CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Brendan Hickey
Hearing dates:	11 -15 April 2016, 19-21 September 2016, 31 October 2016
Date of findings:	22 December 2016
Place of findings:	State Coroner's Court, Glebe
Findings of:	**Deputy State Coroner, Magistrate Teresa O'Sullivan**
Catchwords:	CORONIAL LAW – Cause and manner of death Drowning Risk Assessments Vivid 2014 – Darling Harbour
File number:	2014/157396
Representation:	**Mr Mark Cahill, Counsel Assisting, instructed by Ms Naomi Malhotra on behalf of the Crown Solicitor** **Mr Stephen Rushton SC for Destination NSW** **Mr David Lloyd for Australian Concert and Entertainment Security (ACES)** **Mr Phillip Ryan for Danny Lander and Concept Entertainment Group P/L (CEG)** **Ms Kim Burke for Sydney Harbour Foreshore Authority (SHFA)**

Findings:	**Identity of deceased**: The deceased person was Brendan Hickey. **Date of death**: Mr Hickey died on 23 May 2014. **Place of death**: Mr Hickey died at Cockle Bay, Darling Harbour, NSW. **Manner and cause of death:** Mr Hickey died some time shortly after 10:55pm on 23 May 2014 at Cockle Bay, Darling Harbour, as a consequence of drowning by misadventure to which alcohol intoxication was a contributing factor.

Recommendations:	**To the directors of Concept Entertainment Group Pty Ltd:** 1. That the directors of Concept Entertainment Group Pty Ltd (CEG) give urgent consideration to the retention by the company of an appropriately qualified risk management consultant to perform a review of the company's risk management policies, practices and procedures. 2. That the directors of CEG give urgent consideration to the provision of formal, documented training to directors, officers and employees who are required, from time to time, by the company to conduct risk assessments and to prepare event management and emergency management plans. Such training should be provided by an appropriately qualified risk management consultant or registered vocational training organisation specialising in the provision of risk assessment and risk management training. **To the Minister responsible for Property NSW and the Chief Executive Officer of Place Management NSW [formerly the Sydney Harbour Foreshore Authority]:** 3. That the Minister and the Chief Executive Officer give urgent consideration to the establishment of an independent review of the risk assessment and risk management systems utilised by Place Management NSW (including the divisions known or formerly known as the "Operations" and "Events" divisions) in relation to the planning and conduct of events to be held on the land managed by Place Management NSW (including events organised by a third party). 4. That the independent review referred to in recommendation 3 above should include a review of the steps taken to ensure that officers in charge of Place Management NSW vessels operated in the waters of Darling Harbour / Cockle Bay are appropriately licenced and qualified.

	5. That the Minister and the Chief Executive Officer give urgent consideration to the development by Place Management NSW of documented, identified and quantifiable criteria for the purpose of defining “major” or “large scale” events to be held in the Darling Harbour precinct at which the event manager must be required, for the safety of the public, to erect temporary barriers to isolate the open waters’ edge of Cockle Bay. 6. That the Minister and the Chief Executive Officer give urgent consideration to establishing a systematic review, using historical incident data, of the corporate ‘Risk Decision Criteria’ used by Place Management NSW, in particular, as used in the assessment of the risks to public safety associated with the open waters’ edge at Cockle Bay, Darling Harbour (as outlined in the Reliance Risk Shoreline Risk Assessment report dated 2 November 2015 compiled for Sydney Harbour Foreshore Authority). The purpose of the review is to ensure that an appropriate balance is maintained between the design objectives associated with the preservation of an open waters’ edge to Cockle Bay and the need to ensure public safety in relation to the ongoing operation by Place Management NSW of the Darling Harbour precinct as a major local and international tourist destination.

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The Coroners Act 2009 (NSW) *in s 81(1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.*

These are the findings of an inquest into the death of Brendan Hickey.

Introduction:

1. This Inquest concerns the death of Mr Brendan Hickey, a 34 year-old man who died on 23 May 2014.

2. On the evening of 23 May 2014, Mr Hickey attended the precinct known as Cockle Bay at Darling Harbour to observe a light and sound show called "Vivid Aquatique" with his girlfriend, Julia Szymanska, and two friends, Samantha Travis and Matthew Turner. Shortly before 11:00pm, the group was sitting on the eastern boardwalk at a point south of the entrance of the marina, adjacent to the waters' edge, when Mr Hickey was observed to fall into the waters of Cockle Bay and to disappear below the surface.

3. Ms Szymanska attempted to reach out to Mr Hickey and then ran for help, and Ms Travis and Mr Turner jumped in after Mr Hickey. Despite their attempts to locate Mr Hickey, and further above-water searches conducted by rangers, police and others, Mr Hickey could not be located. Police divers subsequently attended the location and retrieved Mr Hickey's body from the seabed of Cockle Bay in the early hours of 24 May 2014.

4. At the time of his death, Mr Hickey was a healthy, active young man who had immigrated to Sydney from Ireland. He was described by his brother as ambitious, hard-working, social, a great footballer and a family man who was idolised by his nieces and nephews. He was the second youngest of five children from a close-knit and loving family. His death was sudden and his loss has been keenly felt throughout his family, including by his parents, Rosalie and David; his siblings, Linda, Declan, Steven and Shane; as well as his eight nieces and nephews.

5. On the evidence before me there is little, if any, controversy concerning the medical cause of Mr Hickey's death. This inquest has focussed on the *manner* of Mr Hickey's death, in particular, the circumstances in which Mr Hickey fell into the waters of Cockle Bay.

6. In preparing my findings I have taken into account the written submissions prepared by the parties of sufficient interest and I am grateful to them for their efforts in preparing them.

7. I have been greatly assisted by the extremely thorough Submissions of Counsel Assisting, Mr Mark Cahill. I have adopted much of the wording from his submissions in the reasons for my findings

The Evidence:

The fatal incident on 23 May 2014

8. At about 7:00pm on 23 May 2014 Mr Hickey met with his girlfriend, Ms Szymanska, and two friends, Ms Travis and Mr Turner, at a bar in Martin Place. At this time, Mr Hickey was observed by Ms Szymanska to be "mildly intoxicated". After "a couple of alcoholic drinks" the group decided to attend Vivid Darling Harbour to watch the light and sound show. On route to Darling Harbour, the group bought four bottles of wine and some snacks from a bottle shop, before arriving in the Cockle Bay precinct at about 9:00pm where they took up a position at the waters' edge on the eastern promenade just to the south of the entry to the Cockle Bay Marina.

9. At or about 9:25pm Troy Bush, the coxswain of the Sydney Harbour Foreshore Authority (SHFA) vessel, Seahawk II, saw Mr Hickey's group drinking from plastic wine glasses. Mr Bush approached the group and addressed one of the males, identified as Mr Turner, informing him that it was an offence to consume alcohol in Darling Harbour, with a $220.00 fine, and that the group would have to cease drinking in that area. Mr Hickey approached Mr Bush, shook Mr Bush's hand and apologised for consuming alcohol. Mr Bush observed that the male who shook his hand (Mr Hickey) showed signs of intoxication. Mr Bush observed the group as they collected their belongings and began to leave the area, moving off about 30 metres in the direction of the Druitt Street stairs.

10. Mr Bush did not direct either Mr Hickey or the group to leave the Darling Harbour precinct nor did Mr Bush ensure, when the group left the area near the marina, that the group left the Cockle Bay precinct. Mr Bush stated in evidence that he recognised that Mr Hickey, due to his intoxication, might be at risk if he remained near the water. It appears Mr Bush understood that, once the group appeared to comply with his "corrective advice", he did not have the authority to direct Mr Hickey or the group to leave the Darling Harbour precinct, if they stopped drinking alcohol on the promenade / boardwalk.

11. Following the initial interaction with Mr Bush, the group left the area near the entrance to the marina and repositioned themselves on the eastern boardwalk

at a point about 20 metres to the south of the entrance of the marina, adjacent to the waters' edge.

12. Ms Szymanska stated that, just before 11:00pm, the group decided to leave the location and go to dinner. She saw Mr Hickey start to stand up and she "observed him lose [his] balance and fall into the water".[1] Ms Travis says in her statement that she vaguely recalls that seeing Mr Hickey "lose balance and his back was facing the water".[2] Mr Turner observed in his statement that he "saw out of the corner of my eye on the left hand side Brendan fall into the water. I thought he was mucking around and had jumped in for a joke. I watch[ed] Brendan go under the water, and I realised it was serious and he had actually fallen in."[3]

13. The NSW Ambulance recorded a call to 000 being 'picked up' at 10:55:54pm, which was made by Ms Taleetha Boyd, who was seated on the eastern boardwalk a little to the north of the group. She recorded in her statement to police:

"I heard a splashing sound and I said to my friend on the phone "someone just fell in the water". I went down to the water with the intention of telling him to get out because there were electronics in the water. I looked down and I saw a male, who I would describe as flailing around in the water with his head just below the surface of the water and using only his arms. I initially thought he was joking around however after 20 – 30 seconds it became apparent that he was drowning. I said to my friend on the phone "he is drowning" and hung up."[4]

14. Ms Szymanska knew Mr Hickey was unable to swim and screamed out trying to reach him, and then ran to seek help. Ms Travis and Mr Turner jumped in to try to retrieve Mr Hickey.

15. Mary Rahme, a ranger employed by Australian Concert and Entertainment Security Pty Ltd (ACES) who responded to a radio call concerning the incident, stated that, after instructing Ms Travis and Mr Turner to get out of the water, "[t]hey [Ms Travis and Mr Turner] replied saying their friend (Brendan) had jumped into the water and did not come back up." Ms Rahme expanded on this version of the events in evidence stating that: "…..we asked what happened, they told us that he thought it would be funny if he got up and

[1] Ex 1, Vol 1, tab 21 at [8]: Statement of Julia Szymanska, 24 May 2014.
[2] Ex 1, Vol 1, tab 22 at [8]: Statement of Samantha Travis, 24 May 2014.
[3] Ex 1, Vol 1, tab 23 at [7]: Statement of Matthew Turner, 24 May 2014.
[4] Ex 1, Vol 1, tab 24 at [4]: Statement of Taleetha Boyd, 29 May 2014.

jumped into the water, and they said no, and then he got up and jumped and never came back up."[5]

16. Ms Rahme conceded in evidence that she could not remember the exact words that were used and that she was reporting her understanding of what she had been told by Ms Travis and Mr Turner. Further, the description provided in her incident report locates Ms Travis and Mr Turner in the water when the subject conversation is taking place, whilst Ms Rahme stated in evidence that the subject conversation took place at some time later in the evening after the light and sound show had finished and that the conversation took place with Ms Travis and Mr Turner standing on the boardwalk in front of her.[6] In addition, Ms Rahme's account of the information provided to her by Ms Travis is to be contrasted with the evidence of Sergeant Markham who stated that Ms Travis informed him that Mr Hickey "fell from [the] boardwalk. I don't think he can swim".[7]

17. I do not consider it necessary to make a finding about the terms of the conversation between Ms Travis and Mr Turner, on the one hand, and Ms Rahme on the other, regarding the manner in which Mr Hickey is said to have entered the waters of Cockle Bay.

18. Having regard to the balance of the evidence, in particular the observations of Mr Hickey's group and the evidence of Ms Szymanska and Shane Hickey, Mr Hickey's brother, that Mr Hickey could not swim and that he held a genuine fear of the water, I am satisfied that the evidence is consistent with Mr Hickey entering the water involuntarily at about 10:55pm on 23 May 2014, as the group was preparing to leave the area.

The response

19. Shortly after Mr Hickey entered the water, Ms Szymanska ran north along the boardwalk to Cockle Bay Marina where she sought assistance from Christopher Webster, the Cockle Bay Marina attendant. As Ms Travis and Mr Turner observed Mr Hickey sink down under the water, they both entered the water to look for Mr Hickey.

20. Ms Boyd observed Ms Travis and Mr Turner jump into the water after Mr Hickey. Ms Boyd said that she "*scanned the poles along the pier for an angel ring however one did not stand out to me."*[8] She dialled '000' and requested an ambulance. Ms Boyd said she *"found it quite difficult to describe*

[5] Transcript of evidence of Mary Rahme, 12 April 2016, T80: 47-49.
[6] Transcript of evidence of Mary Rahme, 12 April 2016, T82: 11-12; T81:21-37; 39-50.
[7] Ex 1, Vol 1, tab 20 at [4]: Statement of Sergeant Shane Markham, 19 February 2015.
[8] Ex 1, Vol 1, tab 24 at [5]: Statement of Taleetha Boyd, 29 May 2014.

my location as the pylons are not numbered." Photographs tendered in the inquest demonstrate that there was a lifebuoy (or 'angel ring') located on a pylon close by the incident scene. However, given the low lighting and the fact that the lifebuoy was white and attached to a white pylon, the lifebuoy was not visible to Ms Boyd.

21. At about 10:56pm Mr Webster placed a call to Mr Bush, then on board the vessel Sea Hawk II, stationed at the north-western end of the marina. At about 10:56pm Mr Bush radioed the SHFA Control Room Operator, Bryan Csineros, and reported that there were two persons in the water to the south of the Cockle Bay Marina in proximity to the eastern boardwalk.

22. The SHFA Darling Harbour Control Room was the SHFA operations control centre for Vivid Darling Harbour SHFA Ranger operations. On that evening, Mr Csineros was the sole Control Room Operator stationed in the SHFA Darling Harbour Control Room. Mr Csineros described his primary role as being to monitor the CCTV, and to deploy rangers to areas where there have been reported incidents, and liaise with emergency services when required. The CCTV system which Mr Csineros was required to monitor consisted of six monitors and approximately 105 cameras; 75 of the cameras having the capacity to tilt, pan and zoom.

23. Upon receipt of the radio call from Mr Bush, Mr Csineros panned a CCTV camera into position looking north along the eastern boardwalk towards the Cockle Bay Marina. At about 10:55–56pm, the CCTV images show two people in the water in the area to the south of the Cockle Bay Marina proximate to the eastern boardwalk. The images do not enable the two persons to be identified, however, I am satisfied based on the evidence that the two persons who can be seen in the water in the CCTV images are Ms Travis and Mr Turner. There are no CCTV images which depict Mr Hickey.

24. At 10:56:56pm the CCTV camera zoomed out and HighVis vests can be seen in the images, as well as two persons in the water adjacent to the eastern boardwalk. On the available evidence, the HighVis vests indicate the arrival of the initial SHFA ranger response.

25. At 10:57:40pm a '000' call to the NSW Police from a member of the public, identified in the Police Incident Log as Mikhail Langham, was 'collected'. The message recorded in the log notes: "Someone has fallen in the water AA and no one can see them now to get them out." In the course of Ms Boyd's '000' call, she confirms the arrival on scene of "ranger(s)" and "the water police with blue flashing lights." At 10:57:55pm, consistent with Ms Boyd's observations, the Police Incident log notes: "Informant has lifeguard and ranger on scene now."

26. Upon being notified of the incident by Mr Webster, Mr Bush immediately drove Sea Hawk II to the area where Ms Travis and Mr Turner had entered the water. At about 10:58pm Sea Hawk II can be seen in the CCTV images entering the area south of the Cockle Bay Marina, adjacent to the eastern boardwalk, where Ms Travis and Mr Turner can be seen moving around on the surface of the water. It is noted that Sea Hawk II was described by LSC Pemberton as a commercial vessel[9], whereas Mr Bush stated that he was the holder of a general boat licence.

27. At this point I note and I adopt the submission of Destination NSW regarding the issue of licensing for those in charge of vessels. It is not suggested that anything Mr Bush did or failed to do contributed to the tragedy in any way. Nevertheless, the control of the SHFA Rangers vessel on 23 May 2014 might have been critical in the event that a rescue was possible. It may also be critical in the future if persons enter the waters of Darling Harbour from time to time. Mr Bush had a recreational boat licence only. He was not licenced or trained to carry out his important duties. The Rangers vessel was a commercial vessel and the operators of commercial vessels require further qualifications.

28. Responding to Mr Bush's initial radio call to the SHFA Control Room (i.e. at about 10:55-56pm), the Vivid Darling Harbour Event Manager, Mr Michael Prescott, contacted Event Control. This radio call is logged on the Destination NSW (DNSW) timeline for the event at 10:58:21pm. Mr Prescott was a sub-contracted special events manager working for the Vivid Darling Harbour 2014 event management company, Concept Entertainment Group Pty Ltd (CEG).

29. On his arrival on scene, Mr Prescott immediately boarded the SHFA vessel, where he assisted the coxswain, Mr Bush, in recovering the two swimmers (Ms Travis and Mr Turner) from the waters of Cockle Bay and subsequently assisted with a search of the surface of the water, including the areas under the eastern boardwalk.

30. Sergeant Markham, who was rostered to perform crowd control duties at Vivid 2014 and was operating in the Darling Harbour precinct under the call sign "Bennelong 151", responded to a police radio call that a male had fallen into the water and had not resurfaced. Sergeant Markham notes in his statement that the squad, to which he was assigned, were located approximately 200 metres from the location at the time and they ran over to the waters' edge outside the IMAX theatre. He went on the say that, "*I had to push through a*

[9] Transcript of evidence of LSC Pemberton, 13 April 2016, T28-29.

small to moderate sized crowd that had formed around the foreshore to watch one of the key light displays. I stood on the edge of the boardwalk near Imax Theatre and could see a young male and female splashing around in the water directly outside Home Nightclub (3 – 4 metres from the boardwalk); both were fully dressed and were swimming near a motor boat that had two council rangers onboard. There was no other person in the water. I saw that the general crowd was not overly fussed by the swimmers and were mostly focussing on the light display that had only just started. I could hear the female swimmer screaming something but I could not hear what she was saying because of the loud music associated with the light display. The music from the speakers was so loud that I could barely communicate with my fellow officers that were standing next to me, yet (sic) alone the people in the water. Senior Constable Fali threw a life buoy towards the swimmers and we both boarded the boat in order to hear what the female was saying and to help remove the swimmers from the water …"[10]

31. The evidence of Sergeant Markham places the arrival of the first police responders just after the light display had started, at some time shortly after 11:02pm (being the time when Sergeant Markham heard the radio call before running the approximately 200m to the scene). Leading Senior Constable (LSC) Pemberton arrived on the scene shortly after 11:05pm and assumed command of the search.

32. LSC Pemberton spoke to two police officers from police rescue who were already at the scene, one of whom was getting changed into a wetsuit (Senior Constable Hart). Senior Constable Hart was not qualified to dive into the waters, but entered the water and proceeded to conduct a surface search for Mr Hickey, by searching with a torch under the suspended timber walkway which went back approximately 30 metres towards the bars and nightclubs, for the purpose of determining whether Mr Hickey was holding on to a pylon under the boardwalk or floating on the surface of the water. At 11:19pm, the CCTV images depict a person in a wetsuit descending a ladder from the eastern boardwalk and entering the waters of Cockle Bay in the search area to the south of the Cockle Bay Marina. An ambulance helicopter had arrived at the scene, and LSC Pemberton requested that it shine its night sun over the boardwalk to allow for better visibility for the surface search.

33. LSC Pemberton was approached by a person he described as a 'Vivid worker' who informed him that there were high-voltage cables in the water. At this point, LSC Pemberton directed Senior Constable Hart to get out of the water

[10] Ex 1, Vol 1, tab 20 at [4]: Statement of Sergeant Shane Markham, 19 February 2015.

immediately, and told the Vivid worker "We need to have this power shut off".[11]

34. At 11:00pm, Mr Kubow, a sub-contract special events manager who was in the CEG Vivid Darling Harbour event control room, delayed the commencement of the Aquatique show, then scheduled to commence on the hour at 11:00pm.

35. At 11:02pm Mr Prescott authorised the commencement of the 11:00pm Vivid light and sound show. The evidence indicates that the sound of the Vivid show was cut at about 11:12pm to assist the police search, and the light show appears to have been permitted to run to its conclusion.

36. Mr Prescott gave evidence that he made the decision to commence the show having regard to the amount of people in the area and his view that large egressing crowds would hinder search efforts. Mr Prescott also said in evidence that he took the decision to commence the show without consulting any of the SHFA Rangers, including the Ranger Supervisor, Mr Akkan, who was on scene and / or the Control Room Operator, Mr Csineros. Mr Prescott did state that he made a call to the Government Control Centre (the GCC) – nominating "Paul, the operator". None of the radio logs produced in the course of the investigations record a radio call with the GCC in which Mr Prescott consulted with the GCC about the decision to commence the light and sound show. In any event, Mr Prescott conceded in evidence that he spoke to no person 'on the ground' before giving the 'go ahead' for the show.

37. The evidence indicates that, as part of its procedures (which are detailed further in these findings below) CEG provided Mr Prescott and Mr Kubow with a "Show Stop Procedure"[12], which "outlines the steps and procedures for an incident where the show has to be stopped" including in the event of "risk to life". The Show Stop Procedure formed part of the materials addressed in the CEG Vivid 2014 Darling Harbour induction which was undertaken prior to 23 May 2014 and was available in the CEG control tower on the evening.

38. However, the evidence supports a conclusion that on the evening of 23 May 2014 neither Mr Prescott, nor Mr Kubow, consulted the Show Stop Procedure. It is apparent that neither Mr Prescott nor Mr Kubow received any training with respect to the initiation of the Show Stop Procedure, including scenario and / or table-top emergency operations training, which would have better equipped them (in particular, Mr Prescott as Vivid Darling Harbour Event Manager) to make a properly informed decision, taking into account issues including the

[11] Transcript of evidence of LSC Matthew Pemberton, 13 April 2016, T25:15.
[12] Ex 1, Vol 4, tab 80: CEG Vivid 2014 Show Stop Procedure.

apparent risk to life, the impact of the show on the ongoing search and recovery operation, and the impact of any egress of the crowds which would likely be an issue in all cases where a show is stopped prior to completion.

39. Further, the CEG Vivid 2014 Show Stop Procedure does not form part of the materials produced by Destination NSW, SHFA or ACES in the course of the investigation. Neither Mr Dimitrioski (SHFA Darling Harbour Precinct Security Manager), nor Mr Akkan (SHFA Ranger Supervisor) were aware of the existence of any show stop procedure.

40. The evidence of the police was to the effect that the sound of the light show interfered with the efforts of the rescuers to co-ordinate an effective response. It is also noted that the commencement of the light and sound show some minutes after the disappearance of Mr Hickey below the surface of the water is understandably a source of added distress to Mr Hickey's family and friends. In circumstances where command in respect of the incident was to pass to senior police upon their arrival at the scene, I consider that a more appropriate course would have been to await the arrival of the police and to confer before directing that the show was to go ahead.

41. The related issue referred to above is the presence of electrical cabling installed along the eastern boardwalk and, also, on the Cockle Bay Marina as part of electrical works associated with the Vivid Aquatique light and sound show. The evidence given in the inquest indicates that the Aquatique electrical installation was not isolated until about 11:40pm, after a request was made by Mr Prescott to Aquatique to turn off all of the power. Mr Prescott notes in his statement that he made this request "for the safety of people in the water" [13] and clarified in his evidence before the inquest that the electrical cabling posed no risk to the safety of persons in the water, noting that all of the joins were above ground, but he made the decision to have the power turned off as a "precautionary measure". On all of the evidence, it appears unlikely that the electrical installation actually presented an immediate risk to Mr Hickey and / or any of the persons who entered the water during the course of the search for Mr Hickey.

42. Nevertheless, this was another issue that impacted on the coordination of the police search efforts, as demonstrated by the evidence of LSC Pemberton referred to above.

43. In the circumstances, I consider that procedures concerning the stopping of the Vivid Aquatique light and sound show, including the disabling of the electrical installation, ought to have formed part of the emergency

[13] Ex 1, Vol 1, tab 45 at [17]: Statement of Michael Prescott, 24 May 2014.

management plans and procedures for Vivid Darling Harbour 2014 and that officers of the relevant entities involved in conducting the event, particularly those who were required and authorised to engage the procedures in the event of an emergency, ought to have received appropriate training in the implementation of the show stop procedures.

44. Nonetheless, I am satisfied that the decision, taken by Mr Prescott about 11:02pm, to commence the light and sound show did not have any effect on the survival of Mr Hickey, having regard to the medical cause of his death outlined below. I am also satisfied that there was no delay in the response to the initial report of a person entering the waters by Mr Prescott, the SHFA Rangers, Ambulance NSW or the NSW Police.

45. Following the initial response to the report of Mr Hickey entering the waters, police officers from the New South Wales Police Diving Unit subsequently attended the scene. Police divers "conducted an arc search in 6.3 metres of water with zero visibility".[14] Mr Hickey's body was located on the seabed of Cockle Bay at a location described as "from the last finger wharf at the eastern end of Cockle Bay the deceased was found 3 metres from the wharf between the 7th and 8th pylon." This location is consistent with Ms Boyd's last reported sighting of Mr Hickey. One of the police divers noted that, based on his depth gauge, at the point where Mr Hickey's body was found, the water was 6.3 metres deep. Mr Hickey's body was retrieved at 1:20am on 24 May 2014.

Medical cause of death

46. At autopsy, the forensic pathologist determined the cause of death to be "in keeping with drowning", and referred to acute alcohol intoxication as a condition contributing to the death but not relating to the condition causing the death. The significant pathological findings were identified as follows:

    (a) The body was that of an adequately nourished adult male;
    (b) There were no external signs of significant injury;
    (c) There were remnants of white foamy plume in the mouth;
    (d) On internal examination, there were findings of severe pulmonary oedema and congestion and generalised organ congestion;
    (e) No significant natural disease; and
    (f) No pathology was found on either gross examination or histological examination.

[14] Ex 1, Vol 1, tab 8 at [5]: Statement of LSC Steve Wye, 29 June 2014.

47. Analysis of a femoral blood sample recovered in the course of the autopsy indicates a blood alcohol reading of 0.256g/100ml and a vitreous humour alcohol concentration of 0.261g/100mL.

48. In his expert report dated 26 March 2016, Professor Ian Whyte, clinical toxicologist and clinical pharmacologist, opines that:

    (a) The blood alcohol concentration of 0.256gm/100ml and vitreous humour alcohol concentration of 0.261g/100mL recorded post-mortem (the latter of which confirms the blood alcohol concentration of 0.256gm/100ml) is an accurate representation of Mr Hickey's blood alcohol concentration as at the time of death;
    (b) At a blood alcohol concentration of 0.256gm/100ml Mr Hickey would have been at least in the excitement stage of alcohol influence with emotional instability; decreased inhibitions and loss of attention, critical judgement and control; along with increased reaction time and some muscular incoordination; and there would probably also have been some features of the confusion phase of alcohol influence such as dizziness, impaired balance and a disturbance of perception of dimensions – for example depth perception; and
    (c) The effects of the subject concentration of blood alcohol were more likely than not to have contributed to Mr Hickey's fall into the water and also to Mr Hickey's "subsequent difficulties staying afloat".

49. The following evidence of Ms Boyd is also noted: "*I am a nurse and I have my bronze medallion and at this point considering his head had not come above the surface for at least five minutes in my opinion his morbidity and mortality rate was quite high*."[15]

50. Having regard to the level of Mr Hickey's intoxication, his inability to swim and his fear of the water, I am satisfied that, once Mr Hickey entered the waters of Cockle Bay at about 10:55pm on 23 May 2014, there was little, if any, prospect of self-rescue and that, in the absence of an immediate in-water rescue, there was little, if any, prospect of Mr Hickey being rescued.

51. I am satisfied that the immediate cause of Mr Hickey's death was drowning, with alcohol intoxication as a contributing factor.

Inadequacies in the emergency plan and in instruction and training

[15] Ex 1, Vol 1, tab 24 at [9]: Statement of Taleetha Boyd, 29 May 2014.

52. The light and sound show, Vivid Aquatique, was part of a broader event known as 'Vivid 2014 - Darling Harbour' (Vivid DH 2014). Vivid DH 2014, in turn, formed part of a multi-venue event known as 'Vivid Sydney'.

53. Inaugurated in 2009, in 2014 Vivid Sydney was in its sixth year of operation. As is noted in the evidence, Vivid Sydney is a major, internationally renowned event. Vivid Sydney 2014 attracted more than 1.43 million people. In 2014, Vivid Aquatique – a water show incorporating water fountains, jets, lasers and 3D water projections on Cockle Bay – was 'a feature event'.

54. A number of entities were involved in the Vivid DH 2014 event. In 2014 Destination NSW (DNSW) was the 'event organiser' both in relation to the overall event 'Vivid Sydney' and in relation to each of events / exhibitions conducted across the multiple event venues which made up 'Vivid Sydney 2014' – including Darling Harbour / Cockle Bay.

55. The Sydney Harbour Foreshore Authority, as it then was (SHFA) was the "*statutory body representing the Crown and the land owner and place manager of the Darling Harbour and The Rocks Precinct".* In that capacity, SHFA entered into a Memorandum of Understanding dated 17 April 2014 (MOU) with DNSW.[16] Pursuant to the MOU, SHFA 'partnered' with DNSW in relation to the production of Vivid DH 2014 and Vivid at The Rocks – each of which was the subject of a separate appendix to the MOU.[17]

56. SHFA also engaged rangers from Australian Concert Entertainment and Security Pty Ltd (ACES) who were on duty during Vivid DH 2014 (SHFA Rangers). The evidence discloses that in the period leading up to and during Vivid 2014, the SHFA Rangers were co-ordinated by, and worked under the instruction and supervision of, the SHFA Darling Harbour Precinct Security Manager (Mr Dimitrioski).

57. Concept Entertainment Group Pty Ltd (CEG), an external event management company, managed the Vivid Darling Harbour 2014 event. CEG entered into a contract with Destination NSW concerning the management of the event,[18] as well as a licence agreement with SHFA.[19]

58. There was accordingly a range of responsibilities held by the respective entities concerning the conduct of the Vivid DH 2014 event, some of which overlapped in certain respects. In these circumstances, it was essential that

[16] Ex 1, Vol 4 at tab 65.
[17] Ex 1, Vol 4 at tab 65, Appendix 2 Vivid in Darling Harbour Annexure to Memorandum of Understanding – Vivid Sydney 2014; pages 16 – 24.
[18] Ex 1, Vol 4 at tab 66.
[19] Ex 1, Vol 4 at tab 71.

clear emergency management procedures were in place, which were effectively promulgated to key officers of, or engaged by, those entities.

59. Unfortunately, the evidence before this inquest left a distinct impression of uncertainty as to the procedures to be followed, and by whom, in the event of an emergency of this nature. Having regard to the evidence, I have formed the view that there were a number of systems failures relevant to the manner of Mr Hickey's death, as summarised below.

Risk assessment / emergency management planning by CEG

60. The CEG Vivid 2014 Darling Harbour Precinct Risk Assessment dated 11 April 2014[20] (CEG Risk Assessment 2014) was performed by Mr Lander.

61. Mr Lander confirmed in evidence that he holds no formal risk management or risk assessment qualifications. Mr Lander also confirmed that he has not undertaken any formal risk assessment training courses conducted by a registered training organisation. Mr Lander stated that he created the CEG template for the risk assessment based on other risk assessment documents that he had seen "over many years".

62. In April 2015, as part of preparations for Vivid Sydney 2015, ACES, the employer of the SHFA Rangers, received copies of the CEG Risk Assessment 2014 and the CEG Risk Assessment 2015. Following receipt of those documents in about April 2015, ACES undertook a critical analysis of the CEG Risk Assessment 2015.[21] Whilst the criticisms set out in the ACES report refer specifically to the CEG Risk Assessment 2015, Mr Semmens of ACES, Mr Lander (of CEG) and Mr Rowley (of SHFA) agreed in evidence that the criticisms set out in the ACES report are equally applicable to the CEG Risk Assessment 2014.

63. It was Mr Rowley's evidence that even a cursory examination of the CEG Risk Assessment 2014 by an appropriately qualified person, applying recognised risk management principles and a critical mind, would disclose that the CEG Risk Assessment 2014 is entirely inadequate.

64. I agree with Mr Rowley's assessment and consider that the CEG Risk Assessment 2014 and the CEG Risk Assessment 2015 were fundamentally flawed. Critically, the CEG Risk Assessment 2014 did not identify the risk to patrons presented by the open waters' edge of Cockle Bay and, as a consequence, did not assess the need, if any, for controls to be put in place to

[20] Ex 1, Vol 4 at tab 78.
[21] See "Darling Harbour Planning for Vivid Sydney 2015, Version 6 dated 22 May 2015" at pages 6 – 7 of the report [Ex 1 Vol 2 tab 58A, pages 55 – 56].

eliminate, isolate or reduce that risk. There is no reference to, or consideration of, the controls that SHFA had in place as at 2014 i.e. lifebuoys; fixed emergency ladders; some signage; ranger patrol services; patrol boats; public address system; CCTV cameras monitored from the DH Control Room); and no critical assessment of those controls within the specific risk analysis and planning context of Vivid DH 2014 – a large scale, night-time event which was focussed on a light and sound show to be staged on the waters of Cockle Bay providing a prime viewing point in proximity to licensed premises.

65. CEG, as the manager of the event, also prepared the CEG Event Plan and Plan of Management for Vivid Darling Harbour 2014, which included an emergency management plan.[22] I consider that this documentation contained the following deficiencies:

(a) No distinction is drawn between minor emergency operations, which were to be managed by the Chief Warden on site and without the intervention of emergency services; and major or serious emergency operations which required the intervention of emergency services – including a "hand-over" by the Chief Warden to the Senior Officer upon the arrival of the Emergency Services;

(b) The emergency management plan did not clearly and adequately define emergency roles and responsibilities;

(c) The table (at [6(a)]) outlining the actions required of site staff in the event of an emergency is inconsistent with the chain of command at [6(b)]. In particular, [6(a)] identifies the Vivid Darling Harbour Precinct Manager as "Vivid Chief Warden" but the Emergency Chain of Command at [6(b)] appoints SHFA Darling Harbour Control Room as "SHFA Chief Warden" who sits at the top of the chain for the on-site emergency response;

(d) By placing the SHFA Chief Warden higher in the chain of command than the Vivid Chief Warden, the Emergency Chain of Command (at [6b]), appears to make the SHFA Darling Harbour Control Room responsible for the key initial emergency response and for the management and control of the incident, as well as being responsible for liaising and co-operating with police and emergency services. However, the ACES report 'Darling Harbour Planning for Vivid Sydney 2015'[23], indicates that best practice suggests the Event Manager – in this case CEG – should hold the Chief Warden's position; with the landholder – in this case SHFA – being a party to be notified, to co-operate and co-ordinate in an emergency;

[22] Ex 1, Vol 4, tab 79,page 8 at [6].
[23] Ex 1, Vol 2, tab 58A at pages 55-56.

(e) The emergency management plan did not incorporate any specific emergency procedures and, in particular, did not incorporate the CEG Show Stop Procedure referred to above;

(f) The emergency plan did not make any provision for scenario planning and / or scenario training for the event of an emergency.

66. In relation to 65(c) above, Mr Prescott stated in evidence that, on 23 May 2014, he was the "Vivid Darling Harbour Precinct Manager". As a consequence, under the CEG Event Plan and Plan of Management (at [6(a)]), in the event of an emergency Mr Prescott was the "Vivid Chief Warden" who bore the following responsibilities in the event of an emergency:

"*1. Manage response to Emergency*
2. Liaise with SHFA/NSW Police/TMC [Traffic Management Consultant] to manage appropriate response to emergency
3. Assign jobs to available staff

In the case of an Emergency
1. Decide on the course of action with the SHFA Control Room/NSW Police/TMC and advise staff to commence emergency procedures.
2. If required FOH – Conduct appropriate crowd control speech instructing guests to standby and take instruction.
3. Communicate directive to SHFA/NSW Police/TMC.
4. Ensure Action is taking place by all staff, contractors and personnel.
5. Liaise and provide assistance to Emergency Services."

67. However, Mr Prescott is not identified in any of the relevant documentation as either the "Vivid Darling Harbour Precinct Manager" for 23 May 2014; and/or, in the event of an emergency, as the "Vivid Chief Warden" for the Darling Harbour precinct. Mr Akkan (SHFA Ranger Supervisor) gave evidence to the effect that he had not been instructed about or informed of the identity of the person from CEG with whom he was to liaise if an emergency occurred in the course of Vivid at Darling Harbour 2014. There is no evidence to indicate that Mr Prescott identified himself to Sergeant Markham as the Vivid Darling Harbour Chief Warden.

68. A comparison may be made in these regards with the Event Site Safety Management Plan developed for Vivid 2014 at Sydney CBD in which the Emergency Control List identifies the various Emergency Control Organisation members by name and, in addition, includes both radio and mobile telephone contact details for each member.[24]

[24] Ex 1, Vol 2 at tab 62, pages 252 – 267.

Lack of auditing / cross-checking systems by DNSW

69. Mr Lander gave evidence that CEG submitted the CEG Risk Assessment 2014 to DNSW, and that CEG expected to receive feedback which was not forthcoming.

70. DNSW retained the services of Event & Sports Projects Australia Pty Ltd (ESPA) to prepare, on behalf of DNSW, the Event Risk Management Plan 2014 and the Vivid Sydney 2014 Event Operations Manual. DNSW required all of the Vivid 2014 event production management companies, including but not limited to CEG, to submit precinct risk assessments and precinct event management plans to ESPA for compilation into the Event Risk Management Plan 2014 Vivid Sydney and the Vivid Sydney 2014 Event Operations Manual. Mr Lander gave evidence that CEG also submitted the CEG Risk Assessment 2014 to ESPA and that no feedback was forthcoming.

71. However, as is directly conceded by DNSW, ESPA was not required to cross-check contractor risk assessment plans and contractor plans of management for each site, including the CEG Risk Assessment 2014 and CEG's Event Plan and Plan of Management, for consistency of risk treatment and / or consistency of emergency management planning.

72. Having regard to the purpose of preparing the overarching event risk management plan and the overarching event operations manual, it follows that the failure to have in place a system of cross-checking, designed to ensure consistency of approach to risk management and planning across the event – including adherence to relevant standards and best industry best practice – represents a significant omission in the context of the overlapping and inter-related safety management systems under which the event was being produced.

73. This omission also represented the loss of a very significant opportunity for corrective action in the course of events leading up to the subject incident. As stated by DNSW in its submissions to this inquest, *"[p]ut another way it would have emerged that CEG had not addressed the risk that, either intentionally or accidentally, patrons might enter the waters of Darling Harbour*."[25]

Lack of assessment by SHFA

74. Mr Rowley, who was the SHFA Head of Operations as at 23 May 2014, gave evidence that he had line management responsibility for the delivery of security, via the SHFA Rangers, for Vivid DH 2014. Mr Rowley, as the head of SHFA Operations, gave evidence in the inquest to the effect that:

[25] Submissions on behalf of Destination NSW, at [50].

(a) In the normal course of events he expected that a risk assessment would be undertaken in relation to the conduct at Darling Harbour of an event such as Vivid DH 2014; and that a plan of management and an emergency management plan for such an event would be provided to SHFA;
(b) In the normal course of events such documents would be delivered to SHFA Events – an arm of SHFA which was separate to SHFA Operations, and that SHFA Events would, in turn, deliver those documents to SHFA Operations, as a necessary step to enable the SHFA Rangers to carry out their jobs whilst such events are being conducted;
(c) The CEG Risk Assessment 2014 was patently deficient including, as a major deficiency, a failure to identify and address the risk to patrons of falling into the waters of Cockle Bay and drowning, as a consequence of the open waters' edge of Cockle Bay;
(d) Mr Rowley sought a review of the CEG Risk Assessment 2015 by Avert Risk (ACES), which was in a similar form as the CEG Risk Assessment 2014 (i.e. a similar CEG template) and suffered similar deficiencies;
(e) Following the review by ACES of the CEG Risk Assessment 2015, Mr Rowley rejected the document as deficient, and there was no reason why SHFA could not have sought a review of the CEG Risk Assessment 2014 prior to 23 May 2014 and then similarly rejected that risk assessment as deficient; and
(f) Barriers were erected to isolate the open waters' edge of Cockle Bay for both Vivid DH 2015 and 2016, and there was no physical reason why barriers could not have been erected to isolate the waters' edge for Vivid DH 2014.

75. Having conceded the obvious deficiency of both the CEG Risk Assessment 2014 and the CEG Event Plan and Plan of Management Vivid 2014, Mr Rowley conceded in his evidence that members of his team in SHFA had a responsibility to review the CEG documents before those documents were permitted to be put in place for Vivid Darling Harbour and before those documents were provided to the SHFA Rangers as procedures under which the SHFA Rangers were to work whilst on duty in the precinct during Vivid DH 2014.

76. However, Mr Rowley was unable to offer any explanation for the apparent failure of the SHFA to carry out such a review.

Lack of promulgation of plans / procedures to rangers

77. Neither the CEG Event Plan and Plan of Management Vivid 2014 nor the CEG Risk Assessment 2014 were received by ACES prior to 23 May 2014 – even though ACES employees, namely the SHFA Rangers, were required to work to those documents in the event of an emergency on the ground.

78. Further, on the evidence, there was no effective provision for training of the SHFA Rangers who were on duty in the Darling Harbour Precinct on the evening of 23 May 2014 in relation to any of the following:

- The SHFA RCQ & DH Vivid Sydney 2014 Operational Plan;
- The (abridged) SHFA Vivid Sydney Security Operations Plan, which contains the "Darling Harbour Content" extracted from the SHFA RCQ & DH Vivid Sydney Operational Plan (commencing at page of 55 of that document);
- The CEG Risk Assessment 2014; and/or
- The CEG Event Plan and Plan of Management – including Emergency Management & Control.

79. It appears that Mr Dimitrioski received and distributed the various documents (referred to in paragraph [78] above) to the SHFA Control Room on or about 22 May 2014. Access was provided in electronic form via computer, and a hard copy of the Vivid Sydney Security Operations Plan, the CEG Risk Assessment 2014 and the CEG Event Plan and Plan of Management Vivid 2014 were included in a folder placed in the SHFA Darling Harbour control room. Mr Rowley was unable to identify the means / route by which the CEG documents were delivered to Mr Dimitrioski for distribution to the SHFA Rangers.

80. Mr Dimitrioski gave evidence that he did not make a critical assessment of the documentation. He accepted the documents and passed them on. Further, even at that late stage, no provision was made for reading time, and no training or instruction was provided to the rangers regarding the content of the documents. In the circumstances, it is hardly surprising that none of the SHFA Rangers, who were on duty on the evening of the subject incident and who have given evidence in the proceedings, were able to identify the subject documentation and / or identify the Vivid Chief Warden who bore key responsibilities in the event of an emergency.

81. In all of the circumstances detailed above, I am of the view that there were a number of significant systems failures relevant to the circumstances in which Mr Hickey, as a patron attending Vivid Darling Harbour 2014, fell into the waters of Cockle Bay.

(a) First, failures in the systems of risk assessment and emergency management planning by CEG;
(b) Second, a failure in the cross-checking / auditing systems adopted by Destination NSW, as the "owner" of the event, in relation to its assessment of the CEG Risk Assessment 2014 and the CEG Event Plan and Plan of Management Vivid 2014;

(c) Third, failures by SHFA – apparently in both SHFA Events and SHFA Operations – in its assessment of the CEG Risk Assessment 2014 and the CEG Event Plan and Plan of Management Vivid 2014; and

(d) Fourthly, a failure by SHFA in relation to the effective promulgation of the CEG Risk Assessment 2014 and the CEG Event Plan and Plan of Management Vivid 2014 to the relevant SHFA Rangers – in particular, the Ranger Supervisor (Mr Akkan) and, also, in relation to the training and instructions provided to the SHFA Rangers with respect to those documents.

Changes since the incident

CEG

82. The evidence indicates that, following the adjournment of the inquest in April 2016, a number of changes were introduced regarding the role to be played by CEG, as the event management company, in relation to risk assessment for Vivid 2016. It is also apparent that CEG adopted a number of new procedures, as the event management company, in relation to the actual day to day conduct of Vivid 2016.

83. The changes, which are outlined in Mr Lander's supplementary statement dated 20 September 2016, are to be welcomed as practical responses to issues raised in the inquest.

84. However, there is no evidence that the underlying weaknesses in CEG's risk assessment and risk management processes have been addressed, for example, by the provision of additional risk assessment and risk management training to Mr Lander.

85. The CEG Risk Assessment for Vivid 2016, which is attached to Mr Lander's supplementary statement, is in a format which is effectively identical to the risk assessments undertaken for Vivid 2014 and Vivid 2015. The template repeats a number of the fundamental errors identified in the previous templates – for example: the credentials of the author are not identified; whilst there is evidence of stakeholder consultation, there is no provision for sign off by the stakeholders and/or the duty holders; the template does not identify the level of risk prior to the application of the nominated control; and the risk assessment is still being conducted against a corporate risk management consequence table rather than a consequence table which deals with risk of injury to the individuals exposed to the subject risks.

86. In these circumstances, I propose to make the recommendations to CEG outlined below. In doing so, I welcome the indication given by Mr Lander to

this inquest that he intends to commence training in early 2017, and that he has resolved to engage on behalf of CEG the expertise of an external risk assessment consultant for all large scale public events. I would add, however, that risk management principles and the proper conduct of a risk assessment are fundamental to the proper planning and conduct of any business or undertaking whatever the size.

Destination NSW

87. The evidence of both Mr Sheridan and Ms Chipchase of DNSW indicates:

- A recognition by DNSW of the failures in its risk management systems, particularly in its quality control, cross-checking and auditing of the risk management procedures of its event management sub-contractors such as CEG; and
- That changes have been introduced by DNSW, as the Vivid event organiser, post-incident, with a view to reducing the risk of relevant failures in quality control, cross-checking and auditing being repeated.

88. In particular, having regard to the evidence of Mr Sheridan, I am satisfied that DNSW has put in place:

- Enhanced systems for the review of venue documentation and risk assessments designed to a commonality of approach and the application of current standards;
- The conduct of a table-top risk assessment exercise addressing key issues such as command and control and communications, together with scenario testing;
- An independent, pre-event walk-through of all venues / precincts;
- On-site, real time independent risk reviews conducted during the event with a view to ensuring that nominated risk controls are in place and working; and
- An independent post-event review process designed to identify improvements that may be adopted for future events.

89. In the circumstances, I do not propose to make any recommendations in relation to DNSW.

ACES

90. I agree with Counsel Assisting's submission that it is difficult to comprehend how a sophisticated security, risk management and event management company like ACES permitted a situation to arise in which its employees went to work as SHFA Rangers under the CEG Risk Assessment 2014 and the CEG Event Plan and Plan of Management on 23 May 2014 without the

company having received and assessed those documents well in advance of such a major event.

91. Nonetheless, the evidence indicates that ACES have adopted a pro-active approach to the investigation of the subject incident and to the inquest, for example, the disclosure by Mr Semmens of the company's involvement in the delivery of FIFA Fan Fest 2010 at Darling Harbour including the provision of documents relevant to risk management in that event including photographs depicting the use of barriers / fencing in the course of that event to isolate the open waters' edge of Cockle Bay.[26]

92. I am satisfied that the evidence indicates that the directors of ACES have undertaken an appropriate level of review to date and that the company will continue to look to proactively improve its risk management and review systems in relation to its employees, including employees who are deployed in third party undertakings – such as the provision by ACES of SHFA Ranger services.

93. In the circumstances, I do not propose to make any recommendations to ACES.

SHFA / Place Management NSW

94. The evidence discloses that SHFA has undergone a significant re-organisation in the period since the subject incident. The NSW Government has consolidated the Authority's functions with Property NSW.

95. On 25 October 2016 SHFA underwent a change of name. The authority formerly known as SHFA is now known as Place Management NSW.[27]

96. The evidence also discloses that, in the period since the subject incident, SHFA has undertaken a somewhat belated shoreline risk assessment in relation to its Sydney Harbour foreshore properties – Darling Harbour/Cockle Bay; Campbell Cove; and Darling Island.

97. At the time of giving evidence, Mr Rowley continued to have responsibility for the delivery of security and ranger services at SHFA properties/precincts, including Darling Harbour, Campbell Cove and Darling Island.

98. Mr Rowley's evidence indicates that, following the incident and the Reliance Risk Shoreline Risk Assessment, SHFA has introduced a number of changes

[26] Exhibit 11.
[27] See: Schedule 1 clause 13 of the *Statute Law (Miscellaneous Provisions) Act (No 2) 2016* (NSW) and clause 19 of Schedule 5 to the *Place Management Act 1998* (NSW).

to its foreshore risk mitigation or controls – particularly at Darling Harbour, including the following:

- Changing the colour of the lifebuoys at Cockle Bay from white to orange;
- Installation of permanent planta boxes and/or timber bollards[28] near the water's edge at Cockle Bay to act as hazard recognition devices for patrons;
- Installation of tactile markers;
- Installation of further lighting; and
- Deployment of temporary fencing for all "large scale events".

99. Mr Rowley's evidence also indicates that in the course of 2016 steps have been taken to develop a risk assessment guide and generic risk register to assist third parties holding events at SHFA properties and the "events team" in the identification of relevant risks and the development of appropriate risk controls.

100. However, whilst the steps taken by SHFA since the incident are to be applauded, it is apparent on the evidence that issues remain.

101. Mr Rowley stated in evidence that Mr Dimitrioski has undergone risks assessment training in the last three months, and that he (Mr Rowley) has worked with ACES to develop a risk assessment criteria guide and generic event risk register to assist third party event holders and the events team to identify necessary risk controls. Otherwise there is nothing in evidence in this inquest demonstrating that SHFA / Place Management NSW has undertaken a review of or introduced any changes to risk assessment and / or risk management at an organisational level, for example, revising the organisation's risk decision criteria for Darling Harbour.

102. Similarly, there is no evidence that SHFA / Place Management NSW has undertaken any review or introduced any changes to the risk assessment and / or risk management procedures adopted by SHFA / Place Management NSW 'Operations' (i.e. what was, at the relevant time, Mr Rowley's team).

103. In this context, it is significant to note the conclusions expressed by Mr Middleton in the Reliance Risk Shoreline Risk Assessment,[29] which Mr Middleton confirmed in his evidence at inquest. Those conclusions are as follows:

[28] See Exhibit 8.
[29] Ex 4 at tab 2.

(a) The history of Cockle Bay indicates that the current controls have been only partially effective (ie. historically people have entered the waters of Cockle Bay - most of those persons have either exited the waters voluntarily or they have been recovered successfully - however, there have been two drownings, of Mr Hickey and a patron who was pushed into the waters of Cockle Bay in about February 2012);
(b) Temporary fencing to isolate patrons from the open waters' edge, such as that used for Vivid Darling Harbour 2015, provides an effective temporary control of the subject risk and, absent a permanent engineering solution – such as permanent fencing, temporary fencing should be adopted for "all large scale events";
(c) The use of planta boxes and bollards do not constitute a means of effectively isolating patrons from the waters' edge;
(d) The number of visitations to the precinct are increasing;
(e) Increased patronage means that more persons will be exposed to the subject risk;
(f) Given the level of resources already deployed at Darling Harbour, increasing levels of operational surveillance and security (i.e. enhanced CCTV monitoring and/or increasing ranger numbers) will have only a marginal effect on safety.

104. It is Mr Middleton's evidence that, having regard to historical experience, in the future patrons will continue to enter the waters of Cockle Bay, both intentionally and by misadventure and that, as a consequence, it is inevitable that the associated risk of a patron drowning will be realised.

105. It is also Mr Middleton's evidence that, from a risk management perspective, the erection of permanent fencing to isolate the waters' edge at Cockle Bay will significantly reduce the risk of drowning, particularly in relation to the high risk area proximate to the licensed premises along the raised promenade on the eastern foreshore of Cockle Bay which is identified in the Reliance Risk Shoreline Risk Assessment report.

106. In this context, Mr Middleton opines:
"*It is Reliance's view that public safety and design objectives must be balanced against the community's right to enjoy the facilities and utility of [the Darling Harbour Precinct] in a safe and secure way. These design objectives should be continually reassessed against public expectations, SHFA's legal duties as land owner and historical data to ensure that the balance that is maintained is appropriate*."[30]

[30] Ex 4, tab 2, pages 14, 67, 71-72.

107. Against this background, I propose to make the recommendations outlined below to the Minister responsible for Property NSW and the Chief Executive Officer of Place Management NSW. In doing so, I acknowledge and welcome the indication given by counsel for SHFA in her submissions that Sheridan Consulting Group has been engaged to conduct a 'Strategic Risk and Security Operational Readiness Review' for Property NSW.

Recommendations:

To the directors of Concept Entertainment Group Pty Ltd:

1. That the directors of Concept Entertainment Group Pty Ltd (CEG) give urgent consideration to the retention by the company of an appropriately qualified risk management consultant to perform a review of the company's risk management policies, practices and procedures.

2. That the directors of CEG give urgent consideration to the provision of formal, documented training to directors, officers and employees who are required, from time to time, by the company to conduct risk assessments and to prepare event management and emergency management plans. Such training should be provided by an appropriately qualified risk management consultant or registered vocational training organisation specialising in the provision of risk assessment and risk management training.

To the Minister responsible for Property NSW and the Chief Executive Officer of Place Management NSW [formerly the Sydney Harbour Foreshore Authority]:

3. That the Minister and the Chief Executive Officer give urgent consideration to the establishment of an independent review of the risk assessment and risk management systems utilised by Place Management NSW (including the divisions known or formerly known as the "Operations" and "Events" divisions) in relation to the planning and conduct of events to be held on the land managed by Place Management (including events organised by a third party).

4. That the independent review referred to in recommendation 3 above should include a review of the steps taken to ensure that officers in charge of Place Management NSW vessels operated in the waters of Darling Harbour / Cockle Bay are appropriately licenced and qualified.

5. That the Minister and the Chief Executive Officer give urgent consideration to the development by Place Management NSW of documented, identified and quantifiable criteria for the purpose of defining "major" or "large scale" events to be held in the Darling Harbour precinct at which the event manager must

be required, for the safety of the public, to erect temporary barriers to isolate the open waters' edge of Cockle Bay.

6. That the Minister and the Chief Executive Officer give urgent consideration to establishing a systematic review, using historical incident data, of the corporate 'Risk Decision Criteria' used by Place Management NSW, in particular, as used in the assessment of the risks to public safety associated with the open waters' edge at Cockle Bay, Darling Harbour [as outlined in the Reliance Risk Shoreline Risk Assessment report dated 2 November 2015 compiled for Sydney Harbour Foreshore Authority]. The purpose of the review is to ensure that an appropriate balance is maintained between the design objectives associated with the preservation of an open waters' edge to Cockle Bay and the need to ensure public safety in relation to the ongoing operation by Place Management NSW of the Darling Harbour precinct as a major local and international tourist destination.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

The deceased person was Brendan Hickey.

Date of death

Mr Hickey died on 23 May 2014.

Place of death

Mr Hickey died at Cockle Bay, Darling Harbour, NSW.

Manner and cause of death

Mr Hickey died as a consequence of drowning by misadventure to which alcohol intoxication was a contributing factor.

I would like to thank my Counsel Assisting, Mr Mark Cahill and his instructing solicitor, Naomi Malhotra from the Crown Solicitor's Office for their tireless efforts before during and after this inquest.

Finally, I would like to thank Brendan's family and in particular his brother, Shane and Shane's partner Catriona for their contribution to this inquest and helping to make events such as Vivid safer for the public.

I would like to end with Shane's words:

“The death of Brendan has left a huge hole in our family and in our hearts. We are a really close family and the loss of Brendan was just devastating to all of us, he was such a major part of our lives that we will never be able to replace. We hope that no other family ever has to go through what we have been through over the last 2 years. With that in mind, hopefully this inquest can really help to ensure public safety.”

I hope so too.

I close this inquest.

Magistrate Teresa O’Sullivan
Deputy State Coroner
Date: 22 December 2016