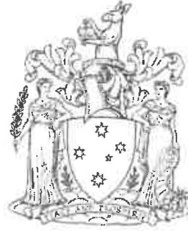

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 001632

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	Paresa Antoniadis Spanos, Coroner
Deceased:	Danny Leigh Edlington
Date of birth:	27 September 1989
Date of death:	4 April 2015
Cause of death:	Head Injury
Place of death:	Seaford, Victoria

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of DANNY LEIGH EDLINGTON without holding an inquest:

find that the identity of the deceased was DANNY LEIGH EDLINGTON

born on 27 September 1989

and that the death occurred on 4 April 2015

at the Frankston City Motorcycle Park, 102R Old Wells Road, Seaford, Victoria

from:

I (a) HEAD INJURY

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Mr Edlington was a 25 year old man who resided in Wy Yung, Victoria, and is survived by his wife, Katherine (Katie) Edlington, and child, Tate Edlington (Tate). Mr Edlington was a self-employed spray painter who had a past medical history of Klippel-Trenauney Syndrome (KTS) that affected his right leg.[1]

2. Mr Edlington had ridden motorcycles from a young age but stopped riding for a time after being advised by his general practitioner that KTS could cause him to 'bleed out' if he had an accident.[2] Mr Edlington took up riding again in mid-2014 against his parents' wishes. When he started riding again, Mr Edlington rode a smaller 250cc motorcycle in the bush and on a small private track in Bairnsdale. According to Mrs Edlington, he said he did not enjoy riding in the bush and expressed a desire to begin track riding again.

3. Sometime in early 2015, Mr Edlington bought a 450cc motorcycle. He rode it every weekend at open track days at different motorcycle parks but mainly rode at a track in Sale, Victoria.

4. At about 7.30am on 4 April 2015, Mr Edlington travelled from Bairnsdale to the Frankston City Motorcycle Park (the track)[3] with his wife and child arriving at about 10.30am. The track was moderately dry, the weather conditions were clear[4] and it was considered a fairly average day at the track with an acceptable number of motocross riders.[5]

5. A short time after arriving at the track Mr Edlington went out for a ride to familiarise himself with the track. He rode two 20 minute sessions. After each circuit, Mr Edlington would

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[1] Klippel-Trenaunay Syndrome is a rare congenital vascular disorder in which a limb may be affected by port wine stains (red-purple birthmarks involving blood vessels), varicose veins, and/or too much bone and soft tissue growth. The limb may appear to be larger, longer, and/or warmer than normal. The cause is unknown.

[2] Coronial Brief of Evidence, Statement of Katherine (Katie) Edlington.

[3] Frankston City Motorcycle Park was established in 1980 and is run by volunteer members. The track now operates under an affiliation with Motorcycling Victoria and a lease agreement with Frankston City Council. At the time of Mr Edlington's accident the track was not affiliated with Motorcycling Victoria.

[4] Coronial Brief of Evidence, Statement of Senior Constable Darren Morgan.

[5] Coronial Brief of Evidence, Statement of Wayne Ridley. Motocross is a form of off-road motorcycle racing held on enclosed off-road circuits.

return to his family for a break of around 30 minutes where he would have a drink and something to eat. He wore all of his safety gear during the sessions which consisted of a helmet, knee braces, motorcycle boots, motorcycle pants and a motorcycle jersey. According to Mrs Edlington, her husband told her during one of the breaks that he thought that the jumps were 'big' but not beyond his capabilities.[6]

6. At about 2.00pm, Mr Edlington returned to the track for the third time. Before he left he told his wife that he would not do anything he was uncomfortable with, as he was acutely aware that his parents did not like, or want him riding. Within minutes of returning to the circuit Mr Edlington approached a two-stage jump on the main track. "*The jump itself is the first jump on straight number four of the track. It is preceded by a right turn which leaves enough room to accelerate to the required speed to successfully navigate the jump. The jump consists of an initial elevation which plateaus in the middle and then has another smaller jump 25 metres further along*".[7]

7. According to one witness, Mr Edlington landed awkwardly on the plateau after attempting the jump. The same witness saw Mr Edlington begin to fall from the motorcycle but continue to hold onto the handlebars in an attempt to maintain control. This action caused Mr Edlington to 'whiskey throttle' the motorcycle,[8] leading him to fall to his knees, the motorcycle dragging him from the right side of the jump to the left and causing him to end up on the crest of the second jump.[9]

8. As this occurred another rider approached the jump[10] at a speed estimated by one witness to be between 80 and 90km/h when he took the first stage of the jump. The rider was airborne and unable to change direction or reduce speed when he saw Mr Edlington. As a result, the second rider made contact with Mr Edlington, the lower frame of his motorcycle impacting Mr Edlington's head. After impact, both riders fell from their motorcycles.

9. On seeing this, the track Marshall activated the stop lights for the entire track. Within seconds other riders arrived at the scene to offer assistance to both riders.[11] When the seriousness of

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[6] Coronial Brief of Evidence, Statement of Katherine (Katie) Edlington.
[7] Coronial Brief of Evidence, Statement of Senior Constable Darren Morgan.
[8] Whiskey throttle is when a person gives too much throttle and they start to slip off the back of the bike and their hand pulls the throttle more. The rider then loses control, panics and loses even more control. Senior Constable Darren Morgan stated that whiskey throttling is caused when riders are falling from the motorcycle but attempting to hang on and regain control, and as a result the motorcycle accelerates and decelerates uncontrollably.
[9] Coronial Brief of Evidence, Statement of Jarrod Martin.
[10] Senior Constable Darren Morgan's investigation identified that the second rider's experience comprised of riding for several years, with him knowing the track well after riding at the venue for several months up to two to three times a week.
[11] The second rider sustained the injuries of a broken hand, cheekbone and other bruises and abrasions. He did not require hospitalisation.

Mr Edlington's injuries were realised a call was immediately made to 000 while cardiopulmonary resuscitation (CPR) was commenced.

10. At 2.24pm, the Ambulance Victoria paramedics arrived at the scene and took over CPR. About 20 minutes later, Senior Constable (SC) Darren Morgan from Frankston Highway Patrol arrived at the scene and commenced a coronial investigation, later compiling the brief of evidence on which this finding is largely based.

11. The paramedics ceased CPR at about 3.02pm, having assessed that Mr Edlington's injuries were too severe to sustain life. They pronounced Mr Edlington deceased at 3.04pm.

12. A short time later, at SC Morgan's request, police Crime Scene Officers arrived and took photographs and measurements of the scene. A WorkSafe Inspector also attended the track, later determining that as the incident did not take place at a "workplace", a WorkSafe investigation would be beyond their remit.[12]

13. During his investigation SC Morgan spoke with other riders and track officials about the incident. He concluded that experienced riders would have attempted to take the jump in one movement at a speed between 80 and 90km/h in order to complete the jump successfully. SC Morgan suggested that *"less experienced riders will approach at a lower speed, navigate the first jump, land on the plateau, and then attempt the second part of the jump"*.[13] He further suggested that this appears to have been what Mr Edlington was attempting to do when he came to grief.

14. Senior Forensic Pathologist, Dr Michael Burke of the Victorian Institute of Forensic Medicine, reviewed the circumstances of the death as reported by police to the coroner, post-mortem computer assisted tomography (PMCT) scans, and performed an external examination of Mr Edlington's body in the mortuary. Dr Burke stated that the PMCT showed an extensive fracture to the left side of the head with a depressed fracture at the left temporal region[14] with associated traumatic subarachnoid haemorrhage.[15] He advised that the external examination showed injuries in keeping with the clinical history and that Mr Edlington's KTS did not contribute to his death. Routine post-mortem toxicological analysis did not detect any alcohol or other commonly encountered drugs or poisons in Mr Edlington's system.

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[12] Leading Senior Constable Tracey Ramsey of the Police Coronial Support Unit of the Coroners Court of Victoria advised me on 19 April 2018, that she had received verbal advice from WorkSafe Victoria that they had not undertaken an investigation on the day of the incident, as the people at the Frankston City Motorcycle Park were volunteering their services, rather than 'working' in a paid capacity at the venue.

[13] Coronial Brief of Evidence, Statement of Senior Constable Darren Morgan.

[14] The temporal region relates to one of the four major lobes of the cerebral cortex in the brain of humans. Temple indicates the side of the head behind the eyes.

[15] Subarachnoid haemorrhage is defined as the sudden leak (haemorrhage) of a blood vessel over the surface of the brain. It occurs in various clinical contexts, the most common being head trauma.

15. Dr Burke advised that it would be reasonable to attribute Mr Edlington's death to a *head injury,* without the need for an autopsy.

16. Following Mr Edlington's death the Frankston City Council (FCC) immediately closed the track for a period of time. The track was re-opened on 21 November 2015, after the track's operators, Frankston City Motorcycle Park Incorporated (FCMP) became affiliated with Motorcycling Victoria as a condition of their lease from FCC.[16] The terms of the lease also stipulated that the track was to be represented to the community as a "recreational" facility where no competitive riding was permitted to take place. The FCC were of the view that providing access to a non-competitive based venue would deter motorcycles being ridden illegally within Council parks and other recreational areas.

17. The FCC also advised that annual independent audits of the track had been undertaken,[17] and that Council Officers receive updates, reports, and continue to meet regularly with the operators to discuss the outcomes and recommendations of audits and any other safety concerns that have been identified or have arisen.[18] They acknowledged that the main safety concerns that had been addressed were the presence of trees and their proximity to the track, as well as the adherence of the track operating within the constraints of "Site Conservation" secondary to the existence of an Environmental Clause with the Frankston Planning Scheme and State Control Clauses.[19]

18. I made enquiries with the FCMP's president, Wayne Ridley, regarding what, if any, regulation there is of the track or whether there are any industry guidelines in relation to safety. Mr Ridley advised that Motorcycling Victoria had conducted an inspection of the track prior to Mr Edlington's death and concluded that they were satisfied that the track was safe.[20] Mr Ridley also affirmed that it was standard for the number of riders on the track to be controlled by the Marshall on duty at the time, where the number was determined by a 'visible count' with 22 motorcycles being ridden on the day of Mr Edlington's incident. Mr Ridley went on to say that leading up to the accident, 50 motorcycles had been permitted to be on the track at any one time, however, this number had since been revised to 35 in the aftermath of Mr

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[16] Affiliation with Motorcycling Victoria provides membership to the operators of the track and ensures a level of accreditation to operate the facility in accordance with the standards set out in in the Motorcycling Victoria Guidelines. Membership with the governing body ensures that Motorcycling Victoria have greater oversight into the operations of the track.

[17] Frankston City Council's Chief Executive Officer, Dennis Hovenden identified in his statement of 7 September 2017, that the Council has ensured for many years that annual independent audits of the track had been undertaken. In 2014, an "On Site Track Assessment" was prepared by Australian Risk Services. In September 2014, a licenced Motorcycling Australia Venue Inspector undertook an inspection of the track. He was the same person engaged to review the track after Mr Edlington's accident.

[18] Statement of Dennis Hovenden, 7 September 2017.

[19] Ibid.

[20] Statement of Wayne Ridley, 16 March 2017.

Edlington's death. He also advised that the minimum safety gear required to be worn on the track was an Australian Standards approved helmet, correct off-road motorcycle boots, a full length jersey and pants, and approved motorcycle gloves.

19. In light of the circumstances surrounding Mr Edlington's death, I requested that the Court's Coroners Prevention Unit (CPU),[21] provide me with information about previous coronial findings involving off-road motorcycling use and advice about the extent to which off-road motorcycling is regulated.

20. The CPU identified that between the years 2000 and 2015 there were a total of 84 off-road motorcycle deaths. Of these, 18 occurred at a motorcycle track venue, with two deaths being recorded as occurring at the Frankston Motorcycle Park.[22] With regard to my enquiry about regulation the CPU advised that the industry is only regulated when a club is affiliated with Motorcycling Victoria,[23] with it being the club's choice to affiliate themselves with the organisation. Affiliation is voluntary however in some instances councils who lease the land to clubs might require affiliation as part of the lease agreement.

21. In addition to comments and recommendations made by me in the findings into the deaths of Mr Garni Suleman[24] and Mr Adam Alward,[25] comments and recommendations have been made by coroners in five other findings, concerned in some cases with specific safety issues arising from the circumstances of the particular case, and in others with the broader challenges of regulating and improving the safety of off-road motorcycle riding. [26] For convenience, a list of all the recommendations made by Victorian coroners dating back to the year 2000 are outlined in 'Attachment A' to this finding.

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[21] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the Coroner. The CPU assists the Coroner to formulate prevention recommendations and comments, and monitors and evaluates their effectiveness once published. They provide and identify areas of improvement so that similar deaths may be avoided in the future.

[22] Since Mr Edlington's death, there has been a further fatality at the Frankston City Motorcycle Park. This matter is still under investigation and involves a 16 year old male rider who died on 16 December 2017 from apparent head injuries when he fell from his motorcycle after attempting a jump. Whilst on the ground he was struck by another rider from behind.

[23] Motorcycling Australia is the peak body for motocross in Australia. It is supported by the Australian Sports Commission. Each year, Motorcycling Australia develop a Manual of Motorcycle Sport which outlines the rules and guidelines for participating in and conducting motorcycle sport. Motorcycling Victoria is the State Controlling Body (SCB) aligned with Motorcycling Australia that represents motorcycle sport and recreation in Victoria. Motorcycling Australia and the SCBs administer all competitions under common rules and the SCBs have delegated authority to licence competitions, venues and control the sport at State level. The two bodies are also concerned in part with venue and track standards, risk management and all aspects of safety.

[24] COR 2010 0243.

[25] COR 2013 1022.

[26] Deputy State Coroner Iain West conducted an investigation into the death of Blade Barrett (COR 2000 1069), Coroner Jane Hendtlass conducted an investigation into the death of Anthony Roach (COR 2007 0739), Coroner John Olle conducted an investigation into the death of Simon Gardner (COR 2009 3877) and Coroner Rosemary Carlin conducted an investigation into the deaths of Phillip Harrison (COR 2011 0488) and Oscar McIntyre (COR 2012 0741).

22. I find that Mr Edlington, late of 185 Bullumwaal Road, Wy Yung, Victoria, died at the Frankston City Motorcycle Park, 102R Old Wells Road, Seaford, Victoria, on 4 April 2015, as a result of a head injury sustained when he fell while negotiating a two-stage jump and was impacted by another rider and his motorcycle.

23. The weight of the evidence supports a finding that while Mr Edlington was relatively unfamiliar with the track in question, he had successfully ridden two prior circuits earlier that day and had responsibly rested and refreshed himself in between circuits.

24. The weight of the evidence also supports a finding that the other rider was airborne when Mr Edlington fell into his path and was unable to avoid the collision.

COMMENTS

Pursuant to section 67(3) of the ***Coroners Act 2008,*** I make the following comments in connection with the death:

1. This case highlights once again the inherent dangers of motocross riding or off-road motorcycle riding, even at specifically designed venues.

2. Mr Edlington was wearing appropriate protective gear and had ridden the circuit twice in order to familiarise himself with its layout and challenges.

3. Safety audits of the track appears to focus on safe negotiation of the track in terms of a good surface, an absence of latent dangers, proximity of trees and shrubs and the like.

4. While the track is for recreational use and is not a "racing" or competitive track, there is no indication that FCMP or its official address competitive behaviour like racing.

5. A reduction of riders allowed on the track at any one time from 50 to 35, in the aftermath of Mr Edlington's death, should improve safety at the track to some extent, if enforced by FCMP officials.

RECOMMENDATION

Pursuant to section 73(2) of the ***Coroners Act 2008,*** I make the following recommendation in connection with the death:

1. That FCMP develops protocols or guidelines to be enforced by their officials at the track requiring separation of riders by requiring them to stagger their starts and/or otherwise maintain a safe distance from each other in order to minimise the risk of collision between riders and the risk that they may collide with each other and or come into contact with each other when one has already come to grief.

I direct that a copy of this finding be provided to the following:

The family of Danny Edlington

Senior Constable Darren Morgan, Frankston Highway Patrol, Carrum Downs

Frankston City Council

Frankston City Motorcycle Club

Motorcycle Victoria

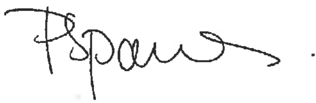
Motorcycling Australia

VicRoads/Victorian Motorcycle Advisory Council

Transport Accident Commission

WorkSafe

Signature:



PARESA ANTONIADIS SPANOS
CORONER
Date: 11 July 2018

Attachment A

21 November 2003 – Deputy State Coroner Iain West

Case 20001069 Blade Barrett, 12 year old male

Brief Circumstances Mr Barrett was riding his Kawasaki KX 80CC motorcycle at the Frankston Motorcycle Park in Seaford, Victoria. It appears that he lost control of the motorbike on a bend, eventually landing sideways in a ditch. Ambulance Victoria paramedics attended the scene and conveyed him to the Frankston Hospital. Mr Barret died from a head injury he sustained after he fell from his motorcycle.

Recommendations

Recommendation 1. That there be greater interaction between non-competition orientated clubs such as Frankston Motorcycle Park and Motor Cycling Victoria, the controlling body for competition motorcycle activities in the State. Such interaction would ensure that the expertise of Motor Cycling Victoria, in all aspects of this sport, would be available to the benefit of recreational clubs.

Recommendation 2. That the Frankston Motorcycle Park consider the installation of a suitable public address system that would enable spectators and/or family members of riders, to be promptly alerted to the location of an adverse incident occurring at an unsighted part of the track. Sadly a lack of communication regarding the location of Blade deprived his mother of the opportunity of being with him for any significant period, prior to his transfer to hospital.

Recommendation 3. That upon purchasing a second-hand vehicle for which it is not mandatory to obtain a Roadworthy Certificate, the purchaser ensures that the vehicle is mechanically assessed by a licensed vehicle tester, or appropriately qualified automotive mechanic, before using it.

Responses The Coroners Act 1985 was the current legislation in force at this time and did not mandate that recommendations required a response. As such no responses were received by the Court.

15 March 2011 – Coroner John Olle

Case 20093877 Simon Gardner, 14 year old male

Brief Circumstances Mr Gardner was riding an unregistered motorcycle in a paddock with three friends in Gisborne South, Victoria. Two of the friends were driving an unregistered Datsun station wagon. Mr Gardner rode his motorcycle into a ravine at the end of the paddock. One of his friends drove the Datsun towards the ravine where Mr Gardner approached the car at speed. The driver steered the Datsun to the left to avoid a collision however it appears the Mr Gardner has turned to the right and the two vehicles have collided with the Datsun driving over the top of Mr Gardner. Mr Gardner died from chest injuries which included a lacerated aortic artery, bilateral pneumothoraces and lacerations to his main bronchus and right lung.

Recommendations **Recommendation 1**. That the Department of Health implement a Victorian Injury Prevention Strategy and place off-road motorcycling safety as a key priority under this Strategy.

Recommendation 2. That as part of the Victorian Injury Prevention Strategy, the Department of Health facilitate a targeted awareness campaign to address the safety of children riding motorcycles informally with friends and family.

Recommendation 3. That VicRoads establish a sub-committee of the Victorian Motorcycling Advisory Council whose prime responsibility should be examining off-road motorcycling in order to develop evidence-based strategies to reduce the number of injuries. The committee members should extend beyond road safety groups to include appropriate bodies such as the Department of Sustainability and Environment, the Department of Health and off-road riding associations.

Responses The Department of Health implemented recommendation 1 and advised that recommendation 2 and 3 were under consideration. No further update has been received. Additionally, VicRoads implemented recommendation 3.

18 May 2011 – Coroner Paresa Spanos

Case 20100243 Garni Sulemani, 21 year old male

Brief Circumstances Mr Sulemani was riding his unregistered Honda 450CC motorcycle on a private dirt track in Campbellfield, Victoria. After negotiating a bend in the track he attempted a double jump. Whilst mid-jump it was reported that he jumped from his bike when he was unable to negotiate the second jump. He pushed the bike away, landing face first onto the ground. Mr Sulemani died at the scene from a left haemothorax that was thought to have occurred as a result of the accident causing him to rupture his aorta.

Recommendations

Recommendation 1. I recommend that VicRoads establish a sub-committee of the Victorian Motorcycling Advisory Council, whose prime responsibility is to examine off-road motorcycling incidents in order to develop evidence-based strategies to reduce the number of injuries and fatalities.

Recommendation 2. Reflecting the diversity of off-road motorcycling or riding, I recommend that the subcommittee examine incidents across the broad spectrum of off-road riding disciplines and settings.

Recommendation 3. Without wishing to be prescriptive about the sub-committee's composition, I would expect that Motorcycling Victoria and WorkSafe Victoria would have a valuable contribution to make in respect of motocross riding at official venues.

Responses VicRoads implemented the recommendations.

26 June 2013 – Coroner Jane Hendtlass

Case 20070739 Anthony Roach, 41 year old male

Brief Circumstances Mr Roach was a participant in an organised motocross race riding a Yamaha 250CC motorcycle at the Nunawading and District MX Club in Nunawading, Victoria. Mr Roach crashed his bike after completing a jump on the circuit. On beginning to get up, a rider behind him who also had completed the jump collided with him from behind while he was on the ground. Mr Road died at the scene from acute internal blood loss, laceration of the aorta in tandem with spinal fracture, and blunt force trauma to the back.

Recommendations	**Recommendation 1.** The Nunawading & District MX Club implement a random and targeted cannabis saliva testing programme for race participants on race days. **Recommendation 2.** The Nunawading & District MX Club and Motorcycling Victoria re-consider the way in which motocross races are started to improve the time and/or space separation of race participants early in the race and reduce the risk of serious incidents involving following riders. **Recommendation 3.** The Nunawading & District MX Club and Motorcycling Victoria explore the possibility of cooperating with the Sportsinjutytracker sports injury surveillance system. **Recommendation 4.** The Nunawading & District MX Club ensure that the Club Application Form requires riders to belong to an Ambulance Fund and requires applicants to notify the organisers if they take prescribed substances.
Responses	Motorcycling Victoria referred recommendation 2 to Motorcycling Australia and the MX Commission. Recommendation 3 will not be implemented as a different database will be implemented. A response has not been received from the Nunawading & District MX Club.

26 June 2014 – Coroner Paresa Spanos

Case	20131022 Adam Alward, 27 year old male
Brief Circumstances	Mr Alward was riding his motorcycle with his brother down Jenkin Link Track in Tyaak, Victoria. While travelling up a hill he struck a branch in the region of his neck. The impact threw Mr Alward off his motorcycle, with the branch moving as he fell. Mr Alward then walked approximately 1km down the track with his brother before collapsing. Mr Alward's brother rode the motorcycle to go and get help. He was later airlifted by the Ambulance Victoria AirAmbulance to the Alfred Hospital. Mr Alward deteriorated and died enroute from the penetrating neck injury that he sustained from the motorcycle incident.
Recommendations	**Recommendation 1.** That the road safety agencies, particularly VicRoads, the Transport Accident Commission and the Department of Sustainability and the Environment, consider the Road Safety Committee's finding and adopt the recommendations set out in this report. **Recommendation 2.** That VicRoads and the Transport Accident Commission treat off-road motorcycle safety no differently to that of on-road motorcycles. **Recommendation 3.** That VicRoads and the Transport Accident Commission ensure all current and future motorcycle safety initiatives specifically include a component aimed at improving the safety of off-road riders. **Recommendation 4.** That road safety interventions, strategies and initiatives focus on both on and off-road motorcycles, relying on the definition of a road and road related area in the Road Safety Act 1986 as a basis for including or excluding motorcycles.

Recommendation 5. That the Department of Sustainability and the Environment be involved in the monitoring of off-road safety, and be included in the design, development, implementation and consultation stages of off-road safety initiatives, strategies and countermeasures and in the gathering and sharing of off-road crash data.

Recommendation 6. That an ongoing public education campaign be undertaken by the Transport Accident Commission to educate off-road riders of the coverage they are afforded under the Transport Accident Compensation Scheme.

Responses	VicRoads and the Department of Environment and Primary Industries advised the recommendations will be implemented in part. Of the six recommendations, four were supported in-principle (1, 2, 3, 6), one was supported in part (4) and one was fully supported (5).

21 July 2015 – Coroner Rosemary Carlin

Case	20110488 Philip Harrison, 49 year old male
Brief Circumstances	Mr Harrison was participating in an organised motorcycle race which was being held at Winton Motor Raceway in Winton, Victoria. He was riding a Triumph Daytona 675CC motorcycle on the day. While on the fifth lap of the six lap race he lost control of the motorcycle, sliding 116 metres on the bitumen surface, onto the dirt verge of the track and into a tyre barrier. The motorcycle slid first into the barrier, with Mr Harrison following; impacting into the rear of the motorcycle. Mr Harrison died at the scene from multiple injuries which included haemothoraces and pneumothorax.
Recommendations	**Recommendation 1.** Motorcycling Australia should revise the current edition of the Track Guidelines (1st Edition - January 2012).

Recommendation 2. The committee revising the guidelines should include a person who is an expert in drafting standards documents. This person might be someone who has previously worked for Standards Australia or some person with expertise in drafting technical manuals.

Recommendation 3. Prior to issuing the new Track Guidelines Motorcycling Australia ought to obtain a peer review from an independent reviewer with recognised expertise in safety measures for motorsport venues.

Recommendation 4. The guidelines should contain the relevant technical information for those charged with licensing venues.

Recommendation 5. The guidelines should be written so that they are readily comprehensible to race officials who conduct venue checks prior to race meetings.

Recommendation 6. Licensing officials and race state officials responsible for checking venues prior to a race meeting should have a kit which includes: i. a copy of the Track Guidelines; ii. a copy of the track licensing conditions applicable to the particular venue; iii. checklist sheets generated for the particular ;venue and for the particular configuration of the venue; iv. contact details to enable the officials to readily obtain assistance in relation to any queries pertaining to the conditions applicable to the track •or other issues which may arise in the field.

	Recommendation 7. Risk assessment documents and venue checklist documents should include the following question: Are there any obstructions in the vicinity of the race which are not essential to the proper functioning of the race track? **Recommendation 8.** Motorcycling Australia should compile a database of accidents, injuries and near misses (to be defined) occurring during any race meeting. The data is to be collected from reports filed by race officials after each event. The data should be analysed periodically to identify systemic problems at venues. This process should be developed in association with the medical data currently collected by RACESAFE.
Responses	Motorcycling Australia will implement the recommendations.

14 April 2016 – Coroner Rosemary Carlin

Case	20120741 Oscar Mcintyre, 17 year old male
Brief Circumstances	Mr Mcintyre was an entrant in an Australian Superstock motorcycle race held at the Phillip Island Race Circuit as part of the Australian Superbikes event in Phillip Island, Victoria. He was riding a Yamaha R6 (No. 66) 600CC motorcycle on the day. When travelling down the main straight he was seen to leave the track and continue under power across grass, a long gravel trap, a bitumen brake area and a shallow ditch before colliding with a slight incline and falling from the bike. Both the bike and Mr Mcintyre continued separately back onto the track where he was struck at high speed by another motorcycle. Mr Mcintyre's right leg was torn away and a second collision between two other motorcycles occurred in the debris field. Mr Mcintyre died at the scene from the injuries he sustained from the accident which included bilateral haemothoraces, right leg avulsion and an open pelvic fracture.
Recommendations	**Recommendation 1.** As recommended by Professor Troutbeck, I recommend that Motorcycling Australia Limited, Phillip Island Operations Pty Ltd and the Federation Internationale de Motorcycleisme ensure that the conspicuous visual, (non-retarding) barrier is installed at the Phillip Island Race Circuit in a position to dissuade riders who have left the track from attempting to cross the infield to re-join the track.
Responses	Motorcycling Australia Limited and Phillip Island Operations Pty Ltd advised the recommendation will be implemented.