STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	**Inquest into the death of REECE POTTER**
Hearing dates:	**1-2 April 2014**
Date of findings:	**2 April 2014**
Place of findings:	**Parkes Court House**
Findings of:	**Deputy State Coroner H.C.B. Dillon**
Catchwords:	**CORONIAL LAW – Cause and manner of death – Horse-racing accident – Why horse fell in mid-race – Whether horse struck marker post before or after falling – Whether course configuration contributed to fall – Why air retrieval helicopter not available to transport injured jockey to hospital from racecourse**
File number:	**2011/00388979**
Representation:	Sgt E. Mulligan (Advocate Assisting) Mr McLeod instructed by General Counsel of Racing NSW (for Racing NSW)

Findings:	I find that Reece Potter died at the Royal Prince Alfred Hospital, Camperdown, NSW on 14 March 2011 as a result of head injuries sustained when he was thrown from his horse during a race at the Tottenham Picnic Races on 12 March 2011.

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REASONS FOR DECISION

Introduction

1. On 12 March 2011, Reece Potter, a young jockey aged 23 years, received fatal head injuries while riding in the last race at the Tottenham Picnic Races on a four-year old gelding, "Half Handy". While leading the race to about the 1200 metre mark, "Half Handy" fell, throwing Reece.

2. Reece was immediately attended by racecourse ambulance officers. He was unconscious and had apparently suffered significant head injuries as a result of the fall.

3. He was transported to Dubbo by ambulance then flown to Royal Prince Alfred Hospital. By the time he got to Royal Prince Alfred Hospital, however, his position was irretrievable. On 14 March, after consultation with his family, his life support system was turned off and he died.

4. Reece was a third-generation jockey. He had ridden horses since he was three years old. He was a highly skilled horseman. Although he undertook an apprenticeship in butchery, at the same time he rode trackwork at Rosehill and Hawkesbury race courses before becoming a full-time jockey. At the time of his fatal accident he had been a registered jockey for two years. As well as coursework and racing, he gained experience in rodeos, competing on horses and rodeo bulls.

5. He was, however, more than an adventurous country boy who loved horses and racing. He was a much-loved son of Vicki Williams and Michael Potter and the friend of many. The premature death of a young man with so much potential, so full of life and optimism, has left his parents and family to carry a burden of grief that is beyond anything but time to lighten. One of the distressing aspects of Reece's death for them is that there are questions that they have been waiting for three years to be investigated at an inquest. I am very sorry that it has taken so long.

The coroner's role

6. The primary function of a coroner is that of fact-finder. Coronial proceedings are inquiries not trials. Coroners investigate sudden, unexpected deaths. The Coroners Act requires us to ask five questions: who died? When did he or she die? Where did the death take place? What was the physiological cause of death? And how did the death come about?

7. In this case, it is the last issue that has been the focus of this inquest.

8. A coroner also has a power to make recommendations if he or she thinks it is necessary or appropriate to do so to reduce the chances of future deaths happening in the same way.

The issues

9. A number of specific factual issues must be investigated before an answer to the question of how Reece's death came about can be found:

- Why did "Half Handy" fall?
- Was the Tottenham track in appropriate condition for racing at the time of the incident?
- Did the white poly pipes inside the running rails contribute to "Half Handy's" fall?
- If so, has the use of poly pipes altered or been rectified since the race?
- Why was the emergency helicopter that is generally available to transport critically-ill patients not used at the time of the accident?
- Since the accident, have there been any changes made to the use and deployment of emergency air retrieval services in this region of NSW?

The factual background

10. The Tottenham Picnic Races is the only race meeting held at the course each year. Before an official race meeting is held, a course must be inspected and meet standards set by Racing New South Wales.

11. On 12 March 2011, the track surface was inspected and found to be in good condition. The barrier rail at Tottenham was constructed from steel piping. The rail ran for about half the length of the circuit. This type of rail is no longer approved by Racing NSW. The standard rail now required is a flat colourbond aluminium rail that is designed to flex and buckle to absorb the energy of a collision. Such a rail ran along the home straight.

12. To keep horses off the steel piping, PVC marker posts were positioned several metres inside the running rail. The posts were hollow plastic pipes standing about 180cm tall (with a further 20cm below ground). The posts were not connected but were positioned about 20-30 metres apart. These marker poles complied with the Australian Racing Rules and the then current NSW Local Racing Rules.

13. On the day, Reece had ridden in each of the six races on the program.

14. "Half Handy" was a reasonably experienced racehorse, and had previously run in 14 races.

15. Between the 1200 and 1100 metre marks "Half Handy" was leading with another horse coming up the outside. "Half Handy" was then seen to fall in the vicinity of a set of marker posts, throwing Reece and falling heavily over him. In the accident Reece suffered severe trauma, especially to his head. He was found to be comatose when the ambulance arrived on the scene shortly after the incident.

16. While Reece was attended to be ambulance officers, "Half Handy" was examined by the veterinarian Dr Charles Tilly. The horse was very distressed and Dr Tilly diagnosed a fractured pelvis and possible spinal damage. He then euthinased the horse with a dose of "lethabarb". Because Tottenham is remote from specialist equine centres, and it was late in the day, in consultation with Dr Tilly, Racing NSW decided not to direct that an autopsy be undertaken.

17. Following the accident, the track was inspected again. Nothing unusual was found on the track surface and there were no slip marks to be seen.

Why did "Half Handy" fall? Did the white markers inside the running rails contribute to "Half Handy's" fall?

18. I have had the benefit of repeated viewings of the race at slow motion and the expert evidence of Mr Harry Williams, Mr Todd Smith and Mr Troy Vassalo who have watched the films of the race from a number of angles many times over. Mr Williams, Reece's grandfather, is a very experienced horseman, jockey and trainer with over 50 years in the industry. Mr Smith and Mr Vassalo are stewards, each with long experience in the industry. Their opinions are consistent with each other. Each of them believes that, about half a minute into the race, "Half Handy" broke down, with his pelvis splitting, causing his hindquarters to collapse, his head to rear up, striking Reece Potter who was trying to control the horse, throwing Reece and rolling over him.

19. None of those who knew the horse before the incident were aware of the latent defect in his pelvis that caused it to fracture. Having seen Mr Rodney Robb, the trainer of the horse, give his evidence I am persuaded that "Half Handy" appeared to be a very sound horse until moments before the fatal accident. He stated that he had bought "Half Handy" from a friend of his, Mr Brett Cavanough, from whom he had previously bought horses and in whom he had every confidence. His intention was to give "Half Handy" a few starts before giving him to his daughter for barrel-racing. "Half Handy" had trained well and was improving. Indeed, Mr Harry Williams described the horse having his best start in the fatal race. He said that horses carrying injuries are usually slow to start but this had not been the case with "Half Handy" on this particular day.

20. This suggests that "Half Handy's" injury was completely latent and undetectable (except perhaps by radiological examination) until the moment the pelvis gave way in the midst of the race. This might be described as an equine equivalent of an "egg-shell" skull in a human being.

21. Mr Rodd would not have raced the horse had he had doubts about its fitness. He also gave evidence that Reece himself would have drawn any problems he had noticed himself to Mr Rodd's attention or to the authorities at the race meeting. It appears that until well into the race nothing alarmed Reece about "Half Handy's" performance.

22. Although there was some evidence from jockeys who had competed in the race to the effect that the fall may have been caused by "Half Handy" running over the hollow marker pegs set inside the running rail, close examination of the video does not support these impressions. As "Half Handy" blundered, the other jockeys close at hand, although travelling at similar speeds, would have had very little time to observe exactly what had happened. My impression is that "Half Handy" may have brushed one of the sets of marker pegs but that he did not trip or become entangled with them before his fall. It was as he fell and rolled that he struck another set of pegs about 30 metres from the first set.

23. Evidence was given by both Mr Stuart Brown and Mr Ben Duggan that they had ridden on courses with such marker pegs for many years without serious incident.

This suggests that the peg system, although it has now been superseded in New South Wales, was a relatively safe system, certainly safer than horses running against inflexible steel rails.

24. Rumours that the marker pegs were supported by star-pickets are unfounded. The pegs were stuck straight into the ground to a depth of about 20 cm without any other reinforcement.

25. Although the eye-witnesses, Mr Duggan and Mr Brown, were patently honest and doing their very best to give accurate accounts of what had happened, the speed with which the event took place, and the post-accident discussion in the jockeys' room, meant that they were trying to piece together a coherent explanation of the accident from fragmentary and momentary impressions. The jockeys did not have the benefit of the video replays, whereas the expert witnesses did. The experts also had time to view the video many times over and to slow it down, enabling them to analyse the action in a far more accurate way than the eye-witnesses – through no fault of their own – were able to.

26. My own observations of the video evidence and the expert interpretations of that evidence suggest that the fall was not caused by a collision with the pegs or any attempt by "Half Handy" to jump over a peg. In the fleeting moment of observation available to the riders, it is easy to see how the impression of a horse's head suddenly coming up and his hindquarters collapsing could lead a witness to think that he was attempting to jump an obstacle.

27. It is highly unlikely that a mere brushing of a light plastic peg by a horse weighing about 430 to 440 kgs could have caused the catastrophic injury that resulted in his fall, fatally injuring himself and Reece Potter.

Was the Tottenham track in appropriate condition at the time of the incident?

28. All the evidence indicates that the Tottenham track was in excellent condition on the day of the 2011 Picnic Races. The fall was not caused by any holes or other defects in the track. The only significant criticism of the track was that it was bounded by the steel rail but this did not play a part in the accident. It has since been replaced by a flexible, shock-absorbing aluminium rail.

Improvements to running rails on NSW race courses

29. Although the issue of whether the plastic marker pegs contributed to the accident has been dealt with, it should be noted that, since 2013, Racing NSW has phased out the use of such markers and all courses under its jurisdiction are now equipped with flexible shock-absorbent plastic or aluminium running rails.

Emergency air retrieval: why was no helicopter available?

30. Unfortunately, at the time Reece was injured, an emergency helicopter was not available to attend the race course to fly him to an appropriate hospital for treatment. Ambulance officers found him to be unconscious and obviously badly injured. It was immediately apparent that he needed urgent treatment. It was not

clear at the time whether his injuries were survivable but they were critical and time was of the essence.

31. Evidence was given by Dr Ron Manning, the director of the Statewide Services Division of the NSW Ambulance Service. It is responsible for emergency air retrieval services.

32. He said that the call for an emergency helicopter was received at 5.17pm at Ambulance Western Control. They requested a helicopter from Orange. Unfortunately, the Orange helicopter was then operating only between 8am and 6pm and the pilot had already flown a long medical transfer that day from Orange to Sydney. He had insufficient flying hours left available that day to undertake the requested flight legally.

33. It therefore became necessary to drive Reece to Dubbo Base Hospital by ambulance with intensive care being administered en route. A transfer from Dubbo was arranged with Royal Flying Doctor air retrieval aircraft flying Reece to the Royal Prince Alfred Hospital that evening.

34. The added distress this delay caused Reece's family is entirely understandable. Whether or not the time lost made a critical difference is impossible to tell. Certainly Reece's injuries were so serious that, even with a helicopter transfer straight from the race course to Sydney, his chances of survival were slim and perhaps it was already too late. In the accident he suffered severe brain trauma and was comatose when attended to by ambulance officers on the course. His family, unfortunately, will never know whether an opportunity to save his life was lost.

Review of air retrieval services

35. Following Reece's death, the family gathered massive community support for improvement of aeromedical services in western NSW. In part because of an already planned review, but no doubt also because of the Potter/Williams family campaign, emergency air services have been improved significantly since Reece's death.

36. Since Reece's fatal accident, a number of changes have been instituted to emergency air retrieval services in western and north-western NSW.

37. In May 2012, changes to helicopter pilot rostering were made to address the problem that arose in Reece's case. It was the coincidence of two incidents requiring long flight times on a single day that resulted in the service being refused for Reece. Since May 2012, there have been no further cases in which, due to excess flying hours, the emergency helicopter has not been able to retrieve a patient.

38. A 24-hour helicopter service now operates from Orange and a 24-hour service will commence in Tamworth in January 2015. Further improvements to types of aircraft, capacity of aircraft, clinical standards and monitoring of services are now being introduced.

Conclusions

39. Harry Williams had the terrible experience, time and time again, of watching his own talented young grandson thrown and fatally injured as he sought to understand what had happened to Reece and his mount and why. His evidence was of great assistance to me as I sought to comprehend this accident. I am very grateful to him for this.

40. Vicki Williams and Reece's father Michael Potter watched the video footage of their son's fatal accident during the inquest. The shock and heartbreak they must have felt was described by the Greek playwright Euripides 2500 years ago when he wrote, "What greater pain can mortals bear than this: to see their children killed before their eyes?"[1]

41. One of the reasons this pain is so great is that we cannot rewind time to make things turn out differently. That is what we really desire when something like this happens. There is no remedy for this kind of grief, except time and love.

42. It is clear that although he died very young, Reece had already made a mark on his fellow jockeys and others in the racing world he loved so much. I was struck by how deeply affected Mr Duggan and Mr Brown and Mr Rodd appeared to have been by Reece's death and how much respect they had for him as a horseman, a sportsman and a human being. It was evident that they felt their community had lost an important member and this saddened them a very great deal.

43. Although it may be small consolation, I hope that there is some comfort to be found for Reece's family in hearing how much his fellow riders admired this adventurous young up-and-coming jockey who was, as Mr Rodd put it, was "as good as we've ever seen out here" and as Mr Duggan put it, "could really ride" and "was the one we were all afraid of".

44. He cannot be brought back but he is obviously very much alive in the hearts of his very loving family and in the memories of the people who rode with him and against him. As sad as his far too premature death is, Reece left a considerable legacy for a young man of 23.

45. I am sure, too, that Reece's family and the horse-racing community of western NSW will also understand this inquest has been a mark of the wider community's respect for human life generally, and Reece's life and the concerns of his family and of his fellow riders in particular. A civilised society pays attention to the sudden and unexpected deaths of its members because we are mutually dependent on one another. Reece was one of us; his family's loss is also the community's.

46. On behalf of the community I offer to Reece's family and friends my appreciation of the quiet dignity with which they have conducted themselves throughout this inquest. And I offer my very sincere and respectful condolences on the loss of a fine young man so much loved by them all.

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[1] *The Suppliant Women* lines 1120-1121.

Findings

47. I find that Reece Potter died at the Royal Prince Alfred Hospital, Camperdown, NSW on 14 March 2011 as a result of blunt force head injuries sustained when he was thrown from his horse during a race at the Tottenham Picnic Races on 12 March 2011.

Magistrate Hugh Dillon
Deputy State Coroner for NSW