Court Reference: **COR 2019 000968**

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

INQUEST INTO THE DEATH OF GEORGE DIAMOND

Findings of:	Judge John Cain State Coroner
Delivered on:	19 September 2024
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria, 3006
Inquest Hearing Dates:	4 - 6 June 2024

Counsel Assisting:	Dr Gideon Boas of Counsel instructed by Ms Abigail Smith, Senior Coroner's Solicitor, Coroners Court of Victoria

REPRESENTATION

Peninsula Health	Mr Robert Harper of Counsel instructed by HWL Ebsworth
Four Wise Men trading as Sting Gym	Ms Roisin Annesley KC with Mr Dan Wallis, instructed by Wotton Kearney
Dr Pejman Hajbabaie	Mr Paul Halley instructed by Kennedys
The Diamond Family	Mr Chris Winneke KC with Ms Andrea de Souza, instructed by Slater and Gordon

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INTRODUCTION

1. George Diamond was 18 years of age when he died on 21 February 2019 at the Alfred Hospital as a result of complications of acute chronic subdural haemorrhage sustained in a boxing (sparring) activity.

2. George was a much-loved son of Vic and Shayna Diamond and the oldest of five children in a very close family. He lived with his parents and his four siblings, and next door to his grandfather. George was employed as an apprentice carpenter and was known to be a committed and dedicated worker.

3. In his coronial impact statement to the Court, George's father said the following:

> '*George was a second-year apprentice carpenter. He never missed one day of work. He didn't like school much, but he loved his work. George was a very happy young man who loved life. He loved his family. We are a very close family, and he loved his friends. He was the oldest of our five children and the siblings are extremely close. They really looked up to George'*.[1]

THE PURPOSE OF A CORONIAL INVESTIGATON

4. George's death constitutes a 'reportable death' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and the death appears to have been unnatural and unexpected.

5. The jurisdiction of the Coroners Court of Victoria is inquisitorial. The role of the coroner is to independently investigate reportable deaths to ascertain, if possible, the identity of the deceased, the cause of death and the circumstances in which death occurred.

[1] T 338.

6. It is not the role of the coroner to lay or apportion blame, but to establish the facts. It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

7. The expression 'cause of death' refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

8. For coronial purposes, the phrase 'circumstances in which the death occurred' refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and casually relevant to the death.

9. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's 'prevention' role.

10. Coroners are also empowered to:

    a) report to the Attorney-General on a death;

    b) comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

    c) make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health and safety or the administration of justice.

11. These powers are the vehicle by which the prevention role may be advanced.

12. All coronial findings must be based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in

Briginshaw v Briginshaw.[2] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

13. The proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved.[3] Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences; rather, such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[4]

14. Victoria Police assigned Detective Acting Sergeant (**D/A/Sgt**) Denai Fitzpatrick to be the Coroner's Investigator for the investigation into George's death. D/A/Sgt Fitzpatrick conducted inquiries on my behalf and submitted a coronial brief of evidence.

15. This finding draws on the totality of the material obtained in the coronial investigation of George's death, that is, the material on the court file, the coronial brief, further material including expert reports obtained by the Court, together with the transcript of the evidence adduced at inquest and the submissions of Counsel Assisting and the interested parties.

16. In writing this finding, I do not purport to summarise all of the material evidence but refer to it only in such detail as appears warranted by forensic significance and narrative clarity. It should not be inferred from the absence of reference to any aspect of the evidence that it has not been considered.

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[2] (1938) 60 CLR 336.

[3] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.

[4] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at pp 362-3 per Dixon J.

17. With an investigation of this magnitude, it is appropriate that I acknowledge the significant work of all who were involved in assisting me.

18. I thank D/A/Sgt Fitzpatrick, the Coroner's Investigator in this investigation who compiled a comprehensive coronial brief that was of great assistance.

19. I thank Counsel Assisting, Dr Gideon Boas and the counsel and solicitors who represented the interested parties, for their work and comprehensive submissions.

20. I also acknowledge and thank Ms Abigail Smith, Senior Solicitor at the Coroners Court of Victoria who has worked diligently and provided me with invaluable assistance throughout the inquest.

INQUEST

21. I convened the Coroners Court of Victoria for the inquest on 4 - 6 June 2024 (inclusive).

SCOPE OF INQUEST

22. The scope of inquest was finalised on 20 May 2024 pursuant to section 64(b) of the Act, as follows:

    1) The cause/s and circumstance/s of George's death.

    2) The medical management provided to George by Dr Pejman Hajbabaie at the Pearcedale Medical Centre in respect of the boxing sparring injuries that he sustained on 25 October 2018.

    3) The appropriateness of the decision made by Dr Pejman Hajbabaie to clear George to return to boxing on 25 January 2019.

    4) The medical management of George by Dr Yigal Reuben and Frankston Hospital Emergency Department (**ED**)/Peninsula Health on 5 November 2018.

23. In determining the scope of inquest, consideration was given to including the regulatory arrangements for amateur boxing and combat sports in Victoria. In the *coronial inquest into the death of Shane Tuck (COR 2020 003895)* (**Tuck Inquest**), I considered the regulatory structure of professional and amateur boxing in Victoria and issues associated with head injuries in boxing including concussion as well as Chronic Traumatic Encephalopathy (**CTE**).

24. In Victoria, the professional boxing and combat sports industry is regulated pursuant to *Professional Boxing and Combat Sports Act 1985* and the *Professional Boxing and Combat Sports Regulations 2018*. There is no formal relationship between professional boxing and amateur boxing in Victoria.

25. The legislation does not give the Professional Boxing and Combat Sports Board (**the Board**), any power to oversee amateur boxing organisations and it does not regulate amateur boxing in Victoria save for any contest or exhibition that is conducted for profit where there is a monetary reward or an admission fee.

26. In this regard, amateur boxing in Victoria is self-regulated and oversight is provided by amateur boxing organisations which obtain their recognition from the relevant Minister.

27. These organisations are responsible for amateur boxing activities in Victoria including the training and accreditation of amateur boxing coaches, judges and referees, the registration of boxers, coaches and officials and the enforcement of safety standards in the sport.

28. In the Tuck Inquest, the Department of Jobs, Skills, Industry and Regions (**DJSIR**) advised the Court that the Victorian Government had funded a review of the Board's regulatory framework and any reforms required to ensure that it is empowered to adequately address participant safety. In light of the evidence elicited from the Tuck Inquest, I directed two recommendations (14 and 17) to DJSIR which can be summarised as follows:

a) extend the terms of reference for the regulatory review to include a review of the oversight and regulation of amateur boxing and combat sports in Victoria; and

b) recommend that the training and education regimes in amateur and professional boxing and combat sports, be aligned and standardised, and that the review be extended to the protection of participants, particularly of minors participating in boxing.

29. In the lead up to this inquest, I invited DJSIR to provide an update on their response to Recommendations 14 and 17 from the Tuck Inquest.

30. On 31 May 2024, the Secretary to DJSIR wrote to me to advise that:

> '*DJSIR has appointed KPMG to conduct the Regulatory Review of professional and amateur boxing and combat sports in Victoria, which includes an examination of competition and training settings.*'[5]

31. In light of section 7 of the Act, which requires me to avoid duplicating other inquiries, I determined that the scope of inquest would not be broadened to include the regulation of amateur boxing and combat sports in Victoria. I also suggested that George's family may be interested in sharing their insights and experience with KPMG as part of the regulatory review. I understand that contact has been arranged by KPMG with George's family. A copy of this coronial finding will also be provided to KPMG.

INTERESTED PARTIES

32. Five interested parties were granted leave to appear at the inquest. They were:

- George Diamond's Family.
- Peninsula Health.

[5] See letter from the Secretary Department of Jobs Skills Industry and Regions dated 31 May 2024.

- Four Wise Men Pty Ltd, trading as Sting Gym.
- Dr Pejman Hajbabaie.
- Dr Yigal Reuben.

EVIDENCE

33. A coronial brief was prepared by the coroner's investigator containing witness statements and exhibits, including material from the forensic pathologists. The coronial brief was then supplemented with additional records, witness statements, expert reports and material from the Victorian Amateur Boxing League.

34. At inquest, viva voce evidence was heard from four witnesses:

- Vic Diamond - George's father.
- John Paule - Boxing trainer and co-owner of Sting Gym.
- Dr Pejman Hajbabaie - General Practitioner (**GP**) at Pearcedale Medical Centre.
- Dr Yigal Reuben - Specialist Emergency Physician at Peninsula Health.

35. In addition, I heard expert evidence from five witnesses, as follows:

- Dr James Lynch – General Practitioner at Doctors of Northcote.
- Dr Martine Walker – Specialist General Practitioner.
- Associate Professor (**A/Prof**) Anna Holdgate – Specialist Emergency Physician.
- A/Prof John Raftos – Specialist Emergency Physician.
- Professor (**Prof**) Paul D'Urso – Consultant Neurosurgeon.

36. The expert witnesses (other than Dr Walker) gave evidence concurrently. Dr Walker gave evidence separately as she was unavailable at the time the expert panel convened.

37. Following the inquest, Counsel Assisting and Counsel for all interested parties provided written submissions. In writing this finding, I have considered all of the evidence and the submissions of the interested parties.

38. I also received a coronial impact statement from Vic Diamond, on behalf of his family, which he read on the last day of the inquest in open court. I am very grateful to Mr Diamond for providing me with the coronial impact statement which enabled me to better understand more about George and the family and the enormous loss and pain that the whole family have felt since George's passing.

The sport of boxing

39. In his opening remarks, Counsel Assisting made reference to some general comments of A/Prof Raftos from his report about the sport of boxing. These comments provide relevant context and bear repeating here:

> '*Boxing is a contact sport whose primary aim is to render the opponent unconscious by striking blows to his or her head. Since the introduction of the Marquess of Queensberry's Rules governing modern boxing in 1867 there have been more than 1,800 recorded deaths following a boxing match. When the head is struck a blow, the skull accelerates away from the blow. The brain also accelerates but slower than the skull so that the brain impacts on the skull. The differential movement of the brain and skull also strains blood vessels that connect the two with the potential to tear those vessels causing haemorrhage either into or around the brain. Most deaths following a boxing injury involve a subdural haemorrhage and/or contusion swelling of the brain.*
>
> *Second impact syndrome also known as second concussions syndrome, is a well-documented phenomenon in which an individual, usually a young person, suffers a*

rapid and often fatal cerebral oedema or brain swelling in response to a blow to the head before concussion symptoms from an earlier blow have subsided.'[6]

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

Identity of the deceased, pursuant to section 67(1)(a) of the Act

40. On 21 February 2019, George Diamond born 22 June 2000, was visually identified by his father, Vic Diamond.

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

Scope of inquest, Issue 1 – Cause and circumstances of George's death

Medical cause of death, pursuant to section 67(1)(b) of the Act

42. On 26 February 2019, Dr Melanie Archer, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an autopsy and provided a written report of her findings dated 2 August 2019.

43. In her report Dr Archer made the following comments:

    a. Death was caused by a subdural haemorrhage, which is bleeding under the fibrous outermost membrane surrounding the brain (the dura). This occurred in the setting of martial arts activity, which comprised warmup exercises and a sparring bout.

    b. The deceased's collapse on 18 February 2019 was caused by an acute (fresh) subdural bleed. When the volume of a subdural haemorrhage is sufficient, it can apply pressure to the brain and lead to loss of coordination, seizures, collapse and central nervous system depression.

[6] Statement Associate Professor Raftos, CB 1, Tab 19.

c. Neuropathology examination confirmed severe and irreversible brain injury, which developed despite surgical attempts to intervene. This brain injury was caused by the direct effects of the subdural haemorrhage and its complications (e.g. infarction of brain tissue and secondary haemorrhage).

d. Neuropathology examination also demonstrated that there was not only an acute subdural haemorrhage, but there was also evidence of an older subdural haemorrhage. Neuropathology demonstrated chronic subdural membranes over parts of the left and right sides of the brain; membranes are analogous to scar tissue laid down under the dura over the weeks and months following a subdural haemorrhage. These membranes cannot be aged with certainty, and the neuropathology report states that this membrane was "mature and is indicative of past injury".

e. Subdural haemorrhage is often caused by traumatic tearing of the "bridging veins" between the brain surface and the dura. Tearing results from motion of the brain within the skull due to force applied to the head (such as after a fall with a headstrike, or due to a punch, or a kick).

f. The amount of trauma required to cause subdural haemorrhage can be substantially reduced or even "trivial" in those with a risk factor for subdural haemorrhage. Subdural haemorrhage can occur more easily in persons with a bleeding disorder, or those taking anticoagulant or antiplatelet medications (there was no evidence that these risk factors applied to the deceased). Brain infection can also increase susceptibility to haemorrhage. However, autopsy showed no evidence of this.

g. Subdural haemorrhage can also occur more easily in those who have had a previous subdural haemorrhage due to the phenomenon of "re-bleeding", which appears to have occurred in this case due to the finding of a chronic subdural

membrane. It was noted in the neuropathology report that "…rebleeding can occur within chronic subdural membranes, either spontaneously, or in the setting on relatively minor trauma. This can cause catastrophic collapse if this rebleeding event is associated with substantial mass effect".

h. The deceased reportedly sustained a symptomatic head injury in November 2018 during the practice of martial arts. Subdural haemorrhage could have occurred in this context. However, it is not possible to determine when the chronic (old) subdural haemorrhage occurred.[7]

44. Further, Dr Linda Iles, Head of Forensic Pathology at Victorian Institute of Forensic Medicine, provided a neuropathy report dated 9 July 2019. Dr Iles commented that:

> '*Features demonstrate secondary ischaemic change and craniectomy herniation following craniectomy and evacuation of acute subdural blood clot. This has occurred on a background of chronic subdural membrane. This membrane is mature and is indicative of past injury. Rebleeding can occur within chronic subdural membranes, either spontaneously, or in the setting on relatively minor trauma. This can cause catastrophic collapse if this rebleeding event is associated with substantial mass effect.* '[8]

45. Dr Archer formulated the cause of death as *complications of acute chronic subdural haemorrhage (operated) in the setting of martial arts activity*.

46. I accept Dr Archer's opinion as to the cause of death.

<u>Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act</u>

[7] Dr Melanie Archer report dated 2 August 2019 CB1 Tab 2.
[8] Dr Linda Iles report dated 9 July 2019 CB1 Tab 4.

47. On 7 July 2018, George joined Sting Gym, which was located at 6A Universal Way, Cranbourne West.[9] George's father said:

> '*George was a healthy and fit 18-year-old man. He was an apprentice builder and had started at a gym to be fit and healthy. George had recently lost a bit of weight through exercise and good eating but had no health concerns. Around July 2008, George started training at Sting Gym in Cranbourne. George had a membership there*.'[10]

48. Sting Gym was owned by four partners - John Paule, Urich Simpson, Ryan Jones and Michael Vukovic.[11] Mr Paule was the boxing trainer at Sting Gym at the time that George was a member. Mr Paule has been a licensed and registered boxing trainer with the Victorian Amateur Boxing League (**VABL**) for more than 12 years. He was also previously an amateur boxer, a two-time national champion and Victorian champion.[12]

49. Sting Gym organised for its members to fight in contests under the auspices of the VABL from time to time. The VABL is a recognised amateur boxing association pursuant to the *Professional Boxing and Combat Sports Act 1985*.[13]

50. In his statement to the Court, Mr Paule stated that George had joined the gym for fitness, but as he showed talent and interest in boxing, George began to participate in boxing training, including regular sparring at Sting Gym.[14]

<u>First incident</u>

[9] Membership agreement & indemnity form dated 9 July 2018 and Transcript, 4 June 2024, p 16.27.
[10] Statement of Vic Diamond, CB 1, Tab 6.
[11] Statement of Michael Vukovic, CB 1, Tab 8.
[12] T 143.
[13] Letter from Professional Boxing and Combat Sports Board dated 7 January 2022 and letter from Minister for Sport and Recreation dated 18 December 2003.
[14] Statement of John Paule, CB1 Tab 9.

51. On 25 October 2018, George was participating in a live sparring session with another gym member when he received a blow to his groin area and, immediately thereafter, several blows to his head. He fell to the floor, experiencing at least dizziness and discomfort. Mr Paule, who was present on the evening, says that he did not see the incident but spoke to George afterward and provided him with a drink.[15]

Finding 1

On 25 October 2018 George was engaged in live sparring and was struck in the groin and, immediately thereafter, he was struck several times to the head.

52. At inquest, Mr Paule also gave evidence to the effect that he assessed George for concussion but was unable to provide any clear evidence as to what that assessment might have constituted. He also told the Court that he had limited first aid training, which did not include any specific training concerning concussion.[16]

53. George was offered a lift home by Mr Paule but declined and drove himself home that evening.[17] At home, George reported to his father, Vic, that he was suffering from nausea, a headache and a sore back. Vic recalled that George took Panadol and Nurofen that night and that he and his wife checked on him regularly overnight to ensure he was alright.[18]

54. Sting Gym provided the Court with a photograph of a diary entry from 25 October 2018 which provides a narrative of the incident, as follows:

> '*George hit in testicles during sparring, felt a bit dizzy afterwards, so I assessed him for concussion. He seemed fine after a drink and rest*'.

[15] T 85 and Statement of John Paule, CB1 Tab 9.
[16] T 86.
[17] Statement of John Paule, CB1 Tab 9.
[18] T 21 & T 71.

55. Mr Paule did not recall making the diary entry but acknowledged that it was his handwriting.[19] Mr Paule also gave evidence that he is unable to account for the whereabouts of the diary.[20]

Consultation with Dr Tayebeh Kazerouni – 26 October 2018

56. The following day, George went to work, but he was unwell and vomiting and was sent home by his boss. Vic took George to the Pearcedale Medical Centre that afternoon where he attended GP, Dr Tayebeh Kazerouni.

57. According to the medical records, Dr Kazerouni recorded that George had head trauma while boxing the previous night and now had a headache and mild swelling in temple on left side, no reported diplopia, seizures or loss of consciousness, no neck tenderness and normal reflexes and balance, his pupils were reactive to light with normal visual acuity. It was noted that George had vomited after head trauma but returned to work. Dr Kazerouni discussed 'red flags' with George and his father with instructions to "review if any red flags" and diagnosed George with concussion.[21]

Consultation with Dr Pejman Hajbabaie – 31 October 2018

58. Six days later, on 31 October 2018, George returned to Pearcedale Medical Centre where he attended another GP, Dr Pejman Hajbabaie. It was recorded in Dr Hajbabaie's notes of that visit that George's head injury was not getting better, that his "obs" were stable without neurological symptoms, that he had developed lumbar back pain, no neurological deficient was detected, reg flags were discussed and he was sent for bloods (related to requirements to engage in amateur boxing bouts) with instructions to return in five days for review.[22]

[19] T 88.
[20] T 88.
[21] CB, Exhibit Folder 1, Medical Records, 1-15, 16.
[22] CB, Exhibit Folder 1, Medical Records, 1-16, 17.

59. George's father recalled George being prescribed Panadol, Nurofen, and another anti-inflammatory medication specifically for the back pain.[23] The clinical notes record a prescription of Naprosyn[24] and Panadeine Extra.[25] The clinical notes made on 31 October 2018 also recorded a request for blood tests, although the records do not document the reason for those tests.[26]

60. On 1 November 2018, George attended the clinic to have blood samples collected. These were Human Immunodeficiency Virus (HIV) antibody/antigen combo and Hepatitis serology serum tests.[27] Those test results were later used by George in his return to boxing. From a review of the available evidence, it is reasonable to conclude that, as of 31 October 2018, George intended to return to boxing.

Presentation to Frankston Hospital – 5 November 2018

61. George's next medical presentation was at the Frankston Hospital ED on 5 November 2018. George was assessed by Dr Yigal Reuben, Specialist Emergency Physician.

62. Dr Reuben stated that he had an independent recollection of George presenting to the ED. At Inquest, he stated that George was walking and talking and there were no obvious signs which would indicate that he should have been concerned about George.[28]

63. The medical notes of that visit indicate that George complained of '*ongoing headache, worse in the morning, few vomits on the first day, vomit today, otherwise well, nil seizures/confusion/focal neurology*'.[29] George also reported worsening back pain radiating down to his posterior thigh in both legs.[30]

[23] Statement of Vic Diamond, CB 1, Tab 6.
[24] Naproxen, a nonsteroidal anti-inflammatory.
[25] Paracetamol and codeine phosphate.
[26] Clinical Notes of Pearcedale Medical Centre 31 October 2018.
[27] Clinical Notes of Pearcedale Medical Centre 31 October 2018.
[28] T 193.
[29] Coronial Brief, Exhibit Folder 1, Medical Records, 2-26.
[30] Coronial Brief, Exhibit Folder 1, Medical Records, 2-31.

64. Dr Reuben explained that he performed a screening peripheral neurological examination,[31] as well as chest and abdominal examinations and an examination of George's back.[32] Of note, Vic Diamond says he asked and '*begged*' Dr Reuben to undertake a CT scan or MRI but that Dr Reuben told him it was unnecessary and the radiation of a CT scan would not be good for George.[33] Dr Reuben accepted that he was pressed to undertake a scan on George but advised that his '*guiding principle*' is that if he does not think a test is going to change his management of a patient, he does not perform the test, particularly if that test has risks, including the risk of cancer from radiation from a CT brain scan.[34] Dr Reuben considered that the risk of a CT brain scan outweighed any potential benefits.[35]

65. Dr Reuben diagnosed George with 'Intracranial injury (includes concussion)'.[36] Dr Reuben advised George and his father that if George had ongoing symptoms, he should return to the ED and that he should not return to boxing until he was medically cleared by his GP as he had a '*high risk of having a severe or worsening injury or delayed recovery should he suffer another head injury in a short space of time*'.[37]

Sting Gym membership suspension

66. On the day of his presentation to Frankston Hospital ED (5 November 2018), George sent a text message to Mr Paule which stated that:

[31] T 188.26-27.
[32] Statement of Dr Reuben, CB 1 Tab 13 p 2.
[33] CB 1, Tab 6 p 3.
[34] T 195.
[35] CB 1 Tab 13 p 2.
[36] CB 1, Medical Records, 2-25.
[37] T 197.

> '*[I] was in hospital today getting a scan done my headache had still not gone away they said there was small amount of bleeding to the brain and [they're] not sure how long it will take before I feel alright again but said not to participate in any sport until I feel 100%'.*

67. In a further text message, George also advised Mr Paule that he would not be able to participate in boxing or sparring for a few weeks and Mr Paule indicated that he would pull George out of an upcoming exhibition fight to make sure that he did not '*do anymore damage*'.[38]

68. Following this exchange of text messages, it appears that an entry was made in the Sting Gym incident diary which restates the information that George had provided Mr Paule by text and that George's membership was to be suspended.[39]

69. Suspension of George's membership occurred on 16 November 2018. This was not unusual given that George was not training and was not using the boxing gym. His membership was reinstated on 11 January 2019.[40] Mr Vukovic stated that the suspension was due to George's having been struck in his groin and having complained about headaches. Mr Vukovic also stated that Mr Paule had requested the suspension.[41]

70. The evidence supports a conclusion that the owners and operators of the boxing gym were aware that George was suffering from a concussion which arose out of the sparring session on 25 October 2018.

71. Whilst Mr Paule did not mention any specific protocol or guidelines for the management of George's concussion, in general terms he seemed to know that George should avoid boxing training for a period of time and should act on medical advice, his return to

[38] CB, Exhibit Folder 3 – Messages from George's phone p 6 – 7.
[39] CB 2 Tab 26A p 1.
[40] Statement of Michael Vukovic, CB 1, Tab 8.
[41] Ibid.

fighting should be graduated and was conditional upon his obtaining a medical clearance.[42]

Sparring event at Doveton Boxing Club – 11 December 2018

72. What training or other activity (if any) that George undertook in late November and December 2018 was an issue relevant to the circumstances of George's death. As already noted, Mr Paule had suspended George's membership at Sting Gym around 5 November 2018 on the basis of George's message to him.

73. The evidence was initially unclear as to whether George attended and participated in a sparring contest at Doveton Boxing Club on 11 December 2018. Mr Paule initially did not agree that Geoge had attended.

74. However, in his third statement provided to the Court, close to commencement of the inquest, Mr Paule did concede that it was possible that George attended and sparred at the event. Indeed, the evidence strongly suggests that this was so. It also supports the conclusion that Mr Paule was present at the event and knew that George participated in sparring at the event. A Facebook post from Doveton Boxing Club on that date with three pictures of George sparring,[43] photographs on George's phone showed the same and were created on his phone on 11 and 12 December,[44] a text message exchange between George and Mr Paule indicating George was to attend that event,[45] and Mr Paule's evidence that he was present, supporting and watching all the Sting members sparring that night,[46] supports this conclusion.

[42] T 141.

[43] CB, Exhibit Folder 6.
[44] CB, Exhibit Folder 4, 1-13.
[45] CB, Exhibit Folder 3, 8.
[46] T 93.21, 94.15-17.

75. I am satisfied that on 11 December 2018, George attended a sparring event at Doveton Boxing Club. I have also concluded that whilst George attended and was engaged in sparring there is no evidence that he suffered any significant knock to his head or body at Doveton on 11 December 2018 that was causally connected to his death.

Appointment with Dr Pejman Hajbabaie – 25 January 2019

76. The final medical appointment under consideration in this inquest was on 25 January 2019 when George attended again upon Dr Hajbabaie. The purpose of the appointment was to receive his blood test results (taken on 1 November 2018) and have Dr Hajbabaie sign a VABL 'Certificate of Fitness' form that certified him fit to compete in amateur boxing contests.[47] Dr Hajbabaie stated in his evidence that he had no independent recollection of the appointment including signing the Certificate of Fitness form.[48]

77. At that appointment, Dr Hajbabaie recorded the HIV and Hepatitis test results, the only otherwise relevant notes indicated that George had attended '*to discussed [sic] results…form for competition filled as well*'.[49] The clinical notes do not refer to any ongoing symptoms, nor did George's father refer to his son complaining of any ongoing headaches, dizziness, vomiting or back ache at that time.[50]

78. At inquest, Dr Hajbabaie was asked questions about whether he reviewed previous medical notes at the appointment and/or the discharge summary from Frankston Hospital following George's attendance on 5 November 2018.

79. With respect to the previous notes, Dr Hajbabaie's evidence was that he did not document looking at any previous notes, but his usual practice is that he would, especially if he had been asked to complete a certificate, as occurred in this case. In relation to the discharge summary, Dr Hajbabaie's evidence was that upon reflection and in reviewing the medical

[47] CB 2, 29-1.
[48] T 151.
[49] CB, Exhibit Folder 1, Medical Records, 1-17.
[50] Statement of Victor Diamond, CB, Tab 6.

practice system at the medical clinic, he did not believe that he had seen the discharge summary and that it had already been 'checked' by Dr Kazerouni on 12 November 2018 who recorded that no further action was required.[51] Due to this, on 25 January 2019, there would not have been a notification or reminder on the main screen to alert Dr Hajbabaie that there was new correspondence or that this correspondence required action.[52] Dr Hajbabaie noted that the discharge summary was in the correspondence folder and that he did not access or review any information from that folder.[53]

80. In his first statement to the Court, Dr Hajbabaie stated that:

> '*I believe I would have asked him at the start of this consultation how he was going and George didn't report any ongoing concern…I might not have enquired specifically …as it had been over two months since he had come to me [with headache and lower back concerns].*'[54]

81. At inquest, Dr Hajbabaie gave evidence to the effect that if George was not complaining of any further signs or symptoms at the 25 January 2019 appointment, that he would not ask any further questions or conduct any additional examinations.[55]

Return to boxing

82. In late December 2018 or early January 2019, George returned to regular training.[56] Mr Paule says that George's training consisted of '*just bag work no sparring'*.[57] Mr Paule says that he would continue to do so until George had a medical certificate. I

[51] T 152; CB 1 Tab 15-4.
[52] CB 1 Tab 15-4 -5.
[53] Ibid.
[54] CB l 1, 12-3 (para 17).
[55] T 156:26-31; T157:1-3.
[56] Statement of Victor Diamond, CB 1, Tab 6.
[57] Statement of John Paule, CB 1, Tab 9.

note that the statements of Mr Paule and George's father are generally consistent as to the time that George returned to regular training at the boxing gym.

83. Following his appointment with Dr Hajbabaie on 25 January 2019, the evidence supports a conclusion that George increased the intensity of his training and, on 2 February 2019, participated in an exhibition contest which was conducted under the auspices of the VABL. A medical certificate was provided by Dr Pratap Phillip who examined George both before and after the bout and stated that the results were unremarkable.[58] There were no reports of any injury or difficulty recorded.

84. On 12 February 2019, George was able to spar at the XFC gym in Narre Warren. He made no complaint to any of the trainers at the gym, his parents or to any medical practitioner after participating in that activity. George's father stated that when his son came home from his training session, he did not appear to be '*too bad*'.[59]

The second incident

85. On 18 February 2019, George participated in a five-kilometre run organised by the boxing gym after work. George completed the run and went home to get his gloves, before attending the boxing gym that evening.[60]

86. The CCTV footage from Sting Gym for the training session that evening depicts the following:

- 18:13 - George entered the boxing gym and commenced skipping at 18:14 which he continued until 18:30.
- 18:35 - after wrapping his hands, George commenced sparring. He was wearing a black head and face protector, fastened with a Velcro flap at the rear.

[58] Certificate of Dr. P. Philip dated 2 February 2019; Statement of Dr. P. Philip dated 19 July 2021.
[59] Statement of Victor Diamond, CB 1, Tab 6.
[60] Ibid.

- 18:51 - George ceased his sparring and left the ring, moving to what appeared to be the weights area. George's legs appeared to be shaking, and he sat down heavily on a bench, and
- 18:52 – George gets up from the bench in an unsteady manner.[61]

87. After leaving the weights room through a glass exit door into the carpark, George stumbled backwards through the doorframe and collapsed to the ground. Gym members attended to him, and emergency services were contacted at 18:55.

88. At 19:04, Ambulance Victoria paramedics arrived on scene and found George to be in an unresponsive state.[62]

89. George was transported by ambulance to the Alfred Hospital where a CT scan of his brain demonstrated an *acute right convexity subdural haematoma with resultant mass effect*.[63]

90. George underwent surgery in the form of craniectomy, subdural haemorrhage evacuation, and intra-cranial pressure monitor device insertion. However, despite aggressive management, on 20 February 2019, nuclear medicine scanning demonstrated absent cerebral perfusion, indicating brain death. George's family were advised, and his life support was switched off.[64]

91. On 21 February 2019 at 5.30pm, George sadly passed away.[65]

Scope of inquest, Issue 2 – George's medical management by Dr Pejman Hajbabaie

Dr Hajbabaie's note taking

[61] CCTV footage from Sting Gym dated 18 February 2019.
[62] Ambulance Victoria VACIS ePCR #11277.
[63] Neuropathology report, Dr. Linda Iles 9 July 2019.
[64] Dr Mohamed Gaber, Medical E-Deposition dated 21 February 2019.
[65] Dr Mohamed Gaber, Medical E-Deposition dated 21 February 2019.

92. Earlier in this finding I have summarised the notes that were taken by Dr Hajbabaie at the medical consultation on 31 October 2018. The adequacy of the notes that were taken by Dr Hajbabaie was considered during the inquest, and he was questioned about his note-taking practices. I also heard expert opinion on the issue.

93. At inquest, Dr Hajbabaie initially gave evidence to the effect that he was '*comfortable*'[66] with his note-keeping during this appointment but then accepted that the notes could '*definitely could be better but that is not like in [his] usual style of…documentation*'[67], and that they were '*not adequate*'.[68] Dr Hajbabaie commented that his usual practice is to write quick notes when with a patient to document '*important things*' and that he would come back to the notes later and expand. However, '*for some reason I didn't have the opportunity to do it*'.[69]

94. Dr Lynch, Dr Walker and A/Prof Holdgate were each highly critical of Dr Hajbabaie's note-keeping of the 31 October 2018 appointment.[70]

95. As with Dr Hajbabaie's note-keeping in respect of the 31 October 2018 visit, the notes of the 25 January 2019 visit are also poor and were the subject of criticism by the medical experts.[71]

96. In written submissions, Counsel Assisting submitted that the evidence clearly establishes, including partly by admission, that Dr Hajbabaie's note-keeping at the 31 October 2018 appointment was *'parlous and not in accordance with proper GP practice*'. Consequently, Counsel Assisting further submitted that this admission in conjunction with Dr Walker's evidence, made it impossible to assess the crucial question of whether George's headaches were worsening at the 31 October 2018 appointment. Dr Walker

66 T 153.
67 T 154.
68 T 165 and T 178.
69 T 153.
70 See, Dr Lynch, CB 1, 18-6; Dr Walker, CB 1, 22-11; Associate Professor Holdgate, CB 1, 23-19.
71 See, Dr Lynch, CB1 1, 18-7; Dr Walker, CB 1, 22-11; Associate Professor Holdgate, CB 1, 23-26.

opined that if George's headaches were indeed worsening, his condition would have necessitated a referral for an urgent CT brain scan or referral to an ED.[72]

97. At inquest, Dr Hajbabaie gave evidence to the effect that he could not say what happened beyond the notes and could only speculate about what he might have done, including that if George did not raise any issues about the symptoms with which he presented on 31 October 2018 he "*wouldn't ask any further question or examination or anything else*".[73] Dr Hajbabaie's note-keeping on this occasion and on 25 January 2019 fell well below the standard that could be reasonably expected of proper GP practice.

98. Having reviewed all of the evidence on this issue and noting the concessions made by Dr Hajbabaie, I have concluded that Dr Hajbabaie's note-keeping of the appointments with George on 31 October 2018 and 25 January 2019 fell well below the standard that could be reasonably expected of proper GP practice. I agree with the submissions of Counsel Assisting on this issue.

Finding 2

That Dr Hajbabaie's note-keeping of the appointments with George on 31 October 2018 and 25 January 2019 fell well below the standard that could be reasonably expected of proper GP practice.

Dr Hajbabaie's medical advice and treatment

99. A central issue that the expert panel was asked to consider was whether Dr Hajbabaie should have ordered a CT scan or MRI for George on 31 October 2018.

[72] Dr Walker, CB 1, 22-11.
[73] T 156.28-157.3.

100. In summary, the experts concluded as follows:

a) Dr Lynch was of the firm view that George should, at that stage, have been referred for a CT Scan or MRI, because of his symptoms and the fact that he was not getting better.[74] He opined that the history, having regard to the persistent headache in the context of head injury on its own, warranted investigation by CT or MRI at that stage,[75] the former being available within 24 hours and the latter about a week (or sooner with assistance of a GP letter or phone call).[76]

b) A/Prof Raftos stated in his evidence that from his experience in general practice '*prudent practice would have been to obtain a CT scan of his head and, given the time of the evening, the best way to do that would have been to send Mr. Diamond to a hospital emergency department*'.[77] This was because a persistent headache for six days after a person has been punched violently in the head '*warrants investigation to ensure that there's no intra-cranial injury*'.[78]

c) A/Prof Holdgate said that '*based on the limited information available regarding that consult, [she did not] think there was an absolute indication to do a CT necessarily on that day*"[79] but also *"it would have been not unreasonable to do one'*.[80]

d) Dr Walker concluded that if the headaches were worsening, then a CT scan should have been ordered and, if not, then it was inappropriate not to have advised George to receive a scan at that time.

[74] CB1, 18-6; T 248.11-15.
[75] T 250.21-24.
[76] T 250.24-30.
[77] T 248.26-29.
[78] T 252.13-17.
[79] T 252.2-6.
[80] T 251.13-14.

e) Prof D'Urso opined that, on the balance of probabilities, it would appear likely that George had a subdural haematoma at the time of his presentation on 31 October 2018, which would have been revealed if a scan been performed at that time.

101. In written submissions, Counsel Assisting submitted that the opinions of Dr Lynch and A/Prof Raftos should be preferred on this matter as the injury was a traumatic head injury received in a boxing context in a young man with persisting symptoms. Counsel Assisting also submitted, in the alternative, that at the least Dr Hajbabaie should have expressly raised with George the prospect of undertaking a scan and having advised not just that he return in five days for review, but that he should return in five days with a view to undertaking a scan if his symptoms had worsened or not improved.

102. Counsel for the Diamond family in their written submissions adopt the submissions of Counsel Assisting that the opinions of Dr Lynch and A/Prof Raftos are to be preferred over the other experts. They suggest that in circumstances where the notes of Dr Hajbabaie are inadequate, I should be reluctant to accept that the notes reliably or accurately reflect the symptoms that George and his father complained about at this appointment. They further suggest that I cannot be satisfied of the adequacy of inquiries made by Dr Hajbabaie at this consultation on 31 October 2018. They draw my attention to the evidence of Mr Diamond that the symptoms complained of would have been that George was still vomiting, had a headache, was still dizzy and still in pain.[81] The Diamond family submit that I should find that a reasonable GP ought to have recommended or arranged for George to undergo a scan of his brain, likely a CT scan.[82]

103. Counsel for Dr Hajbabaie submitted that although the totality of the evidence allows for a finding that it was open for Dr Hajbabaie to refer George for a CT scan on 31 October

[81] T 18-23.
[82] Submission of Counsel for Diamond family.

2018, the preponderance of the evidence should lead to a finding that it was reasonable not to do so. In support of this submission, Counsel for Dr Hajbabaie suggested that I should consider the following in relation to the evidence from the expert panel:[83]

(i) In his written report, Dr Lynch made an assumption (based on symptoms present when George presented to the ED on 5 November 2018), that George had a headache (ongoing, worse in the morning) and other neurological symptoms (vomiting) at presentation to Dr Hajbabaie on 31 October 2018. Such assumption is invalid (see conclave evidence Prof D'Urso),[84] conceded as such by Dr Lynch[85] and thus undermines the opinion expressed by Dr Lynch in his report.

(ii) In oral evidence, Dr Lynch erroneously asserted that the records of Dr Hajbabaie on 31 October 2018 indicated that George had a vomit on that particular day and that this was a significant component of the history[86] - the records do not indicate that George had a vomit on that day as conceded by Dr Lynch.

(iii) A/Prof Raftos's evidence was that "*given the persistence of headache and vomiting on that day*", prudent practice would be to do a CT scan or refer to ED – A/Prof Raftos is in error about the vomiting on that day and therefore no reliance can be placed on his opinion.

(iv) Dr Lynch's initial oral evidence stressed that the '*history on its own was sufficient with regards to those two significant components [headache and vomiting] to warrant investigation by CT scan*' [87]– the two components were not present.

[83] Submissions of Counsel for Dr Hajbabaie.
[84] T 314.5-20.
[85] T 330.22-331.1.
[86] T 248.11-15.
[87] T 250.21-24.

(v) Dr Lynch's evidence reduces to the proposition that merely because George had ongoing headache six days after his initial injury, a CT scan was warranted.[88]

(vi) Dr Lynch conceded that a concussive headache can carry on for 10-14 days in accordance with the report of Dr Walker.[89]

(vii) Dr Lynch conceded that head injury was not an area of medicine he was familiar with.[90]

(viii) Dr Lynch took into the witness box with him a number of articles regarding head injury and CT scan – no article supported the proposition that ongoing headache alone (rather than severe or worsening headache) some six days after head injury warrants a CT scan.[91]

(ix) Similarly, Dr Lynch characterised ongoing headache at day six as a "red flag"; however, the articles Dr Lynch took into the witness box with him do not characterise ongoing headache as a "red flag", rather they characterise severe or worsening headache as a "red flag". [92]

(x) A/Prof Holdgate gave evidence that ongoing headache on its own at day five following a head injury would not be a concerning symptom or "red flag".[93]

(xi) There is no good evidence to suggest that as of 31 October 2018, George had severe or worsening headache. Rather, the evidence is that he had ongoing headache (not severe or worsening) without other neurological signs or symptoms or any "red flags" – indeed Dr Hajbabaie was unequivocal in his

[88] T 297.5-9.
[89] T 302.2-8.
[90] T 302.15-29.
[91] See for example T 310.1-29.
[92] Ibid; T 326.15-17.
[93] T 315.18-22.

evidence that if it had been reported to him on 31 October 2018 that George's headache was getting worse, he would have sent him to hospital.[94]

(xii) Dr Walker's evidence is that as of 31 October 2018, in the absence of worsening headache, worsening vomiting or neurological symptoms, she would have considered the diagnosis to be concussion and not refer for a CT scan.[95]

(xiii) A/Prof Holdgate's evidence is that there was not an absolute indication to do a CT scan on 31 October 2018.[96]

104. Having considered the available evidence on this issue and the written submissions of Counsel Assisting and the interested parties, I have come to the following conclusions:

a) The inadequate notes taken by Dr Hajbabaie make it very difficult to reach a conclusion on this issue as it is unclear what actually occurred at the consultation on 31 October 2018.

b) On balance, however, I prefer the evidence of A/Prof Holdgate that 'there was no absolute indication to do a CT scan necessarily on the day, but it would not have been unreasonable to do one'.[97]

c) Consistent with A/Prof Holdgate's evidence, although there was no absolute indication to do a CT scan, the most prudent course would have been for Dr Hajbabaie to either recommend to George that he have a CT scan or MRI on 31 October 2018, or alternatively inform George (and his father) that if his symptoms continued or worsened that he should return for further assessment and that a referral for a CT scan or MRI would likely be made at that time.

[94] See records of Dr Hajbabaie; T 180.4-17; T 181.4-11; T 182.22-183.
[95] T 251.6-252.6.
[96] T 251.6-252.6.
[97] T 251.

105. I acknowledge that Dr Hajbabaie did suggest returning for further review in five days, but the medical notes do not make any reference to a referral for a CT scan or MRI being made if he did return with continuing or worsening symptoms.

Finding 3:

a) The inadequate notes taken by Dr Hajbabaie made it very difficult to reach a conclusion on this issue as it is unclear what actually occurred at the consultation on 31 October 2018.

b) On balance however I find, in accordance with the evidence of A/Prof Holdgate, that 'there was no absolute indication to do a CT scan necessarily on the day, but it would not have been unreasonable to do one'.

c) Consistent with A/Prof Holdgate's evidence and the preponderance of the medical expert evidence, the most prudent course would have been for Dr Hajbabaie to either recommend to George that he have a CT scan or MRI on 31 October 2018, or alternatively inform George (and his father) that if his symptoms continued or worsened that he should return for further assessment and that a referral for a CT scan or MRI would likely be made at that time.

Scope of inquest, Issue 3 – The appropriateness of the decision by Dr Pejman Hajbabaie to clear George for return to boxing on 25 January 2019

106. As noted earlier, George returned to Dr Hajbabaie on 25 January 2019 for Dr Hajbabaie to sign a boxing medical clearance form and to receive his blood results from 1 November 2018.

107. At the 25 January 2019 appointment, Dr Hajbabaie was asked by George to sign the VABL Certificate of Fitness. Dr Hajbabaie acknowledged in evidence that he rarely encountered forms such as this, and said:

'The form I received is not a very common form we see in general practice…my belief was that this is related to the blood-borne, but still I'm signing someone to go back to the sport, especially something like boxing. So, I would in my general - usual practice, I would ask the patient if they have any symptoms and signs, to make me concerned not to sign such a form.'

108. At Inquest, Dr Hajbabaie was asked about any additional questions or investigations he may have undertaken on 25 January 2019 in relation to George suffering from ongoing symptoms or in relation to whether it was appropriate for George to return to boxing. However, Dr Hajbabaie was unable to recall.

109. As a result of the inadequate note taking by Dr Hajbabaie, it is unclear what actually occurred at this consultation including any discussions about the VABL Certificate of Fitness form and George's physical health.

110. Dr Lynch was critical of Dr Hajbabaie for not referring to notes of previous visits.[98] In his evidence, Dr Lynch said that the Royal College of General Practitioners expects general practitioners to review the medical record, and not just of the preceding consultation.[99] Dr Hajbabaie said he would normally go back to the last couple of visits of a patient.[100] Dr Walker also said a GP should look back one or two consultations.[101] Dr Hajbabaie does not appear to have done that; he said he was not sure if he did that[102] and nothing in his notes, treatment or recollection suggests that he did. Neither did he open up relevant windows in the electronic medical record management system which

[98] CB 1, Tab 18-7.
[99] T 319.16.
[100] T 174.5-6.
[101] T 235.28.
[102] T 162.25-27.

would also have notified him of George's ED presentation on 5 November 2018,[103] the failure to do so being something Dr Lynch said was '*not competent*', '*not adequate*'.[104]

111. In light of the above, it is unclear why Dr Hajbabaie signed the VABL Certificate of Fitness form when he was not familiar with it but understood that he would be certifying for George to return to boxing.

112. At inquest, Dr Lynch opined that he had never seen such a form and that there are areas for certification that he would not do, including scuba diving and pilots and that if he was presented with such a form, he would refer the patient to another practitioner or other person that is appropriately trained and qualified to certify the form, or he would defer signing the form until he had an opportunity to conduct his own research into what was involved.[105] Dr Lynch was highly critical of Dr Hajbabaie for signing this certificate.

113. In written submissions, Counsel Assisting submitted that the evidence strongly supports a conclusion that Dr Hajbabaie did not ask George about any symptoms, did not refer back to his previous appointment on 31 October 2018 and did not access the discharge summary from 5 November 2018 from Peninsula Health. Counsel Assisting also submitted that, on the available evidence, Dr Hajbabaie should not have signed the form without undertaking the appropriate steps about which Dr Lynch opined.

114. In their written submissions, the Diamond family submitted that Dr Hajbabaie ought not have signed the certificate of fitness in circumstances where he was not familiar with the certifying a person's fitness for boxing and ought to have made further enquiry in relation to the progression of George's symptoms after his last attendance on 31 October 2018.

115. In submissions made on his behalf, Dr Hajbabaie relied on his evidence about what he would usually do in such a case when asked to complete a form; including reviewing

[103] T 163.6-9.
[104] T 293.28-29.
[105] T 275.29-277.6.

recent medical history and asking relevant questions about symptoms of headaches, back pain and joint pain, and further, that if George had reported ongoing symptoms, then he would not have signed the form. Reliance is also placed on the evidence of Dr Walker who gave a very strong opinion that in the absence of symptoms in a three-month period since the incident, it was reasonable to assume that the symptoms had resolved and required no further enquiry.[106]

116. Dr Lynch reached a different conclusion on this issue to Dr Walker. As noted above, Dr Lynch was strongly critical of Dr Hajbabaie for signing the form in the circumstances. He noted that it certified George as "fit for boxing".

117. Having reviewed all the evidence on this issue and the written submissions of Counsel Assisting and the interested parties, I have concluded that Dr Hajbabaie should not have signed the form without undertaking a comprehensive review of George's medical history and undertaking the steps about which Dr Lynch opined, that is, undertaking research as to what was involved in providing a medical clearance to return to boxing. In the alternative, Dr Hajbabaie should have referred George to another practitioner that had the requisite training and experience to sign such a form.

118. Counsel Assisting also proposed two recommendations relevant to certificate of fitness:

    a) As part of DJSIR's regulatory review, being undertaken by KPMG, consideration should be given to including:

        (i) That DJSIR and KPMG, as part of its regulatory review, consider the requirements for signing certificates of fitness forms for return to amateur boxing by adequately certified medical practitioners and/or for expansion of the forms to contain more detailed information for medical practitioners.

[106] T 231.

(ii) That the RACGP consider preparing appropriate training and information for GPs to assist them when they complete forms relating to returning to boxing.

119. In considering these proposed recommendations I have also reviewed the VABL Certificate of Fitness form and believe that there are improvements that could be made to this form to make it absolutely clear to medical partitioner the significance of what they are being asked to do in the boxing context. I am of the view that this work can be done as part of the regulatory review being undertaken by KPMG in conjunction with the VABL. These recommendations are explored further below.

120. I also consider that it would be appropriate for medical practitioners (particularly GPs) to be required to undertake further training before they are able to sign forms such as the VABL Certificate of Fitness which provide clearance for individuals to return to high-risk sporting activities.

Finding 4:

Dr Hajbabaie should not have signed the form without undertaking a comprehensive review of George's medical history and undertaking the steps about which Dr Lynch opined, that is undertaking research as to what was involved in providing a medical clearance to return to boxing, or in the alternative, Dr Hajbabaie should have referred George to another practitioner that had the requisite training and experience to sign such a form.

Scope of inquest, Issue 4 - George's medical management at Frankston Emergency Department on 5 November 2018

121. A further issue considered at inquest was whether Dr Reuben should have ordered a CT scan on 5 November 2018 when George presented to the ED at Frankston Hospital. Dr

Reuben's evidence at inquest was that a scan was not warranted, and the risk involved in George having the scan outweighed the benefits. Dr Reuben stated:

> '*One of the risks certainly but not limited to is cancer from radiation, other risks would be a risk of cataracts and risk of incidental findings that then go on [to] need multiple investigations to work out what they are even if someone presents with something, and it might be something unrelated to why they've come in. I have to balance all of these things*.'[107]

122. Counsel for Dr Reuben in written submissions suggested that I can conclude that the decision by Dr Reuben to not conduct a CT scan on 5 November 2019 was reasonable and in considering this issue the evidence of the peer emergency physicians should guide me. It is submitted that the evidence of A/Prof Holdgate is particularly relevant and supports a conclusion that:

    a) it was not mandatory for Dr Reuben to have performed the CT scan.[108]

    b) what was required was for Dr Reuben to consider whether to perform a CT scan.[109]

    c) the evidence shows that Dr Reuben did consider whether to perform a CT scan.[110]

    d) the decision which Dr Reuben faced was a nuanced one[111] with no absolute answer.[112]

    e) Dr Reuben in his evidence at inquest raised a "reasonable argument" as to why a CT scan need not have been performed at that time.[113]

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[107] T 195.16-22.
[108] T 316.25-27.
[109] T 260.21-25; T 261.12-13.
[110] T 316.28 – T 317.8.
[111] T 317.9-19.
[112] T 259.27-29.
[113] T 259.24-27.

123. Dr Reuben summarised his position in his evidence:

> *'[A] guiding principle is if I don't think that doing a test is going to change my management, I don't perform a test especially a test that does have risks. ....'*
>
> *'And using my experience and my teaching and everything that I had in front of me at that point in time I did not feel that a CT scan done on that day represented something that I needed to look at from a point of view of needing an acute neurosurgical intervention and so I did not perform the CT.'*[114]

124. The evidence of the expert panel in summary offered the following opinions:

a) Dr Lynch considered that due to the duration of headaches and vomiting a scan should have been undertaken.[115] He also considered that in light of the history, it would have been reasonable and prudent to do so.[116]

b) A/Prof Raftos opined that the duty of the emergency physician in the circumstances of George's presentation, including the history of the trauma, '*was to exclude the potentially life-threatening stuff by doing a CT scan*'.[117] He states that he personally would have ordered a CT scan.[118]

c) Prof D'Urso's opinion was that:

> '*just on the history alone and the intensity of his father being there at the consultation concerned by his son, that should have immediately alerted the physician to consider a CT scan of the head, because he's at very high risk of repeat injury [based on the boxing context and the likelihood of George*

[114] T 195.13-16, 23-28.
[115] CB1, Tab 18.6-7.
[116] T 262.9-12.
[117] T 259.13-18. See also, his statement at CB1 Tab, 19.11.
[118] T 252.17.

continuing to box] and we know that a second injury and a third injury and a fourth injury is an exponential curve to death'.[119]

Prof D'Urso, when pressed under cross-examination, stated that the advice Dr Reuben gave was not reasonable and was flawed, because it was not based on any sensible diagnosis:

'*there [had not] been any sensible investigation and diagnosis made here of what actually was wrong with the patient before he was discharged from the hospital… you can't advise a patient if you haven't made a diagnosis and I don't think there was a diagnosis made here*'.[120]

d) A/Prof Holdgate considered the application of the Canadian CT Rule to a non-acute, mild presentation such as George's. In her opinion, while there was no absolute indication to perform a CT scan at that time:

'*on balance in my opinion a CT scan should have been performed. I base this opinion on a) that this was George's third presentation to see a doctor b) that his symptoms were not improving c) that he did not meet the Canadian CT Rule to exclude significant intracranial injury due to his history of vomiting and d) his family were concerned and requesting a scan*'.[121]

125. A/Prof Holdgate's opinion was put to Dr Reuben at inquest who disagreed with her comments.[122] He addressed each issue, saying that (a) a third presentation in and of itself is not an indicator that a CT scan should be done, (b) that the fact symptoms are not improving is not relevant as symptoms may take some weeks to improve, worsening symptoms may have been a trigger but there was no evidence of that, and (c) the Canadian

[119] T 263.11-17.
[120] T 321.4-322.16.
[121] CB 1, Tab 23-22.
[122] T 192.

CT Head rules do not apply to George as they specifically exclude people who present with an injury greater than 24 hours old.[123]

126. A/Prof Holdgate acknowledged Dr Reuben's response to her opinion, but nevertheless opined that '*on balance, taking everything into consideration, ... most emergency physicians, including me, would have done a CT scan on that day and would have probably been very surprised by the findings*'.[124]

127. Further, as outlined above, Dr Reuben considered the radiation risk to outweigh the benefits of a CT scan. The balance of the evidence from the expert panel did not agree with Dr Reuben on this issue.

128. A/Prof Raftos opined that one '*outcome from this incident would be that doctors should be encouraged to image people who've had head injuries and the barriers like the dose of radiation and things like that should be de-emphasised*'.[125] A/Prof Raftos suggested that a CT scan would provide '*a miniscule increase in the risk of cancer" and a "a single CT scan is not going to do anyone any harm*'.[126]

129. A/Prof Holdgate's view was that the risk of radiation in a single scan is very low[127] and '*as a single event the radiological risk…is far outweighed by the potential benefits of doing a scan'*.[128] Prof D'Urso also added that radiation exposure from a CT scan (particularly modern CT scanners) is '*negligible*', and clinicians should not be concerned about radiation exposure when investigating head injuries at all.[129]

130. Counsel Assisting submitted that:

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[123] T 194-195.
[124] T 261.2-25.
[125] T 266.22-26.
[126] T 267.10-20.
[127] CB 1, Tab 23-22; T 272.20.
[128] T 273.7-9.
[129] T 282.7-12.

a) the overwhelming weight of the expert evidence is to the effect that Dr Reuben should have undertaken a CT scan of George's brain as part of his treatment of George on 5 November 2018,

b) at the least, Dr Reuben should, if he considered that a scan was not appropriate in the immediate ED setting, have advised George to seek a CT scan, or if concerned about radiation an MRI through his GP, and not to return to boxing or any potentially traumatic activity until that was undertaken, and

c) consistent with the unchallenged opinion of Prof D'Urso, it is likely that George had a subdural haematoma at the time of his presentation on 5 November 2018, which would have been revealed had a scan been done at the time.

131. Having considered all of the available evidence on this issue and the written submissions, I have concluded that Dr Reuben should have ordered a CT scan for George as part of the treatment provided to George on 5 November 2018 in the ED at Frankston Hospital, or if Dr Reuben did not consider that a CT scan was appropriate in the immediate ED setting, he should have advised George to seek a CT scan or, if concerned about radiation exposure, an MRI through his GP, and not to return to boxing or any potentially traumatic activity until that was undertaken.

132. I also accept the opinion of Prof D'Urso that, had a CT scan been undertaken on 5 November 2018, it is more likely than not it would have revealed that George had a subdural haematoma. In this regard, I find that this was a missed opportunity to prevent George's death, as I consider it unlikely that, had George and his family been aware that George was suffering from a severe head injury, he would have returned to sparring or boxing in the future.

Finding 5:

The weight of the evidence supports the conclusion Dr Reuben should have ordered a CT scan for George as part of the treatment provided to George on 5 November 2018 in the ED at Frankston Hospital. Alternatively, if Dr Reuben did not think the ED was the appropriate place for a CT scan, he should have referred George to his GP to organise a CT scan or MRI.

Had a CT scan been undertaken on 5 November 2018, it is more likely than not that it would have revealed that George had a subdural haematoma.

MATTERS CONNECTED WITH THE DEATH PURSUANT TO SECTION 67(3) OF THE ACT AND RECOMMENDATIONS PURSUANT TO SECTION 72(2) OF THE ACT

133. Section 67(3) of the Act provides:

> *'A coroner may comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice.'*

134. Further, section 1 of the Act provides that one of the purposes of the Act is to 'contribute to the reduction of the number of preventable deaths and fires through the findings of the investigation of deaths and fires and the making of recommendations.'

135. In that regard, section 72(2) of the Act empowers a coroner to make recommendations to any Minister, public statutory authority or entity on any matter connected with a death, including recommendations relating to public health and safety or the administration of justice.

136. The meaning of the words 'connected with the death' were considered in *Thales Australia Limited v Coroners Court of Victoria & Ors*.[130] In that matter, Beach J stated that whilst

[130] [2011] VSC 133.

the words 'connected with' are capable of describing a spectrum of relationships ranging from direct and immediate to tenuous and remote, his Honour agreed with the interpretation of these words given by Muir J in *Doomadgee v Cements*,[131] where Muir J noted that:

> '*…there was no warrant for reading "connected with" as meaning only "directly connected with" …something connected with a death may be as diverse as the breakdown of a video surveillance system, the reporting of the death, a police investigation into the circumstances surrounding the death, and practices at the police station or watchhouse concerned*.'

137. There are several issues connected with George's death which warrant comment by me. In formulating my comments and recommendations in this matter, I have had regard to all of the relevant evidence, including the coronial brief, viva voce evidence and the written submissions of Counsel Assisting and the interested parties.

Requirements for specialist medical clearance prior to commencing or returning to boxing and other combat sports

138. As foreshadowed above, Counsel Assisting suggested that as part of the review being undertaken by KPMG, consideration should be given to the medical clearance requirements for participants who are commencing or returning to boxing/combat sports. I accept this suggestion, and recommend as follows:

Recommendation 1:

As part of DJSIR's regulatory review, being undertaken by KPMG, consideration should be given to including:

[131] [2006] 2 Qd.R.352.

a) **the requirements for an individual to be cleared before commencing amateur boxing/combat sports for the first time, and before returning to amateur boxing/combat sports following an injury, including whether this clearance should be obtained from a medical practitioner certified to do so; and**

b) **as part of this review, consideration should be given to whether the current VABL Certificate of Fitness form should be enhanced, with more information given to medical practitioners.**

Recommendation 2:

The Neurosurgical Society of Australasia, the Royal Australian College of General Practitioners (RACGP), in conjunction with Australasian College of Sport and Exercise Physicians (ACSEP) should consider developing appropriate mandatory training for medical practitioners in relation to providing medical clearance for individuals to commence and return to boxing and other combat sports.

Review of George's death by Peninsula Health

139. Following George's death, Peninsula Health conducted an internal review and produced two outcome documents to the Court. The first is a three-page document entitled 'Comprehensive Report',[132] and the second is a two-page document entitled 'Significant Clinical Event'.[133] Both documents consider George's attendance at the ED at Frankston Hospital on 5 November 2018.

[132] CB, Medical Records, Tab 6.
[133] CB, Medical Records, Tab 7.

140. In the Significant Clinical Event document, under 'System Issues' on page 2, it is stated that:

> '*Reasonable for CT not to be performed on 5/11/19 according to CT rules at his age? 1. Canadian CT head rules – "consider" because of >2 episodes of vomiting…Do you apply rule 1 week after injury?"…."Discussion regarding lowering threshold to CT in patient groups in danger of significant injury*'.

141. In the 'Comprehensive Report' document it is stated on page 3: 'Decision on first presentation not to CT was a clinical decision. Nil issues identified'.

142. It appears that Dr Reuben was not involved in either of these reviews as he had no recollection of having a conversation with anybody at Peninsula Health regarding the decision not to order a CT scan or whether that decision in other cases might or might not be modified[134] and said in evidence that he did not participate in a departmental review.[135]

143. The expert panel was asked whether:

a) The apparent response by Peninsula Health was adequate, and

b) Whether an event like this might be expected to generate some sort of circular in the emergency department, policy, guideline, rule or some other form of notification.

144. Prof D'Urso said in response that, there is only one sport where the objective of the sport is to deliver a head injury to your opponent and that needs to put boxing in a class of its own,[136] and opined:

> '*the guideline from the Frankston Hospital needs to be people who engage in boxing who've had a concussive head injury need to have a CT scan, if not an MRI*

[134] T 202.27.
[135] T 202.13.
[136] T 265.14-18.

scan of the brain to determine whether or not they've acquired a brain injury, and it's really that simple, I think. So that would be the interpretation here of the events and what the recommendations for that emergency department should be'.[137]

145. A/Prof Raftos said that the guidelines are relevant to 80 to 90 percent of cases but no guideline would really address the issue that George presented with.[138] However, he agreed with Prof D'Urso that boxing is a special case, and boxers should regularly receive imaging (MRI if there is a concern about radiation), and that should be placed in guidelines.[139]

146. Dr Lynch supported the use of imaging, that he would not be concerned about radiation in a single CT scan and if there was a concern, then an MRI could have been arranged but would take longer to have completed.[140]

147. A/Prof Holdgate said that, first of all, the appropriate response of the hospital (Peninsula Health) in a case like this is to expect some level of assessment and investigation as to what occurred and what could or should have been done differently, and that the outcome of such an investigation should be widely spread to all the staff likely to be involved in similar situations in the future.[141] She observed that this did not appear to have occurred.[142]

148. A/Prof Holdgate also said that it is unlikely that a specific policy would necessarily change what happens to the next person like George that presents to an ED, but there should be an awareness of the case, presented at meetings and in a memorandum, so that there is '*a highlighted awareness in general within the emergency department for patients*

137 T 266.1-8.
138 T 266.10-15.
139 T 266.15-21.
140 T 268.21-262.12.
141 T 269.21-30.
142 T 270.1-11.

such as George'.[143] While agreeing with Prof D'Urso that boxing is a particularly high risk activity, she said that in her practice experience she has seen relatively few boxing injuries compared with other sports and general assaults.[144]

149. As to any changed or developed guideline, A/Prof Holdgate agreed that it should be a nationally applicable guideline.[145] In response to a question about which would be the most appropriate body to make recommendations about guidance for the threshold for performing CT scans or MRI investigations in the boxing context, Prof D'Urso said he believed the appropriate body would be the Neurosurgical Association of Australasia[146] (Neurosurgical Society of Australasia).

150. I am persuaded by the evidence of the expert panel and in particular by the evidence of A/Prof Holdgate, that it is unlikely that a specific policy would necessarily change what happens to the next person like George that presents to the ED, but there should be an awareness of the case, presented at meetings, in a memorandum, so that there is a highlighted awareness in general within the emergency department for patients such as George.[147]

151. Counsel Assisting submitted that I should consider making a Finding that Peninsula Health should have taken further steps to address George's case within the Frankston Hospital ED, including by way of meetings and memoranda and that Peninsula Health review its significant clinical event processes to ensure that in the future critical incidents are not just reviewed but that information is effectively disseminated to relevant medical staff to assist them in making more informed clinical decisions.

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143 T 270.12-20.
144 T 270.27-271.14.
145 T 319.16.
146 T 319.27-320.4.
147 T 270.12-20.

152. Peninsula Health, in response, submitted that both these matters are outside the scope of the inquest and that there is insufficient evidence from Peninsula Health for these issues to be properly considered. Peninsula Health suggested that if I wish to further consider either of these matters that I should seek additional evidence and statements so that I have a proper evidentiary basis to consider the issues. I am not minded to make the finding or recommendation suggested by Counsel Assisting, nevertheless I do urge Peninsula Health (if they have not already done so) to conduct a review of their current procedures within the ED in light of the comments made by the expert panel in their evidence.

153. Counsel Assisting also submitted that it would be appropriate for guidelines concerning the threshold for undertaking a CT scan or MRI of a person's brain where injury has occurred in a boxing context and noting the very high likelihood of a person involved in boxing suffering further head trauma, be developed. Prof D'Urso identified the Neurosurgical Association of Australasia as the appropriate body.

154. Peninsula Health in response, submitted that there should be a broader approach, as GPs and emergency medicine physicians are ordinarily the first point of contact for those suffering head injuries, and as such, the input of their respective professional associations as to the scope and content of any such Guidelines is vital in ensuring the resultant document adequately addresses the range of public health and safety improvement initiatives. Peninsula Health suggested that this could include the procedure to be followed in respect of patients presenting with mild head injuries but resulting from potentially dangerous mechanisms, and which fall outside the scope of the Canadian CT Head Injury/Trauma Rule (**CT Head Rule**). This is so that any guidelines developed are broad enough to encompass this cohort as a whole and thus mitigate an equivalent risk for all in the cohort, rather than being confined to head injuries suffered in the context of boxing. They suggest that the appropriate groups would be the Royal Australian College of General Practitioners (**RACGP**), the Australasian College of Emergency Medicine (**ACEM**) and the Neurosurgical Society of Australasia. I agree with this proposal.

Recommendation 3:

The Neurosurgical Society of Australasia, Royal Australian College of General Practitioners (RACGP) and the Australasian College of Emergency Medicine (ACEM), consider developing guidelines to be followed in respect of patients presenting with mild head injuries but resulting from potentially dangerous mechanisms and which fall outside the scope of the Canadian CT Head Injury/ Trauma Rule (CT Head Rule) and also include the appropriate threshold for undertaking a CT Scan or MRI of a person's brain where injury has occurred in a boxing or mixed martial arts context.

REFERRAL TO AUSTRALIAN HEALTH PRACTITIONER REGULATION AGENCY

155. Having considered the available evidence, including the expert opinions and the submissions of the interested parties, whilst I do not intend to formally notify AHPRA regarding the conduct of either Dr Hajbabaie or Dr Reuben, I have included AHPRA on the distribution list for this Finding.

FINDINGS AND CONCLUSIONS

156. Having investigated the death of George Hayden Diamond and having held an inquest on 4 – 6 June 2024, I make the following findings, pursuant to section 67(1) of the Act:

    a) The identity of the deceased is George Diamond born 22 June 2000.

    b) The death occurred 21 February 2019 at Alfred Hospital, Commercial Rd Prahran.

    c) The cause of death was *complications of acute on chronic subdural haemorrhage (operated) in the setting of martial arts activity*.

d) The death occurred in the circumstances described above.

RECOMMENDATIONS

Section 72 of the Act empowers me to make recommendations on any matter connected with a death. These recommendations are made in the interests of improving the medical treatment provided to people engaged in high-risk activities, such as boxing. Pursuant to section 72(2) of the Act, I make the following recommendations:

1. As part of DJSIR's regulatory review, being undertaken by KPMG, consideration should be given to including:

    a) the requirements for an individual to be cleared before commencing amateur boxing/combat sports for the first time, and before returning to amateur boxing/combat sports following an injury, including whether this clearance should be obtained from a medical practitioner certified to do so; and

    b) as part of this review, consideration should be given to whether the current VABL Certificate of Fitness form should be enhanced, with more information given to medical practitioners.

2. The Neurosurgical Society of Australasia, the Royal Australian College of General Practitioners (RACGP), in conjunction with Australasian College of Sport and Exercise Physicians (ACSEP) should consider developing appropriate mandatory training for medical practitioners in relation to providing medical clearance for individuals to commence and return to boxing and other combat sports.

3. The Neurosurgical Society of Australasia, Royal Australian College of General Practitioners (RACGP) and the Australasian College for Emergency Medicine (ACEM), consider developing guidelines to be followed in respect of patients presenting with mild head injuries but resulting from potentially dangerous mechanisms and which fall outside the scope of the Canadian CT Head Injury/Trauma Rule (CT Head Rule) and also include

the appropriate threshold for undertaking a CT Scan or MRI of a person's brain where injury has occurred in a boxing or mixed martial arts context.

I convey my sincerest sympathy to George's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

George's Family

Mr John Paule

Four Wise Men Pty Ltd trading as Sting Gym

Dr Pejman Hajbabaie

Dr Yigal Reuben

Peninsula Health

Secretary, Departments of Jobs, Skills, Industry and Regions

KPMG

Royal Australian College of General Practitioners

Neurosurgical Society of Australasia

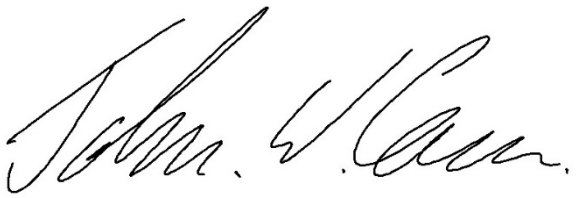
Australasian College of Sport and Exercise Physicians

Australasian College for Emergency Medicine

Australian Health Practitioner's Regulation Agency

Acting Detective Sergeant Denai Fitzpatrick, Coroner's Investigator

Signature:



JUDGE JOHN CAIN
STATE CORONER
Date: 19 September 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 inquest. 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.