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 Nicholas William Hildyard

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

a) The identity of the deceased is Nicholas William Hildyard;
b) Mr Hildyard died as a result of traumatic closed head injuries sustained in a motor vehicle crash;
c) Mr Hildyard's cause of death was traumatic closed head injuries; and
d) Mr Hildyard died on 6 March 2020 at Arthur Highway, near Forcett, Tasmania.

Introduction

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

- Police Report of Death for the Coroner;
- Affidavits establishing identity and life extinct;
- Post-mortem report – Dr Donald Ritchey, Forensic Pathologist;
- Report – Forensic Science Service Tasmania;
- Ambulance Tasmania records;
- Affidavit – Mr Paul Wells, Transport Inspector;
- Affidavit – Mrs Stacey Belbin;
- Affidavit – Mr Donald Belbin;
- Affidavit – Mr John-William Reynolds;
- Record of Interview – Mr Garry John Ransley, 17 March 2020;
- Affidavit – Ms Maxine Fox;
- Affidavit – Mr Heath Kean;
- Affidavit – Mr Rodney Kean;
- Affidavit – Mr Paul Jacobson;
- Affidavit – Ms Jordyn Stubbs;
- Affidavit – Senior Constable Timothy Keenan;

- Affidavit – Senior Constable Kelly Cordwell;
- Affidavit – Constable Jared Gowen;
- Forensic Science Service Tasmania – Report of Analysis of Blood Sample, Garry Ransley;
- Scene photographs;
- Scene sketch map; and
- Telephone records.

The role of a coroner

2. A coroner in Tasmania has jurisdiction to investigate any death which appears to have been unexpected or unnatural. Obviously, the circumstances of Mr Hildyard's death meet this test. When investigating a death, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. She or he is required to look at the circumstances surrounding a 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 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.

3. It is important to understand 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.

4. As was noted above, one matter that the *Coroners Act* 1995 requires is a finding (if possible) as to how the death occurred. This phrase involves the application of the ordinary concepts of legal causation. Any coronial investigation 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.

5. The standard of proof in a coronial investigation 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 investigation 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*[1], that is,

[1] [1938] 60 CLR 336.

that the task of deciding whether a serious allegation against anyone is proved should be approached with a good deal of caution.

Circumstances of death

6. Mr Hildyard died as a result of injuries sustained in a motor vehicle crash which occurred on his 24 birthday. He had celebrated with family and friends in the hours leading up to his death. Part of that celebration involved the consumption of alcohol. Mr Hildyard appears to have made a decision to drive, after drinking, to get to his work where he intended to sleep. He did this so he would not be late for work the following morning.

7. Just after midnight on 6 March 2020, as Mr Hildyard drove his silver Toyota HiLux in a westerly direction along the Arthur Highway near Forcett (near Gangell's Road), a silver Holden Rodeo was being driven in the opposite direction by Mr Garry Ransley. It was raining and the roadway was wet. The driving conditions were bad.

8. The two vehicles collided. Mr Hildyard suffered terrible injuries and died at the scene. Mr Ransley and his passenger, Ms Maxine Fox, were both injured, but not seriously.

Investigation

9. Police, fire and ambulance officers were quickly on the scene. It was apparent that nothing could be done for Mr Hildyard and no efforts were made to resuscitate him.

10. An investigation was commenced at the scene. The scene was secured and specialist officers from Forensic Services and Crash Investigation Services attended to conduct enquiries. Mr Hildyard's body was examined and photographed. The scene was examined and marked and then re-examined in daylight.

11. Mr Hildyard's body was formally identified and was then taken by mortuary ambulance to the Royal Hobart Hospital ('RHH'). At the RHH, an autopsy was performed by the Tasmanian State Forensic Pathologist, Dr Donald Ritchey. Dr Ritchey provided a report in which he expressed the opinion that the cause of Mr Hildyard's death was a traumatic closed head injury. Dr Ritchey said that Mr Hildyard's death would have been almost instantaneous.

12. I accept Dr Ritchey's opinion as to the cause of Mr Hildyard's death.

13. Samples taken at autopsy were subsequently analysed at the laboratory of Forensic Science Service Tasmania. That analysis showed that, at the time of his death, Mr Hildyard had a blood alcohol level of 0.163g per 100mL of blood.

14. The other driver involved, Mr Garry Ransley, submitted to a blood test. The analysis of that blood did not reveal the presence of any alcohol or illicit drugs in his system.

15. Both vehicles involved were impounded by investigators and later examined by Mr Paul Wells, a Transport Inspector. Mr Wells provided a report in which he outlined the results of that inspection. He found that Mr Hildyard's vehicle was unroadworthy due to some compliance issues relating to a rear spring, window tint and vehicle height and lift. I do not consider any of those deficiencies caused the crash.

16. Mr Wells said that the vehicle driven by Mr Ransley had been maintained in a roadworthy condition prior to the accident.

17. I consider that Mr Wells is qualified to express the opinions that he did. I accept his opinion in relation to both vehicles.

18. Mr Ransley later told investigators that he was 'dazzled' by Mr Hildyard's lights and had been travelling at about 80km/h at the time of the crash. His passenger, Ms Fox, corroborated the speed of Mr Ransley's vehicle.

19. Mr Hildyard's headlights were examined by police officers in the immediate aftermath of the crash. The headlights of the vehicle were in a low beam position. It is possible, I suppose, that the lights had been pushed back into low beam as a result of impact damage following the collision. It is also possible that Mr Hildyard had turned his lights to low beam before the collision. I also note that Mr Hildyard's headlights were, as a result of aftermarket modifications, higher than the average vehicle. This may have given Mr Ransley the impression that his lights were on high beam.

20. I have had specific regard to the results of the comprehensive investigation carried out by Senior Constable Cordwell of Crash Investigation Services. I am unable to determine in which lane the collision occurred. In making this finding I do not overlook the evidence that oil spilt from a crack in Mr Ransley's vehicle's sump onto the road and that the majority of that oil spill was in the west bound lane of the Arthur Highway. Nonetheless, there were no gouge or skid marks in or on the surface of the highway to help assist to determine the point of impact.

21. Finally, there is evidence from a number of independent witnesses that the road was very wet and there was poor visibility at the time of the crash.

Conclusion

22. Viewing the evidence as a whole I conclude that Mr Hildyard died as a result of injuries sustained by him when his vehicle and a vehicle driven by Garry John Ransley collided on the Arthur Highway near Forcett in the early hours of 6 March 2020. I do not consider speed to have been a factor in the collision. I am satisfied on the basis of the evidence that it is likely weather conditions were a factor in the happening of the crash. It is also possible that the height of Mr Hildyard's vehicle may have contributed to Mr Ransley being "dazzled" by Mr Hildyard's headlights.

23. I am also satisfied that at the time the two vehicles collided Mr Hildyard's ability to safely manoeuvre and operate his vehicle must have been impaired by the alcohol that was present in his body.

Comments and Recommendations

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

25. I convey my sincere condolences to the family and loved ones of Mr Hildyard. His death is a terrible tragedy.

Dated 27 July 2021 at Hobart in the State of Tasmania.

Simon Cooper
Coroner