Findings and Recommendations by the Coronial Inquest into the Death of Jessica Michalik

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After 21 months, and 25 days of witness and expert testimonies, the Coroners Inquest into the death of 16 year old Jessica Michalik, at the 2001 Big Day Out (BDO), was finalised on Friday, 8th November 2002, when Senior Deputy Coroner, Ms. Jacqueline M. Milledge handed down her finding.

Given the ever increasing number of incidences over the last few years, particularly the Roskilde tragedy and the subsequent Danish Government report, crowd safety practitioners around the world have been eagerly awaiting the finding and resultant recommendations of the Inquest. The world was waiting to see whether Ms. Milledge would see through various inconsistencies of opinion given by evidence providers and make a statement for the betterment of the industry and the safety of those patrons who spend millions of dollars each year in return for a safe entertainment environment.

She had heard incident accounts and evidence opined from many people. From eye witnesses in the mosh pit at the time; from the promoters; from production managers; from security and safety experts; from photographers; from investigating Police inspectors; from band members and their touring party; from booking agents and management; from barricade experts; from emergency services officers.

Ms. Milledge heard about a professional relationship disintegrating between the promoters and the band and its management team. She heard of a 'we said '/ 'they said', 'we did' / 'they didn't' scenario commencing at an incident at the Auckland BDO and continuing until the ultimate divorce; when Limp Bizkit cancelled their remaining performances.

It was evidenced that a major crowd collapse incident occurred at the Red Hot Chilli Peppers performance at the 2000 BDO; that one of the promoters was on stage during the Roskilde incident and how crowd safety had, therefore, become the

hottest topics by event practitioners following the Danish tragedy. And how the Chilli Peppers incident prompted a BDO production manager to suggest the implementation of a secondary barricade to assist in the management of the crowd and their safety; and how that suggestion was disregarded.

The Court also heard that a collective decision by the promoters to implement a 'reactive' solution to the Chilli Peppers crowd crush and collapse rather than a 'proactive' response; that nothing would curb crowd actions and activities such as moshing and therefore the best crowd management strategy was to improve rescue methods and systems.

It was described how a BDO Operational Health & Safety document was drafted but not completed prior to the Limp Bizkit incident. How the document purported to be a 'Risk Assessment", how it was taken, and approved, as that by the venue and licensing Authority when it held no semblance to the Australian Standard AS/NZS 4360:1999 – Risk Management – document; Australia's benchmark document.

Crowd densities and dynamics along with barricade configurations, staging and event design options were discussed in detail and at length. Opinions of experts concurring and differing at various points; requests by the band for additional barricades; conversations and requests between the promoters and the band regarding the preferred configurations of each party were described and reasoned, and how the 'Licensing Authorities' in Australia, allegedly, wouldn't permit a change in the barricade configuration.

Ms. Milledge heard how performance cessation procedures had been developed but hadn't been emitted to, or discussed with, the Limp Bizkit camp until after the Auckland incident; and how artist reaction to the situation and control of the crowd can assist any resultant rescue operation. She also heard that there was no separate public address system or 'God' microphone, other than the artists' microphone, to address the crowd and inform then of scenarios in the case of an emergency. It was evidenced that it could have been quickly arranged but later heard that it would have taken about 10 minutes.

The Court heard about the 12 new crowd safety measures that were launched, in a flurry and major Press campaign in September, and implemented for the 2002 BDO; measure which were ultimately 12 months too late. Measures that, ostensibly, weren't anything that hasn't already been done by other crowd safety practitioners at previous events in Australia.

Indeed, most of the 12 measures have been readily available since 1995 in the Third Annual Rock Concert Safety Survey Report published by Crowd Management Strategies (USA) in February of that year[1]. Titled "Can Moshing Be Made Safer?" the moshing guidelines were introduced in 1994 by Mr. Paul Wertheimer at the International Association of Assembly Managers' International Crowd Management Conference. Measures that have been readily available on the www.crowdsafe.com website since then.

Ms. Milledge also took time out to criticise the media in the general reporting of various days throughout the Inquest; and also certain 'wasted time' exercises of key players. Ms. Milledge wanted the facts and to stay on the right track; to hear all the relevant information, deduce and deliver a finding and recommendations to the industry.

Ms. Milledge read from a prepared, and highly detailed, document interspersed with additional commentary from witness statements and some ad lib comments, as she saw relevant. She firstly wished to thank the investigating officers, cable television station, Channel V, who made available footage from the event and Triple J journalist Ronan Sharkey for his coverage and making many resources available to the Inquest.

She ultimately found that Jessica died of Hypoxic Encephalopathy due to crowd crush/mechanical asphyxia.

Ms. Milledge painted an historic picture of the BDO from it's beginnings at the old Showground through to conditions and details of that fateful event at the new Showground, at Homebush Bay, on January 26 2001. She provided snippets from

[1] http://www.crowdsafe.com/cafe.html

the Inquest including the report from the investigating Police and comments from the Fire Brigade, Ambulance and Security services in attendance that day.

The involvement of WorkCover in the Inquest, and subsequent protestation from the Creative Entertainment legal agent, and the possibility of further actions by them, should they deem it appropriate, was detailed. (WorkCover is a Government authority that regulates, educates and polices safe workplace practices and, where applicable, prosecutes breaches and unsafe practices by businesses.) Section 16 of the Occupational Health and Safety Act 1983 could well be applicable in the instance of Jessica's death and other injuries sustained by patrons and others at the BDO Festival. The latest Act also allows WorkCover to draft industry codes of practice.

Throughout the 25 days of the hearing Ms. Milledge was inundated with information regarding the concert and festival industry however considerable time was spent questioning issues regarding barriers configurations, the protocols regarding performance cessation in an emergency situation, whether the Promoters had provided a safe entertainment environment and whether the industry requires to be regulated and governed by an appropriate authority.

Barrier configuration rose as a major point of animosity between the promoters, Creative Entertainment, and Limp Bizkit following an incident at the Auckland festival, the first event of the 2001 tour. This initial incident bought crowd safety issues to a head and much has been written regarding the ongoing debate between both parties up to, and since, the Sydney event and resultant incident.

It was evidenced that the Press Release issued by the BDO on 27 January 2001, on behalf of both themselves and Limp Bizkit stated that, "Several times during their performance Limp Bizkit urged the audience to step back and assist fellow concert-goers in need of assistance, and promoters compliment the band's diligence in this. The organizers of the event would like to acknowledge the full co-operation of Limp Bizkit through this difficult situation and their commitment to the safety of their audience.[2]" When questioned during the Inquest, Mr. Lees stated that "I think what I was trying to do was put a positive read on the very difficult situation that we were

[2] Limp Bizkit & Big Day Out joint Press Release 27/1/2001

within and the need for us to be able to maintain a working relationship with Limp Bizkit". When asked further by the Coroner if the statement was true or not he responded "At the moment I would be remiss in saying that that paragraph was true, yes."

Configurations were also a consideration after the 2000 BDO when a crowd collapse occurred during the performance by the Red Hot Chilli Peppers however, the Promoters decided not to take the suggestions and advice of Mr. Warren Perryman, of D&P Concert & Event Barricades. Mr Perryman, who has for many years provided barricades to BDO as well as most other major events in Australia, suggested to the BDO Production Manager, Mr. Matt Doherty, that the use of a secondary barricade should be considered for future BDO Festivals. This warning was ignored as "they (the Promoters) won't go with that". It was found to be inconclusive whether Mr. Doherty actually forwarded and discussed this suggestion with Mr. West and Mr. Lees, it was found that Mr. Doherty should have been receptive to Mr. Perryman's timely and pertinent suggestion.

Mr. Mick Upton, a Senior Risk Consultant for the rock and festival industry from the United Kingdom, opined to the Inquest information regarding barricades, crowd movements and densities. He testified that "Barricading can be used to control crowd density levels and crowd migration from one point in the audience to another" and that barriers "must be designed for a particular event; there is no one appropriate system. Where crowd density levels need to be controlled and crowd migration encouraged a secondary barricade may be employed….Typically, this secondary barricade can be constructed as a semi-circle and is sometimes known as a D barricade".

Both Mr. Upton and Mr. Perryman concurred that the introduction of a 'T' barricade, as requested by Limp Bizkit, would not be effective for a two stage concert believing that crushing points would be a significant concern in crowd safety.

Mr Andrew Tatrai, Managing Director of Australian Concert and Entertainment Security (ACES), who worked with the BDO from 1992-97 gave evidence that he had broached crowd safety and crush concerns with Mr. West during his tenure as Head of Security.

He raised his concerns in 1994-95 due to the fact that the festival had become considerably larger and “I felt that a large critical mass of people at the front and that the crush would become life threatening at that staged due to the large number of people”. The relationship between ACES and Creative Entertainment ceased; though both sides proffered different and varying reasons.

Mr. Tatrai and Mr. Upton could not concur regarding the potential effectiveness of a secondary barricade and its ability to save Jessica; Mr. Tatrai believed it certainly would have saved her while Mr. Upton did not agree. One must wonder how two very high profile and extremely experienced Security practitioners can not agree on this topic and it certainly must be an area for concern.

Mr. Upton also delivered evidence regarding the crowd density at the front of the stage area and described it as “satisfactory”, “I don’t believe the density levels were exceeded” and that “The front of the stage was .3 density”. Mr. Upton had identified earlier in his testimony that “.19 is at which point everybody becomes alarmed, but .15 is generally accepted as being critical density on a static crowd…”.

Ms. Milledge continued her finding, with the qualifying comment, “I find this amazing”; “He stated “Crowd movement can definitely cause a crowd collapse. There’s no question of that, but I’ve not seen evidence on the tape to indicate that it was crowd movement. It could have been heat exhaustion. It could have been a faint. It could have been any number of things. It could have been an accident, a slip, a trip. There’s all sorts of….I don’t know, I wasn’t there.”

The Coroner then found that there was “overwhelming evidence that the crowd density was **not** (Coroners emphasis) acceptable. Mr Upton suggests it was just the first 5 rows at the front where crowd density was an issue. Witness accounts fly in the face of that assertion. There is also overwhelming evidence that crowd surges pushed people over and because of the critical crowd density, people could not get up.”

Ms. Milledge then proceeded to detail accounts of the aforementioned witness statements from many patrons who were in the mosh pit and around Jessica.

They “overwhelmingly establish that the crowd density was not at acceptable levels, indeed, the crowd density level was dangerous to say the least” according to Ms. Milledge. These statements portrayed graphic details; some so disturbing that it was emotionally too much for some of the public gallery and others in attendance.

In describing these statements, it was concluded that they were necessary “because there appears to be a reluctance on the part of the promoters and Mr. Upton to accept that the situation on that day was completely unacceptable”. It also became evident, through these witness accounts that the crowd “problems also began at the end of Powderfinger and at the beginning of Rammstein”.

Given that Mr. Upton was highly credentialed and respected in the security industry, one must wonder about the agenda of Mr. Upton seeing that he was only able to view video tapes of the incident. One must also wonder about his relationship with his apparent sponsor, the promoters, and how bipartisan Mr. Upton remained during his testimony. Mr Upton has personally been involved at least 2 major incidences; the Monsters of Rock concert in Donington Park, England on August 2, 1988 where 2 patrons dead. Mr. Upton was the head of security on that day when young men were crushed near the front stage during the Guns N' Roses set. The second incident was a David Cassidy concert at White City Stadium, London, England on May 26, 1974 where a 14-year-old girl was crushed to death near the stage during David Cassidy's performance. Mr. Upton was providing personal security for David Cassidy in this instance.

It was evident that Ms. Milledge could see through any form of collusion presented to her. This was also evident when Mr. Lees and M. West presented their individual witness statements that provided numerous points and comments verbatim, both citing a ‘united front approach’.

Ms. Milledge also took exception to the promoters blaming the volatility of the Limp Bizkit performance as “the reason for the crowd behaving the way it did”, though accepted that the crowds’ “behaviour will greatly be governed by the act performing”. She, again, berated the Promoters stating that the “style of Limp Bizkit could and

should have been known to the promoters before they engaged them" and "To suggest there was an element of surprise in LB's style is nonsense", "that should have been factored into the overall management and 'risk assessment' of the BDO by the promoters" and "How they react should have been predicted based on sound research of the act they were hiring".

Ms. Milledge also criticised the lack of proper protocols in place in order to stop the concert in the case of an emergency. While the BDO organisation stated that protocols were in place, they were not explained to Limp Bizkit until after the initial incident in Auckland when a crowd collapse occurred. The Auckland incident was the starting point to the degeneration of the relationship between Limp Bizkit and the promoters (and their staff). Describing the actions of Fred Durst, during that incident, as reprehensible, Ms. Milledge added that the artist should have been more proactive in assisting the promoters, with controlling the crowd, in a dangerous situation.

Mr. Durst also came in for additional criticism for the band's actions during the rescue attempts at the Sydney event commenting that his statements (made over the PA) were "alarming and inflammatory. You can see that by the way the crowd reacted". Ms. Milledge added that it was "an unrealistic notion to think that Mr. Durst should be 'monitoring' the mood and behaviour of the crowd, his brief is clear….to entertain'. However it was iterated further that the performance cessation protocol had triggered and that Mr. Dursts' comments were found "inflammatory and insulting to the security personnel who were engaged in their best efforts to extricate crucially injured patrons from the crowd collapse." And that "Mr. Durst took advantage of a terrible situation to air his contempt for the promoters and security. Yet there were moments when he sensibly urged them to look after one another and pick each other up".

Ms. Milledge praised the security officers during the rescue attempts and that they "performed extremely well under the worst possible conditions". Her criticism was left for "Mr. Lees, Mr. West and Mr. Doherty (who) relied on Mr. Grey's team to be 'reactive' to problems without them, the promoters, focussing on a 'risk assessment' approach to the Big Day Out festival".

Conclusion

In concluding, the Coroner cited several major points of reference and signs that should have been heeded.
She cited that:

- BDO Festival adopted a primary barrier system for the BDO, that they say had worked since the beginning of the Festival.

- The dynamics of rock concerts and festivals have been changing over a number of years. A fresh approach was needed after Roskilde Festival in Denmark, where 9 people were crushed to death.

- 9 deaths in 1990(sic) at a pop festival should sound alarm bells for the industry. We heard during the course of the inquest that some members of industry actually blame the barrier system for the deaths. The issue hear(sic) is crowd control. Ensuring density levels are safe and comfortable. The evidence at this inquest, by both experts Mr. Upton and Mr. Tatrai, is that barriers can have a positive effect of crowd management.

- The incident in Auckland where the crowd collapsed and the performance had to stop to allow rescue operations should have been seen as an indication of similar problems in other venues. After all, Mr. Perryman had alerted Mr. Doherty to his concerns that a secondary barrier was needed.

- The document, Ex 16, which is titled Operational Plans: Site and Security Risk Assessment does not have one scintilla of a risk assessment within its pages. How anyone could consider that a ‘risk assessment’ is beyond me….It is however, a very good document for what it is. A compilation of site and operational plans

- It is apparent that the BDO organisers focused on rescue, how to react to any given situation. And their response to crises was good. Security finely tuned, the use of police and fire brigade worked well and the medical response to casualties, particularly Jessica, was faultless.

- However, the crowd densities and the lack of an appropriate barrier system meant that they needed a ‘reactive’ plan as the pro-active approach was sadly lacking.

- The minutes Jessica was on the floor with people falling on her and around her were critical. Because of the crush of the crowd and the enormity of the task in moving people back, security could not get to her quickly enough to remove her from the crowd for urgent medical assistance.

- The promoters have blamed the band and the crowd for their predicament on 26 January 2001. They even submitted that the ‘risk assessment’ document has been seen by the Police and they did not disapprove. The promoters also said that Senior Sergeant Chellew hadn’t advised them of concerns regarding the ‘mosh pit’.

- I have not heard of any evidence to convince me that Mr. Lees, Mr. West or Mr. Doherty had prepared the necessary ‘risk assessment’. The responsibility is their (sic). No one else’s, and their reluctance to accept this has been as concern. However, having said that, the pro-active ’12 point plan’ implemented at the BDO 2002 was certainly a step in the right direction. The introduction of the secondary barrier system is a good indication that crowd safety is very much on their agenda.

- The industry needs to be carefully scrutinised and regulated. I am not saying these very good festivals should not go ahead. Nor am I saying moshing, slam dancing and crowd surfing should be banned. Those activities will be considered by a working party and a subsequent regulatory authority should one be established.

- Mr. Michalik has said many times, that Jessica’s legacy should be to improve conditions at these events to ensure patron safety. She would not want these activities outlawed.

- There are some limited but very good guides for promoters….The ‘Pop’ guide…provides a sound foundation…The Australian Standard AS:4360 of 1999 sets out what is required for a proper ‘risk assessment’.

- Mr. West & Mr. Lees have been promoters for many years….have a wealth of experience…It is, however, they need to be assisted by industry experts when addressing issues such as crowd control and ‘risk assessment’.

- The indicators were there, Roskilde and Auckland. Now this terrible tragedy involving 15 year old Jessica must stand as a warning that the industry must be regulated and crowd safety given the priority it deserves.

The ‘Jessica’ Recommendations

In handing down her recommendations, Ms. Milledge paid homage to Jessica by naming them after her and furthering the legacy that she has left for all concert goers. Jessica’s father, George Michalik, has always maintained that his daughter would always want festivals and concerts to continue, and added that Jessica would be proud of the way the Coroner has handled the Inquest.

1. That a ‘working party’ be established under the auspices of WorkCover Authority of NSW, to review current ‘entertainment’ industry standards and practices and develop guidelines to ensure the safety and comfort of patrons attending large scale events. This working party should comprise of representatives from the police, ambulance, fire brigade, local government, promoters, security, entertainers and any other appropriate ‘stakeholders’.

   Given then changing dynamics of rock and pop festivals and the alarming number of deaths at outdoor venues, the working party should be established forthwith.

   The ‘working party’ to devise guidelines for promoters to be adopted at events such as the Big Day Out and other large scale entertainment events.

   The guidelines should be developed with the intention that they be adopted as a ‘National Code of Conduct’. Australian Standard AS:4360 of 1999 should be used when considering the issues of ‘risk assessment’.

   The working party should have regard to (but not limited to):

   - crowd numbers generally and at individual venues
   - the compulsory preparation of comprehensive ‘risk assessment’
   - emergency protocols for stopping artists during performance
   - age restrictions
   - the accessibility of water, shade and first aid
   - the suitability of crowd activity such as moshing, slam dancing, crowd surfing etc
   - barrier configurations

2. That the State Government establish a regulatory authority responsible for the licensing, regulating and policing of large scale entertainment events. This body should have enforcement powers to ensure compliance.

3. That Local Governments and the Sydney Olympic Park Authority request and review a comprehensive 'risk assessment' for all large scale entertainment events before granting permission.

4. That a National Code of Conduct be adopted by each state and territory, to ensure uniformity of approach to safety issues for large scale events.

5. That anyone promoting or conducting a large scale event prepare a comprehensive 'risk assessment' after consultation with all stakeholders and service providers.

6. That the Minister for Education encourage all schools to educate teenage students of the dangers of moshing, crowd surfing and the possibility of heat and stress exhaustion when attending concerts and festivals.

7. That promoters ensure that protocols for stopping artists in emergency situations are clearly documented and agreed to by all parties affected.

8. That promoters of large scale events give consideration to devising an effective and immediate 'alert' to artists in an emergency situation.

9. All performance artists must adhere strictly to emergency procedure protocols once they are invoked. The laborious 'chain of command' where one person speaks to another, who speaks to another, is too time consuming.
   A coloured card or coloured light would be the fastest way to communicate a problem.

10. That ‘user pays’ services i.e. Fire Brigade, Ambulance and Police, insist on, and sight, a comprehensive ‘risk assessment’ prior to agreeing to supply there services.

Ms. Milledge took a holistic approach when not suggesting any specific changes to the event but suggested that a “coordinated response drawing on experts in the field” could advise on the variables such as the type of event, the artists and the intended audience and ultimately “devise guidelines for all large scale events”.

Summary

The Senior Deputy Coroner, Ms. Jacqueline M. Milledge endured many days of party wrangling between the Limp Bizkit and Creative entertainment representatives during the Inquest. As previously mentioned she saw through many red herrings and attempts to cast blame by both parties.

In an Inquest as such, the first of it’s kind in Australia (and hopefully the last), she has made excellent recommendations to improve the entertainment industry and safety of those who financially support it every year. Now the ball is in the WorkCover court, it’s up to them to garner relevant information from safety experts and develop standards and regulations to make entertainment events safe to attend. It’s, also then, up to WorkCover to police these events, all of them, and show not only the promoters, but the patrons as well, that things have changed. And make a difference for the sake of Jessica.

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Ian Weirs' event management career commenced in the early '80's staging professional surfing tournaments for the Australian Professional Surfing Association and working in the surfing industry. He also wrote for local, state and national publications during this period.

VEMS was created in 1998 to provide a diverse array of services to the venue and event management industries.

Prior to establishing VEMS, Ian held management positions at a number of major Sydney venues such as the Sydney Convention & Exhibition Centre (SCEC), as Assistant Operations Manager, then the Sydney Showground, as the Venue Operations Manager.

During his time at the Showground he managed 3 Big Day Out's and many concerts in the Hordern Pavilion. He has also managed an array of other events such as the Mardi Gras & Sleaze Ball dance parties, Sydney Showground Speedway, Australian Fashion Week and the Sydney Motor Show while at the SCEC.

Prior to the Sydney Showground, Ian managed a number of small independent artists as a partner in High Noon Publicity & Management. High Noon provided publicity services for major touring performances as well as the Big Backyard Concert and the large Alternative Nations festival at Eastern Creek.

Ian has travelled to numerous diverse events overseas, including the Roskilde Festival in Denmark, and also inspected many major overseas venues.

He has continued to attend Big Day Out's and other major festivals and events advocating and recording patron, and event workers, safety.