STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Thanh Pham
Hearing dates:	28-29 April 2016, 15-19 August 2016
Date of findings:	3 February 2017
Place of findings:	State Coroners Court, Glebe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	Coronial law-manner of death- karate- traumatic head injury
File number:	2011/390934
Representation:	Ms Samantha Ferguson, Sergeant, Coronial Advocate Assisting. Mr I Fraser of counsel for the Pham family instructed by Younes Espiner Lawyers. Ms E Elbourne of counsel for the International Federation of Karate Kyokushinkai (IFFKA) and for Douglas Turnbull, Ali Aryan, Jenny Fuller, Ben Osland, Peter Mylonas, Margaret Le, Andre Noujaim, Earl O'Campo, Shahain Yussof, Luke Trotz and Tony Le, instructed by McCabes Lawyers. Ms K Edwards of counsel for the Offfice of Sport, instructed by Mr Greig, Office of Sport.
Findings:	**Identity of the deceased** The deceased person was Thanh Pham. **Date of death**

	Thanh Pham died on 18 October 2011. **Place of death** Thanh Pham died at St George Hospital, Kogarah, NSW. **Cause of death** Thanh Pham died of a traumatic brain injury. **Manner of death** Thanh Pham's death occurred as a result of injuries he received while participating in a karate grading.
Recommendations	**To the Minister for Sport** 1. That the Office of Sport consider working with NSW Karate (and possibly other martial arts organisations) to develop a general head injury/concussion protocol or policy for the use of karate organisations at gradings and training. This process should take place with expert medical advice. Once developed, the policy could be published and promoted on NSW Karate's website and made available more widely. 2. That the Office of Sport, through funding contracts with State Sporting Organisations, mandate the adoption of appropriate head injury/concussion protocols or policies. 3. That the Office of Sport consider working with Karate

	NSW (and possibly other martial arts organisations) to develop a guideline on best practice for grading days. Once developed this guideline could be published and promoted on NSW Karate's website and made available more widely.

IN THE STATE CORONER'S COURT
GLEBE
NSW
SECTION 81 CORONERS ACT 2009

REASONS FOR DECISION

1. This inquest concerns the death of Thanh Pham.

2. Section 81(1) of the *Coroners Act* 2009 requires that when an inquest is held, the coroner must record in writing his or her findings in relation to the death. These are my findings.

Introduction

3. Thanh Pham was 30 years of age at the time of his death. He came from a close and loving family. His parents had come to Australia as refugees after the Vietnam War. After his parents separated, their five children grew even closer, helping to support their mother and each other. I acknowledge that Thanh's death and the circumstances surrounding it have caused enormous grief and suffering to the Pham family.

4. In 2011 Thanh was studying to be a primary school teacher. He was also very committed to his study of karate and hoped one day to run his own *dojo* or karate centre. Gaining his black belt qualification was to be the culmination of a long held dream and an important step towards this future. Thanh studied karate in the Kyoshushinkai traditon under Doug Turnbull at a *dojo* in Tempe. Thanh found that karate gave him self-confidence and a high level of fitness. After many years of training Mr Turnbull had finally agreed that Thanh was ready to undertake his black belt grading and a date was set for October 2011.

5. Tragically, on 16 October 2011 during the second day of the grading process, Thanh collapsed while sparring with an experienced black belt. He was taken by ambulance to Sutherland and then to St George Hospital. He was pronounced dead at 2.30pm on 18 October 2011.

6. An autopsy was conducted by Dr Issabella Brouwer at the Department of Forensic Medicine, Glebe on 21 October 2011. She recorded Thanh's cause of death as a traumatic brain injury.[1]

The role of the Coroner and scope of the inquest

7. Thanh's death was reported to the New South Wales Coroner on 18 October 2011. Initially, a determination was made by Deputy State Coroner McMahon to dispense with holding an inquest. Following correspondence from Thanh's family, the New South Wales State Coroner Michael Barnes reviewed the circumstances of Thanh's death in November 2014. Pursuant to section 29 of the *Coroners Act* (NSW) 2009 he ordered that an inquest should be held. An inquest did not commence until April 2016.

8. An inquest is intended to be an independent examination of all the available evidence in relation to the circumstances of a person's death. The Act requires a Coroner to make findings as to the identity of the nominated person and in relation to the date and place of death. The Coroner is also to examine the manner and cause of the person's death[2] and to make recommendations in appropriate circumstances.[3]

The Evidence

9. The inquest ran over 5 hearing days and heard detailed evidence from the officer in charge of the investigation and from each of those people present during the grading. There was also expert medical evidence and evidence in relation to the mats which were used. A significant amount of documentary material was tendered including photographs and a triple 000 recording.

[1] See Autopsy Report for the Coroner, Exhibit 1, Tab 4
[2] Section 81 *Coroners Act* 2009 (NSW)
[3] Section 82 *Coroners Act* 2009 (NSW)

10. Unfortunately, because of the lapse in time from Thanh's death to the inquest, some of the witnesses struggled to remember, with any degree of accuracy, what had occurred. Many of the most important eye witnesses did not even make a written statement until 2016. Some had been advised by a solicitor apparently acting for IFFKA not to make statements at the time, others appeared to be quite unaware that statements had even been requested[4]. In any event, as the inquest proceeded it was clear that the lack of immediate information available for family members about what had happened compounded their grief and understandably contributed to feelings that there had been some kind of a cover-up. The passing of time also affected the quality of the recollections available to the court.

Karate and its regulation in NSW.

11. There are many ways of practising the martial art or sport of karate. All involve some inherent risk. Forms range from those which prohibit physical contact between participants to "full contact" forms where there is very significant body contact including kicks and punches to the head and face. Pursuant to the current *Combat Sports Act* 2013, some versions of karate would be likely to fall within the definition of a combat sport, while others would not.[5]

12. While the New South Wales Karate Federation is recognised by the Office of Sport as the State Sporting Organisation for karate, it represents only a fraction of those participating in the sport[6]. According to its 2013-2016 strategic plan the New South Wales Karate Federation has approximately 40 full members incorporating over 100 *dojos* or training centres. Participant numbers are estimated to be approximately 4500 people. The inquest heard that the numbers participating in all forms of karate would be much larger. One estimate

[4] See statement of Senior Constable Catherine Rae, Exhibit 1, Tab 7 for discussion of this issue and elsewhere in evidence.
[5] See discussion of this issue in Submission of the Office of Sport for the Coroner, page 5
[6] It should be noted that representatives from Karate NSW were invited to participate in the inquest, but declined.

was that more than 10 000 people regularly participate in Karate in NSW. It may be more. [7]

13. Many karate groups choose not to affiliate with the NSW Karate Federation. The International Federation of Karate Kyokushinkai Australia (IFFKA), the group Thanh trained with is one of those groups. A number of witnesses referred to the differences between karate organisations. Mr Turnbull described different forms as being like "different religions".[8] Others agreed that there would be little or no prospect of all the forms agreeing on rules as they were each attached to their own procedures and traditions. It was generally agreed that IFKKA practised a form of karate involving a substantial amount of body contact.[9]

14. IFFKA has been in existence since 1994 and sees itself as a direct descendant of the broader Kyokushin tradition. It is a not-for-profit organisation that is made up of volunteers from different but associated *dojos*. While each *dojo* may be run as a business, the organisation itself is now also open to individual membership.[10]

15. The IFFKA website explains that Kyokushin was founded by Masutatsu Oyama in 1964 and has become known as "the strongest karate". Its reputation is for rigorous training and full contact fighting.

16. Leaving aside whether or not IFFKA's brand of karate should properly be classified as a combat sport, it is clear that the sparring Thanh was undertaking prior to his death was not a "combat sports contest" within the meaning of the Act. Therefore, under the current regime at least, there would be no relevant statutory requirements in place with respect to safety standards.[11]

Camp set up and equipment

17. The IFKKA black belt grading was scheduled to take place over a weekend camp on 15-16 October 2011 at the Heathcote Scout Hall. Some participants arrived

[7] Peter Mylonas 29/4/16, page 47, line 21 onwards.
[8] See Doug Turnbull's evidence 17/8/2016 , page 92, line 5 onwards.
[9] See for example Doug Turnbull's evidence 17/8/2016, page 92, line 15 onwards.
[10] See Jenny Fuller's document dated 19 August 2016. Exhibit 11
[11] Earlier legislation was in place at the time of Thanh's death.

on the Friday evening ready to commence first thing Saturday morning. The camp had scheduled activities for participants at various levels, including children, but the black belt sparring was to be held privately in accordance with the traditions of the organisation. There were two candidates being graded for their black belts that weekend, Thanh Pham and Tony Le. On the first day of the camp they were to be tested on their *kata* or pattern work.

18. The sparring component of the grading was to commence on the Sunday morning. Sparring was to take place in two rectangles or "rings" made up of interlocking mats[12]. The mats were placed on a concrete/parquetry floor. I am satisfied that 20mm mats were used and that they were of a quality currently recognised within the sport as adequate.[13] I accept that there is a balance between the need for adequate padding and the requirement that the participant's stability is not compromised. I note that IFFKA has now purchased thicker mats (30mm) which will be used at black belt grading events in the future. However, the inquest did not hear sufficient evidence to make any general conclusions in this regard.

19. The participants did not wear helmets, as is usual at events of this nature. While the inquest heard some evidence about the possibility of using helmets[14] there was no real support for this course from any of the parties[15]. Dr Davies, a consultant neurosurgeon who treated Thanh, was of the view that a helmet may

[12] Only one witness, Margaret Le gave evidence that the sparring took place without mats. I am satisfied, having weighed all the evidence in relation to this issue that she is simply mistaken. I accept that a photograph (Exhibit 1, Tab 55) produced by Jenny Fuller was taken shortly after Thanh went to Hospital on 16/10/11. It clearly shows the edge of the mats which make up both rings.
[13] There was considerable information before the Court in relation to the mats used and useful evidence was received from a sporting mat supplier, Mr Alenaddaf. I accept his evidence that the mats were of the "usual standard" currently used in Australia and International competition.
[14] See Exhibit 3, Photograph of the helmet tendered in proceedings. See also Exhibit 6, "Review of the Evidence in Relation to Headgear for Combat Sport".
[15] A number of witnesses expressed some of the practical problems with helmets. Mr Trotz noted that helmets can cause issues with spatial awareness and heat retention. See his evidence at 15/8/16 page 38, line 13 onwards. Others, including Ms Fuller, noted that some people can feel "bullet proof" and have a false sense of security. See for example her evidence 16/8/16 Page 15, line 12 onwards.

not have protected Thanh from the kind of injury he suffered.[16] On the limited evidence before me, I do not intend to comment on this issue further.

The rules

20. Proceedings got underway before 9 am on Sunday. While some of those present said there was a briefing on the morning just prior to the sparring commencing, it was Doug Turnbull's evidence that there was no need for a briefing as everyone "knew what they had to do". Sparring participants came from both IFFKA and another organisation called Kempo Ru, which apparently has similar, but slightly different rules and traditions. It appeared that there was a need for a number of sufficiently qualified fighters to conduct the sparring and for this reason both organisations drew on each other from time-to-time to make up the numbers. The Kempo Ru participants turned up just before the sparring began.

21. Notwithstanding Mr Turnbull's evidence that everyone knew "what they had to do", when one reviews the evidence it is actually quite clear that there was significant variation in what each of the participants thought was allowed. [17] Some participants apparently believed kicks and punches to the head were permitted, some thought kicking to the face was not permitted, others believed head contact was allowed, but only if it was light.

22. Similarly, the number of bouts one needed to endure was an area of some confusion, as was the number of breaks allowed. There were considerable discrepancies in the various recollections as to who was supervising each ring and in relation to who was time keeping at any given point. Perhaps, unsurprisingly, given the hierarchical nature of the group, everyone agreed Doug Turnbull was in charge. There was also general consensus that it was a hard physical challenge to endure a black belt grading. It was expected to be a real test of one's capacity. Ms Fuller called it "an endurance event", [18] others

[16] Evidence at Inquest, 18/8/16, Page 16, line 37 onwards
[17] See a useful summary in this regards set out at page 3 of the Family Submissions.
[18] Evidence at Inquest 16/8/16, page 26, line 44

called it an exhausting experience. Mr O'Campo said it was "the most difficult thing he has ever done".[19]

The fights on the day

23. I have carefully considered each of the accounts as to what happened once fighting began. I do not intend to restate the evidence in any detail. There is considerable variation in what participants remembered. In my view, a number of the accounts, while genuinely given, were affected by the passage of time and possibly by the trauma of what occurred. For reasons that have been referred to, some of the witnesses were giving their first detailed account of events in court. The discrepancies are also understandable given that each person took part in the fighting at one point or another and their attention would have shifted to themselves. Some took turns in time-keeping and refereeing. Some took breaks from the hall. Some participants were more focussed on the ring where Tony Le was fighting and were only peripherally aware of what was happening with Thanh.

24. Ben Osland had some recollection of Thanh getting knocked down two or three times, but he could not remember what caused it or the individual circumstances of the falls. He remembered Thanh falling backwards on at least one occasion, but could not recall seeing Thanh hit his head. It was Mr Osland's evidence that Thanh also took some strikes or kicks to the head.

25. Peter Mylonas was fighting Thanh during the final bout. He saw Thanh fall three times in that bout alone and was aware that he had fallen in earlier bouts. He did not recall Thanh falling backwards and hitting his head on the mat at any point. Mr Mylonas had a distinct memory of the last fall. He said "I remember the last time when he fell and that's the time I actually looked at Doug and I said, "This is, he's fallen three times now. Do we want to continue this?"[20]

26. Earl O'Campo did not remember Thanh falling either during the time they were sparring or indeed at any time. He stated that he returned from a break to find

[19] Evidence at Inquest, 29/4/16, page 72, line 18
[20] Evidence at Inquest 29/4/16, page 11, line 6

Thanh "was already on the ground".[21] Similarly Luke Trotz did not see anything of concern until he noticed that the bout in Thanh's ring had been stopped. He certainly had no memory of Thanh falling during the several bouts he had with Thanh.[22]

27. Margaret Le did not remember Thanh falling. Although she appeared to be trying to assist the inquest, she agreed that her memory of events was "limited".[23] It is difficult to rely on her account of what happened on the morning, given that she was wrong in some significant observations such as whether or not there were mats in the hall[24] and that she had no memory whatsoever of the ambulance being called.

28. Ali Aryan recalled Thanh being knocked to the ground more than once. On one of those occasions it was accompanied by a "pretty loud thud".[25] In Mr Aryan's opinion it was a significant noise. He said "I'm pretty sure everyone in the hall heard it, I mean it's a hall there's a sound of an echo, so if you didn't hear it you were deaf."

29. Tony Le's recollection was understandably limited, given that he was simultaneously undertaking his own grading. However he was able to remember looking across and seeing Thanh on the ground a couple of times. He gave evidence that it was the noise of Thanh hitting the floor that made him look across to Thanh's ring.

30. Jenny Fuller gave evidence of Thanh falling and hitting his head during his first bout with her. She appeared to have a distinct memory of this event. She did not remember him receiving a blow to the head, but rather that he slipped and fell backwards, hitting his head on the mat. She remembered that he did not seem to break his fall, but got up and rubbed the back of his head. It is significant that Ms Fuller informed Doug Turnbull that Thanh had hit his head. She said she wanted

[21] Evidence at Inquest 29/4/16, page 62, line 36
[22] Evidence at Inquest 15/8/16, page 23, line17
[23] Evidence at Inquest 15/8/16, page 11, line 8
[24] In my view her evidence in relation to mats can be disregarded. I am satisfied, given the weight of the evidence that there mats in the hall.
[25] Evidence at Inquest 15/8/16, page 78, line 14 and elsewhere

to emphasise not just that Thanh had fallen, but that he had hit his head. She thought Mr Turnbull should know, as he was in charge of the grading. She felt "Doug should keep an eye on him".[26]

31. Shaharin Yossof spent most of his time at Tony Le's ring but sparred with Thanh on one occasion. He did not see Thanh hit his head. Similarly, Mr Andre Noujaim was primarily involved with the sparring in Tony Le's ring and did not see Thanh fall backwards and hit his head.

32. Mr Turnbull's evidence is important, both because he was in charge of the event and also because unlike most of the other witnesses he had made a written statement just days after the grading. In that initial statement he recorded that he saw Thanh fall on three occasions. He also recorded his conversation with Jenny Fuller, making it clear that he knew that Thanh had "hit his head heavily on the mat".[27] It was significant enough for Mr Turnbull to watch Thanh more closely and to check he was feeling well enough to continue. In evidence Mr Turnbull said he did not consider that Thanh may have had a head injury because he seemed "fine".[28] After checking, Mr Turnbull described Thanh as "vibrant". He watched Thanh fight other people and then fought him himself. Mr Turnbull stated that Thanh was "still hitting very hard, kicking very hard" and he kicked Thanh in the abdomen, knocking him down again.[29] It was Mr Turnbull's evidence that it wasn't until Thanh was fighting Peter Mylonas that he became concerned. He saw Thanh and Peter "getting quite physical with each other". Peter punched Thanh in the abdomen or chest and he collapsed. Mr Turnbull could not remember if Thanh's head hit the floor on this occasion.[30]

33. A number of the participants gave evidence that Thanh was not pressured into continuing fighting at any time during the morning.[31] Right up until his final collapse, even when he was obviously tired, he was described as keen to continue. Various witnesses described times when he was given an opportunity

[26] Evidence at Inquest 16/8/16, page 50, line 30 onwatds
[27] Statement of Doug Turnbull, Exhibit 1, Tab 18
[28] Evidence at Inquest, 18/8/16, page 44, line 1
[29] Evidence at Inquest, 18/8/16, page 44, line 4 onwards
[30] Evidence at Inquest, 18/8/16, page 47, line 6
[31] See for example Mr Aryan's evidence Transcript 15/8/16, page 78, line 33 onwards

to stop, but it was also acknowledged by some that the culture of the event meant that it would have been difficult. Most of the participants described themselves and others as cheering him on and encouraging him to continue. There appears to have been a general consensus that Thanh was always keen to carry on. Mr Aryan said "that's the kind of person he was, he wouldn't turn back…he wasn't the kind of person that would be pushed into anything…"[32]

34. Overall it is impossible to reconstruct exactly what happened, bout by bout. However I am of the view that the most reliable evidence available indicates that Thanh was knocked down a number of times and on at least one occasion before his final collapse, he was knocked down so heavily it caused a loud thud. I accept Jenny Turnbull's evidence that he hit his head heavily. I think it likely that this corresponds with the thud so clearly heard by Mr Aryan. It is corroborated by Mr Turnbull who says Ms Fuller told him immediately that Thanh had hit his head and for that reason he specifically asked Thanh about it. I note that there is also reliable evidence that Thanh would also have received some additional body contact to the head while sparring, by way of sweeping kicks or strikes. [33]However, the strength of that contact on any particular occasion is impossible to estimate.

35. The evidence reveals that there was no independent person supervising the event. Mr Turnbull was nominally in charge, but he was also fighting and time-keeping. He was involved with both rings to some degree. There was certainly evidence that Mr Turnbull could have stopped the event at any time if he had been concerned about Thanh's welfare. However, it is important to remember that Thanh was also his long standing pupil. In those circumstances it is not surprising that Mr Turnbull wanted Thanh to complete the sparring and to be able to achieve his black belt.

The initial response

36. There were significant discrepancies in relation to the initial response to Thanh's collapse. In my view it is impossible now to establish exactly what

[32] Evidence at inquest, 15/8/16, page 78, line 33 onwards.
[33] See for example Ben Osland's evidence at Inquest, 28/4/16, page 81, line 30 onwards

occurred with any level of certainty. I accept that those present attempted to render assistance, many were first aid trained. At some point Thanh was carried or walked outside. Somehow he was brought back into the hall and appears to have been placed on his side. Emergency Services were called. However, the initial response appears to have been somewhat disorganised, with some participants apparently thinking that Thanh may have been suffering from dehydration and no single person being clearly in charge.

37. According to the ambulance incident report, there was a triple 0 call made from Jenny Fuller's phone at 10.08 am[34]. Mr Yussof spoke with the operator and reported that Thanh was "going stiff". There was conversation about the possibility of a seizure. What appears extraordinary is that the operator was not told that Thanh had earlier fallen and hit his head heavily. Both Jenny Fuller and Doug Turnbull knew this information and had been concerned enough about it to "keep a watch" on Thanh. In my view, it should have been passed on to the Ambulance Service at the first available opportunity.

38. At 10.11 am an ambulance was assigned and it arrived at 10.20 am. The ambulance officers assessed Thanh and quite quickly arranged for him to be transported. Records show he arrived at Sutherland Hospital at 10.58 am.

39. One of the potential problems identified in relation to Thanh's death was the lack of information immediately available to those responsible for his medical care. According to the ambulance patient healthcare record, the ambulance officers were told that Thanh had "suffered nil direct head trauma but several rolls and falls onto head onto a mat".[35] But by the time of the inquest nobody could remember with any accuracy exactly what the ambulance officers had been told or indeed who they had spoken to. Ms Fuller did not recall telling the ambulance officers of the fall she had witnessed or of Thanh hitting his head heavily.

40. One of the ambulance officers, Mr Hall gave evidence. He remembered having been told that Thanh had collapsed or "frozen". Mr Hall recalled that he thought

[34] Exhibit 7
[35] Patient Record, Exhibit 1, Tab29

Thanh may have suffered a seizure. He thought it was a medical incident rather than a recent trauma, based on what he had been told and on Thanh's presentation. Mr Hall explained that Sutherland Hospital was the closest hospital to the camp and that a person having a stroke or seizure would be taken to Sutherland in the normal course. However, had the ambulance officers been informed of a serious head trauma it appears they would have bypassed Sutherland Hospital and taken Thanh directly to St George.

41. Once at Sutherland Hospital Mr Hall needed more information. He and a colleague then returned to the scout camp in an attempt to get more information for the treating doctors. At the camp, he remembers that they spoke to one of the participants who then spoke directly to a doctor by telephone.

42. According to the Sutherland Hospital records[36]someone spoke with Dr Jamadar. The note reads "spoken to instructor (sic) over phone regarding the collapse(sic) - he said - patient was looking tired this morning, during practice a few times he fell down and get up slowly. then the last time he did not (sic)get up patient not responding so call ambulance. Unable to get much past HX as instructor (sic) did not know much."

43. Later notes, written in retrospect, state that there was "No head injury reported by the Coach" and that Thanh had "Collapsed after becoming stiff during the fight suddenly?" The doctor also inexplicably recalls being told about "possible h/o DD with the patient???" One can only wonder why the doctor was not told of Thanh striking his head heavily on the mat, when the incident was significant enough for Ms Fuller to bring it to Mr Turnbull's attention and for them both to think Thanh should be observed.

44. The information passed to medical staff was wholly inadequate given the circumstances that had just transpired. There is no sound reason why the Hospital was not informed that Thanh had hit his head heavily on the mat. The only appropriate response was to give a full picture of what had occurred throughout the morning or to pass the telephone to someone who had more

[36] Sutherland Hospital Records, Exhibit 1, Tab 32

information or was in charge of the event. Medical staff were asking for more information to assist in their diagnosis. In my view, what occurred was either the result of a disorganised and inadequate first aid response which may also demonstrate a poor understanding of head trauma or it was a completely misguided attempt to avoid any possibility that the events could somehow reflect badly on IFFKA or on one of the individual participants involved in the grading process.

45. It is clear that the doctors at Sutherland Hospital were not informed in a timely manner that Thanh had fallen heavily and struck his head, or even that he may have received blows or kicks to the head as part of the sparring process. Given what we now know it may not have changed the outcome, nevertheless it was relevant information for doctors who were still trying to understand the reason for Thanh's lowered level of consciousness. It was Dr Jamadar's evidence that initially they weren't treating Thanh's presentation as "a head injury" because they had not been told of any possible head trauma.[37] They were still looking at a number of possible causes including infection, tumour and epilepsy.

46. Thanh was sent for urgent investigations including a CT scan, which took place at 12.39 pm. On reviewing the results of the scan, Dr Jamadar was immediately aware of a serious subdural bleed and formed the view that it was possibly traumatic[38]. Thanh was intubated and transferred to St George Hospital.

47. Thanh arrived at St George Hospital just after 2pm [39]. Dr Davies was of the view that by the time he had arrived at St George Hospital Thanh's condition was likely to have already been untreatable. Dr Davies is a neurosurgeon. He gave impressive evidence at the inquest. It was his view, having examined and treated Thanh that he had suffered a "devastating head injury".[40] It was his opinion that even if Thanh had been brought directly to St George Hospital, tragically it is still unlikely that he could have been saved.

[37] See discussion of this issue at 16/8/16, page 56, line 10 onwards.
[38] See Dr Jamadar's medical notes at Exhibit 1, Tab 32
[39] Exhibit 1, Tab33
[40] Evidence at Inquest 18/8/16, page 2, line 3

48. Thanh's family conceded that the medical treatment provided by ambulance officers and by doctors at both Hospitals was appropriate and that all possible steps were taken to save their relative. Unfortunately, Thanh never regained consciousness and on 18 October when life support was removed, Thanh was pronounced dead.

The cause of death

49. An autopsy was conducted by Dr Issabella Brouwer.[41] She found that Thanh had died of a traumatic brain injury. She identified a focal area of bleeding on the left side of the back of the head. Subsequently Dr Rodriguez conducted a neuropathological examination of the brain. His findings were consistent with there being a traumatic component to the haemorrhage.

50. Dr Davies, the consultant neurosurgeon who treated Thanh was prepared to put it even more firmly. He was in no doubt that what he saw on the scans was the result of a traumatic injury. He was ably cross-examined about the possibility of an aneurysm or other spontaneous bleed, but he expressed the view that the pattern of bleeding was not consistent with that.[42]

51. It is unnecessary to review all the medical evidence at this stage[43], suffice to say at the conclusion of proceedings, taking into account both the medical and civilian evidence, I am in no doubt that Thanh's death was the result of a traumatic brain injury sustained during and immediately after sparring. In this regard I rely heavily on Dr Davies, whose expert testimony was both comprehensive and impressive.

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[41] Autopsy Report, Exhibit 1, Tab 4

[42] See discussion of these issues at 18/8/16, page 19 onwards.

[43] The Court also received a report from an expert emergency physician, Dr Roberts, Exhibit 1, volume 3, Tab 50. His report was based on the assumption that Thanh had been participating in a tournament and had received a direct head injury. For that reason it is perhaps less useful in establishing the cause of death. Both he and Dr Davies were ably cross-examined in relation to a number of possibilities including the possible effect of the painkiller Neurofen, the possibility of a pre-existing injury or slow bleed, the possibility of a tear, tumour, vascular malformation or aneurysm. I have considered this evidence carefully, but remain confident that the mechanism causing Thanh's death can be properly characterised as a traumatic brain injury.

Changes since Thanh's death made by IFFKA

52. Jenny Fuller gave evidence that following Thanh's death, IFFKA has made a number of changes with the hope of introducing "better operating procedures".[44] She described the slow process of modernising procedures in a hierarchical organisation where traditionally the highest ranked fighter is also the leader of the organisation. She outlined a number of changes which she suggested will make gradings safer in the future, these included the use of a three person panel of assessors, a clearer and more standardised grading procedure, better record keeping, the introduction of an independent first aid officer at black belt gradings and medical assessment before black belt gradings.

53. At the time of Thanh's death, it appears that there was no formal policy in place in relation to dealing with potential head injuries. Ms Fuller gave evidence that IFKKA had now developed a head injury protocol.[45] The document was shown to Dr Davies in the witness box and while he considered it "broadly reasonable" it appeared to be his view that it should be strengthened.[46] On the evidence before me I am not in a position to comment further on the specific policy. Nevertheless in the light of his comments I urge IFFKA to undertake its review.

54. While the changes outlined by Ms Fuller are to be commended, I was not convinced that her level of enthusiasm was shared by all those involved in the organisation. Thanh died almost five years before Ms Fuller gave her evidence and yet it was apparent that others in the organisation were unaware or only vaguely aware of some of the changes she mentioned. Some remained in draft form.

55. I have some real concerns that cultural change in the organisation may be slow, but I urge Ms Fuller and others to continue the process at the conclusion of this inquest. I accept that it can be difficult to tackle comprehensive change in an oprganisation reliant on volunteers and I hope IFFKA has the necessary resolve

[44] See Exhibit 11 and her evidence at Inquest
[45] Exhibit 1, Tab 50. This document was included in the bundle supplied by IFFKA
[46] See his brief discussion of this point at 18/8/16, page 18, line 27 onwards

to follow through. Given Ms Fuller's responsible approach to the task at hand, I refrain from making any formal recommendations in this regard.

Need for recommendations

56. Pursuant to section 82 of the *Coroner's Act* 2009, Coroners may make recommendations connected with a death in an attempt to increase public safety or reduce the likelihood of dangerous circumstances recurring. I have considered carefully whether or not any recommendations should be made on the basis of the evidence arising from this inquest.

57. There was evidence before me that a number of the participants had seen serious injuries at karate events over the years. Concussions and fractures had certainly been witnessed at tournaments, if not at gradings or training sessions. However there was no evidence that there is a serious systemic issue at play. Thankfully, on the evidence before me, Thanh's death appears to have been an isolated tragedy. Certainly, The Office of Sport submitted that it was the only one of its kind known to that authority. [47]

58. It needs to be remembered that while people who take part in karate or any other martial art undertake some risk by their participation, they nevertheless have a right to expect that basic safety standards will be adhered to. Karate is a self -regulating sport but it appears that it may benefit from some assistance in developing further safety protocols and procedures.

59. At the end the inquest I was not persuaded that the evidence before me disclosed a need for further regulation of karate under the *Combat Sports Act* 2013. However, I am of the view that the Office of Sport could nevertheless play a positive role in the development and promotion of appropriate protocols in relation to head injury/concussion and in the development of useful guidelines for best practice for grading days.

[47] According to information obtained by the Office of Sport, the only other death "associated with" karate appears to have been due to "natural causes" and not traumatic injury.

Conclusion

60. Thanh's death was a terrible, but isolated tragedy. The processes involved in this inquest have already forced IFFKA to reflect on their safety protocols and commence improvements to their procedures. I am confident that the Office of Sport will now assist in bringing some of these issues to a wider audience. I thank the Pham family for their tenacity in bringing about these results.

Findings required by section 81 (1) *Coroners Act 2009* NSW

61. As a result of considering all the documentary evidence and the oral evidence heard at inquest, I am able to make the following findings.

Identity of the deceased

The deceased person was Thanh Pham.

Date of death

Thanh Pham died on 18 October 2011.

Place of death

Thanh Pham died at St George Hospital, Kogarah, NSW

Cause of death

Thanh Pham died of a traumatic brain injury.

Manner of death

Thanh Pham's death occurred as a result of injuries he received while participating in a karate grading.

Recommendations

To the Minister for Sport

1. That the Office of Sport consider working with NSW Karate (and possibly other martial arts organisations) to develop a general head injury/concussion protocol or policy for the use of karate organisations at gradings and training. This process should take place with expert medical advice. Once developed, the policy could be published and promoted on NSW Karate's website and made available more widely.

2. That the Office of Sport, through funding contracts with State Sporting Organisations, mandate the adoption of appropriate head injury/concussion protocols or policies.

3. That the Office of Sport consider working with Karate NSW (and possibly other martial arts organisations) to develop a guideline on best practice for grading days. Once developed this guideline could be published and promoted on NSW Karate's website and made available more widely.

Finally, I offer my sincere condolences to the family and thank them once again for participating in the inquest.

Magistrate Harriet Grahame

Deputy State Coroner

3 February 2017