MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Oswyn Leigh Fitzgerald

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

a) The identity of the deceased is Oswyn Leigh Fitzgerald;
b) Mr Fitzgerald died as a result of injuries sustained in a motor vehicle crash on 18 March 2017 at Baskerville Raceway;
c) The cause of death was blunt injuries of the head and neck; and
d) Mr Fitzgerald died on 19 March 2017 at the Royal Hobart Hospital in Tasmania.

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

Mr Fitzgerald was born in Hobart on 8 January 1947 and he was aged 70 years. Mr Fitzgerald and his son, Christopher Fitzgerald, had a shared interest in car racing for many years. For the most part Mr Fitzgerald was a pit-crew member, but approximately five years before his death he started racing cars himself.

Mr Fitzgerald had a history of ischaemic heart disease which culminated in coronary artery bypass surgery in 2010. Specialist examinations until 2013 describe his post-operative condition as being extremely stable. Subsequently, Mr Fitzgerald was transferred to the care of his general practitioner and had only sought treatment for common ailments.

On Saturday 18 March 2017 Mr Fitzgerald was scheduled to participate in the Tasmanian Super Series Round Two at Baskerville Raceway in Old Beach.

At 7.30am Mr Fitzgerald and Christopher arrived at Baskerville Raceway. Mr Fitzgerald's vehicle, a 1971 yellow Mini Morris, passed the scrutineering safety check. Christopher then spent approximately an hour preparing the vehicle, checking the tyre pressures and ensuring adequate fuel levels.

At approximately 8.30am a drivers' briefing was conducted during which time race protocols were addressed and copies of the briefing notes were provided to all drivers participating in the race.

At approximately 8.40am Mr Fitzgerald prepared himself for the practice warm-up session which was due to commence at 9.00am.

Mr Fitzgerald completed the warm-up lap and then successfully completed a second lap. On the third lap, Mr Fitzgerald's vehicle was observed by witnesses to approach the top of the 'S' bends at which time its speed decreased considerably before continuing to travel much slower than was anticipated for that corner, estimated at 40km/h. As the vehicle exited the corner on a downhill section, it drove off the track and continued without any apparent braking, acceleration or steering. It then crashed into a tyre wall, colliding at a speed estimated by witnesses to be 50-60km/h.

Track marshals immediately attended the crash site followed by ambulance officers. Mr Fitzgerald was not conscious and in ventricular fibrillation. He was treated for approximately 50 minutes before being transferred to the Royal Hobart Hospital. Upon medical assessment, it was ascertained that Mr Fitzgerald had suffered significant head trauma (a CT scan showed the presence of extensive subarachnoid haemorrhage), and also that he had likely suffered a cardiac event. Despite surgical intervention, Mr Fitzgerald passed away at around 3.00am on Sunday 19 March 2017.

Police officers, including officers from Forensic Services and Crash Investigation Services, attended the scene of the crash. They conducted an assessment of the scene and obtained relevant evidence (including witness affidavits) for investigation of the crash. The evidence obtained was consistent with Mr Fitzgerald being unconscious before and at the time of the crash.

I am satisfied that weather and track conditions did not contribute to the crash. Although inspection of the vehicle revealed several issues with its structural integrity, these faults did not contribute to the crash.

Dr Donald Ritchey, forensic pathologist, conducted an autopsy upon Mr Fitzgerald. He concluded that the injuries to the head and neck sustained by Mr Fitzgerald caused death. However, he noted that there was advanced natural disease of the heart and blood vessels including remote coronary artery bypass grafts and an evolving acute myocardial infarct in addition to an old infarct scar. He stated that this advanced natural disease would be sufficient to account for death under different circumstances. However, the presence of the fatal traumatic injuries that occurred during the crash precluded the possibility of successful resuscitation following a probable cardiac arrhythmia prior to the accident.

The evidence allows me to conclude that Mr Fitzgerald suffered a cardiac arrhythmia in the moments prior to the crash. This caused him to slow his vehicle abruptly and then to lose control of it so that it veered off the track and crashed.

Comments and Recommendations:

I extend my appreciation to investigating officer Constable Hannah Schuurmans for her investigation and report.

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

I convey my sincere condolences to the family and loved ones of Oswyn Leigh Fitzgerald.

Dated: 23 February 2018 at Hobart in the State of Tasmania.

Olivia McTaggart
Coroner