MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

Record of Investigation into Death

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of John Ernest Mansell

Hearing Dates

25, 26, 27, 28 May 2015 (Launceston) and 20 November 2015 (Hobart);

Counsel

Counsel Assisting the Coroner: DJ Barclay

Counsel for Confederation of Australian Motorsport (CAMS): K Stanton

Counsel for Targa, Octagon and Mr S Benson: D Coombes

Jurisdiction

Introduction

1. John Ernest Mansell was killed on 17 April 2013 in a motor vehicle crash whilst competing in Targa Tasmania 2013. He was driving his Porsche sedan on stage one, Porters Hill Road, not far from Deloraine, when his vehicle left the road and struck a tree.

2. Mr Mansell died at the scene; his navigator (or co-driver) Tristan Catford was seriously injured but recovered.

3. The investigation of deaths in Tasmania is governed by the *Coroners Act* 1995 (the 'Act').

4. Section 21 of the Act provides that "a coroner has jurisdiction to investigate a death if it appears to the coroner that the death is or may be a reportable death".

5. Section 3 of the Act defines a reportable death as meaning, *inter alia*, a death which occurred in Tasmania and "that appears to have been unexpected, unnatural or violent ***or to have resulted directly or indirectly from an accident or injury***" [emphasis added].

6. Section 24 of the Act deals with the holding of inquests. Section 24(1) outlines the circumstances in which an inquest must be held. None of those matters are relevant in relation to Mr Mansell's death. Section 24(2) provides "a coroner may hold an inquest into a death which the coroner has jurisdiction to investigate if the coroner considers it desirable to do so".

7. Section 3 of the Act defines an inquest as "a public inquiry that is held by a coroner in respect of a death…".

8. In this instance I determined that it was desirable to hold an inquest in relation to Mr Mansell's death. I reached that view because Mr Mansell's death as a competitor in an internationally recognised motorsport event which occupies a significant place in this State's sporting calendar meant, in my view, that public scrutiny of the circumstances was warranted.

9. As a consequence, the public hearing of evidence in relation to the circumstances surrounding Mr Mansell's death was heard in May 2015. Due to the regrettable inability of the Court administration to provide a transcript of the evidence given in a timely manner to the parties (and to me) final submissions, were not able to be made until November. It is essential that the court is adequately resourced to ensure delays such as this do not happen again. The death of an individual is difficult enough for the family, the fact of an inquest may be more so. However it is unacceptable that the inquest process is delayed because of want of adequate staffing levels.

10. Section 28 of the Act, relevantly provides as follows:

> "**1)** A coroner investigating a death must find, if possible –
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> **(a)** the identity of the deceased; and
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> **(b)** how death occurred; and
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> **(c)** the cause of death; and
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> **(d)** when and where death occurred; and
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> **(e)** the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act 1999*.
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> **(f)** . . . .
>
> **(2)** A coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.
>
> **(3)** A coroner may comment on any matter connected with the death including public health or safety or the administration of justice."

11. This provision delimits the extent of any coronial inquiry. No inquest is an inquiry at large. Every investigation in relation to a reportable death has limits. Those

limits are to be found in section 28.

12. In this case there was no dispute as to the identity of Mr Mansell, the cause of his death, when and where death occurred, and the information needed to register his death under the *Births, Deaths and Marriages Registration Act* 1999.

Births, Deaths and Marriages Act

13. I observe that difficulty attends compliance with this last requirement (section 28 (1) (e)). The *Births, Deaths and Marriages Registration Act* 1999 deals of course with, *inter alia*, the registration of death.

14. Section 40 of that Act provides:

> **“40. The Register**
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> **(1)** The Registrar must maintain a register or registers of registrable events.
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> **(2)** The Register –
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> **(a)** must contain the particulars of each registrable event required under this Act, or another law, to be included in the Register; and
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> **(b)** may contain further information if the Registrar considers its inclusion appropriate.
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> **(3)** The Register may be wholly or partly in the form of a computer database, in documentary form, or in another form the Registrar considers appropriate.
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> **(4)** The Registrar must maintain the indexes to the Register that are necessary to make the information contained in the Register reasonably accessible.”

15. Sections 32 and 38 of the same Act deal with the registration of death. However nothing in the *Births, Death and Marriages Registration Act* 1999 deals with what particulars are to be entered upon registration of a death. The regulations made under that Act do not deal with the matter either. In my view this is a matter that requires attention from the appropriate authorities.

Ambit of Inquest

16. Nor was there any real dispute as to how Mr Mansell’s death occurred. However the ambit of the inquest and the extent to which any recommendations could and should be made was the subject of disagreement between the parties. It is to this point that I turn.

17. It is worth emphasising that in addition to investigating a death with the requirements of section 28 (1) in mind, a coroner is under an obligation also, whenever appropriate, to make recommendations with respect to ways of preventing further deaths and “on any other matter that the coroner considers appropriate”. These sections outline the parameters in which an inquest operates.

Law and Principle

18. In *Harmsworth v State Coroner* [1989] VR 989 Nathan J said at 995 that a coroner's source of power arises from the particular death. His Honour made the point that a coroner does not have general powers of inquiry; that any inquiry must be relevant in the legal sense to the death the subject of the inquest. In *Quinlan v Deputy State Coroner* [2000] NSWSC 434 Bryson J said "an inquest is not an occasion for investigating… behaviour or events which do not bear upon the manner and cause of death". It is also quite clear that a coroner is obliged to attempt wherever possible to determine what the "real cause" of a death the subject of an inquest was. In *ex parte Minister of Justice; re Malcolm* [1965] NSWR (SC) 1598 McClemens J drew a distinction between what he described as the 'terminal' and the 'real' cause of death.

19. At 1604 His Honour said:

> "The problem of causation has bedevilled philosophers for centuries and will do so in the future. If a man is knocked down by a car and the injury to his system is such that it causes heart failure, does he die from injury or from heart failure? If a senile person who has been sinking for weeks slowly into death contracts terminal pneumonia and that actually carries him off, does he die of senile degeneration or does he die of terminal pneumonia? Without examining such things as precipitating causes, contributing causes, *causa sine qua non* and all the other elements of causation, suffice it to say that I think where the Coroners Act speaks of the cause of death that means the real cause of death; namely, the disease, injury or complication, not the mode of dying as e.g. heart failure, asphyxia, asthenia et cetera".

Ex-parte Malcolm (supra) was recently followed in *Raymond-Hewitt v Northern Territory Coroner* [2011] NTSC 94, a case concerned with whether an autopsy should be carried out. In that case the court quashed a finding made after inquest concluding that the coroner had misconceived the nature of the inquest since he found that the deceased, Mr Malcolm, whose death was the subject of the inquest had died of pneumonia but ignored completely the fact that he appeared to have been poisoned by a toxin in the course of his employment.

20. Although the requirement to find the identity of any person who contributed to the cause of a death was abolished early in 2015 with the repeal of section 28 (1) (f) of the Act, provided there is sufficient causal connection with the death the subject of an inquest, then issues associated with contribution still can, in my view, appropriately fall for coronial scrutiny. The test is one of ordinary legal causation as the Australian Capital Territory Supreme Court made clear in *R v Doogan; ex parte Lucas – Smith and ors* (2006) 158 ACTR 1 at paragraph 24.

21. Although that case was concerned with the review of a coronial inquest in relation to bushfires the principles are apposite. The court said:

> "A line must be drawn at some point beyond which, even if relevant, factors which come to light will be considered too remote from the event to be

regarded as causative. The point where such a line is to be drawn must be determined not by the application of some concrete rule, but by what is described as the "common-sense" test causation affirmed by the High Court of Australia in *March v E & M H Stramare Pty Ltd* [1991] 171 CLR 506. The application of that test will obviously depend upon the circumstances of the case and, in the context of a coronial inquiry, it may be influenced by the limited scope of the inquiry which, as we have mentioned, does not extend to the resolution of collateral issues relating to the compensation or attribution of blame".

22. In *March v E & M H Stramare* (*supra*) the High Court made clear that the "but for" (or '*causa sine qua non'*) test was no longer the law (although it might be in appropriate circumstances a useful "aid in determining whether something is properly to be seen as an effective cause of something else" per Deane J at 552). The court emphasised that causation is essentially a question of fact in that the question as to whether something is causative of an outcome is to be determined by reference to common-sense and experience.

23. In my view the proper approach is to identify, to the extent possible, the factors which brought about a deceased person's death and to make recommendations where appropriate or comments as necessary. As has already been noted the inquiry is not one at large. It must necessarily be limited to a consideration of how the particular death, the subject of the inquest, came about. This involves considerations of both causation and remoteness. The inquiry is constrained to investigate the *particular* death and make recommendations and comment upon matters which relate to the *particular* death. In so doing the appropriate approach, consistent with principle, is the application of what might be described as the "usual" test for causation as explained by the High Court in *March v E & M H Stramere* (*supra*).

24. Necessarily the application of the common-sense test of causation in this case (or any other) will depend on the particular circumstances of the case. So long as there is an identifiable common-sense causal link between the matters which a coroner is investigating and required to make findings about pursuant to section 28 of the Act, then a coroner has both jurisdiction to hear evidence about those matters, and to make findings, comments and recommendations as the case may be.

Matters for Inquiry

25. Before the commencement of the inquest proper the following were outlined as being the matters for inquiry:

    a. What Rules and Regulations were adopted by CAMS and Octagon in the sanctioning and running of Targa for 2013 and the reasons for the adoption of the Rules and Regulations which were in place including the reasons for not adopting the CAMS Tarmac Rally Standing Regulations?

    b. What safety precautions were taken in respect to the design of each stage

of Targa (and in particular stage 1)?

c. Whether speed limiting devices were in use on the stages of Targa and if none were used what consideration was given to the use of such devices?

d. What safety personnel were engaged at Targa and what were their roles and how were these roles defined?

e. Why the maximum average speeds specified in the CAMS Tarmac Rally Standing Regulations were not enforced for 2013?

f. What system was in place for breathalysing drivers before they commenced to drive in the event on each day?

g. Whether there was a beginners briefing prior to the commencement of Targa, and if not, why not?

h. What was the minimum personal safety equipment and whether HANS type devices were required as part of the minimum requirements?

i. What role, if any, CAMS, as sanctioning body, and Octagon, as organiser, play in respect to the use of pace notes by drivers, and in particular, the use of pace notes purchased by drivers from outside sources? and

j. What the contractual arrangements were between Octagon and CAMS in respect to the running of the 2012 and 2013 Targa events?

26. It was with these matters in mind, as well as the requirements imposed by section 28 of the Act, that the evidence was adduced at the inquest. The extent of the coronial jurisdiction to inquire into some of these matters was contested by some of the interested parties.

27. I am satisfied, after hearing submissions in relation to each, that each issue is an appropriate area of inquiry. Each is, in my view, sufficiently causally related in a common-sense way, to Mr Mansell's death. It seems to me that that the applicable rules and regulations, which control and regulate the event in which a competitor met his death are matters which are directly relevant to any inquiry concerned with how that death occurred. Similarly, issues in the context of a death of a competitor in a rally relating to safety precautions, speed limiting devices, safety personnel and speed generally are all matters properly within the jurisdiction of a coroner inquiring into a death such as this.

28. In the same way, the consideration of the testing regime with respect to alcohol in events such as Targa is, in my respectful view, completely within the proper consideration of a coroner, as are broader considerations such as the minimum personal safety equipment required by competitors.

29. Consideration of the contractual arrangements as between Octagon and CAMS in respect of the running of the 2012 and 2013 Targa events was also contentious. In my view, enquiry in relation to those contractual arrangements is within

jurisdiction because clause 8.5 of the contract which applied to the running of the 2013 event dealt expressly with the use (or perhaps more accurately non-use) of chicanes as speed limiting devices. Clearly speed is a matter into which, in a case such as this, a coroner not only is permitted to enquire but should enquire. *A fortiori* a provision in a contract which deals with that very issue is in my view a proper matter for enquiry at the inquest.

Findings of Fact

30. In reality there was little dispute in relation to the circumstances attending Mr Mansell's death. Mr Mansell was a competitor in the 2013 Targa Tasmania Tarmac Rally event. He was competing in a 2009 Porsche Cayman S owned by him (registered number 1CHILI, but with Targa petition number 933). His navigator (or co-driver) was Mr Tristan Craig Catford. Mr Mansell and Mr Catford met in Hobart in late January 2013 (a couple of months before the Targa event) and they competed in the Targa Wrest Point event utilising pace notes purchased from Smooth Line Stage Notes. Those pace notes were produced by Mr Bernie Webb and Mr Steve Glenney. During Targa Wrest Point Mr Mansell and Mr Catford achieved a "podium finish" in their Targa category; although it is noted that there were few competitors in their category.

31. Mr Catford gave evidence that as a result of their success in Targa Wrest Point they decided to compete in Targa Tasmania.

32. On 10 April 2013 Mr Catford and Mr Mansell met at the Launceston airport. They checked into their hotel in Launceston and then commenced to drive over stages of the Targa Tasmania rally in a hire car. When they did that they had with them a copy of the Targa Tasmania 2013 pace notes as prepared and supplied by Smooth Line Stage Notes.

33. The purpose of the driving of the stages was a reconnaissance. During the drive Mr Catford made highlights and extra notes in those pace notes where they required emphasis or additional detail.

34. Mr Catford gave evidence that they twice drove the Deloraine stage. It was on this stage that the crash occurred, and which subsequently claimed Mr Mansell's life.

35. In all four days were spent by Mr Mansell and Mr Catford covering the course. In the two days leading up to the commencement of Targa, having completed their reconnaissance, Mr Mansell and Mr Catford prepared the Porsche and attended to documentation and scrutineering.

36. On Tuesday 16 April 2013, Mr Mansell and Mr Catford completed, along with all other competitors, the George Town prologue. They completed the prologue, I find, without incident although it is apparent from in-car footage shown at the inquest that Mr Mansell had some difficulty following Mr Catford's clear instructions.

37. After the prologue Mr Mansell and Mr Catford returned to Launceston. Mr Catford

spent the night at the Launceston Country Club Casino. Mr Mansell was staying at the Balmoral on York Hotel where he was apparently a regular guest.

38. Mr Mansell and Mr Catford dined with a group of other persons associated with Targa that evening at the Black Cow restaurant in Launceston. Mr Catford said that Mr Mansell "enjoyed a drink" over dinner. Mr Catford did not drink any alcohol that evening. When the meal came to an end Mr Catford took Mr Mansell back to the Balmoral on York Hotel. He described Mr Mansell's character as being entirely normal; that is to say, he was not affected by, or so it appeared to him, alcohol.

39. Mr Catford then returned to his accommodation at the Launceston Country Club Casino.

40. The next morning, Tuesday 17 April 2013, Mr Catford and Mr Mansell went to the Silverdome, just outside Launceston, where the Porsche had been secured overnight. They collected the vehicle and drove out of the Silverdome at 8.24am. No breath test was administered to either Mr Mansell or Mr Catford (although it is noted that breath tests had been administered the previous day by Tasmania Police during the George Town prologue and that Mr Mansell's body was found after his death to contain alcohol).

41. Mr Mansell drove the Porsche to the start of the first competitive stage not far from Exton, near Deloraine, arriving there at approximately 9.10am. At the start of that stage the vehicles lined up in order for the stage to begin. Pre-event checks were carried out by checkpoint officials (or stewards).

42. At 9.12am they commenced the stage. Mr Mansell was driving and Mr Catford was in the passenger seat. The whole stage was captured on a "GoPro" portable digital camera, the footage from which was subsequently downloaded and tendered at the inquest.

43. Approximately five kilometres after the start the Porsche reached a crest in the road. At the crest the vehicle became airborne. I find, that Mr Mansell lost control of his vehicle when he drove it at a speed in excess of 200 km/h over that crest. As the vehicle travelled over that crest it became airborne, in the sense that all four wheels ceased to be in contact with the road surface. The vehicle landed, swerved to the right, rotated through 180°, left the bitumen surface and collided with a large gum tree. Standing very close to the tree was a photographer, Mr Juris Puisens. Mr Puisens is a professional full time photographer. In the six years prior to 2013 he had travelled to Tasmania, and photographed, Targa as an officially accredited event photographer. Mr Puisens has been photographing motorsport for 13 years, including V8 Supercars between 2003 and 2007 and the Australian Rally Championship between 2000 and 2007. In his affidavit tendered at the inquest he said that he saw Mr Mansell's Porsche come over the crest and that as it did so it "appeared to be travelling at about 20 to 30% faster than other vehicles" he had already seen travel over the same crest.

44. Mr Puisens described looking through the viewfinder of his camera and seeing the Porsche completely leave the road and land heavily nose first very close to him.

He heard the front of the vehicle impact with the ground (something subsequently confirmed by further investigation). He saw the Porsche slide around in a clockwise direction and continue to slide sideways off the road flattening vegetation for about 30 metres until it impacted on the rear quarter of the passenger side of the vehicle with a large tree.

45. Immediately after the crash Mr Puisens saw flames coming out of the rear of the vehicle (where the engine is). He put his camera down and ran to the top of the crest to alert following competitors by waving his reflective vest. Mr Puisens was able to stop the next three vehicles, and competitors from those vehicles used their fire extinguishers to tackle the flames coming from the Porsche.

46. Mr Puisens continued to wave at, and slow down, oncoming competitors who he noted were still coming through at race pace. It was, he said, about 10 to 15 minutes before vehicles slowed down.

47. The impact of the Porsche with the tree caused fatal injuries to Mr Mansell. Mr Catford was terribly injured. He suffered, amongst other things, fractures to his C5 – C7 vertebrae ultimately requiring the fusing of those three vertebrae. Fortunately he made a full physical recovery.

48. Police and emergency services were on the scene not long after the crash happened. Senior Constable Nicholas Crawford, an officer with Tasmania Police stationed at Deloraine Police Station, was the first police officer on the scene. In his affidavit, made under the Act and tendered at the inquest, he said that on 17 April 2013 he was conducting road closure duties on Porters Bridge Road, Exton. At about 9.15am he overheard a transmission on the police radio which indicated a crash had occurred on the stage. At that point no further details were available to Senior Constable Crawford. He continued with road closure duties and shortly after was directed to leave his position and attend the crash as it had been by then identified as involving a fatality.

49. Senior Constable Crawford headed north, approximately 4.5 kilometres along Porters Bridge Road, until he came upon the scene of the crash. He said that he noticed upon arrival the red Porsche with Targa plate number 933 off to the side of the road having sustained heavy damage. The driver (Mr Mansell) was still in his seated position with his harness attached. Senior Constable Crawford described him as slumped over and deceased. The passenger, Mr Catford, was being treated by Targa medical personnel but was still trapped inside the vehicle.

50. Senior Constable Crawford noted that the road conditions appeared mostly fine apart from some dew on parts of the road surface and certainly there was nothing to suggest any rain had fallen in the time immediately preceding the crash. Senior Constable Crawford commenced the formal investigation in relation to the circumstances of Mr Mansell's death pursuant to the *Coroners Act* 1995.

51. Senior Constable Peter McCarron, attached to Launceston Forensic Services, arrived at 10.00am. He took a number of photographs as well as collected forensic samples for later analysis. Senior Constable McCarron's affidavit was

tendered at the hearing along with the photographs that he took.

Crash Investigation

52. At about 10.45am experienced Tasmania Police crash investigator, First Class Constable Nigel Housego, along with Sergeant Nick Clarke, arrived at the scene. First Class Constable Housego gave evidence at the inquest. Neither the substance of his evidence nor his qualification to give it were challenged. Further, the methodology that he used to reach several conclusions, and those conclusions, were not the subject of any challenge. I have no hesitation in accepting First Class Constable Housego's evidence.

53. Constable Housego gave evidence that he had attended 41 fatal motor vehicle crashes and a similar number of serious motor vehicle crashes in his 21 years as a police officer. He outlined his experience in crash investigation and in particular his work in the Northern Crash Investigation Section where he has been posted full time since October 2009. He outlined his formal qualifications to the Court which, as I have mentioned, were not challenged.

54. Constable Housego assumed responsibility for the investigation into the crash. When First Class Constable Housego arrived, Mr Mansell's body was still in the driver's seat of the Porsche. Mr Catford had been extracted from the wreck and taken to the Launceston General Hospital in what was then a critical condition. The scene had been fully preserved and, by then at least, the whole race stage cancelled. First Class Constable Housego's investigation into the circumstances surrounding Mr Mansell's death commenced at the scene. He said that he inspected the site and surrounding area noticing tyre scuff marks and scrapes in the road surface as well as scuff marks, gouges and vegetation damage on the northern side of the roadway. First Class Constable Housego marked the scene with yellow paint. Senior Constable McCarron, who as has already been noted was already at the scene, took numerous photographs of the scene at the direction of First Class Constable Housego.

55. Whilst Constable Housego was at the scene the mortuary ambulance arrived and Mr Mansell's body was removed from the wreck of the Porsche. His body was transported to the Launceston General Hospital and formally identified to police by Mr Stuart Benson. From there, Mr Mansell's body was transported to the mortuary at the Royal Hobart Hospital. At the Royal Hobart Hospital an autopsy upon the body of Mr Mansell was carried out pursuant to the Act. I will deal with the forensic pathology aspects later in this finding.

56. Constable Housego gave evidence that the road surface on that portion of Porters Bridge Road leading up to the site of the crash was constructed of a coarse aggregate bitumen mix in good condition. There were no surface defects. At the time of the crash the road was both dry and free from any loose material. Enquiries conducted both at the scene and of the Tasmanian Bureau of Meteorology records confirmed that no rain fell on that day and in particular no rain fell in the lead up to the crash. I am satisfied nothing about the weather or the

road surface caused or contributed to the happening of the crash.

57. Porters Bridge Road is oriented in a north-west direction. First Class Constable Housego described it as a two way rural road that travels between the Meander Valley Highway at Exton and River Road, Deloraine. Although the road surface is sealed and in good condition there are no line markings or sealed edges and vegetation grows very close to the road edge.

58. Constable Housego said the crash site was situated five kilometres from the stage start. He described the road as having a slight downhill gradient of 3.3% which then sharply dropped off to a steep gradient of 8.75%, which in turn decreases to 1.66%, 58 metres west of the commencement of the drop-off (or crest).

59. Constable Housego described thick scrub and vegetation as growing approximately three metres either side of the sealed roadway. The sealed surface of the road is 5.7 metres wide at or about the crash site. A small gravel verge and a shallow ditch separate the sealed edges of each side of the road from the scrub and vegetation.

60. He said that 90.4 metres west of the crest, and well beyond the crash site, signs had been placed by Targa Tasmania officials on each side of the road warning of another crest in the road. The relevant crest, that is to say, the crest immediately before the crash scene was not marked in any way and specifically no warning signs were in place at, near or before that crest.

61. Constable Housego gave evidence that clearly visible on the road surface were four tyre yaw marks which commenced 43.9 metres west of the top of the drop-off. Those yaw marks were depicted in photographs taken by Senior Constable McCarron and tendered at the inquest.

62. Also clearly visible was the place where the four yaw marks left the road edge. First Class Constable Housego gave evidence about observing deep gouges in the road verge. He said, and I accept, that those gouges were continuations of those yaw marks. Also apparent, and also photographed, was the flattening of vegetation in a direct path following the gouges. First Class Constable Housego said he noticed three gum trees, approximately five metres from the northern edge of the road that had clear fresh impact marks. The trees were located between 107.1 and 114.9 metres from the top of the drop-off referred to earlier. A further 21.5 metres west of those trees and 4.9 metres from the northern road edge the Porsche Cayman S Coupe was stationary facing north away from the road edge.

63. Constable Housego said the Porsche had obvious and extensive damage to the left side and left rear. The damage that he reported seeing at the scene was completely consistent with the damage depicted in the photographs tendered at the inquest and the damage observed by the Transport Inspector Mr Maclean. It is apparent that it was all damage sustained in the crash.

64. As a result of data collected at the scene and observations made, Constable Housego was able to conduct a speed analysis in relation to the crash. He gave evidence that in crash reconstruction, a skid test to determine co-efficient of friction road surface, is required to conduct a speed analysis. He did that on the afternoon of the day of the crash and was able to calculate a co-efficient reading of 0.817. He said, and I accept, that he had conducted numerous skid tests in the past. First Class Constable Housego was satisfied that the co-efficient reading of 0.817 was acceptable as the co-efficient of friction for the particular road surface.

65. Utilising an accepted equation and a computer programme designed for the task, First Class Constable Housego performed a series of calculations. Ultimately it was his conclusion that the minimum speed of the Porsche at the commencement of the yaw was 156 km/h. During the investigation of the crash it emerged that the Porsche was fitted with electronic devices that provided evidence supporting that calculation. Specifically the vehicle was fitted with a rally safe GPS tracking device. That device corroborated Constable Housego's calculation of the vehicle's speed.

66. Moreover, the Rally Safe device and video footage taken from the "GoPro" camera mounted in the cabin of the Porsche show that at the time the Porsche became airborne over the drop-off or crest, it was travelling at 200 km/h (at least). Upon landing and commencing to yaw the speed reduced, but it was still travelling extremely fast.

67. Constable Housego gave evidence, again unchallenged, and again which I accept, that upon impact with the tree the vehicle was travelling at 154.5 km/h.

68. The speed at which Mr Mansell was travelling was, of course, the logical reason why when he lost control of the vehicle it crashed into the tree causing his death. That speed, and the reason for it, need to be examined carefully and in context. I will return to a consideration of the vehicle speed later in this finding.

Findings at Autopsy

69. In evidence tendered at the inquest Dr Christopher Hamilton Lawrence, the State Forensic Pathologist, said as follows:

> "this 71-year-old man, John Ernest Mansell, died as a consequence of neck, chest and abdominal injuries following a single motor vehicle collision. Other significant contributors include ischaemic heart disease.
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> ….
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> Autopsy reveals extensive injuries to the lower thoracic region and the upper abdominal region, some lower neck injuries and sub arachnoid and sub dural haemorrhage to the brain. The major injuries appear to have occurred in the lower part of the thorax and the upper part of the M2 them, possibly due to some form of compression. [Mr Mansell] had severe ischaemic heart disease and severe atheroma which has contributed to the damage to the abdominal

aorta which was the major source of bleeding. It appears likely the ischaemic heart disease probably accelerated death due to other injuries.

Toxicology reveals a low level of alcohol (0.012g/100 mL). It is unlikely this contributed.

One issue that probably should be considered is whether this man was fit to undertake high speed driving given his cardiac condition."

70. I accept this evidence; like almost all the evidence at the inquest it is not the subject of challenge. I find accordingly that the cause of Mr Mansell's death was the neck, chest and abdominal injuries he sustained in the motor vehicle crash.

Mechanical Examination of the Porsche

71. The Porsche was towed from the scene and taken to the Launceston Police garage at Youngtown. There it was the subject of an extensive examination by Mr Paul Maclean, a Transport Inspector. Mr Maclean made an affidavit pursuant to the Act in which he set out the details of his experience and qualifications as well as his findings as a result of that examination. Neither his experience, expertise nor his findings were challenged. I accept both his qualification to express the opinion that he did and the opinion that he expressed.

72. It was Mr Maclean's view that the Porsche Cayman S was roadworthy prior to, and at the point of, impact with the tree. Mr Maclean was unable to locate any mechanical defects in the vehicle which may have caused or contributed to the crash. I am satisfied that this was so.

The Speed of the Porsche at the Time of, and the Lead up to, the Crash

73. The investigation in relation to Mr Mansell's death involved a broad consideration of the circumstances surrounding the crash. Most significant was the fact that it was ascertained that Mr Mansell took the crest at 200 km/h, a much higher speed than any other driver in the previous year over the same stage; most notably Mr Jason White, the winner of Targa Tasmania rally in 2012. A consideration of the speed and any reasons for it were, I consider, essential in the context of the inquest. In respect of Mr Mansell's driving in general and speed in particular I was particularly assisted by the expert evidence of Mr Ed Ordynski.

74. Mr Ordynski was until his retirement a full time, professional rally driver for over 30 years. He was the Australian Rally champion and winner of the Australian Group N Rally Championship four times. Mr Ordynski has competed extensively in World Rally Championship events in Sweden, Finland, New Zealand and Australia as well as Asia – Pacific Rally championship events in Japan, Thailand, New Zealand and Australia. He has participated in major rallies in China, Indonesia and Malaysia. In 1995 in a two-car team along with the famous Peter Brock, he was the winner of the 20,000 kilometre "Round Australia Rally".

75. Mr Ordynski was employed as a factory driver for team Mitsubishi Rally Art, as well as Holden and Volvo. He was a sponsored driver for Subaru and Toyota during his career. He was team Mitsubishi's lead driver in Australia and also drove for Mitsubishi's World Rally Championship team and the Asia-Pacific factory team.

76. In 2001 he was voted Australian rally driver of the year. On eight occasions he received Mitsubishi's worldwide rally driver of the year award. He was awarded the Australian Sports Medal in 2000, a national award given to acknowledge and recognise national sporting excellence. That medal has also been awarded to, amongst others, Sir Donald Bradman, Eddie Charlton and John Bertram.

77. Mr Ordynski has competed in the famous Bathurst 1000 motor car race and in a number of other production car races at circuits in Australia. He competed as a driver for the Holden team in Targa Tasmania in 1993 and also Rally Tasmania, a tarmac rally in North-West Tasmania.

78. In 1994 he was asked by the then organisers of Targa Tasmania to conduct a safety review of the event.

79. For many years Mr Ordynski was the competitor advisor to CAMS Australian Rally Commission. He chaired that Commission in 2007. He has chaired four CAMS commissions of inquiry into fatalities in rallying and was a panel member of the fifth inquiry. Four of those five commissions of inquiry were concerned with tarmac rallies such as Targa Tasmania.

80. Mr Ordynski has in the past provided training services to both South Australian and Queensland police. He is an international coach of rally competitors. A significant amount of the training provided by Mr Ordynski as a trainer and coach has focused upon the use of pace notes in rallies.

81. CAMS submitted that his experience as an organiser and administrator is limited and much less than other witnesses. I reject this submission. In my view his level of actual expertise and involvement in tarmac rallies is unparalleled. The level of experience in relation to competition and administration possessed by Mr Ordynski was significantly superior to all other witnesses. Most importantly, he was in my assessment entirely independent of the process. It is not without significance that CAMS have on four occasions in the past chosen him to chair commissions of inquiry into fatalities in rallying, including tarmac rallies. CAMS recognise, by reason of having Mr Ordynski act on its behalf as a member of the FIA Asia-Pacific Rally championship working group, his high level of expertise.

82. Finally I note Mr Ordynski's unchallenged evidence that following Mr Mansell's fatal crash he was contacted by Mr Bruce Keys from CAMS who requested Mr Ordynski's assistance by, amongst other things, viewing and commenting upon the in-car vision by then in the possession of the police and taken from the "GoPro" camera. Plainly CAMS recognised Mr Ordynski's expertise.

83. Mr Ordynski was in my view uniquely placed to provide assistance to the inquest

by way of expert evidence for, quite apart from his unchallenged credentials set out above, he was the driver of a course car 999, commonly called the sweep vehicle, during Targa Tasmania 2013. He was accompanied by Mr Adam Carr, the former event checker.

84. Mr Ordynski explained the role of the sweep car is to follow competitors as the last vehicle in the field. He said “the competing cars in order from slowest, at the front of the field, the fastest at the rear and the [sweep car] started each Targa stages as close to thirty seconds behind the final car as possible. Competitors are not permitted to fall behind the sweep. This keeps competitors moving to schedule within the road closure window. Sweep may also be the first vehicle at a serious incident to the final car – normally next competitor is first on the scene; obviously the final car has no next competitor”.

85. When he arrived in the sweep car at the start of the Porters Bridge Road stage emergency services turned into the stage at speed. Mr Ordynski said, and this was not challenged, competing cars were still being dispatched “albeit at touring speeds, as that stage had been downgraded due to a serious incident”.

86. Mr Ordynski and Mr Carr travelled on Porters Bridge Road and came upon the scene of the crash. They attempted to contact Targa Rally HQ but were unable to do so as there was neither radio coverage nor mobile service at that point. They retraced their steps until they were in phone range, contacted HQ, and generally took charge of the scene.

87. Subsequently, and as has already been mentioned, at the request of CAMS and Tasmania Police Mr Ordynski viewed the in-car footage. That footage included not only the stage on Porters Bridge Road but also footage of the prologue the day before at George Town. Mr Ordynski said that when viewing the footage he was essentially looking at whether the crew would follow the normal pre-stage procedures.

88. Mr Ordynski said that Mr Catford appeared to him to carry out his functions as co-driver entirely professionally. However there were several indicators that Mr Mansell was not, perhaps, as professional in his approach, which in turn leads me to conclude, accepting the evidence as I do from Mr Ordynski, that Mr Mansell did not possess the necessary experience or requisite skill to be driving at the speed that he was.

89. First, the window of the Porsche was down and Mr Mansell appeared to ignore the windows check ‘call’ during the pre-stage briefing by Mr Catford. Mr Ordynski said that noise from a window open at high speeds can be very loud and distracting. It is noted that the window was open during the prologue as well as stage 1. The significance, of course, to the window being open is that the noise can diminish the driver’s ability to hear the pace notes properly.

90. Second, a water bottle was not appropriately stowed by Mr Mansell, being placed in a cup holder rather than in secure stowage. This might be thought a small matter but in my view it is not. In the event of a crash, inappropriately stowed

articles within the cabin of any vehicle become missiles that could cause injury quite apart from the effects of the crash. In addition the failure to properly stow an article is indicative, in my view, of a less than professional approach to the dangerous job of driving a high performance motor vehicle at very high speed on tarmac roads. Mr Ordynski described the failure to properly store the water bottle as "irregular" and highlighted its potential to become a deadly projectile. The other point is, as Mr Ordynski also pointed out, loose items like water bottles can also become lodged under the pedals of the vehicle and potentially cause a crash.

91. Third, and critical in my view, was that it was Mr Ordynski' s view, and quite apparent when viewing the in-car footage that was played at the inquest, that during the George Town prologue there was apparent confusion on the part of Mr Mansell responding to Mr Catford's clear instructions. As to this Mr Ordynski said:

> "while on the start line, [Mr Catford] reads the first line of the pace notes and [Mr Mansell] seems to have no idea what the call means, despite it being a simple kink, visible through the windscreen."

92. Mr Mansell's confusion was plainly apparent on the footage played during the inquest.

93. Most importantly Mr Ordynski was able to view, and interpret from the perspective of a highly experienced professional rally driver, the footage of the moments leading up to the fatal crash. He said that Mr Mansell appeared to be relaxed, steering with small inputs, and appeared to place the car accurately on the road. Mr Ordynski said that in the moments leading to the crash that Mr Catford called from the pace notes, correctly, "care, stay right over drop, air". However he said that Mr Mansell did not stay right and did not reduce speed, probably not heeding (or possibly not even hearing) the call at all. The reason for his failure to heed or hear that call may well be the noise of the wind through the open window. Mr Ordynski noted that an experienced driver would slow down if not hearing clearly or in doubt about where the navigator is on the notes, especially on such a fast and tricky piece of road. This was particularly so when there was no competitive reason whatsoever to be driving as fast as Mr Mansell was in the immediate lead up to the crash.

94. In the moments leading to the crash he said, and the in-car vision was clear, that in the final few metres before the crest Mr Mansell was steering slightly to the left (and not to the right as he should have been). This in turn was confirmed by data taken from the Rally Safe unit fitted to the car. He said that as soon as the photographer, Mr Puisins, came in to vision it was apparent that left lock was applied by Mr Mansell. He said that the car flew towards the left hand side of the road and Mr Mansell then straightened the wheel and applied a very small amount of right lock. Mr Ordynski said that the car continued to yaw left while airborne so on landing it continued to go left. He said "perhaps as a result of that, the driver pulls on a very large amount of right lock – far too much, as it is nearly a quarter turn of steering input which, to put in perspective, is probably enough steering in a Porsche to take a T-junction".

95. Important evidence from Mr Ordynski about the immediate lead up to the crash was, and I accept that:

> "an experienced driver would know it is imperative to make only very small inputs with the steering if the car flies at 200 km/h – indicating John Mansell's lack of experience in such situations. Most importantly, an experienced driver would not attempt to take this crest at 200 km/h, as confirmed by other rally safe tracking, including the fastest driver in the event, Jason White, but considerably slower after braking noticeably for the crest."

98. It should be clear from the foregoing, and I find, that the primary cause of Mr Mansell's death was because, as Mr Barclay submitted, he was driving too fast over the crest, became airborne, and lost control. In turn his lack of experience contributed to his decision to drive at the speed that he was. For the reasons I have already expressed, I consider that the reason why he was travelling at the speed he was, aside from his lack of experience, is sufficiently causally connected to his death to be examined in some detail.

Defined Matters for Enquiry

(a) Rules and Regulations

99. As I have already indicated the regulatory framework of the event, and the Rules and Regulations in force, are sufficiently causally related to Mr Mansell's death to require examination. The evidence was that the following rules and regulations were in use for the 2013 Targa Tasmania Rally:

    a) The International Sporting Code of FIA;

    b) The National Competition Rules of CAMS;

    c) The Targa Tasmania Supplementary Regulations 2013;

    d) Any bulletins issued by the organisers for the time being in force; and

    e) The route instructions.

    It was clear and common ground that the CAMS Tarmac Rally Standing Regulations (TRSR) were not in force. Mr Ordynski expressed the opinion that they should have been in force. No witness could satisfactorily explain why they were not. Indeed the TRSR are expressly designed to regulate tarmac rally of which Targa Tasmania is the preeminent example in the country.

100. As Mr Barclay submitted, and there is no dispute about this, the TRSR regulate, amongst other matters the following:

    - The maximum average speed for stages of 132 kph;
    - If the maximum average speed is exceeded in the previous year then the stage will not be run the following year unless measures are taken to limit the speed

- The use of speed limiting devices;
- The option for maximum speed limits;
- Untimed warm up stages;
- Specific event personnel (safety assessor, event checker, event observer) and their duties; and
- Specific requirements for stage security, event planning, road closure officials.

I consider that the TRSR should have been applied to the event. As I have said no witness could explain, satisfactorily, why they were not in force. Mr Smith and Mr Waldon both addressed the issue of the TRSR's non adoption for the event, but their evidence on the issue was not in the least persuasive. It may be true that the TRSR do not have force of law and are not mandatory in operation, and while I accept that it is arguable that even if in force they would not necessarily have prevented Mr Mansell's death, that they were not in force bespeaks, to me at least, a surprisingly amateurish approach to the organisation and running of an inherently very dangerous activity.

101. I am satisfied the reason the TRSR were not in force was because no official gave them any thought at all. The various witnesses expressed a series of assumptions as to the adequacy of the regulatory framework which applied to the 2013 event, and those assumptions were not justified; especially in light of the fact that I am satisfied they were never even considered.

102. Had the TRSR applied in 2013 then at the very least, as Mr Barclay submits, issues such as average speed and speed limiting devices would have had to have been considered. Because the TRSR were not in force then those matters appear to have escaped any attention at all. This is extremely unfortunate.

(b) Safety Precautions – for each stage and stage 1 in particular

103. There was no evidence at the inquest about the design of stages generally and little specific evidence about the design of stage 1. There is evidence that the stage had been used in previous years, certainly in 2012, although the past configuration of the stage was not clear to me. However what was clear on the evidence was that what passed for a review of the safety of each stage was utterly inadequate. The evidence about safety review was, as best I understood it, that stage 1 in 2012 was reviewed after the event and found to have no safety issues identified relating to it. However there were no minutes of that safety review produced, seemingly because there were none. No outcome of the review was recorded anywhere. The utility of conducting a review without records being kept is, to say the least, doubtful. In fact I am doubtful anything in the nature of a formal review even took place and, even if it did, as I have said it served no purpose whatsoever.

104. I am satisfied that had a proper, formal review been undertaken, then at the very least it would have been apparent that the maximum speeds for stage 1 were high. This in turn may well have led to a more formal review of the stage and at least consideration being given to the utilisation of speed limiting devices. Had this

occurred and speed been limited in some way, either by the use of physical or virtual chicanes or even the placing of a warning sign at the approach to the crest, then the high terminal speed reached by Mr Mansell immediately prior to the crash would have been unlikely.

105. The other aspect of the failure to undertake a formal system of review of the course design and safety is that it is indicative of a generally poor approach to safety.

(c) Speed Limiting Devices

106. It was common ground that speed limiting devices were not in use on stage 1. Indeed, Mr Benson gave evidence that the only speed limiting device on stage one was the driver's right foot, that is to say the brake on the vehicle being used to compete. I have already touched upon the absence of any formal review. The position of the organisers seems to be during evidence that the base time was a form of speed limiting device. That assertion was abandoned, and rightly so, for on no reasonable view of the base time system could it be said that it operated, and is anything in the nature of a speed limiting device.

107. The failure at least to consider the use of speed limiting devices was in my view directly as a result of the informal and amateurish approach to course review. I have already said that it cannot be said that had a speed limiting device in the form of physical or virtual chicanes been in place then the crash which claimed Mr Mansell's life would not have occurred. However, the error in my view was the failure to even consider the use of such devices on the stage. At the very least the use of speed limiting devices should have been considered as part of a proper safety review.

(d) Safety Personnel

108. The various safety personnel were identified by Mr Benson in evidence. There was vagueness about the various roles, a vagueness which would not have occurred had the Targa Tasmania Supplementary Regulations been in place. I say this because those regulations define with precision the roles and responsibilities of each of the safety positions.

109. Again it is not possible to conclude that the lack of definition of roles played any particular part in the crash which caused Mr Mansell's death. Indeed the evidence suggests that the response of the various safety personnel, with the exception of the fact that cars continued to travel through stage 1 at race pace for a considerable period of time, was entirely appropriate. That having been said, I accept Mr Barclay's submission that it is not ideal that most of the responsibility for safety seems to rest on the shoulders of one person, that is to say, the course checker. I consider this needs to be addressed.

(e) Maximum Average Speeds

110. It was common ground on the evidence that maximum average speeds were not enforced. Maximum average speeds were not enforced because the Tarmac Rally

Standing Regulations were not in force. The reason why they were not in force has already been dealt with.

111. There is an undoubted tension, identified by Mr Stanton, between the safety of competitors in events such as Targa, and the enjoyment experienced by participants as a consequence of driving powerful cars at speed. I accept as Callinan J said in *Agar v Hyde* (2000) 201 CLR 552 (whilst talking about rugby union, but the principles are the same) that:

> *"In practically every sport safer rules could be adopted. Should the international body controlling cricket have been held liable for not prescribing the wearing of helmets by batsmen before the West Indian cricket selectors unleashed upon the cricketing world their aggressive fast attack of the 1970s? Should cricket be played with a soft, rather than hard ball? Should hockey sticks be made of semi-rigid materials only?"*

I accept also that the participants in events such as Targa participate because considerable enjoyment is derived by them from the risks associated with the challenge of driving a powerful car on tarmac very quickly. Expressly, I do not conclude that the fact that the maximum average speed of 132 km/h was not in force directly contributed to Mr Mansell's fatal crash. However, in my view, at the very least, the question of maximum average speeds is something that ought to have been considered when a formal review of the safety of each particular stage was undertaken. It is self-evident that no such review, and no such consideration, was undertaken. It should have been.

(f) Breathalysing of Drivers

112. It was a condition of the permit issued by the Commissioner of Police for the running of the event that the organisers were responsible for the breathalysing of competitors. As has already been touched upon Mr Mansell had alcohol in his blood at the time of the crash. As such he ought not to have been driving in the event. He should not have been allowed to start the stage at all. However, the presence of alcohol in his blood was not detected as he was not required to undertake a breath test before competing for the first stage. Whilst I do not conclude that the level of alcohol in his blood contributed to the crash occurring, at the risk of repetition the point is, he ought not to have been driving at all.

113. The evidence was that the organisers of Targa have recommenced compulsory breath testing of all participants prior to each stage. This is to be commended and should continue.

(g) Beginners Briefing

114. The evidence at the inquest was that there was no 'beginners briefing'. A beginners briefing is a special, separate, briefing for first-time competitors in the event. I accept that a beginners briefing would add little to the standard briefing. I note also that there was no evidence as to the content of a beginners briefing. The evidence

was that a beginners briefing for all first-time competitors was introduced (or perhaps reintroduced) to the Targa Tasmania event in 2014.

115. It is not possible to conclude, and I do not, that the absence of a beginners briefing caused or contributed to Mr Mansell's fatal crash. However I commend the organisers for the decision to introduce beginners briefings. It seems to me that the beginners briefing emphasises for first-time competitors the safety aspects that need to be focused on in an event such as this.

(h) Personal Safety Equipment – HANS Devices

116. Evidence was led as to the minimum safety requirements for each competitor, in terms of personal safety equipment. That equipment was a fire retardant racing suit, helmet, footwear and gloves. Mr Mansell met these minimum safety requirements. The applicable standards were subject to regulation by CAMS.

117. HANS devices were not, in 2013, part of the compulsory personal safety equipment requirements. Mr Mansell was not wearing one; Mr Catford was. Mr Mansell died in the crash and Mr Catford did not, although the evidence does not allow a conclusion that had Mr Mansell been wearing a HANS device he would have survived. In fact, his injuries were crush injuries and it is doubtful that a HANS device would have made any difference to his chances of survival.

118. The evidence also was that effective from July 2013 (that is to say, for all subsequent Targa type events) the wearing of a HANS device was mandatory for all classes of cars except for the classic car category (quite why classic cars are excluded was not apparent on the evidence). In any event, the requirement of competitors to wear a HANS device whilst competing is welcomed.

(i) Pace Notes

119. The use of pace notes in events such as Targa was examined in some detail at the inquest. It was apparent on the evidence that commercially prepared pace notes are ubiquitous, and purchased pace notes extremely widespread both at Targa and in events of a similar type. Mr Catford gave evidence that for Targa Tasmania 2013 he and Mr Mansell "purchased pace notes from Smooth Line Stage Notes produced by Bernie Webb and Steve Glenney" (Mr Webb gave evidence at inquest). He said that he used those pace notes during Targa Wrest Point and Targa Tasmania, and that he made his own pace notes for each stage as well.

120. The evidence was that pace notes are a driver's description of every key feature of every stage. They include information as to where to position the car properly on the road. They are read by the navigator or co-driver to the driver as the event is being participated in. Mr Ordynski said "to make the notes is very time-consuming for a long event like Targa and [that] professional drivers would probably spend around seven days making their pace notes for the first time… [and that] inexperienced crews would take longer". He explained that inexperienced crews (in other words non-professional drivers) routinely shortcut the pace notes writing

production process by buying commercially produced pace notes. That is what occurred in this case.

121. Mr Ordynski gave evidence that the use of commercially produced pace notes purchased from an outside supplier was common in Targa Tasmania. He highlighted however a number of potential problems with the purchase of commercially produced pace notes. Before I turn to deal with those issues I wish to make it clear that there is no criticism of the notes produced and sold by Mr Webb and Mr Glenney. Similarly, there is no basis to reach a conclusion that the manner the pace notes were used by Mr Catford caused or contributed to the fatal crash.

122. However Mr Ordynski gave evidence, and I accept, that the use of pace notes by inexperienced drivers and co-drivers can be dangerous. He said in effect, and I find, that a lack of investment in the compilation of the knowledge contained in the pace notes can lead to a false sense of security. The importance of pace notes in Mr Ordynski's view was the production of them, that is to say, driving the stages, examining every detail, and dictating it. He said this cannot be replicated by purchasing someone else's notes. So much is, I find, correct. However the reality is that the nature of events such as Targa Tasmania, in which non-professional crews routinely participate (in fact make up the vast majority of the competitors), means that the use of externally produced pace notes will continue to be commonplace, if only because the non-professional crews simply do not have the time and resources to create their own. The difficulty is that relying heavily on unfamiliar notes, or worse notes of poor quality, could lead competitors into positions of extreme danger. I emphasise that there is no suggestion in this case that the notes were deficient in their quality. However it seems to me, given that the use of pace notes is ubiquitous, that some system of accreditation would be appropriate. As Mr Barclay submitted, persons of the calibre of Mr Ordynski and Mr Webb may well be the precise type of persons who could assess those applying for accreditation. Whilst various problems were identified by CAMS and other interested parties none of the problems seem to me to be insurmountable. None of the problems in relation to issues associated with accreditation and the like stand in the way of at least a consideration of the concept of accreditation. None of the problems in my view, in any way, impact unfavourably upon the running of the event. In fact, it seems to me that an accreditation system can only enhance the enjoyment of the participants and increase their safety.

123. It was quite clear on the evidence that neither CAMS as sanctioning body nor Octagon as the organiser played any role whatsoever in respect of the use of pace notes in events sanctioned or organised by either. Certainly neither organisation provides pace notes to any drivers nor sanctions the use nor sanctions the product of any particular producer. I accept that once again the use (or abuse) of pace notes was not causative of the fatal crash. There was evidence which I have already touched upon of plain confusion on the part of Mr Mansell in the George Town prologue in responding to Mr Catford's very clear and professional reading of the notes, but that was not a factor which contributed to the crash. That aside, the issue of accreditation of those who produce for sale pace notes to competitors at

least needs to be considered.

(j) Contractual Arrangements between Octagon and CAMS

124. The final issue identified in advance of the inquest for consideration at the hearing was what the contractual arrangements between Octagon and CAMS were as to the running of the 2012 and 2013 Targa events. The relevance of the contractual arrangements was that clause 8.5 of the contract that governed the 2013 event expressly provided that chicanes were not to be used. Once this clause was operative the effect of it was to ensure that no speed limiting devices, whether virtual or actual in the nature of chicanes, were even considered. Mr Smith and Mr Benson both gave evidence that it was their understanding that the clause was intended only to relate to physical chicanes (and not virtual chicanes) but that was not the effect of the clause.

125. No witness could explain why it was considered necessary to have clause 8.5 in the contract at all. It is difficult to conceive of a reason why it was included and, as I have already said, the consequence of it was that nothing in the nature of speed limiting devices was considered – a regrettable state of affairs indeed in the context of the event that was regulated by that contract. I accept that the positioning of physical chicanes can be problematic. In this case however, in the lead up to the place where a fatal accident occurred, there was a relatively straight section of road that ought at least to have been considered for a physical or virtual chicane. It was not. The reasons why it was not considered at least include, or so it seems to me, to be clause 8.5 of the contract. The failure to consider the use of actual or virtual chicanes was exacerbated by the informal and amateurish review system to which I have already averted. In my view this situation should be addressed.

Formal Findings:

126. Pursuant to Section 28 (1) of the *Coroners Act* 1995 I make the following formal findings:

   a) The Identity of the deceased is John Ernest Mansell;

   b) Mr Mansell died in the circumstances outlined in this finding;

   c) The cause of Mr Mansell's death was injuries sustained by him in a motor vehicle crash, in particular neck, chest and abdominal injuries;

   d) Mr Mansell died on Porters Bridge Road near Deloraine in Tasmania on the morning of Wednesday 17 April 2013; and

   e) Mr Mansell was born in Launceston on 14 October 1941 and was 71 years of age at the time of his death; he was a married man and a business owner when he died.

Recommendations:

127. Pursuant to section 28 (2) of the *Coroners Act* 1995 I recommend:

i. that the CAMS Tarmac Rally Standing Regulations (TRSR) apply to the running of any future events;
ii. that there be compulsory alcohol testing for all competitors before all stages, in all future events;
iii. that there be a formal, transparent system of review of course design and safety after each event, including the recording of the outcomes of the review;
iv. that consideration be given to the appointment of a safety assessor to assist the event course checker;
v. that there be a separate beginners briefing for all first-time competitors in the event;
vi. that the use of HANS devices be mandated for all competitors;
vii. that consideration be given to the accreditation of those who prepare pace notes for sale, including a system of uniformity of symbols and meanings; and
viii. that the contractual prohibition on the use of chicanes (real and/or virtual) be dispensed with.

Concluding Comments:

I express my thanks to counsel, and in particular Mr Barclay, for the assistance afforded to me in this matter.

I commend First Class Constable Housego for the highly professional investigation he conducted into Mr Mansell's death.

In concluding I convey my sincere condolences to the family and friends of Mr John Ernest Mansell.

Dated: 20 January 2016 at Hobart in the state of Tasmania

Simon Cooper
Coroner