IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 000346

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the ***Coroners Act 2008***

Findings of:	Coroner Leveasque Peterson
Deceased:	Jesse Lee Christopher Edwards
Date of birth:	27 May 1998
Date of death:	19 January 2019
Cause of death:	1(a) Prone restraint asphyxia in the setting of alcohol intoxication and centripetal obesity
Place of death:	117 Campbell Street, Swan Hill, New South Wales, 3585

Aboriginal and Torres Strait Islander readers are advised that this content contains the name of a deceased Aboriginal person. Readers are warned that there may be words and descriptions that may be culturally distressing.

INTRODUCTION

1. Jesse Lee Christopher Edwards (**Jesse**) was a proud Yorta Yorta and Mutthi Mutthi man.

2. On 18 January 2019, Jesse was 20 years old when he passed, following a physical altercation on the footpath nearby Barrell's Nightclub in Swan Hill.

3. During the altercation, Jesse was restrained by security officer and owner of Barrel's Nightclub, Steven Bartalotta (**Mr Bartalotta**) for upwards of four minutes.

4. Jesse was a young leader in his community and his passing continues to have a profound impact on his family and friends, as well as the wider Aboriginal community in Swan Hill.

THE CORONIAL INVESTIGATION

5. Jesse's passing was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[1]

8. Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

9. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of

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[1] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

10. Victoria Police assigned Sergeant Kyle Simpson to be the Coroner's Investigator for the investigation of Jesse's passing. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

11. This finding draws on the totality of the coronial investigation into the passing of Jesse Lee Christopher Edwards including evidence contained in the coronial brief.

12. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

13. In particular, I note that there is differing, and sometimes conflicting, evidence with regard to the circumstances of the altercation which occurred immediately prior to Jesse's passing.

14. While these details are set out in the coronial brief, I have determined that it necessary to include a high level summary of the circumstances for the purposes of my finding. In this regard, I am satisfied that the events of the altercation have already been considered thoroughly in a criminal context and that further detailed consideration is unnecessary in order to fulfil my legislative mandate.

15. Instead, I have determined to focus my investigation on identifying any opportunities to prevent future deaths in similar circumstances.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

16. On 18 January 2019, Jesse spent the evening at home with his brother, Dylan Edwards, and two friends. During the night, they consumed a number of alcoholic drinks and were described as "drunk" and "happy". At some time between 11-12pm, the group travelled by taxi to the Commercial Hotel on Campbell St, Swan Hill. At this venue, they met up with Jesse and Dylan's two sisters and another friend.

17. Shortly before 1am, Jesse and Dylan left the Commercial Hotel and walked south towards Barrell's Nightclub (**the nightclub**). Jesse arrived at the nightclub first and stood outside an open window speaking with an unknown male. At this time, an unrelated group of patrons

exited the nightclub and there was a brief verbal exchange with Jesse. This group included Matthew Guy, Sandy Guy and Marissa Magnusson.

18. As the group continued walking north towards the Commercial Hotel, Matthew engaged in another verbal exchange, this time with Dylan as they crossed paths. Matthew's group then continued walking and entered the Commercial Hotel, while Dylan proceeded south towards the nightclub.

19. After arriving outside the nightclub, a verbal altercation occurred between Dylan and owner and security officer of the nightclub, Mr Bartalotta. According to Mr Bartalotta, the altercation related to a previous incident where Dylan had been ejected from the premises. At 1.11am, Jesse and Dylan left the nightclub and began to walk back towards the Commercial Hotel.

20. At approximately the same time, Matthew, Sandy and Marissa exited the Commercial Hotel and proceeded towards the nightclub. The two groups crossed paths on the footpath between Voyage Fitness and Syd Wilson Electrics and following a brief verbal exchange, a physical altercation commenced.

21. While details of the fight differ amongst various accounts, there have been subsequent criminal convictions in relation to the following events:

    a) Matthew struck Jesse to the face causing him to fall backwards to the ground.[2] After a few seconds, Jesse regained his feet with the assistance of a passerby and continued to participate in the fight.

    b) Dylan struck Marissa to the face.[3] After observing this incident, security officers from the nightclub subsequently notified Marissa's husband, Troy Magnusson, who had previuosly been inside the venue but subsequently attended the scene of the fight.

    c) After joining the fight, Troy attempted to strike Jesse and Dylan who fought back against him.[4] Troy was subsequently struck in the face causing him to fall to the ground before he regained his footing.

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[2] On 18 February 2020, Matthew Guy was found guilty of the offence of affray at Swan Hill Magistrates Court without conviction and fined $1200.

[3] On 9 November 2020, Dylan Edwards was convicted of affray and other offences at Swan Hill Magistrates Court and placed on a Community Corrections Order for twelve months.

[4] On 3 December 2019, Troy Magnusson was found guilty of the offence of affray and other offences at Swan Hill Magistrates Court without conviction and fined $2000.

22. After observing these events, Mr Bartalotta intervened and attempted to separate the parties.

23. At 1.15am, Mr Bartalotta restrained Jesse by placing his arm around Jesse's upper body from behind. Jesse lent forwards and subsequently went to ground where Mr Bartalotta continued to restrain him in a face-down prone position. Dylan also fell to the ground and was simultaneously restrained by Mr Bartalotta.

24. While Jesse was being held in a prone position by Mr Bartalotta, Troy approached and kicked Jesse in the upper body or stomach region. The kick was described as "a big football kick that connected with Jesse's stomach" and "looked like it took the wind out of him."

25. As Jesse and Dylan were held in position by Mr Bartalotta, the fight stopped and an employee of the nightclub was requested to call Triple Zero.

26. Dylan was subsequently assisted to his feet by another security officer while Jesse continued to be restrained by Mr Bartalotta.

27. CCTV footage shows that for approximately two minutes, Jesse continued to kick his legs back and forth before becoming still and ceasing to move at approximately 1.17am.

28. At 1.16am, another employee of the nightclub made a call to emergency services. At the beginning of the call, the employee indicated that only police were required. However, later in the call, the employee requested an ambulance stating, "cause he's on the ground, he's hit his head," but further noting that Jesse was conscious and breathing.

29. While this was occurring, Mr Bartalotta attempted to lift Jesse up from the prone position but noticed he was still and not breathing. Mr Bartalotta checked for a pulse and rolled Jesse into the recovery position.

30. Mr Bartallotta then commenced cardiopulmonary resuscitation (**CPR**) on Jesse with assistance from another security officer.

31. At approximately 1.21am, Victoria Police members arrived at the scene, activated their Body Worn Cameras, and assisted in providing CPR to Jesse until the arrival at Ambulance Victoria.

32. At approximately 1.31am, Ambulance Victoria paramedics took over in providing care to Jesse. Upon initial examination, Jesse was found to be asystole.

33. CPR was continued but Jesse was sadly unable to be revived and was pronounced deceased at the scene at 2.06am on 19 January 2019.

Identity of the deceased

34. On 19 January 2019, Jesse Lee Christopher Edwards, born 27 May 1998, was visually identified by his mother, Christine Donaczy.

35. Identity is not in dispute and requires no further investigation.

Medical cause of death

Medical Examination Report dated 24 April 2019

36. On 20 January 2019, Forensic Pathologist Dr Linda Iles from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy. Dr Iles also reviewed materials available at that time, including:

    a) Post mortem CT scan
    b) Victoria Police Section 27 Request for Autopsy
    c) Victoria Police Report of Death (Form 83)
    d) Victoria Police memo, including witness statements, dated 5 February 2019;
    e) Additional statement of Steven Bartalotta dated 13 February 2019
    f) Ambulance report.

37. Dr Iles provided a written report dated 24 April 2019 which included key findings as follows:

    a) World Health Organisation Class 3 Obesity with a BMI of 55;
    b) No evidence of intracavity haemorrhage;
    c) No evidence of significant intracranial haemorrhage;
    d) Decompositional change;
    e) Bruising and abrasion to the dorsum of the big toes bilaterally;
    f) A 0.8cm mucosal laceration to the mid-left upper lip;
    g) A 4cm x 3.5cm focus of bruising behind the left elbow;
    h) Early vascular anoxal injury throughout the brain in keeping with resuscitation.

38. Toxicological examination of post mortem samples demonstrated a blood alcohol concentration (**BAC**) of approximately 0.20g/100ml. No other common drugs or poisons were identified. Vitreous humour alcohol concentration was 0.23 g/100mL. Dr Iles

commented that despite the presence of decompositional change, this result indicated that it is likely the blood alcohol concentration was not significantly affected by decomposition.

39. Dr Iles recognised that the presence of relatively advanced decompositional changes had potentially obscured subtle anatomical findings at post mortem, particularly with regard to mucosal surfaces about the face. She noted that the presence of advanced decompositional changes despite a relatively short post mortem interval were contributed to by environmental conditions and Jesse’s body mass index of 55.

40. Taking into account these limitations, Dr Iles stated that only minor traumatic injuries had been identified. These include a mucosal laceration on the left upper lip and minor abrasions to the lower legs. Subcutaneous dissections were performed but no occult bruising was identified. In particular, no abdominal soft tissue bruising was identified. Dr Iles noted, however, that the absence of identifiable bruising did not preclude a blow to the abdomen. Further, while no substantive neck bruising had been identified, she commented that subtle bruising may be obscured by decomposition changes.

41. Dr Iles stated that no significant pathology had been identified, despite WHO Class 3 obesity. However, as in relation to the identification of injuries, Dr Iles noted that her assessment of natural disease was also limited to an extent as a result of decompositional changes.

42. Dr Iles concluded that the post mortem did not demonstrate an anatomical cause of death in relation to Jesse. She summarised, “There is no evidence of head injury, abdominal or chest haemorrhage or underlying natural disease process to account for Mr Edwards’ death.”

43. Taking into account the absence of specific diagnostic features, and noting the “somewhat variable witness accounts around the circumstances” immediately proximate to the passing, Dr Iles considered that two possibilities were presented:

    a) The first possible scenario involved blunt head trauma in the setting of alcohol intoxication (commotio cerebri or commotio medullaris). Dr Iles explained that this is a condition in which the central nervous system depressant effects of alcohol magnify any concussive effects to the brainstem consequent to blunt trauma, which can result in prolonged apnoea and/or respiratory and cardiorespiratory arrest.

       Under such circumstances, there are minimal findings at autopsy. In such a scenario, no purposeful movements would take place following a fatal concussive blow. This does not preclude fitting type movements in the setting of increasing cerebral hypoxia.

b) The second possible scenario was that of prone restraint asphyxia in the setting of alcohol intoxication and centripetal obesity. In this scenario, someone of Jesse's body habitus being placed in a prone position while intoxicated can result in physiological hypoventilation which may result in death. There are no specific diagnostic findings in such a scenario, ie. autopsy findings are minimal and non-specific.

44. Taking into account the information which was available to her at the time, Dr Iles was unable to elevate one cause above the other and so provided an opinion that a reasonable formulation for the medical cause of death was, '1(a) Unascertained.'

Supplementary report dated 22 August 2019

45. On 22 August 2019, Dr Iles provided a supplementary report after reviewing additional materials provided by the Homicide Squad, as follows:

a) Two CCTV footage files titled "Barrels Night Club";

b) Four CCTV footage titled "Swan Hill Council footage";

c) Summary logs from CCTV footage labelled "Barrels" and "Swan Hill Council Log";

d) Statement of witness, Mr Brandon Aumann dated 15 July 2019.

46. Following review of the additional materials, Dr Iles provided the following analysis:

The video footage indicates that JE [Jesse Edwards] was on the ground in a prone or semi prone position with one or more individuals kneeling or standing above him for a period of time. It is not apparent from this video footage whether there is anything placed around JE's neck, nor is the position of JE's head apparent, particularly with reference to anything obstructing his mouth and nose. What is however apparent by the swinging leg movements that these are purposeful movements and not movements observed in the setting of seizure activity, for example in the setting of terminal hypoxic ischaemic brain injury.

Furthermore, based on the statement provided by [witness] Mr Aumann, it is clear that Mr Edwards engaged in purposeful activity i.e. saying "get me up, get me up" and walking over to where his brother and other people were arguing, following the alleged punch to his face described at point 9 of Mr Aumann's statement. Based on the video footage and this witness statement, the possibility that Mr Edward's death

is due to commotio cerebri/medullaris (cardiorespiratory arrest immediately following blunt head trauma in the setting of alcohol intoxication) is ***excluded****.*

Furthermore, according to Mr Aumann's statement, he indicates at point 19 that Mr Edwards was on his stomach and individual Steve is on top of him in a bear-hug position lying on his back. At point 32 and 33 of his statement, it is indicated that Mr Edwards was gasping for breath after being kicked in the stomach area whilst lying on the ground. Following this, Mr Edwards was reportedly trying to breathe (gasping) and trying to get air back in. Following this, he stops struggling in trying to get himself up.

As per autopsy report dated 24 April 2019, no anatomical cause of death is identified at autopsy. Mr Edwards' cause of death was given as unascertained. Given the autopsy findings, ie. the absence of an anatomically demonstrable cause of death, at points 9 through to 12, potential causes of death are discussed. These are considered potential cause of death given the circumstances as described (albeit variably in witness statements) and the absence of any specific findings at autopsy to indicate another cause of death. As above, the scenario involving blunt head trauma in the setting of alcohol intoxication is ***excluded*** *based on this video footage and witness statement.*

The second scenario raised is that of ***prone restraint asphyxia in the setting of alcohol intoxication and centripetal obesity****. In my opinion, based on autopsy findings, witness statement and video footage I have observed, this appears to be the most likely cause of Mr Edwards' death. However this opinion is based on the totality of autopsy findings, the video footage that I have observed and witness statements that I have been provided with. The shortcomings and variable reliability of the latter components is acknowledged. However, based on the totality of information available to me at this time, there is no other reasonable conclusion that can be drawn.*

47. Taking into account all available information, including advice provided by Dr Iles, I am satisfied to the requisite standard that the medical cause of death was: '*1(a) Prone restraint asphyxia in the setting of alcohol intoxication and centripetal obesity.'*

POLICE INVESTIGATION

48. Upon arrival at the scene, Victoria Police members established a crime scene and immediately commenced investigations.

49. As part of this investigation:

    a) Victoria Police Major Crime Scene Unit conducted an examination of the scene which was documented through photographs and video recording.

    b) CCTV footage was seized and reviewed from Swan Hill Council, Barrell's Nightclub, Voyage Fitness, Syd Wilson Electrics, Swinton's Home Maker Centre, and the Commercial Hotel. This footage depicted various stages of the events leading to Jesse's passing.

    c) Statements were obtained from all relevant individuals, including witnesses and persons involved in the fight.

Criminal proceedings

50. Following police investigations, a number of persons involved in the fight were charged and convicted of related offences:

    a) On 9 November 2020, Dylan Edwards was convicted of affray and other offences at Swan Hill Magistrates Court and placed on a Community Corrections Order for 12 months.

    b) On 3 December 2019, Troy Magnusson was found guilty of the offence of affray and other offences at Swan Hill Magistrates Court without conviction and fined $2000.

    c) On 18 February 2020, Matthew Guy was found guilty of the offence of affray at Swan Hill Magistrates Court without conviction and fined $1200.

51. In relation to Jesse's passing, Mr Bartalotta was charged with one count of negligent manslaughter on 18 June 2020.

52. On 21 June 2021, a contested committal was heard before Her Honour McRae at Swan Hill Magistrates Court. Evidence was heard over three days. At the conclusion of evidence, Counsel for Mr Bartalotta made an application for discharge which was opposed by the Crown.

53. Following deliberation, Mr Bartalotta was discharged by Her Honour McRae on 24 June 2021.

54. An internal review conducted by the Office of Public Prosecutions decided against directly presenting Mr Bartalotta and criminal matters were completed.

FAMILY CONCERNS

55. Throughout the coronial investigation, Jesse's family raised several concerns including:

    a) Dissatisfaction with regard to the outcome of criminal proceedings against Mr Bartalotta;

    b) Concern with regard to repeated and ongoing violence at the site of Jesse's passing, ie. the footpath on Campbell St, Swan Hill between the Commercial Hotel and Barrell's Nightclub; and

    c) The need to ensure that security licence holders receive sufficient training to prevent unnecessary deaths from positional asphyxia.

56. These concerns have been carefully considered and are addressed in turn below.

The outcome of criminal proceedings

57. As noted above, Victoria Police pursued charges of negligent manslaughter against Mr Bartalotta, although these were subsequently discharged by Her Honour McCrae following a contested committal hearing. This outcome has been the source of significant distress to Jesse's family.

58. After reviewing the coronial brief compiled by Coroner's Investigator, Sergeant Simpson, I am satisfied that Victoria Police conducted a comprehensive and thorough investigation – including through taking statements from all relevant witnesses and reviewing all available CCTV footage.

59. Through the course of my investigation, I have not identified any new facts or circumstances which would cause me to form a belief that an indictable offence may have been committed in connection with Jesse's passing. As such, I am satisfied there is no basis for any notification to the DPP.

Repeated and ongoing violence at the location of Jesse's passing

60. There is no evidence to suggest that the altercation which led to Jesse's passing arose as a result of issues which related to that specific location.

61. It is almost trite to note that the circumstances of this altercation may relate to broader social issues that commonly play out in concentrated areas of licensed premises and are related to alcohol consumption, and violence, however I do not consider that these social issues emerged in such a singular way as to warrant further investigation in this matter.

Training for existing security licence holders in relation to positional asphyxia

62. Jesse's family raised concerns that Mr Bartalotta had not undertaken adequate training with regard to the safe use of restraint techniques or the risks of positional asphyxia.

63. At the relevant time of the incident, Mr Bartalotta had maintained a crowd controller, security guard and unarmed guard licence since 2007. His most recent renewal was in March 2019.

64. Taking into account my finding that Jesse's passing was caused by prone restraint asphyxia in the setting of alcohol intoxication and centripetal obesity, I am satisfied that restraint was one factor which contributed to Jesse's passing.

65. Further, I am satisfied that there is a sufficient causal link to warrant investigation and comment with regard to the appropriateness of training requirements for security personnel in relation to safe use of restraint techniques.

66. In considering this issue however, I am not satisfied to the requisite standard either that:

    a) Mr Bartalotta's use of restraint departed materially from the standards of his profession; or

    b) Mr Bartalotta's use of restraint would have caused Jesse's passing in the absence of other contributing factors, namely, alcohol intoxication and centripetal obesity.

67. Nonetheless, I consider that the circumstances of Jesse's passing may provide an opportunity to improve public safety.

68. The adequacy of training for security officers regarding safe use of restraint techniques has been previously considered across numerous other investigations and reviews.

69. In 2016, a review was undertaken by the Australian Skills Quality Authority (ASQA) into training in security programs (**the ASQA review**). This review was initiated in response to repeated concerns raised by coroners across various Australian jurisdictions, following incidents in which a patron had died during restraint or intervention by security personnel.

70. Coroners had repeatedly suggested that inadequacies in training may be a contributing factor to fatalities, observing that:

    a) *'People working in the security industry should be required to complete a revised competency module dealing with restraint asphyxia in order to renew their licence'*[5]

    b) *'The standard and quality of the training given to security guard applicants varies considerably from jurisdiction to jurisdiction.'*[6]

    c) *'Security guards can be trained interstate and then seek to be registered in New South Wales under the Mutual Recognition Act 1992. This in my view leaves a system that is open to abuse and can result in people with insufficient training being employed in this state and ... ultimately putting lives at risk.'*[7]

    d) *'It cannot be over-emphasised that guards, security officers and others need to fully understand that positional asphyxia can occur when a person is restrained ... in a prone, face down position.'*[8]

    e) *'There was no requirement to be examined or observed in any sort of real environment ... The current training is classroom based ... Consideration should be given to requiring a crowd controller to first receive a probationary license ... [and be] observed ... in his/her workplace on at least one occasion.'*[9]

71. The ASQA review found that there was deficiency in the training package in relation to explicitly addressing the risks and dangers of restraints and the safe use of restraint techniques. The ASQA review also supported findings by coroners that deficiencies in training and

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[5] Office of the State Coroner (24 November 2014), Findings of Inquest into the death of Stephen Arthur Nash, pp. 26-27.
[6] Coroner's Court of NSW (8 December 2011). Inquest into the death of Paul Ahsin.
[7] Ibid.
[8] Coroner's Court of Victoria, State Coroner Judge Gray (27 March 2015) Inquest into the death of Anthony William Dunning.
[9] Coroners Court of Victoria, State Coroner Judge Coate, (5 October 2011), Inquest into the death of Jerry Karamesinis.

assessment were potentially contributing to fatalities, and raised a concern that security licensees should be required to maintain the currency of such critical skills and knowledge.

72. The final ASQA review report included the following recommendation:

> ***Recommendation 5:*** *It is recommended that:*
>
> - *In its review of the Certificates II and III in Security Operations, the training package developer specifically reviews the relevant units of competency relating to restraints and the use of restraint techniques, in order to ensure these explicitly embed knowledge and skill requirements to sufficiently address key safety issues such as positional asphyxiation.*
> - *Licensing authorities in all jurisdictions identify—and include as mandatory in the nationally agreed single set of competency standards—the most appropriate unit/s of competency to ensure security licensees meet the knowledge and skill requirements relating to restraints and the safe use of restraint techniques.*
> - *Licensing authorities in all jurisdictions require all relevant current security licensees to refresh their skills and knowledge of safe restraint techniques prior to renewing, or re-applying for, their licence. The exact requirements should be determined in collaboration with industry and be consistent across all jurisdictions.*

73. On 23 October 2018, the Victorian Government commissioned a further review of the Private Security Industry **(the Victorian Review**). The Victorian Review involved extensive consultation with stakeholders and analysis of more than 50 submissions. It was completed in December 2021.

74. A key issue considered by the Victorian Review was the quality of training including with regard to safe use of restraint techniques and de-escalation skills.

75. The Victorian Review noted that an updated training package implemented in July 2020 had included improvements in this regard.

76. Under current arrangements, an applicant who wishes to obtain a private security licence must complete the relevant CPP20218 Certificate II training in Security Operations (Certificate II)

through an approved Registered Training Organisation (**RTO**). The Certificate II training consists of 14 units of competency delivered over 130 hours, incorporating various LRD approved topics, including training on the risks associated with positional asphyxia and safe use of physical restraint techniques.

77. More specifically, the 'Apply Security Procedures to Remove Persons from Premises' unit contained in Certificate II requires a student to demonstrate:

    a) knowledge of adverse health effects from the use of restraint, the signs of positional asphyxiation, and how to escort a person from premises using safe and suitable restraint;

    b) knowledge of negotiation techniques and how they can be used to defuse and resolve conflict.

78. It is hoped that this unit of competency will increase the skills of future security personnel and reduce the risks of unsafe restraint techniques.

79. However, as noted in the Victorian Review, the benefits of the new training package will be limited, as the requirements only apply to new applicants rather than existing licensee holders.

80. This is part of a broader issue, whereby existing licensee holders are not required to undertake refresher training upon renewal of their licences, other than refresher training in first aid and cardio-pulmonary resuscitation.

81. In response to this issue, the Victorian Review final report included the following recommendation:

> ***Recommendation 8:*** *That prior to licence renewal, applicants should be required to undertake refresher training with an LRD-approved RTO.*

82. Following the completion of the Victorian Review, the Victorian Government committed to implementing the recommendations made in the Final Report and to consulting as widely as possible with regard to implementation.

83. Recommendation 8 in particular has been endorsed by:

    a) The Department of Justice and Community and Safety;
    b) The Victorian Security Industry Advisory Committee;

c) The Licensing & Regulation Division (**LRD**) of Victoria Police;

d) Australian Security Industry;

e) Security Providers Association;

f) Security Trainer Association;

g) United Worker Union; and

h) Victoria Security Institute.

84. To support ongoing work in this regard, I have determined to include a recommendation directed to the Licensing & Regulation Division (**LRD**) of Victoria Police.

85. In a statement to the Court dated 12 December 2023, the LRD indicated that it was supportive of the recommendation as formulated below.

FINDINGS AND CONCLUSION

86. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

a) the identity of the deceased was Jesse Lee Christopher Edwards, born 27 May 1998;

b) the death occurred on 19 January 2019 at 117 Campbell Street, Swan Hill, New South Wales, 3585, from unascertained causes; and

c) the death occurred in the circumstances described above.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendation:

(i) That Victoria Police Licensing & Regulation Division (**LRD**) establish a requirement that prior to licence renewal, existing security licence holders must undertake refresher training with an LRD-approved Registered Training Organisation, including with regard to the safe use of restraint techniques and the risks of positional asphyxia.

I convey my sincere condolences to Jesse's family for their loss.

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

Daniel Edwards And Christine Donaczy, Senior Next of Kin, C/- Siobhan Doyle, Victorian Aboriginal Legal Service

Chief Commissioner of Police, C/- Georgie Austin, Wotton Kearney

Victoria Police Licensing & Regulation Division

Mehnaz Mahmood Sait, Koori Victims of Crime Assistance Tribunal

Sergeant Kyle Simpson, Coroner's Investigator

Signature:

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Coroner Leveasque Peterson

Date : 08 July 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.