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 Mr Darren Stuart Clark

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

a) The identity of the deceased is Mr Darren Stuart Clark;
b) Mr Clark died as a result of injuries sustained in a single motor vehicle collision;
c) The cause of Mr Clark's death was atlanto occipital dislocation and a transection of the aorta; and
d) Mr Darren Stuart Clark died on 19 August 2017 at Forester, Tasmania.

Introduction

1. Darren Stuart Clark died when the 1979 Mazda RX7 he was driving in a car rally in North East Tasmania left the road and crashed into a tree stump. Mr Clark was aged 49 at the time of his death. He was the holder of both a Tasmania driver's licence and a licence issued by the Confederation of Australian Motor Sport Ltd (CAMS). It is apparent he had a number of years' experience competing as a driver in motorsport rallies. He had a history of having competed in several state and club races. From 2014 onwards he had competed in a number of gravel rallies in Tasmania with the same navigator Mr Keegan Buckley.
2. Mr Clark had been competing in motorsport rallies since at least 2008. He had completed relevant Rally course checker training.
3. Mr Buckley was also an experienced competitor. In addition he was an active CAMS official holding a silver stage commander and timekeeper licence.
4. At the time of his death Mr Clark was driving in the Scottsdale Classic Rally with Mr Buckley as his navigator. The vehicle he was driving was lawfully registered, mechanically sound and fitted with all CAMS required safety equipment. The equipment included a roll cage, race seats, race harnesses, fire extinguishers and first aid equipment. Relevantly the car was fitted with Kuhmo Rally tyres which were fit for purpose and in good condition with approximately 8 – 10 mm of tread above the tread wear indicator.
5. During the event and at the time of the crash both Mr Clark and Mr Buckley were wearing CAMS approved helmets, forward head restraint devices (HANS devices) and protective motorsport suits.
6. The vehicle was also fitted with a Rallysafe system. Rallysafe is a system that comprises a unit for the vehicle which, amongst other things, enables real-time global tracking coverage and a sophisticated alarm system.
7. Mr Clark and Mr Buckley were supported by Mr Timothy Gadsby who performed the role of their service crew for the rally. Mr Gadsby had known Mr Clark for many years. Both

men had competed in rallies on and off over a long period of time. Mr Gadsby described Mr Clark as a "great driver, not short of any talent". Mr Gadsby was very familiar with the Mazda. Together he and Mr Clark had restored the Mazda Mr Clark was driving when he died.[1]

8. At the time of his death Mr Clark was living with his wife of 23 years Theresa. Together they had an 8-year-old son. Mr Clark was a partner in a business dealing in industrial laundry machines.
9. The evidence suggests that Mr Clark was in good health. He had been diagnosed with depression in early 2016 for which condition he was medicated at the time of his death. The drug venlafaxine was prescribed for him and he was taking it at the time of his death.

The Rally

10. On Saturday, 19 August 2017 the North West Car Club held an organised rally near Scottsdale. The rally – the Scottsdale Classic Rally 2017 – was held primarily on closed forestry roads. As the event is a gravel rally none of the roads upon which it was conducted were sealed. Mr Clark was entered in the Classic Rally Car Class.
11. The "philosophy" of the Classic Rally Car Class is to allow cars to be presented "in competition a similar form to that which they appeared in the era of Rally competition more than 30 years ago".[2]
12. The club had secured all necessary permissions including a CAMS organising permit issued on 14 August 2017, a permit to hold the event issued by Tasmania Police and the necessary permits from the local council and Forestry Tasmania.
13. The Rally's Clerk of the Course (or Event Commander) was Mr Stephen Peters. I am satisfied Mr Peters held the necessary CAMS qualifications to perform that role. Mr Peters was responsible for oversight of the running of the entire rally. Mr Peters was assisted by an assistant Clerk of the Course Mr Stephen Mott.
14. In addition to Mr Peters and Mr Mott the event had two stewards, Mr Wayne Richards and Mr Lynn Rattray both of whom held the necessary CAMS stewards licenses to perform those roles.[3] The event had a certified Course Checker Mr Michael Ashton-Luscombe.
15. A private ambulance, with an appropriately qualified paramedic, was present at the event.
16. The North West Car Club was affiliated with CAMS. CAMS classify the event as a Multi-Club Special Stage Rally. The rally operated under a number of sets of rules and regulations. These included:
    - the International Sporting Code of the Fédération Internationale de l'Automobile (FIA);
    - CAMS' National Competition Rules (NCR);
    - the National Rally Code (NRC); and
    - Any supplementary regulations and bulletins, instructions and route instructions that may be issued.

[1] Affidavit of Timothy Gadsby sworn 5 September 2017
[2] CAMS Scottsdale Rally fatality report 15 September 2017 at page 3
[3] I note the CAMS organising permit for the event issued 14 August 2017 indicates a third steward Matthew Von Bertouch and a Chief Scrutineer Vern Little

The material obtained through the investigation into Mr Clark's death suggests the Car Club complied with all of the applicable rules and regulations to the extent necessary, with two exceptions identified below.

17. The Scottsdale Classic consisted of 14 special stages separated by transport stages. Transport stages are sections designed to take vehicles to the start of the next section in a non-competitive fashion. They take place on open public roads. The special or competitive stages took place on closed, unsealed forestry Roads. The special stages totalled 164.24 km and the transport stages 152.36 km.
18. Perhaps obviously, the transport stages imposed minimal driving and navigational demands upon the driver and his or her passenger. The event documentation makes it clear the driver should "take it easy" and obey all applicable speed limits whilst on a transport stage. In contrast the special sections are competitive sections where driving and navigational demands were pronounced. The crash which claimed Mr Clark's life occurred on a special stage.
19. All competitors were provided by the organisers with a road book. The road book is a diagrammatic depiction of the stages of the rally. It consists of a number of pages of maps and so-called "tulip" diagrams. Tulips, or ball and arrow instructions, are diagrams of the route junctions with the ball indicating the direction a competitor has travelled from and the arrow the direction towards which a competitor is headed.
20. The content of the road book (or route instructions) is governed by the CAMS National Rally Code, part 6.
21. The rally did not involve the use of pace notes. Pace notes are a common feature of what might be described as more professional rallies such as Targa Tasmania. They are a driver's description of every key feature of every stage. Pace notes are much more detailed than the information contained in a road book. Pace notes are specifically designed to be read by the navigator or co-driver to the driver as the driving is actually taking place.
22. In contrast a road book provides an overview of the route to be taken, provides a guide to the general route to be taken and is a record of all notable features of the route which may affect the way a driver approaches it. Details typically included are distance between features, the degree and severity of bends, adverse road camber, the location of crests and hills, surface typing conditions, significant potholes and any special instructions to the driver.
23. On the second page of the Scottsdale Classic road book a disclaimer appears in which competitors are advised not to rely exclusively upon the road book (which in that part of the road book is described as "route instructions") when estimating the degree of severity of any hazard or the manner in which any section of the road is to be driven.
24. On the first page of the briefing notes under the heading "safety" the following appears:

    > "The rally is NOT pace-noted. Tulips are NOT pace notes. They are a guide only to what you see on the road, but not necessarily accurate to pace note level. Please drive on what you can see, and read the stage advice at the start of the stage instructions."

25. The circumstances in which the road book was created is unclear on the evidence. However it was informed by a CAMS pre-event check carried out by Mr Ashton-Luscombe and Mr Peters on 28 July 2017. Mr Ashton-Luscombe said that as a result of the check, he

made some changes to the road book. In particular he changed the entry dealing with the location of the fatality. Mr Ashton-Luscombe said that the "particular corner of Stage SS8 was changed from a simple road goes to the left to the 'care' tulip in the road book". He said it was his opinion at the time that there was no need for a caution.[4]

26. I observe that the National Rally Code at page 26 contains 'standard Tulip Information' along with gates, culverts, banks and so forth, one of the tulips depicted is a 'Log'. 'Log' is marked as a caution, with one exclamation mark. Mr Clark's Mazda left the road and collided with a large log (or stump), the only such log on that side of the road for a considerable distance.
27. I note that the crash happened at the location the subject of Tulip 18 in the road book which appears at the top of page 72. The previous Tulip, Tulip 17, is the last entry on page 71. There is only a distance of approximately 100 metres between the features covered by tulips 17 and 18 but they appear on different pages. This is an apparent breach of the National Rally Code, part 6 (j) and/or (k). Those parts require closely related information (i.e. within 200 metres) not to be separated and the combining of information less than 100 metres apart into one tulip.
28. Mr Buckley, whilst checking the road book and planning the rally prior to starting, did not notice the short distance between the two tulips.[5] It is likely that he would have been alerted to the closeness of the entries if either Part 6 (j) or (k) of the National Rally Code had been complied with.
29. I also note the road book at page 68 has a map with SS 9 Start and Finish on it but is headed SS 8. I do not consider in the circumstances that this error misled either Mr Clark or Mr Buckley and is therefore not a factor which either caused or contributed to the death the subject of inquiry. However it is a matter that should, in my respectful opinion, be attended in the event the road book is ever used again.
30. Mr Clark and Mr Buckley had the Briefing Notes and Road Book with them in the Mazda when they were competing in the rally.
31. Before taking part in the rally, all vehicles underwent a pre-race safety check. In the case of this matter the check occurred on either 14 or 16 August 2017.[6] The fact of the pre-race safety check having been performed is recorded on an undated Scrutineers Report, signed by 'DS Wiggins 886490'. The identity and role of this person is not clear on the evidence. He or she is not mentioned anywhere in any of the event documentation.
32. I note that the fact of the pre-race check is not recorded in the Mazda's CAMS vehicle logbook #2005 0737.
33. On the day of the event each driver was, in accordance with a condition imposed by the Tasmania Police permit, breath tested. The evidence is that no driver, including relevantly Mr Clark, returned a positive result.[7]

[4] Affidavit of Michael John Ashton- Luscombe, sworn 21 Sept 2017

[5] Affidavit of Keegan Buckley, sworn 24 august 2017

[6] The CAMS fatality report at page 4 says scrutineering was completed on 14 August. In contrast the Tasmania Police Crash Investigation Services report of 1 March 2018 at page 3 says the pre-race safety check occurred on 16 August. It may be that scrutineering and pre-race safety checks are different (although the terms are used interchangeably) but this is unclear on the evidence.

[7] This is a contrast, and a positive one, to the Targa Tasmania Event in 2013, see In Re Mansell [2016] TASCD 001

34. A briefing for all 20 competitors was conducted at the Scottsdale RSL club commencing at 8.30am on the morning of the rally. All drivers submitted an event entry form at the briefing which the driver, co-driver and service crew all signed. At the briefing, crews were made aware of an amendment to the road book.
35. The cars then left the briefing and commenced competition. The weather was fine. Seven stages were completed without incident.

Circumstances of Death

36. The accident in which Mr Clark died occurred on special stage 8, 11.07 km into that stage at about 5.25pm. The stage was taking place on Williams Hill Road approximately 24 km north north-east of Scottsdale. Mr Clark and Mr Buckley were the second car on the stage.
37. Data obtained as part of the investigation indicates that the first car on the stage travelled through the area of the crash over 10 km an hour slower than Mr Clark.
38. Subsequent interrogation of the Rallysafe data indicated that as the Mazda approached a left hand corner at 90 km an hour Mr Clark reduced speed to 82.8 km an hour as he entered the corner. The vehicle then drifted toward the right road edge and commenced an anti-clockwise side slip rotation. It then left the road and collided with a large tree stump. The tree stump was situated approximately 1.1 m from the south eastern edge of the road. It was approximately 1 m high and 1.75 m in diameter. It was the only stump (or indeed obstruction of any type) in an otherwise cleared area.
39. The location of the crash is marked in the road book at page 72 as being a single caution "care R.G. L." (Road Goes Left). No additional information is contained in the road book about the location. Specifically the stump is not singled out for any attention.
40. The vehicle's driver's side door area was the point of most impact. The driver's door was forced inwards and was detached from its hinges and the Mazda's A pillar was significantly deformed as a result of the collision.

Investigation

41. The competitor following Mr Clark's vehicle (Mr Peter Barrett) arrived at the scene of the crash within a minute or so. Mr Barrett alerted rally officials by means of the alarm on his Rallysafe unit. The Event coordinators were already aware of the crash because of Mr Clark's Rallysafe unit which automatically issued an alert following the crash. He then extinguished the engine (which was on fire) and had his co-driver move further up the road to alert any other competitors approaching the scene.
42. Before any emergency responders arrived Mr Barrett attended to Mr Clark and Mr Buckley. He was unable to locate any vital signs on Mr Clark but noted that Mr Buckley, whilst unconscious was clearly breathing.
43. Emergency responders were quickly on the scene. The first to arrive was the Ambulance Private paramedic Mr Philip Triffett. Assisted by other people at the scene attempts were made at CPR on Mr Clark. SES personnel, paramedics from Ambulance Tasmania and police arrived at the scene. Nothing could be done to resuscitate Mr Clark and he was pronounced dead at the scene.

44. The first police to arrive at the scene were Sergeant Hansen and Constable Wadley from Scottsdale and Bridport respectively. They arrived at about 6.20pm (having received a call at approximately 5.30pm to attend the crash). While Constable Wadley began taking details, Sergeant Hansen managed the scene. He provided situation reports to the police radio room and coordinated notifications of other resources such as Ambulance Tasmania, the medevac helicopter, SES, Tasmanian Fire Service, Tasmania Police Crash Investigation Services and Forensic Services. The scene proved impossible to secure intact given the number of people that were present attempting to provide assistance to both Mr Buckley and Mr Clark.
45. Mr Buckley was taken from the scene by road ambulance. Although injured he made a good recovery. When interviewed some weeks after the crash, Mr Buckley had no recall of the crash or its immediate aftermath.
46. After their arrival, officers from Crash Investigation Services and Forensic Services took over the investigation. The examination of the scene took several hours and was assisted by volunteer SES personnel staying at the scene to operate portable lights. Because the scene had been significantly disturbed by the movement of vehicles and people in the immediate aftermath of the crash as Mr Clark and Mr Buckley were attended to, investigators were unable to clearly determine whether marks on the roadway were yaw or acceleration marks. This in turn meant that a speed analysis using data collected at the scene could not be conducted. However the vehicle's Rallysafe GPS tracking device recorded and stored speeds relevant to the crash. The information obtained from an interrogation of that data was invaluable in the investigation.
47. After it had been photographed and formally identified,[8] Mr Clark's body was removed from the scene and transported by mortuary ambulance to the Royal Hobart Hospital. At the Royal Hobart Hospital an autopsy was carried out by the State Forensic Pathologist Dr Christopher Hamilton Lawrence. Dr Lawrence found that Mr Clark died as a consequence of an atlanto occipital dislocation and transection of the aorta.[9] I accept Dr Lawrence's opinion. In plain English, Mr Clark died of a broken neck and a torn aorta. The injuries he suffered in the crash were unsurvivable and his death was effectively instantaneous.
48. Samples taken at autopsy were subsequently analysed at the laboratory of Forensic Science Service Tasmania. No alcohol or illicit drugs were identified as being present in those samples. The prescription antidepressant medication desmethylvenafaxine was identified as being present at a level in the "high therapeutic" range.[10] Mr Clark's medical records indicate that the drug - a selective serotonin reuptake inhibitor - was one prescribed for him. Low levels of paracetamol and an antihistamine agent were also detected in the samples taken at autopsy. Dr Lawrence expressed the opinion, which I accept, that the antidepressant medication is unlikely to have affected Mr Clark's driving. There is no evidence at all that Mr Clark's driving was in any way impaired. Indeed Mr Buckley described him as being his "normal self" and "driving really well".[11]
49. The Mazda RX 7 was carefully examined by a Transport Inspector several days after the crash. The inspector expressed the opinion that prior to and at the time of the crash it was

[8] Affidavit of Andrew Wayne Hanson, 19 August 2017
[9] Affidavit of Christopher Hamilton Lawrence, Forensic Pathologist, 5 October 2017
[10] Affidavit of Miriam Connor, Forensic Scientist, 15 September 2017
[11] Affidavit of Kegan James Buckley, 24 August 2017

mechanically sound. No faults or failures were identified that may have caused or contributed to the happening of the crash.[12] I accept the inspector's opinion. I am satisfied that Mr Clark's death was not due to any mechanical issue or defect.

Conclusions

50. I am satisfied on the evidence that neither drugs nor alcohol caused or contributed to the happening of the crash. Neither did any mechanical deficiency on the part of the vehicle. I am satisfied that Mr Clark was suitably experienced, fit and properly equipped and licensed at the time of his death. The weather conditions and road itself (recognising the limitations of a gravel surface) played no role in Mr Clark's death.
51. It is clear that the fatal crash occurred when Mr Clark lost control of his vehicle as he entered, at speed, a left hand bend. Less clear is what contribution was made to the happening of the crash by the deficiencies identified in the road book, in that the relevant tulips were on different pages and arguably given the distance separating them, should have been combined into one tulip.
52. The stump or log should, in my view, have been marked with a caution tulip, as envisaged by the National Rally Code, page 26. It was the only obstruction or danger on the right hand side of the road, near or just after the apex of a left hand bend. Because it was not marked no driver or navigator had warning of its presence.

Comments and Recommendations

53. I extend my appreciation to investigating officer Constable Darren Chynoweth for his investigation and report.
54. The circumstances of Mr Clark's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.
55. I convey my sincere condolences to the family and loved ones of Mr Clark.

Dated 11 September 2019 at Hobart in the State of Tasmania.

Simon Cooper
Coroner

[12] Affidavit of Michael Ronald Leonard, Transport Inspector, 25 September 2017