

IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

Court Reference: COR 2014 000551

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 60(2)*

*Section 67 of the Coroners Act 2008*

I, JUDGE IAN L GRAY, State Coroner, having investigated the death of KATIE LOUISE BROADBENT

without holding an inquest:

find that the identity of the deceased was KATIE LOUISE BROADBENT

born on 19 October 1978

and that the death occurred on 26 January 2014

at Bonn Road, Rochester Victoria 3561

**from:**

I (a) INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT.

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances:**

**Background**

1. Ms Broadbent was a 35-year-old woman who was a theatre technician and lived in Yarraville. At the time of her death, she was in a relationship with Mr Scott O'Connor.
2. On 25 January 2014, Ms Broadbent, Mr O'Connor and his friend Mr John Forbes attended the '2014 Milky Bar Beats from the Teats' music festival in Rochester together with other friends. The festival was held on a private rural property and approximately 250 to 300 people attended. Guests paid an \$80 donation to cover costs, were supplied with dinner and some alcohol and were advised to bring their own food and drinks. They camped in tents on

the property overnight. The festival consisted of various bands that played throughout the day, night and into the early hours of 26 January 2014.

3. The camping area was set up with rows of parked cars and tents nearby. Ms Broadbent and Mr O'Connor set up their tent in front of Mr Forbes' car. Mr Forbes planned to sleep in his car.
4. Many of the attendees were drinking throughout the night and some were consuming ecstasy and other substances. Mr Forbes was observed by several people to be intoxicated, and witnesses noted that he consumed one ecstasy tablet.
5. Mr Forbes left the music area of the festival with a friend, who accompanied him to his car where he fell asleep in the driver's seat at around 3.55am on 26 January 2015. Later, witness Ms Samantha Turner made her way back to the camp area and saw Mr Forbes' car. She stated that there was a dark coloured tent tangled under the car, virtually under the driver's seat. Ms Turner saw Mr Forbes revving the engine loudly and saw the wheels spinning. She asked him why he had driven over the tent and told him that somebody could have been sleeping in it. Tragically, Ms Broadbent had been sleeping in the tent, and Mr Forbes had not realised.
6. At around 8.45am on 26 January 2015, Mr O'Connor made his way back to his tent and found it collapsed on the ground. He began to search for Ms Broadbent, went over to the tent shortly afterwards and found her injured body inside. An off-duty nurse performed CPR and paramedics and police were called, but Ms Broadbent was deceased.
7. Mr Forbes pleaded guilty to one charge of dangerous driving causing death. He was tested for the presence of alcohol and drugs after his arrest at around 12.00pm and 0.13g/100mL ethanol (alcohol) and 0.08mg/L of MDMA (ecstasy) were detected. Mr Forbes was sentenced to four years' imprisonment with a non-parole period of two years, and his licence was suspended for the duration of the custodial sentence.

#### **Medical Examiner's Report and Cause of Death**

8. An autopsy of Ms Broadbent's body and post mortem CT scanning (PMCT) were performed by Forensic Pathologist Dr Noel Woodford of the Victorian Institute of Forensic Medicine,

who formed the opinion that the cause of her death was *injuries sustained in a motor vehicle incident*.<sup>1</sup>

9. Dr Woodford stated that the most striking external finding at autopsy was prominent suffusion and congestion of the face, neck and upper chest associated with petechial haemorrhages, haemorrhage within the conjunctivae and haemorrhage within both external auditory canals. Dr Woodford also noted scattered non-specific areas of blunt force injury in the form of bruising and abrasion to the torso and limbs, areas of deep bruising to the scalp, torso and limbs as well as bilateral rib and pelvic fractures. Dr Woodford stated that there was no natural disease identified of a type likely to have caused or contributed to death.
10. Dr Woodford commented that the presence of bilateral rib fractures of the type and distribution seen at autopsy was on the whole to be more likely due to severe compressive force applied to the chest rather than simply due to chest compression of the type delivered during resuscitation attempts. Dr Woodford further commented that the presence of pelvic fractures indicated severe compressive force applied to the pelvis, and that it was likely that the presence of significant layers of material (tenting, doona and clothing) had minimised the cutaneous stigmata of blunt force trauma delivered to the chest and torso.
11. Dr Woodford concluded that it appeared that the mechanism of death was likely to have been one of mechanical asphyxia in the setting of severe compressive force applied to the torso. He explained that '*[m]echanical asphyxia refers to an interference with breathing mechanisms (principally chest expansion) due to the application of significant externally applied compressive force*'.<sup>2</sup>
12. Post mortem toxicological analysis revealed the presence of elevated levels of ethanol (alcohol) at 0.15g/100mL in blood and 0.18g/100mL in vitreous humour, MDMA (ecstasy) in blood and urine, methylenedioxyamphetamine (MDA) in blood and urine, Delta-9-tetrahydrocannabinol (cannabis) in urine, morphine in urine and paracetamol in urine. Dr Woodford stated that the results indicated more remote use of codeine, paracetamol and cannabis.

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<sup>1</sup> Report of Woodford dated 11 April 2014.

<sup>2</sup> Ibid page 17.

## Administration of the Music Festival

13. The festival took place on private property and was essentially unregulated. The festival was organised by an incorporated association 'Got Milk Incorporated'. Its six members were the main organisers, including the owner of the property, Mr Tom Acocks. The property was part of a dairy farming operation. The association had only been registered with Consumer Affairs Victoria on 22 January 2014. 2014 was the fifth (and final) year that the festival had run, and it had grown each year. It was advertised online, but most attendees were friends or relatives of the organisers. Guests pre-purchased tickets online and communication was via a Facebook page and email.
14. A stage area was set up with several bands and DJs playing from 1.30pm on 25 January 2014 until about 2.00pm on 26 January 2014. Other amenities included a bar area, food stalls, toilets and a first aid area. T-shirts were available for sale.
15. Entrance to the event was via a gate on Bonn Road, and festival 'staff' were stationed on the property to mark off names and hand out wristbands and a flyer to guests. The flyer contained information about the performances as well as a *House Rules* section.
16. The *House Rules* stated, among other things, that no driving was allowed on the property. Guests were told to keep their cars parked once they entered the site, to walk up to the party and to remove their keys from the ignition. There was no lighting in the car park and camping area. Several witnesses stated that it was difficult to see as they were returning to their tents, and there was no security presence or supervision of the car park/camping area.
17. Consumer Affairs Victoria confirmed that 'Got Milk Incorporated' it is still registered<sup>3</sup> and the Court obtained a copy of its certificate of incorporation. Incorporated associations are registered with Consumer Affairs Victoria under the *Associations Incorporation Reform Act 2012*.
18. Every incorporated association must have rules. The association may use the model rules or create its own rules. The rules must address every item listed in Schedule 1 of the *Associations Incorporations Reform Act*. There is no requirement under the Act to have rules in relation to safety or regarding the particular activities of the association.

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<sup>3</sup> As at 4 November 2015.

19. As a not for profit association, the incorporated association may trade, but not in order to distribute profits to its members. It is unclear whether the members did profit from the festival, however Mr Acocks' statement refers to the \$80 payment being only to cover the association's costs of running the festival.
20. The Campaspe Shire Council, Victoria Police, Country Fire Authority and Ambulance Victoria were not informed or consulted about the music festival and there were no permits issued allowing the festival to take place on the property, which falls under the land use term 'Place of Assembly' in clause 74 of the Campaspe Planning Scheme. Planning permission is required to use the land for the purpose of a music festival.
21. In his capacity as an owner of the land, Mr Acocks was charged with using the land in contravention of the Campaspe Planning Scheme. Mr Acocks pleaded guilty and on 18 March 2015, he was fined \$7,000 without conviction.

#### **Coroners Prevention Unit Advice**

22. I asked the Coroners Prevention Unit (CPU)<sup>4</sup> to undertake research to identify similar deaths nationally, in order to explore prevention opportunities. The CPU sought to identify deaths from 1 July 2000 to 31 July 2015 of people killed in a motor vehicle collision in circumstances where the deceased was camping at a festival or party and had been run over by a motor vehicle. Intentional deaths were excluded as were deaths resulting from illicit drugs.
23. The CPU identified four relevant deaths where a person was camping at a festival or party and died from a motor vehicle run over. As with Ms Broadbent's death, the identified deaths occurred in circumstances where they were on rural property and the deceased persons were all sleeping in tents or swags.<sup>5</sup> However, none of the identified deaths occurred at music festivals, but took place at private gatherings.

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<sup>4</sup> The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The CPU assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations.

<sup>5</sup> In NSW in 2010, two people aged 19 years attended a gathering at a private property with friends and acquaintances. A driver and owner of a motor vehicle, aged 17, ran over them whilst they slept in a swag.

In Queensland in 2011, a 73-year-old man suffered fatal injuries when he and two others travelled with their utility to a camp ground at Tinnanbar for a camping and fishing weekend. All three had consumed alcohol. One of the members of the group started the vehicle, drove into the tent and over the two occupants.

## **Further investigation**

24. I identified three areas for further investigation and possible recommendation:
1. Police response to music festivals and entertainment events
  2. Local government consultation with police
  3. Review of the current legislative and regulatory regime for music festivals.

## **Police response to music festivals and entertainment events**

25. I conducted further investigation in order to establish whether comparable music festivals regulate the camping, parking and tent and vehicle placement issue for safety and, if so, how this is done.
26. In January 2012, \_\_\_\_\_ died from an accidental mixed drug overdose at the Rainbow Serpent Festival in Lexton, Victoria. Coroner Heffey investigated the death and made a finding without inquest that dealt with the issue of regulation of music festivals.<sup>6</sup> The Rainbow Serpent festival is much bigger than the Beats from the Teats festival was, with over 10,000 people attending each year. The investigation in \_\_\_\_\_ focused on the adequacy of the arrangements in place to provide medical assistance to attendees who may be drug affected, however, some of the principles apply to the circumstances surrounding Ms Broadbent's death, particularly regarding risk management generally.
27. In order to hold a festival, organisers must obtain a planning permit from their local council. In addition, organisers must obtain a Place of Public Entertainment (POPE) occupancy permit pursuant to section 49 of the *Building Act 1993*.
28. Festivals in rural areas are very popular and are welcomed by locals because of the increased tourism and revenue that they bring. Recognising this, Sgt Paul Martin, the Station Commander at Beaufort Police Station, undertook significant work after the death of Mr \_\_\_\_\_ to improve the relationship between festival organisers and police and to improve public safety at these events.

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In 2012 in Western Australia, a 21-year old woman attended a 21st birthday party on a private farming property at Darkan. She was sleeping in her swag when she was run over by a large farm harvesting machine called a header. Earlier, another guest at the party had had started the machine and had driven it up an incline to position it near the campfire. No other person was in the machine when it began to roll backwards down the incline. Guests were unable to stop the machine, which crashed into a parked vehicle and ran over the woman.

<sup>6</sup> COR 2012 000353 Finding without Inquest into the death of \_\_\_\_\_

29. In light of his experience, Sgt Martin resolved that police had to be more involved in the planning and organisation of future Rainbow Serpent festivals. He concluded that the POPE permit process was the best avenue through which police could demand greater engagement from festival organisers and require them to properly consider and address risk management challenges posed by the festival, given its remote location where emergency services are limited.
30. Inspector Graham Banks is the Local Area Commander for the City of Greater Geelong and Borough of Queenscliff. I made enquiries with Inspector Banks who explained that in 2013, he was tasked to review the police response to a number of annual music festivals in the region following death. Inspector Banks worked with Sgt Martin who had developed an understanding of the risks presented and the requirement for building and POPE permits. Inspector Banks stated that currently, police can only seek to influence and cannot veto a POPE permit application and that he was not of the view that police should be granted this authority, but that police should nevertheless engage in the POPE permit approval process.
31. There were several significant and positive changes in the running of the 2013 festival. Inspector Banks stated that the learnings of Sgt Martin formed the basis of important information that should be considered by any police commander who is tasked with providing a police response to an event such as the Rainbow Serpent Festival, and that they were the foundation for the work that Inspector Banks undertook in completing a police guide to the management of events of this nature.
32. The guide, titled 'Planning Guide for Entertainment Events' (the Planning Guide) was produced in September 2013 and its focus was on risk identification and mitigation, particularly as regards illicit drug use at the Rainbow Serpent and other festivals and the risks associated with drug-affected drivers.<sup>7</sup>
33. Coroner Heffey concluded in as follows:

*[i]t is important that Councils, beyond the Pyrenees Shire Council, benefit from the lessons learnt in the context of the Rainbow Serpent festival.... A "Planning for Music Festivals – Practice Guide" has been prepared for Victoria Police.... It draws heavily on the experiences of Sgt Martin with the Rainbow Serpent Festival and provides guidance for police on the POPE process and how this should be utilised to ensure*

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<sup>7</sup> Inspector Banks stated that at the 2015 Rainbow Serpent Festival, a police drug driver bus was set up after the event and resulted an approximate increase of 1100 per cent of positive test results compared to the state average.

*appropriate police involvement in event planning and approval. However, the utility of the Guide is ultimately dependent on Councils alerting police when they receive a POPE permit application and requiring event organisers to consult and cooperate with emergency service providers.*<sup>8</sup>

34. I am of the view that the Planning Guide represents positive action by Victoria Police and I propose that it be reviewed and adopted by Victoria Police more broadly in order to improve the liaison between festival organisers and police (as well as other emergency service providers).
35. Victoria Police was consulted in relation to this proposal informed me that the Planning Guide, whilst it relates to the Western Region of Victoria Police, is currently available on the Victoria Police Intranet and is accessible to all Victoria Police employees. Victoria Police consulted with the Superintendent responsible for Operations Support in each region, and advised that it appears that no region objects to the proposal that the Planning Guide be reviewed and adopted in some form. Similarly, I am advised that this position has been confirmed by the Victoria Police State Event Planning Unit (SEPU),<sup>9</sup> and that Victoria Police therefore has no objection to the proposal that the Planning Guide be reviewed and adopted broadly across Victoria Police. I thank Victoria Police for its contribution and assistance, and I will recommend accordingly.

#### **Local Government consultation with Police**

36. As Inspector Banks indicated, the utility of the Planning Guide is ultimately dependent on local councils first alerting police when they receive a POPE permit application or when they approve such application, and secondly, requiring event organisers to consult and cooperate with emergency service providers once a permit is approved.
37. I therefore propose to recommend that, before approving a POPE permit application, local councils be required to consult with Victoria Police upon receipt of the application. I sought

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<sup>8</sup> COR 2012 000353 Finding without Inquest into the death of \_\_\_\_\_, pages 7-8.

<sup>9</sup> Victoria Police explained that in addition to music festivals and other large scale events being coordinated by regional management, there are some events for which coordination is overseen by the Victoria Police State Event Planning Unit (SEPU). The role of the SEPU is to provide event assessments, effective liaison, planning and coordination of complex events, major police operations and emergency incidents. This includes the preparation and coordination of planning and resourcing for specified police events and operations, both planned and unforeseen.



comment on this recommendation from both Victoria Police and the Victorian Local Governance Association (VLGA).<sup>10</sup>

38. For unknown reasons, the VLGA declined to provide a response to the Court.
39. Victoria Police stated that it supports this recommendation. I again thank Victoria Police for its contribution and I will recommend accordingly.

#### **Review of the current legislative and regulatory regime for music festivals**

40. Currently, a POPE certificate is required for music festivals and similar events, however, it appears that this particular festival would not have qualified for the POPE permit as there were less than 5,000 people attending and the festival was apparently not set up for profit. The POPE process, whilst seemingly the only option currently in place for regulating such festivals, does not extend to smaller festivals and does not adequately involve emergency services.
41. I sought contribution from the Minister for Planning and the Victorian Department of Environment, Land, Water and Planning (DELWP) regarding
  1. my proposal for review of the legislative and regulatory regime in order to develop a framework that is a better fit for the regulation of music festivals, the current POPE permit process being the only option currently in place
  2. whether there is scope for the introduction of any requirement as regards the separation of camping and parking areas at music festivals.
42. Mr John Ginivan, Executive Director of Planning and Building Systems at DELWP provided a response on behalf of the Minister. Mr Ginivan noted that a planning permit had not been obtained by Mr Acocks and explained that, had a planning permit been obtained for the event, the Shire of Campaspe could have included permit conditions relating to parking and traffic management designed to ensure the safe management of traffic at the event.
43. Mr Ginivan also stated that had an event permit been obtained under the Shire of Campaspe General Local Law No. 7 2005, the Shire would have required compliance with its 'Event Ready Reference' guide, which assists event managers to minimise risk and maximise the

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<sup>10</sup> The Victorian Local Governance Association (VLGA) is a peak body whose membership comprises local government, community organisations and individuals. In its online publication the VLGA states that its Mission is '*a unique peak body for councillors, community leaders and local governments working to build and strengthen their capacity to work together for progressive social change*'.

likelihood of a successful event. The guide also requires safety measures such as event management plans, public safety measures security, traffic management and the management of alcohol. Mr Ginivan explained that similar requirements exist under planning schemes for other councils and shires, who also have the ability to make local laws requiring event permits.

44. Mr Ginivan explained that the POPE provisions in the Building Act may, in some cases, operate to complement planning controls and local laws in relation to event management but that the key focus of the POPE provisions is to protect the safety of the public when attending public entertainment in buildings and enclosed outdoor places that present similar risks. The primary focus is on integrity of structures and the POPE provisions also require an occupancy permit to be obtained for prescribed temporary structures that include stages or platforms. Mr Ginivan stated that application for such a permit must be made to the Victorian Building Authority rather than local council. It is not clear whether the size of the stage in this case was such that it constituted a prescribed temporary structure.
45. Mr Ginivan concluded as follows:
  - a. that the current planning scheme and planning permit requirements, coupled with council and shire local laws setting out event management requirements that can be tailored by councils and shires, provide the regulatory framework for managing safety at small outdoor music festivals; and
  - b. that replicating aspects of the current planning and local law requirements in the POPE framework is unlikely to produce any improvement in compliance with any of the requirements, and seeking to extend POPE requirements to cover smaller events that are not for profit could impact on a range of family events and other social gatherings held on private properties.
46. I note the position of DELWP that the current legislative and regulatory regime is adequate and that legislative amendment might have unintended consequences for small, private events. The main contention of DELWP in its response is that the appropriate laws were in place at the time of Ms Broadbent's death and, had they been adhered to, this tragedy would not have occurred. However, I am of the view that the current legislative and regulatory regime as described by Mr Ginivan would not have adequately addressed the problem of lack of separation of camping and parking areas at music festivals. Furthermore, careful and considered legislative and regulatory amendment should ensure that there are no unintended

adverse impacts on private events and social gatherings held on private properties. I will therefore make the proposed recommendation.

### **Findings pursuant to section 67 of the *Coroners Act 2008***

47. I find that:

- a. the identity of the deceased was Katie Louise Broadbent; and
- b. Ms Broadbent died from injuries sustained in a motor vehicle incident, on 26 January 2014, at Bonn Road, Rochester Victoria 3561, in the circumstances described above.

### **RECOMMENDATIONS**

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

1. I recommend that the Planning Guide for Entertainment Events be reviewed and adopted by Victoria Police more broadly in order to improve the liaison between festival organisers and police, as well as other emergency service providers.
2. I recommend that local councils be required to consult with Victoria Police upon receipt of a Place of Public Entertainment occupancy permit application.
3. I recommend that the Victorian Department of Environment, Land, Water and Planning review the current legislative and regulatory regime in order to develop a framework that is a better fit for the regulation of music festivals and to consider whether there is scope for the introduction of a requirement for the separation of camping and parking areas at music festivals.

I convey my sincere condolences to Ms Broadbent's family and friends.

I direct that a copy of this finding be provided to the following for their information only:

**Mr Michael Broadbent, Senior Next of Kin**

**Ms Teresa Doyle, Senior Next of Kin**

**Senior Sergeant Belinda Bales, Civil Litigation Unit, Victoria Police**

**Mr John Baring, Senior Policy Officer, Department of Environment, Land, Water and Planning**

**Mr Stuart Stevens, Shire of Campaspe**

**Dr Andrew Hollows, Chief Executive Officer, Victorian Local Governance Association**

**DSC Kelly Carvill, Victoria Police, Coroner's Investigator**

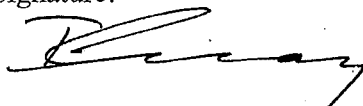
**LSC Amanda Maybury, Police Coronial Support Unit.**

I direct that a copy of this finding be provided to the following for action:

**Mr Adam Fennessy, Secretary, Department of Environment, Land, Water and Planning**

**Chief Commissioner Graham Ashton, Victoria Police.**

Signature:



JUDGE IAN L GRAY

STATE CORONER

Date:

