FINDINGS and COMMENTS of Coroner Simon Cooper following the holding of an inquest under the *Coroners Act* 1995 into the deaths of:

Shane Navin, Leigh Mundy, Dennis Neagle and Anthony Seymour

Table of Contents

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the deaths of Shane Navin, Leigh Mundy, Dennis Neagle and Anthony Seymour with an inquest held at Hobart in Tasmania, make the following findings:

Hearing Dates

24-26 September 2024 at Hobart, Tasmania

Representation

SJ Knott – Counsel Assisting the Coroner

B Hodgkinson AM SC and K Edwards SC – Motorsport Australia

G Stevens and N Pearce-Rasmussen – Commissioner of Police[1]

D Jordan SC and E Sullivan – Targa Australia

K Andrews – Mrs Sandra Seymour

Introduction

1. Targa Tasmania is a world-renowned motor sport event conducted on the roads of Tasmania. First held in 1992, the event is a tarmac rally in which purpose-built (or modified) rally cars compete on sealed closed roads in competition stages. Competition stages involve the competitors starting at 30 second intervals where the cars race for the fastest time with the winner being the fastest over all the stages. In addition to the competition aspect of Targa Tasmania, a Targa Tour also takes place. That event, not relevant to this inquest, is non-competitive and not timed.

2. Over the history of Targa Tasmania six competitors have died whilst participating in the competition. Three of those deaths occurred in 2021 and one further death in 2022.

[1] The Commissioner of Police was granted leave to appear at the inquest in relation to potential issues surrounding the grant of permits to conduct both events. However, it became apparent that there were, in fact, no issues associated with the grant of either permit and thus Mr Stevens was granted leave to withdraw.

3. Shane Navin died on the morning of Friday, 23 April 2021 at Double Barrel Creek on the Lyell Highway between Queenstown and the Derwent Bridge. He was driving a 1979 Mazda RX-7 Series One motor vehicle, car number 602, in Targa Tasmania competition stage 26 when the vehicle left the roadway, travelled down an embankment and came to rest upside down in the creek. Mr Navin was trapped in the vehicle with his head and face underwater. Despite the efforts of his co-driver (sometimes also referred to as a 'navigator'), Mr Glenn Evans, Mr Navin drowned in the car.

4. The following day, during the Cygnet Targa Tasmania competition stage 33, Mr Leigh Mundy, the driver, and Mr Dennis Neagle, his co-driver, both died when their vehicle, a 2019 Porsche 991 GT3 RS, car number 902, left the road at the 6.2 kilometre mark of the 15.69 kilometre stage at high speed and crashed into a large tree. Both men were killed instantly.

5. There was no more competition in that year's Targa Tasmania, officials deciding to suspend all further competition.

6. The following year, on 26 April 2022, during the first full day of competition in Targa Tasmania, Mr Anthony (Tony) Seymour died in a crash on the Mt Roland competition stage 7. The vehicle he was driving, car number 903, with his wife, Mrs Sandra Seymour, as co-driver, was a 2013 Lotus Exige. The vehicle left the road approximately 11.4 kilometres into the stage, impacted with, and broke, a cable 'Brifen' barrier at a speed of about 61 km/h, before sliding down a steep embankment and came to rest on its right-hand side with the roof impacting on a large tree. Mr and Mrs Seymour were both trapped inside the vehicle. Mr Seymour died at the scene; Mrs Seymour survived.

7. Like the Porsche in which Mr Mundy and Mr Neagle died the year before, the Lotus Exige driven by Mr Seymour was, in effect, a racing car, designed to be driven on a race circuit.

The role of a coroner

8. Before considering the circumstances of each man's death in further detail, it is necessary to define the general role of the coroner. In Tasmania, a coroner is an independent judicial officer and has jurisdiction to investigate any death that appears

to "*have been unexpected, unnatural or violent or to have resulted directly or indirectly from an accident or injury*".[2] Each death in this inquest meets that definition.

9. A coroner may hold an inquest (which is a public hearing) into any death that the coroner has jurisdiction to investigate "*if the coroner considers it is desirable to do so*".[3] In this case, having regard to the similarity of each death and the close temporal connection of each, I considered it was desirable to hold an inquest. I also took the view that there was significant public interest, both within the motor sport community and amongst the general community of Tasmania in the circumstances surrounding each death being publicly, independently, and transparently examined.

10. When conducting an inquest, a coroner performs a role different to other judicial officers. The coroner's role is inquisitorial. An inquest might be best described as a quest for the truth, rather than a contest between parties to either prove or disprove a case. In an inquest, a coroner is required to thoroughly investigate the death and answer the questions (if possible) that section 28(1) of the *Coroners Act* 1995 (the "*Act*") asks. Those questions include who the deceased was, how they died, the cause of the person's death, and where and when the person died. It is settled law that this process requires a coroner to make various findings, but without apportioning legal or moral blame for the death.

11. A coroner is required to make findings of fact about the death from which others may draw conclusions. A coroner may, if she or he thinks fit, make comments about the death or, in appropriate circumstances, recommendations to prevent similar deaths in the future.[4]

12. It is important to recognise that a coroner does not punish or award compensation to anyone.[5] Punishment and/or compensation are for other proceedings, in other courts, if appropriate. Nor does a coroner charge people with crimes or offences arising out of a death that is the subject of an inquest.

13. As was noted above, one matter that the *Act* requires, is a finding (if possible) as to how the death occurred.[6] '*How*' has been determined to mean "*by what means and in what circumstances*",[7] a phrase which involves the application of the ordinary concepts

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[2] Section 3 of the *Coroners Act* 1995.
[3] Section 24(2) of the *Coroners Act* 1995.
[4] Section 28(2) of the *Coroners Act* 1995.
[5] Section 45(3) of the *Coroners Act* 1995
[6] Section 28(1)(b) of the *Coroners Act* 1995.
[7] *Atkinson v Morrow* [2005] QCA 353.

of legal causation.[8] Any coronial inquest necessarily involves a consideration of the particular circumstances surrounding the death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.

14. The standard of proof at an inquest is the civil standard. This means that where findings of fact are made, a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an inquest reaches a stage where findings being made may reflect adversely upon an individual, it is well-settled that the standard applicable is that expressed in *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation against anyone is proved should be approached with a good deal of caution.[9]

15. A coroner is not bound by the rules of evidence in holding an inquest and may be informed and conduct an inquest in any manner the coroner reasonably thinks fit.[10] To be properly received at an inquest, the evidence must be capable in some way of assisting the coroner to determine the matters under section 28(1) or, in appropriate circumstances, to assist in making a comment or recommendation. A coroner has significant latitude in receiving evidence, providing the evidence is something more than "*mere supposition, guess or intuitive hypothesis*". The question of weight to be given to any evidence tendered at an inquest is a question for the coroner after receiving submissions from interested parties.

16. The final matter that should be highlighted is the fact that the coronial process, including an inquest, is subject to the requirement to afford procedural fairness.[11] A coroner must ensure that any person (person includes a legal entity) who might be the subject of an adverse finding or comment is made aware of that possibility and given the opportunity to fully put their side of the story forward for consideration. To that end, all persons and entities considered to have sufficient interest in the outcome of the inquest, and who may have been at risk of adverse comment, were identified well in advance of the inquest, provided with notice, and invited to participate in that inquest. Their participation was facilitated by the complete disclosure of all material obtained as a result of the investigation under the *Coroners Act* 1995.

Evidence at the inquest

17. A number of witnesses gave evidence at the inquest. In order, they were:

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[8] See *March v MH Stramare Pty Ltd and Another* [1990 – 1991] 171 CLR 506.
[9] (1938) 60 CLR 336.
[10] Section 51 of the *Coroners Act* 1995
[11] See *Annetts v McCann* (1990) 170 CLR 596, *Attorney General v Copper Mines of Tasmania Pty Ltd* [2019] TASFC.

a) Mr Graham Malcolm – Targa Event Course Checker 2021;

b) Mr Glenn Evans – Mr Navin's co-driver;

c) Mrs Sandra Seymour – Mr Seymour's co-driver (and his Senior Next of Kin in terms of the *Coroners Act* 1995);

d) Mr Lynn Rattray – Motorsport Australia driver of Zero Car in 2021 and Competition Checker 2022;

e) Mr Stephen Horobin – Targa Event Course Checker 2022;

f) Mr Scott McGrath – Motorsport Australia Chief Scrutineer 2021 and Technical Delegate 2022;

g) Mr Sunil Vohra – current CEO Motorsport Australia;

h) Mr Hamish Marquis – Targa Clerk of Course 2021 and 2022;

i) Mr Mark Perry – current CEO Targa Australia Pty Ltd; and

j) Mr Garry Connolly AM, Chair, Motorsport Australia Review Panel.

18. I formed a favourable view of all the witnesses who gave evidence at the inquest. I considered all were honest and forthright and aided me in carrying out my function as defined under the *Act*. I will discuss the evidence of the witnesses later in this finding.

19. In addition to the verbal evidence from the witnesses listed above, a significant mass of documentary evidence was tendered at the inquest. Annexure to this finding. That material informed these findings. Full details of the material tendered is to be found at annexure A to this finding.

Scope

20. In advance of the inquest and only after receiving submissions from all interested parties, the scope of the inquest was determined to be as follows:

a) What rules and regulations were adopted by Motorsport Australia (MA) and Targa Australia Pty Ltd (Targa) in the sanctioning and running of Targa Tasmania for 2021 and 2022 and the reasons for the adoption of the rules and regulations which were in place.

b) What recommendations from the Targa Tasmania 2021 Investigatory Tribunal Report and Findings were implemented by MA and Targa in the sanctioning and running of Targa Tasmania for 2022 and if there were recommendations not implemented, the reasons for not implementing those recommendations.

c) What role, if any, MA, as the sanctioning body, and Targa, as the organiser, play in respect to enforcing compliance with the relevant rules and regulations and ensuring the overall safety of the event, including the implementation of the recommendations.

d) What were the contractual arrangements between MA and Targa, in respect to the running of Targa Tasmania for 2021 and 2022.

e) What system was in place for determining whether vehicles were compliant with the Technical Regulations.

f) What system was in place for determining the eligibility requirements of vehicles for the Technical Regulations.

g) What system was in place for determining competitors' eligibility to compete and what consideration was given to medical fitness to drive.

h) What safety precautions were taken in respect to the design of each stage of Targa Tasmania for 2021 and 2022 (and in particular, the Mt Arrowsmith, Mt Roland and Cygnet stages).

i) Whether speed limiting devices were in use on the stages of Targa Tasmania for 2021 and 2022 and if none were used, what consideration was given to the use of such devices.

j) Whether a Risk Management Plan was provided to the Commander of Police in accordance with the Permit to Conduct a Public Event Affecting Road Closures(s) dated 29 March 2021, and if so, what was that Risk Management Plan.

k) What version of the Rally Road Checker's Manual was in operation prior to April 2021.

l) What consideration was given to determining a stage a "wet stage" and what system was in place for declaring a "wet stage".

m) What training was provided to staff and competitors on the use and operation of the RallySafe system.

n) Was it a requirement of competitors to stop and render assistance when a RallySafe SOS alert was received, if not, why not.

o) What system was in place for tracking cars throughout each stage, including at each SOS point and what consideration was given to determining the SOS points in the stages.

p) What crew briefing was provided to competitors and what system was in place for ensuring that the competitors attended or otherwise viewed and understood the crew briefing.

21. I will return to the issue of the scope of the inquest later in this finding. It is appropriate now to describe in more detail the lives and deaths of Mr Navin, Mr Mundy, Mr Neagle and Mr Seymour.

Background – Shane Navin

22. Shane Navin was born in Ivanhoe, Victoria on 4 April 1953. He was 68 years of age at the time of his death. A resident of New South Wales, Mr Navin was married to Jennifer Navin. By profession he was a manager. Mr Navin was not, and never had been, a professional race or rally car driver. He was appropriately licensed to participate in Targa Tasmania.

23. He had extensive experience as a competitor in motor sport over a number of years. He first competed in Targa Tasmania in 2014 and took part in seven events including the one in which he died. He did not finish the 2019 Targa Tasmania as he crashed on the Mount Roland stage and wrote his vehicle off. In addition to Targa Tasmania, Mr Navin competed in Targa High Country (an event similar to Targa Tasmania but conducted in Victoria) and Targa's Great Barrier Reef events, amongst others. His health appears to have been good.

24. Following the Targa Tasmania 2019 event, Mr Navin bought a red 1979 Mazda RX7, but without either an engine or gearbox. He was able to fit the engine and gearbox from the vehicle written off in the 2019 event into his new vehicle. The installation of the engine and all pre-race preparation was carried out by a fully qualified mechanic.

25. The work included fitting electrical assisted steering, some minor cooling fabrication work and a complete re-wire and servicing of the brakes. I am satisfied that the vehicle in which Mr Navin was competing in 2021 was in good condition.

26. Mr Navin's co-driver for the 2021 Targa Tasmania event was Mr Glenn Evans. Mr Navin and Mr Evans had competed together in 10 tarmac rally events prior, including one Targa Tasmania prior to the 2021 event (on the other occasions Mr Navin competed in Targa Tasmania, his co-driver had been his son Ashley). The car was allocated the event number 602. At all relevant times both men were wearing all necessary and appropriate personal protective equipment including helmets, Head and Neck (HANS) devices, harnesses, race suits and the like.

Circumstances of death – Shane Navin

27. The evidence is that Mr Navin and Mr Evans arrived in Tasmania on Wednesday, 14 April 2021 with a plan to conduct a reconnaissance of a few stages close to Devonport (where they arrived by ferry). Accordingly, they carried out a reconnaissance of the Mount Roland, Castra, Golden Valley, Poatina and Riana stages (along with a few others) but not the Mt Arrowsmith stage, because Mr Evans said Mr Navin "*had a good knowledge of it*".[12]

28. The pair used commercially produced pace notes, sometimes referred to as race notes (Smoothline Stage Notes). Pace notes are a commonly (probably universally) used booklet which sets out a route for any particular event in extreme detail. Ordinarily, the notes will include details of turns, junctions, curves, crests and other relevant information. The co-driver uses the pace notes to provide advice and instruction to the driver during the course of any particular stage. The actual notes themselves were recovered by the crash investigator from Tasmania Police, Constable Sven Mason. The pages which deal with the Mount Arrowsmith stage highlight that accidents are common at the 33.9 kilometre and 33.4 kilometre marks. At the 34.9 kilometre mark, the words "bumpy" and "Double Barrell Ck" (as well as 7 RLng appear). The fact that the stage is wet is also noted in handwriting (probably that of Mr Evans).

29. I am satisfied that there is no issue with either the contents of the pace notes generally, the additions in handwriting nor the manner in which Mr Evans used them.

[12] Exhibit 2.38 - Affidavit Glenn Evans, sworn 25 April 2021, page 2 of 6.

30. Returning to the course of Targa Tasmania 2021, Mr Navin and Mr Evans then participated in the event without incident until the Mt Arrowsmith stage. They started that stage at about 9.40 am at Bradshaw Bridge, on the Lyell Highway east of Queenstown. The stage starts at Bradshaw Bridge and finishes at Derwent Bridge. The stage was 53.13 kilometre in length and Mr Navin died when the car he was driving left the road 35.5 kilometre into the stage. It was stage 26 of Targa Tasmania 2021.

31. Mr Graham Malcolm, the Event Course Checker said in his evidence at the inquest that when he checked the Mount Arrowsmith stage it was raining, and the road was wet. He said the rain was not particularly heavy, but he needed to have his windscreen wipers on.[13] Of the area where the fatal crash occurred, Mr Malcolm said:

> "*I found the Lyell Highway either side of Double Barrell Creek to be slippery but the corner on which the crash occurred was not un-duly slippery. I travelled through the area of the crash with an approach speed of 70 km/h, then through the corner at 70 – 80 km/h before accelerating out of the corner at 83/84 km/h. I entered the corner prior to the Double Barrell Creek sign on the right-hand side of the road and stayed on that side through the whole corner. There is a bump in the road, but it did not upset my car and I safely travelled through the area.*"[14]

32. I note that Mr Malcolm was driving a 2020 Skoda Octavia RS wagon – what might be described as an ordinary, average motor vehicle and not a race car or modified rally vehicle. I do not consider anything turns on that fact in the circumstances of this case. In particular, I do not consider that it impacted in any way upon Mr Malcolm's ability to assess the safety of the stage. In any event, following his assessment of the stage, the stage was declared wet and competitors made aware of the declaration by that fact being displayed on boards at the start of the stage. I am also satisfied that he carried out the other aspects of his role which included checking the correct positioning of SOS points and medical intervention vehicles. He confirmed that each SOS point could communicate with the start of the stage either through radio or by the use of satellite phones.[15]

33. Car 602 commenced the stage at 9.40 am. Mr Evans said that he and Mr Navin had no problems or incidents on the day of the crash. Both were made aware that the stage had been declared wet. As I have already mentioned, the pace notes include a handwritten note to that effect.

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[13] Exhibit 2.35 – Affidavit – Graham Malcolm, sworn 31 May 2021, page 2 of 2.
[14] *Supra*.
[15] *Supra*.

34. Mr Evans said that Mr Navin was driving safely and that he, (Mr Evans) at no stage felt unsafe. Mr Evans described in detail what occurred as Car 602 approached Double Barrel Creek:

> "*We drove through the stage at competitive speeds but not unsafe speeds. We never experienced any slipping off the road or any near misses. At the 33 km mark into the stage I told Shane that we had just entered the slippery section of the stage. We continued on for another couple of kilometres and past three – four cars that had slid off the road and entered into a right hand curve at Double Barrell Creek. Pace notes indicated this curve to be an 8, maybe and 8 long. That is a fast curve but you need to slow down for it. We had already negotiated curve with an 8 rating which Shane slowed down to quite a slow speed for, probably slower than I expected.*
>
> *Shane entered the curve. I was looking up, looking down at the pace notes and trying to deliver the pace notes in a timely manner and cannot recall the exact line he took into the corner. I know Shane would have kept the wheels on the bitumen and would not have cut the corner on the inside. We would have come in from the left, travelled out to the apex on the right and then back to the left. I don't recall if it was raining, if it was it may have been raining lightly. The road was very wet and slippery.*
>
> *Shane hit a slippery patch on the outer portion of the road. The vehicle started to understeer. I was not concerned because Shane would correct it or we would just slide off the outside of the curve. Shane allowed the car to run wide until we had two wheels on the dirt, both the left wheels. He steered the car to get back on the bitumen. The rear of the car stepped out quite significantly towards the right, Shane corrected, and we appeared close to being straight on the road, without the tail swinging back to the left, and with, I believed, only a small amount of momentum toward the inside of the corner. I believed that Shane had the car virtually under control and that we were good to go. I expected the car to grip up and Shane would accelerate away, and we would continue with the stage. I said words to the effect, "Nice catch mate" and got no response from Shane. I would have expected something from Shane like "Yep" or "Thanks" or "next". The lack of response surprised me. He would usually give some acknowledgement. I think that Shane realised that he did not have the car fully under control and was still busy trying to regain control. I do not recall what steering inputs Shane made from that point. I think that I probably looked down at the pace notes to regain my place, anticipating that we would resume racing.*

I was surprised that we then slid, driver side first, at a slight angle, off the right-hand side of the road… and landed very hard on our roof in a creek."[16]

35. The car came to a rest on its roof. Mr Navin was trapped. His head, still in its helmet, was submerged in the creek and he was unresponsive. After checking on Mr Navin and receiving no response, Mr Evans removed his own helmet and harness and wound down the passenger's side window (there was already water in the car), before climbing out of the car and making his way up the bank of the creek to the road. He tried to attract the attention of other competitors but could not. Mr Evans then went back to the car. Mr Navin was still unresponsive. Mr Evans kept Mr Navin's face out of the water and as he tried to assist him. Mr Evans found that Mr Navin's harness was already unclipped. Logically Mr Navin must have done this himself in the immediate aftermath of the crash before he became unresponsive.

36. Mr Evans was unable to revive Mr Navin. He went back a second time to the side of the road. Shortly after the 999 car came along and stopped to provide assistance. Mr Evans reported the crash. A medical intervention vehicle followed shortly after, before another official car. Despite the efforts of various officials at the scene, Mr Navin could not be saved.

37. I make the following findings of fact as to the fact that Mr Evans could not obtain any assistance in a timely way for Mr Navin. The car left the road at 10.02 am but it was not until 32 minutes later that any assistance in the form of the crew of car 999 (the "sweep" car) arrived at the scene. By then, Mr Navin was dead and had been, in my view, for some time. About 60 other competitors in cars went past the location of the crash without any providing any assistance to Mr Evans. At least four of those cars would have driven past the location within two minutes after the crash – at a time when Mr Navin could have potentially been saved.

38. The car's RallySafe unit transmitted a "Slow car hazard" at 10.02.55 am followed by a "Rollover hazard" one second later. It is clear on the evidence that both of those messages were received at Rally Command, with the Rally Command log recording that a manual SOS was noted at 10.07 am (transmitted when Mr Evans pressed the SOS button on the unit). Nonetheless, nothing appears to have been done by Rally Command to dispatch a medical intervention vehicle or do anything at all to respond to the incident. This was, to say the least, unfortunate.

[16] Exhibit 2.39 – Affidavit – Glenn Evans, sworn 25 May 2021, page 3 and 4 of 18.

39. It may be that because the vehicle was upside down in the creek with its external GPS aerial facing downwards, and below the road surface, the unit did not repeat to cars following on the stage behind it. If this is so, then the unit is not, in my view, fit for purpose. It did not transmit an SOS, which is what it is supposed to do.

Investigation

40. Mr Navin's body was recovered and taken by mortuary ambulance to the Royal Hobart Hospital where it was formally identified.[17] At the hospital's mortuary, highly experienced forensic pathologist Dr Christopher Lawrence performed an autopsy. Following the autopsy, Dr Lawrence provided a report which was tendered at the inquest.[18] In his report Dr Lawrence expressed the opinion, which I accept, that the cause of Mr Navin's death was drowning.

41. Toxicological analysis of samples taken at autopsy found only paracetamol at therapeutic levels and ibuprofen at sub therapeutic levels to have been present in Mr Navin's body at the time of his death.[19] Relevantly, no alcohol or illicit drugs were found to have been present and no other substances – lawful or unlawful, which could have affected his ability to safely drive his vehicle were present. I am affirmatively satisfied that neither alcohol nor drugs played any role in Mr Navin's death.

42. An investigation in relation to the circumstances surrounding Mr Navin's death was commenced by Constable Sven Mason, a Tasmania Police Crash Investigator.

43. The investigation was also informed by car 602's in-car video, which in addition to speaking for itself, was also reviewed in detail by a highly regarded rally driver Mr Lynn Rattray. Mr Rattray's assessment, having viewed the footage, was that car 602's speed and line was appropriate to the prevailing conditions. He also expressed the opinion that the suspension of the Mazda, which was probably adjustable, was possibly set too stiffly for the prevailing conditions. He also said that he thought Mr Navin reacted too slowly to the initial loss of control of the vehicle and his hands were occasionally placed incorrectly on the steering wheel. I accept the substance of Mr Rattray's opinion. I consider he is qualified to express the views that he has.

44. In summary, the evidence satisfies me that Mr Navin lost traction at the 34.75 kilometre mark and car 602 "fishtailed". Within a matter of metres, at a speed of about 100 km/h, the car hit a bump in the northbound lane which appears to have

[17] Exhibit 2.10 – Identification Affidavit for Mr Navin, sworn 26 April 2021.
[18] Exhibit 2.13 – Post-Mortem Examination of Mr Navin, sworn 20 August 2021.
[19] Exhibit 2.12 – Toxicology Report of Mr Navin, sworn 14 July 2021.

upset the vehicle. It is evident thereafter (as described by Mr Evans) that Mr Navin attempted, unsuccessfully, to regain control of the vehicle.

45. A review of several other videos obtained from in-car cameras of competitors traversing the same area where the incident occurred shows each vehicle taking a similar line—albeit at a slightly lower speed—but none of them appear to be affected by the bump in the northbound lane.

Formal Findings pursuant to section 28(1) of the *Coroners Act* 1995 – Shane Navin

a) The identity of the deceased is Shane Navin;

b) Mr Navin's death occurred in the circumstances set out in this finding;

c) The cause of Mr Navin's death was drowning; and

d) Mr Navin died in Double Barrel Creek, off the Lyell Highway, east of Queenstown in Tasmania on 23 April 2021.

Background – Leigh Mundy

46. Mr Mundy was born in Hobart on 5 December 1952. Like Mr Navin, he was 68 years of age when he died. He was an enthusiastic competitor in motor sport events having driven in Targa Tasmania on a number of occasions. Mr Mundy held the necessary license to enable him to participate in the event. He was not and had never been a professional racing or rally car driver.

47. The evidence is that Mr Mundy suffered from poor mental health including bipolar disorder and depression.[20] He had received treatment for his mental health for many years. The treatment included specialist referrals for psychiatric treatment, treatment as an inpatient in a mental health facility and regular medication. His last reported period as an inpatient in a mental health facility was for seven days in January 2021. His discharge summary on that occasion, roughly three months before he died, includes a note that he '*will be careful with driving [and] decisions*'.[21]

48. I note that the application to participate in Targa 2021 only asks questions about diabetes, allergies and major ***physical*** disabilities. Any medication being taken is required to be declared. Mr Mundy did so, declaring he was taking daily doses of

[20] Exhibit 3.2 – Mundy's Medical Records.
[21] Exhibit 3.4 – Dr MacArthur – Part 1, page 3 of 8.

vortioxetine and mirtazapine (both anti-depressants). However, no questions were asked, at all, in relation to a driver's mental health.[22] This is a curious, and to my mind, potentially very dangerous omission.

Background – Dennis Neagle

49. Mr Mundy's co-driver, Mr Dennis Neagle was born in Auckland, New Zealand on 12 June 1961. He was 59 years of age when he died. Mr Neagle was described as a semi-retired mechanic who lived in Queensland. He too was an enthusiastic and experienced motor sport competitor. The 2021 Targa Tasmania event was the tenth occasion in which he had participated as a co-driver. He had participated in one previous motor sport event with Mr Mundy. Louise Neagle, Mr Neagle's widow, said in her affidavit tendered at the inquest that Mr Neagle had been unable to speak to Mr Mundy, "*Dennis couldn't get through to Leigh [Mr Mundy] the week before he left Queensland as Leigh wouldn't answer his phone. Leigh was having some mental health issues*".[23] Nonetheless Mr Neagle chose to continue as Mr Mundy's co-driver in the event.

Circumstances of death – Leigh Mundy and Dennis Neagle

50. The vehicle in which the men were competing was a green two door Porsche GT 3 RS vehicle fitted with an optional Porsche club sport package. It was a high-performance car – in effect a racing car – designed to be used on a racetrack, with all the in-built safety features of such facilities, which are not present on ordinary Tasmanian roads.

51. The evidence is both men were wearing the mandated personal safety equipment of helmets, harnesses, gloves, HANS devices and racing suits.

52. The stage where the fatality occurred – the Cygnet stage, or stage number 33 – was a closed competitive stage with an open speed limit. The road surface at the location of the crash is sealed bitumen and in reasonable condition. Neither edge of the road surface was marked and both edges have soft gravel. The sealed surface is approximately five metres wide. 30 or so metres before the scene of the crash, the road has a vertical crest. The fact of the crest is specifically mentioned in the pace notes and the road book. In addition, shortly before the crest, caution boards displaying double exclamation marks were positioned by the organisers and clearly visible to competitors.

[22] Exhibit 3.7 – Targa Medical Information – Mr Mundy – dated 19 April 2021.
[23] Exhibit 3.30 – Affidavit of Louise Neagle, sworn 21 May 2025, page 2 of 3.

53. The evidence satisfies me that Mr Mundy approached the crest (which is not particularly steep or excessive) at about 188.5 km/h, either ignoring or overlooking the information available to him from the pace notes, road book and the warning from the double caution board. As the Porsche reached the crest, all four wheels left the ground, returned to the road surface, moved to the left-hand side of the road surface into the gravel at the verge, returned to the road surface on a north-western angle heading for trees. Mr Mundy suddenly applied brakes, immediately before the vehicle impacted with the trees. As I have already mentioned, both men died at the scene.

54. The circumstances of the crash were captured on photographs and on film by Mr Jarrod Leonard, an experienced motor sport photographer. Mr Leonard had photographed Targa Tasmania at least 10 times before 2021 and was an accredited photographer for the event. He set up a remote film camera as well as shooting frames with a still camera. His video footage and still photographs which were tendered at the inquest[24] provided great assistance in determining how the crash occurred.

55. Two other witnesses, both of whom had been competitors in Targa Tasmania in the past, Mr Marcin Jankowiak and Mr Jie Holton, were also positioned near the crest, heard and saw the Porsche crash and responded quickly to the wrecked vehicle. They also provided affidavits which were tendered at the inquest which described the circumstances they observed leading up to the crash.[25]

56. Other responders – Targa Tasmania officials – were also quickly on the scene but nothing could be done for either Mr Mundy or Mr Neagle.

57. Subsequent investigations and evidence tendered at the inquest satisfy me that neither weather conditions, the road surface or the actions of any other person and/or mechanical defect had any role in the happening of the crash.

58. All of the evidence shows very clearly what happened and why. Senior Constable Kelly Cordwell APM, Tasmania Police Crash Investigator, said, and I accept, that excessive speed on the part of Mr Mundy was the primary cause of the crash.[26] In short, I am satisfied to the requisite legal standard that the speed at which Mr Mundy approached the crest was excessive, dangerous and unnecessary. His speed, and his resulting loss of control, were the causes of his and Mr Neagle's death.

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[24] Exhibits 3.34 and 3.35 – Photographs and video of crash taken by Jarrod Leonard.
[25] Exhibits 3.32 and 3.33 – Affidavits from Holton and Jankowiak.
[26] Exhibit 3.44, report – Senior Constable Kelly Cordwell, page 14.

Forensic Pathology evidence

59. Mr Mundy and Mr Neagle's bodies were removed from the wreck of the Porsche and taken by mortuary ambulance to the Royal Hobart Hospital where they were formally identified.[27]

60. Dr Christopher Lawrence also performed autopsies on both bodies. In both cases following autopsy, Dr Lawrence provided reports which were tendered at the inquest.[28] Dr Lawrence found Mr Mundy to have severe ischaemic heart disease which, he considered, as do I, raised an issue in relation to his fitness to be competing in a high-speed car rally in a high-performance motor vehicle. His report expressed the view, which I accept, that the cause of Mr Mundy's death was multiple injuries including significant traumatic injury to the chest with a very large fracture of the left chest wall, some associated bleeding, and damage to the liver and the lungs.

61. Toxicological analysis of samples taken from Mr Mundy's body at autopsy indicated that at the time of his death he had therapeutic levels of mirtazapine in his body.[29] That drug is an atypical antidepressant, the side-effects of which can include drowsiness, dizziness, agitation and hypertension. There is clear evidence that acute use of mirtazapine can impair driving. There is insufficient evidence in this case to enable me to reach a concluded view as to whether or not Mr Mundy's driving was impaired by either his severe ischaemic heart disease and/or use of the prescription drug mirtazapine, although I cannot rule either out.

62. In Mr Neagle's case, Dr Lawrence expressed the opinion, which I accept, that the cause of his death was head and chest injuries including a laceration of the pericardial sac and the right atrium (which would have been rapidly fatal) as well as a left peri-orbital haematoma, left frontal cranial fossa fracture and diffuse subarachnoid haemorrhage. Mr Neagle also had a heart condition, but I do not consider that was relevant in the context of his death. Toxicological analysis of samples taken at inquest revealed only the presence of therapeutic medications. I do not consider those medications caused or contributed to Mr Neagle's death.[30]

Formal findings pursuant to section 28(1) of the *Coroners Act* 1995 – Leigh Mundy

a) The identity of the deceased is Leigh Rex John Mundy;

[27] Exhibits 3.15 and 3.22 – Identification Affidavits of Mr Mundy and Mr Neagle.
[28] Exhibits 3.18 and 3.25 – Post-mortem Examinations of Mr Mundy and Mr Neagle.
[29] Exhibit 3.17 – Toxicology Report of Mr Mundy.
[30] Exhibit 3.24 – Toxicology Report of Mr Neagle.

b) Mr Mundy's death occurred in the circumstances set out in this finding;

c) The cause of Mr Mundy's death was multiple injuries sustained by him as driver in a single motor vehicle crash; and

d) Mr Mundy died on Wattle Grove Road, near Cygnet in Tasmania on Saturday, 24 April 2021.

Formal findings pursuant to section 28 (1) of the *Coroners Act* 1995 – Dennis Neagle

a) The identity of the deceased is Dennis John Neagle;

b) Mr Neagle died in the circumstances set out in this finding;

c) The cause of Mr Neagle's death was head and chest injuries sustained by him as passenger in a single motor vehicle crash; and

d) Mr Neagle died on Wattle Grove Road, near Cygnet in Tasmania on Saturday, 24 April 2021.

Background – Tony Seymour

63. Mr Seymour was 59 years of age at the time of his death. He was born in Bloemfontein, South Africa on 6 April 1963. He was married to Sandra, who was his co-driver. Together the couple had a daughter. Like the other men whose deaths are the subject of this finding, Mr Seymour was not, and never had been, a professional racing car driver although he was driving a racing car when he died. Like Mr Navin and Mr Mundy, he was appropriately licensed to compete in the event.

64. His medical records indicate that Mr Seymour had a number of pre-existing medical conditions before commencing Targa Tasmania 2022. Those conditions included vocal cord paralysis and sarcoidosis. His GP record indicates that he was diagnosed with COVID-19 on 20 March 2022,[31] although in his entry for the event dated 20 April 2022, he declared he had not been diagnosed with COVID-19. The discrepancy remains unexplained on the evidence at the inquest. Similarly, in the medical questionnaire included in the application Mr Seymour answered "no" in relation to whether he suffered from heart disease,[32] when his medical records indicate that in January 2022 he was diagnosed as suffering mild coronary artery disease "anomalous

[31] Exhibit 6.5 – Mr Seymour's GP records, page 2 of 30.
[32] Exhibit 6.6 – Anthony Seymour – Entry, Medical, Recce Declaration dated 20 April 2022.

RCA origin".[33] Again, this discrepancy remains unexplained on the evidence at the inquest.

65. Mr Seymour was involved in motor sport for many years. Relevantly he and Mrs Seymour competed in Targa Tasmania in 2017, 2018 and 2021. They also competed in the Targa High Country event on several occasions as well as Targa Great Barrier Reef.[34]

Circumstances of Death – Tony Seymour

66. As I have already mentioned earlier in these findings, Mr Seymour died when the vehicle he was driving on 27 April 2022, on the Mount Roland Targa stage, left the road surface, crashed through a wire barrier, travelled down an embankment, and hit a tree.

67. The evidence was Mr Seymour bought that vehicle, a Lotus Exige S Coupe, in around 2016. Some modifications were made to it, including, relevantly, the fitting of an aftermarket bolt in roll cage manufactured by Simply Sports Cars Pty Ltd.[35] Simply Sports Cars were apparently Lotus specialists who provided technical support during events. That support included checks every day before and after stages.[36]

68. Mr and Mrs Seymour had previously used the Lotus in a number of Targa style events without any significant incident.

69. While in Tasmania in March 2022, the couple hired a car and drove all of the stages at least twice marking up their Smoothline pace notes. They then returned home and went back over those notes.[37]

70. Mr and Mrs Seymour flew into Tasmania several days before the commencement of Targa Tasmania 2022 and carried out more reconnaissance drives in a hire car before the arrival of their Lotus.[38]

71. Upon arrival (on 24 April 2024) of the Lotus (car number 903) it was subject to scrutineering by Motorsport Australia at the Silverdome in Launceston. It passed that process.[39] More will be said about that in due course.

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[33] Exhibit 6.5 – *Op. Cit.,* page 2 of 30.
[34] Exhibit 6.18 – Affidavit of Sandra Seymour sworn 22 June 2022, page 3 and 4 of 6.
[35] Exhibit 6.38 – Affidavit Senior Constable Michal Rybka, Crash Investigator, sworn 10 December 2022, page 4 of 7.
[36] Exhibit 6.18 – *Op. Cit.* page 4 of 6.
[37] *Supra*, page 5 of 6.
[38] *Supra*, page 4 of 6
[39] Exhibit 6.2 – 2022 Targa Tasmania event - Scrutineering Checklist - Car #903

72. As with the other drivers and co-drivers involved in these deaths, I note Mr and Mrs Seymour were wearing appropriate personal protective equipment.

73. On 26 April 2022, Mr and Mrs Seymour took part in the George Town prologue stage in which the vehicle glanced a curb with its front left wheel.[40]

74. On Wednesday, 27 April 2022, Mr and Mrs Seymour got up between 5.00 am and 6.00am. Mrs Seymour said that her husband did not drink any alcohol at all the night before. Both Mr and Mrs Seymour were subject to the usual mandatory pre-competition alcohol breath testing at the Silverdome and both returned a result of 0.0g of alcohol in 100 mL of blood.

75. The Mount Roland stage (Targa Stage 7) was also a closed stage, where speed limits (except for a maximum limit of 200 km/h) did not apply. On the day, there was considerable rain in the area, and the road surface was wet. The conditions were such that the Targa officials decided to declare the stage 'wet', a decision which was signposted at the start of the stage. At the time of the crash, and in the area of the crash, it was not actually raining.

76. The incident occurred on a downhill, right-hand bend which commenced after crossing a cattle grid. The fact of the right-hand bend was recorded in both the Targa Racebook and the Smoothline pace notes, the latter containing a warning that accidents in that location were common.

77. The circumstances of Mr Seymour's fatal crash were captured on in-car dashcam footage.[41] That footage, along with a comprehensive crash investigation carried out by Senior Constable Michal Rybka, and technical data, informed the following conclusions.

78. 91 metres after the Lotus crossed the cattle grid (without any loss of control or speed) it was travelling at 101 km/h. At that point Mr Seymour applied a steering input to the right, but despite the input, the car continued in a straight line, a dynamic term known as understeer.

79. What happened next is well described in Senior Constable Rybka's evidence:

> *"As [Mr] Seymour progresses in the understeer, it can be seen that he …applies full steering lock to the right in a desperate attempt to correct the vehicle. The MOTEC[42] download also indicates that he has been braking at this point. This had*

[40] Exhibit 6.18 - *Op. Cit.,* page 4 of 6.
[41] Exhibits 6.19-6.26 – Footage of and aftermath of crash
[42] Basically, an onboard computer.

> *no affect [sic] in changing the vehicle's path of travel, and it impacts with the cable barrier at a speed of approximately 61 km/h with its front left side*."[43]

80. The cable barrier failed – probably as a result of a combination of age, poor or no maintenance, and the fact that two other cars had already hit it in that stage. The Lotus crashed through, plunged driver side first down the steep embankment before coming to rest, roof first against a large tree.

81. In any event, Mrs Seymour was able to get out of the wreck, but she could not help her husband and by the time emergency responders arrived, he was dead.

Why the crash happened

82. In my view, based on the evidence presented at the inquest, several factors caused or contributed to the happening of the crash in which Mr Seymour died. A fundamental factor among those was that Mr Seymour lost control of his vehicle while travelling at a speed of 101 km/h on a wet road. It seems that Mr Seymour, having recognised he had lost control of his vehicle, applied his brakes and made a steering input to the right, but the vehicle continued to travel forwards.

83. It is also evident (particularly from the in-car video evidence tendered at the inquest)[44] that after crossing the cattle grid, two bumper bars from two other vehicles were visible on the road. It is impossible to determine what impact, if any, the presence of those bumper bars on the road had upon Mr Seymour. It certainly seems possible (or even likely) that Mr Seymour saw either or both and reacted to them to avoid hitting them. However, that is supposition only – in the absence of evidence from Mr Seymour himself, it is impossible to reach a concluded view about that fact.

84. Nonetheless, if Mr Seymour did see one or both of the bumper bars, then it is reasonable to assume that this may have caused or contributed to the happening of the crash in which he died. It is clear on the evidence that the organisers had no system in place for addressing the presence of debris on the roadway left by other competitors driving a stage. Nor did the crews of the vehicles responsible for leaving their bumper bars at the scene where Mr Seymour left the road appear to have informed any official that they had left debris on the roadway. To me, it seems a matter of basic common sense that such a fact should be reported.

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[43] Exhibit 6.38 – *Op. Cit.* page 6 of 7.
[44] Exhibit 6.19-6.26 – *Op. Cit.*

85. Another factor was the absence of any speed limiting devices (such as a virtual chicane) in the lead up to the point where the Lotus left the road.

86. Finally, the wire barrier failed – although its failure neither caused nor contributed to the happening of the crash.

87. I should say, I consider the emergency response to have been reasonable in the circumstances. Nor do I believe that the presence of caution boards would have made a significant difference to the outcome. The fact of the danger and the fact that accidents at that location were common, were more than adequately identified in the Race book and pace notes.

Forensic Pathology evidence

88. Mr Seymour's body was recovered from the wreck of his car and transported by mortuary ambulance to the Royal Hobart Hospital. Following formal identification,[45] Dr Andrew Reid, the Tasmanian State Forensic Pathologist, performed an autopsy. The autopsy did not show any evidence of fatal blunt force trauma. In particular, there were no head, neck or chest injuries which could have caused or contributed to Mr Seymour's death.

89. Dr Reid did find conjunctival petechial haemorrhages, anomalous right coronary artery, pulmonary inflammation and that Mr Seymour was suffering a respiratory virus infection (that is COVID-19).

90. Dr Reid inspected the wreck of the Lotus as well. He provided a comprehensive report in which he expressed the opinion that the most likely cause of Mr Seymour's death was positional asphyxia.[46] I am satisfied that Dr Reid was well qualified to express the opinion that he did, and I accept it.

91. Positional asphyxia is a diagnosis of exclusion. Differential diagnoses for exclusion in this case include cardiac and respiratory diseases – both of which were identified as being present. The circumstances in which Mr Seymour's body was found, his height and weight (183 cm and 95.2 kg) and particularly the evidence of the failure of the roll cage (which I will deal with presently) leads me to conclude, on the balance of probabilities, that the cause of Mr Seymour's death was, in fact, positional asphyxia.

[45] Exhibit 6.9 – Police Identification Affidavit for Mr Seymour
[46] Exhibit 6.12 – Post-mortem Examination of Mr Seymour, sworn 20 December 2022.

The Lotus

92. The Lotus was recovered from the crash scene and taken to the Police Garage in Kings Meadows, Launceston. The wreck was examined there by Senior Constable Rybka and Mr Benjamin Hunt, a Transport Safety and Investigation Officer employed by the Department of State Growth. Mr Hunt is a qualified automotive mechanic with many years of experience and has inspected numerous vehicles that have been involved in fatal or serious motor crashes. After his inspection, Mr Hunt authored a report, which was tendered at the inquest.[47]

93. Mr Hunt did not find any mechanical defects which may have caused or contributed to the happening of the crash. To the extent that he could tell, Mr Hunt considered the vehicle to have been well maintained prior to the crash. However, and extremely importantly in the context of Mr Seymour's death, Mr Hunt found that all three upper rear connection bolts of the roll cage had "*separated in their threaded sections*".[48] Senior Constable Rybka reported the same thing.[49] In short, the roll cage failed because the connecting bolts sheared, the cage components then collapsed into the cabin of the car, trapping and pressing down on Mr Seymour. The high winged seats fitted to the Lotus prevented Mr Seymour from getting out (even if he had been able to do so).

94. Mrs Seymour only survived because she was of slighter build than her husband and the impingement of the broken roll cage into her side of the Lotus' cabin was less.

95. I note that the Lotus had passed a scrutineering process upon its arrival at the Silverdome. I will deal with this issue later in these findings.

Formal findings pursuant to Section 28(1) of the *Coroners Act* 1995 – Anthony Seymour

a) The identity of the deceased is Anthony Graeme Seymour;

b) Mr Seymour died in the circumstances set out in this finding;

c) The cause of Mr Seymour's death was positional asphyxia due to being trapped in a position adverse to respiration; and

d) Mr Seymour died on Oliver's Road, Liena, Tasmania on Wednesday, 27 April 2022.

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[47] Exhibit 6.41 – Affidavit of Benjamin Thomas Hunt, sworn 3 June 2022.
[48] *Supra*, page 7 of 7.
[49] Exhibit 6.38 – *Op. Cit*, page 6 of 10.

96. As I indicated earlier in this finding, the evidence presented at the inquest focused upon the scope. It is appropriate to consider that evidence in the context of the scope now.

What rules and regulations were adopted by Motorsport Australia and Targa Australia Pty Ltd in the sanctioning and running of Targa Tasmania for 2021 and 2022 and the reasons for the adoption of the rules and regulations which were in place?

97. The rules and regulations adopted and in place for Targa Tasmania 2021 were:

    a) Fédération Internationale de l'Automobile (FIA) Code, including appendices;

    b) National Competition Rules (NCR), including appendices;

    c) Motorsport Australia Tarmac Rally Standing Regulations (TRSR) including appendices;

    d) TARGA Technical Regulations;

    e) Motorsport Australia TARGA Championship Sporting Regulations;

    f) Targa Tasmania 2021 Supplementary Regulations; and

    g) Motorsport Australia Occupational Health and Safety and Risk Management Policies.

98. The rules and regulations adopted for Targa Tasmania 2022 were the same as the above excluding (f) and with the addition of:

    a) TARGA Tour Regulations; and

    b) Targa Tasmania 30, Supplementary Regulations.

99. The rules and regulations adopted by Motorsport Australia were further shaped by the international standards for the conduct and organisation of motor sport events as developed by the FIA, and with input from domestic motor sport bodies such as the Australian Institute for Motor Sport Safety (AIMSS).

100. The evidence was that prior to each event, Targa Australia Pty Ltd developed its own event-specific rules and regulations in compliance with the NCR and the applicable appendices within the Motorsport Australia Manual, which Motorsport Australia

approved. This was consistent with the contractual arrangements between Motorsport Australia and Targa Australia.

101. The TRSR provided for, among other things, permission for the use of safety (also known as pace) notes, the minimum licence to be held, vehicle eligibility, appointment of Motorsport Australia officials such as the Event Checker and the Tarmac Rally Safety Assessor, a safety plan, maximum average speed, approved speed reduction methods and positive tracking.

102. The rules and regulations adopted provided one method for ensuring the safe conduct of the event. The fact that the rules and regulations drew largely upon international and national codes meant, in my view, that something approaching "best practice" was adopted.

103. That being said, it was apparent that the primary reason for the rules and regulations adopted was because Targa Australia Pty Ltd agreed that the events would be conducted in accordance with Motorsport Australia's rules, regulations, policies and procedures. This allowed Motorsport Australia to issue permits to Targa Australia Pty Ltd to run the events.

104. Motorsport Australia agreed that Targa Australia Pty Ltd would draft the event regulations, but the regulations were to be materially consistent with the NCR and approved by Motorsport Australia.

105. The agreement between Motorsport Australia and Targa Australia Pty Ltd, particularly the mechanism for approval of the event regulations, provided for consistency across the multiple rules and regulations used to run the events.

106. I do not consider that the regulatory regime, other than as observed below, played any role in the happening of any of the fatal crashes.

What recommendations from the Targa Tasmania 2021 Investigatory Tribunals Report and Findings were implemented by Motorsport Australia and Targa Australia Pty Ltd in the sanctioning and running of Targa Tasmania for 2022 and if there were recommendations not implemented, the reasons for not implementing those recommendations.

107. It was common ground that recommendations 9 (development of a system for vehicle set-up) and 11 (development of a tiered licensing system) were not implemented prior to the 2022 event.

108. At the time of the hearing of the inquest, only recommendation 9 remained outstanding; recommendation 11 having been implemented by the time the inquest was held. Nonetheless, I do not think the failure to implement either of those recommendations caused or contributed to Mr Seymour's death.

109. Insofar as recommendation 9 was concerned, Mr Sunil Vohra, the current Motorsport Australia CEO, gave evidence at the inquest about the balancing act between the intention of the recommendation and the application in practice to ensure the system is effective. He said that the issue is complicated and requires further work and understanding. Mr Vohra did not give any evidence as to the reason for the non-implementation of recommendation 11 before the 2022 event although I do note that he was not in the position of CEO at the relevant time.

110. Mr Perry gave evidence that while Targa Australia Pty Ltd works cooperatively with Motorsport Australia, Motorsport Australia was responsible for recommendation 9.

111. Recommendation 21, which dealt with the issue of communications on course (relevant generally but also particularly to Mr Navin's death) was for Targa Tasmania to "c*onduct a thorough review of its Communications Network and implement, by the 2022 event, an effective and efficient Communications Network which comprises at least the following*":

    a) Radio communications between Rally Command and each Start and Finish of each Stage, plus each Medical Intervention Vehicle and Course Car, in the Field;

    b) Internal Stage Communication to ensure that every Start, Finish and SOS Radio Point can communicate with each other; and

    c) A system that enables the manual Positive Tracking of Cars within each stage to be replicated at Rally Command.

112. The evidence indicated that this issue remained, at least to some degree, problematic. As Mr Marquis' evidence highlighted, communications between Rally Command and the stages—including with the medical intervention vehicles or SOS points—were conducted via mobile phone from the start line. The reason for this is, apparently, that because of the distance that is covered, it is not possible to communicate via a radio network back to Rally Command. Mr Marquis gave evidence that the communications network system implemented in the 2022 event was effective for running the event. However, in circumstances where it was reported after Targa Tasmania 2022 that

there were still some communication issues on certain stages, it is questionable whether the issue had truly been resolved. Hopefully, as digital and internet-based communication improves - with the wider availability of platforms such as "Starlink" - communication will continue to improve.

113. There were areas of the stage where mobile phone coverage was insufficient. Satellite phones were used to address this issue; however, their reliability was said to be questionable due to operational issues that can result in poor reception.

114. There was no one "calling" (or checking) vehicles travelling past SOS points, only at the start line. The evidence was that Rally Command would listen via speaker on a mobile phone of the trackers at the start calling the departure of cars and replicate a note of the cars on the same form as the trackers. This system does not positively report the passage of each car past each SOS point, it only positively reports the departure of each car at the start of each stage.

115. The communication system for Targa Tasmania was sub-optimal in 2021 and requires ongoing attention.

What role, if any, [did] Motorsport Australia, as the sanctioning body and Targa Australia Pty Ltd as the organiser, play in respect to enforcing compliance with the relevant rules and regulations and ensuring the overall safety of the event, including the implementation of the recommendations?

116. The Motorsport Australia stewards, and Targa Australia Pty Ltd's Clerk of the Course had the power to enforce competitor compliance with the relevant rules and regulations by, among other things, issuing penalties for any breaches.

117. Motorsport Australia had the power to enforce Targa Australia Pty Ltd's compliance with the relevant rules and regulations by their agreement, and by issuing a permit to run the event if it was satisfied it could be run in accordance with, among other things. the relevant rules and regulations.

118. Motorsport Australia could also enforce Targa Australia Pty Ltd's compliance with the relevant rules and regulations by requiring Motorsport Australia licensed officials to carry out specific functions and checks before, during and after the events. These licensed officials included the Course Checker (also known as the Event Checker), Tarmac Rally Safety Assessor (Safety Assessor), Stewards, the Chief Scrutineer and the Chief Medical Officer.

119. Despite the above system in place, in the 2021 event, there were multiple examples of non-compliance with the TRSR.

120. First, a Safety Assessor was not appointed by Motorsport Australia for the 2021 event despite the unequivocal requirement in the TRSR that there be one. No witness at the inquest could explain why this requirement had not been complied with. I do note that Mr Garry Connelly AM said in his evidence that while the 2021 Tribunal did not investigate the absence of a Safety Assessor, it considered the omission to be an oversight. However, the Tribunal believed that even if a Safety Assessor had been appointed, it would not have altered the decision to drop the stages or affected the conduct of the 2021 event.

121. Second, not all stages were checked before the event by Mr Malcolm, the Course Checker appointed by Motorsport Australia, and Mr Marquis, the Clerk of the Course. Relevantly, the Cygnet stage where the fatal crash which claimed the lives of Mr Mundy and Mr Neagle occurred was not checked. As with the failure to appoint a Safety Assessor, no witness was able to explain satisfactorily why some stages were not checked.

122. Mr Malcolm's evidence at the inquest was that he was verbally advised (or perhaps instructed), immediately prior to the pre-event course check, not to check stages 2 and 6, but could not recall by whom. However, he was comfortable that there were no significant changes to previous events given his familiarity with the roads and that there would be an on-event day check. I note that Mr Malcolm was empowered to not permit the stage run if he found anything particularly untoward, a power he could not, of course, properly exercise if he had not conducted a check.

123. Mr Marquis' evidence was that there were no changes in the stages that were not checked. He believed an agreement was reached about that, but he was not involved in reaching that agreement or any discussions about the agreement. He said he received the direction not to check the stages from Mr Perry. Mr Perry could not recall giving Mr Marquis a direction not to check stages 2 and 6 and repeated that it was the Course Checker's role to do that.

124. It is difficult to know quite what to make of this evidence, although I am satisfied that there were in fact no changes to the Cygnet stage. That being the case, even if the stage had been checked, it seems clear that the stage would have proceeded as planned. Nonetheless, the regulatory regime envisages the checking of each stage prior to running of the event by the relevant responsible officials. There is an obvious reason for this to occur and in every case, it should.

125. Third, the maximum average speed of 132 km/h was exceeded on two stages for the 2021 event. The evidence at the inquest does not enable a conclusion to be reached as to which stages and by how much, but there is clear evidence that such breaches did in fact occur.

126. Mr Connelly gave evidence that the reason the maximum average speed was exceeded was because there were "*too many straight pieces of road for cars of those performance standards*".[50] This may be correct and is an issue associated with course design. It is also incumbent upon the organisers to ensure that the average maximum speed is not exceeded and if it is, that there are consequences for competitors. There needs to be a system in place to avoid it happening again; stages where the maximum average speed was exceeded should not be used again without review and change.

127. Fourth, there was no positive tracking of cars on the stage. I will expand upon this point later in these findings.

128. Finally, the following additional anomalies were identified in the course of the evidence presented:

    a) Mr Malcolm was not using the Rally Event Checkers Manual that was in force when performing his role as 2021 event Course Checker. Rather, he was using an older version;

    b) During the 2022 event, the competition checker and Zero Car Safety Checker, Mr Rattray, did not liaise with, or assist, the event checker or complete a check of the course with the event checker present;

    c) There was no document or guide for the Role of the Competition Checker; and

    d) There were no notes available to be tendered at the inquest (or probably even kept) of the Targa Tasmania 2022 pre-event planning meetings.

129. I do not consider that when running events such as Targa Tasmania that there is any room for non-compliance with any aspect of the regulatory regime. This remains the case despite the fact that I have been unable to identify any of the numerous areas of non-compliance as being causative of, or contributing to, any of the deaths examined at the inquest.

[50] Transcript – Day 3, page 214.

What were the contractual arrangements between Motorsport Australia and Targa Australia Pty Ltd in respect to the running of Targa Tasmania for 2021 and 2022?

130. As has already been mentioned, there was an agreement between Motorsport Australia and Targa Australia Pty Ltd, which provided for the running of both events.

131. Amongst other things the agreement provided, that:

    a) All competitors and participants were required to hold a Motorsport Australia licence;

    b) The use of each proposed stage would be assessed based on its overall suitability for the majority of competitors entered; and

    c) Motorsport Australia would assist Targa Australia Pty Ltd with the running of the events generally, including with the preparation and approval of event regulations.

132. I am satisfied on the evidence at the inquest that each of the competitors whose deaths were the subject to the inquest, held a Motorsport Australia licence. It is also apparent that, broadly speaking, an assessment of the proposed stages was carried out and assistance was provided by Motorsport Australia with general preparation and approval of event regulations.

133. In any event, I am also satisfied that the contractual arrangements between Motorsport Australia and Targa Australia Pty Ltd did not have any causal connection with the any of the four deaths investigated at the inquest.

What system was in place for determining whether vehicles were compliant with the technical regulations?

134. This issue is particularly important in the context of Mr Seymour's death and the roll cage fitted to his vehicle, which failed and contributed significantly to his death.

135. Motorsport Australia's Mr Scott McGrath, the 2021 event Chief Scrutineer and Technical Delegate, gave evidence at the inquest as to the scrutineering process whereby vehicles are checked for compliance in the competition environment.

136. Each vehicle is presented for scrutineering at a nominated time and place prior to the event.

137. Mr McGrath said that checks would be conducted on various things as determined by the scrutineers at the time. Mr McGrath said that for the 2021 event, a range of items were to be checked, with a primary focus on retention of the occupants in the vehicle and items that provide protection to the occupant, including, but not limited to the seat, safety helmet, and restraint.

138. Insofar as what was checked, Mr McGrath said checking was for compliance with the standards that existed for each of those items and that they were "*mounted in accordance with the requirements of Motorsport Australia*" and the event.[51] The evidence was that checks were not carried out of the competitor when they were actually sitting in the seat in the vehicle.

139. In his evidence, Mr McGrath said that the process of checking for compliance did not end at scrutineering. There were spot checks throughout the event. Mr McGrath said it was a continuous evolution of watching for a non-exhaustive list of matters including safety, technical and modifications to enhance performance. I accept that this was so.

140. Mr McGrath's evidence was that the scrutineer was only required to determine whether vehicles were compliant with the Technical Regulations. It was not part of the scrutineering process to determine whether a vehicle was mechanically sound, or fit for purpose. It is difficult to see how it could ever be that the organisers of an event such as Targa Tasmania could possibly implement a system whereby every vehicle was checked for mechanical soundness or fitness for purpose. Counsel Assisting submitted, and I accept, that the ultimate responsibility for technical compliance, safety of the vehicle, mechanical worthiness and fitness for purpose rests with the competitors.

What system was in place for determining the eligibility requirements of vehicles for the technical regulations?

141. The system involved the application of Motorsport Australia's Technical Regulations. Any changes to these regulations are informed by, among other things, changes made by the FIA.

142. For Targa Tasmania 2021 and 2022, Targa Australia developed its own sporting and technical regulations which provided for the vehicle eligibility requirements. These regulations are submitted to Motorsport Australia for review and approval.

[51] Transcript – Day 2, page 108.

143. The technical regulations must comply with Motorsport Australia's safety requirements in terms of specified safety equipment. It otherwise does not have to comply with Motorsport Australia Technical Regulations.

144. There was no evidence as to the process by which Targa Australia Pty Ltd determined the vehicle eligibility requirements for the event. As I have already noted, the vehicles driven by both Mr Mundy and Mr Seymour were, in effect, circuit racing cars. There is considerable merit in the proposition that neither vehicle, nor vehicles like them, are suitable for tarmac rallying. However, that issue is beyond the scope of this inquest.

145. I do note that Mr Vohra's evidence was that from Motorsport Australia's perspective, the removal of high-performance vehicles from Targa Tasmania would provide an element of "*relief*".[52] His position finds support in the Motorsport Australia external review.[53] This appears to be contrary to the attitude of Targa Australia Pty Ltd, whose CEO, Mr Perry, said in his evidence that the types of vehicles driven by Mr Mundy and Mr Seymour are an important part of the event and comprise a significant number of entries to the event.[54]

146. While I do not consider that the *system* for determining vehicle eligibility is causally connected to the deaths—given that the common cause of the accidents was driver error—I do think that serious consideration needs to be given to the question of whether racing cars should be driven at high speed on ordinary roads, with, in practical terms, no safety protection at all for competitors. There much to be said for the proposition that racing cars are for racing tracks.

What system was in place for determining competitors' eligibility to compete and what consideration was given to medical fitness to drive?

147. In short, apart from a self-assessment and declaration system, and a reliance upon the Motorsport Australia medical conducted by the general practitioners of individual competitors, there was no system. Given the conclusions I have reached in relation to Mr Mundy and Mr Seymour's general level of health and fitness, I consider this issue needs further consideration. I note that Mr Mundy's regular general practitioner considered him fit to participate in motor sports following a medical assessment some 18 months before the incident. With respect, it is difficult to accept that assessment as reasonable. However, in the absence of further evidence about the matter, I cannot reach a reasoned conclusion about the assessment.

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[52] Transcript – Day 2, page 128.
[53] Exhibit 7.1 – Targa Tasmania Review Panel's Report (2022).
[54] Exhibit 10.2 Statement of Mark Perry, 8.62-8.65, generally.

148. There also seems to me to be a fundamental problem with a "system" which allows a man of Mr Mundy's age to drive a high-performance racing car at high speed in a competitive event on the basis of a medical assessment that was carried out 18 months before the event. There is also a fundamental problem with Mr Mundy being able to participate in the event, having recently been discharged after a period as an inpatient in relation to his mental health, noting that his discharge summary indicated that he would "*be careful with driving*". I do note that his severe ischaemic heart disease appeared to have been undiagnosed (until autopsy) and would not have been diagnosed unless he had undergone a heart stress test. It does not appear unreasonable to me to require older competitors to in fact undergo that very type of testing.

149. In relation to the issue of fitness to drive generally I make the following observations:

    a) First, there was no evidence about what consideration, if any, Targa Australia Pty Ltd gave to the medical declaration upon entry – which in the case of Mr Seymour was, in fact, misleading.

    b) Second, the questions asked on the declaration were reasonable as far as they went, but they were incapable of eliciting the full information. Mr Mundy's case demonstrates this point well.

    c) Third, there is considerable merit, in my view, to consideration being given to engaging external (independent of the competitor) medical practitioners to carry out medical examinations to determine whether an individual is in fact fit enough to be participating in the event. I note Mr Vohra's evidence at the inquest was that Motorsport Australia is considering engaging external medical experts to carry out examinations rather than relying on the competitor's attestation of their own health and relying also upon an examination by their own clinician.

150. I also note the evidence about the practicality, ongoing maintenance, and cost of implementing such a regulatory system, particularly given the evidence that there are 24,000 Motorsport Australia licence holders across the country. I do not consider that those difficulties are insurmountable. Guidance may be found in the regulatory regime that applies to non-professional pilots in Australia.

What safety precautions were taken in respect to the design of each stage of Targa Tasmania for 2021 and 2022 (and in particular, the Mount Arrowsmith, Mount Roland and Cygnet stages)?

151. The issue of safety precautions generally, and in respect of the relevant stages, naturally, is an important issue at the inquest. The TRSR required course design to consider the following matters:

    a) No stage on a tarmac rally should exceed 132 km/h in average speed;

    b) On roads which will likely result in higher average speeds, measures can be taken to reduce average speeds. The ideal goal of these measures should be to reduce top speeds and reduce entry speeds into corners which would otherwise have high-speed braking beforehand and/or have some other feature which may deem the corner 'difficult';

    c) Such measures should be discussed with and approved by the Safety Assessor; and

    d) If the permitted maximum average speed in a tarmac rally stage is exceeded, then that stage will not be approved for inclusion in the event the following year unless some measure has been taken that would likely result in the reduction of the average speed of any competing vehicle to below the maximum.

152. The evidence in relation to approved methods of speed reduction on a stage were virtual chicane (in effect an electronic speed reduction zone), physical chicanes, restriction zones (speed or time), and a maximum speed limit.

153. Targa Australia developed the course design which was endorsed by Motorsport Australia on the issue of the permits for the 2021 and 2022 events. Developing the course design each year involved consideration of data from previous events, including base times, average speeds, stage times, incidents and qualitative feedback from competitors, organisers and officials, as to safety and suitability.

154. The TRSR also required Motorsport Australia to appoint:

    a) A Safety Assessor to check that as far as practicable, the event will meet the safety requirements relating to the competitors; and

    b) An Event (or Course) Checker designed to assess the course layout and ensure the safety of participants, among other responsibilities.

155. For the 2022 event, as a result of the 2021 Tribunal recommendations, the Safety Assessor was replaced with a Safety Delegate, and a Competition Checker role was introduced.

156. I think it is sufficient to say that I am satisfied that appropriate safety precautions were either taken, or due consideration was given to them, when designing the course for the 2021 and 2022 events.

157. I am satisfied that appropriate safety precautions were taken in respect of each of the stages considered at the inquest. And irrespective of those safety precautions, I consider neither Mr Mundy nor Mr Seymour took proper precautions for their own safety by travelling at speeds that were excessive in the circumstances.

Whether speed limiting devices were in use on the stages of Targa Tasmania for 2021 and 2022 and if none were used, what consideration was given to the use of such devices?

158. The evidence was that speed limiting devices were in use during both events that were the subject of the inquest. Moreover, in the 2022 event, the number of restricted time zones implemented increased almost three-fold. However, there were no speed limiting devices used on or immediately prior to the three incident locations in Targa Tasmania 2021 and Targa Tasmania 2022.

159. The evidence at the inquest was that a speed limiting device was considered for the Mount Arrowsmith stage, but a decision was reached that it was not warranted in the circumstances. I think this was a reasonable decision when regard is had to the circumstances of Mr Navin's death. I am of the view that a speed limiting device was unlikely to have altered the outcome of the crash in which he died, particularly given that the vehicle was not travelling at excessive speed in the circumstances, and it hit a bump which upset the vehicle.

160. A speed reduction method was not considered for the Cygnet stage because double caution boards were physically placed before the crest and these boards have the effect of warning a driver to slow down.

161. A speed reduction method was not considered for the Mount Roland stage in 2022 because the incident corner was highly visible. However, given the wet conditions, it was on "full course care" which had the effect of warning the drivers to slow down and take care.

162. Considering the methods that were in place, which should have had the effect of reducing speed on the Cygnet and Mount Roland stages immediately before the crashes, in circumstances where these warnings were not heeded, I am of the view that the use of speed limiting devices was unlikely to have altered the ultimate outcome in each case.

Whether a Risk Management Plan was provided to the Commander of Police in accordance with the permit to conduct a Public Event Affecting Road Closure(s) dated 29 March 2021 and if so, what was that Risk Management Plan?

163. The evidence was that a Risk Management Plan was provided as part of the application process for a permit to be issued by the Commissioner of Police.[55] In my view, the Risk Management Plan and its contents had in no bearing at all upon the circumstances of the deaths which occurred in Targa Tasmania 2021.

What version of the Rally Road checker's manual was in operation prior to April 2021?

164. The version of the Rally Road Checker's Manual in operation prior to April 2021 was 'Version 1' (June 2017) which was updated to 'Version 2' after the event in July 2021. That aside, Mr Malcolm, the Course Checker for Targa Tasmania 2021 did not use version 1 (June 2017) but apparently used an undated (and evidently older) version 1.7A. He said in his evidence at the inquest that he was not made aware by Motorsport Australia that a new manual had been produced.[56] Although it is, to say the least, undesirable that the person responsible for checking the course was apparently not made aware that a new manual was in use, I do not consider that this fact had any role in the deaths of Mr Navin, Mr Mundy or Mr Neagle. The differences between the June 27 Version 1 manual and the manual that Mr Malcolm used were, in my assessment, insubstantial.

What consideration was given to determining a stage a "wet stage" and what system was in place for declaring a "wet stage"?

165. In summary, as I understood the evidence at the inquest, the situation was that if the weather was wet while the on-day event check was conducted by the Course Checker, the stage would be declared wet. It was the role of the Course Checker to assess, amongst other things, road conditions, including the state of the surface prior to the commencement of the competition. Mr Marquis, said that practically speaking, if

[55] Exhibit 1.12A, Affidavit of Commander Debbie Williams sworn 4 March 2024, annexure A.
[56] Transcript – Day 1, page 14.

rain was reported anywhere along where the stage was conducted, and the road surface was, as a result, wet, then the stage was downgraded immediately to wet.[57] He said, "*There is no debate; if my team on the ground says it is raining, the stage is downgraded to wet immediately*".[58]

166. The effect of downgrading the stage to "wet" is to change times for competitors and once downgraded the stage remains "wet" even if the weather improves.

167. All competitors are immediately made aware, at the start of the stage, of the declaration to wet which having been made, remains in place for the rest of the stage. In terms of the event, the stage becomes a "full course care" and every corner on the stage is classified as "care". The practical effect of such a declaration is to warn drivers to slow down and be careful.

168. I have already said that I am satisfied that Mr Navin and Mr Evans were informed by officials at the start of their stage of the fact that the Mount Arrowsmith stage had been declared "wet" before they commenced it.

169. Mr and Mrs Seymour had fitted wet weather tyres to compete on the Mount Roland stage. Obviously, they did so because they were aware that the road was wet. Mrs Seymour said that they had been warned of "*wet and slippery conditions by… other drivers via [WhatsApp] prior to the Mount Roland stage*",[59] and consequently, fitted the wet weather tyres.

170. It is apparent that several other competitors understood that the stage was wet.[60] Interestingly, Mr James Stewart, who crashed and lost his rear bumper at the spot where Mr Seymour's Lotus left the road and hit the wire cable barrier, described changing to wet weather tyres at the Sheffield Oval prior to commencing the Mount Roland stage. He expressed surprise that "*the organisers did not declare it as a 'wet-stage' with compulsory wet weather tyres*". He said that was a "*common declaration in past motor racing that I have seen in those type [sic] of conditions*".[61] Mr Stewart was the only person to suggest that there had not been a formal declaration of the stage as "wet". I am quite satisfied that the stage was downgraded to wet, and the fact of that downgrade was appropriately communicated to competitors.

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[57] Exhibit 10.1 – statement of Hamish Marquis – dated 7 August 2024 – Paras 1.76 – 1.78
[58] *Supra.*
[59] Exhibit 6.18 – *Op. Cit.*, page 5 of 6.
[60] See, for example Exhibit 6.28 – Affidavit of Anthony Carr, sworn 26 July 2022.
[61] Exhibit 6.29 – Affidavit of James Stewart, sworn 31 August 2022, page 3 of 3.

What training was provided to staff and competitors on the use and operation of the RallySafe system?

171. RallySafe is an integrated tracking, timing and safety device. The system comprises a unit fitted to each competitive vehicle which in effect "speaks" to a command unit at race control and broadcasts information in certain circumstances to other competitors. Its use was (and is) mandatory in Targa Tasmania. All cars are required to be fitted with the unit. The unit naturally comes with a manual which deals with all aspects of its operation. According to the manual in force as of 2022, the unit's primary function is to help alert competitors and race control of incidents on the course. The manual says, "*if the car stops during a stage… the unit will automatically transmit a HAZARD notification to Race Control and following competitors*". In addition, the manual states "*if the vehicle is involved in an accident with high G-forces, an automatic SOS message is sent and displayed on the unit*", which automatic message is sent to race control and other competitors.

172. The operation of RallySafe was an issue at the inquest in relation to the deaths of both Mr Navin and Mr Seymour.

173. In relation to Mr Navin's death, Mr Evans' evidence was that he did not initially press the "OK" button on the RallySafe unit. His understanding was that the RallySafe system would be sending an SOS signal, automatically. Mr Evans said that he was convinced he had been informed during a first-time competitor's briefing for a tarmac rally in November 2015 that, in the event of a high G-force impact or a rollover, the RallySafe unit would automatically broadcast an SOS signal. This understanding is entirely consistent with the information provided in the operator's manual.

174. Mr Evans also said in his evidence that as he was trying to save Mr Navin, he "*stopped to figure out which button [on the unit] would be the SOS signal and pressed it*".[62] I am satisfied that he did as he said.

175. Mrs Seymour said in the immediate aftermath of the crash in which her husband died, she "*pressed the SOS button on the Rally Safe [sic] device screen*".[63] I am also satisfied that Mrs Seymour did as she said, and indeed probably pressed the SOS button more than once.

176. I am satisfied that on the evidence, that the training given to competitors – at face-to-face and online briefings to competitors prior to both the 2021 and 2022 events in the

[62] Exhibit 2.39, *Op. Cit*, page 8 of 18.
[63] Exhibit 6.18, *Op. Cit*, page 5 of 6.

use and operation of RallySafe – was sufficient. Self-evidently, both Mr Evans and Mrs Seymour knew to press the SOS buttons on the unit and did so.

177. In my view, the training provided to event officials was, however, potentially less than comprehensive. So was the practical "on ground" utilisation of that training by event officials. So far as Mr Navin's death is concerned, Mr Marquis said in his evidence that he was unaware a rollover hazard alert had been received at Rally Command at 10.02 am. Whether that alert was actually broadcasted (and therefore received) seems unclear – certainly the Tribunal concluded that the G-force associated with Mr Navin's fatal crash was insufficient to trigger the SOS alert. If this is correct, it is, to my mind, a surprising outcome and indicates a fundamental problem with the functioning of the unit. I have also commented earlier in this finding about the functionality of the unit generally.

178. There was no evidence as to whether staff at Rally Command received training in the use and operation of the RallySafe system. However, if there was any training provided to staff, one would expect it would involve the use of the program, how to interpret data and how and when to respond to an alarm. It is an area which warrants further consideration by organisers if the event is to be held at any time in the future.

Was it a requirement of competitors to stop and render assistance when a RallySafe SOS alert was received, if not, why not?

179. The evidence in relation to this issue was very clear. The applicable regulations in force for both events provided the procedure to follow when a vehicle was stopped. In summary, it was that the first two competing crews following the vehicle are required to stop and render any assistance necessary in the following circumstances:

    a) When the crew involved in the incident displays the red SOS sign and switches their RallySafe unit to SOS; or

    b) When the vehicle involved in the incident is stopped but there is neither an "okay" or SOS sign on display.

180. The evidence at the inquest was that no one stopped and rendered assistance to Mr Navin and Mr Evans following their crash on the Mount Arrowsmith stage. I do not think any criticism can be made of any of the following competitors for initially failing to stop given that the vehicle was not visible from the road. There is also clear evidence that even though Mr Evans pressed the SOS button (or thought he did), the

RallySafe unit did not broadcast an SOS, at least initially, probably due to the location of the car and the fact that it was upside down.

181. At least one vehicle - car 666, driven by Mr Graham Copeland - passed by while Mr Evans was on the road (having extracted himself from the vehicle in the creek). Mr Copeland said he saw Mr Evans "*on the right-hand side or inside corner… waving his arms about"* but did not see any car.[64] The RallySafe unit in his car had not received a hazard warning. As I say, it was not unreasonable for Mr Copeland not to have stopped, and even if he had, I do not consider that it would have made any difference in the particular circumstances of this accident and Mr Navin's unfortunate death.

What system was in place for tracking cars throughout each stage, including at each SOS point and what consideration was given to determining the SOS points in the stages?

182. The system in place was a combination of real time monitoring of vehicle location by RallySafe and manually by event officials as vehicles left the start, passed SOS points and at the finish of each stage.

183. So far as the manual aspect is concerned, the evidence was that as vehicles left the start line, their numbers are written down on a tracking form and information was transmitted to the finish by radio. There was no official calling of the passing of vehicles at SOS points located on longer stages over the radio network. However, officials at SOS points could (and would) check-off the vehicles on their tracking form as they passed. I do not consider that the tracking of cars throughout the stage was relevant to any of the deaths who are the subject of the inquest, other than in relation to Mr Navin as I have already dealt with above.

184. The evidence in relation to the positioning of the SOS points was that their location was determined by Targa Australia Pty Ltd with the input of the Course Checker. Factors that were considered included general safety considerations and the number of volunteers operating at the location. Broadly speaking, for stages longer than 15 kilometres, Motorsport Australia guidelines say the SOS points are to be situated "*no more than 15kms apart*" and this appears to have been adhered to. Once again, I do not consider the location of any of the SOS points was a contributing factor in relation to any of the deaths.

[64] Exhibit 2.37 – Affidavit – Graham Copeland, sworn 28 July 2021, page 2 of 2.

What crew briefing was provided to competitors and what system was in place for ensuring that competitors attended or otherwise viewed and understood the crew briefing?

185. The evidence for Targa Tasmania 2021, was that the 'first-time competitors briefing' was compulsory and in-person for one hour. None of the men who died in Targa Tasmania 2021 were first-time competitors.

186. The briefing to other competitors (which of course included Mr Navin, Mr Evans, Mr Mundy and Mr Neagle) was via a PowerPoint presentation. Competitors were required to acknowledge the viewing of the PowerPoint presentation via a DocuSign set up. The PowerPoint presentation included, among other things, accident procedures, and information about warning boards, speeding and restricted time zones.

187. Mr Perry gave evidence that Targa Australia Pty Ltd did everything it could to make the briefing to other competitors an in-person briefing during the COVID-19 restrictions that were in force at the time.

188. Event Stewards had power to impose a penalty for not attending or acknowledging viewing the presentation. There is no evidence that anyone was actually penalised. Relevantly Mr Navin, Mr Evans, Mr Mundy and Mr Neagle all electronically acknowledged receiving the briefing material for Targa Tasmania 2021.

189. For Targa Tasmania 2022, Mr Perry provided the compulsory briefing to all competitors in-person. The same power to impose a penalty mentioned above applied. Again, there is no evidence that anyone was so penalised (including, relevantly, Mr and Mrs Seymour who I am satisfied must have therefore attended the briefing). Mr Perry gave evidence that there was a sign-in sheet on entry to the room. The sign-in sheet was the final list of competitors that was produced. Any non-attendance was passed on to the Clerk of the Course and the Stewards.

190. According to Mr Perry, the briefing was the most extensive he had ever conducted (and he has been conducting briefings for a long time). It went for an hour and 45 minutes, which was an hour more than normal. The key messages from the briefing to competitors were to look after yourself, think about your families and keep Targa in perspective.

191. Relevantly, the briefing, which of course involved the use of PowerPoint presentation, included the additional feature of the new safety procedure for hand signals to alert

passing vehicles. Evidently, this was a consequence of the learnings from Mr Navin's death.

192. The evidence of Mr Perry at the inquest suggests, and I accept, that the competitor's briefing plays a vital role in preparing competitors for the event. It provides important information for novice competitors and is a reminder to returning competitors. It is an opportunity for competitors to ask questions and hear answers.

193. It was, perhaps, unfortunate (although completely understandable) that the competitor's briefing for Mr Navin, Mr Evans, Mr Mundy and Mr Neagle was not in-person. However, the circumstances nationally created by the COVID-19 pandemic impacted on all aspects of life and required adaption and flexibility. I note that in his evidence, Mr Perry said Targa Australia Pty Ltd was, in effect, overwhelmed by running the event during COVID-19 restrictions in 2021. It is, I suppose, possible that as a consequence, other options for the delivery of the competitor's briefing, such as real-time online or using a questionnaire to confirm a competitor's understanding were overlooked, but I am satisfied that Targa Australia Pty Ltd did what was necessary in the circumstances to deliver an adequate competitor briefing. The briefings for both years, to my mind, provided key preparation information, including the safety procedure after an accident. In any event, I do not consider the fact that the competitors briefing for Targa Tasmania 2021 was "virtual", played any role whatsoever in the deaths that occurred in that event.

194. The fact that Mr Navin, Mr, Mundy, Mr Neagle, Mr Seymour (and Mr Evans and Mrs Seymour) were all experienced competitors cannot be overlooked, and in the circumstances, it is reasonable to infer that they understood the briefings and the risks of competing. In fact, to my mind, that is the only conclusion reasonably open.

Tarmac Rally Competitors Association of Australia Inc - submissions

195. Submissions were received from the Tarmac Rally Competitors Association of Australia Inc., which is said to represent the interests of competitors in events such as Targa Tasmania. Those submissions were outside the scope of the inquest and do not, in any way, address any of the matters on which I am required to make findings pursuant to section 28 of the *Coroners Act* 1995.

Conclusion

196. I am satisfied that driver error was the cause of the three fatal accidents investigated at the inquest. The common factor for the fatalities on the Cygnet and Mount Roland

stages was excessive speed. Having regard to the evidence as a whole, I have reached the conclusion that I do not consider Mr Mundy and Mr Seymour took adequate precautions and care for their own safety (and the safety of their passengers) by driving at speeds that were, in all of the circumstances, excessive. As I hope should also be reasonably clear, I consider Mr Navin's death was also due to driver error.

197. I also observe that in the cases of Mr Mundy, Mr Neagle, and Mr Seymour, the vehicles they were competing in were designed specifically for racing on racetracks. I question whether such vehicles, built for controlled environments, should be used in races on public roads, which involve variable conditions such as changing road surfaces, weather, and the absence of purpose-built safety features that are standard on modern racetracks.

198. I **comment** that I consider that health was also a factor in each case. Each of the deceased men were aged over 59 years and all had pre-existing health conditions for which all were taking medication in one form or another. Mr Mundy had significant ischaemic heart disease which was apparently undiagnosed. Mr Seymour had sarcoidosis, vocal cord paralysis and had recently suffered from COVID-19. As should be clear from what I have said earlier, I consider that all these factors raise significant questions about Mr Mundy and Mr Seymour's medical fitness to compete in high-speed racing cars in a tarmac rally.

199. It is quite clear on the evidence that the driver licensing system that existed, as at 2021-2022, could or would not have raised any impediment to their driving. Especially stark is the fact that in the case of Mr Mundy, no questions were asked which could have elicited any information in relation to his poor mental health. Nonetheless, individual responsibility is not something that can be overlooked. All of the men who died (and their co-drivers in the case of Mr Navin and Mr Seymour) were experienced competitors. They all knew the risks of competing and voluntarily assumed those risks. That having been said, I do not consider people suffering from the medical conditions that Mr Mundy and Mr Seymour had, should have been competing in such an event.

200. The recommendations that were made as a result of the internal investigations were comprehensive, and in my view, adequately address many of the factors associated with the inquest. I do not consider it necessary to repeat any of those recommendations. I note that most, if not all, have been implemented. To the extent that any remain outstanding, I urge Targa Tasmania Pty Ltd and Motorsport Australia to ensure their implementation before the event is held again. That said, and at the

risk of repetition, careful consideration must still be given to the physical and mental fitness of competitors participating in the event.

201. I wish to extend my appreciation to all counsel involved in the inquest for their assistance.

202. I conclude by expressing my sincere and respectful condolences to the families of Mr Navin, Mr Mundy, Mr Neagle and Mr Seymour on their losses.

Dated: 19 June 2025 at Hobart, in the State of Tasmania.

Simon Cooper
Coroner

Annexure 'A'

INQUEST INTO THE DEATHS OF SHANE NAVIN, LEIGH MUNDY, DENNIS NEAGLE AND ANTHONY SEYMOUR AT THE TARGA TASMANIA MOTORSPORT EVENT IN 2021 AND 2022

INDEX TO CORONER'S BRIEF OF EVIDENCE

NEW TAB	OLD TAB	DOCUMENT	DATE
CORONER'S SCOPE OF INQUIRY			
A		Matters for Inquiry	6 February 2024
B		Witness Schedule	5 July 2024
C		Summary of Factual Matters	16 August 2024
C.1		Summary of Factual Matters (Updated)	16 September 2024
VOLUME 1 - 2021 TARGA TASMANIA EVENT DOCUMENTS			
Motorsport Australia			
1.1	*A.4O*	2018 to 2022 Targa Agreement	18 January 2018
1.2		Targa Framework - Variation Letter - Executed	5 February 2020
1.3	*A.4P*	Motorsport Australia Tarmac Rally Standing Regulations	Undated
1.4	*A.4Q*	TARGA Technical Regulations	20 November 2019
1.5	*S.22*	2021 MSA Technical Appendix – Safety Cage Structures	1 January 2021
1.6	*N.27F*	Motorsport Safety Rescue – Rally Stages Procedures Guide and Forms	January 2021

NEW TAB	OLD TAB	DOCUMENT	DATE
1.7	*A.4S*	Motorsport Australia Rally Event Checker's Manual (in effect as at 2021 event)	Undated
1.7A		Rally Checker Manual Final Draft Board Approved	Undated
1.8	*A.4R*	Motorsport Australia TARGA Championship Sporting Regulations	29 March 2021
1.9	*N.27E*	Motorsport Safety Rescue – Medical Services Manual	6 April 2021
1.10	*A.4U*	Pre-event Checker's Report signed by Graham Malcolm	19 April 2021
Permits & third parties			
1.11	*A.4T*	Organising Permit issued by Motorsport Australia for 2021 Targa Tasmania event	19 April 2021 - 24 April 2021
1.12	*N.27C*	Tasmania Police Targa Event Policy 2021 (Woolley report)	Undated
1.12A	*N.31*	Affidavit of Debbie Williams (Commander of Police)	4 March 2024
1.13	*N.27H*	Rallysafe Course Vehicle Operation	Undated
Targa Australia			
1.14	*A.4V*	2021 Targa Tasmania 2021 Supplementary Regulations	9 March 2021
1.15	*A.8J*	2021 Targa Operations Manual	19 March 2021
1.16	*A.8C*	2021 SOS Point Manual	25 March 2021
1.17	*N.27B*	2021 Targa Tasmania Road Book	29 March 2021
1.18	*N.27G*	Targa Tasmania 2021 Team Handbook	12 April 2021
1.19	*N.27I*	Targa Tasmania 2021 Safety Plan	2021

NEW TAB	OLD TAB	DOCUMENT	DATE
1.20	*N.27D*	Targa Australia COVID-19 Safety Plan	Undated
1.21	*N.27J*	Targa Tasmania Summary of Road Closures	2021
1.22	*N.27K*	Targa Tasmania Leg Maps	2021
1.23	*A.8A*	2021 Reconnaissance Notes	2021
1.24	*A.8B*	2021 Road Book	2021
1.25	*A.8D*	2021 Set Up Diagrams	2021
1.26	*A.8E*	2021 SOS Diagrams	2021
1.27	*A.8F*	2021 Strip Maps	2021
1.28	*A.8G*	2021 Start and Finish Diagrams	2021
1.29	*A.8H*	2021 Targa Tasmania Competitor Briefing	2021
1.30	*A.8I*	2021 Targa Tasmania Competitor Briefing Electronic Verifications	2021
1.31	*A.8AB*	2021 Mt Arrowsmith Condition Blue Form	23 April 2021
1.32	*A.8AA*	2021 Cygnet Condition Blue Form	24 April 2021
1.33	*A.4Y*	Motorsport Australia Venue and Personnel Report signed by Hamish Marquis	19 April 2021
1.34	*A.4Z*	Motorsport Australia Venue and Personnel Report signed by Hamish Marquis	20 April 2021
1.35	*A.4AA*	Motorsport Australia Venue and Personnel Report signed by Hamish Marquis	21 April 2021

NEW TAB	OLD TAB	DOCUMENT	DATE
1.36	*A.4AB*	Motorsport Australia Venue and Personnel Report signed by Hamish Marquis	22 April 2021
1.37	*A.4AC*	Motorsport Australia Venue and Personnel Report signed by Hamish Marquis	23 April 2021
1.38	*A.4AD*	Motorsport Australia Venue and Personnel Report signed by Hamish Marquis	24 April 2021
Event Reports			
1.39	*A.4W*	Stewards Closing Report for the 2021 Targa Tasmania event signed by Ross Ferguson	19 April 2021 - 24 April 2021
1.40	*A.4X*	Post-event Checker's Report signed by Graham Malcolm	11 May 2021
1.41	*C.16* *N.11*	Statement of Dr Rik Hagen – Chief Medical Officer Targa Tasmania 2021	Undated
VOLUME 2 - DOCUMENTS RELATING TO NAVIN (CAR 602, 2021)			
Entry and pre-event documentation			
2.1	*A.4B*	2021 Targa Tasmania event - Scrutiny Statement of Vehicle Compliance #602	19 April 2021
2.2	*A.4F*	Shane Navin Driver Licence	Undated
2.3	*A.4G*	Glenn Evans Driver Licence	Undated
2.4	*A.4A*	Shane Navin Condition Registration Papers - Reg. No. 10893R	Undated
2.5	*A.4C*	Medical Information Form signed by Shane Navin	Undated
2.6	*A.4D*	Medical Information Form signed by Glenn Evans	Undated

NEW TAB	OLD TAB	DOCUMENT	DATE
2.7	*N.27A*	Miscellaneous documents (e.g. car registration, medical and licence of Mr Navin)	Various
Car 602 - Incident related documentation			
2.8	*N.01*	Police Report of Death for the Coroner	Undated
2.9	*N.02*	Affidavit of Life Extinct for Mr Navin	23 April 2021
2.10	*N.03*	Identification Affidavit for Mr Navin	26 April 2021
2.11	*N.06*	Interim Report for Preliminary Findings as to Cause of Death of Mr Navin	26 April 2021
2.12	*N.07*	Toxicology Report of Mr Navin	14 July 2021
2.13	*N.05*	Post-Mortem Examination of Mr Navin	20 August 2021
2.14	*N.04*	Identification Affidavit (Mortuary) for Mr Navin	8 November 2021
2.15	*A.4J*	2021 Targa Tasmania event - Vehicle Damage & Personal Injury Report - Shane Navin	23 April 2021
2.16	*N.08*	Transport Inspector – Alan Fitzpatrick	28 May 2021
2.17	*N.25*	Course checker footage	Undated
2.18	*N.25*	2021 Targa Tasmania Double Barrel Creek Car 650 (Footage)	Undated
2.19	*N.25*	753 MAC RUSSELL (Footage)	Undated
2.20	*N.25*	Nik Preston (Footage)	Undated
2.21	*N.25*	Volvo 122S Mt Arrowsmith (Footage)	Undated
2.22	*N.25*	Targa Tasmania – Mt. Arrowsmith second half – Car 714 [wvJdCyQ9MH4].mp4	Undated

NEW TAB	OLD TAB	DOCUMENT	DATE
2.23	*N.25*	**SENSITIVE** VTS_01_1.VOB	Undated
2.24	*N.25*	VTS_01_2.VOB	Undated
2.25	*N.25*	**SENSITIVE** VTS_01_3.VOB	Undated
2.26	*N.26A*	**SENSITIVE** - Photographs of incident	Undated
2.27	*N.26B*	**SENSITIVE** – Photographs of incident	Undated
2.28	*N.26C*	Photographs of the Mazda	Undated
2.29	*N.26D*	Photographs of car / helmet / seat and location of incident	Undated
2.30	*N.26E*	Photographs of road where incident occurred	Undated
Car 602 - Statements			
2.31	*N.10*	Affidavit of Andrew Perkins (Rallysafe report)	24 April 2021
2.32	*N.12*	Affidavit of Jennifer Navin (Next of Kin)	28 June 2021
2.33	*N.13*	Affidavit of Dean Gamblin (Attending Paramedic)	18 June 2021
2.34	*N.14*	Affidavit of Shayne Andrews (Attending Fireman)	4 May 2021
2.35	*N.15*	Affidavit of Graham Malcolm (Event Course Checker)	31 May 2021
2.36	*N.16*	Affidavit of Lynn Rattray (Driver of the Zero Car)	25 May 2021
2.37	*N.17*	Affidavit of Graham Copeland (Competitor)	28 June 2021
2.38	*N.18*	**SENSITIVE** - Affidavit of Glenn Evans (Navigator to Mr Navin)	25 April 2021

NEW TAB	OLD TAB	DOCUMENT	DATE
2.39	*N.18*	**SENSITIVE** - Further Affidavit of Glenn Evans (Navigator to Mr Navin)	25 May 2021
2.40	*N.19*	Affidavit of Constable Heather Gunton (Attending Police Officer)	6 July 2021
2.41	*N.20*	Affidavit of Senior Constable Timothy Anderson (Attending Police Officer)	18 July 2021
2.42	*N.21*	**SENSITIVE** - Affidavit of Sven Mason (Crash Investigation Officer)	15 July 2021
2.43	*N.22*	**SENSITIVE** - Further Affidavit of Sven Mason (Crash Investigation Officer)	15 July 2021
2.44	*N.23*	Affidavit of Constable Paul Squire (Police Photographer at scene)	3 May 2021
2.45	*N.24*	Affidavit of Senior Constable Leslie Barrow (Police Photographer at scene)	7 July 2021
VOLUME 3 - DOCUMENTS RELATING TO MUNDY AND NEAGLE (CAR 902, 2021)			
Entry and pre-event documentation			
3.1	*C.35*	Porsche Service Records	Various
3.2	*C.13*	Mundy's Medical Records	Various
3.3	*C.13*	Mundy: Exported Patient Record	Various
3.4	*C.13*	Mundy: Dr MacArthur (7 parts)	Various
3.5	*A.4E*	Leigh Mundy License Renewal Application	22 October 2019
3.6	*C.30*	Team Mundy and Neagle Targa Entry Documents	Undated
3.7	*C.31*	Targa Medical Information – Mr Mundy	19 April 2021
3.8	*C.32*	Targa Medical Information – Mr Neagle	Undated

NEW TAB	OLD TAB	DOCUMENT	DATE
3.9	*C.33*	Driver's Licence – Mr Mundy	Undated
3.10	*C.34*	Registration Details – Mr Mundy	Undated
3.11	*C.28*	Cygnet Stage Pace Notes	Undated
Car 902 - Incident related documentation			
3.12	*C.1*	Police Report of Death for the Coroner for Mr Mundy	Undated
3.13	*C.2*	Affidavit of Life Extinct for Mr Mundy	24 April 2021
3.14	*C.4*	Identification Affidavit (Mortuary) for Mr Mundy	24 April 2021
3.15	*C.3*	Identification Affidavit for Mr Mundy	25 April 2021
3.16	*C.5*	Interim Report for Preliminary Findings as to Cause of Death of Mr Mundy	26 April 2021
3.17	*C.6*	Toxicology Report of Mr Mundy	20 July 2021
3.18	*C.5*	Post-Mortem Examination of Mr Mundy	20 August 2021
3.19	*C.7*	Police Report of Death for the Coroner for Mr Neagle	Undated
3.20	*C.8*	Affidavit of Life Extinct for Mr Neagle	20 April 2021
3.21	*C.10*	Identification Affidavit (Mortuary) for Mr Neagle	24 April 2021
3.22	*C.9*	Identification Affidavit for Mr Neagle	25 April 2021
3.23	*C.11*	Interim Report for Preliminary Findings as to Cause of Death of Mr Neagle	26 April 2021
3.24	*C.12*	Toxicology Report of Mr Neagle	22 July 2021
3.25	*C.11*	Post-Mortem Examination of Mr Neagle	20 August 2021
3.26	*C.36*	Tasmania Police – Incident Response	21 October 2021

NEW TAB	OLD TAB	DOCUMENT	DATE
3.27	*C.25*	In car footage	Undated
3.28	*C.37*	Property Receipts	Undated
Car 902 - Statements			
3.29	*C.14*	Affidavit of James Mundy (Next of Kin)	26 April 2021
3.30	*C.15*	Affidavit of Louise Neagle (Next of Kin)	21 May 2021
3.31	*C.17*	Affidavit of Marcin Jankowiak (Spectator)	21 May 2021
3.32	*C.18*	Affidavit of Jie Holton (Spectator)	21 May 2021
3.33	*C.19*	Affidavit of Jarrod Leonard (Spectator / photographer)	21 May 2021
3.34	*C.19*	Photographs taken by Jarrod Leonard	24 April 2021
3.35	*C.19*	Video of Crash – Leonard	24 April 2021
3.36	*C.20*	Affidavit of Jane Forey (Friend of Mr Mundy)	25 October 2021
3.37	*C.21*	Affidavit of Andrew Perkins (Examination of Rallysafe Unit)	8 May 2021
3.38	*C.21*	Andrew Perkins Rallysafe System Overview	Undated
3.39	*C.21*	RallySafe Data	Undated
3.40	*C.24*	Affidavit of Constable Angela Ghedini	10 November 2021
3.41	*C.24*	**SENSITIVE** - Photographs taken by Constable Angela Ghedini	Undated
3.42	*C.26*	Affidavit of Jason Hardy (Transport Inspector)	14 October 2021
3.43	*C.22*	Affidavit of Kelly Cordwell	16 January 2023

NEW TAB	OLD TAB	DOCUMENT	DATE
3.44	*C.22*	**SENSITIVE** - Kelly Cordwell's Collison Analysis Report	21 April 2021
3.45	*C.23*	Affidavit of Senior Constable Adam Hall	18 September 2022
3.46	*C.23*	Scene Survey conduct by Senior Constable Hall	Undated
VOLUME 4 - DOCUMENTS RELATING TO 2021 MOTORSPORT AUSTRALIA INVESTIGATORY TRIBUNAL			
4.1	*A.4L*	MSA Incident Investigation Report - Car #602 - Scott McGrath	05 July 2021
4.2	*A.4K*	MSA Incident Investigation Report - Car #902 - Scott McGrath	15 July 2021
4.3	*C.27* *N.09*	Targa Tasmania 2021 Investigatory Tribunal Report and Findings	1 September 2021
4.4	*N.28*	Richard Townley comments on the report of Targa Tasmania 2021 Investigatory Tribunal updated 27 November 2021	27 November 2021
4.5	*N.18*	Further Affidavit of Glenn Evans responding to Tribunal's Findings	6 October 2021
4.6	*N.18*	Email from Mr Evans to Mr Mason regarding further affidavits	6 October 2021
4.7	*N.18*	Glenn Evans response to Targa Tasmania 2021 Investigatory Tribunal Report and Findings	October 2021
4.7A		Glenn Evans, TS07 Cethena, Car 602 in-car footage	29 April 2021
4.7B		Glenn Evans, TS07 The Slideling, Car 602 in-car footage	19 August 2024

NEW TAB	OLD TAB	DOCUMENT	DATE
4.7C		Response to Targa Tasmania Investigatory Tribunal Report	28 October 2021
4.7D		Preliminary Response to Addendum Report of the MA Tribunal	15 February 2022
4.8	*N.29*	Emails between Motorsport Australia and Tasmania Police	Various
4.9	*N.29A*	Addendum and Amended Addendum to the Targa Tasmania 2021 Investigatory Tribunal Report and Findings	14 March 2022
4.10	*N.30*	Email from Mrs Navin to the Coroner's Court	22 November 2023
4.11	*N.30a*	Letter to the Coroner from Ashley Navin	10 November 2021
4.12	*N.30b*	Mrs Navin response to Targa Tasmania 2021 Investigatory Tribunal Report and Findings	Undated
4.13	*A.5*	Letter from Hall & Wilcox to Counsel Assisting regarding Confidential Memo	22 July 2024
4.14	*A.6*	Confidential Memo from 2021 Investigatory Tribunal to Motorsport Australia	24 August 2021
VOLUME 5 - 2022 TARGA TASMANIA EVENT DOCUMENTS			
Motorsport Australia			
5.1	*C.29*	Rally Road Checker's Manual – Motorsport Australia	July 2021
5.2	*A.8M*	2022 Motorsport Australia Technical Regulations	2 February 2022
5.3	*A.8N*	2022 Motorsport Australia Sporting Regulations	14 April 2022

NEW TAB	OLD TAB	DOCUMENT	DATE
5.4	*A.4AH*	Pre-Event Competition Checker Report -for the 2022 Targa Tasmania Event signed by Lynn Rattray	4 April 2022
5.4A		Pre-Event Event Checker's Report	20 April 2022
Permits & third parties			
5.5	*A.4AE*	Organising Permit issued by Motorsport Australia - Targa Tasmania 2022	22 April 2022
Targa Australia			
5.6	*A.8R*	2022 SOS Point Manual	25 March 2021
5.7	*A.8O*	2022 Targa Operations Manual	18 August 2021
5.8	*A.4AF*	2022 Targa Tasmania - Supplementary Regulations	28 March 2022
5.9	*A.8P*	2022 Targa Tasmania Safety Plan	2022
5.10	*A.8Q*	2022 Risk Management Plan	2022
5.11	*A.8K*	2022 Reconnaissance Notes	8 April 2022
5.12	*A.8L*	2022 Road Book	26 April 2022 - 1 May 2022
5.13	*A.8S*	2022 Set Up Diagrams	2022
5.14	*A.8T*	2022 SOS Diagrams	2022
5.15	*A.8U*	2022 Strip Maps	2022
5.16	*A.8V*	2022 Start and Finish Diagrams	2022
5.17	*A.8W*	2022 Targa Tasmania Competitor Briefing	2022
5.18	*A.8X*	2022 Targa Tasmania First Time and Tour Briefing	2022

NEW TAB	OLD TAB	DOCUMENT	DATE
5.19	*A.8Y*	2022 Targa Safety Video	2022
5.20	*A.8Z*	2022 Rally Safe Presentation	2022
5.21	*A.8AC*	2022 Mt Roland Condition Blue Form	27 April 2022
5.22	*A.4AL*	Motorsport Australia Venue and Personnel Report signed by Hamish Marquis	26 April 2022
5.23	*A.4AM*	Motorsport Australia Venue and Personnel Report signed by Hamish Marquis	27 April 2022
5.24	*A.4AN*	Motorsport Australia Venue and Personnel Report signed by Hamish Marquis	28 April 2022
5.25	*A.4AO*	Motorsport Australia Venue and Personnel Report signed by Hamish Marquis	29 April 2022
5.26	*A.4AP*	Motorsport Australia Venue and Personnel Report signed by Hamish Marquis	30 April 2022
5.27	*A.4AQ*	Motorsport Australia Venue and Personnel Report signed by Hamish Marquis	1 May 2022
2022 - Post-Event Reports			
5.28	*A.4AG*	Stewards Closing Report for the 2022Targa Tasmania event signed by Ross Ferguson	26 April 2022 - 1 May 2022
5.29	*A.4AK*	Safety Delegate Checklist Targa Tasmania 2022 signed by Michael Smith	1 May 2022
5.30	*A.4AI*	Post-Event Checker's Report for the 2022 Targa Tasmania Event signed by Stephen Horobin	8 May 2022

NEW TAB	OLD TAB	DOCUMENT	DATE
5.31	*A.4AJ*	Clerk of the Course Report for the 2022 Targa Tasmania signed by Hamish Marquis	2 June 2022
5.32	*S.28*	Miscellaneous Paperwork	Various
5.33	*S.20*	MOTEC Engine Report undertaken by Mark O'Connor	30 October 2022
5.34	*S.21*	Report of Andrew Perkins (Examination of Rallysafe Unit)	Undated
5.35	*S.21*	Rallysafe TS07 Car 903 Speed Data (Note)	Undated
5.36	*S.21*	Rallysafe TS07 Car 903 Speed Data (Google Earth file)	Undated
VOLUME 6 - DOCUMENTS RELATING TO ANTHONY SEYMOUR (CAR 903, 2022)			
Entry and pre-event documentation			
6.1	*A.4H*	2021 Targa Tasmania event - Infringement Notice - Anthony Seymour	21 April 2021
6.2	*A.4I*	2022 Targa Tasmania event - Scrutineering Checklist - Car #903	Undated
6.3	*S.24*	Olivers Road Crash History	Undated
6.4	*S.24*	Olivers Road Crash History Table	Undated
6.5	*S.07*	Mr Seymour's GP Records	Various
6.6	*A.4M*	Anthony Seymour - Entry, Medical, Recce Declaration	20 April 2022
6.7	*S.23*	Bureau of Meteorology – Daily Weather Observations for Sheffield, Tasmania	April 2022
Car 903 - Incident related documentation			

NEW TAB	OLD TAB	DOCUMENT	DATE
6.8	*S.01*	Police Report of Death for the Coroner	27 April 2022
6.9	*S.02*	Police Identification Affidavit for Mr Seymour	29 April 2022
6.10	*S.03*	Mortuary Identification Affidavit for Mr Seymour	29 April 2022
6.11	*S.04*	Interim Report for Preliminary Findings as to Cause of Death of Mr Seymour	29 April 2022
6.12	*S.04*	Post-Mortem Examination of Mr Seymour	20 December 2022
6.13	*S.05*	Toxicology Report of Mr Seymour	Undated
6.14	*S.26*	Tasmania Police Incident Report	27 April 2022
6.15	*A.4N*	2022 Targa Tasmania event - Competitor Injury Report - Anthony Seymour	27 April 2022
6.16	*S.27*	Property Receipts	Various
Car 903 - Statements			
6.17	*S.06*	Affidavit of Andrew Francey (Intensive Care Paramedic)	10 November 2022
6.18	*S.08*	Affidavit of Sandra Seymour (Next of Kin)	22 June 2022
6.19	*S.08*	**SENSITIVE** – In car footage (20220427_151914_NF)	27 April 2022
6.20	*S.08*	**SENSITIVE** – In car footage (20220427_151914_NR)	27 April 2022
6.21	*S.08*	**SENSITIVE** – In car footage (20220427_152015_NF)	27 April 2022
6.22	*S.08*	**SENSITIVE** – In car footage (20220427_152015_NR)	27 April 2022

NEW TAB	OLD TAB	DOCUMENT	DATE
6.23	*S.08*	**SENSITIVE** – In car footage (20220427_152025_EF)	27 April 2022
6.24	*S.08*	**SENSITIVE** – In car footage (20220427_152025_ER)	27 April 2022
6.25	*S.08*	**SENSITIVE** – Crash footage	27 April 2022
6.26	*S.08*	**SENSITIVE** – In car footage (SNOK)	27 April 2022
6.27	*S.09*	Affidavit of Crichton Lewis (Competitor)	25 July 2022
6.28	*S.10*	Affidavit of Anthony Carr (Competitor)	26 July 2022
6.29	*S.11*	Affidavit of James Stewart (Competitor)	31 August 2022
6.30	*S.12*	Affidavit of Ethan Fletcher (Competitor)	Undated and unsigned
6.31	*S.13*	Affidavit of Senior Constable Peter McCarron (Crash Investigator) – photos included	15 May 2022
6.31A		Snip of Photographs 135-143	5 May 2022
6.31B		Photographs	
6.32	*S.13*	Walkthrough video of the incident	27 April 2022
6.33	*S.14*	Affidavit of Senior Constable Maree Fish	15 May 2022
6.34	*S.14*	**SENSITIVE -** Photos to the Affidavit of Senior Constable Fish	Undated
6.35	*S.15*	Affidavit of Senior Constable Tracy Lincoln (Police photographer of the Lotus)	18 October 2022
6.36	*S.15*	Photos relating to the Affidavit of Senior Constable Lincoln's Affidavit	18 October 2022

NEW TAB	OLD TAB	DOCUMENT	DATE
6.37	*S.16*	Affidavit of Sergeant Scott McKinnell (Drone pilot and created 3D model of the incident site)	17 November 2022
6.38	*S.17*	Affidavit of Senior Constable Michal Rybka (Crash Investigator)	10 December 2022
6.39	*S.18*	Affidavit of Senior Constable Matthew O'Neil (Attending Police Officer)	5 January 2023
6.40	*S.18*	Scene sketch (related to Affidavit of Senior Constable O'Neil)	5 January 2023
6.41	*S.19*	Affidavit of Benjamin Hunt (Transport Safety Officer)	3 June 2022
VOLUME 7 - DOCUMENTS RELATING TO 2022 REVIEW PANEL			
7.1	*S.30A*	Targa Tasmania Review Panel's Report (2022)	2022
7.2	*S.30B*	Media Release, '*Targa Tasmania Postponed to October*'	22 February 2023
7.3	*S.25*	Submission to Targa Review Panel – Richard Townley	Undated
VOLUME 8 - CURRENT MOTORSPORT AUSTRALIA DOCUMENTS (2024)			
8.1	A.4AR	2024 Motorsport Australia Rally Standing Regulations	1 January 2024
8.2	A.4AS	2024 Motorsport Australia Tarmac Rally Technical Regulations	Undated
8.3	A.4AT	2024 Motorsport Australia Tarmac Rally Event Organiser Requirements	Undated
VOLUME 9 - RELEVANT CORRESPONDENCE FROM INTERESTED PARTIES			
9.1	*S.29*	Letter from MSA CEO Eugene Arocca to Coroner's Court registering inquest interest	4 May 2022

NEW TAB	OLD TAB	DOCUMENT	DATE
9.2	*S.30*	Letter from Hall & Wilcox to the Coroner	27 February 2023
9.3	*A.1*	Letter from Hall & Wilcox to Counsel Assisting enclosing Summary of Factual Matters	11 July 2024
9.4	*A.2*	Summary of Factual Matters	16 July 2024
9.5	*A.3*	Letter from Hall & Wilcox to Counsel Assisting enclosing additional documents	11 July 2024
9.6	*A.4*	Index of additional documents provided by Motorsport Australia	11 July 2024
9.7	*A.7*	Letter from Kingston Reid to Counsel Assisting enclosing additional documents	29 July 2024
9.8	*A.8*	Index of further documents provided by Targa	29 July 2024
9.8A		Email from Kingston Reid regarding online verification process *note: Attachment included at tab 1.30*	2 August 2024
VOLUME 10 - FURTHER EVIDENCE SERVED BY INTERESTED PARTIES			
10.1		Statement of Hamish Marquis - served by Targa	7 August 2024
10.1A		Supplementary Statement of Hamish Marqus	22 August 2024
10.2		Statement of Mark Perry - served by Targa	7 August 2024
10.3		Statement of Barry Oliver - served by Targa	7 August 2024
10.4		Statement of Neville Mould - served by Targa	13 August 2024
10.5		Institutional Response – Updated	26 August 2024

NEW TAB	OLD TAB	DOCUMENT	DATE
10.6		Statement of Scott McGrath	Undated
10.7		Statement of Lynn Rattray	20 September 2024
10.8		Statement of Graham Malcom	20 September 204
10.9		Timeline of Safety Actions 2021&2022	Undated
10.10		Neal Bates CV – Motorsport	2024
10.11		Garry Connelly CV – Motorsport	2024
10.12		Matthew Selley CV – Motorsport	2024
10.13		Statement of Stephen Horobin	24 September 2024