CITATION: *Inquest into the death of Styles Isaac King* [2016] NTMC 002

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Katherine
FILE NO(s):	D0041/2013
DELIVERED ON:	18 March 2016
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HEARING DATE(s):	16 and 17 February 2016
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Death as a result of positional asphyxia, crowd controllers and their training.**

REPRESENTATION:

Counsel:

Assisting:	Jodi Truman
Family of Deceased	Stephen Karpeles
Director-General of Licensing and the Northern Territory of Australia	Greg MacDonald

Judgment category classification:	B
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IN THE CORONERS COURT
AT KATHERINE IN THE
NORTHERN TERRITORY
OF AUSTRALIA

No. D0041/2013

In the matter of an Inquest into the death of
STYLES ISAAC KING
AT KATHERINE DISTRICT HOSPITAL, KATHERINE
ON 27 MARCH 2013

FINDINGS

Mr Greg Cavanagh SM

Introduction

1. Mr Styles Isaac King died on 27 March 2013 at the Katherine District Hospital following an altercation at Kirby's Bar with a crowd controller and duty manager employed by the Katherine Hotel. Out of respect for the family and in accordance with their request, I will hereafter refer to Mr King as "the deceased" or Mr King, with the exception of the formal findings.

2. Mr King was an Aboriginal man who was born in Katherine on 16 June 1982. His mother is Eunice Rose Wanongumara Isaac and his father was Arthur Elwyn King (deceased). Mr King was initially raised in the Borroloola Community before attending Kormilda College in Darwin for his high school years and boarding there. He left high school in year 11.

3. Mr King was married to Colleen Hale. They met in Borroloola in May 2000 and shortly thereafter commenced a boyfriend/girlfriend relationship. A few months later, Ms Hale resided with Mr King and his mother. The couple went on to have 6 children together. Unfortunately their relationship had a history of domestic violence and they were separated as a result of these issues in January 2013. A "no intoxication" and "no harm" domestic violence order ("DVO") was made for a period of two years from 8 January 2013 and was in place at the time of his death. As a consequence of these

domestic violence incidents Mr King was familiar with the criminal justice system. Despite this, it is clear that he was also a man who was loved by his family and friends and is deeply missed by them who each grieve his loss in such tragic circumstances.

4. Mr King's death was violent and unexpected. As such it is a "reportable death" as defined under s.12 of the *Coroners Act* ("the Act"). This inquest has been held as a matter of exercise of my discretion under s.15 of the Act. Pursuant to s34 of the Act, I am required to make the following findings if possible:

> "(1) A Coroner investigating:
>
> a. A death shall, if possible, find:
>
> (i) The identity of the deceased person.
>
> (ii) The time and place of death.
>
> (iii) The cause of death.
>
> (iv) Particulars required to register the death under the *Births Deaths and Marriages Registration Act*.
>
> (v) Any relevant circumstances concerning the death"

5. Section 34(2) of the *Act* operates to extend my function such that I may comment on a matter including public health or safety connected with the death being investigated. Additionally, I may make recommendations pursuant to section 35 as follows:

> "(1) A Coroner may report to the Attorney General on a death or disaster investigated by the Coroner.
>
> (2) A Coroner may make recommendations to the Attorney General on a matter, including public health or safety or the

administration of justice connected with a death or disaster investigated by the Coroner.

(3) ……."

6. This inquest was held on 16 and 17 February 2016. A total of six (6) witnesses were called to give evidence, namely; Detective Sergeant Anthony Henrys, Rickie Cullen, Mark Humphries, Margaret Stinson, Paul Graham and Ms Anna McGill. A brief of evidence containing various statements, together with numerous other reports and police documentation was tendered at the inquest, together with documentation related to the prosecution of Mr Tim Hoermann and Mr Shaun Clark and the medical records for the deceased. Public confidence in Coronial investigations demands that when police (who act on behalf of the Coroner) investigate deaths that they do so to the highest standard. I thank Detective Sergeant Henrys for his diligent investigation.

7. As previously noted, both Mr Hoermann and Mr Clark were prosecuted on a charge of manslaughter following the death of Mr King. The matter proceeded by way of a jury trial before the Supreme Court of the Northern Territory in Darwin. Both Mr Hoermann and Mr Clark were found not guilty of the charge of manslaughter by a jury of their peers. It is clear on the evidence tendered before me however that Mr King's death occurred immediately following the conduct of both Mr Hoermann and Mr Clark and was caused by their man-handling of him.

Background of Styles King

8. As noted earlier, Mr King was born in Katherine in the Northern Territory on 16 June 1982. He was the first child to his parents Eunice Rose Wanongumara Isaac and Arthur Elwyn King (who passed away in 1995). I note that Ms Isaac attended court (with a number of other family members) and also provided a formal statement to me setting out her son's

background. I thank Ms Isaac and her family for the respect they showed the coronial process. I was pleased to receive her evidence. The concerns she raised in her statement were kept firmly in the forefront of my mind as I considered the whole of the evidence. It is clear that Ms Isaac loved her son very much and that she and other members of the extended family continue to miss him every day.

9. Mr King was the second eldest child and had 5 siblings. He grew up in the Borroloola Community, but then moved to Darwin to board and attend Kormilda College for his high school years. He left school in year 11. After returning to Borroloola, met his wife, Colleen Hale, in May 2000. The young couple moved in together and lived with one another at the home of Mr King's mother. Ms Hale was only 17 years old and Mr King was only 18 years old. They went on to have 6 children together; Stylee King who was 12 when Mr King passed away, Chenaey Hale who was 11, twins Layven and Styleasha King who were 7, Eunice Hale who was 5 and Kassia Hale who was only 3 years old. From 2007 to 2013 the family lived at an address in Karama.

10. The relationship between Mr King and his wife was marred by domestic violence almost from its commencement. There was a domestic violence order in place between the couple from 8 January 2013 for a period of 2 years and it was following that order that Mr King moved from the couple's matrimonial residence in Karama. Unfortunately Mr King's last recorded involvement with police prior to his death was on 2 March 2013 when he was charged with a breach of that order. Although Mr King worked from time to time, he was unemployed at the time of his death and had no usual occupation.

Events of 27 March 2013 at the Katherine Hotel

11. On Wednesday 27 March 2013 the deceased was in Katherine. I received evidence from Ms Isaac that her son was on his way from Darwin to

Borroloola for the funeral of his cousin-sister. During that afternoon he was seen drinking at various locations throughout Katherine with various persons. Sometime around 9.00pm the deceased attended Kirby's Bar which is a bar located at the Katherine Hotel situated on Katherine Terrace in Katherine. He was accompanied by two friends.

12. The group continued drinking at the bar together and socialising with other persons at that location. I received a number of statements from various persons who saw the deceased drinking at the bar. He was described by those witnesses as being at various levels of intoxication. None of those witnesses describe the deceased as causing any particular trouble that night prior to his involvement with the relevant staff members employed at the Katherine Hotel.

13. Working at the Katherine Hotel that night was Mr Tim Oliver Hoermann ("Mr Hoermann"). Mr Hoermann was employed as a crowd controller at the hotel and had been so since 11 February 2013. Mr Hoermann had also previously worked at the hotel for approximately 6 months in 2012. I received a copy of Mr Hoermann's electronic record of interview ("EROI") with police into evidence. Mr Hoermann described observing the deceased and his friends that night and making a decision to "cut" Mr King off from being able to purchase any further alcohol because of his level of intoxication.

14. Mr Hoermann described to the police that after telling the deceased that he was cut off, some of his friends began purchasing drinks for him. As a result he advised the deceased and others that they would have to leave the premises after they had finished their drink. Mr Hoermann stated that he waited for the deceased to finish his drink so that he could ensure he left, however as soon as the deceased finished his last mouthful he struck out at Mr Hoermann with his fists. Unsurprisingly, Mr Hoermann immediately reacted to that strike by grabbing the deceased and a struggle ensued.

15. Also working at the Katherine Hotel that night was Mr Shaun Anthony Clark ("Mr Clark"). Mr Clark was employed as a duty manager at the hotel that evening. Mr Clark had previously been employed as a crowd controller for the Katherine Country Club and as a duty manager at the Katherine Hotel he was required to have a crowd controller's licence. I received a copy of Mr Clark's EROI with police into evidence. Mr Clark told police that whilst he was in the cash office of the hotel, he heard the sound of an argument coming from the bar area. A member of staff then approached him in the office and asked if he could assist Mr Hoermann.

16. As a result Mr Clark went out to the bar. He stated that when he first came out, Mr Hoermann was in fact involved in an argument with another man who was not Mr King. He stated that he could see Mr King finishing his drink, but that as soon as Mr King took his last mouthful he took a swing at Mr Hoermann and the two men became involved in a struggle. As a result he grabbed at the deceased and also became involved in the struggle.

17. I had tendered into evidence a copy of the closed circuit television ("CCTV") footage of the incident. It was played at the commencement of the inquest. The strike by the deceased to Mr Hoermann and the struggle that ensued between all three men can be seen. The footage then shows Mr Hoermann place the deceased into a headlock and begin pulling him down towards the ground.

18. All three men move across the floor wrestling with one another. Eventually the deceased is forced to the ground near the poker machine area located within the bar. At this point in time, instead of releasing the deceased once he had him on the ground, Mr Hoermann maintains his grip around the deceased's head and neck. From the CCTV footage it appears as if Mr Hoermann also positions his upper body on top of the deceased's shoulder area and neck area. Mr Hoermann's explanation to police was that he was attempting to maintain "effective control" of the deceased.

19. I note that in their interviews with police both Mr Hoermann and Mr Clark attempt to downplay the amount of weight they placed upon the deceased and also how much of their own body was on top of Mr King. I do not however accept the self-serving versions of how each man says they were positioned in relation to the deceased. I rely instead on what can be seen from the CCTV footage, which I find speaks for itself.

20. Once on the ground Mr King is seen to continue to struggle. Mr Hoermann appears to have control of the head and neck area of Mr King throughout. Mr Clark appears to also have placed his weight onto the deceased's torso via his knees; effectively pinning Mr King to the ground. I note the evidence that Mr King was 168 cm tall and 91 kilograms in weight, compared to Mr Hoermann who was 197cm tall and 110.5 kilograms in weight and Mr Clark who was approximately 182cm tall and approximately 90 kilograms in weight.

21. During the struggle Mr King is seen to grab at Mr Hoermann's arm, which was still wrapped around his neck. I received evidence via the statements tendered, and also via the recording of a 000 call to police, that it was at this stage that the deceased was heard by various witnesses to scream that he could not breathe. I listened carefully to that 000 call as it was played and I too could hear someone screaming that they "cannot breathe". Despite these screams, Mr Hoermann and Mr Clark did not release Mr King and I note that both men told police that they never heard such words during the struggle.

22. On the evidence, Mr King then began to scratch, bite and gouge at Mr Hoermann's arms and face as he continued to be pinned to the ground and held in the headlock. Mr Hoermann's reaction was to punch Mr King several times to the head and keep the headlock in place. I find that it is more likely than not that Mr King's scratching, biting and gouging at this point in time was because he was unable to breathe, rather than a further attempt to resist.

23. Mr King is also seen to attempt to slide his legs up. I find this may have been part of an attempt to get off the ground. When this occurred however, another staff member employed at the Katherine Hotel but who was not on duty, namely Mr Stephen Kerr, intervened and held the deceased's legs preventing him from being able to move any further.

24. I had tendered in evidence a time line prepared by police that noted the occurrence of significant events as recorded on the CCTV footage. It records that Mr King was taken to the ground at 22:15:07. He is on the ground, in a headlock, and pinned down by Mr Hoermann and Mr Clark in the manner described above (with Mr Kerr eventually intervening to hold his legs) until 22:21:49. At total of 6 minutes and 42 seconds. As I stated during the evidence, as I watched Mr Hoermann and Mr Clark continue to hold Mr King on that hard floor even before the involvement of Mr Kerr, it took only a short period before all I could think was "why don't you just get off him?" On any viewing; the continued pinning of Mr King face down on that hard floor by two (2) large men is an extremely lengthy period to be holding anyone, let alone to also be holding that person in a headlock.

25. During the struggle, police were contacted and attended at Kirby's bar. The CCTV footage shows officers Elisha Kennon and Douglas Thompson arrive at 22:21:49. Mr Kerr is seen to release his hold of Mr King's legs at 22:22:10. However officers Elisha Kennon and Douglas Thompson are then required to direct both Mr Hoermann and Mr Clark to remove themselves from the deceased and this does not occur until 22:22:33. This is almost a further minute from the arrival of the police. Mr King was therefore restrained on his stomach in the manner earlier described for over 7 minutes on the hard floor of the Kirby's bar.

26. Upon his release, police immediately noted the deceased to be unresponsive and a pulse could not be found. Officers Kennon and Thompson immediately commenced cardio pulmonary resuscitation ("CPR") until the

arrival of St Johns Ambulance paramedics. Upon their arrival the paramedics examined the deceased and found he had a Glasgow Coma Scale ("GCS") of 3. A GCS score refers to a person's neurological state and records the conscious state of a person. A patient is assessed against the criteria of the scale, and the resulting points give a patient score between 3 (indicating deep unconsciousness) and either 14 (original scale) or 15 (the more widely used modified or revised scale meaning fully conscious). Mr King was therefore deeply unconscious.

27. Mr King had no palpable pulse, was not responsive and his pupils were fixed and dilated. Paramedics applied defibrillation pads, which showed he was in Asystole, which is a state of no cardiac electrical activity. Paramedics also provided oxygen through a bag valve mask and administered adrenaline. Following this the deceased's heart rhythm reverted to a sinus rhythm (i.e. normal heart beat), though there was no palpable pulse.

28. CPR continued with the deceased's rhythm reverting to asystole. A further two doses of adrenaline were administered, however the deceased remained in asystole and pulseless up until delivery to the Katherine District Hospital ("KDH") arriving at 10.52pm. Advanced Life Support was continued at KDH however the deceased was subsequently pronounced deceased by Dr Malcolm Johnson-Leek at 11.20pm on 27 March 2013.

Cause of death

29. There was no issue raised as to cause of death in this matter. Although Mr Hoermann and Mr Clark were found not guilty of manslaughter, the evidence is clear that the condition leading directly to his death was traumatic asphyxiation. Mr King was described by witnesses who saw him that night as having a "beer belly". An autopsy was carried out by Dr Terence Sinton on 28 March 2013 who recorded Mr King's measurements of 168 centimetres in height and 91 kilograms in weight. He was overweight and that could also be seen from the footage. I do note however that Mr

King had no significant health issues as far as is recorded prior to his death and he had not had cause to attend upon a medical practitioner for some time.

30. Dr Sinton's autopsy report was tendered into evidence before me and noted the significant findings to include the following:

    i. "Abrasions and bruises variously to the face and both arms.

    ii. Subcutaneous bruising to the head, right side of the upper chest, right shoulder and middle (mid lumbar) region of the lower back.

    iii. Mild conjunctival haemorrhage in both eyes.

    iv. Frothy fluid in the upper airways.

    v. Fluid accumulation in the lungs consistent with acute heart and lung failure".

31. I note also Dr Sinton's findings of "mild but deep haemorrhage through the left sterno-mastoid muscle". Coincidentally this is the same side that Mr Hoermann is seen to be located in the CCTV footage during the time that Mr King is restrained.

32. Dr Sinton also noted that toxicological analysis reported an alcohol concentration of 0.210% with cannabis metabolites also being detected. Of note, there was no evidence of any clinically significant naturally occurring organic disease which might have caused or contributed to Mr King's death and there was no evidence of any significant recent bony trauma.

33. Dr Sinton expressed his opinion as to the cause of death as follows:

    "Given the history of restraint, and the autopsy findings of conjunctival haemorrhage, frothy fluid in the upper airways, and the fluid accumulation in the lungs, he likely died during acute heart failure as a

result of acute asphyxiation (the mechanical inhibition of breathing) while concurrently suffering from acute alcohol toxicity".

34. Having considered all of the evidence, I find the cause of death is not in doubt. It was traumatic asphyxiation which occurred during the restraint of Mr King by Mr Hoermann and Mr Clark to the floor of the Kirby's Bar at the Katherine Hotel. It was their conduct that caused Mr King's death.

Issues for consideration

35. As stated at the commencement of these findings, the purpose of this inquest is not to consider the criminal responsibility of Mr Hoermann or Mr Clark. That has already been determined by a jury of their peers and both men were found not guilty of the manslaughter of Mr King. That decision stands.

36. The purpose of this inquest is however to consider the wider issue of public health and safety and determine whether both men, who were qualified as crowd controllers, received the necessary education and training for them to have appreciated and understood the significant risks associated with their conduct in holding Mr King to the floor for over 7 minutes and whether the training provided in the Northern Territory to persons is appropriate, or needs changing, so as to attempt to avoid another tragic death like this occurring.

Licensing of crowd controllers in the Northern Territory

37. The licensing for security providers, including crowd controllers, in the Northern Territory is governed by the *Private Security Act* ("PSA"). The Licensing NT Division ("Licensing NT") of the Department of Business is the unit within the Department responsible for the administration and operation of the PSA. The Director-General of Licensing is the licensing authority.

38. A crowd controller is defined under section 5 of the PSA as follows:

"5 Crowd controllers

In this Act, a crowd controller is a person who, in respect of licensed premises within the meaning of the *Liquor Act*, a place of entertainment, a place to which the public has access or a public or private event or function, as part of his or her duties, performs the function of:

(a) controlling or monitoring the behaviour of persons;

(b) screening persons seeking entry; or

(c) removing persons because of their behaviour,

or any other prescribed function."

39. Section 12 of the PSA requires crowd controllers to be licensed. There are two (2) methods of obtaining a licence in the NT:

39.1 By lodging an application for a licence with the Director General; or

39.2 By making an application to the Director General for the issue of a licence under the *Mutual Recognition Act*, if already licensed in another State or Territory.

40. Licences are issued for one, two or three years, depending on the period applied for. A person is entitled under s.15 of the PSA to be granted a licence if they meet certain criteria, which includes successfully completing the course in training approved under s.53 of the Act.

Training Requirements in the Northern Territory

41. Section 53 of the PSA empowers the relevant Minister to approve both the competency standards and the training required for the attainment of those standards in respect of a licence. Such approvals are only given following receipt of advice from the Director-General of Licensing. The current

competency standards and training required are provided under a Certificate II in Security Operations. Ms Anna McGill, Director of Policy and Strategic Planning, with the Licensing NT Division of the Department of Business provided evidence of what the prescribed units have been within that Certificate since July 2014.

42. Relevant to the matters arising in this inquest, I note that within those prescribed units only two (2) units make reference to positional asphyxia, namely:

42.1 CPPSEC2017A Protect Self and Others Using Basic Defensive Tactics: which teaches techniques that may include: avoidance techniques, blocking techniques, body positioning, body safety, empty hand techniques, impact techniques, locking and holding techniques and take-down techniques. The Participant Guide for CPPSEC2017A indicates that positional restraint asphyxia is also a topic of this training; and

42.2 First Aid. This includes information on avoiding asphyxia due to body positioning.

43. Applicants are required to complete the first aid training and renew their first aid certification every three (3) years. However the other units of competency and training are not time limited, although they may be superseded from time to time. Persons holding crowd controller licences are therefore not required to undergo refresher training or to update their qualifications unless it is decided by Licensing NT or another regulatory body that significant changes are required.

44. Although the Minister approves the competency standards and training with respect to a licence, the training package is one that has been developed by the Industry Skills Council (a Commonwealth body). In the case of the security industry; the relevant body is the “Construction and Property

Services Industry Skills Council". The training however must be provided through a Registered Training Organisation ("RTO"). The Australian Skills Quality Authority ("ASQA") is the Commonwealth body that regulates RTO's nationally and regulates the courses and training providers to ensure nationally approved quality standards are met. Ms McGill provided evidence that most other Australian jurisdictions require many of the same units of competency as those required under the PSA in the NT, however there are varying additional units in some other jurisdictions

Evidence of the training undertaken by Mr Hoermann and Mr Clark

45. A copy of the relevant materials relating to the criminal investigation formed part of the coronial brief tendered before me. This included the EROIs undertaken with both men. During the course of his EROI, Mr Hoermann stated relevantly as follows:

45.1 He had only spoken English since commencing travel in Australia in November 2011 (tp.6).

45.2 In Germany he had worked in security and held a "normal" security licence and a "special" licence to "work as a bouncer" (tp.8).

45.3 He had received training in Katherine before applying for his security licence in Australia.

45.4 He had learnt "pressure points" during his security training in Australia, "but we never learn how to put a person on the ground" (tp.63).

45.5 He had learnt "by myself over the years" that putting a person on the ground is "the safest position" and he had done so during his "whole career as a security … five hundred times" (tp.64).

45.6 He had put people in headlocks before and "its easiest, easiest way, they can't go out of there" (tp.65).

45.7 He had not heard the term “positional asphyxia” before, however “the police told me last night, yes, it is, so I didn’t knew it before, but the police told me, after all everything what’s happened” (tp.66).

45.8 It was not, to his knowledge, dangerous to place someone on their stomach on the floor “because normally it’s alright to place someone on the ground” (tp.66).

45.9 He had his first aid certificate but “the problem was … the person who did it was not the best” (tp.70).

45.10 That “the trainer from the whole security company, it was a joke” (tp.71).

46. Mr Hoermann also gave evidence at his trial and a copy of the transcript was tendered into evidence. In cross examination, Mr Hoermann was asked if part of his training involved discussion about the use of minimum force and Mr Hoermann stated (tp.688):

> “I can’t recall what we done in the course. I can’t. Because the course – I have big problems with the course because of the teacher we got. Like when I came here my English was pretty bad, like I learned it here. Our teacher was a guy from Africa and his English I reckon was even worse than mine and he had a really bad accent. So I had really bad problems listening to the words through the course and I complained about it…”.

47. I note that during the course of his EROI with police, Mr Clark stated relevantly as follows:

47.1 He had been a security guard “on and off for the last three years” and held a “dual license of a security guard and a crowd control and I’m also an armed guard” (tp.6).

47.2 He had “gone through extensive courses and that to be a security guard and how to take down people and how … to deal with the situations” (tp.6).

47.3 The course was “really only a two week course … a lot of paperwork involved … in the way of … how to fill out reports … there’s a lot of repetitive of that. [H]ow to take down a person and how to not … injure a person, but how to take down and hold a person … and we get training in that …” (tp.6).

47.4 In relation to being taught how to take down a person; “I wouldn’t say how to take down a person, but how to approach a person, how to try and dissolve the situation before it becomes a violent situation” (tp.7).

47.5 At the course “they don’t really go into … how to hold a person, how to, you know … they don’t go into great specifics”. However, “they also teach us how to read body language and … how to try and approach that person without … having to put your hands on a person” (tp.7).

47.6 During his training they did not “really” explain what could happen if “a bunch of people pile on top of someone” (tp.25).

47.7 He understood the term positional asphyxia “now. …[B]ut I didn’t previously, no” (tp.25).

47.8 As for the mention of headlocks in his training and whether there was any mention about whether they should be used or not; “not really, you know, like when you’re trying to defend yourself I’spose all that training goes out the window” (tp.26).

47.9 That “sometimes” a headlock is “the only way to drag a person down” (tp.27).

47.10 Two weeks prior to this death a police officer explained in a "passing comment" whilst "we had someone wrapped on the ground … sort of explained … asphyxiation to us" (tp.39).

47.11 It was his "understanding" that with positional asphyxiation there was "normally … you see signs of it, but he was fighting us the whole time so I didn't think of asphyxia" (tp.39).

48. Mr Clark was found not guilty and discharged prior to having to consider whether to give evidence.

49. In relation to their training and licences, the records held by Licensing NT were as follows:

49.1 Mr Hoermann was first issued with a NT Crowd Controller licence on 22 November 2012 and had completed the training and qualifications associated with the attainment of CPP20207 Certificate II in Security Operations.

49.1.1 His licence was suspended on 3 April 2013 in accordance with Part 4 of the Act, as a result of him being charged with a disqualifying offence following the incident that resulted in the death of Mr King.

49.1.2 Prior to that incident, Licensing NT had not received any complaint in respect of Mr Hoermann's conduct as a Licensee working in the Northern Territory.

49.1.3 His licence expired on 22 November 2013 and he is no longer licensed to conduct Crowd Controller duties in the Northern Territory.

49.2 Mr Clark was first issued with a Licence under the mutual recognition scheme on 22 February 2011. He had completed the training and

qualifications associated with the attainment of CPP20207 Certificate II in Security Operations in 2010.

49.2.1 His licence was suspended on 3 April 2013 in accordance with Part 4 of the Act, as a result of him being charged with a disqualifying offence following the incident that resulted in the death of Mr King.

49.2.2 Prior to that incident, Licensing NT had not received any complaint in respect of Mr Clark's conduct as a Licensee working in the Northern Territory.

50. As for the actual training undertaken by both men, I received evidence from representatives of the registered training organisations that had provided the training to both Mr Hoermann and Mr Clark. Mr Hoermann had undertaken his training with MSS Security. Mr Mark Humphries was one of the trainers for the NT for MSS Security at the relevant time. Mr Humphries did not deliver the course to Mr Hoermann. This was in fact done by Mr Donald Unzi, however despite the best endeavours of Det. Sgt Henrys he was not able to be located and is understood to now be overseas. Mr Humphries therefore provided evidence of the training provided in the NT and confirmed that he had in fact "sat in" on one of Mr Unzi's training sessions to observe.

51. Mr Humphries gave evidence that he had been in the security industry for the last "almost" 11 years. He held a security officer licence and had undertaken at Certificate IV in training and assessment in order to deliver the training programs for MSS Security. He stated that the Certificate IV took him one week to complete and then he was qualified to train people.

52. In terms of the assessment of participants in the Certificate II in Security Operations, Mr Humphries gave evidence that "in accordance with the national requirements" testing was "open book" and most of the learning was done in open class discussion "and then get the class to write down in

the assessment the correct answers". Mr Humphries stated that in his 8 years as a trainer, he was not aware of anyone having ever failed the Certificate II in Security and considered it part of his role to "ensure" they did not fail and properly understood the units undertaken within the course.

53. Mr Humphries stated that only two (2) of the units he taught within the Certificate II addressed positional asphyxia. These were the first aid unit and the unit entitled "Protect self and others using basic defensive techniques". Within those units however there was no testing of the learning about positional asphyxia. The evidence tendered before me shows that the only information of what was taught about positional asphyxia was set out in three (3) power points and a few short paragraphs. Given their brevity, I will set out in full the information that is provided:

<u>Power points provided under unit CPPSEC2017A - Protect self and others using basic defensive techniques</u>

"Positional restraint asphyxia

- A form of asphyxiation, caused when someone's position prevent them from breathing adequately.
- A small but significant number of people die suddenly and without apparent reason during restraint by police, prison officers and health care staff.
- People may die from positional asphyxia by simply getting themselves into a breathing restricted position they cannot get out of, either through carelessness or as a consequence of another accident.
- The factors that can contribute to death in these circumstances are:

- Position
    - Stomach and face down
    - Being wedged into a confined space such as the back of a car
- Restraint
    - Arms and ankles tied tightly behind the back
    - Sitting on the persons chest or back

Power point provided under unit HLTFA311A – Apply first aid

"Positional asphyxia

- Arises because of the adoption of a particular body position which affects breathing, i.e. a person face down
- A person with their head resting down on their neck at the scene of a car accident
- This is a **FATAL CONDITION**
- **ALWAYS** check for positional asphyxia.

54. In terms of the "theory" provided, I note that the information set out in the Participant Guide for unit "CPPSEC2017A - Protect self and others using basic defensive techniques", is almost word for word what is set out in the power points, and simply states as follows:

> "Positional restraint asphyxia is a form of asphyxiation, caused when someone's position prevents them from breathing adequately. A small but significant number of people die suddenly and without apparent reason during restraint by police, prison officers and health care staff.

Positional asphyxia is a potential danger of some physical restraint techniques.

"People may die from positional asphyxia by simply getting themselves into a breathing restricted position they cannot get out of, either through carelessness or as a consequence of another accident.

"The factors that can contribute to death in these circumstances are:

"Position Stomach and face down
being wedged into a confined space such as the back of a car

"Restraint Arms and ankles tied tightly behind the back
sitting on the person's chest or back".

55. In relation to any information provided to trainees about "headlocks", Mr Humphries was very clear that he taught that headlocks were a "no go" area and participants were told that they were not to touch the head or neck area "at any time".

56. I also received evidence from Ms Margaret Stinson who is the National Training Manager for MSS Security. She confirmed the extent of the training provided by MSS Security on positional asphyxia and that there was no assessment undertaken of what was learnt by participants as to that concept. Ms Stinson was keen to point out that the training provided by MSS Security was "in accordance with the national standards" and that neither the Industry Skills Council nor the Australian Skills Quality Authority ("ASQA") required assessment of positional asphyxia. Ms Stinson sensibly acknowledged however that given the number of deaths involving positional asphyxia within the security industry the training provided on positional asphyxia was "probably not enough". In fairness to Ms Stinson, I note that the training package provided by MSS Security had been audited by ASQA in 2014 and had been passed.

57. As for Mr Hoermann's allegation that he had difficulties in understanding his trainer, Mr Unzi, Mr Humphries gave evidence that whilst Mr Unzi did have a strong accent, he had never had any difficulties understanding him. Ms Stinson gave similar evidence and also noted that whilst there was a method of lodging complaints, she had found no record of any such complaint by Mr Hoermann.

58. In relation to Mr Clark, I received evidence from Mr Paul Graham who is the Director of Australian Security Training Pty Ltd and the provider of Mr Clark's training. Mr Graham also confirmed that the training he provided was in accordance with the national standards. He stated that in terms of positional asphyxia; whilst that "technical" term may not have been used, the concept itself and the risks and dangers of asphyxia were discussed during his course and particularly during the unit known as "CPPSEC2017A – Protect self and others using basic defensive techniques".

59. In relation to headlocks, Mr Graham gave unequivocal evidence that he told participants on his course that "you do not restrain the head or neck area" and that if a person was ever required to be taken to the ground and stabilised, that they were to be brought to a sitting or standing position "as quickly as possible". Mr Graham also confirmed however that there was not any formal "testing" of what participants had learnt with respect to the dangers of restraints and/or asphyxia.

60. Although I accept that this is the training that was provided to Mr Hoermann and Mr Clark, it is clear from the evidence that Mr Hoermann definitely used a headlock whilst restraining Mr King. Such restraint was therefore not in accordance with any training he had received in Australia. I also note that the continued restraint of Mr King to the floor by both men, with their weight upon him (even if only in part), was also not in accordance with the training that either man received.

Requirements of security staff at the Katherine Hotel

61. I received evidence from Mr Rickie Cullen who is part owner of the lease for the Katherine Hotel and was the licensee for the hotel at the relevant time. He gave evidence that in terms of ensuring that crowd controllers behaved appropriately, he relied upon the duty managers to monitor their conduct. Mr Cullen also gave evidence that the hotel had its own Code of Conduct that each member of the security staff had to read, understand and sign confirming that they accepted the conditions of the Code. A copy of the Code that was in place when this death occurred and the one that is currently in place were both tendered into evidence. Both are brief in their terms and there is no reference to positional asphyxia or the risks and dangers of the same.

62. Mr Cullen gave honest evidence that having seen the CCTV footage of the restraint involving Mr King; he accepted the holding on the ground was too long. Counsel for the family also showed Mr Cullen CCTV footage of another incident which showed Mr Hoermann involved in a physical altercation with a man outside the Katherine Hotel on 1 March 2013, only a few short weeks prior to the death of Mr King. After viewing that footage Mr Cullen stated that he had not seen it previously and was unaware of the earlier incident. He stated that had he been aware; he would have instantly dismissed Mr Hoermann and that such conduct was not in accordance with the standards he expected of his staff. He stated that he expected all patrons who came to the hotel to be treated with respect and he believed this was understood by staff.

63. I note that counsel for the family submitted that these two (2) incidents were indicative of a “culture” of the excessive use of force at the hotel or at least a “culture permissive” of the use of such excessive force. As I stated to counsel during the proceedings, I do not agree with that submission and I do not consider there is sufficient evidence to support such a submission based

on two (2) incidents. I accept the evidence of Mr Cullen that he expected more of his staff and was disgusted at such behaviour.

64. I note that after the tender of the current Code of Conduct provided by the Katherine Hotel I indicated to Mr Cullen that a paragraph should be included within the Code that advised security staff that they should ***not*** hold someone on the ground face down by force and that the Code should clearly outline that the risk in doing so was that someone could die. Mr Cullen agreed to make such changes and I was pleased to receive that concession. I should note here that having subsequently received the Practice Direction issued by the Director-General of Licensing, it is apparent to me that the wording contained in that direction may assist the hotel with the wording to be included in its own Code of Conduct.

ASQA review of training for the security industry in Australia

65. As previously mentioned, ASQA is the Commonwealth body that regulates RTO's nationally and regulates the courses and training providers to ensure nationally approved quality standards are met. ASQA also conducts reviews of such training. The most recent review was commenced in 2014 and their report was published only recently on 28 January 2016. A copy of that report was tendered into evidence.

66. The ASQA report confirmed and recognised the same concerns I had experienced when I exercised my discretion to have an inquest into this death. Part of my concerns related to the quality of the training and assessment of persons to obtain a licence as a crowd controller. I note that the ASQA report set out that this had been raised by a number of Coroners all around Australia in a number of inquests into the deaths of patrons during, or as a result of, the restraint or intervention of crowd controllers.

67. Relevantly part of the key findings of the ASQA review included the following:

67.1 “Coroners in several jurisdictions have expressed concerns over public safety given poor training for security personnel.

67.2 Training courses are generally very short and do not allow sufficient time for the development and assessment of skills and knowledge.

67.3 There is evidence of learners with inadequate levels of language, literacy and numeracy skills to undertake security qualifications or to work in the industry.

67.4 There is a deficiency in the training package, in that it does not explicitly address the risks and dangers of restraints and the safe use of restraint techniques.

68. The ASQA review made eight (8) recommendations. I will not set out all of the recommendations, however relevant to this inquest are recommendations 1 and 5:

1. “It is recommended that the training package developer, in consultation with the state and territory licensing authorities and the security industry, progresses as a priority a review of the Certificates II and III in Security Operations, in order to:

- ensure they meet the skill-related requirements for relevant security licence activities, and

- provide a single set of qualifications and units to be agreed by licensing authorities for use in all jurisdictions.

5. It is recommended that:

- In its review of the Certificates II and III in Security Operations, the training package developer specifically reviews the relevant units of competency relating to restraints and the use of restraint techniques, in order to ensure these explicitly embed knowledge and skill

requirements to sufficiently address key safety issues such as positional asphyxiation.

- Licensing authorities in all jurisdictions identify—and include as mandatory in the nationally agreed single set of competency standards—the most appropriate unit/s of competency to ensure security licensees meet the knowledge and skill requirements relating to restraints and the safe use of restraint techniques.

- Licensing authorities in all jurisdictions require all relevant current security licensees to refresh their skills and knowledge of safe restraint techniques prior to renewing, or re-applying for, their licence. The exact requirements should be determined in collaboration with industry and be consistent across all jurisdictions.

69. I note that Ms McGill has stated that the Director-General of Licensing NT is presently considering all the recommendations made and intends to address the deficiencies that have been identified both as a result of the report by ASQA, but also this inquest. In terms of the circumstances surrounding this death, had there not been the kind of recommendation made at recommendation 5 (regarding safe use of restraints and key safety issues such as positional asphyxiation) I would have determined that a similar recommendation was necessary. This is particularly so in light of the evidence as to the complete lack of recollection by Mr Hoermann and Mr Clark of anything relating to positional asphyxiation, but also the evidence of what can only be termed as "threadbare" reference to the dangers and risks of positional asphyxia within the course itself.

70. I also note that just days prior to the commencement of this inquest, the Director-General of Licensing issued a Practice Direction to all Security Providers, including Licensees, and RTO's in relation to the risks of the application of force causing asphyxia. This was entitled "Practice Direction – Security Providers – Asphyxia" and was dated 11 February 2016. This

direction clearly sets out the very real risks of positional asphyxia and the measures to be undertaken by security providers. It is important that these matters are addressed and I am pleased that the Director-General of Licensing has taken such a proactive approach in issuing the Practice Direction addressing the same and intends to be proactive in participating in the recommendations made in the ASQA report.

71. I note also Ms McGill's evidence that the Director-General also intends to issue a recommendation to the Minister that a review of competency standards and the training required to attain those competencies should be undertaken, with the review to consider introducing refresher training, particularly in the areas of communication and negotiation (including in cross cultural situations) and the application of force.

72. Again, I consider this to be an important step in addressing the issues raised as to public safety when dealing with security providers, including crowd controllers, and I encourage the Minister to conduct such a review whilst at the same time considering the matters raised and recommendations made by ASQA. It is as a result of this stated commitment by the Director-General of Licensing via the evidence of Ms McGill that I do not consider it necessary to make specific recommendations in this inquest. I note also that there are important considerations to be given to compliance with the legislation and particularly s.53 of the PSA and consultation with the responsible bodies and stakeholders. I am prepared to accept that the Director-General is genuine in the evidence provided to me of the commitment to making change to ensure improvements are made to the current system and particularly in relation to the competency standards and training required of crowd controllers here in the Northern Territory. I rely upon that stated commitment in determining not to make any such recommendations as a result of this inquest.

Final Comments

73. I accept that from time to time physical confrontations may occur during the course of a crowd controller performing their duties. By definition, "crowd controllers" are required as part of their duties to remove persons because of their behaviour. Not all persons do so voluntarily or willingly and if that person becomes violent or combative it may be necessary to attempt to restrain them which may result in them being placed on the ground and stabilised.

74. It is however well recognised that persons who are overweight, or have what is colloquially known as a "beer belly", are particularly at risk of suffering from positional asphyxia if they are placed into such a position due to the way in which the contents of their abdomen are forced upwards within the abdominal cavity, thus placing pressure on the diaphragm and restricting breathing. Being overweight however is not the only risk factor. Alcohol, drugs, pre-existing medical conditions, respiratory muscle fatigue and the number of persons involved in the restraint are further factors that can contribute to someone suffering from positional asphyxia.

75. The difficulty that commonly arises is that although a person may initially be struggling in order to resist restraint and/or continue their violent or aggressive behaviour, once restrained on the ground their breathing becomes restricted or they suffer discomfort. The person may then believe they are suffocating or suffering pain and may then fight even harder in an attempt to get relief. This unfortunately however can result in the person/s restraining the individual to apply even more force or to prolong the continuation of such force and I find that it is more likely than not that this is precisely what occurred in this matter.

76. Despite the reality that physical confrontations may occur requiring crowd controllers to restrain an individual, the evidence establishes that there is very little training provided to crowd controllers as to the real risks that

exist of positional asphyxia occurring during a restraint. I note this was acknowledged by Ms McGill on behalf of the Director-General of Licensing, when she stated that the "curriculum is deficient and should be clearer, more directed, and without doubt assessed". I agree entirely and I note that steps are now being undertaken to address this deficiency.

77. I note that detailed submissions were made on behalf of the family that certain findings and recommendations should be made based on the evidence. I have considered those submissions carefully and I respond as follows:

77.1 I have already found that the training currently provided under the Certificate II in Security Operations in relation to positional asphyxia is inadequate and note that the Director-General of Licensing is already making proactive changes with respect to this inadequacy.

77.2 I accept the evidence of Mr Cullen on behalf of the Katherine Hotel that information will be included in their Code of Conduct about the dangers of positional asphyxia and the use of neck restraints. I also consider that the recent Practice Direction issued by the Director-General of Licensing addresses this issue and provides appropriate support to any amendments to the Code of Conduct. As a result I decline to make a recommendation to this effect.

77.3 As to a recommendation of review of the current units of competency relating to restraints and the use of restraint techniques; I note that this is already part of the recommendations made within the ASQA report. I do not intend to repeat the substance of such recommendations. I am also persuaded by the evidence of Ms McGill and the submissions made on behalf of the Director-General of Licensing that no matter the decisions made on a national level; the Director-General is already committed to recommending a review by the Minister of competency standards and training. I note also the evidence of Ms McGill that "the

recommended review will consider introducing refresher training, particularly in the areas of communication and negotiation (including in cross cultural situations) and the application of force". As a result I do not consider it necessary to make a formal recommendation in this regard and I simply encourage the Minister to consider undertaking such a review as quickly as possible. I note that such a proposed review addresses a number of the matters raised on behalf of the family.

77.4 As to a recommendation that a minimum number of face to face contact hours be considered, I do not consider such a recommendation necessary and I leave this for the Director-General to consider in light of the recommendations made in the ASQA report.

78. Unfortunately, no matter the level of training provided there will always be "rogues" in the security industry, i.e. persons who are bullies and thugs and despite all their training will use violence which goes beyond any reasonable restraint and is not in accordance with their duties. In my view, Mr Hoermann may very well have been such a person.

79. Mr King should not have died in the manner that he did. It was, as submitted by counsel for the family, "horrible and unnecessary". They have my deepest sympathy. Whilst I am unable to find that changes to training in relation to positional asphyxia and/or the Practice Direction issued by the Director-General would have meant that Mr King's death did not occur, I do consider that they would have provided clear and cogent information and direction to crowd controllers of the risks and dangers of any use of force involving the head and neck and the restraint of a person on the ground. As a result they may have resulted in the crowd controllers involved taking greater care in terms of the restraint of Mr King and in relation to getting him up from the ground as soon as possible, thus reducing the risk of his death.

Formal Findings

80. On the basis of the tendered material and oral evidence given at this inquest, I am able to make the following formal findings:

i. The identity of the deceased person was Styles Isaac King who was born on 16 June 1982 in Katherine in the Northern Territory of Australia.

ii. The time and place of his death was approximately 11.20pm on 27 March 2013 at the Katherine District Hospital, Katherine in the Northern Territory of Australia.

iii. The cause of death was traumatic asphyxiation.

iv. Particulars required to register the death:

a. The deceased's name was Styles Isaac King.

b. The deceased was of Aboriginal descent.

c. The death was reported to the Coroner.

d. The cause of death was confirmed by post mortem examination carried out by Dr Terence Sinton on 28 March 2013.

e. The deceased's mother is Eunice Rose Wanongumara Isaac and his father was Arthur Elwyn King (deceased).

f. The deceased was unemployed at the time of his death.

Dated this 18th day of March 2016

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GREG CAVANAGH
TERRITORY CORONER