IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 4444/07

FINDING INTO DEATH WITHOUT INQUEST

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

I, IAN WATKINS, Coroner having investigated the death of PAUL FLINTOFT

without holding an inquest:
find that the identity of the deceased was PAUL MICHAEL JOSEPH FLINTOFT
born on 4 February 1965
and the death occurred on 3 November 2007
at Mount Buller Road, Mount Buller, Victoria 3723

from:

1a. INJURIES SUSTAINED IN MOTOR VEHICLE COLLISION (CO-DRIVER)

Pursuant to Section 67(2) of the *Coroners Act 2008*, I make these findings with respect to the following circumstances:

1. The circumstances of Mr Flintoft's death have been the subject of investigation by Victoria Police.

2. On 3 November 2007 Mr Flintoft was participating in a motor vehicle rally known as the Mount Buller Sprint. The event is sanctioned by the Confederation of Australian Motor School (CAMS) and was organised by Mountain Motorsport.

3. Mr Flintoft was the navigator and co-driver in a 2006 Elfin Clubman roadster MS8 which was driven by David Allan Reynolds.

4. At approximately 3.35pm the vehicle in which Mr Flintoft was the observer ran off the bitumen surface at a location identified as turn 13 for the event, which was approximately 13 kilometres from the start line. From the video recording from an in-car video it can be seen that the vehicle understeered on approaching a right-hand corner and was unable to recover from that situation before running off the road. The estimated speed of the vehicle upon leaving the road was between 34 and 45km/ph. The vehicle then collided with trees. Mr Flintoft sustained fatal injuries as a result of the collision with the trees.

5. The vehicle was a 2006 Elfin Clubman roadster MS8. It was fitted with a General Motors Holden 5.7 litre V8 engine, was a 2-seater clubman style vehicle and was rear wheel drive. A clubman vehicle is defined as an open sports car with an open cut away cockpit. In order to participate in events such as this it is a requirement of CAMS that any clubman vehicle be coupled to a 4-cylinder engine running engine capacity of more than 2 litres. It is also recommended that such vehicles are fitted with a full roll cage and side intrusion bars.

6. The vehicle in which Mr Flintoft was an observer was not fitted with a roll cage. The fact that the vehicle did not comply with the regulations of CAMS unfortunately did not prevent it from not being entered in this particular event.

7. The weather on the day of the collision at Mount Buller was described as poor, with heavy fog. Competitors were given the option of withdrawing from the event because of the poor weather conditions without penalty. However Mr Reynolds and Mr Flintoft chose to compete in the event. There is however no evidence that would support the suggestion that the adverse weather conditions contributed to the collision.

8. Dr Matthew Lynch, Forensic Pathologist with the Victorian Institute of Forensic Medicine, performed an autopsy and reported that the cause of death was as a result of injuries sustained in a motor vehicle collision (co-driver). His autopsy findings were as follows:

   a. Head injury with dislocated atlanto-occipital joint and transacted upper cervical spinal cord

   b. Patchy subarachnoid haemorrhage

   c. Incised injury anterior neck

Toxicological results indicated that there were no drugs or alcohol in Mr Flintoft's system at the time of his death. The autopsy further found that there was no significant natural disease noted. I accept his findings.

9. Having considered all of the available evidence I am satisfied that there are no suspicious circumstances and that no further investigation is required. On the basis of the evidence available to me I find that Paul Michael Joseph Flintoft died as a result of injuries sustained in a motor vehicle collision on 3 November 2007. I am unable to make any findings as to whether the driving of David Reynolds or the weather was a cause or contributing factor to the collision.

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

1. The vehicle in which Mr Flintoft was an observer was not fitted with a roll cage. I find that there is a significant possibility that had the vehicle been fitted with a roll cage Mr Flintoft may well have survived the impact of the collision.

RECOMMENDATIONS:
Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendations connected with the death:

1. The court received a report from the Confederation of Australian Motor Sport. In that report it makes a number of recommendations, including:

    a. Open top vehicles and/or vehicles without full roll cages be excluded from competitions in the type of event in which Mr Flintoft was competing

    b. The documentation applicable to such events be more readily identifiable so that individual officials can be held responsible for breach of regulations.

    c. Investigations be made into improvement of communication, vehicle identification and vehicle separation in similar such events.

I would indorse those recommendations.

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

The family of Paul Michael Joseph Flintoft

Investigating Member, Victoria Police

Interested parties.

Signature:

IAN WATKINS
CORONER
17 May 2012

Coroners Court of Victoria