CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Olivia Inglis
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:	2016/75934
Representation:	Dr P Dwyer, Counsel Assisting, instructed by Ms A McCarthy (Crown Solicitor's Office) 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 Olivia Inglis.

Date of death
Olivia died on 6 March 2016.

Place of death
Olivia died at Gundy NSW 2337.

Cause of death
The cause of Olivia's death was chest injuries.

Manner of death
The manner of death was misadventure. Olivia sustained the chest 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2009*, I direct that the following parts of the coronial file and brief of evidence containing sensitive material are not to be published: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 6 March 2016 Olivia Inglis was doing one of the things she loved most in life: riding her horse, Togha, whilst competing in the cross country phase of an eventing competition. Approximately two minutes after she began the competition Olivia and Togha reached a section of the cross country course which contained an obstacle know as fence 8A/8B, containing two separate fences. Olivia and Togha successfully jumped the first fence without incident. However, in the process of jumping the second fence Olivia and Togha fell, causing fatal injuries to Olivia.

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, Olivia's death was not the only equestrian-related death which occurred in New South Wales in 2016. On 30 April 2016, almost seven weeks after Olivia's death, another talented young

woman and rider, Caitlyn Fischer, suffered a fatal fall whilst competing in an eventing competition in Sydney. Caitlyn was 19 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 Caitlyn Fischer*. The broader issues connected with the deaths of both Olivia and Caitlyn 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. Olivia'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 Olivia, or Liv as she was known to her family and friends, was born in 1988 to Arthur and Charlotte Inglis. She was a beautiful baby and toddler, with large blue eyes and golden curls. She was an absolute delight, always happy, easy to look after and met all her milestones with ease. Olivia's sister Antoinette was born two years later in 1990, followed by a second sister, Alexandra in 2005.

4.4 Olivia was very much born into an equestrian family; her mother was an accomplished rider and coach, and her father had a long family background in thoroughbred breeding and racing. Although Olivia developed a love for horses almost immediately, she had a natural affinity for all birds and animals.

4.5 Olivia's love for horses is perhaps due to the fact that she effectively began riding even before she was born, when her mother was still pregnant with her. Olivia herself started riding at age four, beginning with pony club and gymkhanas. She tried different types of riding from show jumping to dressage to show classes but decided when she was about 11 years old that eventing was her real love.

4.6 By the age of 12 Olivia had already ridden several horses through the pony club system. She was riding daily and showed enormous talent and skill. Her mother described Olivia as having a great feel and that she lived for horses. Twice a week Olivia had a dressage and a jumping coach come to the family property and she had up to eight hours of tuition per week. The family also had a small cross country course on their property and Olivia often rode before and after school.

4.7 Olivia's skill and talent is reflected in her numerous riding achievements. She won the State eventing championships at Denman at age 12, she was captain her high school equestrian team, she was a member of the NSW State Interschool team, and she was a only one of five juniors in the NSW State development squad.

4.8 Although Olivia's interest and talent in riding was boundless, she enjoyed many other pursuits and had many other accomplishments. During her school years Olivia developed a passion for visual art, design and tech, and drama. She enjoyed team sports at school, especially soccer and hockey. One of her high school achievements was completing one of the Duke of Edinburgh gold certificate requirements which involved a week of camping in the snow in Tasmania on her 17th birthday.

4.9 Olivia enjoyed reading and the movies, had a keen interest in photography, and loved music and singing. She was a proud member of what became known as the non-choir, choir. Antoinette has many fond memories of listening to Olivia's favourite music, and singing some of Olivia's favourite school hymns together whilst riding.

4.10 Olivia had a close circle of wonderful friends who adored her. That is no surprise given what a loving, kind and warm friend that Olivia was, always willing to share fun and laughter with her friends in happy times, but also help and support them in more challenging times. One of Olivia's best friends, Molly, describes Olivia as having a golden glow about her and planting many seeds of joy in their marvellous friendship.

4.11 Olivia's family and friends knew her to be warm hearted, caring, sensitive, and funny with a wonderful sense of humour. She was always authentic and true to herself, never one to succumb to peer pressure, and also never unwilling share her gentle and generous spirit with others.

4.12 Olivia's loss has been widely felt in many ways: the loss of a student with many curricular and extra-curricular achievements; the loss of the loss of a talented rider with immeasurable potential; the loss of a genuine, true, and loving friend. This immense loss is reflected in the national and international response following Olivia's death, from many people who were never even afforded the privilege of meeting her. The extent of that response is a resounding testament of the person that Olivia was and the ability that she had to positively influence those around her.

4.13 But there is no doubt that Olivia's loss was, is, and will continue to be most painfully felt by her family. It is difficult to express in written words the depth of that loss, particularly by someone who also never had the honour of meeting Olivia. Even without having that honour, it is both heartbreaking, and at the same time, uplifting, to know of the many ways in which Olivia will be missed: for her messiness; for wearing her daggy hats; for breaking free of her gluten free and dairy free diet which constituted Olivia's idea of rebelling; for loudly singing her school's songs with a musicality that perhaps only Olivia herself could appreciate; for eating junk food with her sisters without their mother knowing, and then hiding the evidence; for being a faster runner and teeth brusher than her sisters gave her credit for; for being lovingly annoyed by the pranks that her sisters would play on her; for being a sister who could share so many jokes and laughs that only the sisters themselves understood; and for being a most amazing and remarkable sister and daughter who meant everything to her family.

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 6 March 2016

7.1 The 2016 Scone Horse Trials (**the 2016 Scone Trials**) were held over the weekend of 5 and 6 March 2016. The Scone Trials is one of the longest running equestrian events in Australia and probably the most popular regional event in New South Wales. It has attracted around 500 competitors in recent years, including in 2016.

7.2 Olivia was entered in the CNC two star eventing competition with her horse, Togha. The family bought Togha, an ex-racing thoroughbred whose racing name was Coriolanus, when he was about six. Mrs Inglis described Togha as being uncomplicated having the perfect quiet temperament for Olivia to take on and train. Olivia began competing with Togha in around 2013 and rode him from pre-star classes up to the one and two star classes. The 2016 Scone Trials would be the second two star competition for Olivia and Togha. They had completed their first two star competition at the Sydney International Equestrian Centre (**SIEC**) two weeks earlier. Previously, Olivia had completed 13 one star courses and had 28 official starts with no faults in the cross country test. This meant that she had qualified six times over (the requirement being to complete two one star courses with no faults).

7.3 Mrs Inglis and her daughters travelled from Sydney to Scone on Friday, 4 March 2016. Mr Inglis planned to join the family later. Olivia and a friend, Sophia, stayed in a truck at the venue site, whilst the rest of the family stayed in Scone township.

7.4 The following morning, 5 March 2016, Olivia (and her sisters) took part in the dressage test of the eventing competition. Following this, Olivia walked the cross country course by herself for the first time. The show jumping test took place in the afternoon. Unfortunately, Togha did not perform well and incurred a number of penalties for knocking six rails down. After the show jumping test, Olivia walked the cross country course for a second time, this time with her mother. Due to a lack of daylight they were only able to reach fence 21 on the course. They made plans to walk the course again the following morning.

7.5 After walking the cross country course, Mrs Inglis had some concerns about a number of the jumps, or fences[3]: relevantly, fence 2, fence 4A/4B and fence 8A/8B. Both fences 4A/4B and 8A/8B were combination fences, meaning that they consisted of two sequential obstacles (known as elements) for a horse and rider to navigate. Specifically, Mrs Inglis was concerned about the following: [4]

(a) The fact that the diameter (17.5 centimetres) of the rails in the fences were what she described as "*skinny*" and more closely resembled rails found in fences in the show jumping test (which are typically 20 centimetres in diameter);

(b) The fact that the rails were painted white, which made them resemble fences in the show jumping test, which are also typically painted white;

(c) The fact that the rails were painted white, without any colour differentiation, which did not indicate to a horse that there was any spread (or gap) between the rails of the second component of the fence;

[3] The terms fence and jump are used interchangeably throughout the evidence. For convenience, the term fence will be used in these findings.
[4] 16/5/19 at T17.42.

(d) The fact that each jump did not have a ground line: a ground line is an introduced feature (such as flowers) at the base of a fence, that improves the profile of a fence and assists a horse to recognise it and jump it safely;

(e) Although the rear rail of 8B was three centimetres higher than the front rail, the downhill slope of the terrain on the approach to fence 8A/8B made the rails blend together – the consequence of this, Mrs Inglis believed, was that it made 8B appear to be a square oxer;

(f) The fact that the approach to fence 8A/8B was off a right hand bend along a fence line;

(g) The fact that fence 8A/8B was located on a downhill slope which would have resulted in a reduction in speed by horse and rider on their approach; and

(h) The fact that the distance between the two elements of fence 8A/8B was not on a true distance – Mrs Inglis measured the distance between the two elements as 19 metres which, in her opinion, placed it at half a stride longer than a typical four strides. The concepts of striding and true distance will be discussed in greater detail below.

7.6 With these concerns in mind, Mrs Inglis explained in her evidence during the inquest that Olivia needed to approach jumping fence 8A/8B with two plans in mind. Firstly, if everything was going well and Olivia approached the fence nicely, jumped it well and landed at a good distance inside the combination, then she needed to keep riding forward and jump out well. Secondly, if Togha did not have balance through the corner and jumped 8A inadequately, landing short in the distance, then Olivia needed to sit up and ride for five strides so that she was not too far away from the second element. By way of explanation riding forward means to encourage a horse to lengthen its stride whilst, conversely, sitting up refers to a rider shortening a horse's stride length.

7.7 Mrs Inglis summarised her views about fence 8A/8B in this way: "*…because of the extra half stride distance, there was definitely careful consideration needed to be taken as to how you approached, how you jumped in and how you proceeded to 8B*".[5]

[5] 16/5/19 at T19.14.

8. What happened on Sunday, 6 March 2016?

8.1 On Sunday morning, Mrs Inglis spoke about her concerns regarding aspects of the cross country course and fence 8A/8B in particular with another family who had a rider competing in the same event, and also a friend, Shane Rose. Mr Rose is an elite level rider, having previously represented Australia in eventing at the Olympics. He is also an accredited FEI and EA cross country course designer and, at the time, was president of Eventing New South Wales (**Eventing NSW**).

8.2 In evidence Mr Rose described his conversation with Mrs Inglis in this way:

> "*Charlotte came up in the warm-up for the cross-country and was concerned about fences, I believe 2, 4A and B, and 8A and B. That she was concerned about the style of fence and the shape of fence…they were fences that used a skinnier rail than other fences on the course, and that she was concerned that the horse mightn't jump them that well and was asking me how I felt, had I seen them, how did I feel that…the horses would jump them. And in my experience of, of jumping similar fences, both in Europe and in New Zealand…horses actually jumped them surprisingly well and that I felt that they would, that would be a similar case for Olivia*".[6]

8.3 Mr Rose, according to Mrs Inglis, said that the rails were on the skinny side but explained that they were fashionable and that that style of fence was popular in Europe. Mr Rose went on to say that horses respect the fences and give them good clearance.[7] Mr Rose's explanation allayed Mrs Inglis' concerns somewhat.

8.4 Mrs Inglis later spoke to Olivia and told her what Mr Rose had said. Due to Togha's poor show jumping performance the previous day, Mrs Inglis and Olivia agreed on a plan of how to approach the cross country course. They decided that Olivia should simply take part in the cross country test for fun and use it as an opportunity to ride a cross country course in the two star competition. Further, they decided that if Togha did not jump well at fences 2 and 4A/4B that Olivia would retire from the course and walk Togha home.

8.5 Mr Inglis helped Olivia to saddle up Togha and placed studs in his shoes to provide increased traction. Olivia and Togha warmed up in the morning whilst Mrs Inglis watched. She thought that Togha warmed up "*beautifully*" and described it as an "*absolutely standard*" warm up.[8] Mrs Inglis checked through Olivia's personal protective equipment. Olivia was wearing personal protective equipment in the form of a helmet and back protector.

8.6 Olivia started the cross country course at 9:11am. She was the fourth rider on the course. Mrs Inglis stayed in the warm up area to watch Olivia through the first four jumps. Her plan was to then move to the finish line to greet Olivia. Meanwhile Mr Inglis, who had been helping Antoinette in the one star cross country course, had positioned himself near a water jump to watch Olivia ride through that section of the course.

[6] 17/5/19 at T9.30.
[7] 16/5/19 at T20.10.
[8] 16/5/19 at T21.36.

8.7 Pamela Thorne-Seccombe was the jump judge at fence 8A/8B. She had positioned herself at the jump at about 9:00am. She was equipped with a radio which she used to report to control and in position for the first competitor on the course.

8.8 Olivia and Togha proceeded through the first seven fences on the course without issue. At about 9:13am Olivia and Togha reached fence 8A/8B. Ms Thorne-Seccombe had seen the three competitors ahead of Olivia to ride through and fence 8A/8B without incident. She saw Olivia and Togha similarly jump 8A without incident. As Olivia and Togha jumped 8B Ms Thorne-Seccombe described the following:

> "*The front leg of the horse hit the first and second rail of what we call jump B. [Olivia] fell and hit the ground and then the horse landed on top of her. It felt like forever that the horse was on top of her. The horse got to its feet and ran off. [Olivia] didn't move*".[9]

8.9 Following the fall, Ms Thorne-Seccombe saw that Olivia was motionless on the ground. She saw blood running out of Olivia's nose and heard that her breathing was laboured. Ms Thorne-Seccombe used her radio to call control for assistance.

8.10 At this time, Mrs Inglis was standing with a volunteer, Rod Winchester, when she heard Ms Thorne-Seccombe call over Mr Winchester's radio. Mrs Inglis heard that there had been a fall at fence 8A/8B. Knowing the time that it would have taken Olivia to reach fence 8A/8B Mrs Inglis immediately knew that Olivia was the only rider on that section of the course at that time. Mrs Inglis saw that Matt Bates, the technical delegate for the two star competition, was nearby at the time. They got into Mr Bates' vehicle and drove to 8A/8B, arriving in about five minutes.

8.11 David Keys was a paramedic[10] who had been engaged by a private contractor, Health Services International (**HSI**) to provide medical coverage for the event. He was positioned at a location in the approximate centre of the cross country course. After receiving a call for assistance over the radio Mr Keys drove his ambulance[11] to fence 8A/8B. Apart from Ms Thorne-Seccombe, Mr Keys was the first responder on the scene.

8.12 Mr Keys made a quick initial assessment of the situation. He saw that Olivia was lying on her right hand side, was unresponsive and had a large volume of blood coming from her airway. Mr Keys cleared Olivia's airway and found that she was still breathing spontaneously. Mr Keys used his phone to call the Ambulance Service of New South Wales (**NSW Ambulance**) and requested the assistance of a helicopter to attend the location.

8.13 He quickly returned to the ambulance in order to retrieve some medical equipment, which included an oropharyngeal airway and suction kit. Mr Keys had tested the suction kit earlier that morning using water and found that it appeared to be working. However, when he attempted to use it on Olivia "*it wasn't functional…it wasn't working a hundred percent…it really didn't have much, much power at all*".[12] As a result Mr Keys described feeling "*extremely frustrated*".[13]

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[9] Exhibit 1, Volume 1, Tab 7 at [5].

[10] It will become apparent that the inquest considered certain issues related to the level of medical cover that was available at the event, and whether that cover could be described as paramedic services. For convenience, the terms "paramedic" and "ambulance" have been used in these findings. However, consideration of the precise matters related to these issues will be discussed later.

[11] See footnote 10, above.

[12] 17/5/19 at T71.42-48.

[13] 17/5/19 at T72.2.

8.14 About a minute later, Margot White arrived on the scene. She identified herself to Mr Keys as a registered nurse. At around this time Olivia's breathing deteriorated and Mr Keys proceeded to ventilate her with a bag valve mask, which was working effectively. Mr Keys asked Ms White to monitor Olivia's pulse whilst he managed her airway. In evidence, Mr Keys explained that in order to provide advanced airway support for Olivia, he required a laryngeal mask airway[14] (**LMA**) or endotracheal tube[15], neither of which was available in the equipment stored in the ambulance. Mr Keys was trained in the use of both pieces of equipment.

8.15 Mr Keys also identified that, as a result of her chest injuries, Olivia had a tension pneumothorax.[16] However he did not have a decompression kit or a cannula long enough to penetrate the chest wall and decompress the pneumothorax. Mr Keys said that it was again extremely frustrating knowing that he had the necessary skills to treat the condition but lacked the equipment to do so, "*especially knowing how serious and how quickly it can turn bad*".[17]

8.16 When Mrs Inglis arrived on the scene, she saw that Mr Keys and Ms White were providing support to Olivia. Mrs Inglis noticed that Olivia's eyes were non-reactive and that she had blood coming out of her mouth. She asked Mr Keys if Olivia was already deceased and he said that he could feel a faint pulse. Mrs Inglis made the following assessment of the situation when she arrived:

> "*Mr Keys was struggling to work his equipment and so he was sitting beside Olivia and he had a machine that was needed to clear her airways and he was putting it in and out and he was turning it off and on and fiddling with it*[18]*…He was very, very nervous and he just kept fiddling with his equipment*".[19]

8.17 Dr Lyndel Taylor was in the vicinity of the show jumping arena at this time, making preparations to compete. She had been a Career Medical Officer at Wyong Hospital since 2006 and a keen rider, who ran a small equestrian training facility on the Central Coast with her husband, Dr Philip Janson. Dr Janson, an emergency physician, was not present at Scone at the time.

8.18 Dr Taylor heard a helicopter overhead and heard someone say that there had been a fall on the cross country course. She asked a nearby show jumping official if a doctor was required. The official used their radio to convey Dr Taylor's question and received a reply that attempts were being made to call Dr Janson. Dr Taylor immediately informed the official that she was Dr Janson's wife, that he was not present, and that she was also a doctor. Dr Taylor asked the official to repeat the question over the radio whether a doctor was required. A confirmatory message was received in response and a bystander offered to drive Dr Taylor to the scene, which took two or three minutes.

8.19 Dr Taylor arrived on the scene about 10 minutes after Olivia's fall. Dr Taylor saw Mr Keys providing C-spine support and attempting to manage Olivia's airway. Dr Taylor saw that Olivia was unresponsive,

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[14] A medical device that keeps a patient's airway open during anaesthesia or unconsciousness.
[15] A flexible plastic tube that is placed through the mouth into the trachea (windpipe) to help a patient breathe. The endotracheal tube is then connected to a ventilator, which delivers oxygen to the lungs.
[16] This is a lung or chest wall injury which causes air to leak into the chest cavity. It results in compression of the chest structures, including vessels that return blood to the heart. It can be fatal if not treated immediately.
[17] 17/5/19 at T74.50.
[18] 16/6/19 at T24.18.
[19] 16/6/19 at T24.27.

with fixed and dilated pupils, and that she had a Glasgow Coma Scale[20] score of 3. Dr Taylor also noted that Olivia had a chest deformity, with the right side being higher and tracheal deviation to the left, indicating a tension pneumothorax which needed immediate release.

8.20 Dr Taylor asked Mr Keys for a quick assessment. He told Dr Taylor that Olivia initially had cardiac output and gasping respiration, and that he attempted to clear her airway but his suctioning equipment was malfunctioning. Mr Keys indicated that he was unsure if there was any neck trauma. He said he was aware of the chest deformities and that a decompression kit was required but there was none available. Dr Taylor explained the situation in this way:

> "*[Mr Keys] had correctly identified very time-sensitive and time-critical injuries as had I. He had been there quite a bit longer than I had, and his basic equipment was malfunctioning on him which meant he had very limited options to deliver effective care*".[21]

8.21 In evidence, Dr Taylor explained that the limitations of the available equipment also meant that she had similarly limited options in providing care to Olivia. Dr Taylor felt for a pulse and found none. She used Mr Key's stethoscope to listen to Olivia's chest and was unable to auscultate[22] any heart sounds. Dr Taylor informed Mr Keys that Olivia had no cardiac output and commenced cardiopulmonary resuscitation (**CPR**). She began performing chest compressions whilst Mr Keys continued to manage Olivia's airway and provide ventilation. In evidence it was suggested to Mr Keys that it would have been impossible for him on his own to effectively manage Olivia's airway whilst providing CPR. He agreed and said, "*that would have been tap dancing*".[23]

8.22 Whilst performing chest compressions, Dr Taylor saw a NSW Ambulance helicopter circling above. By chance the helicopter had been in the vicinity of the Scone Trials venue when Mr Keys made a call for assistance. Dr Taylor saw the helicopter land in a field below the accident site, but then take off again and land at a location closer to the site. The NSW Ambulance retrieval team, led by Dr Tom Antonio, arrived on the scene a short time later. The retrieval team took over airway management and ventilation whilst Dr Taylor continued with compressions and provided a brief summary of events.

8.23 Bilateral thoracostomies[24] were performed which released the tension pneumothorax. Olivia was intubated and CPR continued as she was given two units of blood, Hartmann's solution[25] and adrenaline. An electrocardiogram was attached which showed that Olivia was in asystole.[26] CPR continued but continuous reassessments showed no return of cardiac output and declining oxygen saturation levels.

8.24 The retrieval team spoke to Olivia's parents informing them that Olivia likely had significant internal injuries and that nothing further could be done for her. CPR was ceased and at about 10:05am Olivia was pronounced deceased by Dr Antonio.

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[20] A neurological scoring system, with scores ranging from 3 to 15, used to assess the level of consciousness in a person according to their eye, verbal and motor responses.
[21] 22/5/19 at T11.47.
[22] Listening to the internal sounds of the body, such as the heart, lungs and other organs.
[23] 17/5/19 at T72.5.
[24] A small incision of the chest wall to allow insertion of a tube in the space between the lungs and chest wall to remove excess air or fluid, commonly used in the treatment of pneumothorax.
[25] A solution used to replace fluids and electrolytes where there is low blood volume or low blood pressure.
[26] A lethal cardiac arrest arrhythmia where there is no discernible electrical activity of the heart.

9. What was the cause of Olivia's death?

9.1 Olivia was later taken to the Department of Forensic Medicine at Newcastle. On 8 March 2016 a postmortem examination was conducted by Dr Brian Beer. Postmortem imaging revealed prominent subcutaneous emphysema, bilateral pneumothoraces, bilateral significant haemothoraces. It was also noted that "*both lungs showed significant air spaces within the lungs consistent with torsion rupturing injury to the lung*".[27]

9.2 Dr Beer ultimately opined that the cause of Olivia's death was chest injuries.

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[27] Exhibit 1, Volume 1, Tab 3, page 5.

10. What issues did the inquest examine?

10.1 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?

10.2 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.

10.3 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.

10.4 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".[28]

10.5 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.

10.6 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.

[28] 13/5/19 at T21.34.

11. What preparations were made for medical coverage at the 2016 Scone Trials?

11.1 The Scone Horse Trials Organising Committee was responsible for preparing for all aspects of the 2016 Scone Horse Trials. On 8 February 2016 the Secretary of the organising committee, Karen Irwin, obtained a quote from HSI. It should be noted that the quote issued by HSI referred to a "*paramedic*" being provided for the event, the job description as "*paramedical services*", and under the heading equipment provided referred to "*all medical supplies*".[29]

11.2 The *NSW Eventing Organisers Handbook* (updated in May or June 2012), published by Eventing NSW, contains a paragraph titled "*Medical Services*" within the section "*Running the Event*". It provides:

> ***Medical services***
> *A first aid service must be present at all times.*
> *Health Services International is the preferred NSW ambulance service*.[30]
> *Provide a full paramedic service including 4WD ambulance.*
> *Emergency vehicles must be able to access all parts of the venue.*
> *An ambulance (or paramedic equivalent) MUST be present during the cross-country test.*
> *A Doctor SHOULD be present during the cross-country test*.[31] (original emphasis)

11.3 The above provisions replicate relevant portions of the 2016 EA Rules. Annex D of the 2016 EA Rules is titled "*Medical Services*" and is set out in identical terms to the 2016 FEI Rules. However the 2016 EA Rules contain an amendment at Annex D.1 titled "*EA CNC/CCN Medical and Veterinary Services*" intended to apply to CNC and CCN events. It stipulates the following:[32]

> *MEDICAL*
> - *A first aid service must be present at all times.*
> - *Emergency vehicles must be able to access all parts of the venue.*
>
> *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.*
> - *If the ambulance (or paramedic equivalent) is not on the ground, then the event must be halted.*

11.4 The President of the organising committee for the 2016 Scone Trials, Blair Richardson, said that he did not turn his mind to what level of medical services was actually going to be provided.[33] Nor did Mr Richardson turn his mind to the number of paramedics that would be present. Mr Richardson said that he was unaware of any difference in the level of paramedic services. He explained: "*I didn't know they were different levels so I presumed 'Paramedic' means someone who, if you have a fall, is equipped, who can help you. I, I didn't know there was different levels*".[34]

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[29] Exhibit 1, Tab BR4.
[30] Exhibit 1, Tab SR5, page 24.
[31] Exhibit 1, Tab SR5, page 24.
[32] Exhibit 1, Volume 3, Tab RK5, page 102.
[33] 23/5/19 at T12.29.
[34] 23/5/19 at T12.50.

11.5 Further, Mr Richardson acknowledged that in 2016 he was unaware of the provision in the 2016 EA Rules that a paramedic equivalent or ambulance must be present during the cross country test and a doctor should be present during the cross country test.[35] He agreed that he did not turn his mind to whether a doctor would be present to assist.

11.6 Mr Keys had worked for HSI on a part-time basis since 2005. At that time Mr Keys was a qualified Combat Medical Attendant with the Army Reserve who had completed bi-annual competency testing in advanced life support since 1998. Mr Keys continued his part-time employment with HSI up until 2009 when the business was purchased by Paul Taylor. Following this, Mr Keys continued to work for HSI, but on a less frequent basis.

11.7 Following the booking request made by Ms Irwin in February 2016, Mr Keys was engaged by HSI to be present at the Scone Horse Trials. By this stage Mr Keys had graduated from James Cook University with a Bachelor of Health Science (Physician Assistant). A physician assistant is a medical professional who works under the delegated authority of a medical practitioner to provide primary healthcare to patients. At the time of his return to work for HSI Mr Keys sought clarification from Mr Taylor as to whether he would be working in a first aid or physician assistant capacity. Mr Keys sought this clarification so that he could understand his scope for the use of medication. According to Mr Keys, Mr Taylor informed him he would be working in a first aid capacity at the 2016 Scone Trials.

11.8 After being engaged for the event, Mr Keys collected the ambulance from a location near Bowral. He was told by Mr Taylor that it was fully stocked. Mr Keys said that he briefly looked at the equipment to make sure that the majority of equipment he expected to be available was in fact available. He did not examine the equipment more closely until the evening of 4 March 2016[36] after arriving in Scone. He said he noticed the ambulance was well stocked for general first aid. He tested the automated external defibrillator, checked the expiry date on the drugs, and checked the oxygen equipment.

11.9 Mr Keys said that he was concerned that he should have been working "*two up*", in other words two paramedics, or a paramedic and a person trained in first aid.[37] He raised these concerns with Mr Taylor in late 2015 and was told that it was cost prohibitive. Mr Keys said that he also considered that the ability to perform cardiac monitoring (such as with an ECG) should have been available, as well as a semi-automatic defibrillator.

11.10 **FINDINGS:** Both the NSW Eventing Organisers Handbook and the 2016 EA Rules mandated that a paramedic (or ambulance equivalent) be present during the cross country test. There was no such mandatory provision regarding the presence of a doctor. It is arguable whether the presence of Mr Keys at the 2016 Scone Trials satisfied the mandatory provisions. This is because the evidence established that he was being employed in a first aid, as opposed to a paramedic (or physician assistant), capacity. This is contrary to the quote provided by HSI which indicated that paramedical services would be provided for the event.

[35] 23/5/19 at T14.28.

[36] In evidence (17/5/19 at T65.30) Mr Keys referred to arriving in Scone on the evening of Friday, 5 March 2016. This appears to be an error as 5 March 2016 was a Saturday. It is understood that because competition began on 5 March 2016, Mr Keys intended to refer to Friday, 4 March 2016.

[37] 17/5/19 at T67.15.

11.11 Notwithstanding, it was fortuitous that Mr Keys brought a care skillset to the event that was actually higher than had been requested or contemplated. Conversely, it is most troubling to know that the equipment which was available to him did not match this skillset.

11.12 Following the events of March and April 2016, HSI was no longer deemed to be the preferred ambulance or paramedic service for NSW eventing competitions. However, the *NSW Eventing Organisers Handbook,* which is believed to still be in force, still provides that HSI occupies this status. It is evident, given the events of 2016 and what had transpired since that immediate amendment of the *NSW Eventing Organisers Handbook* is necessary.

11.13 **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian Australia that the *NSW Eventing Organisers Handbook* be immediately updated to remove reference to Health Services International as the preferred NSW ambulance service for eventing competitions, and that the Handbook be amended to nominate the current preferred service provider (if any).

12. What happened at the 2016 Scone Trials pre-event safety meeting?

12.1 The 2016 Scone Horse Trials were held across eight levels of competition. Mr Bates was the technical delegate for the one star, two star, and three star levels of competition. Ian Menzies, an Assistant technical delegate, was responsible for measuring and approving the remaining levels of competition. On 4 March 2016 Mr Bates, together with Mr Menzies, conducted a meeting prior to the start of competition. This meeting was referred to during the evidence as the pre-event safety meeting.

12.2 According to Mr Bates "*generally the people who attend the meeting are the TDs [technical delegates], representatives of the Organising Committees, the cross country coordinator, the event secretary and as many of the medical personnel, vets, and fence repair crew that are available*".[38] The only document which Mr Bates took with him to the meeting was a one page checklist containing the names and phone numbers of various event staff.[39]

12.3 Mr Keys did not attend the meeting. Having arrived at Scone sometime on the evening of 4 March 2016 it is unclear whether he arrived before or after the meeting. In any event it is clear from the quote issued by HSI that Mr Keys was only engaged from 8:30am to 7:00pm on 5 March 2016 and from 8:00am to 3:15pm on 6 March 2016. According to the quote, no provision was made for him to attend any meeting on 4 March 2016.

12.4 The checklist used by Mr Bates listed David Keys as "MEDICAL AMBULANCE" and Dr Lyndel Taylor as "DOCTOR". Dr Taylor was also not present at the meeting. Mr Bates explained that an equestrian club could usually only afford to have a medical service provider present on the scheduled days of an event, but not on any preceding days when a meeting like the one held on 4 March 2016 was being conducted.[40]

12.5 Mr Bates explained that at the safety briefing there was an expectation that Dr Janson would be the event doctor. At the briefing it was indicated that at the last minute Dr Janson was unavailable but that Dr Taylor would be present at the event as a competitor. On this basis Dr Taylor was listed at the event doctor. Mr Bates said that he did not seek confirmation at the briefing whether Dr Taylor would in fact be the event doctor. He said that he left that matter for the organising committee to confirm. Mr Bates said that he was "*comfortable that there was no requirement under the rules to have a doctor but it was good to know that [Dr Taylor] was at least on the grounds*".[41]

12.6 Dr Taylor herself said that the organising committee knew that she would be present at the 2016 Scone Trials, and that she would be prepared to help if there was an issue. However Dr Taylor said that the committee also knew that she was present as a competitor, and not the event doctor. She explained that she bumped into a committee member on 4 March 2016 who asked where her husband was. Dr Taylor explained that he was at home and the committee member remarked, "*That's a shame. There's a folder with his name on it in the office*"[42] meaning that he was considered to be the event doctor.

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[38] Exhibit 1, Tab 24 at [4.2].
[39] Exhibit 1, Tab MB2.
[40] 16/5/19 at T64.14.
[41] 16/5/19 at T80.13.
[42] 22/5/19 at T7.25.

12.7 Dr Taylor explained that although she had previously been asked to be the event doctor at other events she had only performed the role once or twice. This is because she was usually competing at events and thought it inappropriate to provide medical cover at the same time.[43]

12.8 At some stage during the morning of 5 March 2016, prior to the start of competition, Mr Bates met Mr Keys. Mr Bates did not discuss Mr Keys' qualifications with him. Mr Bates said that he had no understanding of what the medical requirements were in 2016 as the appointment of medical support services was a matter for the organising committee and that he presumed that Mr Keys met the requirements.

12.9 Mr Bates provided Mr Keys with maps and course routes and together they drove around the course in the ambulance to identify difficult vehicle access points. Mr Keys said that Mr Bates mentioned some of the riders included doctors and nurses and persons trained in first aid, and they would assist if needed. Mr Bates identified a central point in the course for Mr Keys to base himself during the cross country test. Mr Bates said that although he took Mr Keys through the course on Saturday, he did not do the same thing with Dr Taylor due to time constraints and acknowledged that this was a mistake.[44]

12.10 Mr Bates learned for the first time during the inquest that an event official was attempting to contact Dr Janson at the time of Olivia's fall. Mr Bates agreed that this demonstrated a breakdown in communications.[45]

12.11 Dr Cross was asked to comment on the fact that neither Mr Keys nor Dr Taylor was present at the briefing. He said:

> "*My comment would be that's not ideal and I - if I was the doctor I would - I would like to be at that event. It's very important to hear from all the people on the committee of how they're planning to run the event. I would ideally like to go to the course before, particularly if I wasn't familiar with it*".[46]

12.12 Dr Cross was also asked about his expectations of the organising committee contacting the purported event doctor to ensure that the doctor was aware of their obligations. He explained:

> "*I think the duty, duty of care was not delivered. I would hope this would never happen again so I would - I, I don't - I think reading of the documents and hearing the evidence I, I think it was inadequate*".[47]

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[43] 22/5/19 at T4.1.
[44] 16/5/19 at T85.50.
[45] 16/5/19 at T81.4.
[46] 22/5/19 at T32.32.
[47] 22/5/19 at T33.16.

12.13 **FINDINGS:** As noted above, neither the NSW Eventing Organisers Handbook nor the 2016 EA Rules mandated that a doctor was to be present during the cross country test at the 2016 Scone Trials. The indication that Dr Janson was to be the event doctor seems to have been a product of the regular practice of organising committees to request medical practitioners to volunteer their time and services in this capacity. Whilst the willingness of medical practitioners to assist in a volunteer capacity is to be commended, it appears that the absence of a formal process that attended such arrangements caused some shortcomings, and created ambiguity at the 2016 Scone Trials.

12.14 It is unclear exactly how Dr Janson came to be nominated as the event doctor. What is clear, however, is that as late as 4 March 2016 there was an expectation that he would be present. Up until this point there is no evidence to suggest that any confirmation was sought by the organising committee or event officials that he would be present. It was only through a chance encounter with Dr Taylor that it became evident that he would not be present. It is also not entirely clear how Dr Taylor came to be listed as the event doctor. Clearly, this determination was made prior to the pre-event safety meeting, given that Dr Taylor's name was already included on the checklist used by Mr Bates. It seems that Dr Taylor's presence at the event as a competitor was seized on as an opportunity to regard her as the replacement event doctor, even though the evidence establishes that this was never confirmed with Dr Taylor herself. Dr Taylor's evidence suggests that if confirmation had been sought it is likely she would have declined to volunteer as she was competing at the event.

12.15 What is troubling is that despite the change of event doctor, it is clear that this was not communicated to all relevant event officials. At the time of Olivia's fall, attempts were still being made to locate Dr Janson in order to have him attend fence 8A/8B. Again, it was only by chance that Dr Taylor heard a radio broadcast in this regard, advised that Dr Janson was not present, but that she was available to assist.

12.16 The absence of both Mr Keys and Dr Taylor (who was believed to be the event doctor) from the pre-event safety meeting seems incongruous if the purpose of the meeting was to ensure that the cross country test was to be conducted as safely as possible. It can be accepted that financial constraints and the dependence on volunteers are limitations. However, it seems that there is scope to improve this process.

12.17 One way may be with the appointment of an Event Safety Officer. It appears that consideration for such a position first arose as one of the recommendations made in the Scone Trials Incident Review Report. Recommendation 16 recommended the appointment of a Safety Officer at every event whose tasks would include the development of a risk management plan. Mr Tapner expressed surprise that such a position had not already been mandated.[48] Similarly, Dr Cross expressed the view that such an officer could perform a valuable role in risk mitigation and safety by "*optimally treating or managing the inherent risk of equestrian competition to achieve a lower risk according to the ALARA (as low as reasonably achievable) principle*".[49]

[48] Exhibit 1, Supplementary Volume, Tab 1, page 10.
[49] Exhibit 1, Supplementary Volume, Tab 6, at answers 13-14.

12.18 Support for this can also be found in measures undertaken by British Eventing (**BE**), an organisation regarded as a leader in safety and risk mitigation in eventing. Section 3.4 of the *2018 BE Rules and Members' Handbook* provides that a Health and Safety Steward is to be appointed to advise an event organiser on all aspects of health and safety, and is to independent of an event organiser or organising committee.[50] Section 3.7.1 of the *2018 BE Rules and Members' Handbook* also provides for the appointment of a Technical Advisor for all events, whose responsibilities include all technical matters related to an event, and interpretation and application of the relevant BE Rules and Guidelines.[51] Mr Etherington-Smith expressed the view that implementation of a similar position within EA would be a positive step, although noted that there are financial constraints because the system is not an inexpensive one to implement.[52]

12.19 EA submits that the position of any proposed Event Safety Officer and Technical Advisor positions can be incorporated into an expanded position description for a Technical Delegate. EA further submits that in respect of Mr Bates, there is no evidence to suggest that the demands of his role in 2016 meant that he could not perform it adequately and effectively. Whilst there is no evidence to suggest that Mr Bates did not perform his role competently in 2016 (indeed, the evidence generally indicates that he is a diligent, respected and approachable technical delegate) the evidence does suggest that there were certain gaps in the organisational process, such as confirming who exactly was to be the event doctor, and conducting a similar pre-event briefing and course tour to the one conducted with Mr Keys.

12.20 **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian Australia 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.[53]

12.21 **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian Australia that (a) the position description of Technical Delegate 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 Technical Delegates on the role change by way of training seminars; and (c) consideration be given to a national standard providing a reimbursement fee for Technical Delegates.

12.22 **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian Australia 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; and (c) develop a program for the monitoring and review of the performance of Event officials on an ongoing and regular basis.

[50] Exhibit 1, Supplementary Volume, Tab 1E, page 18.
[51] Exhibit 1, Supplementary Volume, Tab 1E, page 18.
[52] Exhibit 1, Supplementary Volume, Tab 2, page 8.
[53] In each Recommendation in these Findings, "Event" means all international and national eventing competitions held in accordance with the *FEI Eventing Rules* or *EA National Eventing Rules* in force at the relevant time.

13. Was fence 8A/8B a safe, rule compliant, and appropriate fence for the two star class?

13.1 A considerable portion of the coronial investigation, and the inquest itself, was focused on whether any aspect of the overall design of the 2016 Scone Trials cross country course, and the design of fence 8A/8B in particular, contributed to the fall suffered by Olivia and Togha. Both specific and overall features relevant to this consideration are discussed below.

General principles

13.2 In 1999 the FEI and the former British Horse Trials Association (now known as British Eventing) convened an international eventing safety committee chaired by the Marquess of Hartington CBE. The committee was convened in the wake of five tragic eventing fatalities in Great Britain in 1999. The subsequent report prepared by the committee in April 2000 came to be known as the Hartington Report. In making a number of recommendations, the Hartington Report noted:

> *A fundamental conclusion which pervades every detailed recommendation is that everything should be done to prevent horses from falling: this single objective should greatly reduce the chances of riders being seriously injured as well as significantly improving the safety of competing horses.*

13.3 It can be accepted that the following principles apply to the cross country test:

(a) The cross country test and show jumping test involve the risk of serious injury as each test involves a rider and horse combination travelling at speeds of up to 40 kilometres per hour, jumping fixed fences with horses weighing up to 600 kilograms;

(b) Within eventing, generally the most serious accidents occur in the cross country test as it involves horses jumping fixed fences at a higher speed than in the show jumping test;[54]

(c) The risk of accidents progressively increases as the level of competition increases due to increased fence heights, course complexity, technical challenges and intensity of competition;

(d) Although the potential for life-threatening injury and death are relatively low, the potential is real and needs to be medically planned for; and

(e) Cross country courses are designed in a way to pose questions of a horse and rider; the questions must be clear so that a horse and rider understands what is being asked of them.

Background to construction

13.4 Sometime prior to 2014 the Scone Horse Trials Organising Committee determined that the cross country course "*needed some improvements from an internationally recognised and well-regarded course designer*".[55] Accordingly in 2014 Mr Richardson approached John Nicholson to provide advice

[54] Exhibit 1, Supplementary Volume, Tab 2, page 8.
[55] Exhibit 1, Tab 18 at [10.3].

about modernising the Scone cross country course. At the time Mr Nicholson was an FEI accredited Level 3/4 course designer and had designed a number of cross country courses internationally.

13.5 Mr Nicholson visited Scone in 2014 and walked the existing course with Mr Richardson. They had discussions about making incremental changes to the course (over about a five year period) due to financial constraints.

13.6 Mr Nicholson returned to Scone in 2015 and made number of changes to the initial portions of the one star, two star and three star courses, including at fence 8A/8B. Mr Nicholson engaged the assistance of Darryl Burgess, a course builder and FEI accredited Level 1/2 course designer (at the time) and Level 3/4 technical delegate. Mr Nicholson and Mr Burgess walked the existing course a number of times. Mr Nicholson provided directions to Mr Burgess regarding where the track for each of the one star to three star courses was to go. Mr Nicholson made only rough sketches at the time and no formal drawings.

13.7 Mr Nicholson planned out three open oxer[56] jumps and two combination jumps prior to fence 8A/8B. Element 8A was to be a post and rails fence whilst 8B was to be an oxer. He felt that because fence 8A/8B was positioned where it was a horse would not be surprised by it, and would be focussed and in rhythm.[57]

13.8 Mr Nicholson directed Mr Burgess as to where element 8A was to be positioned. He then directed that 8B be built at a distance of four strides from 8A. Mr Nicholson said that on flat ground four strides was considered to be 18 metres. However because of the downhill terrain, Mr Nicholson considered a horse would lengthen its stride as it approached 8A, meaning that it would land a further distance away from 8A than if it had jumped it on level ground. On this basis Mr Nicholson considered that it would have been dangerous to leave the distance at 18 metres. Accordingly he made the distance 19.5 metres "*so that 8B could be jumped in full strides not half strides*".[58]

Applicable rules

13.9 Both elements of fence 8A/8B complied with Section 546 of the 2016 EA Rules in the sense that the fence defined with boundary flags, and marked with numbers and letters. It also complied with Section 547 of the 2016 EA Rules relating to obstacles in the sense that it was fixed and imposing in shape and appearance, and could be quickly dismantled if a horse was to become trapped or injure itself. Further, it also met the dimension requirements set out at Section 547.3 and Annex B of the 2016 EA Rules. Relevantly, Annex B imposed a height limit of 1.15 metres for a fixed obstacle on a two star course. The height of element 8A was 1.10 metres, whilst the front rail of element 8B was 1.10 metres with the back rail being 1.13 metres.

[56] An oxer, also known as spread, consists of two verticals parallel to each other but set at varying distances apart in order to make a jump wider. Each vertical contains one or more rails. Depending on where the rails are set, an oxer can be known as a parallel, ascending or square oxer. An ascending oxer is where the front rail is set lower than the back rail. This is usually done so that the oxer fits in with a horse's bascule, the natural round arc a horse's body forms as it goes over a jump. A square oxer is where both the front and rear rails are parallel to each other, and the height of the fence is the same as its width.

[57] Exhibit 1, Volume 2, Tab 2 at [33].

[58] Exhibit 1, Volume 2, Tab 2 at [35].

13.10 The Preamble to the 2016 EA Rules states:

> *Although these Eventing Rules set out the detailed rules of the FEI for international Eventing Competitions, they must be read in conjunction with any other FEI Rules and Regulations, including but not limited to:*
> *…*
> *FEI Eventing Cross Country Guidelines*[59]

13.11 It should be noted that no document titled "*FEI Eventing Cross Country Guidelines*" appears to exist. Rather, it has been taken to mean that this is a reference to the FEI Guidelines.

13.12 Under the heading, "*Some simple guidelines for all levels*" the FEI Guidelines provide:

> *The aim of the [course designer] is to provide a suitable test for the level of Competition without exposing Horses and Athletes to a higher risk than what is strictly necessary to produce the right test for that level.*
>
> *Any/all questions must be fair. It is not acceptable to try to catch Horses out using unfair distances or by trying to be too clever or over complicated.*[60]

13.13 It should also be noted that nowhere in the 2016 EA Rules is any mention made of the EA Guide. This appears to be somewhat surprising given that this document almost replicates exactly the FEI Guidelines.

13.14 The Preamble to the EA Guide provides that the Guide itself:

> *"…is a set of standards that the FEI and EA expects [sic] all officials to work and adhere to but not all eventualities are necessarily covered and it is up to the event officials to make decisions based on the fundamental principles of fairness to horse and rider alongside the overall aim of minimising risk. This Guide provides notes for guidance and do not represent a complete guide to course design.*[61]

13.15 **FINDINGS:** The 2016 EA Rules provide that they must be read in conjunction with the FEI Guidelines. No reference is made to the EA Guide. It is entirely unclear as to whether compliance with the 2016 EA Rules also requires compliance with the FEI Guidelines and EA Guide. This is complicated by the fact that whilst the Guidelines and Guide are, by their titles understood to be non-prescriptive, aspects of them are couched in prescriptive, mandatory language. This is an issue which is discussed further below.

[59] Exhibit 1, Tab DB10, page 12.
[60] Exhibit 15, page 7.
[61] Exhibit 1, Tab DB12, page 4.

13.16 Given that the FEI Guidelines and EA Guide are titled as they are, it appears to be the case that the EA Rules do not contemplate that non-conformity with either document amounts to a breach of Rules. However, this is a matter which warrants clarification.

13.17 **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian Australia 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.

Course designer's personal philosophy

13.18 Mr Nicholson explained his design philosophy in this way: "*…you're trying to design a course for the average horse and rider, not for the best and not for the very new, so you're trying to do an average*".[62]

13.19 In evidence Mr Nicholson was asked about what question he was seeking to pose at fence 8A/8B. He said: "*For the rider to come up the hill, turn, get into a rhythm, carry on…Jump A, stay in the rhythm, keep travelling down to B*".[63]

13.20 Overall Mr Nicholson said that he considered fence 8A/8B to be "*quite straightforward*"[64] and there to have been more challenging combinations elsewhere on the course.

Previous experiences in 2015 and examination in 2016

13.21 Mr Rose was asked by Mr Richardson and the Scone organising committee to approve the course design in 2015. He attended two or three weeks before the 2015 event to allow time for changes to be made if he was not comfortable with the new fences. He explained that he walked the course and checked each element of each fence. He eventually concluded that the course complied with the rules[65] and asked appropriate questions of two star riders.[66] In particular Mr Rose said that he strode the distance between the elements and concluded that fence 8A/8B "*was suitable for the level…and the class*".[67]

13.22 Mr Rose said that he approved the course because he was comfortable with it.[68] He said that he knew the venue very well and had probably competed there for 30 years. He said he rode two different horses in 2015 and said that fence 8A/8B "*appeared a good question…a question that I was comfortable with on both of the, the different horses that I had*".[69] Mr Rose further said that he had no issues when he rode fence 8A/8B in 2015 and that he had no concerns for his own safety prior to riding it in 2016.[70]

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[62] 20/5/19 at T10.31.
[63] 20/5/19 at T32.3.
[64] 20/5/19 at T32.26.
[65] Taken to mean the EA Rules, although not explicitly stated in evidence.
[66] 17/5/19 at T29.26-31.
[67] 17/5/19 at T29.41.
[68] 17/5/19 at T31.33.
[69] 17/5/19 at T32.30.
[70] 17/5/19 at T12.2.

13.23 Mr Rose walked the course again in 2016 and strode the distance between 8A and 8B. He formed the same conclusion about distance as he had in 2015. He said that he considered it to be appropriate for the two star level. He said that he saw no problem in 2015 or 2016, from the perspective of a rider and the perspective of a course designer, with either element in fence 8A/8B.[71]

13.24 Mr Richardson said that he saw fence 8A/8B in its dressed state in 2015. He was not competing as he had a broken leg. He said that it was clear to him that the rear rail was higher than the front rail. He said that he did not think a horse would have difficulty identifying the jumps. He watched riders in 2015 and said: "*They just looked to land, ride the distance as it was built and they jumped the oxer coming out and I had no worries that that fence wasn't riding well. I thought it, it rode well*".[72]

13.25 Mr Bates was also the technical delegate for the two star course in 2015. That year, he arrived at the course on the Thursday or Friday preceding the event. He was familiar with the venue as he had ridden there before, but interested in the changes to the course. He walked the course and measured every jump. He said he was comfortable as technical delegate signing off on the course in 2015 as being appropriate and safe as a two star course.[73] Mr Bates re-measured the course in 2016 and also signed off on it as being appropriate and safe as a two star course.[74]

13.26 Christine Bates was the riders representative for the two star course in 2015. She described fence 8A/8B in this way:

> "*…obviously it was a brand new jump. No one had ever jumped that jump in 2015. But I thought it was - the placement of the fence was very good in that you actually travelled uphill and then had a nice curved turn onto the fence. It was obvious what you had to jump. For me there was [sic] no tricks - there was nothing there to try and trick the horse. It was about having the right line, the right speed, and if you had both of those correct it should have produced a good result*".[75]

13.27 Mrs Bates said she walked the distance between 8A and 8B as "*a slightly long four strides*"[76] meaning that she walked it in 21 of her own strides and that, therefore, she had to increase her horse's stride by six to eight inches over four strides. Mrs Bates indicated that this was something that a two star rider would be capable of doing, and expected to do.[77]

13.28 Mrs Bates ultimately described fence 8A/8B in this way:

> "*I had a great ride through there. You know, I found the four strides really easy and, you know, I got to actually sort of sit up and just sit there and the four strides were there. I didn't have to push to get the four strides and I certainly didn't have to wait to get the four. From my horse, at the time in the way he jumped in, it was four nice strides*".[78]

13.29 Emma Bishop was the riders representative for the two star course in 2016. She said that she had no concerns about fence 8A/8B. She explained that her plan was to ride it in four strides and that she

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[71] 17/5/19 at T35.15.
[72] 23/5/19 at T70.34.
[73] 16/5/19 at T91.2.
[74] 16/5/19 at T91.36.
[75] 13/5/19 at T31.20.
[76] 13/5/19 at T66.36.
[77] 13/5/19 at T67.5.
[78] 13/5/19 at T67.16.

needed to plan her approach to the jump in order to be able to execute this.[79] She indicated that the striding on 8A/8B was a particular topic of conversation amongst riders.[80] She also explained that riders were discussing how many strides to ride it in, depending on their horse's stride length and what was most comfortable for their horse. She accepted that a jump might be less intimidating for a rider with her experience than for a less experienced rider.[81]

13.30 The four course design experts (Mr Etherington-Smith, Mr Johnston, Mr Lochore and Mr Tapner) all agreed that it was relevant that if a fence jumped well in 2015, that could be taken into account in assessing the course in 2016, subject to the following:

(a) Mr Lochore emphasised that consideration would need to be given to whether the ground and weather conditions were the same for both years;

(b) Mr Johnston emphasised that there was a need to be mindful of complacency; and

(c) Mr Tapner emphasised that it could be regarded as a variable but was not good enough on its own.

13.31 **FINDINGS:** The evidence establishes that several senior and experienced riders jumped fence 8A/8B in 2015. Further, the riders representatives and technical delegate for both years also gave consideration to the appropriateness of fence 8A/8B. In general terms, there is no evidence to suggest that that any of these persons considered that fence 8A/8B was not an appropriate question for a two star course.

13.32 However, although the previous experience of how fence 8A/8B rode in 2015 and the assessments of conducted of it in 2015 and 2016 are relevant considerations, they are not on their own determinative of the issue. These considerations need to be weighed against other specific considerations discussed in more detail below.

Approach to fence 8A/8B

13.33 The approach from fence 7 to fence 8A/8B involved an ascent up a hill followed by a left-hand turn and then a downhill approach to the first element of fence 8A/8B. The downhill approach was measured as a fall of 0.7 metres over 20 metres, amounting to a 3.5% downhill gradient.

13.34 Mr Nicholson said that there was a lot of room for a rider to make a decision as to how many strides they wanted to give themselves to 8A. He said that a rider could go shorter or wider. He explained the approach in this way:

> "*The slightly lengthening stride was going to come naturally with the slightly [sic] downhill. The uphill approach with the right-angle bend to A balanced the horse, put the horse in a good shape to get a good jump over A, which then maintains the rhythm and balance down to jump 8B. The*

[79] 16/5/19 at T48.19.
[80] 16/5/19 at T48.38.
[81] 16/5/19 at T49.10.

important part is that if they get a good jump over A, B will just come naturally. If you build it so a good jump puts them in trouble at 8B, that becomes tricky".[82]

13.35 Mr Nicholson said that there were more than 20 or 30 metres available on approach and nothing to stop a rider going further out, other than losing time. Mr Nicholson said he expected a horse to travel forward on the approach to 8A, not shorten its stride. He said that he did not expect a horse to jump from a deeper take off than anticipated but agreed that if it did happen it would land closer behind 8A than expected. If this happened, Mr Nicholson said that it would have been better for the rider to sit up and attempt to make 8B in five strides. Despite this Mr Nicholson explained that, consistent with his own design philosophy, he designed fence 8A/8B for the average rider on an average horse.

13.36 Ms Bishop indicated that fence 7 was near the bottom of a hill and that the approach to fence 8A/8B was up a hill followed by a left-hand turn. She described the hill as being in a "*very open paddock*" and that whilst a rider could remain on wide mown track up the hill, "*you could go really wherever you wanted up that hill*".[83] This meant that a rider could make their turn closer to or further away from 8A depending on their own riding plan.

13.37 Mr Rose agreed that a rider could choose their line up the hill, and decide to turn closer to or further away from the fence. The rider could then decide how much distance they wanted in their approach to 8A. Mr Rose estimated the distance from the widest turning point to 8A to be 30 metres, possibly more, and considered that to be a "*lot of room*".[84] Mr Rose drew a distinction between this and the laneway system employed in Europe where paths for riders are usually no more than 10 metres wide. Mr Rose said that in 2015 he considered that there was an appropriate amount of room for two star class riders at all levels to approach the jump appropriately.[85]

13.38 **FINDINGS:** The evidence establishes that the approach from fence 7 to fence 8A provided a rider with sufficient room to determine the distance and number of strides to employ to approach fence 8A, according to their own individual plan.

Vertical with downhill approach is unacceptable / true vertical

13.39 The EA Guide provides that "*for EA competitions true vertical fences should not be used*".[86] The term "*true vertical*" is not referred to in the FEI Guidelines. Mr Tapner, Mr Etherington-Smith, Mr Lochore and Mr Johnston all agreed that the term is not used within eventing to describe a fence.[87] The evidence established that a fence should only be described as vertical or not vertical. It appears that the term true vertical is only used to distinguish a fence with no ground line such as a gate or gatepost.

13.40 Under the heading "*Criteria for evaluating difficulty and risk level*", the FEI Guidelines provide:

Vertical with downhill approach – unacceptable[88]

[82] 20/5/19 at T30.18.
[83] 16/5/19 at T51.30.
[84] 17/5/19 T T29.17.
[85] 17/5/19 at T31.23.
[86] Exhibit 1, Tab DB11, page 30.
[87] 21/5/19 at T21.1-40.
[88] Exhibit 1, Tab DB12, page 19.

13.41 The FEI Guidelines do not define what is considered to be downhill other than noting, under the heading "*A Horse's Perspective*", the following: "*Downhill approach – more difficult because the Horse needs more help from the Athlete to maintain balance*".[89]

13.42 In 2015 the FEI commissioned Charles Barnett to assess the ways in which the risks associated with falls in the cross country phase of eventing could be minimised. The result was the production of document in 2016 titled, "*An Audit into Eventing Incorporating an Analysis of Risk Factors for Cross Country Horse Falls at FEI Eventing Competitions*", commonly known as the Barnett Report. In an analysis of horse falls related to jumping efforts during the cross country test of FEI eventing competitions, it was found that:

(a) There was a significantly higher proportion of horse falls when there was a downhill approach. An uphill approach, conversely, had a slight protective effect compared to approaches on the level.

(b) There was a significantly higher proportion of horse falls when there was a downhill landing and significantly fewer when the landing was uphill.

13.43 There is no dispute that the approach to fence 8A/8B was downhill. As noted already it was at a 3.5% downhill gradient. The question then arises as to whether 8A and 8B can be regarded as vertical fences and if so, whether the provisions of the FEI Guideline applied.

13.44 The evidence relating to consideration of this question may be summarised as follows:

(a) Mr Nicholson sought to describe 8A as an "*an upright type fence*"[90] and not a true vertical. He did not consider it to be a true vertical as the middle rail was forward of the top rail. He said that a true vertical would be a gate or a wall. Mr Nicholson described 8A/8B as being "*very slightly*" downhill and "*not very steep*".[91] He said that the long steady climb and right angles to reach 8A would put a horse balanced and at the correct speed. He agreed that "*the combination at 8A and 8B was slightly downhill so it provided a bit more of a challenge in keeping with a two star course*".[92]

(b) Mr Burgess said that Mr Nicholson wanted 8B to be maximum spread and there to be four strides between 8A and 8B. When asked if there was any discussion about 8A/8B being on a downhill approach, he said: "*There would've been some instruction about where he wanted the A element, but really, the slope downhill was so minor it would hardly matter where you put the A element*".[93]

(c) Mr Lochore said that he did not think that a 3% gradient would be considered downhill, and that a 5.5% gradient was not considerable and not something that would be considered inappropriate at the two star level. He acknowledged that, a 5.5%[94] gradient was possibly not in line with the

[89] Exhibit 1, Tab DB12, page 28.
[90] 20/5/19 at T55.12.
[91] 20/5/19 at T20.21-26.
[92] Exhibit 1, Volume 2, Tab 3 at [33].
[93] 20/5/19 at T73.35.,
[94] Although Mr Lochore referred to a 5.5% gradient in evidence, it has been assumed that this was intended to be a reference to a 3.5% gradient as confirmed by the physical measurements taken.

FEI Guidelines.[95] However, he said that he had designed many courses at the two star and three star level that had not adhered to the guidelines in this respect.

(d) Mr Tapner said that whether the downhill approach could be described as significant or not, the fact remained that the approach was downhill. On this basis he considered that it was inarguable that the FEI Guidelines had been breached.[96]

(e) Both Mr Johnston and Mr Etherington-Smith agreed that fence 8A/8B was not consistent with the FEI Guidelines.[97]

(f) Mr Bates offered this view: "*That's why these are guidelines and not rules because course designers are subject to so many variables and that downhill would be referring to a much a steeper gradient than what that was at 8A/8B*".[98] He explained that the term "*vertical*" was subject to interpretation and that 8A was not a true vertical because the profile of the fence made it appropriate.

(g) Mr Rose did not consider 8A to be a true vertical-faced fence, as it had a sloped profile.[99] He also explained that there was room for interpretation as to what constituted a vertical and what was considered to be downhill with the FEI Guidelines as they are not rules.

13.45 **FINDINGS:** There is no evidence to contradict the principle set out in the FEI Guidelines, and confirmed by the analysis conducted as part of the Barnett Report, that a downhill approach is more difficult and more likely results in a higher probability of horse falls, particularly where there is a vertical with a downhill approach. Even though 8A had a sloped profile in the sense that its lower rail was forward of its top rail, it remained an vertical fence.

13.46 There can also be no dispute that the approach to fence 8A/8B was downhill. Even though the approach was variously described as "*slightly downhill*" and "*not very steep*" these are matters of degree. The FEI Guidelines does not distinguish matters of degree, meaning that the approach to 8A/8B was downhill. Indeed the evidence establishes that Mr Nicholson took this particular aspect of the terrain into account in determining the distance between the two elements at 8A/8B.

13.47 Therefore, as the expert evidence identified, fence 8A/8B did not comply with the FEI Guidelines as it was a vertical with a downhill approach, which made it unacceptable.

Skinny rails

13.48 The rails on fence 8B measured 175 millimetres in diameter. As noted above, Mrs Inglis believed this made them look more like show jumping rails and that a horse would not respect that there was width between them. In other words, a horse when jumping 8B might expect the rail to collapse as it might in the show jumping arena, and therefore exercise less caution, making the possibility of a fall more likely.

[95] 21/5/19 at T49.43.
[96] 21/5/19 at T50.10.
[97] 21/5/19 at T51.14.
[98] 16/5/19 at T98.48.
[99] 17/5/19 at T40.40.

13.49 Mr Nicholson expressed the view that horses normally jump the type of rail used in 8B well, and that the rails were "*not flimsy like a show jump rail*".[100] He went on to explain that if the rails on 8B were to be used in a show jumping arena they would be taken down and replaced, implying that they were not similar to show jumping rails. Mr Nicholson said that if the parent of a rider had expressed concern to him about the size of the rails then he would have asked "*would they like to go and walk the jump with me, and I would explain to them what I think will happen*".[101]

13.50 All of the experts agreed that they would not expect any rail to be less than 150 millimetres in diameter, although they all agreed that a more standard size for a rail would be 200 millimetres.[102] Mr Lochore specifically said that whilst a 175 millimetre rail was on the smaller end of the scale, he did not consider it to be too small.[103] The experts also all agreed that the trend to build fences using rails with a smaller diameter was a product of the increased use of frangible technology. However, all the experts emphasised that frangible technology should not drive the design of particular fence, nor should it be used to justify what would otherwise be an inappropriate fence.

13.51 Mr Bates said that he did not consider the rails to be on the skinny side. He explained that it was a common fence used around the world with similar size timber. Further he explained that identical fences had been constructed at Fence 2 and Fence 4A/4B, which gave the horses a good chance to see them before 8A/8B. Finally, Mr Bates said that the rails were painted white, a colour that is easier for a horse to see, to draw a horse's attention to the top rail.[104]

13.52 **FINDINGS:** The diameter of the rails in fence 8B appeared to be reflective of a worldwide trend at the time that resulted in fence rails with a narrower diameter than had been built previously. It appears that this trend was a product of the advent of frangible technology. The expert evidence establishes that the rails in fence 8B were smaller in diameter than what is regarded as a standard size rail, but still larger than what would be considered the minimum acceptable size. As a result, the available evidence does not establish that the size of the fence 8B rails were so far beyond what would be considered acceptable as to increase the risk of jumping 8A/8B to an unacceptable level.

Colour of the rails

13.53 Mr Nicholson said that he specifically directed Mr Burgess to paint fence 8A/8B white. He explained that there were two reasons for this.[105] Firstly, he wanted the fence to stand out because it was positioned amongst trees which would (depending on the time of day and direction of the sun) place the fence in shade. He explained that colours other than white might make the fence difficult to read in circumstances where a horse might need some time to adjust to the shade. Secondly, he wanted the focus to be on the top rail so that it was clear that there were two elements. Overall Mr Nicholson said that in his view the "*the picture was clear*" at fence 8A/8B.[106]

13.54 Mr Nicholson did not accept the possibility that the white rails made it difficult for a horse to distinguish that fence 8B was an oxer. He said the back rail was clear and able to be seen from a

[100] 20/5/19 at T26.38.
[101] 20/5/19 at T26.45.
[102] 21/5/19 at T34.1-T35.32.
[103] 21/5/19 at T35.45.
[104] 16/5/19 at T70.26.
[105] 20/5/19 at T27.18.
[106] 20/5/19 at T33.20.

distance, and that it was clear that there were two rails. In contrast, he said that if one rail had been painted a different colour it might have looked confusing.[107]

13.55 Mr Etherington-Smith said that he would not have painted the rails different colours. Overall he said that he was "*perfectly happy*" with the colouring and that he "*probably would have done the same*".[108] Mr Johnston considered that the fence contained sufficient distinction.[109] Mr Tapner agreed that the white colour was a risk mitigation feature to ensure that the fence stood out in the shade. However, he considered that this mitigation could have been enhanced further if the fence had been painted in two different shades of white.[110]

13.56 Mr Bates did not accept that the profile of fence 8B and the white rails might be confusing for a horse. He explained that it is usually accepted that two clear strides is sufficient to allow a horse "*to get its eye on*" a fence and that, in this case, there were four clear strides to 8B.[111] However he accepted that if both rails on an oxer were painted white there was the potential for them to appear blended together.[112]

13.57 **FINDINGS:** The rails on fence 8A/8B were deliberately painted white as a risk mitigation feature to distinguish the fence in shade and to keep the focus of a horse on the top rail. Notwithstanding, it would have been possible to enhance this risk mitigation even further by painting the rails in different shades of white. This would have had the effect of more clearly distinguishing the rails from one another.

Ground line

13.58 No ground line was used at fence 8A/8B. Although there was approximately 75 millimetres of red bark chips around the base of both posts at 8B, Mr Burgess explained that it was placed purely for decoration and not intended to be a ground line.

13.59 Mr Nicholson said that he gave consideration to using a ground line. However he eventually considered that one was not required because the downhill approach (being only slightly downhill) was not significant enough to warrant one. He said that it was more important to keep the top of the fence in focus from the first to the second element.[113]

13.60 Mr Burgess indicated that if he had been the course designer from the outset then he probably would have instructed a course builder to create a ground line because he had always done so before in order to make a jump safer.[114]

13.61 Mr Bates said that he did not consider that a ground line was required. He said that the sloped fence profile created the shape of a fence in the same way that a ground line does.[115] He explained that the white colour and flowers on the side of the fence help a horse focus and clearly read both the top rails.

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[107] 20/5/19 at T36.23.
[108] 21/5/19 at T53.1.
[109] 21/5/19 at T53.29.
[110] 21/5/19 at T60.22.
[111] 16/5/19 at T71.40.
[112] 16/5/19 at T76.45.
[113] 20/5/19 at T35.17.
[114] 22/5/19 at T71.41.
[115] 16/5/19 at T76.22.

13.62 The expert evidence may be summarised as follows:

(a) Mr Johnston said that he would have built the fence with a ground line, and that doing so would have made the fence better and safer.[116] He described the use of a ground line was a well-accepted risk mitigation strategy in 2015 and 2016.[117]

(b) Mr Etherington-Smith also said that he would have used a ground line and frangible technology. He said that he would have done so because it would have helped to mitigate risk.[118]

(c) Mr Lochore said that he would have used a frangible device and that he probably would have also used a ground line. Mr Lochore agreed that the use of a ground line would have been an appropriate risk mitigation strategy in the absence of frangible devices.[119] Mr Lochore said that he would also, like Mr Johnston, have considered the fence to have benefitted from having trees at the side and slightly forward. He said: "*I consider that fence to be a perfectly safe jump. I do not think it is a dangerous fence. I think it is a safe jump that would benefit from these additions*".[120]

(d) Mr Tapner said that, at the very minimum, use of a ground line would be an additional safety feature.[121] He added that as it was a long distance, requiring an increase in speed downhill, changing the profile of both fences would have increased safety without increasing difficulty.

13.63 **FINDINGS:** Whilst the use of a ground line appears, from a course design perspective, to be a matter of personal style and design philosophy, the evidence establishes that it is also an appropriate risk mitigation strategy. If this is the case, then risk mitigation should clearly take precedence over matters of personal course design style. Whilst the evidence establishes that fence 8A/8B could be regarded as a safe fence without a ground line, it also establishes that it could have been made safer with one. Whilst it is not possible to entirely eliminate risk in a sport which carries considerable inherent risk, it has been readily acknowledged that the goal should be to minimise risk where possible. The use of a ground line at fence 8A/8B would have achieved this goal.

Number of strides between elements / true distance

13.64 The distance between the two elements of fence 8A/8B was a particular focus of the evidence in the inquest. Essentially the question arose as to whether the distance was a true distance. The concept of true distance is referred to in the FEI Guidelines but not defined other to identify that anything four strides (18 metres) or less must be on a true distance. Therefore it is convenient to begin consideration of this question with what the evidence established regarding the concept of true distance.

13.65 Mr Rose noted that a true distance is not a set measurement. He explained: "*…a true distance is a distance between two fences where you are not trying to ask somebody to change the amount of strides between those two fences*".[122] He went on:

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[116] 21/5/19 at T57.43.
[117] 21/5/19 at T101.32.
[118] 21/15/19 at T58.5.
[119] 21/519 at T59.12.
[120] 21/5/19 at T59.43.
[121] 21/5/19 at T54.25.
[122] 17/5/19 at T40.23.

"*…a true distance is a distance that puts a horse between two fences on a true stride, not a half stride. And whilst the longer the distance, the greater the distance between two fences, the more variation will happen. It is the rider's responsibility to teach their horse to take the appropriate length of stride. So if I've got a long-striding horse, I need to teach him to be able to collect - him or her - to be able to collect to do a normal stride. And vice versa, if I've got a short-striding horse, I need to be able to teach him or her to take a longer stride to conform to what is normal*".[123]

13.66 Mr Rose explained that this skill is taught to junior riders in any form of jumping is one that is needed for every part of competition. He explained that the skill of adjusting a horse's stride length is a skill practised in real terms in every competition, and that to progress levels a rider needs to change a horse's stride lengths to ensure that the horse can negotiate fences without faults. He agreed that the aim of the FEI Guidelines regarding a true distance is to make it easier for riders to have a clear idea of how they are going to stride with their horses.

13.67 Mr Etherington-Smith offered this definition:

"*A true distance in my world is where the [course designer] sets out a three or four stride distance, for example, it is expected that athletes would ride that on three strides and four strides. Where you offer the athletes the opportunity of a longer distance, maybe five, six, seven, eight strides, then that's not what we call true distance because an athlete can choose to do something else*".[124]

13.68 The evidence established that apart from Mrs Inglis' views about the distance between the elements at fence 8A/8B, other riders were also considering this issue. Mr Bates noted:

"*I do recall hearing some talk that a number of less experienced riders thought the distance between Fence 8A and 8B was long, which caused me to double check the distance prior to the event. I had confidence in the combined experience of the course designer, course builder and myself that the distance was correct. It was only slightly longer (19.0m) that a regulation Show Jumping distance (17.7m-18.9m) would be on flat ground*".[125]

13.69 In evidence Mr Bates said that he probably heard this feedback in both 2015 and 2016. He said that he could not recall the circumstances in which he heard it but that it may have been communicated by another official. As a result of what he heard he said that he discussed the issue (and the course as a whole) with Mr Burgess and Mr Richardson.[126] Mr Bates said he re-walked the distance and did not consider it to be an issue. He said that it was more likely that he had a discussion about the fence in 2015 as it had not been jumped before and there was usually more discussion about new combinations.[127] Mr Lochore, Mr Etherington-Smith, Mr Tapner and Mr Johnston all considered this response from Mr Bates to have been appropriate.

13.70 Mr Nicholson said that he was aware that four strides for an average horse is 18 metres on level ground. He said that he deliberately made the distance from 8A to 8B to be 19.5 metres "*because the horse could keep travelling with the slight downhill and the fact that 8A did not have top-spread, the*

[123] 17/5/19 at T33.10.
[124] 21/5/19 at T11.48.
[125] Exhibit 1, Tab 24 at [11.3].
[126] 16/5/19 at T68.43.
[127] 16/5/19 at T69.44.

horse will land further behind 8A and the ground will allow it to keep moving down in the same rhythm to jump 8B".[128]

13.71 Mr Nicholson did not accept that the striding between the two elements was challenging for less experienced riders. He explained that if the distance had been three strides then riders would have to do everything quickly. However, because the distance was four strides it gave riders the ability to sit up or to ride forward.

13.72 Mr Nicholson also did not accept that the striding between the two elements meant that there was no margin for error. He said that "*a rider needed to approach 8A knowing what it wanted to do to get to 8B and it is like that with a lot of the cross-country jumps*".[129] However he did agree that it would have been more difficult for a less experienced rider to navigate the combination if their horse made an error on the first element.[130] He disagreed that there was insufficient distance for a horse to run off if an error was made and referred to the ability of a horse to run off in a one-stride combination.

13.73 Mr Nicholson said that he did not seek similar feedback from less experienced riders, but said that he spoke to Mr Burgess, who was watching the competition, who told him that it rode well. Mr Burgess himself said that he watched four or five riders jump fence 8A/8B in 2015. He said that of the riders he watched "*they all went through safely and with a rhythm and it jumped nicely*".[131] He said that he was able to count the strides that it was ridden in and counted four strides.[132] Mr Nicholson agreed in hindsight that it could have been good practice to ask less experienced riders how they felt about a new jump on a course.[133]

13.74 Mr Nicholson said that as course designer he expected to be told if less experienced riders expressed concerns about the course. He said he was not aware that less experienced riders appeared to be discussing amongst themselves what striding was required. He said that had he been made aware of this he would have gone back to walk the distance to make sure he was happy with it, and "*maybe offered to walk it with the riders and explain what I thought was going to happen*".[134]

13.75 Mr Rose's evidence on this issue may be summarised as follows:

(a) He said that in 2015 he had no concerns about the striding with fence 8A/8B, that it was "*clearly four strides*", and that he jumped the fence with both horses he was riding in the two star class in four strides.[135]

(b) He did not accept that the distance between 8A and 8B was not on a true distance.

(c) He explained that whilst it was possible that a less experienced rider within the two star class might have more difficulty with the striding, he did not think that this was necessarily the case. He placed greater weight on rider ability, as opposed to experience.[136]

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[128] 20/5/19 at T21.3.
[129] 20/5/19 at T31.31.
[130] 20/5/19 at T31.42.
[131] 22/5/19 at T73.26.
[132] 22/5/19 at T73.39.
[133] 20/5/19 at T22.29.
[134] 20/5/19 at T25.26.
[135] 17/5/19 at T32.35.
[136] 17/5/19 at T19.43.

13.76 Mr Bates' evidence on this issue may be summarised as follows:

(a) He said that he saw competitors in 2015 jump fence 8A/8B in four strides. He said this was consistent with his measurement prior to the 2015 event.

(b) He said that although he heard talk from other riders in 2015 about whether 8A to 8B should be ridden in four or five strides, he did not hear rumours that suggested that the jump could not be jumped safely, or that the way in which it was built would be misinterpreted in some way by a horse, or that young riders viewed the jump as inappropriate.

(c) He said that he disagreed with the view that the distance between the elements was not a true distance. He explained: "*My definition would be that if you approach the fence…at a two star appropriate speed, with the correct speed and the correct line, then the horse would take that number of strides, the true distance. There's no way anyone would have planned to ride that in three strides and there's - the only way someone would have planned to ride that fence in five strides, is if they were in trouble over the A element and had a change of plan or if they were on an inexperienced horse at the level or a particularly short-striding horse. It could easily be ridden in five strides if you wanted to but it was designed to be ridden in four strides, four forward strides, and it was a true distance in my mind*".[137]

(d) It was indicated to Mr Bates that Stuart Tinney (an elite level rider who has previously represented Australia in eventing at the Olympics, and a course designer) who was to ride in the two star class at the 2016 Scone Trials, had actually planned to ride one of his horses in five strides. However he said that for someone of Mr Tinney's expertise there would be a reason why he would do that – most likely because he was riding an inexperienced or short-striding horse.

(e) He said that as a technical delegate he would have no difficulty with the same fence being used again. He said: "*It was appropriate for all the varying factors surrounding that combination. If you built the fence again you'd build it in the same distance*".[138]

13.77 The expert evidence may be summarised as follows:

(a) Mr Tapner said that the distance measured (of 19.5 metres), "*by itself would be considered the long four-stride distance but still within the realms of being true but right on the very extremities. At the [19.94] that I've seen measured out then it's right on the borderline of four and a half strides*".[139]

(b) Mr Johnston was asked whether he considered the stride distance to be safe. He said that he had not walked the distance himself. Instead he deferred to the experience of Mr Nicholson, Mr Burgess, Mr Rose and Mr Bates who all walked the distance and said that they were comfortable with it.

(c) Mr Etherington-Smith walked the course in 2019 prior to the inquest. He said that whilst fence 8A/8B was no longer in situ, rails had been laid on the ground to replicate the position of the

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[137] 16/5/19 at T74.37.
[138] 16/5/19 at T75.15.
[139] 21/5/19 at T41.37.

elements. As to the stride distance he said: "*I am perfectly satisfied as a course designer and as a former technical delegate of the highest level of the sport the distance was absolutely acceptable*".[140]

(d) Mr Lochore explained that he conducted his own experiment with respect to the stride distance. He said that he firstly asked his wife to ride an inexperienced horse over distances of 19.5 metres and 60 feet on level ground. He explained that the horse was able to quite comfortably able to negotiate each distance in four strides, although it had to work a bit harder at 19.5 metres than at 60 feet. Secondly, he measured out what he thought to be four strides over terrain similar to what he considered the gradient to be at Scone at fence 8A/8B. He explained again that his wife on the same horse was able to ride it comfortably in four strides. Further, he explained that he deliberately only measured the distance after the experiment and found it to be 20.2 metres. In other words, it was slightly more than the upper limit of 19.94 metres measured between 8A and 8B.

13.78 Further, Mr Etherington-Smith said that if he had heard that Mr Tinney was going to ride it in four and five strides, this would not have made him question whether less experienced riders might not have been able to navigate it. Mr Lochore also said that this comment would not have concerned him. He said that it was common to hear riders saying that they would take out or add a stride when discussing the number of strides to jump a fence. Additionally, Mr Lochore, Mr Etherington-Smith and Mr Johnston all agreed that Mr Tinney's plan to ride a green horse in five strides did not suggest that the distance between 8A and 8B was not true.[141]

13.79 However Mr Tapner disagreed with this. He explained:

> "*But I can assure you that would normally be considered a mistake, not a plannable option before you've even started the course. And if a rider of Mr Tinney's experience was forced into planning that on an inexperienced horse, then that gives me great concern that an inexperienced horse is not going to understand the question posed as set by Mr Nicholson and - which, which takes us back to my interpretation of that fence being, you know, a lot more difficult than what Mr Nicholson's interpretation of that fence. So, if you had an inexperienced horse that you felt that wasn't going to cope with that question then that, you know, if it's a, if it's a two star horse it should be able to cope with that question. So, the fact that Mr Tinney is, is taking such evasive action to avoid the - what Mr Nicholson claims is a very clear question and a very true distance then that poses alarm bells in my head based on my own assumption of the, of the, of, of all of the variables of that jump*".[142]

13.80 Mr Tinney himself said: "*No, I wasn't making it more difficult for the horse and myself. It was a more difficult line to ride skill level wise, but I thought I was actually making a better decision for my horse, not a more difficult one*".[143]

13.81 On 15 May 2016 Samantha Farrar (the safety consultant tasked to assist the Scone Incident Review Panel) sent Dr Vincent Roche (chair of the Review Panel) an email regarding a discussion that she had with Mr Tinney on 10 May 2016. In the email Mrs Farrar wrote:

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[140] 21/5/19 at T43.20.
[141] 21/5/19 at T83.17-23.
[142] 21/5/19 at T86.31.
[143] 24/5/19 at T19.41.

"*I discussed the fence with Stuart Tinney over the phone on Tuesday this week (after speaking to Karen). He said that fence at Scone was 4 and a half strides. He said that he was intending to ride it in 5 strides, and Gemma (his daughter) was going to ride it in 4 (different horses with very different striding). He thought it was a little tough/tricky for 2*…Stuart also thought the combination (8a/8b at Scone) was extra tricky because it was off a turn*".[144]

13.82 Mr Tinney was taken to this email. He agreed that he intended to ride fence 8A/8B in five strides and that his daughter, Gemma, intended to ride it in four strides.[145] However he said that he did not recall walking the distance between the elements in four and half strides. He agreed that some jumps have half strides on courses above the 2 star level. He agreed that a course designer *should not* put half strides on a 2 star course and that they should *never* be put in a one star course.[146] He explained: "*I don't know whether I ever did think it was four and a half strides. I knew it was long and I was planning on riding it angled slowly and bent. I wouldn't do all of that if it was - I wouldn't need to do all of those three things if it was four and a half*".[147]

13.83 Mr Nicholson said that he was surprised when told that Mr Tinney intended to ride one of his horses in five strides and another in four strides and said, "*but Stuart is a professional rider and he knows his horses. But I would have thought that five strides at 8AB would not have been that easy to do, and he must have had the intention of doing it early to adjust the stride*".[148]

13.84 **FINDINGS:** The issue regarding the stride distance between the elements at fence 8A/8B and whether it was on a true distance divided opinion during the inquest. No clear evidence emerges to provide an unequivocal determination about the issue. However, if the definition of true distance is that a rider will ride a fence in the same number of strides that a course designer intended the fence to be ridden, then the available evidence tends to indicate that the distance between the elements at fence 8A/8B was so open to interpretation as not to be on a true distance.

13.85 It is acknowledged that Mr Bates, Mr Rose, Mr Etherington-Smith and Mr Lochore all considered the distance between 8A and 8B to be on a true distance in the sense that it was intended to be ridden in four strides. Mr Nicholson himself intended this to be the case. Further, observations of riders actually riding the course and striding the distance itself confirm this.

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[144] Exhibit 23.
[145] 24/5/19 at T2.48.
[146] 24/5/19 at T4.2.
[147] 24/5/19 at T3.2.
[148] 20/5/19 at T24.35.

13.86 However, the evidence establishes that some riders in both 2015 and 2016 were discussing in how many strides fence 8A/8B was to be ridden. Whilst discussion amongst riders about how to ride aspects of a course is not an uncommon feature of preparation for competition, this particular discussion caused Mr Bates to double check the distance. That in itself tends to suggest that the issue was something more than a general discussion as part of rider preparation. Further, the views expressed by Mr Rose and Mr Tinney are obviously views of experienced and elite level riders. It is to be remembered that the discussion heard by Mr Bates involved less experienced riders. It can be inferred that whilst more experienced riders may not have had difficulty with determining the stride distance for 8A/8B, this may have posed a more difficult question for less experienced riders. This tends to support Mr Tapner's view that fence 8A/8B was more difficult than Mr Nicholson's interpretation of it.

13.87 The intention of Mr Tinney to ride fence 8A/8B in five strides was clearly surprising to Mr Nicholson. He considered that it would not have been an easy thing to do. Although Mr Etherington-Smith, Mr Lochore and Mr Johnston all considered that Mr Tinney's plan was not concerning and not indicative that the distance between the elements was not on a true distance, it remains the fact that it was contrary to the way in which the course designer intended 8A/8B to be ridden.

13.88 Further, Mr Tinney expressed a degree of uncertainty about whether he told Mrs Farrar that the distance between the elements was four and a half strides. In this regard, Mrs Farrar's contemporaneous written records are considered to be more likely reliable than Mr Tinney's recollection of a conversation some three years later. If Mr Tinney did indeed regard the distance as being four and half strides, this is consistent with the views of some riders in 2016 who considered the distance to be long.

13.89 EA submits that the evidence of Mr Tinney and Mr Rose should be given more weight and preferred over the evidence of Mr Tapner. However this is a case where the record of Mr Tinney's conversation with Mrs Farrar is consistent with the opinion expressed by Mr Tapner.

13.90 Overall, the various aspects of the evidence raise considerable doubt about whether fence 8A/8B was on a true distance. On balance, the overall evidence establishes that it was most likely not on a true distance.

Spread as the last element

13.91 The FEI Guidelines provide that "*special care must be taken when using spread fences as the last element of a combination as they could be very punishing for a Horse in trouble in the combination*".

13.92 Mr Nicholson acknowledged that he was familiar with this principle and in evidence said that if he had designed fence 4A/4B with a spread as the second element then it would have been punishing and unacceptable for a horse. Mr Nicholson was asked twice whether he considered fence 8A/8B would have been similarly punishing, given that 8B was also a spread. On both occasions, Mr Nicholson did not directly answer the question asked. He said that he had trouble answering the question[149], and when asked whether the spread as the second element meant that fence 8A/8B

[149] 20/5/19 at T37.2.

represented a risk for less experienced riders, he replied globally, "*all cross country jumps carry a risk*".[150]

13.93 Mr Rose said that he was aware of the FEI Guidelines and gave them consideration. He said that he still considered 8B to be acceptable because the top rail was ascending, it was not a maximum width fence, and the distance was a good distance. He opined that if a horse got into trouble in the first element there was enough room to give the horse the ability to correct themselves in order to safely negotiate the second element.

13.94 Mr Bates said he considered the fact that a spread was used in the 8B element. He was asked if any special care was taken because of this. He said:

> "*Well, it was a very straightforward combination and it was in a dead straight line. There was nothing complicated about it and it wasn't a - it's quite common to have spreads as the last element of a combination. It happens all the time*".[151]

13.95 Mr Bates said that he was not concerned that a horse might misperceive fence 8B. He said that the back rail was clearly higher than the front rail, and the downhill approach allowed this to be seen clearly.[152] He said that even if the approach had been on level ground it would have been "*pretty clear*" for a horse to see that fence 8B was an oxer.[153]

13.96 Mr Burgess said that he knew that the back rail should have been approximately five centimetres higher, and that "*ideally it should've been*".[154] He said that he intended the back rail to be five centimetres higher and measured it with his spirit level but was unable to explain the discrepancy in that it measured only three centimetres in height difference.

13.97 Mr Lochore, Mr Etherington-Smith, and Mr Johnston all agreed that 8B could be described as an ascending oxer. In particular Mr Etherington-Smith agreed with Mr Johnston and said that the top rail definition was very clear and the gentle downslope increased the visibility of the back rail. He said that he had no doubt that the definition of the top rail was very clear.[155]

13.98 Mr Tapner agreed that the back rail was clearly visible in separation to the front rail, but did believe that it could be clearer. He agreed with the other experts that the downhill slope made the back rail more visible. However, he did not agree that it was an ascending oxer and still considered it to be a square oxer. This is because he believed that a horse's interpretation was that it would be square because it was not going to recognise the 3 centimetres in difference between the front and back rail. He said that he did not believe that it was clear that the back rail was higher than the front rail.[156]

13.99 Mr Etherington-Smith explained that horses will jump out with freedom when they see a big open space in front of them, and will not jump with suspicion or feel claustrophobic. He explained that the gentle downslope and open space meant that a horse would jump out with freedom and that if he

[150] 20/5/19 at T41.27.
[151] 16/5/19 at T95.49.
[152] 16/5/19 at T71.6.
[153] 16/5/19 at T71.49.
[154] 20/5/19 at T74.7.
[155] 21/5/19 at T90.25.
[156] 21/5/19 at T100.29.

had been the technical delegate he "*wouldn't even have thought twice about it*".[157] Mr Lochore and Mr Johnston also agreed with this. Mr Johnston explained it in this way: "*The horse, the horse is a bit looser, you know, it's, it's able to, to jump in a way that's given it the best possible jump as opposed to, you know, if it's quite heavy and shadowed they're more likely to keep their head down so they're probably not going to go up as high so but you know, if it's open and free, they're going to give a good jump out*".[158]

13.100 Mr Tapner agreed with Mr Etherington-Smith's explanation for fence 8B. However, he said that it was possible that the converse was true for 8A. He explained: "*I think that at fence 8A that the reverse is, is quite potentially possible. That, that might in fact hold the horse up, exactly what Mr Johnston said. That if you're in an enclosed area, if the, the area is busy, the horse is more likely to either jump lower or - there's more room for error, or the, the horse will jump more conservatively or as [Mr Etherington-Smith] said, it will travel more conservatively. In which case indicates they would have a shorter stride. So at fence 8A, in exactly the converse to what that concept is about, though, I believe that that there is a potential for the horse to reduce its willingness and it's [sic] freeness or whatever terminology you want to do*".[159] He accepted though that he was not aware of any suggestion that any rider had any difficulty jumping 8A.

13.101 **FINDINGS:** Mr Nicholson's inability to directly answer a question about whether having a spread as the last element in fence 8A/8B is somewhat troubling. If the fence was specifically designed that way then it could be expected that the course designer would be able to easily convey his or her reasoning for doing so. Exactly why this could not be done by Mr Nicholson is unclear.

13.102 What is clear is that there is a difference of opinion between experienced course designers and a technical delegate on the one hand, and a former elite level rider on the other. The evidence establishes that a horse would have been able to see the rear rail at fence 8B and identify that it was a spread fence. The issue is whether a horse in seeing the rear rail would also have noticed that there was a difference in height between the front and rear rails. The combined weight of the evidence tends to suggest that a horse would have been able to make this distinction.

13.103 However, the actual difference in height was two centimetres less than what was intended. The reason for the discrepancy is unclear. If fence 8B had been constructed with a five centimetre difference in height as intended, this would most likely have left no doubt as to whether a horse would be able to perceive that 8B was an ascending, and not a square, oxer.

Spread fill

13.104 Mr Nicholson said that he gave no consideration to filling in the spread because he felt the back rail was clear to see and visible from a long way away, and clearly higher.[160] He said that he did not accept that because the back rail was also painted white it was difficult to see that there was a spread. In contrast he said that if one rail had been painted a different colour it would have looked confusing.

[157] 21/5/19 at T89.38.
[158] 21/5/19 at T97.3.
[159] 21/5/19 at T101.23.
[160] 20/5/19 at T35.43.

13.105 Mr Etherington-Smith said that he was "*perfectly comfortable*"[161] with the whole fence. Mr Lochore also said that he was perfectly comfortable with the fence and that he would not have filled the spread. He said that he did not think that this would have made the fence safer and that often open type fences are jumped better.[162] Mr Johnston said that he might have put some pine trees either side but that he would not have necessarily filled the oxer part of the fence.

13.106 Mr Tapner summarised his views in this way: *"…all of the risk variables that can be changed in the fence - whether that's a ground line, fill in the front, fill in the top spread, more ascending nature or different colours of rails, the - none of them have been used, one of them would have been nice*".[163] He said that by doing so would not change the difficulty of the fence as it would still pose the same question. But he emphasised that the point was to mitigate risk and make the fence safer.

13.107 **FINDINGS:** There was again a dispute in the evidence about whether filling in the spread at fence 8B would have amounted to risk mitigation so as to make fence 8A/8B safer. The combined weight of the evidence on this particular issue, and the evidence above establishing that the rear rail on 8B would have been clearly visible, means that it is unlikely that filling in the spread would have amounted to an increased safety feature.

Frangible technology

13.108 Following a number of eventing fatalities internationally leading up to 2000, research was conducted into means by which risk could be mitigated and the possibility of serious injury or death from rider falls reduced. This led to the development of frangible technology. This technology employed the use of pins and, later, clips on fences. The pins and clips are activated by the application of directional forces caused when a horse impacts with a fence. When activation occurs, all or part of a fence collapses.

13.109 It appears that frangible technology was first introduced in Great Britain in about 2002 and had become widespread by about 2006. Following this, it is evident that frangible technology was not introduced in Australia. Judy Fasher, the former Chair of the EA Board, explained: "*It was a question of first of all cost, but secondly the evidence that was available through the FEI, which was that in those, at that time there was no evidence that they improved the falls. And in fact there was evidence, and it was stated in the earlier reports, that sometimes it was thought that they caused falls. In the Crawford Report those two issues could not be separated*".[164]

13.110 It appears that formal consideration of frangible technology by EA occurred shortly after November 2015. At that time Ms Fasher attended an FEI General Assembly where aspects of frangible technology were discussed. This appeared to generate wide discussion amongst course designers and organising committees, but eventually EA did not commission its own report to investigate the viability of frangible technology. Ms Fasher agreed that it was not until the accidents involving Caitlyn and Olivia that there was any serious momentum to introduce frangible technology in Australia.[165]

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[161] 21/5/19 at T52.6.
[162] 21/5/19 at T53.15.
[163] 21/5/19 at T53.42.
[164] 22/7/19 at T12.35.
[165] 22/7/19 at T12.30.

13.111 It was not until February 2018 that EA amended the EA Rules to mandate the use of frangible technology. Section 547.2.4 of the 2018 EA Rules provides:

> *In 2*/3*/4*/5* courses whether for national or FEI competition in Australia, all fences that can be fitted with frangible devices MUST be fitted with frangible devices. These include all open corners, open oxers, verticals or near verticals with open rails, top rail on triple bars and gates where the rail dimensions and weight fit the acceptable parameters of an approved frangible device.*

13.112 Roger Kane, the EA National Safety Officer, explained that the current EA Rules do not mandate use of frangible technology on fences that are able to support them on one star courses because "*when we looked at the situation originally, we, we basically looked at where serious - well, what we did was, data on serious injury is difficult to obtain on a worldwide basis, so we looked at data that was available on deaths and using them as a, a proxy for serious injury over the last, I think we looked back eleven years. Almost of those deaths - I think with one exception - had occurred in two star and above competitions, so that's why we focused on that as a place to, to focus on*".[166] When asked if there was a plan to ultimately include one star competitions he explained that this was under review.

13.113 Mr Nicholson was asked whether he considered the use of frangible technology prior to 2016. He explained: "*I gave thought to it but they don't totally stop horse falls and you still have to put the jump in the right place. By putting a frangible device on a jump does not make it acceptable*".[167] When asked if this demonstrated a degree of scepticism on his part Mr Nicholson said that many rotational falls occur do not occur on fences that are not capable of being made frangible. Further he sought to explain that frangible technology can only be used on certain fences and that the FEI had been considering other safety improvements such as softening the profile of fences. Despite evidence of the reduction in a the number of fatalities following the introduction of frangible devices in 2002, Mr Nicholson did not accept that he and other designers were slow in accepting the significance of the technology. Rather, he explained, he was following the trials being conducted using frangible technology.[168]

13.114 Mr Burgess said that he knew that fence 8A/8B could have been made frangible but that he gave no consideration to this in 2015 as that was a matter for Mr Nicholson as course designer. He said simply that "*the discussion did not come up*".[169] Mr Burgess indicated that to his knowledge only two course designers (Ewan Kellett and Wayne Copping) in Australia had made use of frangible technology prior to 2015 and so "*nobody actually gave it a lot of consideration*".[170] However, he said that if he had been the course designer he would have given consideration to making 8A/8B frangible, but probably would not have eventually done so. He explained why: *"They weren't that available. And most country clubs don't have the finances or the - to buy them. You can't get them unless you get them - order them three months earlier. You can ship them out from England. No-one's supplied them in Australia*".[171]

13.115 Both Mr Etherington-Smith and Mr Lochore stated that following the Hartington Report they commenced using frangible technology in their courses as soon as it became available. This was

[166] 24/7/19 at T18.5.
[167] 20/5/19 at T12.5.
[168] 20/5/19 at T13.34.
[169] 22/5/19 at T70.36.
[170] 22/5/19 at T71.1.
[171] 22/5/19 at T70.5.

sometime around 2002 and 2003. Both Mr Etherington-Smith and Mr Lochore said that they would have built fence 8A/8B with frangible technology. However, Mr Lochore emphasised that "*it would not have been uncommon in 2016 and nor would be exceptional in 2019 to see a fence like [8A/8B] without frangible technology*".[172] However, he agreed that if saw a fence like 8A/8B in 2019 without frangible technology he would look for other methods to mitigate risk, with the most obvious method being the use of ground line.

13.116 Mr Lochore, Mr Johnston and Mr Etherington-Smith all agreed that using frangible technology on fence 8A/8B would have made it safer and that its use was an appropriate way to mitigate risk.[173] However, Mr Johnston explained that whilst frangible technology was available, but not compulsory, as at 2015 and 2016 it was not easily accessible and that appropriate devices would have to be ordered in from England.[174] Mr Tapner said that if he was riding the course in 2015 he would have expected that 8A/8B would have frangible technology (and a ground line) "*even if it was in Australia*".[175]

13.117 **FINDINGS:** The evidence establishes that the use of frangible technology was not widespread in Australia in 2016. It is apparent that financial constraints and debate about the effectiveness of the technology in reducing injury were limiting considerations. However, the evidence also establishes that no consideration at all was given to whether frangible technology could have been used on fence 8A/8B.

13.118 It might be argued that with the benefit of hindsight it is easy to assert that such consideration ought to have been given. However, by 2016 the use of frangible technology was widespread in Great Britain and had been discussed at the international level at the FEI. Further, in less than two years following the deaths of Olivia and Caitlyn, the EA Rules had been amended to mandate their use. All of this suggests that some consideration ought to have at least been given to the use of frangible technology on fence 8A/8B. Whether it was practically capable of implementation will never be known, because no consideration was actually ever given to this. However, the evidence establishes that the technology had been used in limited circumstances prior to 2016.

13.119 In the absence of consideration being given to the use of frangible technology on fence 8A/8B, other risk mitigation methods ought to have been considered and utilised. It has already been discussed above that this was only partially achieved.

Overall riders' perspective of fence 8A/8B

13.120 Mr Tinney was asked about the email sent by Mrs Farrar to Dr Roche on 15 May 2016 in evidence. He said that he did not know if he would have used the word "*tricky*" to describe fence 8A/8B but said that "*tough*" or "*difficult*" might have more been the words he used.[176] He said that he would have described it as tough as it was off a turn, "*which makes it harder cause it's off a turn, as opposed to a dead straight line*".[177] Eventually, Mr Tinney conceded that his reflections on the jump were

[172] 21/5/19 at T59.20.
[173] 21/5/19 at T58.41-T59.13.
[174] 21/5/19 at T57.24.
[175] 21/5/19 at T55.42.
[176] 24/5/19 at T3.32.
[177] 24/5/19 at T3.7.

likely to have been clearer in May 2016.[178] However, Mr Tinney clarified that by describing the jump as tough he was not suggesting that it was not an appropriate jump for the two star competition.[179]

13.121 Mrs Farrar herself explained the genesis of this conversation with Mr Tinney. She explained that she was speaking with Mr Tinney's wife, Karen, on the phone at the time and she (Karen) indicated that her husband wanted to talk to Mrs Farrar about the fence. Mrs Farrar said that she appreciated that the view expressed by Mr Tinney was of significance to the review panel which is why she documented it as soon as she could in an email. She said that she was doing her best to accurately record Mr Tinney and that she would not have documented it if it was not an accurate representation of what was said.[180]

13.122 Mr Tapner's overall view about fence 8A/8B may be summarised in this way. Firstly, he said: "*It's my interpretation of that obstacle that I don't believe the majority of horses would have found that combination as easy as Mr Nicholson proposes they will have done…I, I definitely feel that there would be - there is a, a very high likelihood that the, that the majority of average horses would have found that 8A-8B obstacle far more difficult than Mr Nicholson anticipated and he himself said that that happens*".[181]

13.123 Secondly, Mr Tapner said that he "*would be exceptionally unhappy to jump that combination without a discussion with the TD [technical delegate] and the course designer as to how it could be made more safe*",[182] and noted:

> "*We've already heard how our sport is inherently dangerous. Every time you jump a cross-country jump you are increasing the danger, so it's going to be a matter of opinion when a jump becomes unsafe, or when it is safe, because inherently as we have already discussed in this inquest, it's unsafe to jump a cross-country jump to my interpretation of the risk mitigation factors of those jumps is in the weight and balance so how many risk mitigating features or risk enhancing features and variables of that Scone fence can I list and say, 'Well this is how many increased the danger and this is how many decreased the danger.' The only decrease in danger that we've had is the 3 centimetres which was supposed to be 5 centimetres of difference between the front rail and the back rail and that it was painted white to, you know, accommodate the shade. Every other variable or every other risk mitigating feature that is possible is a negative…But in balance of my decision that it's an unsafe jump and my opinion that it's an unsafe jump is that there is far too many variables and far too many - far too many risk mitigating features of the fence that are not in, included versus the, only the, realistically the only two that are included which is the painting which we know can, could have been enhanced by two different shades of white as the rules now state and the 3 centimetres of height difference which to a horse galloping to a fence is not going to be very visible*".[183]

[178] 24/5/19 at T5.43.
[179] 24/5/19 at T21.11.
[180] 24/5/19 at T40.35.
[181] 21/45/19 at T76.47.
[182] 21/5/19 at T56.17.
[183] 21/5/19 at T60.3.

13.124 **FINDINGS:** Allowing for the inherent fallibility of human memory, the contemporaneous email written by Mrs Farrar is more likely to be an accurate representation of her conversation with Mr Tinney on 10 May 2016. There is no evidence to suggest that Mrs Farrar was not an accurate record keeper. Indeed, as is discussed further below, the evidence indicates that Mrs Farrar was a diligent and thorough investigator. If Mrs Farrar's email of 15 May 2016 is an accurate record then it establishes that Mr Tinney held a particular view about the level of difficulty of fence 8A/8B for a two star course.

13.125 The FEI Guidelines set out the following: "*Any/all questions should be fair. It is not acceptable (and a CD should never try) to catch Horses out using unfair distances or by trying to be too clever or over complicated*".[184] The expert evidence established that this is to be taken to mean that a course designer should never set out to try to trick a horse. The question then is whether Mr Tinney's characterisation of the fence as "*tricky*" carries with it the connotation prohibited by the FEI Guidelines.

13.126 Having regard to Mr Tinney's evidence, in which he sought on numerous occasions to explain that he was only trying to convey that the fence was tough (but not inappropriate for a two star course), the conclusion that must be reached is that Mr Tinney's assessment does not equate to an opinon that Mr Nicholson was attempting to trick a horse at fence 8A/8B. However, Mr Tinney's use of the words "tough" and "tricky" to describe fence 8A/8B is consistent with Mr Tapner's view that the fence was more difficult than Mr Nicholson anticipated it to be.

Overall course designers' perspective of fence 8A/8B

13.127 Mr Rose said that it was possible that a combination of factors (striding, downhill approach, white rails) made fence 8A/8B problematic for Togha[185], but that he thought it would be an appropriate jump for another event[186], although he potentially would not design that jump in that position because it was different in style to what he would do as a designer. He summarised his views in this way:

> "*So if you're asking me is, is that something that I think is unsafe or would, shouldn't be repeated, no, I don't think it's unsafe and shouldn't be repeated. Is it something that I would design in that position in that, with that style? No, I don't think I would*".[187]

13.128 By this Mr Rose explained that if the fence was built today it would be built with frangible technology.[188] Mr Rose clarified that his overall view about the safety of the fence was not contingent on the fence being fitted with frangible technology.[189]

13.129 In summary, Mr Etherington-Smith was asked whether he considered fence 8A/8B safe and appropriate for the two star class. He said:

[184] Exhibit 15, page 7.
[185] 17/5/19 at T13.34.
[186] 17/5/19 at T13.45.
[187] 17/5/19 at T14.2.
[188] 17/5/19 at T14.13.
[189] 17/5/19 at T15.13.

"*I'd say it's entirely appropriate for a two star competition and the word safe, I mean, as far as any, any cross-country fences are safe, yeah, I mean, we live in the world of a risk sport. As I said before would I do things differently, yes? But would I have accepted that if I was technical delegate, discussing with the course designer and I take my course design hat off, put my technical delegate hat on, I would ask that the course designer to talk me through it and if I was satisfied with his or her explanation his, in this case, explanation and I was comfortable with that and found it acceptable then, then, yes fine. Decision made*".[190]

13.130 Mr Lochore offered this view in summary:

"*I consider it to meet within the rules as they were set in 2016 and I consider it to be, have been a safe jump. Yes, it was, it was from my perspective it looked like a well-constructed obstacle that had a clear definition to the horse in the sense that the horse could definitely see that the first fence was an upright and that the second fence was an ascending parallel and I consider that it was appropriate for level and it was clear to the horse, so therefore it was a safe jump*".[191]

13.131 Mr Johnston emphasised that he had not been to the Scone site since 2010 but when asked if he considered fence 8A/8B safe for a two star competition he said:

"*I, I believe it was, I believe it - obviously, I'm only a very new [technical delegate], but as a course designer, if I was walking it with any of the three course designers that are there, again, it would have been one of those discussions, it would have been some of the options that would have come up. As I've sort of articulated, if I was designing it, I might want to have a ground line, all those type of things but the discussion would be had and the agreement would be made. But from what I can see and what was presented is within the rules and safe within the rules of the era*".[192]

13.132 **FINDINGS:** EA submits that fence 8A/8B was appropriate, safe and rule complaint for the two star competition at the 2016 Scone Trials. This submission is correct. Having regard to the totality of the expert evidence, the experience of riders who rode fence 8A/8B in 2015, and the assessment conducted by the technical delegate in 2015 and 2016, it could not be said that fence 8A/8B represented an unsafe fence on 6 March 2016. The evidence also established that fence 8A/8B was an appropriate question to pose in the two star competition, and that it was compliant with the 2016 EA Rules, although not in entire conformity with the FEI Guidelines.

[190] 21/5/19 at T89.49.
[191] 21/5/19 at T95.1.
[192] 21/5/19 at T97.20.

13.133 However, it is to be remembered that the FEI Guidelines specifically provide that "*the aim of the [course designer] is to provide a suitable test for the level of Competition without exposing Horses and Athletes to a higher risk than what is strictly necessary to produce the right test for that level".* To give effect to this principle, it can be accepted that fences should be designed with all risk mitigation methods available. In the case of fence 8A/8B this did not occur. The evidence establishes that the fence generated discussion amongst riders about the stride distance between the two elements, above what might ordinarily be expected in discussions about riding plans. Further, the evidence also establishes that whilst not the most difficult fence that might be seen on a two star course, fence 8A/8B one that had a more than average level of difficulty. Finally, 8A/8B constituted a vertical on a downhill approach, with a spread as the last element. All of these features made it all the more important for consideration to be given to the use frangible technology, and for the following risk mitigation methods to be employed: use of a ground line, different shades of white in the front and rear rails, and having full five centimetre difference in height between the front and rear rails.

13.134 EA submits that there is no evidence to suggest that the use of any design feature could have prevented the fall, or that the lack of any design feature contributed to the fall. This submission is also correct. It should be noted that it is not possible to reach any conclusion about whether the employment of any one, or more, of the above risk mitigation methods would have altered the eventual outcome. To embark on such an exercise would be purely speculative. However, the fact that frangible technology was not considered, and the other risk mitigation methods were not used meant that fence 8A/8B exposed riders to a higher risk than what was strictly necessary to produce the right test for the two star level.

14. Aspects of the EA Guide

14.1 It can be seen from all of the above, that aspects of the FEI Guidelines caused some difficulties with interpretation, even amongst experienced course designers. Further, the use of prescriptive, mandatory language in a document which is purported to be non-prescriptive seems to be, on the face of it, contradictory.

14.2 Mr Rose was asked this second issue. He explained:

> "*So whilst you can look at a fence individually and within the guidelines it doesn't fully comply with the guidelines, the reason it doesn't fully comply with the guidelines sometimes is that there's not - that in an ideal world, yeah, we'd be able to make our ground flat for every fence, if, if we so, you know, had that desire. But we don't live in an ideal world and we have to make things work as best we can within the, the conditions that we have*".[193]

14.3 Notwithstanding the above, Mr Rose acknowledged that the apparent contradiction in terms might pose a difficulty for new designers:

> "*I don't see difficulty with that as a designer, but, for myself. But I definitely see the difficulty in somebody who wants to become a designer looking at that guideline and those rule books and then being able to interpret that to help them. That could be really helpful, but it could also not be helpful enough. Or vice versa, it might be unhelpful or not helpful enough. So yes, I think there could be better examples of, of how that could be written or explained in, in the guidelines*".[194]

14.4 Mr Etherington-Smith also expressed the view that there was scope for improvement and referred to there being ongoing discussion at the FEI level about the issue.[195] Mr Johnston referred to the fact that the FEI Guidelines are intended for a small audience, suggesting that this would assist in their interpretation. However, he agreed that some of the terminology used in the FEI Guidelines required correction or clarification.[196]

14.5 It is evident that EA Guide mostly replicates the FEI Guidelines. The possibility of EA making its own amendments to its own Guide was explored in evidence with Ms Fasher. She suggested that financial issues were the "*controlling consideration*"[197] in the inability of EA to develop its own guidelines, in the same way that BE has, independent of the FEI. She also referred to the fact that EA was concerned to be aligned with the FEI to be recognised as a national federation. On this basis, EA submitted that it was not practical to implement any amendment to its own Guide.

[193] 17/5/19 at T53.44.
[194] 17/5/19 at T54.31.
[195] 21/5/19 at T75.27.
[196] 21/5/19 at T76.36.
[197] 22/7/19 at T27.20.

14.6 **FINDINGS:** EA submits that there are practical difficulties with making any amendments to the EA Rules currently in force due to possible lack of conformity with the corresponding FEI Rules. However, the evidence demonstrates that EA is independently capable of developing its own rules at a national level. Indeed, EA has already made such amendments to the EA Rules following the deaths of Olivia and Caitlyn to provide for the mandatory use of frangible technology and improved medical services for events. The evidence establishes that the lack of clarity about significant aspects of course design, and the apparent contradictory nature of the EA Guide leaves open scope for improvement, particularly to assist less experienced course designers.

14.7 **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian Australia that the current version of the Equestrian Australia *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.

14.8 **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian Australia that (a) a comprehensive review of the Equestrian Australia *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 Equestrian Australia *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.

15. Peer review of course design

15.1 During the inquest, the issue of whether there would be any benefit in having a second course designer inspect a course and sign off on it as being appropriate for competition was considered. Mr Lochore[198], Mr Etherington-Smith[199] and Mr Johnston[200] all agreed that such a procedure would be sound.

15.2 Mr Johnston referred to such a procedure as being another form of checks and balances to ensure all possible risks had been mitigated. In addition, Mr Etherington-Smith indicated that such a procedure occurred at the FEI level but was unsure whether it occurred at the domestic level. However, he raised for consideration practical issues such as whether there would be sufficiently accredited course designers to review courses at the highest star categories, and the logistics of arranging for such second inspections to take place.

15.3 In contrast to the above, Mr Tapner considered inspection by a second course designer to be of limited benefit. Instead, he considered that there was more benefit in having an inspection performed by someone capable of offering a different perspective such as a riders representative, or a ground jury member (in FEI events).[201]

15.4 **FINDINGS:** Inspection of a cross country course by a second course designer prior to competition represents another effective method of risk mitigation. Whilst seeking a different perspective from someone other than another course designer would also be of benefit, it appears that is already provided for by the riders representative system and course inspection by a technical delegate. Although there may be practical and logistical considerations in initiating such a second inspection system, the benefit in relation to mitigating risk suggests that it should be considered.

15.5 **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian Australia 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 Test is appropriate for competition, prior to the commencement of an Event.

[198] 21/5/19 at T79.48.
[199] 21/5/19 at T80.3.
[200] 21/5/19 at T80.40.
[201] 21/5/19 at T81.4.

16. Course designer present at an event

16.1 Section 515.4 of the FEI Rules provides:

> *The Course Designer must be present at the Cross Country course inspection with the specific Ground Jury for the Cross Country course for which the Course Designer is responsible. If for any serious reason, the appointed Course Designer cannot be present also during the Cross Country Test, this information needs to be reported to the FEI with a suitable proposal for replacement before the start of the Event*.[202]

16.2 Whilst the EA Rules also provide that the course designer must be present during the cross country test, there is no equivalent provision as to what should occur if the course designer cannot be present.

16.3 Mr Nicholson was not present at the 2016 Scone Trials. He said that he regarded himself as the co-course designer with Mr Burgess. He said that he interpreted the EA Rules regarding the course designer being present as equating to "*somebody equally as qualified*".[203] Mr Burgess himself denied being the co-course designer in 2016. Instead, he stated that he was the fill in course designer[204], having been asked to perform this role by Mr Richardson.[205]

16.4 Mr Bates explained that the presence of a course designer at an event is dependent on that course designer's availability. He explained that in Scone 2016 he knew leading up to the event that Mr Nicholson would not be present and so his communications were with Mr Burgess (as the course designer on the day) and Mr Richardson (who had been assisting the course designer in the weeks leading up to the event).[206] Mr Bates was asked whether if Mr Nicholson was present in 2016 that would have made a difference to his consideration of what he had heard from the riders regarding the striding distance between the two elements. He said: "*Yeah, possibly. I would have had conversations with him which probably would have covered all aspects of the course we probably would have spoken about that particular fence*".[207]

16.5 Mr Etherington-Smith considered it important for a course designer to watch how his or her course was ridden. He explained:

> "*It's all about watching how horses travel, work - and trying to understand or improve one's understanding of how they work physically, understand the impact of what you put out there for the athletes and the horses to, to jump. How it affects them physically and mentally regardless of the weather conditions, and we have to factor in, you know, it could be good weather, it could be appalling weather. And so, yes, I think it's really important to, to be able to, to see your product and learn from it. There's always something you can learn*".[208]

[202] Exhibit 1, Tab DB11, page 40.
[203] 20/5/19 at T23.46.
[204] 22/5/19 at T62.19.
[205] 20/5/19 at T67.39.
[206] 16/5/19 at T60.18.
[207] 16/5/19 at T93.8.
[208] 21/5/19 at T21.37.

16.6 **FINDINGS:** The inability of Mr Nicholson to be present at the 2016 Scone Trials was problematic. In the absence of a provision in the EA Rules as to what was to occur in such a situation, there was confusion and misunderstanding as to precisely what role Mr Burgess was performing. This should obviously be avoided, particularly because the evidence establishes that there is considerable benefit in the course designer of a courser being present to personally watch how their course is ridden.

16.7 Further, in Olivia's case, it is most likely that Mr Bates would have availed himself of an opportunity, if Mr Nicholson had been present, to discuss an aspect of fence 8A/8B which was generating discussion amongst some riders. It is of course not possible to know what would have occurred if this opportunity had been utilised, but the fact of an opportunity being available would have provided increased reassurance to Mr Bates about the appropriateness of the fence.

16.8 **RECOMMENDATION:** I recommend to the Chief Executive Officer of Equestrian Australia 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.

17. Broader issues

17.1 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.

17.2 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

18. Incident review system

18.1 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 Mr 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 Roche (chair), Liza Carver (an EA Board member and law firm partner, Mr Enzinger and Bruce Farrar (the 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.

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

(a) 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.

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

18.4 The evidence at 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 Philip Rees and Sarah Retallack received a call about six months after Caitlyn's accident at SIEC.

(b) Some witnesses, such as Dr Alexander 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 it did not appear were ever resolved. Mr Burgess said that after being interviewed by Dr Roche he was sent a transcript[209] 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.[210] He said that he was never made aware of the contents of the review panel report or its recommendations.

[209] Exhibit 18.
[210] 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*".[211]

(g) In Olivia's case, no consideration was given to whether an independent course designer should be engaged to review fence 8A/8B.[212]

(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)[213], 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.[214]

(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.[215] 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*".[216]

(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*".[217]

(l) There appeared to be a lack of meaningful engagement with the parents of Caitlyn and Olivia. Caitlyn's mother, Ailsa 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*

[211] 15/5/19 at T55.14.
[212] 22/7/19 at T19.15.
[213] 24/5/19 at T36.34.
[214] 24/5/19 at T39.11.
[215] 24/5/19 at T34.42.
[216] 24/5/19 at T35.6.
[217] Exhibit 1, Supplementary Volume, Tab 8, page 13.

with other health investigations, that - it made me alarmed that they couldn't get things as - what I felt should have been as straightforward as that correct".[218]

Mr and Mrs 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.[219] 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*".[220]

(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*".[221]

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*."[222]

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.

18.5 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:

[218] 14/5/19 at T43.38.
[219] 16/5/19 at T26.43.
[220] 16/5/19 at T27.12.
[221] 16/5/19 at T34.8.
[222] 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*".[223]

18.6 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*".[224]

18.7 **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.

18.8 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.

[223] 23/7/19 at T45.42.
[224] 23/7/19 at T46.10.

18.9 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.

19. Course walk

19.1 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.

19.2 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.[225] 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*".[226]

(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.[227] 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*[228]*…I think in the long run it would be very beneficial for the course designer and the young riders*".[229]

(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*

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[225] Exhibit 1, Tab 24 at [20.2].
[226] 16/5/19 at T83.10.
[227] 17/5/19 at T80.38-T81.12.
[228] 20/5/19 at T25.39.
[229] 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".[230]

19.3 **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.

19.4 **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.

[230] 23/7/19 at T86.17.

20. Rails down in show jumping

20.1 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?

20.2 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*".[231]

20.3 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*".[232]

20.4 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).[233] 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.[234]

20.5 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*

[231] 16/5/19 at T35.7.
[232] Exhibit 1, Tab 10 at [18.1].
[233] 17/5/19 at T81.43.
[234] Exhibit 1, Tab 10 at [18.2].

cross-country".[235] He agreed that further data analysis was required before any rule change should be made.

20.6 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*".[236]

20.7 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 [technical delegate] 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*".[237]

20.8 Mr Richardson confirmed that this practice was adopted at Scone in 2017. If a rider had a significant number (five or six) rails down 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.[238]

20.9 **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.

20.10 **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 delegate 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.

[235] 17/5/19 at T21.13.
[236] 21/5/19 at T69.23.
[237] 16/5/19 at T86.12.
[238] 23/5/19 at T46.36.

21. Riders Representative[239] system

20.11 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

20.12 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.

20.13 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*".[240]

20.14 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 rider's 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*".[241]

20.15 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*".[242]

20.16 Mrs Inglis explained that even if she had known who the rider 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*

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[239] 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.
[240] 16/5/19 at T29.18.
[241] 14/5/19 at T32.7.
[242] 14/5/19 at T42.40.

formal complaints and is something that is not in the culture of the sport".[243] 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*".[244]

Introduction of riders representatives

20.17 The evidence established that riders 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.[245] 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*".[246]

20.18 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*"[247] 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.

20.19 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.[248] 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

20.20 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 a course.[249] 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.

[243] Exhibit 1, Tab 6 at [22].
[244] 16/5/19 at T30.6.
[245] 13/5/19 at T28.32.
[246] 13/5/19 at T60.44.
[247] 13/5/19 at T60.36.
[248] 15/5/19 at T75.19.
[249] 13/5/19 at T63.25.

20.21 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.[250]

20.22 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*".[251]

20.23 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*".[252]

20.24 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*".[253] She explained that a number of riders of different experience levels across different star categories had expressed these views.[254] Mrs Farrar said that the riders she spoke to expressed concern that they 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.[255] 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.

20.25 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.[256] He explained that his priority would be to encourage riders to raise concerns directly, but would have no objection to a second tier where concerns could be raised anonymously.[257]

20.26 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*

[250] 16/5/19 at T42.45.
[251] 16/5/19 at T52.3.
[252] 23/7/19 at T92.41.
[253] Exhibit 1, Volume 7, Tab 30 at [30].
[254] 24/5/19 at T62.17-36.
[255] 24/5/19 at T64.24.
[256] 24/7/19 at T40.24.
[257] 24/7/19 at T41.18.

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".[258]

20.27 The evidence demonstrates that the riders representative system is a useful vehicle not only to facilitate concerns raised by riders, but also for the riders representative to provide constructive feedback following a competition. Mr Bates explained that he had been working with Mr Kane to create a formal riders representative document, similar to a technical delegate report, to provide feedback from a rider's perspective.[259] 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.

20.28 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. 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*".[260]

20.29 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.[261]

20.30 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 be done. He agreed that this system could include anonymous reports submitted by riders. [262] 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.

[258] 23/7/19 at T92.25.
[259] Exhibit 1, Tab 24 at [19.1].
[260] 23/7/19 at T69.34.
[261] 17/5/19 at T51.22.
[262] 23/7/19 at T71.26-38.

20.31 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*".[263]

20.32 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.[264]

20.33 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.

20.34 **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 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.

20.35 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.

[263] 23/7/19 at T72.29.
[264] 24/7/19 at T27.50.

20.36 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 riders 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.

20.37 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.

20.38 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.

20.39 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 what 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.

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

20.41 **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 Representatives, or communicated to the Athlete Representatives by a competitor.

20.42 **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.

20.43 **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.

20.44 **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 on 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.

21. Personal Protective Equipment

21.1 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.

21.2 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*".[265] 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.

21.3 Ms Williams was asked to consider the PPE standards that applied in the 2016 and 2018 versions of 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.[266]

21.4 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.

21.5 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.[267]

21.6 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*".[268]

21.7 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 … an international body that - there's clearly lots of research going on across the world in that space,*

[265] Exhibit 1, Supplementary Volume, Tab 8, page 4.
[266] Exhibit 1, Supplementary Volume, Tab 8, page 6.
[267] 23/7/19 at T63.50.
[268] 14/5/19 at T31.45.

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".[269]

21.8 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.[270] 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*".[271]

21.9 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*".[272]

21.10 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*".[273]

21.11 **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 what 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.

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[269] 14/5/19 at T44.27.
[270] 16/5/19 at T34.29.
[271] 16/5/19 at T22.13.
[272] 23/7/19 at T64.24.
[273] 23/7/19 at T67.31.

21.12 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.

21.13 **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.

22. Data collection

22.1 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.[274] He explained:

> "*I know when you TD [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*".[275]

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

22.3 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*".

22.4 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*".[276]

22.5 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.[277]

22.6 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*

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[274] Exhibit 1, Tab 24 at [21.1].
[275] 16/5/19 at T83.32.
[276] 24/5/19 at T12.30.
[277] 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".[278]

22.7 **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.

22.8 **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 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, 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 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.

[278] 16/5/19 at T33.26.

23. Medical coverage at events

23.1 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

23.2 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.[279] 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.

23.3 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"*.[280]

23.4 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*".[281] 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*".[282]

23.5 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*".[283] 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).[284]

23.6 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,

[279] 15/5/19 at T40.23-28.
[280] Exhibit 1, Tab SR5, page 24.
[281] Exhibit 6 at [4.1].
[282] 14/5/19 at T69.26.
[283] Exhibit 1, Tab RK3, page 81.
[284] 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.

23.7 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*".[285]

23.8 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.[286] 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*".[287]

23.9 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*".[288]

23.10 The evidence during the inquest established that most of the witnesses, including experienced riders such as Ms Bishop[289], 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*".[290]

23.11 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

[285] 14/5/19 at T70.31.
[286] 14/5/19 at T71.25-30.
[287] 14/5/19 at T80.50.
[288] 22/5/19 at T8.17.
[289] 16/5/19 at T50.11.
[290] 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*".[291]

23.12 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.

23.13 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.[292] 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*".[293]

23.14 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.[294]

[291] 22/7/19 at T42.45.
[292] 22/7/19 at T13.44.
[293] 22/7/19 at T16.11.
[294] 22/7/19 at T16.30.

23.15 **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 Sydney International Horse Trials. Rather, it is evident that past practices (probably dating back to 2007/2008) had been adopted regarding this aspect of preparation for the event.

23.16 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.

23.17 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

23.18 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.

23.19 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.*

23.20 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.

23.21 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.

23.22 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.*

23.23 The provisions set out in Annex D.2 reflect the current version of the EA Rules.[295]

23.24 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*".[296]

23.25 **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.[297] Mr Kane acknowledged in evidence that there was a need for significant improvement.[298] 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.[299]

23.26 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.

23.27 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

23.28 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:

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

[295] Exhibit 33, Tab RK8.
[296] 22/7/19 at T53.8.
[297] 22/7/19 at T37.47.
[298] 24/7/19 at T49.34.
[299] 22/7/19 at T17.26.

(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.[300]

(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.[301]

23.29 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*".[302] 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*".[303]

23.30 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*".[304]

23.31 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 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*

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[300] Exhibit 1, Supplementary Volume, Tab 6, page 12.
[301] Exhibit 1, Supplementary Volume, Tab 6, page 2.
[302] 22/5/19 at T43.30.
[303] 22/5/19 at T38.47.
[304] 22/5/19 at T39.28.

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".[305]

23.32 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*".[306]

23.33 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*".[307]

23.34 Professor Brown agreed that the necessary response could be provided by a person possessing certain skills.[308] 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.

23.35 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.[309]

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

[305] 22/5/19 at T40.6.
[306] 22/5/19 at T40.20.
[307] 22/7/19 at T48.16.
[308] 22/5/19 at T49.43.
[309] 22/5/19 at T50.43-T51.1.

"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".[310]

23.37 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*".[311]

23.38 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*".[312]

23.39 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.[313] He explained that it was view of the NMCG that in relation to airway management the minimum skill was using an 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 NMCG was that LMA should be mandated and that surgical airway intervention should be recommended.

Response time and equipment

23.40 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.

23.41 Both Dr Cross and Professor Brown agreed that a response time of less than three minute would be ideal[314], and that having a time benchmark would also assist in determining where medical teams are located and what vehicles are required to reach the furthest away fence on a cross country course.[315] Professor Brown explained: "*I agree that the three minutes is really the, the benchmark for the paramedic doctor crew*".[316]

[310] 22/5/19 at T51.47.
[311] 22/5/19 at T51.6.
[312] 22/5/19 at T59.9.
[313] 24/7/19 at T3.38.
[314] 22/5/19 at T45.12.
[315] 22/5/19 at T41.21-42.
[316] 22/5/19 at T47.31.

23.42 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*".[317]

23.43 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*".[318] 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[319] and pelvic splint should also be available.[320]

23.44 **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.

23.45 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.

23.46 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.

23.47 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,[321] as did Dr Roche.[322] 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.

[317] 22/5/19 at T14.45.
[318] Exhibit 1, Supplementary Volume, at [2b].
[319] Medical equipment to perform a surgical procedure used to gain prompt access to an otherwise compromised and inaccessible airway.
[320] 22/5/19 at T41.49-T42.30.
[321] 22/5/19 at T15.5.
[322] 22/7/19 at T50.27.

23.48 **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.

23.49 **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; 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.

23.50 **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.

23.51 **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, in three minutes or less, where possible.

23.52 **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.

23.53 **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.

23.54 **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.

23.55 **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

23.56 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*".[323] Whilst such plans are used by organising committees, they are not mandated by the EA Rules.[324]

23.57 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;

(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;[325] and

[323] Exhibit 1, Tab VB1.
[324] Exhibit 1, Volume 5, Tab 11 at [14.1].
[325] Exhibit 1, Tab MW2.

(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.

23.58 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*".[326]

23.59 **FINDINGS:** Although the use of an Eventing Serious Incident Management Plan is 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.

23.60 **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

23.61 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

[326] 22/5/19 at T30.16.

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.

23.62 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*".[327]

23.63 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*".[328] She expressed the view that it would be a "*really positive step*"[329] for EA to offer first aid training to jump judges.

23.64 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 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.[330]

23.65 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.

23.66 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*".[331] Professor Brown said that he considered the video to be "outstanding".[332] 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*".[333]

[327] 13/5/19 at T62.42.
[328] 14/5/19 at T9.10.
[329] 14/5/19 at T9.37.
[330] 15/5/19 at T36.22-34.
[331] 22/5/19 at T45.39.
[332] 22/5/19 at T46.3.
[333] 22/5/19 at T46.15.

23.67 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. These courses are targeted towards what is required at an equestrian event. She agreed that this was a positive development arising from the inquest.

23.68 **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.

23.69 **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.

23.70 **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.

23.71 **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.

24. Acknowledgments

24.1 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 focused, resolute, and meticulous approach.

24.2 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 both prior to, and during, 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.

25. Findings pursuant to section 81 of the Coroners Act 2009

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

Identity
The person who died was Olivia Inglis.

Date of death
Olivia died on 6 March 2016.

Place of death
Olivia died at Gundy NSW 2337.

Cause of death
The cause of Olivia's death was chest injuries.

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

26. Epilogue

26.1 At the conclusion of the inquest the court was granted the enormous privilege of hearing Olivia's sister, Antoinette, share some of her fondest memories of Olivia. She recalled memories of many school nights, doing her homework and looking down the hall to see if Olivia's light was still on, and knowing that she was still there. There can be no doubt that Olivia's sisters and parents know that Olivia will always be with them.

26.2 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 Arthur, Charlotte, Antoinette and Alexandra; to the other members of Olivia's family; and to Olivia's friends for their immeasurable and tragic loss.

26.3 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.