IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2014 4730

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

*Section 67 of the **Coroners Act 2008***

I, AUDREY JAMIESON, Coroner having investigated the death of DANIELLE MAXINE LEWIS without holding an inquest:
find that the identity of the deceased was DANIELLE MAXINE LEWIS
born 11 March 1986
and the death occurred on 15 September 2014
at Cranbourne Harness Racing Club, Grant Street, Cranbourne Victoria 3977
from:

1 (a) HEAD INJURY

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

1. Danielle Maxine Lewis was 28 years of age at the time of her death. Ms Lewis lived in Pearcedale. Ms Lewis was an experienced horse trainer and worked at the Cranbourne Harness Racing Club.

2. On the morning of Monday 15 September 2014, Ms Lewis arrived at the Cranbourne Harness Racing Club at just after 6.00am. Ms Lewis entered the stables and prepared her horses for track work. She attached one horse to a sulky; a lightweight metal cart with two lightweight wheels and a seat in the centre rear. At approximately 7.10am, a witness observed Ms Lewis sitting on the sulky, heading towards the training track at a walking pace, leading a second horse alongside the sulky. Before making it to the track, Ms Lewis turned around to return to the stables and trainers' mess room for reasons that are unknown. At speed, the wheel of the sulky hit the sleeper edging around a raised garden bed and Ms Lewis was thrown headfirst

into the wall of a mess room building. A witness observed both horses, one running at half pace, and the other running at what was described as a gallop, with the sulky still attached and without Ms Lewis in the seat.

3. Ms Lewis was found by horse trainer Rick Cashman; she was unconscious and lying face down in the garden bed. Mr Cashman called emergency services and administered cardiopulmonary resuscitation (CPR) as instructed by the call taker. Two ambulances arrived shortly afterwards, but ambulance paramedics were unable to revive Ms Lewis and she was declared deceased. Police, WorkSafe Victoria and members of Harness Racing Victoria subsequently attended. Both horses were located and restrained; by this stage the horse with the sulky had broken free and the sulky had been detached.

INVESTIGATIONS

Forensic Pathology investigation

4. Dr Yeliena Baber, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an external examination upon the body of Ms Lewis, reviewed a post mortem computed tomography (CT) scan and referred to the Victoria Police Report of Death, Form 83. Dr Baber reported that the CT scan revealed a number of fractures in Ms Lewis' skull. Post mortem toxicological analysis detected sertraline at a level of 0.1mg/L.[1] On the evidence available to her, Dr Baber ascribed the cause of Ms Lewis' death to a head injury.

Police investigation

5. Upon attending Cranbourne Harness Racing Club, Victoria Police noticed wheel marks on the garden bed, as well as in the front edge of the garden bed's surrounding wooden sleeper. The wheel marks appeared consistent with the wheel of the sulky, suggesting the sulky mounted the eight inch high sleeper edging, throwing Ms Lewis from the sulky. Hair and blood were found on a building wall, where it appeared Ms Lewis had hit her head. The wall of the mess room building was found to be exceptionally hard, with no give at all.

6. Police also found two broken pieces of visor from Ms Lewis' helmet, as well as a large blue couch cushion on the ground. Ms Lewis was not wearing a safety vest of any type. The sulky was located about 12 metres from Ms Lewis, lodged under a horse training fence with a horse

[1] Sertraline is an anti-depressant drug for use in cases of major depression.

harness attached to its front. The main entrance of the track which led out to the main racing track was about 170m from Ms Lewis. At the top of the track, police observed wheel marks which appeared to be similar to those on the sulky, and indicated the sulky had turned around at this point.

7. Detective Sergeant Geoffrey Rumble, the nominated coroner's investigator[2] conducted an investigation of the circumstances surrounding Ms Lewis' death, at my direction, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by horse trainers Michael Hughes, Rick Cashman, Mary Elliot, Dean Braun and Bill Walker, horse owner Gregory Hansen, as well as trainer and assessor at Bendigo Harness Racing Centre Leigh Graham. In addition, the coronial brief contained a copy of Harness Racing Victoria's Document 26 – 'Race Track Access for Training Work Policy and Procedure.' At the request of the Court, Det. Sergeant Rumble subsequently obtained a statement from Neil Bainbridge, Chief Executive Officer of the Cranbourne Turf Club, which incorporates the Cranbourne Racing Club Inc.

8. Harness racing trainer Bill Walker stated that Ms Lewis had lived with his family for approximately 12 months. She had previously been training at Yarra Valley, but had moved to the stables at Cranbourne. Mr Walker stated that Ms Lewis had gone to bed at 8.30pm on 14 September 2014. He had heard her leave for work at 5.55am. Mr Walker said that Ms Lewis owned several horses, and that the horses she was training at Cranbourne that day were not hers. One belonged to Gregory Hansen, while the other belonged to another individual.

9. Horse owner Gregory Hansen stated that Ms Lewis had agreed to take over training of his horse, 'Artillerist' for about a month, while he recovered from surgery on 13 September 2014. According to the arrangement, Mr Hansen would pay Ms Lewis $30 per day. Mr Hansen said Artillerist was a 16 hand horse and weighed roughly 480kg. Mr Hansen said he had purchased the horse cheaply as it had hit its knee. Mr Hansen explained that this means when the horse is going at speed in a sulky, it would flick its foot up and hit its knee on the other leg. He said this was quite common. Mr Hansen said the horse ordinarily had an excellent temper and was quite placid.

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[2] A coroner's investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator takes instructions direction from a coroner and carries out the role subject to the direction of a corner.

10. Horse trainer Dean Braun assessed the sulky used by Ms Lewis on 18 September 2014, while trainer and assessor at Bendigo Harness Racing Centre Leigh Graham assessed the sulky on 19 September 2014.

11. Upon inspection, Mr Braun was satisfied that the sulky was in good condition and in good working order. Mr Graham observed that the sulky appeared to be old but was suitable for jog use in a training environment. Mr Graham also noted consistent damage to the right side of the sulky and it appeared that the sulky had struck something with force.

12. Mr Braun noticed that the trace on the breast plate on the right hand side was broken, at the point where it hooks onto the metal lug.[3] Mr Braun said several events could have caused the trace to break; it may have just been well worn, although it could have also been subject to a large amount of pressure, such as a solid impact or heavy movement of the horse, and then snapped. Mr Graham opined that the trace may have broken due to significant force on the right hand side of the sulky; if the wheel gets caught on something and the horse is going at a certain speed, he said the trace would be one of the first things to break. However, Mr Graham did not believe that the break in the trace would cause a person to lose control of a horse or cause them to fall out of the sulky. The buckle on the left hand side of the breast plate was broken and Mr Graham opined that this break may have occurred at the same time the trace broke.

13. Mr Graham stated that the bridle and reins are an integral part of the gear, and if either malfunctioned this could significantly hamper the control a driver has over the horse. The bridle and reins were not with the sulky on the day of Mr Graham's assessment, but the coroner's investigator subsequently sent photographs of them through for him to review. Mr Graham noted that they were in excellent condition, with almost no wear and tear. The bit was secured correctly to the reins and bridle, and there was no evidence of any malfunction. However, there was a frayed aspect of one rein which was consistent with the horse becoming free from the sulky and saddle and the reins being dragged through the 'terrets'[4] forcefully. Mr Graham opined that the frayed aspect of the rein would have happened after Ms Lewis was dislodged, rather than before.

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[3] Mr Braun noted that the trace is a vinyl strap about an inch wide. He said it had a hole in it like a belt buckle which slips over a small metal lug to hold it in position.

[4] Mr Graham noted that the 'terrets' are the rings attached to the top of the saddle; each rein is passed through them from the bridle back to the driver.

14. Mr Graham also noticed there was no crupper present, which he described as a piece of equipment which sits under a horse's tail and attaches to the saddle to stop the saddle from slipping forward. He said that different stables have varying opinions on whether the use of a crupper is imperative when jogging horses. Mr Graham prefers to use one as it provides an insurance that the saddle will stop slipping forward. Mr Braun added that if the saddle moves forward and out of position in the absence of a crupper, it can cause the horse to spook and behave irrationally. Mr Braun also always uses a crupper when training but agreed this was not the case with every horse trainer.

15. In addition, Mr Graham noted that the bridle did not have a headcheck[5] attached. While it was common industry practice for well-educated horses to jog without a headcheck, Mr Graham opined that if a horse is fractious and started to kick, with no headcheck or crupper the driver is placed at a severe disadvantage, as the horse can kick higher and has little or no restriction.

16. Mr Graham stated that when driving a sulky, the safety requirements and personal protective equipment which must be adhered to by the driver or trainer on a public track are that they must have a current valid licence, must wear a helmet (recommended to be a maximum five years from the manufacture date), must wear an approved safety vest, and goggles and hard toed shoes are advisable.

17. Horse trainer Rick Cashman noted that Ms Lewis' safety helmet was located next to her in the garden bed. Mr Rickman also noted that Ms Lewis was not wearing a required approved safety vest on 15 September 2014. Mr Braun stated that the vest fits over a driver's shoulders and around their upper body to provide protection.

18. Horse trainer Michael Hughes stated that Ms Lewis always used a cushion to try and soften the sulky's hard plastic seat. Mr Rickman reported that he did not believe the large couch like cushion found next to Ms Lewis would provide stability to sit safely on the sulky. Mr Graham and Mr Braun both stated that it was not uncommon for trainers to use a cushion to improve comfort in the seat. However, Mr Graham noted that the one used by Ms Lewis was on the larger end of the scale in terms of size. Mr Graham opined that such a large cushion could only hamper the stability of the person seated on the sulky. Mr Braun said that he did not believe

[5] Mr Graham noted that a headcheck ensures the horse carries its head up; without it they can carry their head down. It is a strap that has a small bit that is carried in the horse's mouth, the attached strap runs up the front of the horse's nose, over the head, through the top of the bridle, and then attaches to the saddle.

cushions would generally cause very much instability to a sulky driver, but a larger cushion like the one used by Ms Lewis may do so.

19. Coroner's investigator Det. Sergeant Rumble noted that Harness Racing Victoria's Document 26 provides that:

> *'All trainers and drivers must have a track work spotter accompany them prior to entering either the race track and / or training track for the purpose of keeping a watchful eye during all training activities. The assigned track work spotter will hold either a HRV licence card or be at an age of no less than sixteen years. The effectiveness of the track work spotter will be increased with the individual holding a current minimum level first response first aid qualification in the event of an incident occurring. The individual having immediate access to either a mobile or portable satellite phone. The individual having a level of horse handling experience.'*

20. Det. Sergeant Rumble stated that in the course of the investigation he asked every person he spoke to about the procedure provided for in Document 26 and not one was aware of its existence.

21. CEO of Cranbourne Turf Club Neil Bainbridge stated that there are agreements in place between individuals or businesses that operate out of the Cranbourne Harness Racing Club (the Club), whereby the Club issues monthly rental invoices. However, Mr Bainbridge noted that all resident trainers are inducted to the site and required to confirm their commitment to abide by the rules of the Club and Harness Racing Victoria.

22. Mr Bainbridge stated that the Club did not directly supervise track work, but the Club's Racing Manager conducts regular inspections of track work and facility and would not hesitate to report any resident trainers or their employees to the board or Harness Racing Victoria in the case of breaches. Mr Bainbridge said that since Ms Lewis' death, the Club has requested that Harness Racing Victoria stewards conduct random inspections at the training facility to ensure compliance with its rules, such as those relating to wearing safety vests. Mr Bainbridge noted that at the time of the incident, the Club's rules and regulations required resident trainers and their employees to wear Harness Racing Australia and Harness Racing Victoria approved safety equipment when undertaking training activities. This equipment included but was not limited to correct footwear, protective vests and skull/caps/helmets.

23. Mr Bainbridge noted that following Ms Lewis' death, the Club updated its rules and regulations to include that:

- All trainers must read and sign Harness Racing Victoria policy no 26 'Race Track Access for Training Work Policy and Procedure'.
- A high vis fluorescent vest must be worn at all times over safety vest and clothing on training tracks when driving in a sulky.
- The practice of leading a horse/s and driving one in the sulky at the same time is prohibited on the race track and other training tracks.

24. Mr Bainbridge stated that since Ms Lewis' death, the Club has circulated a copy of Harness Racing Victoria's Document 26 to all resident trainers and their employees. In addition, the requirement for resident trainers to arrange a spotter was raised and explained at a meeting. Specifically, this included reference to the spotter needing to hold a Harness Racing Victoria licence or be no less than 16 years old. Mr Bainbridge added that while Document 26 outlines that the spotter will be positioned to oversee both racing and training tracks, one of the benefits of the Cranbourne training facility is that participants are also on hand to assist and support each other in the stable areas and walking tracks around the facility.

25. Mr Hughes noticed the turn marks up the top of the track where it looked as if the sulky had turned around. He noted that Ms Lewis would normally continue straight ahead at this point, but for some reason the sulky had spun around. Mr Hughes said there were multiple reasons that this might have happened, including that one of the horses may have become spooked. Mr Graham agreed that there were a number of things that could occur which would make a horse act in a way which is contrary to what the driver may want, such as noises and unexpected movements. Mr Braun added that anything from a piece of paper blowing in the wind, sudden noise or shadows could cause a horse to shy, take off in a panic or suddenly change directions. Mr Graham added that generally speaking horses do not get worked on Sundays, and from his experience Monday is the day things go wrong, as they are fresh and can be on edge after resting the day before. Mr Graham said that the fact it had been a Monday could have impacted on the chances of a horse being spooked.

26. Mr Braun stated that sulkies are designed to be driven on flat surfaces; they can cope with hitting small objects such as rocks and tree roots, but hitting a larger object or an object at speed will cause a sulky to bounce suddenly and cause instability to the driver.

27. Mr Hughes stated that Ms Lewis loved her horses and always looked after them. Due to the individual nature of their work, he was not able to comment on how she went about her training and how thorough she was regarding her equipment. Mr Hansen described Ms Lewis as very experienced around horses and a good driver, but still young and learning.

Victorian WorkCover Authority (WorkSafe) Investigation

28. As Ms Lewis' death occurred in the course of her employment, the Victorian WorkCover Authority (WorkSafe) conducted an investigation into the circumstances of her death.

29. By way of letter dated 28 October 2015, WorkSafe informed the Court that it did not commence a prosecution against any party in relation to Ms Lewis' death, and enclosed a copy of the WorkSafe brief of evidence. The WorkSafe brief *inter alia* included statements made by Community College Gippsland (Gippsland Harness Training Centre) employees Jennifer Lewis and Kristen Theile, as well as horse owner Danny McIvor, horse trainer Alan Dunsmuir, Caretaker at Cranbourne Turf Club Kenneth Browne, Safety Manager at Harness Racing Victoria Gerhard Hendricks and Operations Manager at Harness Racing Australia Gary Kairn.

30. Ms Jennifer Lewis stated she had known Danielle Lewis for approximately 12 years. She stated that Ms Lewis had completed initial training at the Gippsland Harness Training Centre (GHTC) in 2002, and moved to New Zealand for a time to further her harness racing career. In 2006, Ms Lewis completed a Certificate IV in Racing (Advanced Harness Driver) at GHTC.

31. Horse owner Danny McIvor said he owned a horse registered to race under the name 'Neddy Under Fire', a six year old gelding. Mr McIvor stated that sometime around June 2014, this horse was given to Ms Lewis for a trial to see if she wanted to buy or lease it. No money changed hands and no agreement was signed; it was just on a trust basis. Mr McIvor said the horse was well trained and did not play up. Horse trainer Mr Dunsmuir stated he had previously trained Neddy Under Fire, but stopped because he was of the view the horse was too slow. Mr Dunsmuir suggested that Ms Lewis try training the horse. He had several telephone conversations with her and said she was really happy with the horse. Mr Dunsmuir stated that during the time he trained the horse, it was easy to train and not spooky or fractious.

32. Mr Dunsmuir noted that during his time at Cranbourne, there were no rules regarding the requirement to have a spotter; he had never seen a spotter on the training track. He viewed the Cranbourne track as quite dangerous due to a number of distractions, including car traffic, greyhound training and a walking track close by. Rick Cashman provided a further statement to WorkSafe and stated he was not aware of a requirement to have a spotter at any time, and as far as he was aware this did not occur.

33. Leigh Graham also provided a further statement to WorkSafe and stated that the idea behind Harness Racing Victoria's policy regarding spotters was to ensure that someone is always trackside to keep an eye on the trainer/driver in the event of an incident, or to assist in controlling the entry/exiting of additional horses onto the track if needed. Safety Manager at Harness Racing Victoria Gerhard Hendricks said the policy was developed to provide consistent requirements across all harness racing clubs concerning the need to engage a track work spotter during training activities. The policy was developed following an incident at another harness racing track.

34. Mr Graham said that in reality, spotters are not typically used at harness training tracks in Victoria. However, he observed that the use of spotters is common practice at Thoroughbred racing facilities. Mr Graham added that in Ms Lewis' instance, a spotter would have been of little benefit because the incident occurred before she had reached the training track. Mr Hendricks agreed with this assessment.

35. Mr Dunsmuir added that it was common to see trainers driving a sulky while leading another horse at the Cranbourne harness training track, and that it was just quicker to train two horses at once. Mr Dunsmuir said that in his experience, this was standard industry practice and common place at all harness training tracks. Mr Graham agreed the practice of driving a horse while leading another horse alongside the sulky was a common occurrence and standard practice. Mr Graham was not aware of any industry guidance material or policies that relate to the practice of leading a horse while driving a sulky. However, he noted that the practice increases the risk of injury to the driver and other track users, were the horse to break free. Mr Cashman had never led a horse while driving a sulky at Cranbourne, but noted that it was an occasional practice at the training track. As far as he was aware this practice was definitely allowed at the club. Mr Cashman noted that this practice has since been banned at the club following the incident.

36. Mr Hendricks confirmed that there are no Harness Racing Victoria policies or procedures relating to the practice of driving one horse on a sulky while leading a second horse alongside. However, he had a strong view that trainers should not perform this practice, and was of the opinion that it is extremely hazardous as it is very difficult to maintain effective control of both horses. He said that the risks exponentially increase when trying to control two horses simultaneously, and that a trainer/driver on a sulky cannot physically stabilise themselves while trying to control two horses, especially if they are fractious. Mr Hendricks believed that the practice should be prohibited at Horse Racing Victoria venues.

37. At the time of Ms Lewis' death, Kenneth Browne was the Onsite Caretaker at Cranbourne Turf Club. Mr Browne stated that the club rules incorporated the wearing of safety gear, including an approved helmet and safety vest. He confirmed that the practice of driving one horse on a sulky while leading a second horse alongside was up until Ms Lewis' death an accepted practice. In addition, Mr Browne stated that prior to Ms Lewis' death, there were no spotters for track work at Cranbourne. However, Mr Browne said there were always other drivers/trainers around to act informally as a spotter. Since the incident, the club has banned the practice of leading a horse. Mr Browne added that the club also enforces a spotter rule, so that people are not allowed to train alone without a spotter, or must wait for another trainer to arrive on track.

38. Mr Hendricks noted that following Ms Lewis' death, Horse Racing Victoria sent out an alert to all Victorian Registered Clubs to reinforce its policies and procedures.

39. Operations Manager at Harness Racing Australia (HRA) Gary Kairn was shown a series of photographs depicting Ms Lewis' helmet. Mr Kairn noted that the helmet was an LAS branded helmet, and dated November 2004. Mr Kairn referred to Rule 224 of the AHR General / Offences Rules 202 to 255, which provides that 'a person when engaged in driving or riding a horse shall wear, correctly fastened, a helmet approved under these rules.' Mr Kairn stated that HRA rules also provide that a helmet should only be used for five years, at which time they should be replaced. Mr Kairn noted that Ms Lewis' helmet was approximately 10 years old and hence out of date. Mr Kairn also referred to Rule 223 and noted that drivers are also required to wear an approved safety vest, which are padded and provide additional body and shoulder protection.

40. Mr Graham described the raised sleeper garden edging on the edge of the pathway track as not ideal, because it created a solid object for the sulky wheel to strike and could result in the

driver being ejected. He said this type of design is typical of the sort of thing a 'non-horse person' would do.

41. Mr Dunsmuir considered Ms Lewis to be an experienced trainer and capable of leading a good horse. Mr Browne viewed Ms Lewis as a well-educated horse trainer and driver, with many years' industry experience.

Coroners Prevention Unit investigation

42. I asked the Coroners Prevention Unit (CPU)[6] to provide statistical information regarding the number of people who have died in Victoria while working with horses on racetracks. I also asked for information about any previous coronial comments or recommendations for improving safety in the harness racing industry.

43. The CPU identified six other deaths occurred between 1 January 2000 and 31 July 2015 involving falls from horses at Victorian racetracks. None of these incidents involved a sulky or cart of any kind. In a coronial finding following the death of a strapper who was thrown to the ground from a horse during a training lap in 2002, His Honour Magistrate Rowan McIndoe endorsed a recommendation that signs be installed at entry gates to tracks which indicate the required personal protective equipment that must be worn. The CPU also noted that in 2007, WorkSafe Victoria produced a guide entitled 'Horse Stables and Track Riding Safety' which includes reference to the need for appropriate supervision during track work.

COMMENTS

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

1. In the course of the investigation into Ms Lewis' death, a number of issues arose in relation to the safety, or lack thereof, of the equipment and practices utilised at Cranbourne Harness Racing Club on 15 September 2014.

2. Some of the issues identified related to matters within the control of Ms Lewis. In particular, I note that Ms Lewis was not wearing an approved protective vest required by Harness Racing

[6] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

Victoria, and her helmet was considered out of date and against the rules as it was not manufactured within the last five years. I accept that cushions are commonly used in the harness racing industry to soften the seat of a sulky, and are not banned. However, the evidence suggests that a cushion, particularly the oversized one used by Ms Lewis, could seriously hamper the stability of a sulky driver.

3. Ms Lewis' death has highlighted a certain lackadaisical approach to safety existed at the Cranbourne Harness Racing Club. The environment at the club appears to have enabled Ms Lewis to go about her work on 15 September 2014, wearing an out of date helmet and no safety vest. Prior to the incident, it appears that Harness Racing Victoria's Document 26, relating to the need for a spotter on the track, was not enforced upon or acknowledged or adhered to by horse trainers at the Club. I note that the use of a spotter would not have prevented Ms Lewis' death - as the sulky turned around prior to reaching the track. However, the rules relating to the use of a trackside spotter are based on very real safety issues, and the absence of a practical implementation of this policy by the Club is concerning. In addition, the existence of a raised sleeper surrounding the garden bed, which sulkies frequently pass by, appears to have increased the risk of like incidents by providing an unnecessary obstacle.

4. Driving sulkies while leading another horse appears to be common practice in the wider harness racing industry. In addition, the investigation identified that there are no Harness Racing Victoria policies or procedures relating to the practice. However, I note Leigh Graham's comment that the practice increases the risk of injury to the driver and other track users. I also note Gerhard Hendricks' view that the practice is extremely hazardous as it is difficult to maintain effective control of both horses, especially if they are fractious. I welcome Mr Hendricks' view that the practice of leading another horse while driving a sulky should be prohibited at Harness Racing Victoria venues.

5. In addition, I welcome and acknowledge the proactive and restorative measures taken by the Cranbourne Harness Racing Club in the aftermath of Ms Lewis' death. I particularly applaud the prohibition of the practice of leading a horse and driving one in the sulky at the same time on the race track and other training tracks. By instigating this policy, Cranbourne Harness Racing Club is taking a leadership approach in an industry where this practice remains widely accepted. I also welcome efforts to promote and implement Harness Racing Victoria's policy regarding the use of a spotter on the track.

FINDINGS

The death of Ms Lewis is a firm reminder of the inherent dangers of working with animals. I remain unclear as to why the sulky driven by Ms Lewis on 15 September 2014 turned around prior to reaching the track. However, the evidence supports a finding that one or both of the horses led by Ms Lewis were frightened, quickly gaining speed, causing Ms Lewis to lose control of the sulky. During this period, a wheel of the sulky appears to have ridden over the eight inch sleeper lining the garden bed and Ms Lewis was ejected from the sulky, hitting her head on the proximate wall of the mess room building and sustaining fatal injuries.

I accept and adopt the medical cause of death as identified by Dr Yeliena Baber, and find that Danielle Maxine Lewis died from a head injury whilst working as a horse trainer.

Pursuant to section 73(1A) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

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

Mrs Donna Doyle

Mr David Steer, WorkSafe Victoria

Moray & Agnew Lawyers on behalf of Cranbourne Harness Racing Club Inc

Harness Racing Victoria

Detective Sergeant Geoffrey Rumble

Signature:

AUDREY JAMIESON

CORONER

Date: **22 June 2016**