# STATE CORONER'S COURT
# OF NEW SOUTH WALES

| | |
|---|---|
| **Inquest:** | Inquest into the death of Tommy Ngo |
| **Hearing dates:** | 1-2 February 2016 |
| **Date of findings:** | 15 March 2016 |
| **Place of findings:** | State Coroners Court, Glebe |
| **Findings of:** | Magistrate Harriet Grahame, Deputy State Coroner |
| **Catchwords:** | Coronial Law-manner of death; Chinese lion dancing. |
| **File number:** | 2014/00330871 |
| **Representation:** | Peter Bain – Coronial Law Advocate – Advocate assisting the Coroner<br><br>Mr Fang Wang for the Chinese Youth League (CYL)<br><br>Mr Ben Fogarty of counsel, instructed by the Legal Aid Commission of NSW for Ms My Van Ngo, next of kin. |
| **Findings:** | **Identity of the deceased**<br><br>The identity of the deceased is Tommy Ngo.<br><br>**Date of death**<br><br>Tommy died at approximately 5.20 on 6 November 2014. |

| | |
|---|---|
| | **Place of death**<br><br>Tommy died at St Vincent's Hospital, Darlinghurst NSW.<br><br>**Cause of death**<br><br>Tommy died from an ischaemic brain injury after a cardiac arrest, brought about by blunt force injuries to the neck.<br><br>**Manner of death**<br><br>Tommy's death was as a result of an accidental fall whilst training for Chinese lion dancing. |
| **Recommendations:** | There are no formal recommendations in this matter. |

**These findings have been written without the benefit of a transcript.**

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

# REASONS FOR DECISION

1. This inquest concerns the death of Tommy Ngo.

## Introduction

2. Tommy was born on 18 June 1995. He was raised by his mother My Van Ngo, with the support of her family. He had a happy and healthy childhood. Tommy completed his HSC in 2013 and commenced working. At the time of his death he was completing a mechanical apprenticeship.

3. Tommy had many friends. He played sport and loved rap music.[1] He was, by all accounts, an outstanding young man and a great credit to his mother.

4. Tommy had been involved in lion dancing for four to five years prior to his death. He had initially gone with friends to the Chinese Youth League (CYL) in Sydney's Chinatown and been attracted to the dynamic and creative environment. He developed a passion for lion dancing and soon commenced training two to three times a week.

5. On 4 November 2014 Tommy attended the Chinese Youth League for one of his regular training session. Five others were present including coaches Lokman Leung and Adrian Yeung. Tommy and his regular partner Jonathon Lin were practising for an upcoming performance. During the routine, Jonathon acted as the body of the lion and Tommy the head. The dance involved Jonathon carrying

[1] Statement of My Van Ngo, Exhibit 1, Tab 8

Tommy on his head and shoulders. Tommy's feet were placed on Jonathon's chest. Jonathon's role was to jump between circular platforms or discs which were attached to steel poles high off the ground. Tommy was then propelled forward so that he would land on another platform in front. Unfortunately, at the time of the accident, Jonathon missed his jump and that sent Tommy forward, but without the necessary height to land successfully. Tommy's neck collided with great force against the steel platform edge in front of him and he fell to the ground immediately. The whole incident was captured clearly on CCTV.

6. Tommy suffered significant trauma to his neck which affected his ability to breathe. His friends attempted first aid, without succes . An ambulance was called and Tommy was taken, in an unconscious state to St Vincent's Hospital.

7. Tommy was placed on life support, but his injuries were not survivable. His family and friends gathered at his bedside. Buddhist prayers were commenced. Tommy died at approximately 5.20pm on 6 November 2014.

**The Role of the Coroner**

8. The role of the Coroner is to make findings as to the identity of a nominated person, and in relation to the date and place of his or her death. The Coroner is also to address issues concerning the manner and cause of the person's death.[2] In addition, the Coroner may make recommendations in relation to matters that have the capacity to improve public health and safety.[3]

9. In this case, many of the important facts are already clear. As the incident was captured on CCTV there is little doubt about what occurred. The inquest has been convened to consider the circumstances surrounding Tommy's tragic death and to examine whether such accidents can be avoided in the future.

10. Any consideration of the safety issues involved, raises complex questions about the extent Governments should and can successfully regulate voluntary adult recreational pursuits, particularly those undertaken at community venues.

[2] Section 81 *Coroners Act* 2009 (NSW)

[3] Section 82 *Coroners Act* 2009 (NSW)

Tommy's death was unusual, the first known in the Australian lion dancing community. While injuries are not unheard of in the lion dancing community worldwide, Tommy's death is not part of a known or recurring pattern. Nevertheless, a full examination of the circumstances surrounding the accident is called for.

11. A number of organisations were advised of the inquest and given the opportunity to participate or make submissions. SafeWork NSW, The City of Sydney, NSW Office of Sport, Department of Premier and Cabinet, the Department of Fair Trading were contacted but all declined to participate in the inquest.

**Issues to be investigated**

12. An issues list was circulated prior to the inquest, with the following matters identified.

- Whether any safety measures or systems could or should have been employed so as to have reduced the risk of Tommy falling
- Whether any safety equipment could have reduced the risk of or have prevented the injuries sustained by Tommy as a result of his fall
- Whether the supervision of the lion dancing activity was appropriate in all the circumstances
- Would immediate first aid have prevented Tommy's death?
- Whether any formal oversight or regulation of activities such as lion dancing or groups undertaking activities such as lion dancing is required
- Whether members of volunteer cooperatives or associations partaking in activities such as lion dancing be required to hold first aid qualifications
- Whether volunteer cooperatives or associations whose members engage in physically strenuous, dangerous sporting or recreational activities be required to have first aid signage, similar to those required by the swimming pool regulations

**The Evidence**

13. The inquest ran over two days and heard oral evidence from the police officer in charge of the investigation, Detective Senior Constable Sarah Thomsen, a safety expert, Mr Wayne Pleace, members of the lion dancing team and representatives of the Chinese Youth League. A significant amount of documentary evidence was tendered including medical reports, photographs, and witness statements. CCTV footage of the accident was tendered.

**Background**

**What is Chinese Lion Dancing?**

14. Lion dancing is a form of traditional dance in Chinese culture. It is performed in different forms all over Asia. The performers, dressed in an elaborate lion costume, mimic the animal's movement. Lion dancing is usually performed at Chinese New Year and at other traditional festivals. It may also be performed at important celebrations for business openings, weddings or to honour special guests. Lion dancing is generally performed in pairs, with others in the troupe playing drums, cymbals and gongs in accompaniment. It is an ancient art form that is generally taught as an oral tradition like a martial art. Each of the witnesses involved in the sport told the inquest that there were no known manuals or written curriculums. [4] No records of a student's progress are kept. There is considerable reliance on the master or coach and his personal skill and knowledge of the individual student's capabilities.

15. Knowledge of the form can take years to master. It has close relations to Wushu and is often taught alongside dragon dancing. Lion dancing has spread across the world with the Chinese diaspora communities, developing along the way. International competitions are now held throughout Asia and groups from a variety of countries compete against each other.[5] Dancers are judged on their skill and creativity. This process has encouraged new developments and various

[4] Evidence at inquest, see for example the evidence of the lion dance coaches, Lokman Leung, Holman Leung and Adrian Yeung.
[5] A number of witnesses at the inquest had competed in contests in Malaysia, see for example the evidence of Lokman Leung and Holman Leung

innovations. One such development is the use of small circular platforms raised on steel poles, such as those used by the Chinese Youth League at the time of Tommy's accident. There was extensive evidence at the inquest that indicated only experienced and skilled dancers would ever be allowed to commence training on poles. In fact not all lion dancing groups use poles, even for experienced dancers. Some groups dance only on the ground, others use pots or low beams. Clearly the use of poles adds a more dangerous element to lion dancing than is evident in other more traditional forms.

16. The inquest heard that there were around 25-30 lion dance groups dancing in NSW. It was estimated that only a small number of them would use poles, with the majority concentrating on floor work.

**What is the Chinese Youth League?**

17. The Chinese Youth League (CYL) is a non-profit community organization formed and developed to embrace cultural, sporting, social and welfare activities in the Australian Chinese community. It is an incorporated association regulated by the NSW Department of Fair Trading.

18. It was founded in 1939 and is one of the longest established ethnic community organisations in Australia. Over the years it has developed into an important cultural hub. It supports numerous activities which operate as sub-groups of the parent body including lion dancing, dragon boat racing, dragon dancing, Chinese opera, folk dancing, Tai Chi, table tennis and other like activities.

19. For many years CYL has been located in Sydney's Chinatown, at 10 Dixon Street. The office and an activity room/rehearsal hall is upstairs and the lower level is currently rented out to a Chinese restaurant. There is an office manager but the organisation is run largely by volunteers.[6] A management committee meets regularly and each activity sub-group sends a representative.

20. The Chinese Youth League cooperated with all aspects of the investigation and participated fully with the inquest process. Both Patricia Quah, president of

[6] See Statement of Patricia Quah, Exhibit 1, Tab 29, paragraph 4

the organisation at the time of Tommy's death and Ching Tan, the current president gave evidence at the inquest.

21. The Chinese Youth League has made changes to its policies following Tommy's death. These changes include

- Ceasing the use of poles completely.
- Placing a CPR wall chart and first aid kit in the practise area.
- Mandating that all activity groups within the wider organisation nominate members to undertake first aid training (not fully implemented at the time of hearing)
- Mandating that at least two coaches be present at lion dance training.
- The organisation also appears to be in the process of examining its membership application forms, including permission forms relating to children under 18 years of age.[7]

22. Each of these changes is appropriate under the circumstances.

**The Accident**

23. I have reviewed the footage of the incident carefully, along with the written and oral accounts of all those present. It is clear that Tommy's death is a tragic accident. The accident happened so quickly and in such a location, that it is clear that even if "spotters" had been standing nearby there is nothing they could have done to stop it.

24. Jonathon Lin, Adrian Yeung, Veronica Fung, Lokman Leung, Alicia Tham were all present when the accident occurred. They were all part of a decicated group that trained two to three times a week at CYL. On the day of the accident Lokman Leung and Adrian Yeung were the coaches present pursuant to an understanding that practice would only occur if at least one coach was present. Each of the coaches at CYL had many years experience in lion dancing, having

[7] See Exhibit 5 and the evidence of Mr Chin Tan and Ms Patricia Quah (2/2/16)

commenced training in childhood. Both Holman and Lokman Leung had also competed overseas.

25. Each of those present gave evidence at the inquest, doing their best to remember the traumatic events of the evening. Holman Leung, who was not present on the evening but was a lion dance coach also gave evidence about the usual processes and procedures. I have no doubt Tommy's tragic death has affected them all greatly.

26. As I have said, the events of the evening are clearly recorded on the CCTV footage which was tendered. It shows members of the team arriving and setting up the equipment, including assembling and securing the poles and placing the safety mats in their correct positions. Following that, members of the group commence their individual activities and while there is some interaction between group members, there is no group warm up or formal commencement.

27. Tommy and Jonathon do some minor stretches and routines before they commence drumming. From there they begin to practise their routine on the poles. Jonathon tries the long jump a few times without Tommy, later they try the jump with Tommy on Jonathon's head. While there is some interaction with the others in the room, there are no formal "spotters" or any close supervision of Tommy and Jonathon's activities at this time.

28. The platforms and poles have been set up in a regulation pattern at regulation heights. [8]The jump would require exceptional strength, balance and agility. Jonathon told the inquest that he was not sure why he missed the jump on that occasion. However, it is clear from the CCTV footage that he had been experiencing some difficulties that night even when he tried the jump without Tommy.

29. Unfortunately as has been stated, Jonathon missed his jump and the CCTV footage shows Tommy tragically propelled into the steel pole and platform. The others in the room become aware of what has happened and commence an

[8] See the statement of Detective Senior Constable Sarah Thomsen, Exhibit 1, tab 6, paragraph 15 onwards.

attempt at CPR. They appear shocked and unsure about what to do. Tommy quickly lost consciousness and it was obvious to those present that he had difficulty breathing.

30. An ambulance was called and Tommy was taken to Hospital. He never regained consciousness.

**Cause and Place of Death**

31. Assessment of his injuries following his arrival at the Emergency Department included anterior rupture of the trachea at the level of T1, causing massive air leak into the neck and chest, moderate pneumothoraces, extensive gastric aspiration pneumonitis, severe hypoxic ischaemic brain injury secondary to the period of cardiorespiratory arrest.[9]

32. Tommy was admitted to the Intensive Care Unit, where the non-survivable nature of the hypoxic ischaemic brain injury was confirmed.

33. A limited autopsy was conducted as the cause of death was already apparent. It was recorded by the forensic pathologist as "blunt force injuries to neck and the consequences".[10] It was clear that Tommy had a severe and visible neck injury which appeared to be a crushed trachea.

**Discussion of the circulated issues**

**Whether any safety measures or systems could or should have been employed so as to have reduced the risk of Tommy falling.**

34. It is important to stress that the tragic accident that killed Tommy was extremely rare. There are no known prior like fatalities in this country.

35. While the Chinese Youth League has decided that the risk is now too great and has voluntarily abandoned the use of poles in their lion dancing routines, it appears that a limited number of other groups in Australia still use them.

[9] Report of Professor John Raftos, Exhibit 1, Tab32
[10] Limited Autopsy Report, Exhibit 1, Tab 4

36. The inquest heard a number of suggestions in relation to possible improvements to the systems that were in place at the time of Tommy's death. While it is not suggested that any of these would have themselves alone have prevented Tommy's death, they are all worth considering in attempt to raise the overall safety standard of the activity.

37. These measures included

- Increased use of "spotters" to prevent falling injuries.
- Increased supervision of all lion dancing on poles, including fatigue checks and regular breaks.
- More formalised training processes and procedures to assist coaches
- Increased first aid knowledge and signage
- Improved risk management policies, including an injury and "near miss" register
- More padding around the base of the poles.

38. Mr King Lee, an unsworn employee of the NSW Police Force gave evidence on the second day of the inquest. His role with the Police is as a multicultural liaison officer and he has substantial connections in the Chinese and Asian communities in NSW. He had some knowledge of lion dancing and was already aware of a number of lion dance groups in the Haymarket area and elsewhere throughout Sydney.

39. Mr Lee volunteered to be involved in outreach and education with these groups in relation to the potential danger of using poles and in relation to any suggestions for safety standards that may arise from the inquest. He was of the view that he could have a useful role in community education through visits to known groups and through using the Asian press.

40. A list of lion dance groups was compiled by Mr Lee and also by Mr Holman Leung.[11]It is estimated that only a small number of these groups would use poles.

**Whether any safety equipment could have reduced the risk of or have prevented the injuries sustained by Tommy as a result of his fall?**

41. Careful consideration was given to whether there was any safety equipment that could have prevented Tommy's injuries. The lion dance coaches all stated that that protective equipment such as chest or neck guards would inhibit the performer's movements and in so doing create a safety risk. The safety expert Mr Pleace agreed.

42. Consideration was given to whether padding around the landing disc might have prevented injury. Mr Pleace was of the view that padding could create a trip hazard and he did not recommend it.

43. It is possible that further padding around the poles could prevent various injuries but it would not impact on the kind of injury sustained by Tommy.

44. Mr Pleace had extensive experience in the film industry with stunts and with major event performances such as occurred at the Opening Ceremony of the Sydney Olympics. It was his view that the only way to significantly reduce risk, short of banning the activity altogether, would be to erect a harness and pulley system that would provide protection to the performers if they fell. However, this was only realistic if used on a stage or film set and would be costly and inflexible. It is not a practical option to consider for non-profit organisations and would completely change the nature and flexibility of the dance.

**Whether the supervision of the Lion dancing activity was appropriate in all the circumstances?**

45. There is no doubt that there was minimal supervision of Tommy and his partner Jonathon Lin on the evening of the accident. Mr Pleace stated that the warm-up routine was inadequate. Further, he was of the view that the way

[11] See exhibit 6

Jonathon was jumping prior to the accident indicated that he was not confident or ready to proceed. Mr Pleace also raised the possibility of fatigue or injury in relation to the pair. It is impossible to know for sure, but greater supervision may have detected such issues or potential risks prior to the jump. Jumping on poles should be more closely supervised than it appears to have been on the night. It is an issue that lion group dancers who continue to use poles should consider carefully.

**Would immediate first aid have prevented Tommy's death?**

46. I accept, without reservation, Professor's Raftos's expert opinion that "the cause of Tommy's hypoxic cardio respiratory arrest was probably a combination of the tracheal rupture and the pneumothoraces and aspiration pneumonitis, none of which could have been treated by bystanders"[12] He goes on to say that mouth-to-mouth breathing techniques would have been ineffective, as the air would most likely have leaked out into the neck and chest wall given the ruptured trachea. The only way to treat the ruptured trachea was to insert an endotracheal tube, which ambulance officers did on their arrival.

47. Tragically it appears that even the best bystander CPR would not have affected this tragic outcome. However, while it may not have saved Tommy, first aid training has the potential to save lives and prevent other kinds of tragedies and should be encouraged.

**Whether any formal oversight or regulation of activities such as Lion Dancing or groups undertaking activities such as lion dancing is required?**

48. At present there is no official or unofficial body which could be said to govern or support lion dancing in Australia. Some larger sports and martial arts, such as Karate, for example, have a peak body that receives some Government support to resource affiliated organisations. These kinds of bodies can have a positive influence in promoting safety standards. At this stage there is no obvious

[12] Report of Professor John Raftos, Exhibit 1, Tab32

organisation for Government to support and further community development may be necessary to build one.

**Whether members of volunteer cooperatives or associations partaking in activities such as lion dancing be required to hold first aid qualifications**

49. It is a positive step that the CYL has decided to promote first aid training for members in each of its sub-groups. More needs to be done to make this decision a reality. It was somewhat disappointing that at the time of the inquest, the lion dance coaches had not yet undertaken the relevant training.

50. All lion dance groups should be encouraged to undertake first aid training.

51. However, for a variety of reasons, particularly the difficulties involved in policing such a requirement, it does not seem appropriate to recommend that a blanket mandatory requirement be introduced for all organisations involved in the activity.

**Whether volunteer cooperatives or associations whose members engage in physically strenuous, dangerous sporting or recreational activities be required to have first aid signage, similar to those required by the swimming pool regulations?**

52. All organisations involved in physical activity should be encouraged to have first aid signage.

53. However, for a variety of reasons, particularly the difficulties involved in policing such a requirement, it does not seem appropriate to suggest a blanket mandatory requirement for all organisations whose members engage in such a broad category of activities, at this time.

**Recommendations**

54. I have considered carefully whether the evidence in this inquest calls for formal recommendations to Government pursuant to s 82 of the *Coroner's Act* 2009 (NSW).

55. Unfortunately there is no obvious body with whom to engage in relation to the regulation of recreational activities of this sort. There is no peak organisation in Australia that oversees or governs lion dancing. While it appears that there are a few other groups that use poles in NSW, their numbers appear to be low and their networks informal. The Chinese Youth League, the organisation directly involved in this tragedy has already ceased the use of poles.

56. For this reason I have decided against the making of recommendations in this matter. I am confident that the measures already taken by the CYL, in combination with the outreach Mr Lee will undertake will be sufficient to reduce the likelihood of further tragedy.

57. A copy of these findings will be sent to Mr King Lee of the NSW Police who has already undertaken to disseminate them in the lion dancing community through group visits and information placed in the Chinese and other Asian language press. Specifically Mr Lee is asked to make all lion dancing groups aware of the inherent danger of lion dancing on poles, the urgent need for community groups to improve their first aid capabilities and signage, the need to improve supervision and the need to keep records of accidents and near misses so that the size of the problem can be better judged. At present we have little concrete information about injuries falling short of death that may be occurring. The matters set out at paragraphs 34-53 of these findings could form the basis of any discussions.

58. I would hope that Mr Lee's work may also encourage existing lion dance groups getting together and creating a formal association which would provide a central point for information and advice. Mr Holman Leung gave evidence at the inquest[13] that there had been a previous attempt at creating a National Lion Dancing Association in Australia around 2009 or 2010, but the idea had not developed. Ms Tham spoke of an analogous organisation for dragon boat racing which appeared to have an ongoing interest and role in safety issues.

[13] Evidence at inquest . Mr Holman Leung 2/2/15

59. The Chinese Youth League, which has demonstrated a willingness to learn from this tragedy, may even be in a position to support or assist in calling a meeting to gauge the willingness of other groups to participate in creating a Lion Dancing Association. This proposal is not conducive to expression in a formal recommendation but may be taken up by the Chinese Youth League as an expression of its goodwill.

60. Making certain that existing lion dance groups are aware of Tommy's death and educating them about the potential danger of using poles is an important step forward. Those considering involvement in the activity can then make more informed choices about whether to participate. At the same time a general consideration of the broader safety issues in lion dancing is to be encouraged. I am confident that this process will be supported by Mr King Lee of the NSW Police and the management committee of the Chinese Youth League.

61. I decline to make formal recommendations.

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

62. 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 identity of the deceased is Tommy Ngo.

**Date of death**

Tommy died at approximately 5.20pm on 6 November 2014.

**Place of death**

Tommy died at St Vincent's Hospital, Darlinghurst NSW.

**Cause of death**

Tommy died from an ischaemic brain injury after a cardiac arrest, brought about by blunt force injuries to the neck.

**Manner of death**

Tommy's death was as a result of an accidental fall whilst training for Chinese lion dancing.

**Conclusion**

I offer my condolences to Tommy's family and friends. In particular, I offer my sincere condolences to Tommy's mother, whose pain and anguish is profound and ongoing. I thank her for her participation in the inquest and for her genuine concern that others do not suffer such a tragedy.

I make no formal recommendations, but I urge Mr King Lee to contact all known lion dancing groups in NSW and provide them with a copy of these findings.

I close this inquest

Harriet Grahame

Deputy State Coroner

15 March 2016