
**CORONER'S COURT**
**OF NEW SOUTH WALES**

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| **Inquest:** | Inquest into the death of Caitlyn Fischer |
| **Hearing dates:** | 13 to 24 May 2019; 22, 23 and 24 July 2019 |
| **Date of findings:** | 4 October 2019 |
| **Place of findings:** | Coroner's Court of New South Wales, Lidcombe |
| **Findings of:** | Magistrate Derek Lee, Deputy State Coroner |
| **Catchwords:** | CORONIAL LAW – Equestrian Australia, FEI, eventing, cross country test, show jumping test, Scone Horse Trials, Sydney International Horse Trials, course design, riders representative, fence judge, medical response, medical coverage, medical equipment, event management, risk mitigation, data collection, personal protective equipment, incident review system |
| **File number:** | 2016/133590 |
| **Representation:** | Dr P Dwyer, Counsel Assisting, instructed by Ms A McCarthy (Crown Solicitor's Office)<br><br>Mr B Hodgkinson AM SC and Ms K Edwards for Equestrian Australia instructed by Ms R Arnold (Hall & Wilcox) |

**Findings:** ***Findings pursuant to section 81(1) of the Coroners Act 2009:***

***Identity***
The person who died was Caitlyn Fischer.

***Date of death***
Caitlyn died on 30 April 2016.

***Place of death***
Caitlyn died at Horsley Park NSW 2175.

***Cause of death***
The cause of Caitlyn's death was blunt force head injuries.

***Manner of death***
The manner of death was accidental misadventure. Caitlyn sustained the head injuries after suffering an accidental fall whilst competing in the cross country phase of an eventing competition.

**Recommendations:** ***Consolidated recommendations pursuant to section 82 of the Coroners Act 2009 are contained in Appendix A.***

**Non-publication orders:**

Pursuant to s. 65(4) of the *Coroners Act 2009*, I direct that the following parts of the coronial file and brief of evidence are not to be supplied to any person until such time as any application is made and any contrary direction is made in that regard:

1. The sensitive photographs taken at the scene of the incident involving Olivia Inglis contained in Exhibit 1, Volume 1: Olivia Inglis, Tabs 6 and 13;

2. The sensitive photographs taken at the scene of the incident involving Caitlyn Fischer contained in Exhibit 1, Volume 1: Caitlyn Fischer, Tab 19;

3. The video footage of the incident involving Caitlyn Fischer contained in Exhibit 1, Volume 1: Caitlyn Fischer, Tab 22; and

4. The photograph of the fence 8A/8B combination contained in Exhibit 26.

Pursuant to s. 74(1)(b) of the *Coroners Act 2009*, I direct that the following parts of the coronial file and brief of evidence containing sensitive material are not to be published:

1. The sensitive photographs taken at the scene of the incident involving Olivia Inglis contained in Exhibit 1, Volume 1: Olivia Inglis, Tabs 6 and 13;

2. The sensitive photographs taken at the scene of the incident involving Caitlyn Fischer contained in Exhibit 1, Volume 1: Caitlyn Fischer, Tab 19;

3. The video footage of the incident involving Caitlyn Fischer contained in Exhibit 1, Volume 1: Caitlyn Fischer, Tab 22; and

4. The photograph of the fence 8A/8B combination contained in Exhibit 26.

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## 1. Introduction

1.1 On 30 April 2016 Caitlyn Fischer was with one of her best friends in life, her horse, Ralphie. They were competing together in the cross country phase of an eventing competition at the Sydney International Horse Trials in Horsley Park. Upon reaching a fence only 210 metres from the start of the cross country course, Caitlyn and Ralphie suffered a fall in which Caitlyn was fatally injured.

## 2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death. All reportable deaths must be reported to a Coroner or to a police officer.

2.2 Section 6(1)(a) of the Act defines a reportable death to include an unnatural death; in other words a death that is not due to natural causes, where an external factor has contributed or caused to death. In Olivia's case the evidence clearly established that the accidental fall which she suffered on 6 March 2016 caused catastrophic injuries which caused her death.

2.3 It should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process is very much a public intrusion into what would otherwise be a very private and personal experience for members of our community.

2.4 However one of the fundamental principles underlying the coronial process is that it is independent and transparent. Another fundamental principle is that a coronial process seeks to identify in a public forum health and safety issues which may affect the broader community at large.

2.5 Inquests have a forward-thinking, preventative focus. At the end of many inquests Coroners often exercise a power, provided for by section 82 of the Act, to make recommendations. These recommendations are made, usually, to government and non-government organisations, in order to seek to address systemic issues that are highlighted and examined during the course of an inquest. Recommendations in relation to any matter connected with a person's death may be made if a Coroner considers them to be necessary or desirable.

## 3. Background to the inquest

3.1 Tragically, Caitlyn's death was not the only equestrian-related death which occurred in New South Wales in 2016. On 6 March 2016, almost seven weeks prior to Caitlyn's death, another talented young woman and rider, Olivia Inglis, suffered a fatal fall in similarly tragic circumstances whilst competing in an eventing competition in Scone. Olivia was 17 years old at the time.

3.2 As Caitlyn's death raised similar broader safety issues related to the sport of eventing, a coronial investigation was also conducted. Eventually concurrent inquests into the deaths of both Olivia and Caitlyn were held. The inquests were divided into two phases. During the first phase of the inquests, evidence was taken regarding certain factual matters particular to Olivia's and Caitlyn's incidents. During the second phase of the inquests, evidence was taken regarding broader systemic issues related to the deaths.

3.3 At the conclusion of the inquests, separate findings were prepared and delivered. These findings should be read and understood in conjunction with the findings in relation to the *Inquest into the death of Olivia Inglis*. The broader issues connected with the deaths of both Caitlyn and Olivia have been duplicated in each set of respective findings.

3.4 The inquest began on 13 May 2019. There were ten days of hearing until it concluded on 24 May 2019. There were a further three days of evidence on 22, 23 and 24 July 2019. A total of 34 witnesses were called throughout the inquests, including the following expert witnesses:

(a) Professor Anthony Brown, emergency physician;

(b) Dr Tom Cross, sports physician;

(c) Mike Etherington-Smith, course designer;

(d) Grant Johnston, course designer;

(e) Alec Lochore, course designer;

(f) Paul Tapner, former elite level professional rider; and

(g) Claire Williams, Executive Director of the British Equestrian Trade Association.

3.5 Closing oral submissions were made by counsel assisting and the parties on 26 July 2019. Following this, further written submissions were made by counsel assisting and the parties.

## 4. Caitlyn's life

4.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Recognising the impact that a death of a person has, and continues to have, on the family and loved ones of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future.

4.2 Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore it is extremely important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way.

4.3 Caitlyn was the second child of Mark Fischer and Ailsa Carr. Caitlyn's brother, Kristopher, who was seven years older than her, was enormously proud of his baby sister when Caitlyn was born. This pride was equally shared by Caitlyn's parents who discovered Caitlyn to be a bright, affectionate and inquisitive young child with a love for learning and exploration.

4.4 As a little girl, Caitlyn loved the outdoors. She enjoyed collecting all manner of discarded flora and fauna and used her remarkable imagination to create her own little world on her family farm, in which she spent countless hours enjoying herself.

4.5 Caitlyn was also a book lover and adored reading. Before she could read herself, her parents read to her many children's stories from her favourite authors such as Quentin Blake and Pamela Allen. Later, Caitlyn discovered a love of books by Roald Dahl and even named her cat, Matilda, after her favourite book by Mr Dahl. Eventually Caitlyn came to read stories which involved horses such as *Black Beauty*, *The Snow Pony*, and *The Man From Snowy River*. At the age of seven, Caitlyn decided that she no longer wanted to only read about horses, and instead wanted to have her own pony.

4.6 Caitlyn's parents borrowed a pony and took Caitlyn for riding lessons. This was the just the beginning of Caitlyn's love of horses and riding, which continued to grow over the following years. Caitlyn initially went to pony club and gymkhana, and her parents took Caitlyn to every event that was available in their local area. Also although Caitlyn was generally quiet and unassuming she was someone who enjoyed a challenge, and the challenge of mastering the three disciplines in eventing appealed to her.

4.7 Caitlyn's parents bought Ralphie, an 11 year old thoroughbred, sometime later in 2012. Caitlyn's parents describe her as having a special bond with Ralphie; in the world of eventing they described Ralphie as Caitlyn's life, love, passion, partner in crime and best friend. Caitlyn showed incredible discipline, determination and conscientiousness to develop her talent and skills. She regularly placed at the top in eventing competitions and became a member of the Victorian State eventing squad.

4.8 Perhaps more important than Caitlyn's achievements in eventing were the opportunities that the sport allowed for Caitlyn to travel to events together with her family, to camp out, share experiences, forge indelible memories, and to simply enjoy time together as a family.

4.9 Caitlyn's love of the outdoors meant that she enjoyed many sports including netball, swimming, soccer, running, and participating in her local surf club. In particular, Caitlyn enjoyed giving her father a run for his money on the ski slopes. Caitlyn embraced all that life had to offer with an adventurous spirit and a quiet determination to follow her dreams. She was well travelled, having visited Japan, Vietnam and Europe and was planning to embark on another six month working holiday to Europe later in 2016.

4.10 At school Caitlyn was well regarded for her inquiring mind, eagerness to learn, creativity and compassionate nature. She was considered to be a quiet achiever but also full of positivity and vibrancy with a wry, cheeky sense of humour. One of Caitlyn's teachers remarked that Caitlyn was the type of student that sustains and inspires teachers to teach. In her final year at school Caitlyn finished in the top five percent of the state and was excited to study advanced science at university.

4.11 Caitlyn had many delightful friends who cherished her genuine friendship, warmth, generosity, loyalty, and constant willingness to be supportive and uplifting. They all knew that Caitlyn was thoughtful and kind, and so much fun to be around. One of Caitlyn's best friends described Caitlyn as her sunshine.

4.12 Caitlyn's passion for life, and determination to make the most of everything which it brought, is reflective of her enduring spirit and her qualities as a person. The depth of her loss to those who loved her the most and knew her the best cannot be quantified. But an indication of the enormity of that loss can be demonstrated by the overwhelming national and international response that followed Caitlyn's tragic death.

4.13 At the conclusion of the evidence in the inquest, Caitlyn's parents showed extraordinary generosity by providing those in the court who had never had the honour of meeting their daughter with a moving and heartfelt introduction to Caitlyn. Although that introduction was necessarily brief, it left an enduring memory of and remarkable young woman, a cherished younger sister, and a magical and exceptional daughter.

## 5. The sport of Eventing

5.1 Eventing is an equestrian sport that originated as a military competition which was designed to test the skills of officers and horses in several types of riding that could occur on or off duty. In modern times it consists of three phases, or tests: dressage, show jumping and cross country. The three tests are either held over one day or three days. An eventing competitor rides the same horse in each test throughout the competition.

5.2 Eventing was introduced into the Olympic Games in 1912. It is currently one of three equestrian disciplines in the Olympics, with the others being dressage and show jumping.

5.3 The dressage test consists of a series of compulsory movements that a horse performs at different speeds. The test takes place in an enclosed arena. The show jumping test[1] consists of a number of fences which are designed to test the technical jumping skills of a horse and rider. Like the dressage test it also takes place in an enclosed arena on level ground.

5.4 In contrast, the cross country test takes place on an outdoor circuit. The test is designed to test the ability of a horse and rider to adapt to variable weather and terrain conditions whilst navigating a number of obstacles in the form of fences or jumps. The obstacles are typically constructed of natural materials.

5.5 Various scoring criteria apply to the cross county test. A horse and rider (known as a combination) can incur penalties for: (a) exceeding the time allotted to complete the cross country test; (b) a horse having a refusal at an obstacle, being the failure of the horse to jump an obstacle which the horse is presented; and (c) a run out, where a horse continues past an obstacle and does not jump it, without ceasing its forward motion.

[1] Although both the FEI Eventing Rules and EA Eventing Rules refer to the jumping test, this phase of the competition was more often referred to as the show jumping test or phase in the evidence received during the course of the inquest. For convenience, show jumping test will be referred to in these findings.

## 6. Governance

6.1 The International Federation for Equestrian Sports, or the *Fédération Équestre Internationale* (**FEI**), is the international governing body for equestrian sports. It is the sole controlling authority for international equestrian events.

6.2 The FEI recognises a single national federation for each country. This recognition is required for that country to compete in certain international competitions such as the Olympic Games.

6.3 Equestrian Australia (**EA**) is the peak body for the administration of equestrian sports in Australia. It is recognised by the FEI as the national equestrian federation for Australia. According to its Constitution, EA is comprised of a number of state branches. Relevantly, Equestrian New South Wales (**Equestrian NSW**) is the state branch for New South Wales. In June 2018 there were approximately 18,500 members of EA across Australia who paid direct membership fees to their respective state branches. EA is led by a National Board of Directors and a Chief Executive Officer.

6.4 Prior to 1 January 2019 the FEI assigned two designations to international competitions: Concours Complet International (**CCI**) and Concours International Combiné (**CIC**). Typically, a CCI event was held over three days whist a CIC event was held over one day.

6.5 Different designations are assigned to national competitions: Concours Complet National (**CCN**) and Concours National Combiné (**CNC**). Similar to the above, a CCN event was typically held over three days whilst a CNC event was held over one day.

6.6 Prior to January 2019, each international and national competition was differentiated according to a star category system ranging from one star to four star, in ascending degree of difficulty. By way of example, there are only six four star competitions worldwide.

6.7 In January 2019 the FEI made a number of amendments to the above categorisations. In essence, the existing star categories were increased by a single star (meaning, for example, that a one star competition would now be known as a two-star competition), and abolished the use of CIC to designate competitions. Instead, CCI competitions were designated into two further sub-categories: CCI-L (for long) for CCI competitions and CCI-S (for short) for the former CIC competitions.

6.8 As the relevant events occurred in 2016, prior to the amendments made by the FEI in 2019, references to star categories or classes in these findings will refer to the former system.

6.9 Eventing competitions at the international and Australian national level are conducted pursuant to rules published by both EA and the FEI. Further, the FEI and EA have published guidelines relevant to the design of cross country courses.

6.10 Relevantly, the inquest considered aspects of the following documents:

(a) the FEI Eventing Rules, effective 1 January 2016 (**the 2016 FEI Rules**);

(b) the EA National Eventing Rules, effective 1 January 2016 (**the 2016 EA Rules**);

(c) the FEI Eventing Cross Country Course Design Guidelines (**the FEI Guidelines**);

(d) the EA Guide for Cross Country Course Designers and Officials (**the EA Guide**).

6.11 Each of the above documents was in force at the time of the deaths of Olivia and Caitlyn. It should be noted that updated versions of the above documents have since been published. These updated versions will be referred to in these findings according to their year of publication (for example, the 2018 EA Rules or the 2019 EA Rules).

6.12 Relevantly, Olivia was competing in the CNC two star competition, whilst Caitlyn was competing in a CCI one star competition.

6.13 The *Eventing Vision Statement* contained in the 2016 FEI Rules provides:

> "*Eventing constitutes the most complete combined equestrian Competition, demanding of the Athlete considerable experience in all branches of equitation [sic] and a precise knowledge of his [as written] Horse's ability, and of the Horse a degree of general competence, resulting from intelligent and progressive training. The Cross Country test constitutes the most exciting and challenging all-round test of riding ability and horsemanship [as written] where correct principles of training and riding are rewarded…*
>
> *This test requires by all involved special awareness and acceptance of a certain level of risk inherent to the particular challenging and exciting nature of the test. Every effort must be made to ensure that, at each level, responsible Athletes are participating with progressively trained Horses in order not to be exposed to a higher risk than which is strictly inherent to the nature and level of the Competition*".[2]

6.14 The *Eventing Vision Statement* is replicated in the 2016 EA Rules.

[2] Exhibit 1, Tab RK3 at page 12.

## 7. Background to the events of Saturday, 30 April 2016

7.1 In order to develop her skills and talents as an eventing rider, Caitlyn went to live with Christine Bates at her property at Willow Park in Wilberforce in January 2015 and again in April 2015 for work experience. Mrs Bates is an elite level rider at Australian representative level and high performance equestrian coach. After assisting as a groom at the Adelaide 3 Day Event in 2015 Caitlyn returned to Willow Park as a working pupil.

7.2 Caitlyn and Ralphie were entered in the CCI one star competition at the Sydney International Horse Trials (**SIHT**) on the weekend of 30 April and 1 May 2016. They had experienced a through preparation in the lead up to the event. This involved competing in a number of other events including the Scone Horse Trials on 6 March 2016 (CNC one star), the Quirindi One Day Event (**ODE**) on 27 March 2016 (CNC one star) and the Equestriad ODE on 17 April 2016 (CIC one star). Mrs Bates said that she constantly tested the skills of Caitlyn and Ralphie as if they were competing at the two star and three star level. She said that they were consistently training well above the one star level. Between the Equestriad ODE and the SIHT, Caitlyn had two cross country training sessions on 23 and 26 April 2016. Caitlyn had well exceeded the minimum eligibility requirements to compete in the one star competition.

7.3 On Wednesday 27 April 2016 Caitlyn had a dressage lesson at Willow Park prior to leaving for Sydney. After arriving at the SIHT venue at the Sydney International Equestrian Centre (**SIEC**), Caitlyn helped to unpack the trailer and equipment and Ralphie was settled in his stable. Caitlyn later took Ralphie for a walk to familiarise him with the venue. Ms Carr arrived in Sydney from her home in Bairnsdale at met Caitlyn at the venue. This was the first time that Ms Carr had seen Caitlyn since she moved to Willow Park in January 2016 and she planned to spend the entire weekend with Caitlyn.

7.4 On Thursday, 28 April 2016 Caitlyn had the official one star trot up, a standard procedure at the start of every CCI event where an official inspection of a horse is conducted by the grand jury to determine the soundness of a horse to compete at an event. No issue with Ralphie was identified by the veterinarian in attendance or the grand jury. Caitlyn had a further dressage lesson in the afternoon.

## 8. What happened on 29 April 2016?

8.1 On Friday, 29 April 2016 Caitlyn had a dressage lesson in the morning. She, Mrs Bates and another rider, Tara Rogers, subsequently walked the one star course together. Mrs Bates spoke to Caitlyn about each fence on the course. As fence 1 was only 29 metres from the start box Mrs Bates felt that there may not be enough time for a horse to establish a strong canter, leading them to "*being a bit spooky*"[3] by the time they reached the fence. Accordingly, she advised Caitlyn to "*make sure they get out of the start box, get them going, and ride it like they might spook at it*".[4]

8.2 Mrs Bates said that she specifically told Caitlyn to make sure that Ralphie was watching the fence. This was due to the fact that there were other fences located in the steeplechase track which she considered could be distracting for the horses.[5] Mrs Bates considered fence 2 to be "*a relatively straightforward cross-country jump*".[6] Mrs Bates explained that at that particular venue space on the steeplechase track was limited and there was a possibility Ralphie might be distracted by the fence ahead.[7] Mrs Bates explained that in order to make sure Ralphie was focused on the correct fence Caitlyn needed to check that Ralphie was balanced, straight and jumping in the middle of the fence. Despite these checks Mrs Bates explained that it still remains possible for a horse to make a mistake and not do what a rider wants them to do.

8.3 At around 8:30am Ms Carr met Caitlyn at the stables and helped to fit the saddlery and riding equipment to Ralphie. Ms Carr describes Caitlyn as bright and happy, and that the adrenalin of being about to compete was evident.

[3] 13/5/19 at T40.37.
[4] 13/5/19 at T40.39.
[5] 13/5/19 at T41.1.
[6] 13/5/19 at T41.36.
[7] 13/5/19 at T44.14.

## 9. What happened on 30 April 2016?

9.1 Caitlyn walked the course again on the morning of 30 April 2016. Following this Caitlyn went to warm up. Mrs Bates met Caitlyn and Ms Carr halfway between the warmup area and start box. Mrs Bates discussed each fence on the course with Caitlyn as to what line and striding she was going to take. Mrs Bates and Caitlyn spoke about getting Ralphie to shorten his stride but not lose the quality of his canter when approaching water jumps on the course.

9.2 Mrs Bates made sure that Caitlyn was happy with her course walk and what had been discussed the day before. Mrs Bates asked Caitlyn how Ralphie had warmed up. Caitlyn replied that he was "*feeling a little bit strong*".[8] Mrs Bates did not consider this unusual. She explained that as this was Ralphie's first attempt at a long format she had made sure during his preparation that he was very fit. Mrs Bates said that this did not concern her as she was "*very confident in knowing [Ralphie] and Caitlyn that, once out on the course [Ralphie] would settle into a great rhythm*".[9]

9.3 When Caitlyn and Mrs Bates arrived at the start box there were two riders ahead of Caitlyn. As Caitlyn was being counted down the starter received a radio call to stop the course due to a rider fall. Mrs Bates spoke to Stuart Tinney (an elite level rider who has previously represented Australia at the Olympics, and course designer for the one star course) and learned that there had been a rotational fall on the B element of a combination (known as the Lego boxes) but that both horse and rider were fine and were being given medical and veterinary assistance. Mrs Bates was also told the combination was going to be removed from the course. Mrs Bates relayed this information to Caitlyn who appeared to be unconcerned.

9.4 Caitlyn was in the start box at 10:29am. She was originally scheduled to start at 10:30am. However this was delayed due to the rider fall. At 10:35am Caitlyn was given a five minute call and returned to the start box.

9.5 Whilst the hold occurred, Caitlyn went to warm up again and Ralphie jumped a single fence on the steeplechase track, which he did well. Mrs Bates described Caitlyn as remaining relaxed and it did not appear that the delay affected her.[10] Caitlyn was called back to the start box about 10 minutes later. As she was being counted down Mrs Bates said to her, "*Good luck and stick to your plan*".[11]

9.6 Following the start, Mrs Bates stayed and watched Caitlyn and Ralphie jump the first fence. She described Ralphie having "*a good, nice approach and a nice take off over number 1*"[12] and so she turned and ran in the opposite direction to the first water jump.

9.7 When she was about 350 metres from fence 2 Mrs Bates stopped and looked back. Fence 2 was a portable table style fence, which had been secured to the ground by anchors, and had a sloping face, with its back slightly higher than its front. It was situated close to an existing steeplechase rail on its right-hand side. Mrs Bates saw that Ralphie was four to five strides in the approach to fence 2 and that everything looked alright. Mrs Bates turned, kept running for another 10 to 15 metres, then

[8] 13/5/19 at T45.29.
[9] 13/5/19 at T68.22.
[10] 13/5/19 at T49.24.
[11] 13/5/19 at T50.28.
[12] 13/5/19 at T50.34.

turned back again, expecting to see Caitlyn and Ralphie departing from fence 2. She did not and instead saw Ralphie underneath the steeplechase fence.

***The fall***

9.8 John Fallon had a previous background as a competitive rider with experiencing in showing horses. He was with a friend, Phil Rees, on 30 April 2016. He and Mr Rees were positioned about three or four metres away from fence 2, right beside the jump judge, Sarah Retallack. On the approach to fence 2 Mr Fallon said that Caitlyn looked confident and capable as she approached the jump and that Ralphie was travelling at an appropriate speed. However, as Ralphie started to jump Mr Fallon described noticing that something appeared to catch Ralphie's eye. Mr Fallon described Ralphie's attention as changing:

> "*It went from being a perfect picture of what was going to go straight over the top of the jump to his eyes just kind of became brighter and he was focused on something else. And, because of that, he didn't quite get the height. He just seemed to jump flat*".[13]

9.9 Mr Fallon went on to explain:

> "*His, his attention didn't seem to be on the jump. It was on the jump in the lead-up to it but then his attention seemed to go beyond the jump somewhere*".[14]

9.10 However, Mr Fallon was not aware of what may have caught Ralphie's attention, other than it was something in front of him, to the left of his field of vision.

9.11 Mr Fallon recalls that after the jump judge grabbed his hand and told him not to leave her, she immediately used her radio to call for assistance.

9.12 Mr Rees said that he saw that Caitlyn appeared to be in perfect control during the first jump, and appeared to be in the same position as she approached the second jump. Mr Rees describes what he then saw as follows:

> "*I thought [Ralphie] either was going to put an extra stride into the fence, or he tried to leap onto the top of the fence, and somehow, he missed, missed, and then somersaulted over*".[15]

9.13 Mr Rees said that he heard Ms Retallack almost immediately use her radio and say words to the effect of, "*We had a fall on fence 2, we need an ambulance*".[16]

9.14 After seeing that a fall had occurred, Ms Carr ran to fence 2 and was the first to reach Caitlyn. She saw that Caitlyn was lying on her left side, facing away from her, and was motionless. Ms Carr ran around the fence and leaned over her daughter. She saw that Caitlyn's pupils were fixed and dilated and that the left side of her left orbit appeared fractured, with the left side of her head appearing

[13] 13/5/19 at T81.39.
[14] 13/5/19 at T82.18.
[15] 15/5/19 at T6.13.
[16] 15/5/19 at T6.41.

"*crushed and bloody*" but with no obvious active bleeding.[17] The left side of Caitlyn's helmet, which she was still wearing, had been crushed into the ground.

9.15 Ms Carr felt for a pulse and could not find one. She also saw no signs of respiratory effort. Ms Carr realised that, tragically, Caitlyn was already deceased.

9.16 Mrs Bates and Rebecca Andrews, the event volunteer coordinator, were the next to arrive on the scene. They immediately asked Ms Carr what they could do. Ms Carr told them that there was nothing anyone could do and that Caitlyn was gone. Nevertheless, Mrs Bates and Ms Andrews felt that they had to do something. So they removed Caitlyn's personal protective equipment and Ms Andrews commenced chest compressions. This had the effect of causing blood to pour out of Caitlyn's mouth. This was obviously extremely distressing for Ms Carr and she told Ms Andrews that she was a nurse and to please stop what she was doing.

9.17 Dr Alexander Golowenko and Paramedic Michael Brown arrived on the scene a short time later. Dr Golowenko was not able to feel a pulse and CPR was stopped at 10:50am. Caitlyn was pronounced deceased at 11:05am.

## 10. What was the cause of Caitlyn's death?

10.1 Caitlyn was later taken to the Department of Forensic Medicine at Glebe where a post-mortem examination was performed by Dr Rexson Tse on 4 May 2016. Postmortem imaging revealed significant head injuries including a base of skull fracture, complex facial fracture, and diffuse subarachnoid haemorrhage.

10.2 In a subsequent autopsy report Dr Tse opined that the cause of Caitlyn's death was blunt force head injury.

[17] Exhibit 1, Tab 6 at [18].

## 11. What caused the fall?

11.1. Ms Retallack noticed nothing amiss as Caitlyn and Ralphie approached fence 2. However as she looked down to take down Caitlyn's number she did not see what might have caused Ralphie to lose attention.

11.2. All the experts agreed that having an obstacle up against a permanent fence line (steeplechase rail) would be common. Mr Tapner said that he did not believe that the rail played a significant role in causing the fall. Mr Johnston referred to the video evidence and said that it was abundantly clear that the rail played no role in the fall. He said that Ralphie was jumping straight as he should have. Mr Etherington-Smith agreed that the rail also had no role in the fall. Mr Lochore agreed and said that as a rider the rail would not have been something that he would have taken into consideration in approaching the fence.

11.3. Mr Tapner expressed this view about the fall:

> "*The mistake made by the horse was that the horse went to take off for the jump and in almost the same time of deciding to start the jumping effort the horse decided not to jump and attempted to put another canter stride in prior to the jump before taking off*".[18]
>
> All of the other experts agreed with him.

11.4. Mr Tapner was asked what caused Ralphie to do this. He said:

> "*In my opinion on the approach strides to the, the fence the horse had its head carriage far higher and its ears pricked far more than you would expect of a fence that it's jumped many - probably many thousands of times in training and in competition. As we have all said at the beginning, it was a, a fairly inconsequential fence in terms of difficulty and safety so for the horse to make - to have a significantly elevated head carriage approaching that and to make that error leads me to believe - and I know everybody's going to say, "You can't conclusively decide what a horse is thinking," it leads me to believe that the horse was distracted from the jump by something on the landing side of the jump so in the distance the horse was not 100% focused on the jump. It was focused on something beyond the jump and that if it had have been 100% focused on the jump it would have either made a less severe error or made no error at all*".[19]

11.5. However Mr Etherington-Smith said that he was not convinced that Ralphie was distracted by something in the background as he did not consider his head carriage to be noticeable.

11.6. **FINDINGS:** The expert evidence establishes that the fall at fence 2 occurred when Ralphie attempted to put in another canter stride prior to jumping. However, expert opinion was divided about the reason as to what caused Ralphie to do this. It is not possible to determine with certainty the cause of this. However, given that the evidence of an eyewitness, Mr Fallon, is consistent with Mr Tapner's interpretation of the available video footage, it appears to be most likely that Ralphie was distracted by something on the landing side of fence 2. Exactly what was the source of the distraction cannot be determined with any accuracy.

[18] 21/5/19 at T66.1.
[19] 21/5/19 at T66.23.

## 12. Medical coverage

12.1 As Caitlyn was competing in a CCI one star competition, the 2016 FEI Rules applied. Annex D of the 2016 FEI Rules relates to Medical Services. Relevant extracts from Annex D provide:

*1 Medical Attendance at Event*

*The on-site provision of medical care must be available during the hours of the Competition and must include the training areas, stables and on-site accommodation.*

*…*

*A qualified physician with Advanced Trauma Life Support certification ("ATLS"), a paramedic with Pre-Hospital Trauma Life Support (PHTLS) or International Trauma Life Support ("ITLS") certification, or a nurse with Trauma Nurse Core Curriculum ("TNCC") or the equivalent of any of the above in the country in which the Event takes place (hereinafter a "Pre-Hospital Trauma Care Specialist") must have credentials allowing access to the entire facility at all times including the stable area and finish area during Competition.*

*2 Chief Medical Officer*

*A Chief Medical Officer, suitably experienced and with local knowledge must be appointed well in advance, to act in liaison with the Organising Committee and the emergency services for the adequate provision of medical resources.*

*A meeting of medical officers or delegates should be held at the Cross Country venue to familiarise them with the Event plan and services available by the host physicians or the PreHospital Trauma Care Specialist in case of emergency.*

*…*

*3 Cross Country and Jumping Test*

*During the Cross Country and Jumping Test, a fully equipped Pre-Hospital Trauma Care Specialist with trauma and resuscitation skills must be available on site and must have the capability of rapid deployment to any part of the arena or course in adverse conditions.*

*…*

*The Cross Country Test will require Pre-Hospital Trauma Care Specialist. The required number will depend on the layout of the courses and the accessibility of the site. However, there must be at least one Pre-Hospital Trauma Care Specialist present throughout all the tests.*

12.2 Dr Vincent Roche was the Sport Director for the SIHT Organising Committee, and head of the crisis management team. Dr Roche is a general practitioner, and also an FEI accredited technical delegate and course designer. It was part of Dr Roche's role as Sport Director to arrange for provision of medical services at the SIHT.

12.3 In order to do so, Dr Roche arranged the following personnel to be present on 30 April 2016:

(a) Dr Matt Davis: Dr Davis had been a Staff Specialist Emergency Physician since 2004 and a Senior Staff Specialist Emergency Physician at Prince of Wales Hospital since 2012. He had volunteered at approximately 30 cross country events across NSW since 1999, including during the cross country phase at the 2000 Sydney Olympics at SIEC.

(b) Dr Golowenko: Dr Golowenko had previous experience competing in eventing since about 2011 or 2012. He had been employed part time as general practitioner by Dr Roche. 30 April 2016 was the first time that he had volunteered as a medical officer at any sporting event. Dr Golowenko graduated with a medical degree in 2012 and spent two three month rotations in emergency at Bowral Hospital in 2013 and 2014. He had previously completed training in advanced life support and paediatric resuscitation, and had completed Royal Australian Army combat medics training and deployed as a medic for a special operations task group to Afghanistan in 2008.

(c) Christine Grygorcewicz: Ms Grygorcewicz had three years' experience working as an ambulance officer prior to her arrival in Australia in 2013. She completed a Diploma of Paramedical Science in Australia (which was conferred on 16 March 2016) and was informed that her overseas qualifications meant that she could qualify as a basic level paramedic in Australia. Ms Grygorcewicz commenced working for Health Services International (**HSI**), a private contractor engaged to provide medical coverage for the event, and had provided medical coverage at one or two horse riding events prior to 30 April 2016.

(d) Michael Brown: Mr Brown was also employed by HSI. He completed a Bachelor of Paramedic Medicine which was conferred on 26 April 2016.

12.4 Dr Roche explained his role in arranging for paramedic services in this way: "*We had communicated with the provider of the private paramedic service, saying 'Look, we want the most experienced people.' You know, obviously, they've had a heads up at Scone. We want the most experienced people that you're able to provide on the day, but as I said, at that particular stage, there was no registered paramedic, nor was there a registered intensive care paramedic, nor is there at the moment either. That's in the process of being developed*".[20]

12.5 Dr Golowenko said that during the morning briefing prior to the start of competition Dr Davis, who had volunteered at the event before, drove them around the site in separate ambulances to provide a tour of the site. Dr Davis also identified the quickest routes between various points on the course. Although Dr Davis familiarised them with this, Dr Golowenko also drew on his own familiarity, having been to the course multiple times previously as a rider.

12.6 In evidence Dr Golowenko was asked to describe the response to be provided in order to acknowledge a received call: "*There was no specific instruction as to who was to use the radio, but whoever was responding was to acknowledge the call for assistance and state that they were on their way*".[21] This was to be done "*by identifying yourself, be it the doctor or the paramedic, and state your - that you had received the call and were going to attend the scene*".[22]

[20] 15/5/19 at T27.33.
[21] 14/5/19 at T51.3.
[22] 14/5/19 at T51.12.

12.7 Dr Davis determined that he and Ms Grygorcewicz would be stationed in sector 3, on the downhill slope towards the final water complex. Meanwhile, Dr Golowenko and Mr Brown were stationed in sector 1 at control at the top of a grassy hill overlooking the vast majority of the course. Dr Davis decided to position himself in sector 3 because it was close to the water complex and downhill slope, both areas of increased technical jumping ability with greater potential for rider falls. The location also provided easy access to sector 2 and the jumps located within it.

12.8 Dr Davis was aware that the equipment available on the day did not include endotracheal tubes and laryngoscopes. This equipment was beyond the skillset of Grygorcewicz and Mr Brown.[23]

[23] 14/5/19 at T74.14.

## 13. Timing of the medical response

13.1 The inquest received evidence from a number of people who arrived on the scene following Caitlyn's fall. Their evidence is summarised below

***Ms Carr***

13.2 Using information known and made available to her Ms Carr reconstructed a timeline of events from Caitlyn's start at 10:40am. Ms Carr was positioned between fence 1 and fence 2, approximately 50 to 70 metres from fence 2. Caitlyn left the start box at 10:40am and was at fence 1 within seven seconds. According to Ms Carr, Caitlyn was at fence 2 at 10:40:25am, some 18 seconds later. This calculation is based on fence 2 being 150 metres from fence 1, and 210 metres from the start, and data stored in Caitlyn's iPad following her course walk. According to the time stamp on the video footage, Caitlyn's fall occurred at 10:40:30am.

13.3 Ms Carr estimates that she reached Caitlyn at 10:42am. A short time later she made the first call to her husband. Ms Carr's mobile phone records indicate that this call was made at 10:43am and lasted 34 seconds. According to Ms Carr, towards the end of the call Mrs Bates and Ms Andrews arrived and joined her at the scene. Mrs Bates and Ms Andrews then began removing Caitlyn's personal protective equipment. According to a submission prepared for the inquest, Ms Carr estimates that this process took between five to six minutes, and that no other person was present at the time. As this process took place, Ms Carr called Mr Fischer a second time. Again, Ms Carr's mobile phone records indicate that this call took place at 10:46am and lasted three minutes and 28 seconds.

13.4 Towards the end of the call Ms Andrews started external cardiac compressions. However this had the effect of causing blood to pour out of Caitlyn's mouth. Distressed by this fact, Ms Carr told Ms Andrews to stop. Ms Carr estimates that Dr Alex Golowenko and a paramedic (who she subsequently learned was Mr Brown) arrived on the scene sometime between 10:48 and 10:49am, at least eight minutes after the fall.

13.5 Ms Carr said that that Dr Golowenko was not present when she called Mr Fischer a second time at 10:46am.[24] However Ms Carr is unsure how close to the end of that call Dr Golowenko arrived.[25] Ms Carr explained that the compressions did not continue for long because she was "*basically begging them to stop*".[26]

***Ms Retallack***

13.6 Ms Retallack said that upon seeing the fall she used her radio immediately to make call saying, "*Paramedics urgent on jump 2*".[27] From the video footage of the fall it appears that Ms Retallack made her call 11 seconds after the fall at 10:40:41am. Ms Retallack said that she heard no reply and by this time she saw Ms Carr headed towards Caitlyn.

13.7 Ms Retallack said she used the radio a second time to give Caitlyn's bib number and rider number and waved towards the ambulance which she could see at control. Ms Retallack said that she did this

[24] 14/5/19 at T40.18.
[25] 14/5/19 at T40.10.
[26] 14/5/19 at T40.40.
[27] 14/5/19 at T7.42.

because she realised that she had not conveyed Caitlyn's rider number in the first call, as she had been instructed to do so in the morning briefing.[28] She explained: "*I could see the ambulance on the hill at control and I thought, 'Have they heard me? Have they heard me?'*".[29] Ms Retallack said that "*it seemed like forever for the paramedics to come over*".[30] She said she received no response to her second radio call.

13.8 Ms Retallack said that she subsequently used her radio a third time. She said: "*I know that Caitlyn's mother was there. I know that Rebecca and Christine were there and I don't think the ambulance had moved and I think I radioed a third time*".[31] She said she received no response to this call.

13.9 However in cross-examination by senior counsel for EA Ms Retallack agreed that because of the tragic circumstances she found herself in she could not identify the times that persons arrived on the scene, or the time between their arrivals. She agreed that she had perceptions of time and could not determine whether those perceptions were accurate or not.[32]

***Mrs Bates***

13.10 Mrs Bates estimated that she was initially approximately 350 metres from fence 2, and headed towards the first water jump, when Caitlyn was about four to five strides away from fence 2. When she turned back and saw that Caitlyn was on the ground she ran back along the steeplechase track past the start box, yelling at the starter to call an ambulance. Mrs Bates also saw Ms Carr running towards Caitlyn. As Mrs Bates reached fence 1, she saw a golf buggy being driven by Ms Andrews driving by and jumped on it.

13.11 As the buggy approached fence 2 Mrs Bates jumped off and went to Ms Carr. She was the second person to arrive. In evidence Mrs Bates estimated that it took her no longer than 60 to 80 seconds to reach Caitlyn after she started running towards her.[33] She said that she believed that she arrived no more than 20 to 30 seconds after Ms Carr.[34] Mrs Bates did not accept in evidence that she arrived on the scene about 40 seconds after Ms Carr, or when Ms Carr was just ending her first phone call.[35] Instead, Mrs Bates said that Ms Carr would still have been on the phone for "*more than a few seconds*"[36] after she arrived. However later in evidence Mrs Bates said that she heard Ms Carr say that Caitlyn was dead and, "*My girl's gone*" and ended the call immediately after that.[37] Mrs Bates estimated that Ms Andrews arrived within 10 seconds of her.[38]

13.12 Mrs Bates estimated that it took a total of 20 seconds to remove the back number holder, the air vest (which took some time because it had inflated) and the back protector.[39] Mrs Bates allowed for a 10, but not 20, second margin of error for this timeframe.[40] She explained that she returned to the scene the day prior to giving evidence and remeasured her steps.

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[28] 14/5/19 at T11.17.
[29] 14/5/19 at T8.1.
[30] Exhibit 1, Tab 7, page 28.
[31] 14/5/19 at T10.9.
[32] 14/5/19 at T13.16-24.
[33] 13/5/19 at T54.18.
[34] 13/5/19 at T68.37.
[35] 13/5/19 at T70.26-30.
[36] 13/5/19 at T70.50.
[37] 13/5/19 at T74.10.
[38] 13/5/19 at T69.8.
[39] 13/5/19 at T75.15.
[40] 13/5/19 at T75.28.

13.13 When she saw Caitlyn Mrs Bates immediately recognised that Caitlyn was deceased. Mrs Bates said that "*approximately 2 minutes after I arrived (I cannot be exact) the doctors and paramedics arrived and inspected Caitlyn*".[41] Mrs Bates was asked about this in cross-examination by senior counsel for EA and how accurate her estimate of two minutes was. Mrs Bates explained: "*…knowing the distance that [the ambulance] travelled [from the location of the earlier fall] to where Caitlyn was, I believe that it can't have been more than [two minutes]; with Rebecca doing the CPR, you know, I sort of remember that it wasn't for that long and then the doctors arrived. I wasn't, you know, I didn't feel like we were there for minutes and minutes and minutes waiting for ambulances*".[42]

13.14 Mrs Bates recalls Ms Carr making two phone calls although could not recall the timing of each call. Mrs Bates explained in evidence that she was not looking at her watch and that her recollection of timings was good up until the point when the medical response arrived at the scene.[43] However, Mrs Bates could not recall who arrived (only that two people arrived), or whether Dr Golowenko performed CPR, or whether Dr Golowenko told anyone to stop CPR.[44] Mrs Bates agreed that Ms Andrews did not stop CPR at any time, despite Ms Carr telling her to stop.

13.15 However Mrs Bates said that she believed that a doctor was present on the scene when Ms Carr made her second phone call.[45] Mrs Bates said that she did not believe that she was present during the entire duration of the call because the medical response had arrived during the call so she stepped back and allowed them to do their job.[46] However, Mrs Bates said that when she stepped back, Ms Carr was laying over Caitlyn, touching her and not wanting to leave, suggesting that the call had ended by this stage.

13.16 Mrs Bates agreed that there was some discussion between herself and Ms Andrews before external cardiac compressions were commenced. She disagreed with the suggestion that those discussions took at least a minute[47] and said that it was not her recollection that the compressions only started once Ms Carr finished her second phone call.[48]

***Ms Andrews***

13.17 Ms Andrews was at the course start in a golf buggy delivering water when she heard the loud sound of a crash. Mrs Bates jumped on the buggy and they drove towards fence 2. When Ms Andrews arrived she had no recollection that Ms Carr was on the phone.[49] Ms Andrews estimated that it took her around 30 seconds to drive from the start to fence 2.[50]

13.18 By virtue of her past experience as a swimming coach and with the Rural Fire Service, Ms Andrews had past training in first aid and advanced resuscitation, although had never used it in a real life situation. Ms Andrews agreed that she and Mrs Bates took Caitlyn's personal protective equipment

[41] Exhibit 1, Tab 14 at [2.24].
[42] 13/5/19 at T69.27.
[43] 13/5/19 at T52.31.
[44] 13/5/19 at T76.20-23.
[45] 13/5/19 at T71.21.
[46] 13/5/19 at T71.32.
[47] 13/5/19 at T71.49.
[48] 13/5/19 at T72.3.
[49] 14/5/19 at T19.28.
[50] 14/5/19 at T23.29.

off. Ms Andrews agreed in evidence that this took "*a very short time*".[51] Acknowledging that what she was confronted with was obviously a traumatic event, Ms Andrews indicated that it was difficult for her to have anything other than a perception of time. She explained that because she was concentrating on the compressions she was giving to Caitlyn that she was unable to provide a timeframe of events. Further, Ms Andrews indicated that she had no recollection of Ms Carr being on the phone at this time.

13.19 Ms Andrews recalls Dr Golowenko arriving and said that she had the strong feeling that another person arrived or was present at around the same time.[52] Ms Andrews said that she continued with compressions for "*not terribly long*"[53] after Dr Golowenko arrived.

13.20 In her statement Ms Andrews stated: "*The paramedic appeared to be on scene quickly. There was a rapid response by the safety team*".[54] In evidence she was asked to explain what she meant by this. Ms Andrews explained: "*All I know is that not once did I go, 'Geez, where are they all' and that, for an amateur, is the first thing I'd be thinking and I didn't even - those thoughts didn't even go through my mind. I was concentrating like you all wouldn't believe and know I - I've thought about it and thought about it and I would only be guessing. I just know that when I looked up there was Alex and I just never thought, 'Where are they?' I never thought that for a second*".[55]

***Mr Fallon & Mr Rees***

13.21 Mr Fallon recalled two people arriving in close proximity, although he could not say how long it took them to arrive after Ms Carr. Mr Fallon said that the fourth person to arrive on the scene (after Mrs Bates and Ms Andrews) was a paramedic, and that he did not recall a doctor arriving.[56]

13.22 Mr Rees said that he was not wearing a watch and that he could only provide a perception of time. He said that his best estimate was that the ambulance took around five minutes to arrive.[57] In his statement he said: "*The ambulance seemed to take a long time but I think it was probably more like five minutes before it arrived*".[58] In evidence Mr Rees explained: "*…in that circumstance, it's you know, waiting for something to happen, it tends to take forever, but probably in reality, it's probably five, five minutes or so, before the ambulance got there*".[59] Mr Rees said that he could not recall whether Ms Retallack used her radio again, although he acknowledged that it was possible she did so.

***Dr Golowenko***

13.23 Dr Golowenko joined Dr Davis at the location of the earlier fall at the Lego boxes. Even though Dr Davis responded to the call Dr Golowenko also attended because he heard over the radio that the course was not clear and that the rider was down, indicating that assistance may be required. In the event the rider had sustained a musculoskeletal injury and was upright and conscious when Dr Golowenko arrived. He returned to control when no further assistance was required.

[51] 14/5/19 at T24.20.
[52] 14/5/19 at T21.2.
[53] 14/5/19 at T21.20.
[54] Exhibit 1, Tab 14.1 at [11].
[55] 14/5/19 at T24.35.
[56] 13/5/19 at T84.23.
[57] 16/5/19 at T8.8.
[58] Exhibit 1, Tab 8 at [17].
[59] 15/5/19 at T8.3.

13.24 Dr Golowenko recalls hearing the following words to the effect of the following over the radio: "*Rider fall, jump 2, medical assistance required. Course not clear*".[60] Dr Golowenko responded with words to the effect of, "*This is Dr Alex. On my way*"[61] and did not hear anything further on the radio after that. Dr Golowenko said that he did not recall hearing a second call but it is possible that one was made.[62] Similarly he said he was not sure whether he heard a third call over the radio.[63]

13.25 Dr Golowenko and the paramedic, Mr Brown, were sitting in the ambulance when they heard the radio message. He said that their priority was to get to the jump as quickly as possible and that whilst the initial route down a rough track from the hill meant they had to travel slowly, they were able to travel more quickly once they reached the flat ground of the steeplechase track. Dr Golowenko estimated that it took three minutes to drive from control to fence 2[64], although he accepted that it was difficult be accurate without checking his watch at the time. He accepted that there could have been a one minute margin of error, but considered that a two minute margin would be surprising[65], although he did not accept that it would have taken more than five minutes to reach fence 2.[66]

13.26 Dr Golowenko said that when he arrived his attention was focused on Caitlyn but that he did not notice Ms Carr to be on the phone.[67] He accepted that it was possible that he was not on the scene at 10:46am when Ms Carr was on the phone.[68]

13.27 Upon arriving at the scene Dr Golowenko saw that Ms Andrews was performing compressions which were in his view of a high standard. He provided C-spine support and jaw thrust in accordance with his training. Dr Golowenko heard Ms Carr saying that Caitlyn was already deceased and to stop compressions. Dr Golowenko formed a similar view based on his initial assessment. He asked Ms Andrews to cease compressions so that he could assess Caitlyn. Dr Golowenko checked Caitlyn's pulse, checked for any sign of respiratory effort and checked for any eyelash reflex. He saw that Caitlyn's pupils were fixed and dilated and that she had no signs of life. The assessment took 10 or 15 seconds.

13.28 At around this time Dr Roche arrived on the scene. Dr Golowenko asked him to move the ambulance to provide a screen for privacy. When Dr Golowenko indicated that Caitlyn was deceased Dr Roche suggested that they should think about moving Caitlyn into the ambulance.

13.29 Dr Golowenko asked Ms Andrews if she was able to continue with compressions. Ms Andrews said that she was and Dr Golowenko asked her to continue. Even though Dr Golowenko formed the view that Caitlyn was already deceased he asked Ms Andrews to continue because he "*didn't think it was appropriate for CPR to be ceased in the presence of the mother and in such an open place without then a plan of some way to move Caitlyn or screen Caitlyn*".[69] The compressions continued for a further one or two minutes. Dr Golowenko formed the view that Caitlyn had suffered a catastrophic head injury and that any further intervention would be futile.

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[60] 14/5/19 at T53.46.
[61] 14/5/19 at T54.11.
[62] 14/5/19 at T54.36.
[63] 14/5/19 at T54.40.
[64] 14/5/19 at T56.16.
[65] 14/5/19 at T56.34.
[66] 14/5/19 at T57.40.
[67] 14/5/19 at T58.23.
[68] 14/5/19 at T58.35.
[69] 14/5/19 at T60.40.

***Ms Grygorcewicz***

13.30 After attending to the rider fall at the Lego boxes Ms Grygorcewicz gave the rider a lift in the ambulance to the cooling station and dropped her off. As she did so she heard on the radio a call from someone she believed was a jump judge. She heard the words, "*We have a fall of a rider*"[70], and then possibly heard Dr Golowenko respond, "*This is Dr Alex responding*" or "*We're medical and we're responding*".[71]

13.31 Ms Grygorcewicz made her way to fence 2 along the road between fences 3 and 4AB. When she arrived at the scene she saw the other ambulance already parked there and Dr Golowenko and Mr Brown already at the scene. Both Dr Golowenko and Mr Brown indicated that her assistance was not required with Caitlyn and that she should instead tend to Ms Retallack who appeared to be very distressed. Ms Grygorcewicz said that she was unable to estimate how long it took from hearing the radio call to arriving at the scene. She noted that "*it was quite quick because I do know that I dropped the rider off and it was – I was in a main easy road…*".[72]

***Dr Davis***

13.32 Within five minutes of attending to the fallen rider Dr Davis was walking through sector 2 with Samantha Farrar. Dr Davis was unable to recall the precise nature of the call but recalled hearing that Dr Golowenko and Mr Brown, and Ms Grygorcewicz had mobilised to attend to the job.

13.33 A short time later Dr Davis heard mention of a code blue over the radio which indicated to him that the patient was not breathing. Dr Davis continued making his way to fence 2, arriving on his estimate about 10 minutes after Caitlyn's fall. Upon arrival Dr Davis saw Dr Golowenko and the two paramedics on the scene. He asked Dr Golowenko for a situation update and was told that Caitlyn had died on the scene and that resuscitation efforts had ceased not long before his arrival.

***Dr Roche***

13.34 Dr Roche said that he was near the control tent in sight of Dr Golowenko and Mr Brown when he heard the call over the radio regarding a fall at fence 2. He said that the ambulance moved off probably within two or three seconds.[73] Dr Roche said that he made his way to his own vehicle, which was parked about 10 metres away and then drove down to fence 2. He said that drive took two minutes and fifteen seconds.[74]

13.35 Dr Roche said that when he arrived Ms Andrews was still performing CPR and Dr Golowenko was managing Caitlyn's airway. Dr Roche could not recall if Ms Carr was still on the phone at that time. He said that Dr Davis arrived on the scene "*probably a couple minutes later…maybe as many as three or four but…shortly afterwards*".[75] Later in his evidence Dr Roche said that Dr Davis may have arrived on the scene up to five minutes later.[76] Dr Roche rejected the suggestion that he was deliberately

[70] 14/5/19 at T92.43.
[71] 14/5/19 at T92.46.
[72] 14/5/19 at T96.20.
[73] 15/5/19 at T29.48.
[74] 15/5/19 at T31.7.
[75] 15/5/19 at T32.8.
[76] 15/5/19 at T33.22.

attempting to expand the timing of events and said that he was satisfied the response was as timely as it could be.

13.36 He went on to raise the possibility that, despite being informed in the morning briefing how the radio was to operated, Ms Retallack may not have had her finger on the right button, or not spoken into the radio at the correct time, leading to the first radio call not being heard. Dr Roche said that he first heard a radio call that there had been a fall at fence 2 and then some seconds later another call in which it was said, "*The rider's not getting up*".[77] By this stage Dr Roche said that the ambulance was already halfway down the hill. Dr Roche said that he did not believe it was possible that it took five and a half minutes for him to arrive on the scene.[78]

***Patient Care Report***

13.37 The HSI Patient Care Report records the time of the incident as being 10:40am and the time of arrival of Mr Brown as the first attending paramedic as 10:42am. If the fall occurred at 10:40:30am as the video footage suggests, this would indicate that the first paramedic arrived on scene within 90 seconds.

***Analysis***

13.38 It can be seen from the above that there is a wide discrepancy between the various accounts. At one end of the spectrum, as noted immediately above, the HSI Patient Care Report suggests that the first response arrived within 90 seconds of the fall. The author of the report is not known and it is equally unclear on what basis the time of arrival contained in the Report has been arrived at.

13.39 At the other end of the time spectrum, Ms Carr suggests that the medical response did not arrive on scene until towards the end of her second call to her husband. If this is the case, and knowing that the call was made at 10:46am and lasted three minutes and 28 seconds, this would mean that the medical response arrived sometime between 10:48am and 10:49am. This was some eight or nine minutes after Caitlyn's fall.

13.40 It can be accepted that the fall occurred at around 10:40:30am. This is consistent with the timestamp on the video footage, Ms Carr's calculations of how long it took her to reach Caitlyn, and how long it would have taken Caitlyn and Ralphie to travel the 210 metres from the start to fence 2, after starting the course at 10:40am.

13.41 Ms Carr's reconstruction of events is based off her mobile phone records. There is no evidence to suggest that the records do not accurately record the start time and duration of the two phone calls that Ms Carr made. The difficulty lies in placing the phone calls in context with the video footage, and the recollections of the witnesses.

13.42 It can be accepted that because of the traumatic and distressing nature of the events that the various witnesses had just seen, or were responding to, that it is difficult for anyone to be precise regarding times and timeframes. Several witnesses acknowledged during their evidence that they did not look

[77] 15/5/19 at T34.13.
[78] 15/5/19 at T32.42.

at any watch that they might have had, and that they only had a perception of time. This obviously means that it is not possible to make any precise determination about timings.

13.43 It can be seen from the above, that even with this understanding, there was also a discrepancy between the witnesses about their perceptions. For example both Ms Retallack and Mr Fallon felt that it took "*forever*" for the medical response to arrive. In contrast, Mrs Bates and Ms Andrews felt that the response was much timelier and that at no stage were they left wondering when the medical response would arrive.

13.44 Notwithstanding the limitations identified above, the evidence suggests firstly that Dr Roche's recollection is inaccurate. He said that upon hearing the first (and on his account, the only) radio call from Ms Retallack, the ambulance left control within 10 seconds and that he followed, arriving on scene within two minutes and 15 seconds. According to Dr Roche, at this time Dr Golowenko was already managing Caitlyn's airway. If Dr Roche's account is accepted, it would mean that he arrived at around the same time as Mrs Bates and Ms Andrews. There is no evidence to support this. This would also place Dr Roche at the scene before Dr Golowenko, whose most timely estimate of the response time was three minutes. Again, Dr Roche's account is inconsistent with the other evidence.

13.45 It can be accepted that Dr Golowenko and Mr Brown were the first medical responders to arrive on the scene. No witness suggests that Dr Golowenko and Mr Brown arrived before Ms Carr made her second phone call. If it is accepted that Ms Retallack made her radio call at about 10:40:41am and Ms Carr started her call at 10:46am, this means that a period of at least five minutes elapsed before a medical response arrived. This is consistent with Mr Rees' best estimate of it taking five minutes for a medical response to arrive. Even Dr Golowenko was prepared to allow that his best estimate of three minutes could contain a margin of error of up to two minutes, although he considered a five minute response time to be less likely than a three or four minute response time.

13.46 Mrs Bates accepted that Ms Carr would have been on her first phone call for more than a few seconds when she arrived. Even if this is the case, given that the call only lasted 34 seconds, it would place Mrs Bates' arrival at 10:43am. On Mrs Bates' best estimate, the medical response arrived within two minutes or, in other words, by 10:45am. However this calculation is inconsistent with Mrs Bates' other evidence that the medical response arrived sometime after Ms Carr made her second call at 10:46m.

13.47 Neither Ms Carr nor Mrs Bates was able to say at what point during this second call Dr Golowenko arrived on scene. Dr Golowenko himself said that he did not notice whether Ms Carr was on the phone or not when he first arrived. However, he acknowledged that he was not on the scene at 10:46am when Ms Carr began her call. This is consistent with the other evidence of Mr Rees above.

13.48 In her notebook statement to the police, Ms Retallack referred to making only one radio call for assistance. In evidence during the inquest, she referred to making a total of three calls. On her account, the third call was prompted by a lack of movement from the ambulance. Ms Retallack said that she did not receive a response to any of her three calls. Other witnesses state that they heard Ms Retallack's first call. Dr Golowenko said that he broadcast a response to it which was heard by other witnesses. Only Dr Roche said that he heard a second radio call.

13.49 **FINDINGS:** The competing and varying witness accounts have been difficult to reconcile. There is no evidence to suggest that any piece of equipment was not functioning correctly. There is also no evidence to suggest that Ms Retallack was not familiar with the operation of the radio which had been provided during a briefing that morning. Ms Retallack had been a fence judge for eight years, and had regularly undertaken that role (doing 12 events a year) for the previous two and a half years. She had previously volunteered at SIEC and had previously witnessed a fall, but not one in which a rider was injured. She presumably had attended many similar briefings previously where similar instructions would have been provided. It was suggested by Dr Roche that the reason for the discrepancy may be because Ms Retallack did not have her finger on the right button, or speak into the radio at the right time. However, there is no evidence to support this, and indeed, the evidence suggests that Ms Retallack's fence jump experience made this unlikely.

13.50 Regardless there is no evidence to suggest that Ms Retallack was mistaken in saying that she made three radio calls. Even though it is not possible to explain why at least one of these calls was not heard by anyone else, two considerations arise. Firstly, although Dr Golowenko acknowledged that he was responding to the call and was on his way, no estimated time of arrival was provided. Such an estimate would have provided some reassurance to Ms Retallack given the grave and time-critical situation she was confronted with. Secondly, the fact that Ms Retallack was prompted to make a third radio call tends to support Ms Carr's view that the medical response was not as timely as it could have been.

13.51 Ms Carr's reconstruction of the chronology of events is based on her own recollection and the only (apart from the video footage) available independent record being her mobile phone records. However, in order for these records to be accurate the times recorded must be consistent with the timing of the video footage, since that is the starting reference point for Ms Carr's reconstruction. For example, Ms Carr's second call concluded at 10:49:28am according to her phone records. Using the video footage as a starting reference point, this means that the call ended 8 minutes and 58 seconds after Caitlyn's fall. However this calculation is only accurate if the timing of the mobile phone records is the same as that of the video footage. If, for example, there was a discrepancy of just one minute, then it would place the end of Ms Carr's second call at about either seven minutes or ten minutes after the fall.

13.52 Having regard to the totality of the available evidence it is most likely that the first medical response in the form of Dr Golowenko's arrival at the scene did not occur until at least five minutes after Caitlyn's fall given the following factors:

(a) Ms Carr's expressed certainty that no doctor was present at the time that she made her second phone call;
(b) Dr Roche's account and, to a lesser extent, Mrs Bates account are less likely to be reliable than the accounts provided by other witnesses;
(c) there is no evidence to suggest that there is any significant discrepancy between the timing of the video footage and the timing of Ms Carr's mobile phone records;
(d) a five minute response time is consistent with Mr Rees' estimate, the upper limit allowed for by Dr Golowenko, and a timing comparison between Ms Retallack's first radio call and Ms Carr's second phone call;

(e) Dr Golowenko conceded that it was possible that he had not arrived by the time Ms Carr started her second call at 10:46am; and

(f) although Mrs Bates believes that a doctor was present during Ms Carr's second call, it is unclear at what stage during the call (at the beginning, middle, or end) that Ms Bates observed the doctor to be present, meaning that even if Dr Golowenko arrived towards the beginning of the call, a period of five minutes from the fall would have elapsed.

**14. What issues did the inquest examine?**

14.1. Prior to the commencement of the inquest a provisional issues list was distributed to the parties. That list identified the following issues which the inquest proposed to examine:

(a) Are safety procedures at New South Wales equestrian events adequate to minimise unnecessary risk of serious injury or death?

(b) Did any physical aspect of the courses, or any application of course design principles, contribute to the deaths of Olivia and Caitlyn? If so, what amendments to the construction and design of courses are appropriate and how should such courses, and aspects of course design, be reviewed and be regulated?

(c) Is there an appropriate mechanism by which riders can raise safety-related concerns and have such concerns addressed and responded to in an appropriate time-frame?

(d) Were there appropriate risk management and emergency response plans, policies and procedures in place at the equestrian events at which the deaths occurred to ensure that optimal medical treatment was provide to Caitlyn and Olivia?

(e) Did medical personnel have sufficient training and equipment to enable them to attend on Caitlyn and Olivia appropriately and in as timely a manner as possible, and did they attend in accordance with that training?

(f) Are recommendations arising from reports prepared by EA review panels following the deaths appropriate?

(g) What relevant changes have been implemented since the deaths of Caitlyn and Olivia?

(h) Does EA have an appropriate system in place to review critical incidents involving serious injuries or fatalities to riders?

(i) Are further recommendations "necessary or desirable to make" in relation to any matter connected to the deaths?

14.2. To address some of the above issues, expert assistance was sought from a number of experts who both provided reports and gave evidence during the inquest.

14.3. During the course of the coronial investigation, and the inquest itself, it became apparent that there were a number of particular issues relevant to the broader issues identified above. Each of these issues is considered in more detail below.

14.4. At the commencement of the inquest, Lucy Warhurst Chief Executive Officer of EA, made the following statement to the court:

"*We are committed to ensuring that the deaths of Olivia and Caitlyn are honoured by ensuring that all lessons learned will be applied through education and training, the safety of riders,*

*coaches, horses, officials and all participants. Equestrian Australia's number 1 priority is and will remain the safety of its participants*".[79]

14.5. Recommendations have been made pursuant to section 82 of the Act where it has been considered that the evidence indicates that it is necessary or desirable to do so. These recommendations should be understood as being made in the hope that that they will assist EA to achieve its primary priority of ensuring the safety of its participants.

14.6. In this regard it should be acknowledged that the parents of both Olivia and Caitlyn have been engaged, generous, constructive and patient throughout the coronial and inquest process. Despite the confronting, challenging, public, and foreign nature of this process they have demonstrated a selfless desire to advocate for change and improvement, and to learn from personal tragedy for the benefit of others in the wider community. Their determination and selflessness is inspiring.

[79] 13/5/19 at T21.34.

## 15. Broader issues

15.1 Apart from the issues and matters particular to the specific incidents involving Caitlyn and Olivia, the inquest also considered a number of broader issues. These issues are relevant to the question of whether safety procedures at New South Wales equestrian events are adequate to minimise unnecessary risk of serious injury or death of riders.

15.2 In considering these issues the following matters should be acknowledged:

(a) Equestrian sports, and eventing in particular, are heavily reliant upon volunteers to perform important functions;

(b) The willingness of such people to volunteer their time, skill and services is indicative of their passion for, and love of, the sport;

(c) Despite such willingness it is often difficult to recruit sufficient numbers of volunteers to perform important functions;

(d) The operation of the sport carries certain financial constraints in circumstances where there is significant reliance on public funding which is in turn directed towards high performance programs; and

(e) EA has undertaken certain measures, some directly as a result of the coronial process and the inquest, to improve safety and reduce risk within the sport. Some of the safety measures undertaken include:

- Trialling the use of EquiRatings, a data and analytics company which uses horse performance to provide an index indicative of the quality and performance of a horse in the cross country test;

- Introducing helmet tagging, a system which verifies that a rider's helmet complies with certain standards;

- Implementing a Concussion Protocol;

- Mandating the use of frangible technology on suitable fences at certain star classes; and

- Collecting articles and other information relevant to risk management and safety developments on the "Making Equestrian Safer" page on the EA website.

## 16. Incident review system

16.1 Following the deaths of Olivia and Caitlyn panels were formed by EA to review the incidents. The panel members were selected by EA. In Caitlyn's case the panel consisted of Roger Kane (chair), Will Enzinger (chair of the EA National Eventing Committee), and Vivienne Stephens (Victorian Eventing Committee member and legal academic). In Olivia's case the panel consisted of Dr Vincent Roche (chair), Liza Carver (an EA Board member and law firm partner, Mr Enzinger, and Bruce Farrar (Chief Executive Officer of Equestrian NSW). Mrs Farrar, a work health and safety officer with previous experience in workplace incident investigations (and wife of Mr Farrar) was engaged as a safety consultant to assist the panel in its investigative process.

16.2 The terms of reference established by EA for each review were to:

(a) To determine the sequence of events;
(b) Assess compliance with the FEI and EA Eventing Rules relevant to the incident;
(c) Review the risk management controls in place at the event; and
(d) Propose opportunities for improvement, where they exist

16.3 In each report prepared by the respective panels a number of recommendations were made.

16.4 The evidence at the inquest identified a number of issues associated with the review process, namely:

(a) Witnesses at both incidents were contacted by phone at times that were not proximate to the incidents themselves: both Mr Rees and Ms Retallack received a call about six months after the SIEC incident.

(b) Some witnesses, such as Dr Golowenko, were not contacted by the review panels at all. Dr Golowenko said that he would have been happy to be interviewed by the review panel if asked. He only recalled speaking informally to Dr Roche in the weeks following the incident.

(c) Some witnesses, including those mentioned above, were only spoken to over the phone and never asked to make and sign formal statements. Mr Rees said in evidence that he would have been happy to participate in an interview with a representative of EA.

(d) Statements that were taken from some witnesses contained inaccuracies which did not appear were ever resolved. Mr Burgess said that after being interviewed by Dr Roche he was sent a transcript[80] and asked that he sign it. Mr Burgess declined to do so as he asserted it contained inaccuracies. Instead, Mr Burgess prepared his own statement and sent it to Dr Roche, following which he received no response.

(e) Mr Nicholson was called by Dr Roche but said that he did not understand that he was being interviewed for the purposes of an incident review.[81] He said that he was never made aware of the contents of the review panel report or its recommendations.

[80] Exhibit 18.
[81] 20/5/19 at T52.49.

(f) Mr Kane considered there to be a distinction between a review and an investigation and considered that the panel had been formed to conduct the former. Mr Kane was asked in evidence about page 4 of the SIEC report. He explained: "*Had we been doing an investigation…we would probably have gone through a kind of a cross-examination process, a more robust examination of every witness in potentially a, I suppose a, what's the right word, a combative way rather than just an understanding of they're saying way*".[82]

(g) In Olivia's case, no consideration was given to whether an independent course designer should be engaged to review fence 8A/8B.[83]

(h) Mrs Farrar was instructed to not pursue certain lines of inquiry, such as attempting to accurately measure the distance between 8A and 8B (because the panel felt that the focus should instead be on rider experience and their striding)[84], and seeking expert opinions from experienced riders such as Mr Tinney and Mr Tapner about whether the fence could have been built in a way that posed a lower risk.[85]

(i) Mrs Farrar's skills and experience did not appear to have been fully utilised. After sending through a number of drafts of the final report and being asked to amend them Mrs Farrar said that by May/June 2016 she was performing a secretarial role, rather than a safety consultant role.[86] Mrs Farrar described her involvement at that stage in this way: "*I felt as though a lot of the suggestions and recommendations I were making that I felt passionate about, were taken out and I noted that I didn't have any say about them going back in*".[87]

(j) Some items were removed from Olivia's final report which appeared to have relevance such as: rider impressions of the ground conditions at Scone, a diagram taken from the Barnett Report showing the risk of horse fall for different fence types, a recommendation that cross country fence profiles be made more forgiving with no vertical faces even on ascending oxers, and details of discussions with HSI.

(k) According to Ms Williams, the topic of personal protective equipment "*was paid relatively little attention*".[88]

(l) There appeared to be a lack of meaningful engagement with the parents of Caitlyn and Olivia. Ms Carr explained: *"[Mr Enzinger] and [Mr Kane] came and met us in our home and spoke to us. They spent approximately two hours with us, but that during that time they made no notes. They took no documentation and when they left Mark and I turned to each other and said we felt that that had been a complete and utter waste of time. They advised us that they weren't taking formal statements and I think what made us feel, I guess, alarmed was when we received the first draft of the first report into Caitlyn's - review into Caitlyn's death, there were so many errors of fact in relation to some simple things, like the day she arrived, which should have been very clearly documented and I suppose for me, given the experiences I've had with other health*

[82] 15/5/19 at T55.14.
[83] 22/7/19 at T19.15.
[84] 24/5/19 at T36.34.
[85] 24/5/19 at T39.11.
[86] 24/5/19 at T34.42.
[87] 24/5/19 at T35.6.
[88] Exhibit 1, Supplementary Volume, Tab 8, page 13.

*investigations, that - it made me alarmed that they couldn't get things as - what I felt should have been as straightforward as that correct*".[89]

Olivia's parents, Arthur and Charlotte Inglis were provided with a draft report in August 2016 by EA and invited to comment on it. After providing their comments, they sent the report back to EA. Mrs Inglis understood that once their comments were provided they would workshop some of the recommendations with Mr Kane, but this never occurred.[90] Mr and Mrs Inglis also asked Ms Fasher for the supplementary statements that had been made to produce the report, but they were never provided. Despite making repeated requests, it eventually became apparent to Mrs Inglis that the statements would not be provided. She explained at that point: "*We started to feel pretty isolated and also to worry about the fact that maybe nothing would come of the recommendations they'd made and some of them needed to be attended to urgently*".[91]

(m) There appeared to be a lack of meaningful engagement by EA with its members regarding the process of implementing recommendations arising from the review process. Mrs Inglis also expressed the view that whilst the recommendations arising out of the reports were positive, there was no communication to EA members regarding how the recommendations would be implemented, nor any timeline indicated for their completion. Mrs Inglis expressed it frankly in this way: "*…it was just the frustration of the loss of transparency and the fact that they didn't communicate how they would make these recommendations or how long these recommendations could take to put out for the membership. They didn't ever stop running events. So Olivia and Caitlyn were killed and nothing changed. Events continued to be held. No-one was communicated with, and though they had a great set of recommendations, they didn't and couldn't explain to us the timeline that they had around changing things for people that were still doing what our daughters had been doing when they were killed*".[92]

Further, Mrs Farrar noted: "*I remember it being asked repetitively on social media, you know, 'Can we have a forum that we can discuss?' Riders wanted to know why these incidents happened and they wanted to get some feedback, and there were, it was ongoing requests to have a forum and for, for their questions to answered. I remember at the time Bruce [Farrar]…had said to me that he was asking EA if they could release the report to - or even a draft, like an extract of the report to the members, so the members could get the feedback that they were requesting*."[93]

Finally, in May 2016 the Scone organising committee wrote to EA to make a number of observations and recommendations regarding the 2016 Scone Horse Trials. A number of these recommendations were included in the final incident review for Olivia's accident at the 2016 Scone Trials but the committee received no feedback until some of the recommendations had actually been implemented via, for example, amendment to the EA Rules.

16.5 Geoff Sinclair, a Level 3/4 technical delegate, member of the FEI Eventing Committee and chair of the FEI Risk Management Steering Group, was asked at the inquest to provide a view about the matters set out at paragraph (m) above. He said:

[89] 14/5/19 at T43.38.
[90] 16/5/19 at T26.43.
[91] 16/5/19 at T27.12.
[92] 16/5/19 at T34.8.
[93] 24/5/19 at T45.42.

"*I think we need to become more like the airline industry and more transparent. I think it's a, it's a role we have to take on and I think we have tended to hide these things too much, and if there's anything to learn we should learn it as soon as possible. And if that's the next week's event, let's learn it. So, yeah, I'd certainly encourage transparency*".[94]

16.6 Mr Sinclair went on to say:

"*But although, I think, the things that we've learned at Scone or things that were learnt at Sydney and that there wasn't - well, the things that were learned at those things were disseminated in a, a discrete way and started to be implemented. I think it just wasn't totally obvious to the whole eventing community and the world the changes that should and could be made and, you know, that's unfortunate. We shouldn't be frightened about that; we should get on and learn something from this*".[95]

16.7 **FINDINGS:** The evidence establishes that there were a number of aspects of the review process which were deficient in the sense that they did not demonstrate that an entirely comprehensive review process had been conducted following the deaths of Caitlyn and Olivia. Much of this can be attributed to the relative inexperience of the panel members in participating in the kind of review process which they were asked to perform. Notwithstanding, the Scone incident review panel had available to them an experienced workplace incident investigator in Mrs Farrar. It appears that her assistance was not fully utilised. Further, there were missed opportunities to comprehensively inform EA members and the broader equestrian community about the progress of the review process, the implementation of recommendations and the timeline for their completion, and to demonstrate that the incident review process was being conducted in a transparent way.

16.8 More specifically, aspects of the review process had the unintended consequence of undermining some of the confidence that the parents of Caitlyn and Olivia had in the incident review process, and left them with a sense of disengagement. It can be accepted that there was a need to balance the sensitivities of the families in experiencing such traumatic events against the need to conduct a comprehensive evidence gathering exercise. However, the evidence demonstrates that the parents of Caitlyn and Olivia sought a greater opportunity for involvement in the review process than was offered to them.

[94] 23/7/19 at T45.42.
[95] 23/7/19 at T46.10.

**16.9** **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian Australia that a robust and comprehensive process be developed for the review of serious incidents requiring a medical response at an Event. In this regard "serious incident" means: a fatality; or a head or spinal injury which requires an overnight admission to hospital. Such a review process should include, but is not limited to, the following: (a) the creation of a panel consisting of equestrian experts (with experience in, for example, competing and course design) and non-equestrian experts (with experience in, for example, risk management) available to be selected as members of a Review Panel, none of whom are office holders with EA or any state branch of EA; (b) formation of a Review Panel comprised of at least two equestrian experts; (c) input sought from the competitor, or family of a competitor, involved in a serious incident requiring a medical response, as to the composition of the Review Panel; (d) eyewitnesses and persons directly involved in a serious incident requiring a medical response being formally interviewed and requested to provide written statements in a timely manner following the serious incident; (e) the issuing of preliminary findings and/or a safety warning/advisory to EA members and Event Organising Committees if the Review Panel determines that it has identified any issues which may potentially adversely affect the safety and welfare of competitors at Events immediately following a serious incident; (f) the publication to all EA members of any recommendations made by a Review Panel, with a process implemented for feedback to be provided by EA members and reviewed by EA; and (g) the publication to all EA members of updates regarding the progress of implementation of any recommendations made by a Review Panel.

## 17. Course walk

17.1 An essential part of preparation for the cross country test is for riders to walk the course itself, often more than once. When this occurs is usually dictated by a rider's individual schedule and time of arrival at the event venue. During the inquest, consideration was given as to whether an official course walk, involving the course designer and a number of event officials ought to occur.

17.2 The evidence consistently established that an official course walk would be a positive development and an appropriate risk mitigation strategy:

(a) Mr Bates expressed the view that it would be useful for EA to mandate an official course walk prior to a national event.[96] He explained in evidence:

"*I think just another expert set of eyes on a course is always welcome and there's a lot of pressure on the TD [technical delegate] to sign off on a course. FEI events you're helped by having - there's an official course walk where the TD and a course designer and the ground jury all walk it together and I think, if we could have something similar in our EA events, it would help and incorporate a senior rider or the riders' rep as well, would be good*".[97]

(b) Mr Rose agreed that this was a good idea and said this had been done at past events, but emphasised that he would only be expressing an opinion about risk management. He said that he could not instruct riders in how to ride, not knowing the rider or their horse.

(c) Greg Backhouse is a FEI accredited Level 1 show jumping course designer and an FEI accredited Level 3 Jumping Judge. He said that he had observed a course walk with a riders representative take place in the show jumping arena in an informal way prior to 2016 and said that he encouraged this occurring more broadly.[98] Mr Backhouse explained that if any concerns were raised during the course walk they could be raised with the technical delegate.

(d) Mr Nicholson also expressed the view that this would be a good idea. He said:

"*I think it would be good practice for young riders to walk cross-country courses with the course designer. He can explain what he is doing. If he cannot explain to them what he is asking and expecting, he hasn't got it right*[99]*…I think in the long run it would be very beneficial for the course designer and the young riders*".[100]

(e) Finally Mr Sinclair also supported the idea of an official course walk: He explained:

"*All a course designer can really do at that point is explain the question. Again, if you go back to remembering what I said before he doesn't know the horse, he doesn't know the rider, but he can, he can explain the question that he's asking. So I think - and, you know, it was optional whether*

[96] Exhibit 1, Tab 24 at [20.2].
[97] 16/5/19 at T83.10.
[98] 17/5/19 at T80.38-T81.12.
[99] 20/5/19 at T25.39.
[100] 20/5/19 at T25.48.

*people went or not, and quite a, you know, crowd of young riders went and it was certainly done at Melbourne three day event this year in the two star class, the lowest class. And I think, you know, the course designer…got really good reception from people. But it is a matter of just showing them this is what the question I'm asking and they can ask any questions as well, and I think it frees up the relationship particularly with the young riders between the officials*".[101]

17.3 **FINDINGS:** There was universal acceptance in the evidence that an official course walk, attended by the course designer, riders representative and event officials, prior to the start of the cross country phase would be a positive development. It should be emphasised that the purpose of such a course walk would not be to instruct riders as to how they should ride a course. This will always be an individual matter for a rider. Instead, the purpose would be to have a course designer explain the questions that are being asked to better inform a rider in the development of their own riding plan. Moreover, an official course walk would promote opportunities for less experienced riders to feel comfortable in approaching and raising concerns with participants of the course walk.

17.4 **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian Australia that prior to the commencement of an Event: (a) all competitors in the Event be notified of the availability to participate in a formal course walk, with the technical delegate, course designer, Athlete Representatives, Event Safety Officer and a member of the Event Organising Committee to be present; (b) arrange for a formal course walk to be conducted prior to the commencement of the Cross Country Test.

[101] 23/7/19 at T86.17.

## 18. Rails down in show jumping

18.1 Another issue which arose for consideration during the inquest was whether the performance of a horse in the show jumping test was indicative of its likely performance in the cross country test (if held subsequently). In other words, if a horse incurred a certain number of faults in the show jumping test, would this mean that it was likely to also incur faults in the cross country test, thereby exposing a rider to the increased possibility of a fall and serious injury?

18.2 Mrs Inglis expressed the view that cross country courses have, over time, become more technical and that fences on cross country courses can cause serious falls even with frangible technology. She expressed the view that the cross country phase is more related to show jumping now than it was at its inception. At the time of Olivia's fall Mrs Inglis said that she "*considered show jumping and cross-country in two different baskets but the more the sport evolves and becomes more technical, the more there is a correlation in the jumping ability of a horse and the technical component of the cross-country*".[102]

18.3 Mr Backhouse was the course designer for the show jumping course at Scone in 2016. He expressed the view:

> "*In National three-day competitions such as the Scone 2016 event, the show jumping test occurs prior to the cross country test. If a rider/horse combination performs badly in the show jumping (eg. they suffer a number of penalties for knocking over rails), there is a risk that they will also perform badly in the cross country test. I have had discussions with various members of the equestrian community about using show jumping statistics as a tool for disqualifying a rider/horse combination to compete in the cross country test at a particular level*".[103]

18.4 Mr Backhouse explained that the scoresheet from a horse and rider combination's performance in the show jumping could be reviewed by the technical delegate (and the course designer and show jumping judge).[104] However, Mr Backhouse acknowledged that opinion within the equestrian community was divided on this issue and that a number of considerations needed to be taken into account: (a) that some horses are "lazy" showjumpers but competent cross country jumpers; (b) different skills are required in each discipline; (c) disqualifications will impact High Performance riders seeking to qualify for Olympic and World Championship level events; and (d) show jumping does not always occur prior to cross country and so this would produce inconsistent disqualifications.[105]

18.5 Mr Rose explained that his view had changed on this issue. He explained:

> "*The reason it's been changed is I was for the opinion that if a horse has multiple fences down in the show jumping that then perhaps they shouldn't be allowed to go cross-country. I've since been made aware of data that actually negates that completely, and that once a horse has more than I think four or five rails in the show jumping, they're actually apparently proven to be more safe*

[102] 16/5/19 at T35.7.
[103] Exhibit 1, Tab 10 at [18.1].
[104] 17/5/19 at T81.43.
[105] Exhibit 1, Tab 10 at [18.2].

*cross-country*".[106] He agreed that further data analysis was required before any rule change should be made.

18.6 Mr Etherington-Smith supported compulsory retirement based on a number of rails down in the show jumping. He explained:

"*Actually a good jumper is both careful and both brave and that - a horse that is likely to jump regularly jump too low over showjumps doesn't suddenly stop jumping too low when it's presented with a cross-country jump. If it's likely to hit showjumps it's likely to hit cross-country jumps*".[107]

18.7 Mr Bates considered that it would be very valuable for communication to occur between judges and a technical delegate between the show jumping and cross country phase. He explained:

"*FEI events, the ground jury oversee the show jumping normally and the dressage and the cross-country so they get to see all the riders jump in the show jumping normally before they go cross-country so if they have any concerns they are aware of it and they communicate that to the TD and amongst themselves. That's why - the show jumping - the Scone committee tried to bring in a rule that if horses didn't meet the [minimum eligibility requirement] in the show jumping that they couldn't go cross-country or they could go at the lower level*".[108]

18.8 Mr Richardson confirmed that this practice was adopted at Scone in 2017. If a rider had a significant number of rails down (five or six) in the show jumping they were disqualified from the cross country but permitted to rider at the grade below. He explained that this did not cause any problems and that riders accepted it once it was explained that it was a safety measure.[109]

18.9 **FINDINGS:** There is divided opinion about whether the performance of a rider and horse combination in the show jumping test is indicative of its likely performance in the cross country test. However, the available evidence tends to suggest that previous performance is a likely indicator of future performance. In addition, what is evident is that performance of a combination in the show jumping test at least warrants review by event officials prior to the cross country test, even if only for the purposes of communication between event officials and not the automatic disqualification of a combination.

18.10 **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian Australia that at Events where the Jumping Test precedes the Cross Country Test: (a) the technical delegate and Ground Jury (if present) be required to collect and review data to determine whether the number of penalties incurred by a combination in the Jumping Test is potentially adversely indicative of the capacity of the combination to compete safely in the Cross Country Test; and (b) in circumstances where such a determination is made, require that the technical delgate and Ground Jury give consideration to whether the combination should be eliminated from competing in the Cross Country Test, or downgraded to a lower category of competition.

[106] 17/5/19 at T21.13.
[107] 21/5/19 at T69.23.
[108] 16/5/19 at T86.12.
[109] 23/5/19 at T46.36.

## 19. Riders Representative[110] system

19.1 The evidence in the inquest raised for consideration a number of aspects relating to the role of the riders representative.

***Experiences of the families of Caitlyn and Olivia***

19.2 In 2016, it was usual practice for an organising committee to invite a rider to be a riders representative for the star class in which they were competing. Consideration of their suitability for the role was often dictated by the experience of the rider and often, more importantly, their approachability. Usual practice indicated that the names and contact details for the riders representative in each star class are published on a board near the secretary's office at the event venue. At some events, depending on the organisational timing, the contact details of the riders representatives are published with the draw.

19.3 Both Ms Carr and Mrs Inglis were unaware of who the rider representative was for the star class that their daughters were competing in. Ms Carr explained:

> "*…we were actually parked right beside [Ms Bishop]. We were right beside her in the carpark but at that stage with the riders' rep, they would just put a notice up on a board and you'd have to go and actively search it out and I did not go and actively search it out*".[111]

19.4 Ms Carr was asked whether she had a perception of the riders representative role prior to 2016. She said:

> "*The only perception I had of the role of a riders representative was that it was a name and a number that was put on a board that you could speak to if you had any problems, but we rarely knew the names. We rarely knew the people that were up there. It was really just a name and a number*".[112]

19.5 Ms Carr described Caitlyn's interaction with a riders representative in this way:

> "*I think for someone like Caitlyn, she always was much more able to ask questions and speak up once she had got to know someone, whether it was her coach or something. All of her coaches would have described Caitlyn as being extremely shy, very quiet, never saying boo when they first met her, but as they developed a relationship with her, that changed. So for me I think, for someone like Caitlyn, it would be really important that she knew who that person was and that there possibility be an opportunity for them to meet, not necessarily one on one, but that, you know, there was some sort of introduction as to who that person was and, yeah, and just to meet them so that she would feel more comfortable*".[113]

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[110] Although the EA Rules and FEI Rules use the term athlete representative, the term riders representative was used throughout the inquest and it is understood that this is the more commonly used term in actual competition.
[111] 16/5/19 at T29.18.
[112] 14/5/19 at T32.7.
[113] 14/5/19 at T42.40.

19.6 Mrs Inglis explained that even if she had known who the riders representative was for Olivia's class she (Mrs Inglis) "*would not have made a formal complaint as it is not really the done thing to make formal complaints and is something that is not in the culture of the sport*".[114] Mrs Inglis was asked to explain this in evidence. She said that much of the sport is about problem solving and expressed the view that riders were less likely to raise their concerns, and instead to deal with and attempt to solve problems on their own. Mrs Inglis expressed it in this way:

> "*…we were probably lulled into a little bit of a false sense of security because we hadn't had a major fall in Australia for quite a long time and not actually within my riding time in Australia and I think you just think about getting the job done and solving the problems out there and maybe we're not very good at cross-referencing or expressing our concerns about things*".[115]

***Introduction of riders representatives***

19.7 The evidence established that rider representatives are typically introduced during the riders briefing which is held at FEI and EA three day events but not usually at one day events. Mrs Bates had performed the role of riders representative since its inception, at national and international events, and was probably one of the first people to perform that role.[116] She was asked about riders representatives being introduced before a three day event. She said:

> "*I think the system works well with introduction. You, you get a clear, you know, you're introduced, you stand up, you wave, people get to see you, you know, you're not just a name and a phone number, you're actually a person. So I think it identifies the riders rep very well*".[117]

19.8 However, Mrs Bates expressed some reservations about whether the introduction of such a system would work equally as well for one day events. She described such events as more "*hectic*"[118] and explained that it would be difficult to bring all the riders together at the same time, if a rider briefing was not held. In the alternative, Mrs Bates suggested that the contact details of the riders representative should be advertised prior to an event, at the same time that the draw is provided to riders.

19.9 During the first phase of the inquest, Mr Kane referred to the fact that as a result of evidence given during the inquest consideration was given to notifying riders of the names and contact details of riders representatives by text message prior to an event.[119] In the second phase of the inquest, Mr Kane confirmed that such a system had been trialled at recent events.

***Conveying concerns to riders representatives***

19.10 Mrs Bates said that she had previously been approached by riders who had expressed a fear of approaching a riders representative (other than herself), or being unable to approach a riders representative, or being uncertain about what to do regarding a concern that they held in relation to

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[114] Exhibit 1, Tab 6 at [22].
[115] 16/5/19 at T30.6.
[116] 13/5/19 at T28.32.
[117] 13/5/19 at T60.44.
[118] 13/5/19 at T60.36.
[119] 15/5/19 at T75.19.

a course.[120] In such instances Mrs Bates said that she would discuss the issue with the event organisers or the technical delegate or discuss the matter with rider themselves.

19.11 Ms Bishop had previously competed at the four star level. She had previously performed the role of riders representative about 10 times at other events. Ms Bishop explained that in that role she had previously been approached by riders and the parents of riders with particular concerns about a course which she in turn raised with a technical delegate. Ms Bishop acknowledged that riders should feel comfortable approaching a technical delegate with any concerns, but accepted that for someone at the elite level like herself that might be easier than for someone with less experience.[121]

19.12 Ms Bishop described her particular experience of Scone in this way:

> "*Scone to me is always a very friendly competition and the riders do talk a lot amongst themselves and I feel it's even quite open amongst the riders and the officials, especially at Scone. There seems to be a very friendly atmosphere at the Scone event. It's a nice country event and everyone, including the officials, want to help to make the riders feel happy and comfortable in what they're about to do*".[122]

19.13 Carolyn James, an FEI accredited dressage and eventing judge and coach, expressed the view that a culture needs to be created where riders feel comfortable about approaching their representatives. She explained that this was particularly the case where she had previously personally observed a fear by some riders to do so. She explained: "*When I've been, perhaps, standing on [sic] unofficial capacity at a competition sometimes I have witnessed, maybe, that or heard or had people speak to me about where could they go and what they should have done. So, yes, I believe it has happened*".[123]

19.14 Mrs Farrar offered a further view on this issue. She said: "*In interviewing many great riders on this topic, I got an overwhelming feeling that some riders are scared to raise safety related concerns at New South Wales eventing competitions*".[124] She explained that a number of riders of different experience levels across different star categories had expressed these views.[125] Mrs Farrar said that the riders she spoke to expressed concern that if they raised a concern it might lead to receiving an unfavourable draw for a competition, or not having the opportunity to be selected for squads or representative positions.[126] This provided the basis for Mrs Farrar to suggest that consideration might be given to an anonymous reporting system, but that such a system be documented so that feedback could be provided by the riders representative to the person who raised a concern.

19.15 Mrs Farrar's suggestion was put to Mr Kane in evidence. He indicated that he was not opposed to it but did not consider that it would be productive. This is because he felt that an anonymous reporting system would not encourage engagement with riders, or promote cultural change to allow riders to feel comfortable about raising concerns.[127] He explained that his priority would be to encourage

[120] 13/5/19 at T63.25.
[121] 16/5/19 at T42.45.
[122] 16/5/19 at T52.3.
[123] 23/7/19 at T92.41.
[124] Exhibit 1, Volume 7, Tab 30 at [30].
[125] 24/5/19 at T62.17-36.
[126] 24/5/19 at T64.24.
[127] 24/7/19 at T40.24.

riders to raise concerns directly, but would have no objection to a second tier where concerns could be raised anonymously.[128]

19.16 Ms James agreed that educating riders and their parents about available mechanisms would be a positive step. She said: "*Yes, I think that actually came up earlier where a competitor, particularly a young competitor, particularly a new competitor, and maybe their parents haven't been involved in the sport so much, where do they go if they're worried? And maybe that's something that could be done at things like junior development camps which were, I believe, a really good initiative, and so that you can educate both parents and their, their children and competitors on where they could go and what course they could take if they were concerned*".[129]

19.17 The evidence demonstrates that the riders representative system is a useful vehicle not only to facilitate concerns raised by riders, but also for the rider representative to provide constructive feedback following a competition. Mr Bates explained that he had been working with Mr Kane to create a formal riderss representative document, similar to a technical delegate report, to provide feedback from a rider's perspective.[130] He explained that it had been used in some 2019 events to good effect. Mr Bates also explained that he had developed a personal practice of contacting the riders representatives as early as possible and providing a copy of the form to promote communication.

19.18 Mr Sinclair was asked about whether a system exists for a rider, who may have raised concerns with a course designer and had those concerns dismissed, to raise those same concerns directly with EA. Similarly, Mr Rose said that he was not aware of any mechanism by which a rider might give feedback to Eventing NSW about concerns they have regarding safety at an event. He agreed that there probably should be such a mechanism.[131]

19.19 Mr Sinclair said that apart from the course designer the rider could raise their concerns with the technical delegate, riders representative, ground jury if there is one, or an influential rider like Mr Rose or Mr Tinney. However, Mr Sinclair acknowledged that it would be difficult for a less experienced rider to raise such an issue. He explained:

> *"There needs to be the ability to confidentially inform something above those existing event officials about problems that might've existed at a particular event and be a system that I think I'd like to see put more formally in place. I don't think the riders feel very comfortable going to the FEI or EA necessarily about something they might see. And they may be right or wrong, but they deserve investigation. Certainly at FEI level we have a lot of - we have athlete's representative reports which are all confidential and they can be sent direct to the FEI or through the [technical delegate]…But we probably need to, I think at EA level, we could formalise it a bit more and make it a bit more open*".[132]

19.20 Mr Sinclair said that it would be practical for a full-time National Safety Officer to review reports from technical delegates, riders representatives, chief stewards and ground juries, and that it should

[128] 24/7/19 at T41.18.
[129] 23/7/19 at T92.25.
[130] Exhibit 1, Tab 24 at [19.1].
[131] 17/5/19 at T51.22.
[132] 23/7/19 at T69.34.

be done. He agreed that this system could include anonymous reports submitted by riders. [133] Mr Kane said that he does not now review every technical report, nor is it anyone's responsibility to do so. Mr Kane further indicated that under current arrangements only eight hours per week was allowed for the performance of his duties as National Safety Officer, although he spends considerably more time than that allowed.

19.21 Mr Sinclair was also asked if EA has any power to impose sanctions in the event that a concern raised by a rider is discovered, upon review, to have been made out. Mr Sinclair indicted that EA could refuse the registration of an event if this occurred. It was suggested to Mr Sinclair that there was no real way for EA to ensure that its rules were being complied with at national events. He explained: "*Look, I think where you might be heading is there needs to be more formality to the process. It is a small community and I think we do understand when things go wrong or things are not right or people are not following the rules right. Whether we then take enough action is questionable I'd say. So my answers to that would be you guys might recommend that we have the ability with officials or with events to, firstly, bring on more education. I think that's the, the right answer to the problem you're talking about. And then, secondly, obviously discipline as to whether it's an official or an event if they aren't getting it right*".[134]

19.22 Mr Kane was asked a similar question. He expressed the view that if a concern arose the event simply would not run so that there would be no need to issue a sanction.[135]

19.23 Mr Sinclair referred to an initiative introduced by the FEI in 2018 where if a there was a certain percentage or number of riders who raised concerns at a particular fence, then the course designer for that course and the technical delegate for that event would be sent a letter. The letter would invite a dialogue with the recipient regarding what improvements can be made and lessons learned. Mr Sinclair described this as a positive step that had been well-received to date. He said that the focus on this stage should be on education of course designers to reduce the number of falls and the number of letters.

19.24 **FINDINGS:** Despite having spent a number of years within the eventing sphere, it is evident that Caitlyn, and perhaps to a lesser degree Olivia, and their parents, did not feel entirely comfortable with the riders representative system. At the events at which they Caitlyn and Olivia tragically died, their parents were unaware of who the riders representatives were for the star classes in which they were competing. This appears to have been due to an unsophisticated system of notifying riders by simply posting the details of riders representatives at a central location on the assumption that it would be viewed by riders. There is clear opportunity for a more sophisticated, timely and more widespread notification system to be utilised. The evidence established that such a system is in the early stages of development, which is to be commended.

[133] 23/7/19 at T71.26-38.
[134] 23/7/19 at T72.29.
[135] 24/7/19 at T27.50.

19.25 The evidence also establishes that whilst some riders used the riders representative system beneficially by raising queries or concerns (which could then be considered by a technical delegate), other riders were unable to do so, either because they did not feel comfortable in doing so or because of perceived cultural limitations. EA submits that there is no evidence upon which it could be determined that riders, or their parents and coaches, were afraid to come forward to raise any matter due to poor culture or for any other reason. However, the evidence given by Ms James and Mrs Farrar is contrary to this submission.

19.26 It is accepted that evidence of such cultural limitations are based on anecdotal accounts and possibly not indicative of a more widespread issue. That is a matter which extends beyond the scope of an inquest. However, what is clear is that within the parameters of the inquest, the evidence established that these limitations ought to be the subject of sober consideration and reflection and any demonstrated issues of poor culture addressed. Providing opportunities for rider representatives to be introduced personally to riders, and allowing for an anonymised reporting system would go some way to mitigate the potential for a widespread issue to develop.

19.27 EA submits that an anonymised reporting system would be counterproductive to promoting the type of engagement and cultural change that appears to be required. There is some force to that submission given that the intention is to promote openness rather than reticence. However, there is no suggestion that one approach should be preferred over the other. There is opportunity to do both. It can be hoped that by demonstrating that concerns raised anonymously are considered and addressed that this will in effect assist in the process of promoting more direct engagement and willingness to openly voice issues and concerns.

19.28 Further, it is evident that the riders representative role can be used as useful vehicle to complement a formal reporting system, along with the technical delegate role, for review post-competition. It is clear then that a comprehensive reporting system ought to be developed to review and assess safety-related concerns raised in relation to an Event. Such a system should have at its disposal the ability to (a) provide feedback to organising committees; (b) provide feedback and education to course designers; and (c) make use of available sanctioning powers in relation to such concerns.

19.29 If nothing else, the evidence in the inquest demonstrates that if the goals of risk mitigation and not exposing riders and horses to any higher risk than is strictly necessary are to be achieved then it demands the attention of a full-time, and not part-time, National Safety Manger. At the time of the inquest there was evidence that recruitment action for such a full-time role was progressing, which is an encouraging step.

19.30 **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian Australia that a National Safety Manager be appointed on a full-time basis.

19.31 **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian Australia that Annex F of the current version of the National Eventing Rules be amended to provide that: (a) Athlete Representatives for each competition class are required to be appointed for all Events; (b) the name and contact details of the Athlete Representatives are to be communicated to all competitors, and published in the Event draw, at least seven days prior to the Event; (c) the Athlete Representatives are to be introduced in person at the Athlete briefing (if one is held) preceding the Event; (d) The Athlete Representatives are to be present at the competition venue whilst riders are competing and for the entire duration of the competition; and (e) following the formal course walk at an Event, and following each day of competition, the Athlete Representatives are to meet with the technical delegate and course designer to discuss any safety-related issues concerning the Cross Country Test that have been either identified by the Athlete Representative, or communicated to the Athlete Representative by a competitor.

19.32 **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian that the following be developed: (a) a position description setting out the role and responsibilities of an Athlete Representative; and (b) a formal evaluation document which is to be completed by Athlete Representatives following the formal course walk, following each day of competition, and at the conclusion of the competition to record any safety-related issues identified by the Athlete Representative, or communicated to the Athlete Representative by a competitor for review by the Technical Delegate, Event Safety Officer and National Safety Manager.

19.33 **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian Australia that a reporting system be implemented by which a competitor at an Event is able to confidentially (and with the offer of anonymity): (a) communicate any safety-related concerns during an Event; and (b) provide feedback about safety-related concerns following an Event; for consideration and review by the Event Technical Delegate, Event Safety Officer, and National Safety Manager.

19.34 **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian Australia that any implemented reporting system should include, but is not limited to, the following: (a) completion of confidential post-event reports by the Athlete Representative, Technical Delegate, Chief Steward (if present) and Ground Jury (if present) at the conclusion of each Event; (b) review of completed confidential post-event reports by the National Safety Manager; (c) reports to be sent directly to the National Safety Manager by each official, or collected and sent via the Event Technical Delegate; (d) a formal feedback system in which the National Safety Manager is able to provide written feedback (including statistical data of rider falls) and education to organising committees, course designers and technical delegates; and (e) consideration of the use of available powers of sanction against an organising committee.

## 20. Personal Protective Equipment

20.1 Personal protective equipment (**PPE**) is worn by riders primarily to reduce the risk or severity of injury in the event of a fall. The most commonly worn PPE garments are riding hats (protective headgear), body protectors and air vests.

20.2 Ms Williams explained that "*for users to understand what protection is being provided and to ensure expectations of protection offered are consistently matched, it is key that standards be followed in the manufacturing of protective equipment. Without a standard or manufacturing specification being referenced there is no compulsion on the part of the manufacturer to ensure that the garment meets minimum standards*".[136] She went on to explain that the most common current standards for riding hats and body protectors are produced by a number of national standards bodies in Europe, Great Britain, North America and, relevantly, by Standards Australia. There is no national or international standard specifically developed for equestrian air vests.

20.3 Ms Williams was asked to consider the PPE standards that applied in the EA Rules. She noted that the EA Rules appeared to replicate the FEI Rules, and that a number of European, British, North American and Australian standards were referred to. However, Ms Williams noted that reference was omitted to a number of other recognised standards, meaning that PPE which met standards that had previously been withdrawn or were out of date could have been legitimately worn by riders, including some PPE which offered a much lower level of protection.[137]

20.4 Ms Williams considered that the riding hats worn by both Olivia and Caitlyn were not strictly compliant with the standards referred to in the EA Rules, but met the Rules in performance terms, and that the body protectors worn by both Olivia and Caitlyn were in compliance with the EA Rules.

20.5 Ms Williams agreed that with the various standards available on the market it would be difficult for a layperson to understand which was the best piece of PPE for them, and described it as a confusing area.[138]

20.6 This appeared to be the experience of Ms Carr and Caitlyn. Ms Carr explained:

> "*There's lots of research continuing to be done. Standards continue to be reviewed and updated. I think it's hard for a parent, to expect a parent to be able to be on top of all of that and I suppose my thought would be, as a parent, I would be expecting the peak body that I'm paying a membership to would at least have information on that available for parents to be able to access*".[139]

20.7 Later, Ms Carr elaborated further:

> *"…at none of those events can I ever recall or were we ever provided with information about what was the latest information about helmet standards, what was the latest information about air vests? Were they being suggested as a useful thing to purchase or not and I think for me EA, as …*

[136] Exhibit 1, Supplementary Volume, Tab 8, page 4.
[137] Exhibit 1, Supplementary Volume, Tab 8, page 6.
[138] 23/7/19 at T63.50.
[139] 14/5/19 at T31.45.

*an international body that - there's clearly lots of research going on across the world in that space, it seem to me that your peak body would be the place where that information would be channelled through to its members and its participants so that they have easy…access to that*".[140]

20.8 Mrs Inglis was asked about whether she was aware of the best standard of PPE to provide for Olivia. Mrs Inglis expressed challenges with not being provided with enough information in order to make an informed decision about the most suitable PPE to acquire and use.[141] She explained:

"*That scenario I think does need focus. It would be lovely to have guidance from EA. It would be great to [have] surveys on the best equipment and make that available to members. We'd all rather be riding in the best gear available and we sadly did not receive guidance. We followed standards but those standards obviously were, now we understand, quite a minimum standard*".[142]

20.9 Ms Williams was asked whether she agreed that a national federation is best placed to provide guidance to riders about the best standards. She said:

"*Yes, I think with the sport is, is - has to be responsible their riders. They have a duty of care to direct their riders by offering them guidance on what they should wear. I think it's difficult to specify a standard. I think it's appropriate to specify a range of standards due to the nature of, of helmets, the way they're manufactured and the number of models and types available. You've got to find a hat which is right for your head and if you're too specific in the specification of what standard, riders may face that a particular standard in the way it's made by specific manufacturer may not be the best to be had. So having a range available will give the rider the best choice and the best possibility of finding at hat that's right for them*".[143]

20.10 Section 538.3.1 of the 2019 EA Rules (as at 1 July 2019) provides that body protectors manufactured after 2009 and labelled as complying with particular standards are mandated from 1 January 2020. Ms Williams said that this amendment is to be commended and explained: "*I think given a choice I think it's much better to have a mandatory standard specified than with no standard whatsoever. It is too easy for somebody. You have to take responsibility for your own safety, but, I think, in doing so you need to ensure your equipment is up to date and if the governing body can give clear requirements then it ensures people are protecting themselves to the best of their ability*".[144]

20.11 **FINDINGS:** PPE is a primary means by which the risk of injury, or the severity of injury, is reduced. It is an inherent component of the aim to not expose riders to any higher risk than is strictly necessary. The evidence demonstrates that EA as the peak body for equestrian sport is best placed, and bears a responsibility, to provide guidance as to how the difficult and complex area of PPE standards can be navigated by its members. However that guidance has not previously been provided. The absence of such guidance placed riders with confounding decisions as to how best to utilise personal protective equipment to mitigate against the risk, or severity, of injury.

[140] 14/5/19 at T44.27.
[141] 16/5/19 at T34.29.
[142] 16/5/19 at T22.13.
[143] 23/7/19 at T64.24.
[144] 23/7/19 at T67.31.

20.12 The guidance that should now be provided should reflect the most current information available on PPE which is most likely to reduce the risk or seriousness of injury to riders. It is accepted that it is not possible to make a global recommendation as to what piece of PPE is best for an individual rider; individual considerations such as fit need to be taken into account. However, it is appropriate for information to be presented clearly to riders to allow then to make fully informed decisions regarding the type of PPE to be used.

20.13 **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian Australia that (a) research be undertaken to determine which range of personal protective equipment garments meet national and international standards and are most likely to mitigate the risk of injury or reduce the seriousness of injury to riders; and (b) provide on a regular basis to its members the most currently available information regarding such research and standards.

## 21. Data collection

21.1 The collection of data related to horse falls is a valuable means by which understanding can be gained about the likelihood of such falls and methods to mitigate the possibility of them. It is also accepted that data relating to near misses, in other words a narrowly avoided fall, is also of value. Mr Bates expressed the view that the video recording of near misses and falls would be invaluable.[145] He explained:

> "*I know when you [technical delegate] [sic] an event, the first thing you do is go and look at the results from last year or the previous event and the results tell one story but they don't often tell the whole story because there are near misses and things - the horses can jump clear rounds but it's not necessarily a perfect round*".[146]

21.2 However, the evidence in the inquest indicates that defining what constitutes a near miss is difficult and open to variable interpretation.

21.3 Mr Tinney offered this suggestion:

> "*In my view, if we could get more fences videoed by jump judges then the relevant experts, for example leading course designers and senior riders, could form a panel to review and discuss footage. This panel could assess the parameters of what constitutes a near miss and what constitutes dangerous riding, and come up with solutions to help riders and/or sanction dangerous riding. This would be a good way to also form a working definition of what a near miss constitutes*".

21.4 He went on to explain that the use of video technology was a good way to manage risk in the sport:

> "*The video then to be looked at it if there is an issue with the rider, if they are considered to have had a near miss or riding dangerously, or riding inappropriately, if that video is there I think that would be a great tool*".[147]

21.5 Mr Kane similarly agreed that it would be useful to define near miss and for there to be a formal review system of video footage.[148]

21.6 Apart from using data related to falls and near misses to better understand how they might be mitigated, the evidence in the inquest heard that such data might also be used to better inform riders. For example, Mrs Inglis was in favour of a course designer review system based on such data. She explained:

> "*We need more transparency in our sport and we need to be able to have data collected on course builders and course designers and we need to be able to make an educated decision as to whether we would like to jump a course on the [statistics] or rating of the course designer. Some course designers have far more accidents and problems on courses than others and I think that we, as a*

[145] Exhibit 1, Tab 24 at [21.1].
[146] 16/5/19 at T83.32.
[147] 24/5/19 at T12.30.
[148] 24/7/19 at T30.49.

*membership group, need to be privy to the statistics related to the designer to help us to decide whether we want to ride a course or not*".[149]

21.7 **FINDINGS:** Interpretation of available data is a challenging process, not least because it is difficult to define what might constitute a near miss. However, the benefit of being able to accurately collect, analyse and interpret data related to falls and near misses has the potential to be valuable resource in risk mitigation. The evidence establishes that there is opportunity to use available video footage and the expertise of experienced riders and course designers in this regard.

21.8 **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian Australia that a standardised data collection system be developed for all Events which: (a) provides a clear and unambiguous definition as to what constitutes a "near miss" at a fence/obstacle; (b) provides training to fence judges to allow for the accurate recording of instances of a near miss or fall at a fence/obstacle, with such information to be included in the technical delegate report prepared at the conclusion of an Event; (c) incorporates the video recording (where available, and whether conducted by EA or obtained from third party recording services) of each fence/obstacle in a Cross Country Test during competition; (d) dreates a panel of suitable experts (consisting of, for example, technical delegates, course designers and experienced riders) to review data collected in accordance with (b) and (c), above to identify any trends which may adversely impact the safety of competitors at Events; (e) allows for collected data to input into a database; and (f) makes such a database available to EA members to be able to readily identify the particular fence/obstacle, the particular Cross Country Test, and the particular course designer of the Cross Country Test, where a near miss or fall has occurred.

[149] 16/5/19 at T33.26.

## 22. Medical coverage at events

22.1 The issue of medical coverage at eventing competitions, in particular during the cross country test, was one which came into considerable focus during the inquest.

***Medical coverage prior to 2007***

22.2 The evidence established that prior to 2007 medical coverage at equestrian events, including eventing competitions, had been provided by NSW Ambulance pursuant to arrangements made with event organising committees. However, it appears that in 2007 NSW Ambulance determined that providing medical coverage at sporting events would no longer constitute core business. This appears to have been due to the resultant administrative impact relating to the provision of such services.[150] According to anecdotal evidence referred to during the inquest, NSW Ambulance decided to increase their service fee which effectively priced them out of the market.

22.3 The flow-on effect from this decision resulted in organising committees turning to private medical service providers in order to provide medical coverage at events. At some stage HSI was determined to be the preferred service provider for this purpose. This was reflected in, at least, the *NSW Eventing Organisers Handbook* (updated in May 2012), published by Eventing NSW which provides: "*Health Services International is the preferred NSW ambulance service"*.[151]

22.4 Dr Davis explained that prior to 2007, NSW Ambulance provided intensive care paramedics for equestrian events, who came with "*a fully operational ambulance vehicle with equipment commensurate for managing major trauma in the field. Sometimes this included endotracheal tubes and laryngoscopes to definitively manage an airway. These ambulance officers could work independently in the field without the need for medical input, they had the skills and equipment to stabilise those athletes with survivable injuries*".[152] However after 2007 Dr Davis explained "*the level of equipment that was available at those events was not – not as standard as what it could be and perhaps not as much as advanced equipment as there could be*".[153]

22.5 Both the FEI Rules and the EA Rules contemplate the provision of paramedical services during the cross country test. Annex D to the FEI Rules refers to "*a paramedic with Pre-Hospital Trauma Life Support (PHTLS) or International Trauma Life Support (ITLS) certification*" and that "*the Cross Country Test will require [sic] Pre-Hospital Trauma Care Specialist*".[154] Similarly, Annex D.1 to the EA Rules provides that "*an ambulance (or paramedic equivalent) MUST be present during the cross-country test*" (original emphasis).[155]

22.6 However, in 2016 there was no national registration or accreditation for the paramedic profession in Australia. Accordingly, at that time registration varied between jurisdictions, employers and practice settings. However, on 1 December 2018 paramedicine became a nationally regulated profession under the *Health Practitioner Regulation National Law Act* (National Law) and the titles "paramedic" and "paramedicine" became protected by law. The Australian Health Practitioner Regulation Agency,

[150] 15/5/19 at T40.23-28.
[151] Exhibit 1, Tab SR5, page 24.
[152] Exhibit 6 at [4.1].
[153] 14/5/19 at T69.26.
[154] Exhibit 1, Tab RK3, page 81.
[155] Exhibit 1, Tab RK5, page 102.

a Commonwealth government agency that regulates health professions in Australia through its administration of the National Registration and Accreditation Scheme, is responsible for regulation.

22.7 After 2007, when separate arrangements were made by organising committees and Eventing NSW with private contractors to provide medical coverage, Dr Davis expressed concerns about this arrangement in this way:

> "*…they did not have the equipment to provide the gold standard airway support, that's correct, but I also think it's worth qualifying that I had concerns that if those paramedics, with that equipment, were the sole medical providers at events, without more senior medical backup, that that would potentially not be an appropriate level of care*".[156]

22.8 Dr Davis raised his views with Dr Roche informally, usually at a debrief following an event which he had volunteered at. Dr Davis raised the issue that the paramedics should be supported by a medical officer and that the minimum level of paramedic required was one that was capable of using a laryngeal mask or capable of using an endotracheal tube and laryngoscope. Dr Davis recalled that Dr Roche agreed with him although no concrete steps were taken to implement this prior to 2016.[157] Dr Davis went on to explain:

> "*Again, at the end of most of the Sydney events I expressed my view about the level of paramedic cover, which at Sydney I think is appropriate when there's medical backup, but it always concerned me that there were plenty of events going on that that may not be at a level that could be appropriate to manage the injuries that you could receive*".[158]

22.9 Dr Davis was not alone in his views. Dr Taylor said that prior to 2016 she had discussed the level of medical coverage with her husband, Dr Janson. She explained:

> "*…we personally were concerned that there was not adequate equipment, that when, when my husband does the event doctor, he brings his own gear as I think most doctors do. And we knew that there was the, the stock carried within the ambulances was less than we would have carried ourselves*".[159]

22.10 The evidence during the inquest established that most of the witnesses, including experienced riders such as Ms Bishop[160], were unaware of the change in medical service providers after 2007. Mrs Inglis said that until hearing the evidence in the inquest she was unaware of the change in level of paramedic services at events. She said: "*As a member of EA, I had never realised that there'd been a point when that happened and we had suddenly different ambulance, different level of care at the events. That quite shocked me*".[161]

22.11 Dr Taylor also said that, like Dr Davis, the concerns that she and Dr Janson held were mentioned informally. Prior to 2016 it appears that the views held by Dr Davis, Dr Taylor, and Dr Janson were never raised in a more formal forum by EA or any organising committee. However, following the

[156] 14/5/19 at T70.31.
[157] 14/5/19 at T71.25-30.
[158] 14/5/19 at T80.50.
[159] 22/5/19 at T8.17.
[160] 16/5/19 at T50.11.
[161] 16/5/19 at T25.19.

tragic events of 2016 there was increased discussion amongst medical practitioners who had experience in volunteering their services at events. This culminated in a teleconference on 20 December 2016 involving members of what was described as the NSW Eventing Medical Safety Group. Dr Davis, Dr Taylor, Dr Janson and Dr Roche were among the participants. Dr Roche explained the genesis of the teleconference in this way:

> "*Look, it, it actually started very informally where a bunch of us just started emailing to one another, as I said, we, we had a heightened awareness that we could do better, both in terms of preparation, response, planning, et cetera. And it, it, it started quite organically as an email from one person to another and they would copy somebody else in, and the thing sort of gathered momentum. I don't think at any stage it was really sort of formally appointed as a subcommittee, but we, we felt that we were the appropriate people to try and give that knowledge to most of the GPs - sorry, most of the doctors who were providing medical response at New South Wales events, were taking part in that. And that it was appropriate that we advise Eventing New South Wales, who had no other doctors, you know, what we felt was, was the best thing*".[162]

22.12 It appears that this teleconference ultimately resulted in the formation of National Medical Consultative Group (**NMCG**) in June 2017. One of the primary roles of the NMCG was to prepare and implement *Medical Guidelines* which are intended to formalise the initiatives that State branches and organising committees are actioning, or have actioned, regarding provision of medical care. The *Medical Guidelines* were published in May 2018.

22.13 A Risk Management and Safety Working Group had previously been formed by EA in January 2016. Ms Fasher agreed that, in hindsight, it was surprising that there had been no such group prior to this date.[163] Ms Fasher agreed that in the absence of such a group, little guidance was provided to organising committees regarding the level of medical services available. She explained:

> "*Yes, look, I think it's fair to say that as a result of this inquest a lot of us have become acutely aware as to what was the situation. I don't believe the organising committees understood that, nor did very many of the rest of us. We assumed as laypeople that paramedics were in fact paramedics, with all of the things that you assumed in terms of their skill*".[164]

22.14 It was suggested to Ms Fasher that at the national level there was a "dropping of the ball" by EA. Ms Fasher agreed that such an suggestion could be made retrospectively, but that she believed laypersons could be forgiven for believing that if an ambulance was on the course it was capable of delivering a suitable level of paramedical services.[165]

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[162] 22/7/19 at T42.45.
[163] 22/7/19 at T13.44.
[164] 22/7/19 at T16.11.
[165] 22/7/19 at T16.30.

22.15 **FINDINGS:** The evidence suggests that following the change from public to private medical service providers in 2007, no re-evaluation was conducted on a general level by organising committees as to (a) whether the provisions of the NSW Eventing Organisers Handbook and the 2016 EA Rules could be complied with; and (b) whether an appropriate level of medical services could be provided. Certainly it is clear that no specific re-evaluation was conducted prior to 2016 at Scone or at the SIHT. Rather, it is evident that past practices (probably dating back to 2007/2008) had been adopted regarding this aspect of preparation for the event.

22.16 EA submits that prior to 2016 there was no basis to consider that it was necessary to check that a private medical service provider provided an appropriate level of service. To some extent this submission is correct, although the evidence establishes that there was a growing disquiet amongst some medical practitioners, who were riders or who volunteered their medical services to events, about the adequacy of private medical service providers. This disquiet was voiced in informal forums. It is regrettable and unfortunate that they were not voiced in more formal forums capable of investigation and review.

22.17 Notwithstanding, in this context it can be accepted that organising committees, and event officials, having been advised of a preferred medical service provider, could assume that such a provider was capable of providing an appropriate level of medical care. Until the tragic deaths of Caitlyn and Olivia in 2016 there was no direct basis to query whether this was the case or not. However, the change in medical service providers in 2007 represented a missed opportunity for EA to demonstrate appropriate governance by ensuring that the same level of medical care that was provided at events prior to 2007 would similarly be provided after 2007.

***Applicable provisions of the EA Rules and FEI Rules***

22.18 Annex D to the FEI Rules provides:

> *1 Medical Attendance at Event*
> *The on-site provision of medical care must be available during the hours of the Competition and must include the training areas, stables and on-site accommodation.*
> *…*
> *A qualified physician with Advanced Trauma Life Support certification ("ATLS"), a paramedic with Pre-Hospital Trauma Life Support (PHTLS) or International Trauma Life Support ("ITLS") certification, or a nurse with Trauma Nurse Core Curriculum ("TNCC") or the equivalent of any of the above in the country in which the Event takes place (hereinafter a "Pre-Hospital Trauma Care Specialist") must have credentials allowing access to the entire facility at all times including the stable area and finish area during Competition.*
>
> *2 Chief Medical Officer*
>
> *A Chief Medical Officer, suitably experienced and with local knowledge must be appointed well in advance, to act in liaison with the Organising Committee and the emergency services for the adequate provision of medical resources.*

*A meeting of medical officers or delegates should be held at the Cross Country venue to familiarise them with the Event plan and services available by the host physicians or the PreHospital Trauma Care Specialist in case of emergency.*

*…*

*3 Cross Country and Jumping Test*

*During the Cross Country and Jumping Test, a fully equipped Pre-Hospital Trauma Care Specialist with trauma and resuscitation skills must be available on site and must have the capability of rapid deployment to any part of the arena or course in adverse conditions.*

*…*

*The Cross Country Test will require Pre-Hospital Trauma Care Specialist. The required number will depend on the layout of the courses and the accessibility of the site. However, there must be at least one Pre-Hospital Trauma Care Specialist present throughout all the tests.*

22.19 Annex D.1 to the EA Rules provides:

*Cross Country Test*

- *An ambulance (or paramedic equivalent) MUST be present during the cross-country test.*
- *A doctor SHOULD be present during the cross-country tests.*

22.20 The above means that for FEI events a Chief Medical Officer must be appointed and that a Pre-Hospital Trauma Care Specialist must be available on site at the cross country test. In EA events, only an ambulance (or paramedic equivalent) must be present during the cross country test, and a doctor should be present during the same test.

22.21 However, in 2018, the EA Rules were amended to insert Annex D.2. It is titled "*Guidelines for Medical Coverage at Events*". It goes on to stipulate:

*The intention of these guidelines is to assist organising committees and technical officials as to the provision of medical care at eventing competitions consistent with the rules for eventing. Where a conflict exists between the rules and the guidelines the provisions of the rules shall prevail.*

22.22 Annex D.2 reproduces the following from the FEI Rules: "*During the Cross Country and Jumping Test, a fully equipped Pre-Hospital Trauma Care Specialist with trauma and resuscitation skills must be available on site and must have the capability of rapid deployment to any part of the arena or course in adverse conditions".* It then goes on to provide certain guidelines relating to a Pre-Hospital Trauma Care Specialist to the effect that:

*For events with less than 150 competitors that have show jumping and cross country located on the same site and in close proximity can operate with the provision of a single service meeting the specifications below:*

1) *The medical service provider must provide a qualified ALS Paramedic or equivalent…*
2) *The medical service provider must include at least one person who holds a Diploma of Paramedic Studies Ambulance (equivalent or higher qualification) that includes advanced life support skills and capability…*

…

5) *For clarity there must be a minimum of two people in the team providing the service and the vehicle used must have the capability of accessing all parts of the venue.*

22.23 The provisions set out in Annex D.2 reflect the current version of the EA Rules.[166]

22.24 Dr Roche was taken to the reference to pre-hospital trauma care specialist. He acknowledged that this had been reproduced verbatim from the FEI Rules. He said: "*I've sought the clarification from the head of the eventing department of the FEI, and also the head of the medical committee of the FEI, and they said that there was some ambivalence in that, and they weren't quite sure of the answer to my question…because there was ambiguity in the FEI Rules I sought that clarification from the FEI. They were unable to give it. They said they will talk about it at their next meeting which is at the end of this year. At the moment we don't have that clarification*".[167]

22.25 **FINDINGS:** Annex D.1 and D.2 of the EA Rules as presently drafted are ambiguous and confusing. This was also the view taken by Dr Cross in his reading of the EA Rules.[168] Mr Kane acknowledged in evidence that there was a need for significant improvement.[169] Ms Fasher agreed that there was a clear lack of guidance from EA as to how the rules regarding whether a doctor should or must be present, were to be interpreted.[170]

22.26 The current version of the EA Rules at Annex D.1 provides only that a doctor should be present during the cross country test. This was the same position in 2016 and does not appear to have been changed. Although Annex D.2 makes reference to a Pre-Hospital Trauma Care Specialist, it appears to be the case that because that term originates from the FEI Rules, Annex D.2 is not intended to apply to EA events. Further, Annex D.2 appears to provide that for events with less than 150 competitors there must be a medical service consisting of two team members, one of whom must hold a Diploma of Paramedic Studies Ambulance (or equivalent) and one of whom must be a qualified ALS Paramedic or equivalent. It is entirely unclear whether one team member can hold both qualifications. It is also entirely unclear if one team member holds both qualifications, what the qualifications of the second team members should be. Further, Annex D.2 appears to make no provision for any guideline with respect to events with more than 150 competitors.

22.27 Having regard to the above, it is plainly evident that the EA Rules provide no clear and unambiguous rule or guideline as to what level of medical services is to be provided at an event, particularly during the cross country test.

***Level of medical coverage***

22.28 Dr Cross was asked to provide an opinion on the appropriate level of medical coverage that should be available at an event. His opinion can be summarised as follows:

[166] Exhibit 33, Tab RK8.
[167] 22/7/19 at T53.8.
[168] 22/7/19 at T37.47.
[169] 24/7/19 at T49.34.
[170] 22/7/19 at T17.26.

(a) For events with less than 150 competitors, there should be a doctor and two paramedics, and two emergency response vehicles.

(b) For events with more than 150 competitors, and where the show jumping test and cross country test are being held concurrently, there should be two teams comprised of a doctor and paramedic in each team, with each team having their own emergency response vehicle.

(c) The doctor should ideally be a Fellow of the Australasian College of Emergency Medicine (**FACEM**) and the paramedic should be an intensive care paramedic capable of advanced life support.[171]

(d) The doctor should be engaged in a pre-event planning phase which involves liaising with event organising committees, conducting an analysis of potential injuries, assembling a medical team, contacting local hospitals to analyse emergency evacuation contingencies, organising all appropriate medical equipment, ensuring the qualifications of team members, attending event planning meetings, and visiting the site to develop logistics and risk mitigation strategies.[172]

22.29 The issue of whether a doctor such as a FACEM must be present at an event in general, and at the cross country test in particular, was explored in detail during the inquest. Dr Cross confirmed his opinion that a FACEM "*is the ideal that you'd like at these equestrian events*".[173] Dr Cross offered this view:

> "*I do believe the standard of care should be what I've described in my report, that it should be a minimum requirement of a doctor fully trained in advanced life support with a level 1 intensive care paramedic*".[174]

22.30 The same issue was raised with Professor Brown who expressed the following:

> "*I agree with Dr Cross, I think a doctor must be present. Again, I'm not familiar with the legalese difference between "must" and "should" [in the EA Rules] but I think a doctor must be present. The, the key differentiating aspect of all this is someone who is able to provide advanced airway care with drugs and also has a thoracostomy kit. Now it is possible for an intensive care paramedic to have - to be airway trained, drug trained, thoracostomy trained and work independently but that's very, very unusual. And I think, as Dr Cross has said, the ideal is intensive care paramedic backing up a trauma trained doctor*".[175]

22.31 This issue was explored further with Professor Brown when he was asked whether it would be sufficient for a paramedic to use the medical equipment listed in Annex D.2. This list of equipment was not part of the EA Rules in 2016 and only inserted as part of the 2018 amendment to the EA Rules. Professor Brown said:

> "*It would - it's not as ideal - there's a lot of argument about pre-hospital care whether it should be provided by physicians or intensive care paramedics. I'd like to think that a physician brings a*

[171] Exhibit 1, Supplementary Volume, Tab 6, page 12.
[172] Exhibit 1, Supplementary Volume, Tab 6, page 2.
[173] 22/5/19 at T43.30.
[174] 22/5/19 at T38.47.
[175] 22/5/19 at T39.28.

*higher level of training but if you use the word 'sufficient' then yes, an intensive care paramedic who is airway trained, drug trained, thoracostomy trained could act in isolation. Clearly there would need to be at least another paramedic so there's a team of two and as we've heard you may need more than one team. But I think the ideal would be to have a trauma trained doctor as part of the medical crew on the ground and then perhaps split it up and have an intensive care paramedic in one pair and then have a second pair that might both be intensive care paramedics*".[176]

22.32 Dr Cross expressed his agreement:

"*I totally agree with Dr Brown. The doctor's very important for the pre-planning phase, to assemble the team and co-ordinate and so - and also for every other reason Dr Brown mentioned about diagnosis and management*".[177]

22.33 Later in the evidence, Professor Brown was provided with a list of medical skills and asked whether a medical service provider possessing those skills could provide the necessary response in the event of catastrophic event. It appears that list of five skills referred to below was identified from discussions within the NMCG. Dr Roche explained: "*There's an active discussion going on, coordinated by a National Safety Officer with the nationwide group of doctors, where we have been vigorously debating the skill set that we need, both for our doctors and for our paramedics, and probably more important, the sum total of the skill set that needs to be able to be provided by a team*".[178]

22.34 Professor Brown agreed that the necessary response could be provided by a person possessing certain skills.[179] The skills referred to were:

(a) securing an airway, ideally with the ability to intubate or perform a surgical airway;

(b) decompress a chest with an appropriate chest tube;

(c) apply pelvic binder and C-collar;

(d) insert an intravenous line and give crystalloid and analgesia; and

(e) apply suitable splints to fractures.

Professor Brown indicated that the only contentious issue would be the use of drugs for intubation as not all paramedics would have the necessary training.

22.35 Professor Brown agreed that a team comprised of one person with the five skills listed above and another person capable of providing support would be an appropriate response team, and that a team comprised of two persons with all five skills would be the ideal response team.[180]

[176] 22/5/19 at T40.6.
[177] 22/5/19 at T40.20.
[178] 22/7/19 at T48.16.
[179] 22/5/19 at T49.43.
[180] 22/5/19 at T50.43-T51.1.

22.36 Dr Cross also agreed that a person with these five skills would be an appropriate person to act as a responder. However he maintained:

> *"However, a doctor, an emergency physician or a trauma specialist I would argue with respect, with great respect to paramedics, is a more capable first responder to an emergency life-threatening injury. And with all great respect to paramedics. So the difference may be marginal or fractional but if in an ideal world, you'd like the highly trained doctor assisted by a level 1 paramedic. So that's the model I would argue should be, should be available*".[181]

22.37 Dr Cross went on to express this view:

> "*I, I think we should be aiming for the ideal. We live in Australia. The, the personnel that I'm suggesting and Dr Brown and I concurred what the ideal is - should be aimed for - the, the doctor-paramedic combination we've talked about is easily accessible within 100 kilometres of the major regional centres of Australia. If you hold an event in Tamworth, there will be the five emergency positions in Tamworth Hospital who could, who could team up with a level 1 intensive care paramedic. So I think we, we owe it to the families to, to try and mandate the ideal*".[182]

22.38 Dr Cross was asked to confirm whether the ideal would be a specialist emergency physician and an intensive care paramedic. He said: "*That was - that is the ideal complement of training - a skillset that, that we can offer in Australia in all the capital cities and all the big regional towns. We should - we can offer that. That was - that would be the ideal*".[183]

22.39 Mr Kane advised that the NMCG considered that the provision of medical care should be based on skillset and not title, because title was not explicit enough about the skills and equipment that needed to be present.[184] He explained that it was view of the NMCG that in relation to airway management the minimum skill was using a laryngeal mask airway[185] (**LMA**), with surgical airway intervention the ideal. However the NMCG considered that the likelihood of needing a surgical airway intervention would be low and that the availability nationally would be limited, particularly in certain states. Additional cost would also be a significant factor. The conclusion of the NCMG was that LMA should be mandated and that surgical airway intervention should be recommended.

***Response time and equipment***

22.40 Annex D.2 of the current EA Rules provides certain guidelines in relation to rapid deployment of medical services. For the reasons identified above, it is unclear whether such guidelines are intended to apply to events held pursuant to the EA Rules. In any event, Annex D.2 provides no defined timeframe within which such rapid deployment is to occur, or within which medical responders are to reach the location of a rider requiring medical assistance.

22.41 Both Dr Cross and Professor Brown agreed that a response time of less than three minutes would be ideal[186], and that having a time benchmark would also assist in determining where medical teams are

[181] 22/5/19 at T51.47.
[182] 22/5/19 at T51.6.
[183] 22/5/19 at T59.9.
[184] 24/7/19 at T3.38.
[185] A medical device that keeps a patient's airway open during anaesthesia or unconsciousness.
[186] 22/5/19 at T45.12.

located and what vehicles are required to reach the furthest away fence on a cross country course.[187] Professor Brown explained: "*I agree that the three minutes is really the, the benchmark for the paramedic doctor crew*".[188]

22.42 Dr Taylor was also of the view that a three minute response time was ideal. She explained: "*Because a lot of serious accidents have time-critical injuries and if you can manage them appropriately quickly, you get yourself a longer window of time for definitive treatment*".[189]

22.43 Professor Brown considered that the medical equipment that was available at the SIHT was adequate and explained that it was common equipment that was "*more than enough to perform an initial prehospital trauma response*".[190] In evidence, both Dr Cross and Professor Brown were invited to consider the list of equipment set out in Annex D.2 of the current EA Rules. Both considered the list to be appropriate, and only suggested that cricothyroidotomy kit[191] and pelvic splint should also be available.[192]

22.44 **FINDINGS:** Having regard to the current ambiguity contained in the EA Rules regarding the level and scope of medical care that is appropriate for events, there is an obvious need for clarity. In terms of the level of medical care, the evidence establishes that a medical provider with the five skills referred to above would be sufficient to provide an appropriate response in the event of a catastrophic event involving serious injury or life-threatening injuries to a rider.

22.45 However, the question which arises on the evidence is whether sufficiency is an acceptable level of medical care, or whether the ideal level of medical care should be strived for. The evidence establishes that there are two potential limitations with seeking to achieve this ideal: (a) whether medical practitioners at the level of a FACEM are readily available to provide medical coverage, particularly at regional venues; and (b) whether defining the level medical care according to the skills, rather than the title or designation, of the provider would offer greater clarity and consistency. It should be noted that both EA and the parents of Caitlyn support the skills-based approach.

22.46 Having regard to the practical considerations above, it would seem that adopting the skills-based approach would be most likely to achieve the necessary level of medical care that is required at events, particularly at regional venues. However it is also necessary, where possible, for a medical practitioner to be present at an event to offer a higher level of medical care, and to coordinate pre-event planning. Further, given that most life-threatening injuries are time critical, it would be beneficial to identify a defined response time in the EA Rules to assist with determining the location and number of medical responders at an event.

[187] 22/5/19 at T41.21-42.
[188] 22/5/19 at T47.31.
[189] 22/5/19 at T14.45.
[190] Exhibit 1, Supplementary Volume, at [2b].
[191] Medical equipment to perform a surgical procedure used to gain prompt access to an otherwise compromised and inaccessible airway.
[192] 22/5/19 at T41.49-T42.30.

22.47 A final issue which arose in the evidence is whether event competitors should be provided with information, prior to an event, to allow them to understand the nature of medical coverage that was available at the event. Dr Taylor considered that such information should be made available,[193] as did Dr Roche.[194] EA submits that provision of such information is unnecessary given that it is contained in the EA Rules which are readily accessible on the EA website. However, given the ambiguities identified with the EA Rules in this respect, the need for clarity of information is clear.

22.48 **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian Australia that the current version of the National Eventing Rules be amended to mandate that at each Event (a) there must be at least one Medical Response Team consisting of a minimum of two medical providers, one of whom has the minimum skills and experience to: (i) secure an airway, at a minimum with a laryngeal mask airway and ideally with the skill to intubate or perform surgical airway; (ii) decompress a chest with either a purpose-made long decompression cannula or thoracostomy/chest tube; (iii) apply quality pelvic binder (SAM splint or T-pod) and C-collar; (iv) insert IV and give crystalloid and analgesia; and (v) apply suitable splints to fractures; (b) where reasonably possible, subject to geographic limitations, a medical practitioner (the Event Doctor) is to be one of the members of the Medical Response Team; (c) there must be two Medical Response Teams at Events when the show jumping test and cross country test are held concurrently; (d) the Event Doctor (if available), or the Medical Response Team, in consultation with the event organising committee and Event Safety Officer is to determine the number of Medical Response Teams that are required to achieve a response time of three minutes or less to the location of a serious incident requiring medical assistance.

22.49 **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian Australia that the current version of the National Eventing Rules be amended to mandate that a pelvic splint and cricothyrotomy kit are to be included in the medical equipment available at an Event, with: (a) the list of medical equipment to be provided to the Event Doctor or Medical Response Team before the Event for review; (b) the medical equipment to be checked by the Event Doctor or Medical Response Team to be functional and in good order at least 90 minutes before the commencement of an Event.

22.50 **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian Australia that the current version of the National Eventing Rules be amended to mandate that each Event is to have one vehicle with four wheel drive capability and rotating beacon lights, for each Medical Response Team, that can be used to provide a medical response in the case of serious incident.

22.51 **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian Australia that the current version of the National Eventing Rules be amended to mandate that a Medical Response Team must deploy to the location of a serious incident requiring a medical response (a) during a Jumping Test in three minutes or less; and (b) during a Cross Country Test to in three minutes or less, where possible.

[193] 22/5/19 at T15.5.
[194] 22/7/19 at T50.27.

22.52 **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian Australia that the current version of the National Eventing Rules be amended to mandate that before the commencement of an Event, the Event Doctor or Medical Response Team is to (a) be consulted in relation to the Eventing Serious Incident Management Plan and requested to provide feedback as to the adequacy of medical coverage and response; and (b) attend any pre-Event briefing where the Eventing Serious Incident Management Plan is discussed.

22.53 **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian Australia that the current version of the National Eventing Rules be amended to mandate that all riding phases at an Event be ceased in the case of a serious incident requiring the attendance of a Medical Response Team and no riding re-commence until all Medical Response Teams have returned to their base location and provided clearance for the Event to continue.

22.54 **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian Australia that the current version of the National Eventing Rules be amended to mandate that an Event Organising Committee is to advise all competitors registered to compete at an Event of the nature and level of medical services available at the Event, at least seven days before the commencement of the Event.

22.55 **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian Australia that the National Medical Consultative Group is to be required to: (a) conduct an annual review of the Medical Guidelines; and (b) conduct periodic reviews of the Medical Guidelines to identify developing trends and specific issues relevant to the safety of Event competitors.

***Event management***

22.56 The concept of pre-event planning raised by Dr Cross is relevant to the issue of whether a formal management plan is available to organising committees concerning the preparation for, and running of, an event. The FEI provides for an Eventing Serious Incident Management Plan which is "*designed as a quick reference to setting up [a team] before the competition starts, a guide to procedures, and to help with issuing initial statements and logging detail*".[195] Whilst such plans are used by organising committees, they are not mandated by the EA Rules.[196]

22.57 The evidence in relation to Olivia's and Caitlyn's incidents demonstrated that there were certain deficiencies related to aspects of safety planning and management preceding both events. For example, at the SIEC, issues arose in relation to acknowledgement and confirmation of an imminent medical response and provision of a time of arrival at the scene. Further, for example, at Scone:

(a) a pre-event briefing was conducted without a formal management plan and only a list of event officials;

(b) the list of officials incorrectly identified the event doctor;

(c) the event doctor and paramedic for the event were not present at the pre-event briefing;

[195] Exhibit 1, Tab VB1.
[196] Exhibit 1, Volume 5, Tab 11 at [14.1].

(d) a course tour was not conducted with event doctor;

(e) the cross country coordinator and a member of the organising committee were in possession of different GPS coordinates to provide to a helicopter in the event of a critical emergency response;[197]

(f) a difference in GPS coordinates resulted in the helicopter responding to Olivia's fall to initially land in a location that was further away than intended.

22.58 Dr Cross emphasised the importance of pre-event planning in this way:

> "*The pre-event planning phase is the most critical important phase to get right, that, that you understand the event you're about to look after. The, the number of competitors, the venue, the, the epidemiology of what injuries to anticipate and be - to have the right personnel there to manage those injuries, illnesses, scenarios and then to have the right equipment and then have them situated within the right places at the sporting event*".[198]

22.59 **FINDINGS:** Although the use of Eventing Serious Incident Management Plans are not mandated by the EA Rules, they appear to be widely used by organising committees. Having regard to the ways in which such plans can assist with response planning to a serious incident suggests that their use ought to be mandated. Further, having regard to the importance of pre-event planning and the ways in which such planning can be utilised to mitigate the risk of injury, and assist with crisis management, there is scope to beneficially expand the function of Eventing Serious Incident Management Plans as an appropriate risk mitigation strategy.

[197] Exhibit 1, Tab MW2.
[198] 22/5/19 at T30.16.

22.60 **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian Australia that the current version of the National Eventing Rules be amended to mandate that an Eventing Serious Incident Management Plan (**ESIMP**): (a) is to be developed for every Event by an Event Organising Committee, prior to the commencement of the Event; (b) is to be provided to the Event Doctor or Medical Response Team for an Event, prior to the commencement of the Event; (c) is to ensure that an Event Organising Committee is to arrange for the Event Doctor or Medical Response Team to conduct a venue inspection, prior to the commencement of the Event, to ensure that any medical response can be provided in a timely manner, including transportation to off-site medical services; (d) is to ensure that all Event staff (including volunteer staff) are provided with all necessary contact phone numbers for Event Officials, the Event Doctor, and Medical Response Team, and any other medical services providers in the case of a serious incident requiring a medical response; (e) is to ensure that all Event staff (including volunteer staff) are provided with necessary information (including via a mobile phone app) to enable external medical services providers (such as NSW Ambulance) to be directed to the location of a serious incident requiring a medical response in a timely manner; (f) is to ensure that in the case of a serious incident requiring a medical response, Event staff (including volunteer staff) at the location of the serious incident be advised that the arrival of a medical response has been arranged and is imminent; and (g) is to ensure that the Technical Delegate has possession of the GPS coordinates for the location of each fence judge, so that such information can be provided to enable external medical services providers (such as NSW Ambulance) to be directed to the location of a serious incident requiring a medical response in a timely manner.

***Fence judges***

22.61 As each fence on a cross country course is attended by a fence judge, it is evident that they are the persons most likely to be able to first reach a rider who has fallen at a fence. In this context, the inquest considered whether the role of the fence judge in such situations should be confined to being only a communicator, or extended to encompass also being a first responder.

22.62 Mrs Bates expressed the view that first aid training should be offered to jump judges. She considered that if a judge had such training it would give them confidence to check on the welfare of a rider in a time-critical situation. Mrs Bates acknowledged that it has historically been difficult to find enough volunteers to be judges for events but expressed the view that training might increase their confidence. She explained that the deaths of Caitlyn and Olivia had "*highlighted to a lot of jump judges the dangers of the sport and that they could be putting themselves in that situation, and so, I think there has been a decline in numbers for people volunteering*".[199]

22.63 As a fence judge herself Ms Retallack said: "*I personally felt quite helpless without [first aid training] even though I know it wouldn't have made a difference in the particular circumstances*".[200] She expressed the view that it would be a "*really positive step*"[201] for EA to offer first aid training to jump judges.

22.64 Dr Roche indicated that there are already existing challenges in recruiting sufficient numbers of fence judges, let alone insisting that they undertake first aid training. Further, he said that it was difficult to

[199] 13/5/19 at T62.42.
[200] 14/5/19 at T9.10.
[201] 14/5/19 at T9.37.

gain agreement from medical practitioners as to what could be usefully taught to a fence judge in a short period of time. The conclusion reached was that it was better to have an adequate medical response that could attend in a timely fashion, with the most important function of the fence judge to be a clear communicator of the nature of the response required and whether a course was clear following a rider fall.[202]

22.65 As a result, in 2018 Eventing NSW created a video titled "*Cross Country Critical Incident Training*". The video is presented by Dr Janson and outlines the key roles of a fence judge in the event of a rider fall. The video is referred to in Annex D.1 of the current EA Rules. However, there is no requirement for the video to be shown to fence judges prior to competitions. It appears that a YouTube link to the video is disseminated to organising committees so that the video may be shown at fence judge briefings where possible.

22.66 Dr Cross considered "*that the level of training of that video is, is sufficient, that you, you want to get the, the trained doctor and intensive care paramedic to that fence in under three minutes*".[203] Professor Brown said that he considered the video to be "outstanding".[204] Professor Brown went on express this view, which Dr Cross agreed with:

> "*I think offering [first aid training] would be very appropriate and it would be then incumbent on the jump judges to decide if they wish to do it. I cannot see this being a mandate, just literally for logistics. Secondly, I think you need to keep in perspective what a jump judge can realistically do at the - if you like, at the, the side when there's a significant injury… I think the, the video that Phil Janson is in goes a long way to training*".[205]

22.67 Dr Taylor indicated in evidence that she had agreed in an informal capacity to assist with rolling out across NSW six courses in first aid and emergency response to be offered over the next 12 months that was targeted towards what is required at an equestrian event. She agreed that this was a positive development arising from the inquest.

22.68 **FINDINGS:** There can be no doubt that a fence judge who witnesses a fall at a fence is faced with a confronting and traumatic situation. Equally, as already noted above, in the event of a fall resulting in serious injury the medical response time is critical. The evidence establishes that the role of a fence judge in such a situation is better left as a communicator rather than a medical first responder. However, it would be beneficial for fence judges to be offered the opportunity to participate in first aid training to assist them in dealing with such a situation. Further, given the expert opinion expressed about the utility of the *Cross Country Critical Incident Training* video it should be compulsory viewing for all fence judges.

[202] 15/5/19 at T36.22-34.
[203] 22/5/19 at T45.39.
[204] 22/5/19 at T46.3.
[205] 22/5/19 at T46.15.

22.69 **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian Australia that the current version of the National Eventing Rules be amended to mandate that the Eventing NSW *Cross Country Critical Incident Training* video is to be viewed by all fence judges prior to an Event.

22.70 **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian Australia that the current version of the National Eventing Rules be amended to mandate a minimum age requirement for fence judges at all Events.

22.71 **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian Australia that all fence judges be informed prior to an Event of the availability of voluntary first aid training, and that Equestrian Australia make arrangements for such training to be provided to any fence judges who volunteer, prior to the fence judge performing any duties at an Event.

## 23. Acknowledgments

23.1 This inquest was a challenging and profoundly moving one in many ways. The breadth of issues to be considered, and the degree of investigation and examination that was required necessitated a methodical, resolute, and meticulous approach.

23.2 The Assisting Team of Dr Peggy Dwyer, Ms Alana McCarthy, Ms Clare Skinner and Ms Caitlin Healey-Nash brought their considerable skill, expertise and professionalism to this task. They have provided invaluable assistance to the inquest and done so in a most respectful, empathetic and compassionate way at all times. Their tremendous assistance throughout all facets of the coronial process must be acknowledged with great appreciation on behalf of the New South Wales community.

## 24. Findings pursuant to section 81 of the Coroners Act 2009

24.1 The findings I make under section 81(1) of the Act are:

***Identity***
The person who died was Caitlyn Fischer.

***Date of death***
Caitlyn died on 30 April 2016.

***Place of death***
Caitlyn died at Horsley Park NSW 2175.

***Cause of death***
The cause of Caitlyn's death was blunt force head injuries.

***Manner of death***
The manner of death was misadventure. Caitlyn sustained the head injuries after suffering an accidental fall whilst competing in the cross country phase of an eventing competition.

## 25. Epilogue

25.1. Caitlyn was known to collect many quotes made by historical figures such as Abraham Lincoln and Winston Churchill and pin them to her bedroom wall for inspiration. However, her favourite quotes came from A A Milne, the English author best known for his beloved books about Winnie-the-Pooh. At the conclusion of the evidence in the inquest, Caitlyn's parents shared a quote from A A Milne from one of his Winnie-the-Pooh books. Respectfully, it is perhaps fitting to take some liberty to share two further quotes from the same series of books:

*"I think we dream so we don't have to be apart for so long. If we're in each other's dreams, we can be together all the time".*

*"If there ever comes a day when we can't be together, keep me in your heart, I'll stay there forever".*

25.2. On behalf of the Coroner's Court of New South Wales, and the Assisting Team, I offer my deepest sympathies, and most sincere and respectful condolences, to Mark, Ailsa and Kristopher; to the other members of Caitlyn's family; and to Caitlyn's friends for their immeasurable and tragic loss.

25.3. I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
4 October 2019
Coroner's Court of NSW

**Inquest into the Deaths of Caitlyn Fischer & Olivia Inglis**

**Appendix A: Consolidated Recommendations**

For the purposes of these recommendations:

- **Event** means all international (Concours Complet International) and national (CCN/CNC) eventing competitions held in accordance with the Fédération Equestre Internationale (**FEI**) *Eventing Rules* and Equestrian Australia (**EA**) *National Eventing Rules*.

The following recommendations are made to the President of Eventing New South Wales:

**Safety Officers**

1. That the *NSW Eventing Organisers Handbook* **(the Handbook) be** immediately updated to remove reference to Health Services International (**HSI**) as the preferred New South Wales ambulance service for eventing competitions, and that the Handbook be amended to nominate the current preferred service provider (if any).

2. That a National Safety Manager (**NSM**) be appointed on a full-time basis.

3. That the position of Event Safety Officer (or equivalent) be created and that:
    (a) the necessary skills and qualifications for the position, together with the duties and responsibilities of the position, be identified in a position description; and
    (b) an Event Safety Officer be appointed for every Event.

4. That:
    (a) the position description of Technical Delegate (**TD**) be amended to include advising Event Organising Committees in relation to all aspects of an Event, with particular focus on the Cross Country Test, and applicable amendments to the FEI Eventing Rules and EA National Eventing Rules;
    (b) education be provide to TDs on the role change by way of training seminars; and
    (c) consideration be given to a national standard providing a reimbursement fee for TDs.

5. That for the purpose of Event official accreditation, EA:
    (a) Develop a professional development program for ongoing education and training;
    (b) Review and update the current process for accreditation and re-accreditation;
    (c) Develop a program for the monitoring and review of the performance of Event Officials on an ongoing and regular basis.

**Course Design**

6. That the current version of the EA National Eventing Rules be amended to clarify whether:
    (a) the EA Guide for Cross Country Course Designers and Officials is to be read in conjunction with the EA Rules; and
    (b) whether non-conformity with the FEI Eventing Cross Country Course Design Guidelines and the EA Guide for Cross Country Course Designers and Officials amounts to a breach of the EA Rules.

7. That the current version of the EA *Guide for Cross Country Course Designers and Officials* be amended to:
    (a) provide a clear and unambiguous meaning of the term “true distance”;
    (b) eliminate any reference to the term “true vertical” and provide a clear and unambiguous meaning of what constitutes a “vertical” fence;
    (c) provide a clear and unambiguous meaning of what constitutes an “uphill approach” and “downhill approach”; and
    (d) provide a clear and unambiguous explanation of the circumstances in which it is acceptable and not acceptable for a vertical fence to be used.

8. That:
    (a) a comprehensive review of the EA *Guide for Cross Country Course Designers and Officials* be conducted with a view to determining if aspects of cross country course design should be incorporated as mandatory rules, as opposed to discretionary guidelines;
    (b) at least an annual review of the EA *Guide for Cross Country Course Designers and Officials* be conducted to ensure that it appropriately reflects international and national developments and improvements relating to competitor safety.

9. That a mechanism be developed by which a Cross Country Test designed by a Course Designer is subject to peer review and inspection by another Course Designer of equivalent or higher category of accreditation, to certify that the Cross Country Test is appropriate for competition, prior to the commencement of an Event.

10. That Section 515.4.1.2 of the current National Eventing Rules be amended to provide that:
    (a) the Course Designer of a Cross Country Test is to be present (and not competing) during the Test in order to critically review the performance of combinations during the Test as it relates to aspects of course design;
    (b) where the Course Designer of a Cross Country Test is unable to be present during the Test, that this fact be reported to the Event Organising Committee with arrangements made for a replacement Course Designer of equivalent or higher category of accreditation to be present during the Test to perform the requirement set out in (a) above.

**Review Processes**

11. That a robust and comprehensive process be developed for the review of serious incidents requiring a medical response at an Event.

In this regard "serious incident" means:

(i) a fatality; or

(ii) a head or spinal injury which requires an overnight admission to hospital.

Such a review process should include, but is not limited to, the following:

(a) the creation of a panel consisting of equestrian experts (with experience in, for example, competing and course design) and non-equestrian experts (with experience in, for example, risk management) available to be selected as members of a Review Panel, none of whom are office holders with EA or any state branch of EA;

(b) formation of a Review Panel comprised of at least two equestrian experts;

(c) input sought from the competitor, or family of a competitor, involved in a serious incident requiring a medical response, as to the composition of the Review Panel;

(d) eyewitnesses and persons directly involved in a serious incident requiring a medical response being formally interviewed and requested to provide written statements in a timely manner following the serious incident;

(e) the issuing of preliminary findings and/or a safety warning/advisory to EA members and Event Organising Committees if the Review Panel determines that it has identified any issues which may potentially adversely affect the safety and welfare of competitors at Events immediately following a serious incident;

(f) the publication to all EA members of any recommendations made by a Review Panel, with a process implemented for feedback to be provided by EA members and reviewed by EA; and

(g) the publication to all EA members of updates regarding the progress of implementation of any recommendations made by a Review Panel.

**Event Management**

12. That prior to the commencement of an Event:

(a) all competitors in the Event be notified of the availability to participate in a formal course walk, with the TD, Course Designer, Athlete Representatives, Event Safety Officer and a member of the Event Organising Committee to be present;

(b) arrange for a formal course walk to be conducted prior to the commencement of the Cross Country Test.

13. That at Events where the Jumping Test precedes the Cross Country Test:
    (a) the TD and Ground Jury (if present) be required to collect and review data to determine whether the number of penalties incurred by a combination in the Jumping Test is potentially adversely indicative of the capacity of the combination to compete safely in the Cross Country Test; and
    (b) in circumstances where such a determination is made, require that the TD and Ground Jury give consideration to whether the combination should be eliminated from competing in the Cross Country Test, or downgraded to a lower category of competition.

14. That a reporting system be implemented by which a competitor at an Event is able to confidentially (and with the offer of anonymity):
    (a) communicate any safety-related concerns during an Event; and
    (b) provide feedback about safety-related concerns following an Event; for consideration and review by the Event TD, Event Safety Officer, and NSM.

15. That any implemented reporting system should include, but is not limited to, the following:
    (a) completion of confidential post-event reports by the Athlete Representative, TD, Chief Steward (if present) and Ground Jury (if present) at the conclusion of each Event;
    (b) review of completed confidential post-event reports by the NSM;
    (c) reports to be sent directly to the NSM by each official, or collected and sent via the Event TD;
    (d) a formal feedback system in which the NSM is able to provide written feedback (including statistical data on rider falls) and education to organising committees, Course Designers and TDs; and
    (e) consideration of the use of available powers of sanction against an organising committee.

**Athlete Representatives**

16. That Annex F of the current version of the National Eventing Rules be amended to provide that:
    (a) Athlete Representatives for each competition class are required to be appointed for all Events;
    (b) the name and contact details of the Athlete Representatives are to be communicated to all competitors, and published in the Event draw, at least seven days prior to the Event;
    (c) the Athlete Representatives are to be introduced in person at the Athlete briefing (if one is held) preceding the Event;
    (d) the Athlete Representatives are to be present at the competition venue whilst riders are competing and for the entire duration of the competition;
    (e) following the formal course walk at an Event, and following each day of competition, the Athlete Representatives are to meet with the TD and Course Designer to discuss any safety-related issues concerning the Cross Country Test that have been either identified by the Athlete Representatives, or communicated to the Athlete Representatives by a competitor.

17. That the following be developed:
    (a) a position description setting out the role and responsibilities of an Athlete Representative; and
    (b) a formal evaluation document which is to be completed by Athlete Representatives following the formal course walk, following each day of competition, and at the conclusion of the competition to record any safety-related issues identified by the Athlete Representative, or communicated to the Athlete Representative by a competitor, for review by the TD, Event Safety Officer and NSM.

**Personal Protective Equipment**

18. That:
    (a) research be undertaken to determine which range of personal protective equipment (**PPE**) garments meet national and international standards and are most likely to mitigate the risk of injury or reduce the seriousness of injury to riders; and
    (b) provide on a regular basis to its members the most currently available information regarding such research and standards.

**Data collection**

19. That a standardised data collection system be developed for all Events which:
    (a) Provides a clear and unambiguous definition as to what constitutes a "near miss" at a fence/obstacle;
    (b) Provides training to fence judges to allow for the accurate recording of instances of a near miss or fall at a fence/obstacle, with such information to be included in the TD Report prepared at the conclusion of an Event;
    (c) Incorporates the video recording (where available, and whether conducted by EA or obtained from third party recording services) of each fence/obstacle in a Cross Country Test during competition;
    (d) Creates a panel of suitable experts (consisting of, for example, TDs, Course Designers and experienced riders) to review data collected in accordance with (b) and (c), above to identify any trends which may adversely impact the safety of competitors at Events;
    (e) Allows for collected data to be input into a database; and
    (f) Makes such a database available to EA members to be able to readily identify the particular fence/obstacle, the particular Cross Country Test, and the particular Course Designer of the Cross Country Test, where a near miss or fall has occurred.

**Medical Coverage**

20. That the current version of the National Eventing Rules be amended to mandate that at each Event:
    (a) there must be at least one Medical Response Team consisting of a minimum of two medical providers, one of whom has the minimum skills and experience to:
        (i) secure an airway, at a minimum with a laryngeal mask airway and ideally with the skill to intubate or perform surgical airway;
        (ii) decompress a chest with either a purpose-made long decompression cannula or thoracostomy/chest tube;
        (iii) apply quality pelvic binder (SAM splint or T-pod) and C-collar;
        (iv) insert IV and give crystalloid and analgesia; and
        (v) apply suitable splints to fractures;
    (b) where reasonably possible, subject to geographic limitations, a medical practitioner (the Event Doctor) is to be one of the members of the Medical Response team;
    (c) there must be two Medical Response Teams at Events when the show jumping test and cross country test are held concurrently;
    (d) the Event Doctor (if available), or the Medical Response Team, in consultation with the event organising committee and Event Safety Officer is to determine the number of Medical Response Teams that are required to achieve a response time of three minutes or less to the location of a serious incident requiring medical assistance.

21. That the current version of the National Eventing Rules be amended to mandate that a pelvic splint and cricothyrotomy kit are to be included in the medical equipment available at an Event, with:
    (a) the list of medical equipment to be provided to the Event Doctor or Medical Response Team before the Event for review; and
    (b) the medical equipment to be checked by the Event Doctor or Medical Response Team to be functional and in good order at least 90 minutes before the commencement of an Event.

22. That the current version of the National Eventing Rules be amended to mandate that each Event is to have one vehicle with four wheel drive capability and rotating beacon lights, for each Medical Response Team, that can be used to provide a medical response in the case of serious incident.

23. That the current version of the National Eventing Rules be amended to mandate that a Medical Response Team must deploy to the location of a serious incident requiring a medical response
    (a) during a Jumping Test, in three minutes or less; and
    (b) during a Cross Country Test, in three minutes or less, where possible.

24. That the current version of the National Eventing Rules be amended to mandate that before the commencement of an Event, the Event Doctor or Medical Response Team is to
    (a) be consulted in relation to the Eventing Serious Incident Management Plan and requested to provide feedback as to the adequacy of medical coverage and response; and
    (b) attend any pre-Event briefing where the Eventing Serious Incident Management Plan is discussed.

25. That the current version of the National Eventing Rules be amended to mandate that all riding phases at an Event be ceased in the case of a serious incident requiring the attendance of a Medical Response Team and no riding re-commence until all Medical Response Teams have returned to their base location and provided clearance for the Event to continue.
26. That the current version of the National Eventing Rules be amended to mandate that an Event Organising Committee is to advise all competitors registered to compete at an Event of the nature and level of medical services available at the Event, at least seven days before the commencement of the Event.

27. That the National Medical Consultative Group (**NMCG**) is to be required to:
    (a) conduct an annual review of the Medical Guidelines; and
    (b) conduct periodic reviews of the Medical Guidelines to identify developing trends and specific issues relevant to the safety of Event competitors.

**Event organisation**

28. That the current version of the National Eventing Rules be amended to mandate that an Eventing Serious Incident Management Plan (**ESIMP**):
    (a) is to be developed for every Event by an Event Organising Committee, prior to the commencement of the Event;
    (b) is to be provided to the Event Doctor or Medical Response Team for an Event, prior to the commencement of the Event;
    (c) is to ensure that an Event Organising Committee is to arrange for the Event Doctor or Medical Response Team to conduct a venue inspection, prior to the commencement of the Event, to ensure that any medical response can be provided in a timely manner, including transportation to off-site medical services;
    (d) is to ensure that all Event staff (including volunteer staff) are provided with all necessary contact phone numbers for Event Officials, the Event Doctor, and Medical Response Team, and any other medical services providers in the case of a serious incident requiring a medical response;
    (e) is to ensure that all Event staff (including volunteer staff) are provided with necessary information (including via a mobile phone app) to enable external medical services providers (such as NSW Ambulance) to be directed to the location of a serious incident requiring a medical response in a timely manner;
    (f) is to ensure that in the case of a serious incident requiring a medical response, Event staff (including volunteer staff) at the location of the serious incident be advised that the arrival of a medical response has been arranged and is imminent; and
    (g) is to ensure that the TD has possession of the GPS coordinates for the location of each fence judge, so that such information can be provided to enable external medical services providers

(such as NSW Ambulance) to be directed to the location of a serious incident requiring a medical response in a timely manner.

**Fence judges**

29. That the current version of the National Eventing Rules be amended to mandate that the Eventing NSW *Cross Country Critical Incident Training* video is to be viewed by all fence judges prior to an Event.

30. That the current version of the National Eventing Rules be amended to mandate a minimum age requirement for fence judges at all Events.

31. That all fence judges be informed prior to an Event of the availability of voluntary first aid training, and that EA make arrangements for such training to be provided to any fence judges who volunteer, prior to the fence judge performing any duties, at an Event.