Coroners Act, 1996
[Section 26(1)]

Western ***Australia***

RECORD OF INVESTIGATION INTO DEATH

Ref No: 2/13

*I, Dominic Hugh Mulligan, Coroner, having investigated the death of **Gemma Geraldine THOMS**, with an Inquest held at Perth Coroners Court on 21-25 January 2013 and 29 January 2013 find that the identity of the deceased person was **Gemma Geraldine THOMS** and that death occurred on 2 February 2009 at Sir Charles Gairdner Hospital, Nedlands as a result of Acute Methylenedioxymethylmaphetamine (MDMA) in the following circumstances -*

Counsel Appearing :

Kate Ellson assisted the Coroner
Jonathan Davies (instructed by Gary Rodgers) appearing on behalf of Altered State Pty Ltd, Christopher Knight and Kenneth Knight

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INTRODUCTION

1. On 28 November 2008 Gemma Geraldine Thoms turned 17. Her parents gave her a present of 2 tickets to the Big Day Out, which was scheduled to take place on 1 February 2009, at the Claremont Showground.

2. On 31 January 2009, Ms Thoms purchased 5 tablets of ecstasy. Each tablet of ecstasy cost between $30 – $35.

3. She purchased the drugs to share with a friend, Cassandra Southern, during the course of the Big Day Out.

4. At about 10:45Am on 1 February 2009, whilst at home, the deceased consumed 1 ecstasy tablet.

5. At about 12pm, whilst outside the Claremont Showground, she consumed a further 2 ecstasy tablets.

6. Ms Thoms did not know the constituent ingredients of the 3 ecstasy tablets she had just consumed or the quantity of Methylenedioxymethylamphetamine (MDMA) in the tablets.

7. Significantly, Ms Thoms did not know that after she swallowed the third tablet she had just consumed a fatal quantity of ecstasy, which in the context of a very hot day, would inexorably lead to her death unless she was extremely lucky, and received prompt, expert and focused high-level medical attention in a hospital.

8. At about 1pm Ms Thoms was noticeably ill and she was taken to a first aid post for treatment. Ms Thoms was seen by a volunteer first-aider and she remained in the first aid post between about 1:05pm – 1:30pm.

9. Ms Thoms did not tell the volunteer first-aider the truth about the drugs she had taken. She did not tell him that she had taken 3 tablets of ecstasy.

10. At about 1:30pm the first-aider believed to Ms Thoms to be better and she was released from the first aid post, back into the Showground.

11. At about 2pm Ms Thoms went on one of the rides in the Showground. When she came off the ride she collapsed and was taken to another first aid post.

12. First aid volunteers recognised Ms Thoms was dangerously ill and was suffering from hyperthermia. They learned that Ms Thoms had taken 3 ecstasy tablets.

13. Ms Thoms was transported by ambulance to Sir Charles Gairdner Hospital where she was received into the Emergency Department at about 3:05pm.

14. According to Dr Oldham[1], speaking for Sir Charles Gairdner Hospital:

> On arrival in the emergency Department her Glasgow coma score was 6 and rectal temperature was 43°C. She had likely aspiration. She was sedated and intubated, and actively cooled externally. An ECG showed unstable irregular broad complex rhythm. Potassium was 6.6. She was assessed as having a likely amphetamines/ecstasy ingestion in a hot environment leading to severe hyperthermia. She was admitted to the Intensive Care Unit. She developed acute renal failure, acidosis, acute respiratory distress syndrome and massive disseminated intravascular correlation. Her condition deteriorated over the next day despite treatment and she was declared deceased at 1:40 PM on the 2nd February 2009.

15. On 2 February 2009 Gemma Geraldine Thoms (the deceased) died of acute Methylenedioxymethylamphetamine (MDMA) toxicity[2].

16. The deceased had hoped to be an organ donor in the event of her death. This was not possible as, at the time of her death, her organs were no longer suitable for use in the organ donor program. The acute hyperthermia the deceased suffered, in effect, cooked her organs and made them unsuitable for transplant into another person.

17. The deceased's parents, Mr and Mrs Davies, wrote to the office of the State Coroner following the death of their daughter and sought an inquest.

18. Mr and Mrs Davies were concerned to find out the facts that led to their daughter's death. They were also concerned that current first aid and medical guidelines for large-scale public events are inadequate and do not adequately protect public safety at an event like the Big Day Out.

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1 Exhibit 1 Volume 1 Tab 28 – Letter From Dr Oldham
2 Exhibit 1 Volume 1 Tab 35 – Post Mortem Report

19. They not only wrote to the court and prepared witness statements, but Mr Davies also gave evidence during the course of the inquest.

20. Mr Davies brought not only the concerns of a parent but also the experience and understanding of an extremely well qualified paramedic who operates from a rescue helicopter.

21. He highlighted the fundamental differences between the skills that a volunteer first-aider possess and that which a tertiary qualified expert like a paramedic, nurse or doctor bring to bear on potentially life-threatening situations.

22. Mr and Mrs Davies would like to see a much greater medical capability mandated at the Big Day Out, or other similar large-scale concert events.

SOME PRELIMINARY MATTERS OF LAW

23. The inquest into the death of the deceased was held in accordance with the *Coroners Act 1996* (WA) (the Act). Pursuant to section 25 (1) of the Act the coroner must find, if possible-

1. The identity of the deceased;
2. How death occurred;
3. The cause of death; and
4. The particulars needed to register the death under the Births, Deaths and Marriages Registration Act 1998.

24. The obligation to determine the manner of death also arises as part of the enquiry as to how the deceased died pursuant to s 25(1)(b) of the Act. In this context Buss JA noted that '*in my opinion s 25(1)(b) confers on the coroner the jurisdiction and obligation to find, if possible, the manner in which the deceased happened to die*.' ***Re The State Coroner; Ex Parte the Minister for Health*** [2009] WASCA 165 [42].

25. Pursuant to the *Births, Deaths and Marriages Registration Act 1998* (WA) the coroner must find, if possible, the manner of death. The manner of death is registrable information under s 49(2) of that Act and is information that is

captured on a BDM204 form which a coroner, or delegate, must provide to the Registrar of Births Deaths and Marriages.

26. Section 25(2) of the Act provides that a coroner may comment on any matter connected with the death including public health or safety or the administration of justice.

27. When making findings or comment a coroner needs to be mindful of s 25(5) of the Act, which places the only statutory limitation upon how a comment or finding may be framed. Section 25(5) of the Act provides:

> A coroner must not frame a finding or comment in such a way as to appear to determine any question of civil liability or to suggest that any person is guilty of any offence.

28. The analogous provision within the South Australian legislation was considered by the Supreme Court of South Australia in ***Perre v Chivell*** No. SCGRG-99-1218 [2000] SASC 279 (24 August 2000) when considering the appropriateness of a finding that had been made by the South Australian State Coroner in the following terms:

> Accordingly, I find, pursuant to section 25 (1) of the Coroners Act 1975, that the circumstances of the death of Detective Sergeant Geoffrey Leigh Bowen were that he died when he opened a parcel bomb, sent to him by Domenic Perre, and the bomb exploded in his hands.

29. After concluding that the finding did not appear to determine any question of civil or criminal liability, His Honour considered whether or not the finding offended against the Act as '*suggesting*' that Mr Perre was guilty of a criminal offence or liable in a civil context. At paragraph 57 of the judgment His Honour Nyland J stated:

> As I have already mentioned, section 26 (3)[3] refers not only to findings of criminal or civil liability, but also any "suggestion" thereof. The addition of the word "suggestion" is liable to cause confusion as it might be argued that the mere finding of certain facts can, in cases such as the present, suggest or hint at criminal or civil liability and hence breach the section. This is due to the fact that certain acts, such as, in this case, sending a bomb, appear to have no possible legal justification. However, I do not think that section 26 (3) should be read in such a way. The mere recital of relevant facts cannot truly be said, of itself, to hint at criminal or civil

[3] Analogous to s 25(5) *Coroners Act 1996* (WA)

> liability. Even though some acts may not seem to be legally justifiable, they may often turn out to be just that. For example a shooting or stabbing will, in some circumstances, be justified as lawful self-defence. As I have stated, criminal or civil liability can only be determined through the application of the relevant law to the facts, and it is only the legal conclusions as to liability flowing from this process which are prohibited by section 26 (3). Thus, the word "suggestion" in this section should properly be read as prohibiting the coroner from making statements such as "upon the evidence before me X may be guilty of murder" or "X may have an action in tort against Y" or statements such as "it appears that X shot Y without legal justification". In other words, the term "suggestion" in section 26 (3) prohibits speculation by the coroner as to criminal or civil liability. In the present case, the coroner has neither found nor suggested that Perre is criminally or civilly liable for his acts.

30. Section 41 of the Act provides that a coroner holding an inquest is not bound by the rules of evidence and may be informed and conduct an inquest in any manner the coroner reasonably thinks fit. This section provides a coroner with latitude as to the types of evidence that can be considered by the coroner and allows a relaxing of the normal rules of evidence.

31. Section 41 does not allow a coroner to disregard the rules of natural justice or fairness.

32. It is trite to say that the standard of proof in a coronial matter is the civil standard; on the balance of the probabilities.

33. Caution does need to be taken in circumstances where a finding or comment may be adverse to a person involved in the inquest process.

34. Dixon J in ***Briginshaw v Briginshaw*** (1938) 60 CLR 336 at pp 362-3 articulated the concern a tribunal of fact should have when dealing with cases, which could potentially have serious consequences for one or more parties involved in the inquest:

> Reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from the particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the Tribunal. In such matters reasonable satisfaction should not be produced by inexact proofs, indefinite testimony, or indirect inferences… when in a civil proceeding, a question arises whether a crime has been committed, the standard of persuasion is, according to the better opinion, the same as upon of the civil issues… but consistently with this

opinion weight is given to the presumption of innocence and exactness of proof is expected.

35. I take the comments of Dixon J in ***Briginshaw*** to encourage a more cautious approach, than that represented by the normal standard of persuasion, in circumstances where an adverse finding is under consideration

36. It is with that statutory and legal background the inquest into the death of the deceased has been held and this finding delivered.

THE EVENTS BEFORE THE BIG DAY OUT

37. The deceased lived with her mother, Peta Davies, her stepfather, Paul Davies, and 2 half-siblings; Mitchell and Jacinta.

38. The deceased had a normal and happy childhood.

39. She generally enjoyed good health and she had no history of major illness or disease.

40. During her first year at school it was discovered that the deceased was short-sighted. Later in her school career she was diagnosed as suffering Attention Deficit Disorder (ADD) for which she was treated with dexamphetamine in order to control her symptoms.

41. The deceased was dyslexic and in her first 1½ years at high school she had speech therapy.

42. The deceased was a very happy and bubbly person who had a clear career goal of becoming a hairdresser.

43. The deceased left school at the end of year 11 and began an apprenticeship with a hairdresser in Kalamunda. She worked at the salon until her death.

44. The deceased began to use drugs at least 2 years before her death. She used cannabis and ecstasy. She used the drugs with her friends. It appears likely the

deceased only used drugs in social settings when she was with others. There is no evidence to suggest the deceased took drugs when by herself.

45. The deceased's parents were very protective of her and they did their best to ensure that the deceased was not exposed to illicit drugs. They cautioned her against the use of illicit drugs.

46. When the deceased was aged 16 her mother became concerned that she may be using cannabis. Mrs Davies had suspicions that the deceased may have been using cannabis, but no hard evidence to support her concern. Mrs Davies spoke to the deceased about using cannabis. The deceased assured her mother that she was not using drugs.

47. About a week before the Big Day Out, according to the deceased's friend, Cassandra Southern, the deceased had employed a complicated process in order to modify her driver's licence so that it showed her to be a year older than she actually was. This process created a driver's licence that overstated her age by one year and would lead to the conclusion the deceased was 18 years old[4].

48. According to Cassandra Southern the deceased went through this complicated process in order to be able to buy drinks '*at the Big Day Out and any time, at the pub, buy cigarettes and stuff*[5]'.

49. On 31 January 2009 the deceased and her friend, Cassandra Southern, discussed the fact that they were going together to the Big Day Out on the following day. They discussed buying some ecstasy for their use at the Big Day Out.

50. The deceased told her friend that she would buy the ecstasy.

51. The deceased purchased the ecstasy from a source who had previously supplied her with the drug.

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[4] ts 85
[5] ts 46

52. During the evening of 31 January 2009 the deceased and some friends went to the Kalamunda Hotel. The deceased likely gained access to the licensed premises by using her modified driver's licence. The deceased and her friends left the hotel at closing time and returned to her home.

53. After arriving home the deceased began to call her friends and contacts in order to purchase cannabis. She called one of her friends, Justin Carmichael. At about 12:15am.

54. About 15 minutes after receiving the phone call, Mr Carmichael arrived at the deceased's home in a large Toyota four-wheel-drive. Mr Carmichael was the passenger in the vehicle.

55. Mr Carmichael sold the deceased a small quantity of cannabis for $25[6].

56. The deceased, Mr Carmichael, the driver of the four-wheel-drive and another friend then smoked the cannabis using a bong[7].

57. The deceased's use of a small quantity of cannabis during the early hours of 1 February 2009, explains why a very small quantity of Carboxytetrahydrocannabinol was detected in a post mortem sample of blood subjected to toxicological analysis by the Chemistry Centre WA[8]. Carboxytetrahydrocannabinol is a metabolite of cannabis.

THE EVENTS OF 1 FEBRUARY 2009

58. The deceased was at home during the morning of 1 February 2009.

59. At about 8:30am Cassandra Southern arrived at the deceased's home[9]. Both young women were excited and very much looking forward to the day ahead.

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[6] Exhibit 1 Volume 1 Tab 12 – statement of Beau Ronald French and transcript page 19 evidence of Justin Carmichael
[7] Exhibit 1 Volume 1 Tab 12 – statement of Beau Ronald French
[8] Exhibit 1 Volume 1 Tab 36
[9] ts 45

60. At about 10:20am Cassandra Southern drove the deceased to the BP service station in Kalamunda. The deceased wanted to go to the service station so that she could purchase credit for her Sim card which she was going to use in a mobile phone loaned to her by Ms Southern.

61. After running the errand the 2 young women returned to the deceased's home. They arrived home at about 10:45am. The deceased's mother was out shopping at the time.

62. After arriving home Ms Southern was shown the 5 ecstasy tablets the deceased had purchased. The tablets were green in colour and had a heart shape imprinted into them. The drugs were contained in a clip-seal bag, which itself was in another clip-seal bag. The inner bag also contained a chilli pepper, which the deceased believed may be effective in the masking the scent of the drugs from detection.

63. The drugs cost $30 – $35 which was to be split equally between the 2 young women.

64. At about that time the deceased and Cassandra Southern each took 1 ecstasy tablet.

65. A little later Mrs Davies returned home. She then drove the 2 young women to the Claremont Showground. During the course of the drive Mrs Davies noticed nothing untoward in the behaviour of her 2 passengers. They were excited, happy and chatting to one another.

66. During the course of the drive to Claremont Mrs Davies cautioned the young women and told them to get sunscreen, drink a lot of water and to '*do the right thing*'.

67. Mrs Davies, the deceased and Cassandra Southern arrived at the Showgrounds at about midday. The young women got out of the car and began to make their

way towards the Showground. Mrs Davies again told her daughter to be careful to which the deceased replied *'Don't worry. I'll be fine. I love you.'*

68. As the young women were making their way towards the entry gate, they bumped into a number of friends, who they spoke to. One of the friends asked if the deceased and Ms Southern were on drugs. Ms Southern confirmed that they were and the friend said[10] '*You look it*'.

69. Ms Southern and the deceased then continued to walk towards the entry gate. As they did so the deceased started to panic and she became scared of getting caught by the police with the drugs. She was concerned that there were police sniffer dogs in the area that would be able to detect the drugs.

70. The deceased took the remaining 3 ecstasy tablets from where she had them concealed. She gave one tablet to Ms Southern, who swallowed it. The deceased swallowed the remaining 2 tablets in her possession.

71. The deceased did not appreciate the significance of her actions. The deceased did not appreciate that unlike taking some medications, like aspirin or panadol, the difference between taking 1 and 3 ecstasy tablets was the difference between life and death.

72. After taking the 3 ecstasy tablets the deceased's life was at risk. She had unknowingly consumed a fatal quantity of ecstasy.

73. Some illicit drugs have a reversal agent, which if administered in a timely manner, after overdose, tend to reverse the effects of the illicit drug and may be able to save the life of a person who has suffered an overdose. For example those who have suffered an opioid overdose, such as Heroin, may be effectively treated by Naloxone.

74. There is no reversal agent for those who have suffered an overdose of ecstasy.

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[10] ts 52

75. A person who has suffered an overdose of ecstasy may survive if they are extremely lucky and receive prompt high-level hospital treatment which attempts to treat the symptoms and consequences of the overdose. A patient suffering from an ecstasy overdose may need advanced life support, including; airway support, circulation support, medication such as midazolam to control seizures and fitting, IV therapy to provide fluid hydration and efforts to cool the patient in order to prevent or minimise the effects of hyperthermia[11].

76. Both young women then made their way to the entry gate, where they would have their tickets checked and they would have their ages verified.

77. The entry gate was located in a large room divided into a number of channels through which patrons entered. They were initially checked to ensure they had a valid ticket for the event. They then went on to have their age verified. The verification process consisted of the patron telling the responsible person of their age and showing a valid form of identification in support of that claim.

78. Following that process the patron walked a short distance to either receive a bright yellow coloured tamperproof wristband or a black cross on the back of their hand, made by magic marker.

79. Those who received the bright yellow wristband were believed to be 18 years or older. Those who received the black cross marked on their hand were believed to be under the age of 18 and therefore not entitled to enter into the licensed portions of the Showground where alcohol would be served.

80. The deceased went through the entry process and by using her altered driver's licence she was believed to be 18 years old and she was given a wristband.

81. Ms Southern, who was also 17 years old, was identified as a minor. She was directed to a line where she was initially marked with a black cross on the back of her left hand. She then used some water from a bottle and quickly rubbed the black cross from the back of her hand. After cleaning her hand Ms Southern

[11] ts 444 – 445

then presented her wrist to another person working at the entry point. The worker likely noted the absence of a black cross and he or she then put a bright yellow wristband around Ms Southern's wrist[12].

82. I was initially sceptical of Ms Southern's claim that she was able to simply rub the black mark off her hand using nothing more than water. However, Mr Christopher Knight, an employee of Altered State Pty Ltd, the promoter of the Big Day Out, was concerned by the evidence Ms Southern gave during the course of the inquest. He performed a test in which he verified Ms Southern's claim that the black mark could be removed in the manner she described. During the course of his evidence Mr Knight said,[13];

> Having heard Cassandra's evidence, I was sort of quite concerned by that. I actually tested it myself, and it appears that, yes, in the presence of a large form of moisture, if done extremely rapidly after the application, then that could be removed, which is an indication of, you know, maybe we should move away from that system.

83. The effect of the 2 young women's actions were that they obtained access to the Showground as adults entitled to enter licensed premises and able to obtain alcohol. According to Cassandra Southern the 2 young women planned to buy alcohol whilst at the Big Day Out. During the course of her evidence Ms Southern was asked about the plans they had before going to the Showground. During the morning, whilst at the deceased's house, the 2 women had talked about what they intended to do[14]:

> **Ms Ellson:** Did you talk about what you were going to do that day?
>
> **Ms Southern:** Yes, we, yeah, just planned to get drunk and go see the bands.

84. According to Ms Southern the 2 young women used their yellow wristband in order to get into a licensed area at the Showground, where they purchased a small quantity of alcohol. According to Ms Southern she knew the deceased[15]

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[12] ts 46 – 47
[13] ts 530
[14] ts 45
[15] ts 55

'Bought drinks. If she drank it or not – I think she might have drank one, but I don't think she would have finished it'.

85. The deceased and Ms Southern spent about an hour meandering through the Showground. During the course of that time they met several groups of their friends, who noted the deceased to be affected by drugs. The deceased and Ms Southern went to the toilet where Ms Southern vomited. A little later the 2 young women went on a ride known as the '*Ranger*'. After the ride the 2 women went and sat at a table with a couple from Melbourne. The couple from Melbourne did not know either of the women, however, they were concerned for their well-being and gave them their telephone number in the event they needed help.

86. After leaving the couple from Melbourne, the 2 young women went to a cooling station, where they walked through a mist machine.

87. It is likely the deceased had not drunk any water since arriving at the Showground and she did not want to drink water whilst at the cooling station.

88. The 2 young women then went to hear a band who were playing on an indoor stage. Whilst the deceased was listening to the band she accidentally bit off her tongue ring. The deceased did not appear to be concerned by this event.

89. A little later a security officer, Mr Brian Massoudi, saw the deceased, who appeared to be unwell. She had a quivering lip, a nervous twitching type of body movement, she appeared unable to focus and she was having difficulties balancing.

90. Mr Massoudi arranged for 2 of his colleagues to take the deceased to a first aid post.

91. It is likely that when the deceased was en route to the first aid post some of her friends saw her and joined her outside the first aid post, before she went inside. The friends were Luke Grant and Philip Gillespie.

92. According to Mr Grant he was told that the deceased had taken 3 green heart ecstasy tablets[16]. According to Mr Grant, the deceased and her friends were scared that if the truth emerged about the deceased's drug taking she could be arrested and/or ejected from the venue.

93. During evidence Mr Grant was asked a number of questions relating to what occurred outside the first aid room[17]:

Ms Ellson:	How did Gemma seem about going to the first aid tent?
Mr Grant:	We were scared, mainly because we thought we might get kicked out if they knew the truth or anything like that.
Ms Ellson:	What makes you say that?
Mr Grant:	Well, when you've got illegal drugs in a venue, you know, you think you might get kicked out, arrested or something like that.
Ms Ellson:	Did you have a conversation with Gemma and Cass about what you might tell people?
Mr Grant:	Yes.
Ms Ellson:	And what was that?
Mr Grant:	We just talked very briefly about it and we thought we would say that they had dexies, as they're a less-category drug.
Ms Ellson:	Sorry, as a - - -?
Mr Grant:	Like lower-category sort of drug.
Coroner:	So why did you think it would be better telling people that Gemma or Cass had been using dexies, as you put it, rather than ecstasy?
Mr Grant:	I don't know. I wasn't thinking at the time. Just thought it sounded better than, you know, what we really had.
Coroner:	Do you know what ADHD is?
Mr Grant:	Yes
Coroner:	Do you have any friends who have ADHD?
Mr Grant:	I had one friend, yes.
Coroner:	Does that person get treated by way of dexies?
Mr Grant:	Yes
Coroner:	All right, so you know that dexies can be legally prescribed. Was that any part of your thinking?
Mr Grant:	Yes, sort of.
Coroner:	In what way?
Mr Grant:	Just, you know, because I knew they're not illegal for some people. I thought maybe it might have just - you know, got away with it.

[16] ts 122
[17] ts 124

Coroner:	Okay.
Ms Ellson:	Did your conversation involve agreeing how many dexies Gemma would tell people she'd had?
Mr Grant:	Yes, sort of just the number of pills, so it was about three.
Ms Ellson:	All right. Did you go with Gemma to the first aid?
Mr Grant:	No.

94. After speaking with her friends the deceased went into the first aid room where she was examined by Mr Anthony Holding.

95. Mr Holding gave evidence during the course of the inquest. I found him to be a decent, honest, generous and public-spirited man who, after retiring, decided to do voluntary work in the community.

96. Mr Holding's choice of community service was with the St John Ambulance Service, who he joined as a volunteer first-aider.

97. In his time with the St John Ambulance Service Mr Holding qualified as an advanced first-aider. In order to obtain the qualification he first successfully completed a 2 day course run by the St John Ambulance Service. Mr Holding maintained that qualification by performing 60 hours' voluntary service per year and by attending a minimum of 12 events.

98. By the time of the Big Day Out Mr Holding had been volunteering with the St John Ambulance Service for about 18 months.

99. Without intending to diminish Mr Holding, or other volunteers, it is obvious that his degree of training and expertise was far removed from that of medical professionals, such as doctors, nurses and paramedics who have studied and trained for years before obtaining their qualifications.

100. I should emphasise that Mr Holding attended the Big Day Out as a volunteer, without any form of payment or advantage.

101. During the course of his evidence Mr Holding explained what had happened once the deceased entered the first aid post[18]:

Mr Holding: I wasn't treating anyone at the time when a young girl came in; she was with a couple of blokes. I don't remember if they were friends or Security. I spoke to the young girl. The chaps had gone. According to my notes it was about 1.05.

I sat her on the bed; she sat cross-legged. I asked her what was wrong. She said something along the lines she didn't know what she'd been brought in for. I got her name, which I asked her to spell. She gave me the name Gemma Thomas. I had a cadet with me and they wrote the name on her notes. I asked her questions. She gave me an address of 7 Currawong, Gooseberry Hill. Her date of birth was 26 November 1990, and her phone number was 0405019348. I took her pulse, checked her pupils, her respiration and her blood pressure, and we talked so I could work out how she was.

I made notes on an official St John's observation sheet. Official notes and records come to head office at Belmont. The young girl was flushed and hot, but most people were like that when they came in. It was hot. By hot, she just looked hot. I hadn't taken her temperature; we don't generally take temperatures. She had been a bit jumpy and excited when she came in, but most of the kids there were excited. She calmed down slightly while we talked.

She asked if she could leave, two or three times. On my notes it is recorded that she came in at 1.05 and left at 1.30, so 25 minutes she was with us. I was there talking to her for 25 minutes.

I checked her pulse. When she came in it was 120 heartbeats per minute. I can't recall if I did this in 30 secs or calculated on a whole minute. It is recorded at 1.30, or 1330 hours in my notes, but I know it was before that. That was the time I wrote in the notes, unfortunately. Her blood pressure was 135 systolic. You don't do the lower unless you are a doctor or nurse. Her pupils were checked and they registered at four on each eye. A torch was used as a gauge on it. Her respirations were 22 breaths in one minute. She was alert to speak to. She seemed okay. She was relaxed and she was talking okay. I'm pretty sure we gave her water. It was about 37 degrees Celsius, and something outside was giving everyone water. The fans and airconditioning we were using in the room weren't very effective.

The condition she was in seemed okay. Her heart rate was a little bit high but they'd all been jumping about and excited. She did say during the conversation that she'd had a dexy at 10 am. By "dexy" I thought it was a pill or tablet type. At the time I wasn't sure. I now know it meant dexamphetamine, which I understand is a prescribed drug. I asked her how it made her feel, and if she was feeling okay, and she said she was. She kept asking if she could go. She seemed quite okay to me.

[18] ts 153 – 154

> I think some of her friends came in to speak to her while she was there but they wandered off, I think outside to wait. There was a lot of other people in first aid that had been a lot worse.
>
> I gave her advice on making sure she drank water and come back if she felt worse, or to see a doctor. She never said she had a problem the whole time she was there, that I can recall, and she didn't seem like she was anything other than okay, just a bit hot. I didn't hear any more about this young girl or what happened until I saw it in the papers the next day.

102. It should be noted that the deceased was not truthful with Mr Holding. She misled him as to her age by giving the wrong birth date, suggesting she was one year older than she was. She also misled him as to what drug she had taken. The deceased did not tell Mr Holding that she had taken 3 tablets of ecstasy, rather she said she had taken a '*Dexie*'. When asked during the course of his evidence as to whether he knew what a '*Dexie*' was, he replied[19]:

Mr Holding:	I didn't know exactly what it was, other than I understood it to be a milder form of drug, not an ecstasy-type drug, but I didn't know the exact use of it.
Coroner:	Did you understand it to be an illegal, illicit drug?
Mr Holding:	At the time not exactly, no. No. Now I've kind of studied up a bit, so.
Coroner:	All right. Well, was it like taking an aspirin or was it like taking - - -?
Mr Holding:	Well, yes, I thought it was just more - it's just a mild type of drug, not one of the harder drugs, and someone said that she'd only taken "a" dexie and no more than that.
Coroner:	And you've given an overall assessment. What did you write there?
Mr Holding:	Just overall, "Dexie. On a high", because she seemed a bit hyped up, but - - -
Coroner:	So you thought that the dexie had had an effect and that was to make her high?
Mr Holding:	Just a bit high, yes. She didn't seem too high to me, but - - -

103. Mr Holding's cadet completed a Casualty Report (form OB 12) relating to the deceased's time in the first aid post. The cadet completed the document based

[19] ts 159

on information g1ven by Mr Holcling and the deceased. The completed document was in the following form:

CONFIDENTIAL EFAS-80-02

Casualty Report

0812

StJohn Ambulart;;';Australia (Western Australia) Inc.
Volunteer First Aid Service
PO Box 183 Belmont WA 6984 • Telephone:9334 1222

Casualty Name: Surname TboLk:Jn S· . Given Names OeM&..O..

Member Time In Gender

Postcode

History !Allergies

What?, How?, When?, Where?

=CO

Past Medical History: Not known D Diabetic [ ] Epilepsy L MediAlert
D Asthma D Loss of Consciousness D Hypertension
D Other: ::J Cardiac D Medication

Casualty Assessment

Breathing | Skin | Pulse | Conscious | Other Signs & Symptoms
1. Normal | 1. Normal | 1. Normal | Alert
2. | 2. Pale | 2. Slow |
3. Shallow | 3. Flushed | 3. Rapid | 3. Responds to pain
4. Absent | 4. Moist, clammy | 4. Strong | 4. Unresponsive
5. Wheeze | 5. Dry | 5. Weak |
6. Gasping | 6. Sweaty | 6. Can't be felt |
7. Rapid | 7. Cool / Cold | 7. Regular |
8. Slow | 8. Warm/Hot | 8. Irregular |

Overall Assessment:

Time | Pulse | Res | Time | BP | PEFR | Fluid Intake | Fluid Output | APU
8so | B:1? | 2.<- | | Je;t; | | 'Lf' <j_. | | .A-
| 120 | | | | | | |

Other Observations (eg BSL, Pain Score, etc)

A - Abrasion
Bl • Bleeding

Location | RICE | Slings | Dressing
1. Head | 1. Rest | 1. Collar & Cuff | 1. Adhesive
2. Facial | 2. Ice | St John | 3. Non Adherent

Bu - Burns 3. Chest Time on: 3. Triangular 2.0
C .. Contusion

Other 3. Compression 4. Bandage
D • Deformity 5. limb 4. Elevation Tip(Bap;)lied-
F - Fracture 6. Spinal 5. All of above

L - Laccra:io1 7. Mu.,!!iP!e Posture , ls O.x)•gen .,y Referrtl<l to mJL

S-Swelling 8. Back 1. Legs up 1. r-Aask / 1. Hosp. (AMB:I

2. Coma 2. Dem val•.<e 2. Hosp, (CAR)

T • I enderness 3. Sitting 3. Ot!)t.r 3. Owndccto:

lf 4. lyif)g fires per min. 4. Nil

l./. Assisted vent Diochatgeac.

Treatment: 'S c.J\ " ,.,\ - . -<-!\L.. '-.J -

e:::...., -:::!::>,<:::-< <:'12__ (_e);:;:;.'?s

Medication Given: Oose Time Given

/ ::\ f;-f "Z)()!!. 'Sc.e.c.T

Medicabon with Casuatty f.f { \ Yes D No [I Refused Tteatmcnt O Witness

Signature: "-J. Prin; Nome i'-f ¢ ':-:!:..6 Division \--A -=vvM4

TO)COP>'!O S!8!E! J Pink COP"/ to Casual!>' j Time Ou1 [??--, 3,('!

A copy of the above depicts the form 08 12

104. The completed OB 12 form is ambiguous. Part of the document refers to the deceased having '*taken a Dexie about 10am today*' whilst the portion of the document relating to the overall assessment of the patient reads; '*Dexies. On a high*'. I think it most likely that the second entry relating to '*Dexies*' is a grammatical error and the deceased only spoke of taking one pill.

105. Mr Holding recorded a number of observations at about 1:10pm – 1:15pm[20], by which time the deceased had 5 – 10 minutes to calm down. Mr Holding noted that the deceased's pulse was 120bpm, her respiration was 22 breaths per minute and that her blood pressure was 135. The deceased's temperature was not taken as Mr Holding explained that volunteers at his level were not required to take a person's temperature[21].

106. I believe Mr Holding to be mistaken in this regard and I note that the medical kit located at the first aid post where he was working contained 4 disposable thermometers. The current St John Ambulance Service training documentation that supports instruction given to first-aiders about completing requisite paperwork, emphasises the need to record a patient's temperature[22]

107. Mr Holding was not unduly concerned by any of the recordings although he did believe that her pulse was '*a bit rapid*'[23]. He also thought that the deceased's respiratory rate was slightly high but was '*not far off*'[24] a normal respiratory rate. Mr Holding was unconcerned by the deceased's blood pressure. Mr Holding thought that a systolic blood pressure of 150 – 160 would be high[25].

108. Mr Holding believed that the records reflected the fact that the deceased was excited and had been active in a hot environment. He believed that she needed to sit down, and cool down [26] and drink some water. He did not believe that the

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[20] ts 159
[21] ts 160
[22] Exhibit 1 Volume 5 Tab K p 14
[23] ts 158
[24] ts 160
[25] ts 160
[26] ts 161

deceased's clinical picture suggested significant ill-health or that she was in danger[27].

109. Professor Ian Jacobs, Clinical Service Director for the St John Ambulance Service, gave evidence during the course of the inquest. He concluded that the deceased's pulse of 120 bpm was abnormal (according to the St John Ambulance Service's current training documentation an adult should have a pulse of 60 – 90 bpm[28]) as was her respiration at 22 breaths per minute (according to the St John Ambulance Service's current training documentation an adult should have a respiration rate of 10 – 20 breaths per minute[29]).

110. Professor Jacobs believed that the combination of the heat of the day, the deceased's abnormal pulse, her abnormal respiratory rate and the significance of the '*Dexie*', were not adequately identified during the period that the deceased was in the first aid tent[30].

111. The record taken by the cadet suggests that the deceased was at real risk of hyperthermia.

112. I believe the deceased's clinical picture recorded by the cadet warranted the attention of a person with greater medical expertise and experience than Mr Holding, so that an adequate explanation for the deceased's symptoms could be discovered.

113. With the benefit of hindsight, it seems clear that by the time the deceased arrived at the first aid post she was affected by the toxic effects of the 3 tablets of ecstasy she had swallowed earlier.

114. The deceased spent about 25 minutes at the first aid post. During that time the deceased's observations were recorded on only one occasion. The St John Ambulance Service teaches its first-aiders to record observations every

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27 ts 162
28 Exhibit 1 volume 5 Tab K p12
29 Exhibit 1 volume 5 Tab K p12
30 ts 491 – 492

15 minutes and that at least one full set of observations should be taken, although if possible 2 sets of full observations should be taken[31].

115. At about 1:30pm Mr Holding believed the deceased looked better than when she had arrived and he believed it would be appropriate for her to leave the first aid post.

116. Mr Holding advised the deceased return to the first aid post in the event she felt worse, or to see her doctor.

117. The deceased then went and rejoined her friend Ms Southern who was located outside the first aid provision. According to Ms Southern the deceased looked much as she had before she went into the first aid post.

118. The 2 young women talked and slowly made their way to another attraction known as the '*Orbiter*'. The 2 young women decided to take a ride on the '*Orbiter*".

119. When it came time to pay for the ride the deceased had difficulty paying. She appeared confused and she tried to pay using an old docket, rather than money. Her hands were shaking and Ms Southern had to intervene and take money from her pocket in order to pay for the ride.

120. Once on the ride the deceased struggled to secure the safety harness between her legs. Once again Ms Southern had to intervene to ensure that she was secured before the ride started.

121. Once the ride was over both of the deceased and Ms Southern unlocked the straps that had been securing them and they then walked away from the ride.

122. Very shortly after leaving the ride, at about 2:20pm, the deceased began to collapse. She lost control of her legs, began to stumble and then she collapsed onto the grass. Her lips were blue. Her face was drawn. Her hands were sweaty and clammy and she appeared to have lost consciousness.

[31] Exhibit 1 volume 5 Tab K p11

123. It was quickly evident that the deceased was extremely ill and needed immediate medical intervention.

124. The deceased was seen to collapse by a number of people including some security officers. Several security officers went to the deceased's aid and quickly took her to another first aid post where she was cared for by a volunteer first-aider, David Gulland. Mr Gulland is a pharmacist.

125. Mr Gulland observed the deceased convulsing. He also saw that her fingertips and lips were blue. The deceased was hot to the touch and her pulse was over 150bpm. Mr Gulland acted promptly to give her oxygen and to try to cool her down using towels soaked in iced water.

126. Mr Gulland called for other members of the St John Ambulance Service to collect the deceased and have her taken to the principle first aid post, where an ambulance would meet her and take her to Sir Charles Gairdner Hospital.

127. At about 2:46pm the deceased was met by ambulance paramedic officers and transported to Sir Charles Gairdner Hospital where she arrived at about 3:05pm.

128. By the time the deceased arrived at the hospital's Emergency Department, there was no realistic prospect that the deceased would survive the fatal quantity of ecstasy she had consumed.

129. Medical staff at Sir Charles Gairdner Hospital tried hard to save the deceased's life. Those efforts were in vain and the deceased died during the early hours of 2 February 2009. She was certified to be life extinct at 1:40pm, by one of the doctors who had been treating her.

130. Following the deceased's death her senior next of kin, her mother, objected to a full post-mortem of the deceased. The objection was upheld by a coroner.

131. On 2 February 2009 an external post mortem examination was performed on the deceased by a forensic pathologist, Dr Gerard Cadden, who after receiving the

results of a toxicological analysis determined the deceased's cause of death to be 'acute Methylenedioxymethylamphetamine (MDMA) toxicity'.

132. It should be highlighted that ecstasy tablets are manufactured by criminals who want to make money from the consumer. The purchaser has no information as to what has been put into the tablet and how it has been made. There is no information as to the amount of MDMA in the tablet and there is no way of comparing it with other ecstasy tablets the consumer may have experienced before. The purchaser consumes the tablet in the optimistic expectation that the drug manufacturer knows what he or she is doing and cares about the quality of the product.

133. In my opinion, it is extremely unwise to use a potentially fatal illicit drug with the optimistic hope that the drug manufacturer has the consumers best interests at heart when making ecstasy to sell for a profit

134. The toxicology report provided by the Chemistry Centre WA, highlighted the toxicity of ecstasy.

135. A limited toxicological analysis was undertaken of samples of the deceased's blood taken whilst she was in hospital and after her death. The analysis of both samples detected fatal quantities of Methylenedioxymethylamphetamine (MDMA). The levels were 2.2 mg/L and 2.5 mg/L respectively.

136. The report highlighted the deaths of a number of young adults who died as a consequence of ecstasy overdoses. The report highlighted the ease with which a person can suffer an overdose having taken a small number of tablets. In particular the author of the report, Ms Bianca Stevens, noted the cases of 3 young adults who ingested 1 – 3 tablets of ecstasy and who were treated in hospital for severe toxicity. All 3 people eventually died.

137. The 3 patients' admission plasma levels of ecstasy ranged from 0.1 – 1.3 mg/L with an average of 0.7 mg/L.

138. The sample of blood taken whilst the deceased was in hospital was found to have 2.2 mg/L of ecstasy.

139. Ms Stevens also noted the cases of 9 adults who had died as a consequence of ecstasy overdoses and whose post mortem blood concentrations of ecstasy were between 0.6 – 3.7 mg/L with an average of 1.7 mg/L.

140. The deceased's post mortem sample of blood was found to have 2.5 mg/L of ecstasy.

141. The toxicology report further highlighted 5 cases in which the time of the decedents peak plasma levels of ecstasy were known. In those cases the decedents' peak plasma levels of ecstasy occurred between 1½ – 2 hours after oral ingestion of the drug.

142. It should be remembered that the deceased took the last 2 tablets of ecstasy at about midday and she went into a catastrophic collapse about 2 hours later, at about 2:20pm.

143. The Chemistry Centre report highlights the fact that it is extremely important for a person who feels ill after taking ecstasy to seek urgent and immediate medical treatment.

144. Moreover, it is imperative that the person's medical advisers be fully informed about the type and quantity of drugs the person has consumed.

FINDINGS AS TO THE CAUSE AND MANNER OF DEATH

145. On the evidence before me I am satisfied that by about midday on 1 February 2009 the deceased consumed a fatal quantity of ecstasy, which led to her death at about 1:40pm on 2 February 2009. She died as a consequence of acute Methylenedioxymethylamphetamine (MDMA) toxicity.

146. I find the death arose by way of Accident.

DRUGS AT THE BIG DAY OUT 2009

147. The Big Day Out was a large-scale series of concerts held on multiple stages in the Claremont Showground. The gates opened early in the morning and the final concert concluded at about 11:30pm.

148. The Big Day Out attracted a crowd of about 35,000 concert-goers, predominantly aged between 18 – 35.

149. With a substantial crowd of young people, at a concert environment, there were inevitably going to be issues relating to illicit drug use.

150. The deceased and her friends were ordinary, normal, young West Australians.

151. Those that abuse illicit drugs do not necessarily stand out from the crowd and their use of illicit drugs may be unknown to family and friends.

152. During the course of the inquest I heard from 5 of the deceased's friends, who had been at that Big Day Out. Three of the 5 friends admitted using drugs including cannabis and ecstasy. One of the 5 friends admitted to using cannabis and one of the friends denied any drug use at all.

153. The deceased and 2 of her friends, who gave evidence at the inquest, admitted they were affected by ecstasy whilst at the Big Day Out.

154. Illicit drugs such as ecstasy tablets are small in size, easy to hide and difficult to detect.

155. Moreover, as was the case with the deceased and Ms Southern, people may have taken illicit drugs prior to their entry into the Showground and remain at risk of their ill-effects whilst in the Showground.

156. The police did have some success detecting illicit drugs at the Big Day Out, on 1 February 2009. According to a police media release dated 2 February 2009[32]

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[32] Exhibit 1 Volume 1 Tab 28

there were a number of offences committed by those attending the Big Day Out. These offences included:

- ¾ 59× Possession of drugs
- ¾ 4× Possession of drugs with intent to sell/supply (including a male adult for possession of 20 MDMA tablets)
- ¾ 5× Possess smoking implements

157. The police also seized a quantity of drugs including:

- ¾ 129× MDMA tablets (ecstasy)
- ¾ 2 g × methylamphetamine
- ¾ 6 g × cannabis
- ¾ 75× cannabis cigarettes
- ¾ 21× dexamphetamine tablets

158. I suspect the quantity of drugs seized on 1 February 2009, was the tip of the iceberg in relation to the quantity of illicit drugs used by concert-goers before and during the Big Day Out.

MEDICAL INCIDENTS DURING THE BIG DAY OUT 2009

159. As you would expect in a large-scale, day-long event held in hot weather (about 37°C) there were a number of medical casualties.

160. According to records kept by the St John Ambulance Service there were a total of **569** people who sought medical attention during the Big Day Out on 1 February 2009. There were[33]:

- ¾ **23 major medical incidents** (which comprise chest pain, diabetic problems, epilepsy, asthma, overdose, severe shortness of breath, poisons, snakebite, childbirth, unconsciousness)

[33] Exhibit 1 Volume 5 Tab U

- ¾ **450 minor medical incidents** (headaches, heatstroke/exhaustion, bikes, stings, overbreathing, hyperthermia)
- ¾ **37 injuries** (bruises, sprains, dislocations, fail chest, fractures)
- ¾ **49 wounds** (abrasions, penetrating wounds, crater wounds, foreign bodies, lacerations, Burns)
- ¾ **8 emotional/behavioural incidents** (any change in a person's normal behaviour and/or emotional state in the absence of physical injury)
- ¾ **2 incidents of multiple injury** (any combination of the above).

161. 8 people were taken by ambulance to hospital from the Big Day Out.

162. 11 people were directed to be taken home by car and 178 people were referred to their GP for further treatment.

163. The St John Ambulance Service treated 569 casualties at 1 of 5 first aid posts manned by a total of a total of 74 volunteers, who worked in 2 shifts. Additionally there was a 6 person communication team (3 per shift) and 4 people in the 'Retrieval' team (2 per shift).

164. In my opinion, where you have thousands of young people who want to enjoy themselves, together with; hot weather, alcohol and illicit drugs, you are likely to have situations where it would not be surprising if a patron suffered from an illicit drug overdose.

165. In my opinion, it would have been prudent to put in place an adequate strategy and resources to assist those suffering from an illicit drug overdose.

166. In my view, the medical precautions taken during the Big Day Out on 1 February 2009, to identify and treat those suffering the ill-effects of illicit drug use, were not adequate.

167. It would have been prudent for there to have been tertiary qualified practitioners (paramedics, nurses, doctors) employed at the Big Day Out whose identity and

location was known to the first-aiders, who could have provided direct care and assessment of patients as well as providing assistance and guidance to the first-aider volunteers manning the first aid posts.

168. I should emphasise that my comment should not be read as suggesting that either the promoter of the Big Day out or the St John Ambulance Service, did not comply with any standard imposed by law or regulation as to the manner in which a large event should be run.

169. The comment should be read as reflecting my belief that, with the benefit of hindsight and experience, the medical precautions taken on 1 February 2009, were inadequate to deal with major medical emergencies such as that of the deceased.

170. The situation came about, in part, because of the lack of guidelines requiring the provision of higher level medical services at large events like the Big Day Out and a failure to comply with relevant aspects of the guidelines relating to the training of first-aiders in relation to illicit drugs.

THE 2004 GUIDELINES

171. At the time of the deceased's death the event organisers, Altered State Proprietary Limited (Altered State) were required to obtain a number of clearances from health authorities before the Big Day Out could proceed. In particular they needed to obtain an authority known as a Form 1.[34]

172. In order to qualify for the form 1 certificate Altered State were required to file:

a. engineering certificates;
b. a risk management plan;
c. an evacuation plan;
d. license numbers in bars and other controlled areas;
e. traffic management plan;
f. free water points plan;
g. toilet numbers; *and*
h. exit widths.

[34] Exhibit 2 p20

173. As part of the risk management plan the organisers had to consider the health of those attending the Big Day Out. They turned to the St John Ambulance Service, their chosen first aid provider, to provide first aid to services for the Big Day Out.

174. The St John Ambulance Service developed a plan for the Big Day Out which was formalised in a document entitled '*Sunday, 1st February 2009 Operational Plan Claremont Showgrounds'* [35] which was incorporated into the organisers risk management plan.

175. The operational plan drawn up by the St John Ambulance Service was in turn based on guidelines provided by the Department of Health.

176. In September 2004 the Department of Health published '*Guidelines for Concerts, Events & Organised Gatherings*[36]*'* (the 2004 Guidelines), which were the relevant guidelines, relating to large events like the Big Day Out, at the time of the death of the deceased.

177. The 2004 Guidelines mandated the number of first-aiders and first aid posts dependent upon the number of patrons. The St John Ambulance Service met and exceeded the minimum requirements in this regard.

178. The 2004 Guidelines did not call for the participation of higher level medical practitioners such as paramedics, nurses or doctors. The St John Ambulance Service did not provide any volunteers or employed practitioners acting in those higher level medical positions. They only provided first-aiders, of various grades.

179. The 2004 Guidelines provided organisers and first aid providers with guidance in relation to the provision of first aid services. According to the 2004 Guidelines[37]:

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[35] Exhibit 1 Volume 1 Tab 30
[36] Exhibit 1 Volume 1 Tab 63
[37] Exhibit 1 Volume 1 Tab 63 p72

> Experience shows that at least 1 – 2% of the crowd will require some type of first aid or medical care for rock concerts. Of those, about 10% will need ongoing care on site and 1% will require transport to hospital by ambulance. This will obviously increase where there are high-risk activities such as crowd surfing, moshing, presence of alcohol and other related activities. In addition external factors such as weather conditions contribute to patient presentations.

180. According to the 2004 Guidelines experience from previous events has shown that most casualties are from, inter alia[38]:

- ¾ heatstroke, dehydration, respiratory distress; and,
- ¾ illicit drug and alcohol abuse

181. The guidelines also provided that[39] '*Medical staff should be aware of the current illicit drugs scene. This information is freely available from the Drug and Alcohol Office*.'

182. Mr Holding had no real knowledge of illicit drugs and he had received no training in relation to the names of common illicit drugs, the relative danger associated with particular groups of drugs, the signs of impairment caused by the use of illicit drugs or the appropriate way to treat a patient who has suffered an overdose.

183. Those shortcomings are not a reflection on Mr Holding, but they do adversely reflect on the quality of training he was given by the St John Ambulance Service before being allowed to volunteer at the Big Day Out.

184. It would have been prudent, and in accordance with the 2004 Guidelines, for Mr Holding to have received some training in relation to illicit drugs from the St John Ambulance Service, so that he could make informed decisions about those to whom he was providing first aid.

185. Had Mr Holding known more about illicit drugs he may have looked differently at the way the deceased presented on 1 February 2009 and considered more

[38] Exhibit 1 Volume 3 Tab 63 p76
[39] Exhibit 1 Volume 3 Tab 63 p77

closely the potential for the deceased to suffer hyperthermia. He may then have proceeded differently and/or sought higher level intervention.

186. In making that comment it should be noted that Mr Holding's job was made very difficult by the deceased misleading him as to the name and quantity of the drug she had taken.

187. It should also be noted that even had Mr Holding identified the deceased as a person who had taken an overdose of ecstasy, the deceased may nevertheless have still been beyond the point of recovery at the time he saw her.

188. The 2004 Guidelines provided that first aid personnel must not only be aware of the current illicit drugs scene but they also must be appropriately qualified[40].

189. There was no definition within the 2004 Guidelines which spoke to the qualifications required of those who were providing first aid. The St John Ambulance Service only provided volunteers who were acting as first-aiders. They did not provide higher level medical practitioners such as paramedics, nurses or doctors who would be more likely to be aware of the current illicit drugs scene and how to react appropriately in the event of a patient suffering the effects of illicit drugs.

190. In my view, Mr Holding did not have sufficient training or expertise in relation to the nature and effect of illicit drugs, or how to identify and respond to a person suffering from an overdose.

191. The 2004 Guidelines also directed organisers and first aid providers to consider whether there was a need for an ambulance to be located on-site [41] during the course of the event.

192. An ambulance was not located on-site during the 2009 Big Day Out.

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[40] Exhibit 1 Volume 3 Tab 63 p77
[41] Exhibit 1 Volume 3 Tab 63 p76

193. Whilst the St John Ambulance Service were not asked to provide a paramedic, a nurse or a doctor, there were paramedics employed at the Showground on 1 February 2009. Their existence was unknown to the St John Ambulance Service and consequently they were unable to call upon that expertise when considering either the deceased's first attendance at the first aid post or her subsequent collapse.

194. The paramedics were employed directly by the owners of the Big Day Out. They were employed primarily to safeguard the performers and other members of staff and to assist members of the public caught in dangerous situations during the larger concerts.

195. Whilst I have referred to these paramedics as paramedics, it is important to appreciate that there is no definition in Western Australia as to what a paramedic is or what qualifications or experience a paramedic needs to have before he or she can properly be referred to as a paramedic.

196. The paramedics supplied by the owners of the Big Day Out, had no powers under Schedule 8 of the *Poisons Act 1964* to dispense medications and there was no guarantee that their qualifications or expertise met the standard legitimately expected by the Western Australian public, of those who use that title and who respond to emergencies in our State.

THE 2009 GUIDELINES

197. After the death of the deceased new guidelines were formulated by the Department of Health relating to large organised events like the Big Day Out. The new glide guidelines, which are still current, are known as the[42] '*Guidelines for Concerts, Events and Organised Gatherings'* and were published in December 2009 (the 2009 Guidelines).

198. The 2009 Guidelines are designed to include higher level medical interventions by paramedics employed at high risk or extreme risk events.

[42] Exhibit 1 Volume 1 Tab 63

199. The 2009 Guidelines make a specific comment in relation to what are described as '*event-specific serious presentations*', such as drug and alcohol overdoses, which according to the new guidelines[43] '*usually need a higher level of care and may require urgent medical attention and ambulance transport to hospital*'.

200. I think the 2009 guideline requiring, in certain circumstances, the presence of a paramedic are a significant public safety enhancement.

201. In my opinion, a large-scale day-long event like the Big Day Out where there is an expectation of hot weather, illicit drug abuse, multiple hospitalisations, and the potential for illicit drug overdoses required the presence and guidance of a number of personnel with significantly greater experience than could be legitimately expected from a senior first-aider.

202. I would expect that a competent paramedic, nurse or doctor, who had been asked to examine the deceased at Mr Holding's first aid post, would have appreciated that after 5 – 10 minutes of resting at the first aid post, her pulse of 120bpm was abnormal as was her respiration at 22 breaths per minute. The circumstances of the deceased's presentation would likely have inspired further investigations including the taking of the deceased's temperature, determining the significance of the '*Dexie*' and repeating the observations after a period of rest.

203. Whether an event is one that the 2009 Guidelines mandates as being one at which a paramedic should be in attendance depends on the event's '*medical risk classification*' which is determined by the application of a '*medical risk classification tool*' contained within the guidelines[44]. The '*medical risk classification tool*' is used to determine the specific medical risks, at the location and medical resources available to the public, and determined the level

[43] Exhibit 1 Volume 1 Tab 63 p34
[44] Exhibit 1 Volume 3 Tab 64 p34 – 38

of medical planning required for an event, and the need for a medical intervention plan for an event[45].

204. The '*medical risk classification tool*' is used to calculate a score which in turn is used to define the medical risk of an event as low, medium, high and extreme.

205. One of the key components in the calculation is the response time to transfer a patient from the event to tertiary medical care.

206. During the course of evidence Professor Jacobs was asked to use the '*medical risk classification tool*' and apply it to the circumstances of the 2009 Big Day Out. Professor Jacobs did so and the event's medical risk was categorised as '*medium*'. The event fell only slightly short of being categorised as a high risk event. The differences between the medical capabilities at a medium risk event and at a high risk event are significant.

207. High risk events necessitate the provision of qualified paramedics and the provision of adequately equipped medical centres. Those are not requirements of events considered to be of medium risk.

THE 2013 BIG DAY OUT

208. During the course of the inquest I was invited by Mr Davies, who acted for Altered State, to view the advances made by the organisers and the St John Ambulance Service since the 2009 Big Day Out.

209. On Sunday 28 January 2013, I went to the Big Day Out in the company of Detective Sergeant Kylie Simmonds. The Big Day Out 2013 was again held at the Claremont Showgrounds. At the Showground I met Professor Jacobs, Mr Davies and 2 of the representatives of Altered State.

210. My overall impression was that the Big Day Out 2013 was a very well organised event which included very good medical services, well in excess of the mandated minimums.

[45] Exhibit 1 Volume 3 Tab 64 p37

211. Whilst in the Showground I was shown the command area and communications suite which provided the police and other lead agencies with a collective area where incident management issues could be detected and controlled. The facility was well equipped with CCTV cameras, computers and ready means of communication between the relevant agencies.

212. The Showground was also manned by a number of volunteers working in different capacities. Of particular note there were a significant number of 'crowd carers' who acted much in the way their title suggested. They mingled with the crowd and performed a range of functions such as directing patrons to the appropriate venue, looking for signs of sunburn, dehydration or illness and directing those patrons to the first aid facilities.

213. One of the risks of using ecstasy is that of dehydration. Whilst being shown around the Showgrounds my attention was directed to a number of watering stations, water taps, a spray tent, water sprayers and stands selling food and water.

214. I also saw members of the crowd listening to bands being given water on demand, by raising their hand, which resulted in a volunteer providing the individual with a cup of water.

215. Water was also available in a prominent and well sign posted position at each of the licensed bars.

216. It appears to me that that potable water was readily available to all patrons at the Big Day Out 2013 and that they would be able to quench their thirst or cool themselves down with water which was available at no cost.

THE ST JOHN AMBULANCE SERVICE

217. On the morning of the Big Day Out, prior to the public's entrance into the Showgrounds, the St John Ambulance Service conducted a briefing which was given to all staff, including voluntary first-aiders. The briefing included a

caution to be aware of the potential for patients to present having consumed illicit drugs.

218. The briefing also referred to a drug information sheet[46] which was given to each staff member and which was also posted in each first aid station, for easy reference.

219. The drug information sheet was developed in September 2012. It provides the volunteer first-aiders with information about amphetamines, cannabis, cocaine, ecstasy, hallucinogens and heroin. The sheet describes the nature of the drug, its short-term effects, its long-term effects, the symptoms associated with overdose and the potential outcomes of an overdose.

220. The drug information sheet is an important tool which will help volunteer first-aiders understand the nature and significance of illicit drugs taken by their patients.

221. The relevant portion of the drug information sheet describes ecstasy as a derivative of amphetamine which has both stimulant and hallucinogenic properties which begin within 30 minutes of consumption and last up to 6 hours.

222. The short-term effects are described as overheating and dehydration, which can cause muscle meltdown. Other short-term effects include increased pulse rate and blood pressure, hot and cold flushes and sweating.

223. The symptoms of overdose include cardiac arrest, stroke, kidney failure, overheating (hyperthermia) and dehydration.

224. The drug information sheet notes that overdose usually results from the body overheating and becoming dehydrated, which can cause muscle meltdown and a possible death from failure of major organs such as liver or kidneys.

225. The document notes that the risk of overdose increases with a larger dose.

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[46] Exhibit 1 Volume 5 Tab M

226. The drug information sheet would have been of great assistance to a person in Mr Holding's position, particularly if he was provided with accurate information as to the type and quantity of the illicit drug consumed by the deceased.

227. The drug information sheet could be enhanced by making reference to Dexamphetamine (more commonly known as Dexies). A medicine that can be legally obtained but can also be a drug of abuse.

228. Whilst at the Showgrounds Professor Jacobs showed me 4 first aid posts including; the main post near to gates 9 and 10, a first aid station adjacent to the main stages, the first aid post at the Inventors Pavilion and at the Moorish Nuts Pavilion.

229. All of the first aid posts had a tertiary qualified medical practitioner (paramedic, nurse or doctor) in attendance to provide medical care for patients and assistance and oversight of the first-aider volunteers.

230. The tertiary qualified medical practitioners were paid members of the St John Ambulance Service who were working alongside a first-aider volunteer.

231. This event was the first time that the St John Ambulance Service had its paramedics working with volunteers at an event.

232. I was advised that in all cases it was expected that the tertiary qualified medical practitioner would sign off on the discharge of each patient.

233. All of the first aid posts had effective air conditioning and were cool, notwithstanding the heat of the very hot day. All of the first aid posts were clean and well organised and reflected well on the professionalism of the St John Ambulance Service and its volunteers.

234. The main first aid post, near gates 9 and 10 of the Showground was particularly well designed. It had multiple beds and a capacity to perform high levels of pre-hospital treatment.

235. The St John Ambulance Service also had very satisfactory communications equipment so that medical resources could be focused on where it was needed. The communications systems would allow for the smooth and timely movement of a patient from an outlying first aid post to the main first aid post in preparation for transfer to hospital.

236. In addition to incorporating tertiary qualified medical staff into each first aid post, the St John Ambulance Service stationed an ambulance and a paramedic at the Moorish Nuts first aid post.

237. This was the first aid post where the deceased was taken after her collapse at about 2pm. The addition of an ambulance to this first a post greatly enhanced the potential to save lives in life-threatening situations. The ambulance was equipped with a range of medications together with life-support systems able to assist in the event of respiratory failure, cardiac failure or other adverse event.

238. In my opinion, the medical services at the 2013 Big Day Out were of a high standard. They reflected a capability well beyond that which could reasonably be expected from volunteer first-aiders alone. The medical services were well beyond the standards mandated by the 2009 Guidelines, which did not call for tertiary qualified medical staff or require the presence of an ambulance.

239. The total cost to the organiser of the St John Ambulance Service's involvement at the Big Day Out was about $18,000, which in my opinion, is a modest impost considering the site of the crowd and the significant safety advantage provided by the presence of the ambulance and tertiary qualified professional staff.

EVENT PARAMEDICS

240. Other aspects relating to the organisation of the Big Day Out were also highlighted whilst I was that the Showground.

241. I was shown the area around the main stages where the paramedics employed by the owners of the Big Day Out were working. They were working

cooperatively with the St John Ambulance Service staff located at the first station adjacent to the main stages.

IMPROVED ENTRY PROCESS INTO THE SHOWGROUND

242. The entry process into the Showground had been improved so that all entrants received a tamperproof bracelet which identified the wearer as either an adult or a minor. Adults were given a blue bracelet whilst minors were given a yellow/green bracelet.

243. The process of a patron proving his or her age and being fitted with the relevant bracelet was very streamlined and quick. In my opinion the system adopted in 2013 would have prevented Ms Southern from obtaining a wristband identifying her as an adult.

244. The deceased used a complex method of modifying her driver's licence so that her age was shown to be 18 rather than 17. I am less certain that a well executed deception of that nature would be exposed in the entry system adopted in 2013 any more than it would have been in 2009.

WHY MINORS NEED TO BE CORRECTLY IDENTIFIED

245. The significance of correctly identifying minors from adults is twofold. Firstly, it prevents minors from entering licensed premises.

246. Secondly, it helps those organisations like the police and the St John Ambulance Service who treat minors differently from adults, correctly identify which patrons are minors.

247. According to the 2004 Guidelines, the 2009 Guidelines as well as the St John Ambulance Service operational plans for the Big Day Out and their public event management policy and procedure[47] minors who are affected by illicit drugs or alcohol are dealt with in a very specific manner.

[47] Exhibit 1 Volume 5 Tab L p17

248. In all cases where a patient is under 18 years of age and is under the influence of alcohol or drugs the patient must be discharged from care to a parent or guardian.

249. If that is not possible the patient should be discharged into the care of the WA police or into the care of an ambulance.

250. Under no circumstance should a minor be discharged back into an event like the Big Day Out if they are under the influence of any substance.

251. This obligation applied when the deceased presented to the first aid station where Mr Holding was working. Had Mr Holding been aware that the deceased was 17 years old, then she should not have been released back into the Showground after it was identified that she was "*on a high*" having had '*Dexies*'[48]

252. If the truth of the deceased's age had been known the first option should have been to discharge her back into the care of her parents.

253. Whilst I am confident the deceased's parents would have been able to identify the deceased as being unwell, and they would likely have been told the truth about the drugs their daughter had taken, it is by no means clear that by the time they had arrived at the Showgrounds the deceased would have been in a condition where she could have recovered from the overdose.

DRUGS AT THE BIG DAY OUT 2013

254. Just prior to leaving the show ground I was taken through the Police Command Building. I met with a number of police officers and saw some of the drugs that had been seized during the course of the day. By about 3pm the police had already seized a significant quantity of illicit drugs including heroin, cannabis and ecstasy.

[48] Exhibit 1 Volume 1 Tab 31

OUTSTANDING ISSUES AND RECOMMENDATIONS

255. In this case Altered State obtained medical support from the St John Ambulance Service at a level far higher than that mandated by the 2009 Guidelines. They achieved this superior service for a total cost of about $18,000.

256. I note that by adopting a strict application of the relevant calculation the Big Day Out 2009 and the Big Day Out 2013 would have been medium risk event which did not call for a dedicated medical centre or the location of paramedics at the Showground.

257. In my view the 2009 Guidelines should be improved so as to insure that events of the nature of the Big Day Out are ranked as high risk events and that they have medical services on a par with that achieved during the Big Day Out 2013.

Recommendation One

I recommend that the Director General of Health consider revising the current Guidelines for Concerts, Events and Organised Gatherings 2009, so that organisers of future similar large-scale public events are required to provide the standard of medical care achieved at the 2013 Big Day Out.

PARAMEDICS

258. Under the 2009 Guidelines are required to be in attendance at events classified as high risk or extreme risk.

259. This case highlights the fact that there is no definition as to what a paramedic is under Western Australian law.

260. In my opinion, there needs to be a State based definition as to what a paramedic is, so that organisers of events such as the Big Day Out, together with the general public, can have confidence in the abilities of those who are protecting their medical interests at large scale public events. Professor Jacobs was asked about this issue;

Coroner:	Do you think there's a need for a state-based definition as to what a paramedic is?
Prof Jacobs:	Absolutely. The term "paramedic" is bandied around by a variety of people with different qualifications. At this point in time there is actually no definition which is supported by any sort of legislation or regulation based on defining what a paramedic is. As you will be aware, a registered nurse or a medical practitioner, a dentist or physio can't call themselves that unless they are actually registered accordingly. Within Victoria they have protected the name within regulation the term "paramedic". That's not the case in other states of Australia. This was an issue that was raised at the 2009 inquiry in the ambulance service and one of the clear recommendations which is currently being acted on is to develop registration for ambulance paramedics in Australia, and that's actually being pushed by the minister for health in Western Australia, and subsequent to that is now on the AHMAC, Australian Health Ministers Advisory Council, agenda and the COAG, the Council of Australian Governments agenda."

261. Professor Jacobs explained the public benefit a definition of Paramedics;

Coroner:	How would that fact of registration or definition help the community?
Prof Jacobs:	I think it does two things. It means that those who are now called a paramedic would be - the community could feel sure that they have gone through a recognised training program, that they need to maintain and continue their professional standards, and that they're registered under the Australian Health Professionals Registration Authority and therefore are governed by their codes of practice, and that also means sanctions for other processes.

Recommendation Two

I recommend that the Director General of Health consider creating a definition of 'paramedic' and that he considers a form of registration that will ensure that only appropriately qualified people are entitled to use the title of paramedic and to be able to practise in Western Australia as a paramedic.

D H MULLIGAN
CORONER

8 March 2013