash.

Comments and Recommendations

38. The circumstances of Mr Oliver's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

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

Dated 1 October 2020 at Hobart in the State of Tasmania.

Simon Cooper
Coroner