QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of James William Ackerman**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2015/2367
DELIVERED ON:	9 November 2017
DELIVERED AT:	Brisbane
DATE(s):	18 May 2017, 3 July 2017 to 6 July 2017
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, Rugby League football, shoulder charge, carotid artery dissection, steps taken to mitigate risk of injury, rule and penalty changes

REPRESENTATION:

Counsel Assisting:	Ms M Jarvis
Counsel for the Ackerman family:	Mr P Boyce, Butler McDermott Lawyers
Counsel for National Rugby League Ltd:	Mr G Cranny, Gilshenan & Luton
Counsel for Queensland Rugby League Ltd:	Mr D Atkinson i/b Wotton & Kearney

Counsel for Francis Molo:	Mr P Lane i/b Barry Nilsson
Counsel for Brisbane Broncos League Club Ltd:	Ms J Rosengren i/b DLA Piper Australia
Counsel for Northern Suburbs Rugby League Football Club Ltd:	Mr J Fraser i/b Robert Bax & Associates
Counsel for Commissioner of Police:	Mr I Fraser
Counsel for QLD Police Officers:	Mr A Braithwaite i/b Queensland Police Union of Employees

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Introduction

1. At the time of his death, James William Ackerman was 25 years old and was married to Sarah and they have two children, Olliver and Milly. James' death in the circumstances described below continues to distress his wife, his parents, siblings, family, friends and team mates.

2. James was a semi-professional rugby league player with the Sunshine Coast Falcons. On 20 June 2015 the Falcons were playing against the Norths Devils in the Intrust Super Cup.

3. James was playing in the front row. Early in the game James received a ball and ran at the defensive line. Within that defensive line was player Francis Molo. Francis was also a contracted player with the Brisbane Broncos. James and Francis made hard contact with each other, and James immediately fell to the ground, dropping the ball.

4. The referee called time out, concerned that James might be concussed. Very quickly he realised the injury was serious. James was obviously struggling to breathe and was otherwise unresponsive. A doctor came on to the field and an ambulance was called.

5. Emergency medical treatment was provided to James at the ground and then at the Royal Brisbane and Women's Hospital, where James was taken. James was experiencing bleeding to the brain and was placed in an induced coma. Over the next two days, it became apparent that James' condition was incompatible with life, and a decision was made, in consultation with James' family, to terminate his life support. James was declared brain dead on 22 June 2015. The community is forever grateful for the fact that James' family generously consented to organ donation, which took place early the next day.

6. An external only autopsy was conducted on 26 June 2015, and James' cause of death was determined to be a *traumatic subarachnoid haemorrhage*, or bleeding to the brain, resulting from a *right intracranial internal carotid artery dissection*, or severed artery leading into the brain.

7. At the time of the on-field incident, the referee had placed Francis on report for review of the contact by the Match Review Committee. The Incident Report described the contact as a "shoulder charge". The game itself was captured on a video recording and

the incident was therefore recorded. The Match Review Committee referred the case directly to the Queensland Rugby League (QRL) Judiciary Tribunal.

8. The QRL Judiciary Tribunal found Francis guilty of a Grade Five shoulder charge (the most serious grade at the time), and suspended him for a total of nine matches. Francis did not contest the charge, findings or penalty.

9. In submissions made by QRL prior to the inquest, the QRL usefully provided a summary of the position of rugby league surrounding shoulder charges. A conventional tackle in rugby league involves the defensive player approaching the ball carrier from a front-on position, and wrapping his arms around the attacking player, below where the ball is being carried. This was described as an effective tackle.

10. A shoulder charge is a tackle in which a defending player runs at the ball carrier and without attempting to take hold of that player, the defending player makes contact with their shoulder. Because the manoeuvre does not involve the defending player committing his arms, and because it involves force being loaded upon the shoulder, the tackle can be administered with considerable force. There was consistent evidence from a number of coaches and others associated with the game that shoulder charges were not taught or trained for, as they were regarded as ineffective tackles. Nonetheless they remained part of the armoury of some players.

11. Shoulder charges, where they involved contact with the body below the head or neck, were not illegal until 2013.They were illegal where they involved contact with the neck or head of the attacking player by virtue of the general ban in Rugby League on high tackles.

12. Shoulder charge tackles generally were banned by the National Rugby League (NRL) in 2013. This followed a review of shoulder charges and player safety commissioned by the NRL in 2012. The QRL adopted the NRL ban.

13. Francis' suspension finished just prior to the end of the 2015 season. In 2016, Francis played again for the Norths Devils in the Intrust Super Cup. Francis was penalised twice during that season for shoulder charges, both of which were deemed to be Grade One charges being the lowest grade. He received further suspensions of two weeks and three weeks respectively.

Issues for the Inquest

14. James' family requested an inquest in the hope it might address some of the concerns and questions they still have about the circumstances of and response to James' death. The family also hope an inquest might lead to improvements to player safety.

15. A pre-inquest hearing took place on 18 May 2017 and the following issues for the inquest were determined:

    i. The findings required by s. 45 (2) of the *Coroners Act 2003*; namely the identity of the deceased, when, where and how he died and what caused his death.

    ii. The circumstances surrounding the on field incident involving Francis Molo and James Ackerman during the InTrust Super Cup match between the Norths Devils and Sunshine Coast Falcons on 20 June 2015.

    iii. Actions taken by Queensland Rugby Football League Ltd, the Queensland Police Service and Workplace Health and Safety Queensland in response to James' death.

    iv. Actions taken by Brisbane Broncos Rugby League Club Ltd and Francis Molo to manage the risk to player safety associated with shoulder charges, both prior and subsequent to James' death.

    v. Actions taken by Queensland Rugby Football League Ltd and, where applicable, National Rugby League Ltd to improve player safety in relation to the risks associated with shoulder charges.

    vi. Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the *Coroners Act 2003*.

16. The following witnesses were called at the inquest:

    - Stephen KANOWSKI, Level 3 Referee, Queensland Rugby League
    - Tyson BROUGH, Level 3 Referee, Queensland Rugby League
    - Jacob SAMOA, player, Sunshine Coast Falcons

- Thomas MURPHY, player, Sunshine Coast Falcons
- Ryan HANSEN, player, Sunshine Coast Falcons
- Dr Christian IBRAHEEM, Doctor, Norths Devils
- Dr Rohan SAMARASINGHE, Forensic Pathologist, Queensland Health Forensic and Scientific Services
- Senior Constable Shane SMITH
- Detective Senior Constable Christopher MELIT
- Plain Clothes Senior Constable Jocelyn ABLETT
- Plain Clothes Senior Constable Lauren GOWER, Queensland Police Service
- Detective Senior Sergeant Anne Vogler
- Francis MOLO, player, Norths Devils and Brisbane Broncos
- Paul LOWE, Assistant Coach, Norths Devils
- Mark GLIDDON, Head Coach, Norths Devils
- Jamie DOWSE, CEO, Norths Devils
- Paul WHITE, CEO, Brisbane Broncos
- Neil WHARTON, Head of Football, Queensland Rugby League

Evidence on the issues

Autopsy results and medical evidence as to cause of death

17. In accordance with the request of family, an internal autopsy examination was not performed and an external only examination with post mortem CT scan was conducted. The cause of death was already clear from a review of the clinical records. At autopsy James' cause of death was determined by forensic pathologist Dr Rohan Samarasinghe as '*1(a) Traumatic subarachnoid haemorrhage due to or as a consequence of 1(b) Right intracranial internal carotid artery dissection*'.

18. Dr Samarasinghe found no signs of an aneurysm or pre-existing condition that predisposed James to this type of injury, although that could not be excluded. He described the injury as rarely seen in pathology and he has only seen two previous such injuries, both from motor vehicle accidents.

19. Dr Samarasinghe found no real bruising or injury externally other than two minor bruises on the right shoulder and collarbone areas consistent with being sustained in a tackle, fall or resuscitation. There was an area of light bruising with a small superficial laceration on the right frontal area of the head described as a '*2.5cm x 3cm area of stippled bruising with a 0.5cm linear superficial laceration*'. Dr Samarasinghe stated this maybe consistent with having been sustained when he collided with the other player or when he collapsed to the ground.

20. Dr Samarasinghe declined to comment in his autopsy report as to the mechanism of James' injury. At the inquest Dr Samarasinghe stated it was his understanding a traumatic dissection of a vertebral artery (which is more common) or internal carotid artery (such as in this case) are produced by way of a similar mechanism; namely, either direct blunt force to the head or neck, or indirect blunt force causing rotational movement of the head such that the artery stretches and tears. Dr Samarasinghe stated it is difficult to say which area was affected in this particular case. He stated that by looking at footage of the incident and, in particular, the moment of impact, Dr Samarasinghe expressed a view the point of impact appeared to be somewhere on James' neck or head. He agreed he was not able to see what happened clearly on the video.

21. Dr Samarasinghe was asked whether James' internal carotid artery could have been stretched and torn through a whiplash movement of his head. He agreed it was a possibility, but in his opinion and based on his reading about this type of injury, it mostly results from direct trauma. Dr Samarasinghe agreed indirect forces can cause internal carotid artery trauma, however not from a forward and back movement of the head (such as you might see in a whiplash movement). Rather, the head has to move sideways or with a rotational movement. However, Dr Samarasinghe qualified his opinion by stating he would defer to the opinion of a sports physician or biomechanic in terms of these mechanisms.

22. Dr Christian Ibraheem, was the sideline doctor who attended James on the field that day. He has professional medical experience in trauma incidents. As to the mechanism of James' injury. Dr Ibraheem felt the injury was related to a whiplash

movement of James' head causing a coup-contrecoup type reaction (where the force causes significant brain movement within the skull), which has then caused the internal carotid artery to rupture or tear.

23. Dr Ibraheem saw the on field collision from some distance away on the sideline, but distinctly remembers a whiplash movement of James' head. He had since seen the footage of the incident and believes it also shows this whiplash movement. His impression on the day regarding the point of impact between the two players was that it was 'chest to chest'. He agreed with the suggestion that to get that whiplash movement of the head, the degree of force of that impact had to be enormous.

24. Dr Ibraheem explained this whiplash movement could arise from any impact and did not require direct impact to someone's head. He gave the example of a car accident. Dr Ibraheem stated he had seen multiple head injuries but never as a result of a rugby league tackle. He qualified his opinion, stating it was based on general knowledge he had obtained in his capacity as registrar and surgical trainee in the trauma area of the Gold Coast University Hospital and 'not gold standard by any means'.

25. Both Dr Samarasinghe and Dr Ibraheem agreed the mechanism by which James' internal carotid artery was dissected may not necessarily require direct blunt force trauma to the head or neck, and could arise through indirect forces that essentially cause trauma to the internal carotid artery through stretching and subsequent tearing of the artery wall. Dr Ibraheem described a whiplash movement with the head moving forward and backward, whereas Dr Samarasinghe believes you need sideways or rotational movement.

26. There was evidence from some of the persons present on the day, including a Touch Judge and some Falcons' players, describing seeing contact with James' chin or somewhere on James' head. I accept these accounts have been given honestly, but the incident itself took place over seconds and at great speed and was viewed at different angles and from different positions on the field. I can well understand why they came to that conclusion given James' head clearly appears to move backwards.

27. Francis maintained during his evidence he did not make any contact with James' head or neck.

28. I had the distinct advantage of having viewed the tragic footage on many occasions, including in slow motion and frame by frame. The footage shows some right sideways

and perhaps rotational movement of James' head at the time of and immediately following the impact of body on body and as James falls. The footage does not clearly show contact with James' head or neck. Francis was standing at one point relatively straight on but the point of impact is with his Francis' right side high up including the shoulder region.

29. The medical and post-mortem observations show there were no signs of significant external injury to James' head or neck area, apart the area of light bruising with a small superficial laceration on the right frontal area of the head. If there was direct contact with this area of James' head at the time of impact, both the footage and the nature of the bruising suggest it was not the focal point of the impact. It is clear that the bruising and laceration could equally have been sustained earlier in the game; through some grazing contact in the incident; or when James fell to the ground after impact. If contact was made with the head and neck it would more likely to have been on the left side.

30. In its entirety, the evidence suggests if there was contact with James' head or neck, it was not forceful enough to cause significant bruising or fractures. The alternative scenario is there was no contact with James' head or neck at the time of impact. Given the consensus of the medical opinion is there must be significant force (direct or indirect) for the internal carotid artery to rupture or tear, and given the absence of external signs of significant impact to James' head or neck, the evidence (including the video footage) suggests it is more likely that it was the force of the collision itself high in the upper chest/ shoulder region of James rather than any direct impact to James' head or neck that caused the injury to his artery. There is evidence of James' head moving sharply to the right with, in my view, some degree of rotation.

31. In many respects, this finding only adds to the importance of the banning of shoulder charges altogether. Serious injury and death can occur without direct contact to the head or neck due to the immense forces involved creating forceful movement of the head.

Circumstances surrounding the on field incident involving Francis Molo and James Ackerman

32. The Round 15 Intrust Super Cup game between Norths Devils and Sunshine Coast Falcons on 20 June 2015 was not *'a big game'* in the context of the competition. The referee and others officiating stated it was their practice to be alert to any issues with or between teams or individual players prior to the commencement of a game. They

and other witnesses confirmed they were unaware of any particular rivalries between the teams or between Francis and James. I accept there is no evidence of any ill will between Francis and James or their respective teams and this game was being played in that context.

33. James and Francis were both front row forwards. It was quite evident from the evidence that both of them liked to play the game hard. Consistently with what Francis had to say, the coach of Norths, Mr Gliddon stated it was their job as forwards to get on top of the opposition and endeavour to dominate that early part of the game. At the same time the evidence of coaches and other officials associated with the game emphasised players were encouraged to play to the rules of the game, as breaches inevitably simply gave away penalties.

34. Approximately three and a half minutes into the game Norths kicked off from halfway following an early Sunshine Coast try. The ball was collected by another player and passed to James who ran from the in goal area. James was approximately 15 metres from the Norths goal line when Francis made contact with him. Francis had run from behind the halfway line.

35. The touch judge on the western side of the ground, Stephen Kanowski gave the following description of what happened next:

After Norths kicked off, I recall a Sunshine Coast player received the ball. He passed it to James Ackerman who ran at the defensive line very hard and with vigour. I recall the defensive line that met James Ackerman included Francis Molo. I saw Francis Molo turn his body to the side and perform a shoulder charge on James Ackerman. The shoulder charge connected with the neck and lower head area of James Ackerman. The contact was very severe and caused James Ackerman to fall heavily to the ground and drop the ball.

36. At the time of the incident involving Francis and James, the offence of a shoulder charge was defined in the QRL Major Competitions Judiciary Code as follows:

A player is guilty of misconduct if he carelessly, recklessly or intentionally makes forceful contact between any part of his body and the head or neck of an opposing player and/or causes or contributes to any forceful movement of, or impact to, the head or neck of an opposing player when effecting, or attempting to effect, a shoulder charge, that is, using the shoulder and/or upper arm tucked into the side without, at the same time, using the arms and/or hands to tackle or otherwise take hold of the opposing player.

37. Touch Judge Kanowski stated he had a good view of the play at that time. At the inquest he maintained that he saw Francis' body turned slightly to the side with his arms by his side and right elbow tucked in to his side, meeting the indicators for a 'shoulder charge' as per instructions provided to referees and touch judges by the NRL at that time. He said he thought the contact was around the neck but was not sure although he agreed it was certainly high in the shoulder area of James.

38. At the inquest Francis maintained his body was 'front on' or 'chest on' to the expected point of impact with James, with both his arms ready to wrap to complete the tackle. Francis recalled the points of contact as being his right pectoral muscle, collarbone and shoulder area connecting with James' chest and/or possibly with the ball, which James was carrying on his chest.

39. In his statement and at the inquest, Francis described being surprised and 'a bit scared' that James was running straight towards him, as in his experience attackers usually try to change direction or look for space to run into. Francis believed James was trying to impose himself on him by physically running into him to force him backwards. He added that James was just doing his job and playing hard, as was expected of forwards.

40. Francis says he braced himself for what he thought was going to be a high impact collision by bending his legs slightly to generate more power to push the player backwards, as he was taught to do.

41. Francis described the contact as heavy and strong, with the force of the collision forcing James to go backwards. Francis stated at inquest he would have been going forward at the time of the impact, but denied pushing James with his right arm bent at the elbow. Francis recalled his arms were coming up ready to wrap but he did not get time to do this due to James falling backwards so quickly. Francis stated he did not go in to deliberately shoulder charge James.

42. The nature of the tackle attempted by Francis on James was subsequently determined to be a "shoulder charge". There was some contention by some witnesses as to whether the tackle fell within the definition of a "shoulder charge" and there were submissions from the QRL and Norths that the tackle was square on and not side on, meaning it was not an illegal shoulder charge.

43. On the account of Francis Molo, at a minimum it was contact made by his pectoral muscle, collarbone and shoulder area with James' upper chest area, without subsequent wrapping of the arms.

44. Video footage of the game was taken from an elevated area on or near the halfway line on the western side of the ground. The video footage is of reasonable quality, although the position of Francis' arms and body and point/s of contact between the two players at the time of collision and after is obscured somewhat by the speed of the impact and surrounding players.

45. At the request of the family I have placed a non-publication order prohibiting publication of the video footage. Many family members have sensibly declined to view it

46. I also ruled that given the distressing nature of the footage and the distress this was likely to cause Francis I did not require Francis Molo to view the footage during or before he gave evidence. He had not previously done so.

47. As I have stated, there was some contention as to whether this tackle by Francis was a shoulder charge within the laws of the game of Rugby League.

48. The video replay certainly supports a finding there was contact more by the right side of Francis high on his chest and right shoulder area and not front on. I have considered the video evidence and medical evidence earlier and consider the most forceful contact was on James high up on his left shoulder region. This impact did cause forceful movement of James' head and neck backwards and to the right side. If you considered the video evidence only, you could be excused in thinking there could also have been some contact with the head and neck, but the pathology evidence does not support this. There was certainly no wrapping of the arms. Whether the non-wrapping of the arms was intentional on the part of Francis or, as he says, due to the fact he did not have time to proceed to wrap his arms because James fell backwards, is difficult to determine. In viewing the video evidence it does not seem to me that Francis had placed himself in a position to wrap his arms in a traditional tackle but braced himself, lowered himself slightly and led slightly upwards with his right shoulder and chest to absorb the impact. It never looked like a tackle was going to be effected.

49. What can be said is what is described above is effectively the same contact that results when a defender places 'his shoulder or upper arm (tucked into the side)' into

an attacker's body, without spreading the force of that impact through the wrapping of his arms around the player". This was banned in 2013 due to it posing an '*unacceptably high risk of injury even if there is no contact with the players head*', as James' death tragically illustrates.

50. The NRL has continued to acknowledge this risk can arise from 'any forceful contact' with the shoulder or upper arm that does not also involve the use of the defender's arms to spread the force of that contact. In August 2015 the rule was tightened to ensure any forceful shoulder charge irrespective of point of contact on an opposing player's body was banned. On 4 February 2017 the NRL announced a further change to and simplification of the definition of a shoulder charge, whereby a player will be charged if '*the contact is forceful, and the player did not use, or attempt to use, his arms (including his hands) to tackle or otherwise take hold of the opposing player*'. The requirement for the shoulder and/or upper arm to be tucked into the side of the tackling player's body was removed from the shoulder charge rule.

51. What also can be said is that the referee had immediate concerns about the contact and asked for assistance from the touch judges; the touch judge expressed immediately that he saw a shoulder charge and said so; Francis was placed on report by the referee for a suspected shoulder charge; the issue was referred to the Match Review Committee, the Match Committee in turn referred it directly to the Judiciary; the Judiciary in turn accepted a no contest plea from Francis on the basis it was a Grade Five category shoulder charge and suspended him for nine weeks.

52. It was submitted the no contest plea from Francis was in part an acknowledgment by the Broncos that they were in uncharted territory and that out of respect for the family and acknowledging the pain and sorrow the family were obviously feeling, it was felt that the matter should not be contested so as to not throw Francis and the family back into the public arena. I accept that may be a factor in the decision making, which it seems was made by others within the Broncos structure including the CEO and Head Coach and without really any input from Francis. The CEO Paul White stated in evidence Francis was told of the decision. I also note that Rule 57B of the NRL Judicial Code of Procedure provides that an election not to contest the offence charged or the grading does not constitute an admission on the player's part that he is guilty of the charge, but an indication he has chosen for one reason or another not to contest the charge.

53. Nonetheless, there were sufficient steps in the procedures referred to above to warrant the legitimacy of the approach taken by the QRL in proceeding with the charge of misconduct on the basis of the tackle being an illegal shoulder charge.

54. The three QRL match officials were also asked whether they had any concerns about an alleged earlier tackle by Francis on James and about the conduct of Francis once James landed on the ground.

55. With respect to the alleged earlier tackle committed by Francis on James, Referee Brough mentioned an interaction earlier in the game where he noticed Francis attempting to make *'a big tackle*' on James after a drop out from underneath Norths' goalposts. Francis missed the tackle and no contact was made. Referee Brough did not consider there was anything illegal involved, and explained *'it is not unusual, particularly with large forwards for them to attempt to assert themselves early in the game*'. Referee Brough did not consider it necessary to say anything to Francis. He stated that Francis' arms were out as he remembered. At inquest, Referee Brough stated if he had any concerns about that earlier tackle he would have placed it on report.

56. Touch Judge Kanowski also stated he had no concerns with this earlier tackle and observed there was an attempt by Francis to wrap the arms around.

57. Evidence about this earlier tackle was also received from two of James' team mates as well as Sunshine Coast's head trainer Darren Shipley. Consistent with Referee Brough's evidence, the head trainer described there being '*no issues*' with the tackle. The two team mates, Ryan Hansen and Tom Murphy, described it as an attempt by Francis to '*shoulder charge*' James.

58. Footage of this earlier tackle, when played slowly frame-by-frame, appears to show Francis' right arm wrap around James' body at the level of his chest and his left arm wrap around and trail down James' back as James moves forward through the tackle, with Francis losing his footing and falling backwards. The wrapping of Francis' arms in this way would place the tackle outside the definition of a shoulder charge.

59. Mr Hansen and Mr Murphy were asked to review the footage of the earlier tackle prior to attending court to give their evidence, paying particular attention to the position and path of travel of Francis' arms. Mr Hansen when giving evidence was uncertain whether he had watched or paid particular attention to that part of the footage, saying

his focus had been on watching the later incident. Both Mr Hansen and Mr Murphy rejected the suggestion the footage was evidence the earlier tackle was not an attempted shoulder charge.

60. I have considered the evidence of the two team mates and in particular I have viewed the video replay. I am satisfied Mr Hansen and Mr Murphy are mistaken and the earlier attempt by Francis to tackle James involved an attempt to use his arms and would not come within the definition of a shoulder charge.

61. In relation to what happened immediately after the fatal tackle, Touch Judge Kanowski described seeing Francis '*give James Ackerman a push on the ground in the chest area of his body*'.

62. The video footage shows some interaction by Francis with James immediately after he fell to the ground consistent with the description above.

63. At inquest Francis admits to pushing James 'a little bit' on his head or high on his chest area with his right hand. Francis explained he did not know how critical or bad James' situation was at that time, and the push was in the context of his role as a forward to play the game with aggression and to 'get over' your opponent.

64. Francis denied making contact with James with his knee whilst James was on the ground.

65. When asked at inquest about Francis' conduct after James was on the ground, Touch Judge Kanowski recalled the push, which to him looked like 'a deliberate shove'. He did not recall Francis making contact with James with his knee.

66. The referee Tyson Brough, said Francis was '*hyped up*' and protesting the penalty. Referee Brough stated it was not unusual for players to protest penalties, particularly in circumstances where the penalty will deny them an otherwise legitimate try that has been scored (as was the case here). Referee Brough also said it was '*not unusual, particularly early in a game for players to be hyped up after a heavy contact. That is particularly usual when there is a big collision between two players*'.

67. Francis stated at the inquest he was 'a bit upset' at that time, not only because the try had been disallowed but also because he did not believe what he had done was a shoulder charge. He thought a shoulder charge was when your arms were tucked in

and you were going in sideways. Francis stated '*I didn't do any of that. I was front on. Obviously it was a big collision. I didn't get time to wrap my arms around him*'.

68. I have of course reviewed the video evidence many times. I am satisfied that Francis did briefly shove James in the chest area as he was moving forward over James. I accept this was deliberate and many would consider this action not a good look or in the spirit of the game. I also accept Francis did not and could not know how seriously James was injured and the action was in the context of a hard playing forward trying to dominate his opponent physically and psychologically in the early period of a game.

69. As to whether Francis also kneed James in those same seconds after James went to ground, is less clear. The video appears to show some very fleeting non-forceful contact with Francis' left knee to the midriff of James as Francis moved forward over the prone James. There are other players moving around him around him and it is possible he stumbled slightly and then stands up but it does not look like it. James body seems to move slightly but that could be from the chest shove and could also be from impact of the knee. It is also possible there was no actual contact to the midriff with the knee and the left knee of Francis was simply hovering over the midriff as he moved forward.

Actions taken by Queensland Rugby Football League Ltd, the Queensland Police Service and Workplace Health and Safety Queensland in response to James' death.

Actions taken by QRL and its officials

70. Immediately upon seeing James was injured, Referee Brough called time out, which enabled trained and qualified staff to attend to James very quickly. This included Norths' sideline doctor, Dr Christian Ibraheem, who attended to James within less than a minute of the incident and provided continuous treatment, including airway support and spinal immobilisation, until arrival of the Queensland Ambulance Service.

71. The match officials also responded quickly to the contact itself. Referee Brough did not have a clear view of the contact but recognised it was significant and checked with the touch judges. Touch Judge Kanowski said he did have a clear view of the contact and identified it as a possible shoulder charge. He also suggested the contact be placed on report. Referee Brough agreed.

72. Referee Brough then called Francis out and advised him he was being penalised for a shoulder charge and high contact and was being placed on report. Referee Brough agreed an option available to officials is to send a player off, however he said this depends on the severity of the conduct. Referee Brough gave the example of contact with the head or neck as being conduct that may warrant a send-off. Referee Brough explained '*you rule on what you see*' and, where you have doubts, you report the conduct to the Match Review Committee for review. Touch Judge Kanowski gave very similar evidence in response to similar questions about send-offs. It is evident send-offs are not often utilised in Rugby League.

73. The match officials subsequently placed Francis on report. The *Referee's On Field Incident Report* completed by Touch Judge Kanowski alleged Francis '*made high contact with shoulder charge*' in breach of section 15(1)(k) of the Laws. The match officials understood this charge would be referred to the QRL Match Review Committee who would review the video footage and prefer whatever charge was considered necessary. The match officials had no further involvement in the matter.

74. Touch Judge Kanowski also stated during his evidence he was unsure about the point of contact and whether it was high and believed this was a matter best determined by the Match Review Committee, who would have the benefit of the video of the incident.

75. The charge was referred directly by the Match Review Committee to the QRL Judiciary Tribunal. Usually that only occurs in serious cases. Francis elected not to contest any offence or the grading for that offence and was excused from appearing before the judiciary. The QRL Judiciary found Francis guilty of a Grade Five Shoulder Charge and, taking into account time already spent on the sidelines, suspended Francis from playing up to and including Round 24 of the Intrust Super Cup (a total of nine matches).

76. One of the stated objects of the QRL Judiciary Code is to '*provide a system of largely pre-determined penalties so as to promote uniformity and consistency of approach in sentencing, enable players to elect to accept a pre-determined penalty without recourse to a hearing by the QRL Judiciary, and provide a safe system of work for the protection of players*'.

77. Under the QRL Judiciary Code as it was at the time, a Grade Five Shoulder Charge incurred a pre-determined penalty of 800 demerit points. If a player incurred demerit points greater than 799 but less than 900, the player was suspended from playing for

eight matches. The penalty imposed by the QRL Judiciary in this case was effectively one match more than the most severe base penalty for shoulder charges under the QRL Judiciary Code.

78. The family raised concerns regarding the conduct of the QRL in allowing a legal practitioner who was ordinarily a member of the QRL Judiciary to appear for Francis. It was noted the legal practitioner limited his involvement to some administrative matters and did not appear or otherwise advocate for Francis in relation to the circumstances or about the charge, grading or penalty. I accept Counsel Assisting's submission that the evidence would not support a finding that any potential deterrent effect of the QRL disciplinary proceedings was diminished by virtue of the involvement of that legal practitioner.

79. Neil Wharton, Head of Football with the QRL, was asked to describe what steps the QRL has taken or intends to take to ensure judiciary proceedings do act as an appropriate deterrent in relation to unsafe play in the future, relevant to James' death. Mr Wharton expressed a view that changes to the judiciary process were not required. He stated the judiciary process is reviewed and considered on an annual basis in line with any amendments to the QRL and NRL rules. The decision as to appropriate penalties for a breach is determined by three independent persons who are experienced in these matters and Mr Wharton stated fulfil an important role in the overall conduct of the Game.

80. At inquest Mr Wharton was asked whether, at the time of Francis' judiciary proceedings in 2015 following James' death, the QRL had a policy whereby members of the QRL Judiciary Panel would not be permitted to represent players at judiciary proceedings during their period of appointment to the panel. Mr Wharton stated they did not have any such policy at the time but had begun 'looking at that' since the incident and would be introducing such a policy 'this year'.

81. That is certainly a policy that should be implemented to ensure transparency and confidence in the judiciary process going forward.

Actions taken by Queensland Police Service (QPS)

82. Queensland Police have dual roles when investigating deaths where the coroner is also investigating. Their primary role is to determine if the circumstances of the death involves any criminality. They then need to determine if a charge should be brought.

Policy dictates a two tiered test is used considering firstly, the sufficiency of evidence and then secondly, whether it is in the public interest to bring a charge. A secondary role for Police is to assist the coroner in relation to the coroner's investigation. These investigations will no doubt have some commonality to them but there may be particular issues or areas the coroner may want investigated, particularly taking in the prevention role of the coronial jurisdiction

83. During the course of the coronial investigation into James' death, concerns were raised by his family regarding the involvement of QPS in the matter.

84. James' parents were spoken to by QPS officers who attended the hospital whilst James was on life support. They were told QPS were 'investigating the matter on the basis it was a serious injury and if death occurred they would be carrying out further investigations'. The family had not been directly advised of the outcome of any QPS investigations since that time. In submissions by counsel for QPS it was appropriately conceded that communication with the family on this issue could have been improved.

85. Upon becoming aware of a critical injury occurring, QPS immediately took steps to obtain further details about the incident, including attending the ground and hospital to speak with any persons with knowledge of the incident.

86. The QPS officers who attended the ground that evening did not approach potential eye witnesses who were still at the club. It was said this was on the basis those persons appeared to have been drinking or were no longer present and it was not unreasonably considered their evidence could be obtained at a later date if necessary.

87. QPS gained access to video footage of the incident in a timely manner, and a number of officers reviewed that footage. A copy was made available to the Coroners Court office.

88. I accept the initial responses of QPS officers to the incident were appropriate to this point in time.

89. After Police reviewed the footage, QPS made a decision on or around 26 June 2015 that no further criminal investigation was warranted. Whilst questions were raised whether QPS should have attempted to gather further evidence from eye witnesses such as the players and officials before making that decision, the QPS officer with

responsibility for that decision considered she had enough information at that time to make a determination that no criminal offences were identified.

90. A coroner is prohibited from making a finding or a comment that a person may be criminally liable for something. Hence any comments made here do not reflect any view on that issue. My interest is only in ensuring decisions made by prosecuting authorities have followed an appropriate policy and process.

91. A report from QPS' North Brisbane Criminal Investigation Branch (South) was provided at my request detailing the steps they had taken to investigate the matter and the outcome of those investigations.

92. The QPS Report concluded as follows:

…The game of rugby league is a full contact sport and, as a result of that contact, the risk of injury to a player of the game increases. The possibility of a successful criminal investigation in which each element of a criminal charge must be met to the relevant standard of proof, being that of 'beyond reasonable doubt', is highly unlikely and therefore no criminal charges are to be preferred.

93. There are a number of legal and policy issues that make the law around sporting related deaths somewhat complex, although fortunately rarely considered.

94. Counsel for QPS subsequent to the inquest provided information about resources available to guide QPS officers when investigating and in making decisions whether to prosecute someone for a potential criminal offence arising in the context of sporting contests. This included case law guidance on the issue of consent to assault in sporting contests. The QPS Operational Procedures Manual also includes a policy that officers who require advice on legal issues associated with operational matters may seek advice (by telephone, email or in writing) from legal officers with the Legal Division of QPS.

95. The officers who gave evidence at the inquest were aware of their ability to seek legal advice but did not do so. Given the complexity of both the law and in public policy in relation to deaths that arise during sporting contests, Counsel Assisting submitted it may have been prudent for QPS officers involved in the investigation to seek out such advice and guidance to support their decision making in this case. Counsel for QPS concurred with that submission and stated that investigating officers in like cases

should be encouraged to avail themselves of relevant legal and policy resources including, where appropriate, resources external to the QPS.

96. Counsel Assisting also submitted, there were a number of missed opportunities for QPS to take additional steps to ensure greater transparency and confidence in their investigation and decision making, and to reassure James' family that relevant legal and policy considerations in relation to such incidents had been carefully considered and applied in this case. Counsel for the QPS did not argue against that submission but also said there is no evidence the decisions made to not criminally investigate James' death were in error. I generally adopt both propositions.

Actions taken by Work Place Health and Safety Queensland (WHSQ)

97. James' death was notified to WHSQ on 14 September 2016 by Norths. This was most likely in response to a formal request from my office as to whether the incident had been reported to that agency. In response to this notification WHSQ conducted enquiries and prepared a *WHSQ Fatality Enquiry Report* (the WHSQ Report).

98. The WHSQ Report concluded James was a 'worker' and the location of the injury resulting in his death was a 'workplace' under the *Work Health and Safety Act 2011* (the WHS Act), but then states the death was '*not within the scope or intent of the activities*' of WHSQ. The WHSQ Report also includes a comment that no contact was made with next of kin '*as a result of the assertion of this matter being outside the scope of Workplace Health and Safety Queensland investigation*'.

99. The WHSQ Report concludes as follows:

'WHSQ's enquiries into this matter have concluded. It is opined the deceased died as a result of his involvement whilst playing a sport namely Rugby League. Rugby League is a physical game that consists of consensual violence. This report does not assert the death of Mr Ackerman arose from the conduct of the undertaking of the PCBU, Northern Suburbs Rugby League Football Club Limited. No further enquiries into the matter are considered necessary.'

100. WHSQ's legal branch also considered the matter and in a document provided to the investigation there followed a detailed discussion as to whether and to what extent the incident falls within the work health and safety regulatory framework. This document noted the following key conclusions:

a) Relevant duty holders ('the Rugby League and its administering clubs') did have systems in place which were reasonably practicable.
b) Even if players could be described as 'workers' and 'others' and thus have duties under the WHS Act, '*the scope of those sections is quite general and when read against the Act, the Regulations and other relevant material made under the Act (such as codes of practice), public policy and legal interpretation of statute might suggest the incident on 20 June 2015 bears little relationship or nexus to work health and safety legislation*'.
c) Physical contact that is 'outside the rules of play and thus arguably without consent' is a matter more appropriately dealt with by QPS in its role for investigating criminal offences.

101. The legal advice concludes by concurring with the recommendation there be no further investigation by WHSQ.

102. The WHSQ Report does not contain any further discussion as to whether and how relevant duty holders complied with their work health and safety duties under the WHS Act, or what is the scope or intent of WHSQ activities or investigations, and why this incident was considered to fall outside it.

103. The State Coroner recently considered Queensland's work health and safety legislative and regulatory framework as it applied to competitive surf lifesaving.[1] Relevantly the State Coroner noted:

> *Although not a traditional workplace, the OFSWQ Report concluded that the WHS Act applied to [Surf Life Saving Australia (SLSA)] and activities within the surf zone. The OFSWQ Report identified that the WHS Act contains relevant approaches to risk management. The WHS Act imposes duties to ensure health and safety by requiring SLSA, as a person holding a duty of care, to eliminate risks to health and safety as far as reasonably practicable. Where it is not practicable to eliminate risks SLSA is required to minimise those risks, as far as reasonably practicable, by implementing risk control measures. The challenge in complying with this duty in sports such as surf lifesaving, where competitors are likely to be attracted by the inherent risks, is apparent. The fact that some activities engaged in by lifesavers are inherently risky does not relieve SLSA of its obligations under the WHS Act. At the same time, the Act does not require SLSA to ensure that accidents never happen. It must do*

[1] *Inquest into the death of Matthew Stephen Barclay* delivered 15 January 2016

everything that is "reasonably practicable" to ensure the health and safety of competitors. It is clear from the documentation provided by SLSA that it was aware of its obligations under the WHS Act and had attempted to develop a risk management framework with those obligations in mind. The risk management framework was developed in accordance with recognised standards with input from organisations and individuals with specialist expertise in that field.

104. WHSQ had not initially conducted an investigation into the death arising from the surf lifesaving competition. The State Coroner commented that '*…having regard to the different focus of the QPS investigation to an investigation under the WHS Act, it would have been beneficial for a full investigation to have been carried out under that Act given the objects of the WHS Act and the emphasis on risk management in workplaces.*'

105. The State Coroner accordingly made the following recommendation:

That in the event of a future death at a surf lifesaving event an investigation be carried out by the regulator under the Work Health and Safety Act 2011, in consultation with the Queensland Police Service.

106. In response the Queensland Government supported the recommendation noting such an investigation would be conducted under the *Safety in Recreational Water Activities Act 2011*, which Act is linked to the WHS Act. The QPS OPM's have been amended accordingly.

107. Counsel Assisting submitted that arguably the State Coroner's observations and recommendation regarding a death arising from a surf lifesaving competition could equally apply to a death arising from the business or undertaking of rugby league.[2] More broadly, a risk management approach to ensuring the safety of those who play professional sport, even one involving 'consensual violence', is both desirable and achievable.[3]

108. The issue of the applicability of workplace health and safety principles and legislation to sporting events has been the subject of some recent consideration. The recent *Best Practice Review of WHSQ*[4] noted comment by stakeholders that jurisdictional boundaries of WHS and public safety are vague, especially in the instance of an injury

[2] *Professional sport, work health and safety law and reluctant regulators (2015)*, Exhibit G5.
[3] *Catastrophic Injuries in Rugby Union: An Assessment of the Risk* (2007), Exhibit G4.
[4] *Best Practice Review of Workplace Health and Safety Queensland Final Report*, 3 July 2017

or fatality on a sporting field. The review report noted at p 107 *"Different stake holders hold a different legal, policy and sociological views as to WHSQ's proper role and function. If principles of hazard identification/risk assessment familiar to work health and safety assist in understanding "failures" or systems, they do not translate into acceptance of jurisdiction."* The review report noted that in relation to some recreational activities such as diving/snorkelling and amusement devices the legislature has seen fit to intervene. Specific mention of surf life-saving was not referred to but again there is at least a legislative connection to those activities in the *Safety in Recreational Water Activities Act 2011.*

109. The review report commented "*This is not the case with virtually all other public and recreational activities, including sporting and competitive pursuits. Voluntary involvement, and the contractual and civil relationships between/amongst parties will make any incident questionable in the work health and safety jurisdiction, better investigated by others, and will give rise to circumstances from which it may be very difficult to prove any offence. Such incidents are better dealt with under the common law and the law of tort."*

110. The Review further commented that the WHS Act should not be seen as a default setting for all human conduct and stated *"Beyond the clearly delineated areas of work health and safety law designed to have some element of public health and safety protection, the common law in terms of civil liability or remedy might be relevant and the criminal law remains applicable."*

111. It is noted that the Queensland Government has adopted almost all of the recommendations of the review and on that basis it is not intended to make any specific recommendation on this issue. I am aware that WHSQ have taken a similar limited view as to its investigatory and regulatory role in relation to the sport of Sky Diving.

112. WHSQ did not appear as a party to the inquest but given the issues raised and the outcome of the review it would seem appropriate for WHSQ to be asked, as a point of clarity for the future, to spell out in a policy statement, what activities will be investigated by it and what will be seen as outside of its jurisdiction and why. The Coroners Court will liaise with WHSQ through internal consultation processes already in place between the Court and other agencies including WHSQ to discuss how that can best be addressed.

113. Counsel Assisting also considered whether a recommendation should be made to the QRL and NRL that it develops and maintains a risk management approach to player safety in Rugby League in Queensland, having regard to its obligations under the WHS Act, and that it encourages QRL clubs to do the same.

114. The NRL submitted such a recommendation should not be made as risk management processes are already firmly in place and appropriately resourced. The NRL noted that specifically relating to shoulder charges it had undergone a review process in 2012 and the shoulder charge was banned in February 2013 before the start of the 2013 season. There were subsequent rule amendments in 2013, 2015 and 2017 and a 2016 penalty review. The NRL submitted that it had approached these matters in a professional and evidence-based manner.

115. The NRL also submitted that evidence was not sought or given in relation to the NRL's overall current system of risk management regarding player safety in relation to other aspects of the game. Certainly this inquest was focused on what happened to James Ackerman and was limited to considering issues concerning shoulder charges. It was not, nor could it be, a roving commission considering all aspects of Rugby League, how the game was played and the NRL/QRL approach to player safety generally.

116. Counsel for Norths also submitted (supported by oral evidence from a number of witnesses) that the NRL/QRL have in recent times adopted a number of further measures addressing player safety including changes to the laws involving banning a whole range of tackles and dangerous lifting techniques in support of it endeavouring to ensure players are protected when they are in vulnerable positions.

117. I accept the evidence before the court supports the proposition that the game of Rugby League has in more recent times endeavoured to implement policies and practices designed to ensure greater safety of the players and in doing so have utilised some work health and safety principles.

118. I comment however, that even though WHSQ takes the view that competitive sporting activities may not be currently subject to regulatory oversight by WHSQ under the WHS Act, adopting principles of hazard identification/risk assessment similar to those adopted in work health and safety regimes is clearly one of the processes that Rugby League and other competitive contact sports should continue to adopt or endeavour to adopt.

Actions taken by Brisbane Broncos Rugby League Club Ltd and Francis Molo to manage the risk to player safety associated with shoulder charges, both prior and subsequent to James' death.

119. Francis stated prior to James' death and throughout his professional Rugby League career he had received significant coaching and instruction in relation to correct tackle technique, particularly from the Broncos as part of their elite player development program. That would be all quite expected.

120. At inquest, Francis described how he had been taught to tackle. His description was consistent with how the CEO of the Broncos Paul White described the 'Gold Standard' tackle taught by the Broncos to all players.

121. Francis agreed he had never been taught how to perform the shoulder charge technique or encouraged to do so, either by the Broncos or his feeder club, Norths. Francis explained it was something he had admired in other players he had looked up to growing up, and he had made the technique part of his own game when it was still allowed within the rules of the game. Prior to it being banned he does not recall ever being advised about concerns for player safety involving the shoulder charge.

122. When the shoulder charge was banned at the beginning of 2013, Francis recalls receiving a slideshow presentation from the NRL about this and other changes to the rules. He also recalls rule changes being talked about and coached as part of pre-season training with the Broncos.

123. After James' death, Francis stated he did a lot of work on his tackle technique in pre-season training with the Broncos for the 2016 season. He also worked hard on his conditioning and strength.

124. When asked whether he received any one-on-one coaching or instruction specifically in relation to shoulder charges after the incident, Francis said he did approach the Broncos assistant coach on one occasion for some instruction about his tackling technique, and also worked on his tackle technique himself with another player.

125. It is evident that Francis was not spoken to specifically about shoulder charges or how to avoid them since James' death.

126. Broncos' CEO Paul White gave evidence the Broncos' approach to Francis' coaching and instruction both before and since James' death was to focus on correct tackling technique and fitness.

127. Mr White agreed that in relation to Francis' conduct and tackle technique, the responsibility for this rested largely with the Broncos but with some communication back to the affiliate club. When asked what the Broncos did in response to Francis' involvement in the shoulder charge in 2015, Mr White said apart from offering Francis support for his welfare, any coaching or instruction was focussed more generally on defence, conditioning and fitness.

128. Mr White was asked about the shoulder charge offences and suspensions incurred by Francis in the 2016 season of the Intrust Super Cup. Mr White attributed those incidents to fatigue and poor technique, rather than any intentional or reckless conduct. Mr White stated Francis had worked hard, particularly in the 2017 pre-season, to improve his fitness, which Mr White felt was the best way of eliminating those types of shoulder charges from Francis' game into the future.

129. I accept the Broncos and Norths were in what they called "uncharted territory", in dealing with a player fatality on the field. Broncos and Norths understandably expressed they were concerned about Francis' welfare and did not to speak directly with Francis in relation to the actual shoulder charge incident. It was understood Francis was receiving counselling for some period of time. However, given the tragic outcome and then following the incidents involving shoulder charges the next year, there could have been some thought given as to whether the issue should be discussed more directly with Francis at an appropriate time and with appropriate support. This was arguably an ongoing illegal tackling technique issue that could have impacted on the safety of opposition players going forward.

130. I am not particularly critical of the Broncos position about this. It was a judgment call and they made a decision. With the resources at the Broncos disposal it may have been better if professional advice was obtained to determine whether they should directly approach Francis about his tackling technique, rather than presume Francis's welfare concerns were such this could not occur.

Actions taken by Queensland Rugby Football League Ltd and, where applicable, National Rugby League Ltd to improve player safety in relation to the risks associated with shoulder charges.

131. Early in the 2012 NRL season a number of incidents involving use of the shoulder charge technique (which at that time was allowed within the Laws) raised concerns about player safety. In response the Australian Rugby League Commission (ARLC) and the NRL initiated a review of the shoulder charge ('the Shoulder Charge Review'). As an interim measure the ARLC issued a direction that '*any shoulder charge which results in dangerous contact will be referred directly to the Judiciary Panel without grading*'. The ARLC further explained the directive was intended to discourage players from taking unacceptable risks with the welfare of an opponent.

132. The Shoulder Charge Review carried out investigations including literature reviews and comparisons with other codes, utilised data from player GPS devices, consulted with a range of players, coaches, referees, officials and professional consultants endeavouring to establish evidenced based findings and conclusions. The review was published in November 2012 and concluded tackles involving the shoulder charge technique present unacceptable injury risk and recommended the technique be banned. Upon receiving this recommendation the ARLC approved new rules outlawing the shoulder charge, which were effectively adopted by the NRL and the QRL from the commencement of the 2013 season.

133. Key findings of the review included:

- The average impact forces of shoulder charges are 76% greater than in the conventional front on tackle
- Confirmed a perception NRL player size had increased in recent times, and this increase made players more capable of producing greater acceleration and impact force in contact situations
- Whilst the incidence of shoulder charges was low and the majority of those identified by the Shoulder Charge Review (93 in total) resulted in no recorded or reported injury, a meeting of NRL club medical officers nevertheless recommended by majority vote (14 to 1) that '*the shoulder charge is a tackle which has an unacceptably high risk of injury even if there is no contact with the players head and should be removed from our game*'
- The NRL Competition Committee comprising of leading NRL coaches and referee officials determined player safety was the paramount issue and agreed the

shoulder charge involved an unacceptable risk of injury and had no place in the game.

134. Individual players stated the shoulder charge technique should be permitted but with stiffer penalties applied to situations where high impact contact to the head is made.

135. However, the national education and training manager for referees highlighted the difficulty for referees in determining whether a shoulder charge involved high contact during play. He also noted the game had deemed the shoulder charge technique dangerous in junior levels, and suggested the propensity for injury is greater in the older age groups when players become bigger and stronger.

136. Since the 2013 ban, the Laws have been amended a number of times to clarify and simplify the definition of a shoulder charge in an attempt to strengthen the ban. The result is that by 2017 a shoulder charge resulting in forceful contact with any part of an opposing players' body is banned and is an offence that must be considered by the judiciary and not simply dealt with on the field as a penalty.

137. The issue of penalties imposed for shoulder charges was raised in the course of the investigation and was also raised by the family who questioned whether further penalties should be imposed in respect of conduct that results in death or serious injury. The penalty regime was but one aspect of how to manage the risk of injury or death from shoulder charges on the basis they are still being committed.

138. Mr Wharton from the QRL pointed out the changes to the definition of a shoulder charge since 2015, including as recently as February of 2017 had simplified the offence and made it easier to identify.

139. It was also noted a new base penalty points system had been adopted in 2016 by the NRL and QRL following a penalty review, which prescribed fines for less serious offences and demerit point penalties for more serious offences. This also resulted in the removal of Grade Four and Five gradings for shoulder charge offences (and for all other offences). Although it was considered that this may have been a diminution in the penalties imposed, it was subsequently submitted by the NRL/QRL that where any offence is deemed by the Match Committee to be so serious that it cannot be dealt with as a Grade Three demerit point charge, it is automatically referred to the judiciary for determination. The effect, it was said, is that base penalties have not been reduced but more serious offences are likely to be referred to the judiciary.

140. Mr Wharton stated since tracking all judiciary incidences since 2015, the QRL is starting to see data that suggests '*people are starting to learn that you can't do this*'. Mr Wharton expressed a view the simplification of the shoulder charge rule, as well as increased monitoring of and response to repeat offenders by the QRL since early 2017, are sufficient measures for reducing or eliminating the shoulder charge from the game.

141. The 2016 Penalty Review also set out three sliding offences for Intentional, Reckless or Careless High Tackles. It was submitted by Counsel Assisting that the NRL and QRL may also wish to consider treating shoulder charges in the same way. Although the QRL did not cavil with that proposition, the NRL disagreed. The NRL stated that the *Judiciary Code of Procedure* noted that the definition of a shoulder charge is an all-encompassing one and it makes no difference, except as to penalty, whether the conduct was careless, reckless or intentional. Hence, any one of those different mental elements is sufficient to satisfy the charge. It is only at the judiciary that the offending player's mental element is directly relevant to the question of penalty. The NRL considered that the further categorisation of shoulder charges gradings by reference to the mental element involved will confuse, rather than assist, when charging a player with that offence; would have no practical impact upon the sufficiency of existing penalties or actual penalties imposed; and would not act as a greater deterrent.

142. That position did seem somewhat at odds with the position concerning the three way categorisation of intent for high tackles. It was explained by the NRL that this reflected the international position in that high tackles have historically been categorised that way internationally. As well, high tackles are the most prevalent aspect of foul play in the game, and it was thought there is special reason to treat high tackles differently. Further, by definition high tackles are easier to identify, as opposed to shoulder charges, which have by definition historically been more open to interpretation.

143. I conclude that the NRL took action to review the shoulder charge technique when concerns were raised in 2012. The subsequent review resulted in largely evidence-based recommendations about its safety and whether it should remain in the game. The recommendations were expediently adopted and since 2013 the NRL, and by association the QRL, have strengthened the prohibition of the shoulder charge by simplifying the definition and widening the scope.

144. Although there may continue to be differing views on whether this particular tackle was a shoulder charge it is to the point that 'shoulder charges' or similar forceful contact

invariably involve high impact and death or serious injuries can and will occur even though the neck and head are not directly impacted.

145. The NRL/QRL are to be commended in the approach they have taken with respect to the ban on shoulder charges. I also accept as appropriate the position of the NRL/QRL in respect to the issue of grading charges up to Grade Three and all other charges necessarily to be determined by the judiciary. I am less convinced about the issue of having a three way categorisation for high tackles and not for shoulder charges. Given the QRL did not cavil with the proposition I wonder if the NRL and its associates should not reconsider that position. I do not have a strong view on this and it is best left to the game to consider those issues and make a determination.

146. One issue that also arose was the position of the apparent reluctance to utilise send offs from the field of play as a form of deterrent to the offence of shoulder charge. It is evident that send offs for this and other offences are not utilised often in Rugby League unless the dangerous contact is very clear and serious. The referees, as determined somewhat by the game policies, are reluctant to use send offs, particularly if there is some uncertainty, and they prefer to leave this to the Match Review official by placing the player on report. The evidence from a number of witnesses confirmed a reluctance to issue send offs, and certainly witnesses were against the concept of mandatory send offs for all shoulder charges of whatever grade. The reasons given were the decision can change the outcome of the game in circumstances where referees have split seconds to determine what happened and in a situation where there is still very much a grey area.

147. I consider that the issue of the reluctance to utilise send offs is one that may need to be reconsidered by the game. The rules allow for this to happen but at a policy level it is clear the message filtered down to match officials is to use send offs in only exceptional cases. The match officials who gave evidence at the inquest stated that send offs had not been used by them in the past. I accept mandatory send offs for any grade of shoulder charge are not warranted and would no doubt be counterproductive as a deterrent. I am not making a prescriptive recommendation about this issue as any change in policy needs to consider all illegal play, but there is clearly a place for this level of deterrence to be considered.

148. James' family also suggested that recommendations should be made about making headgear compulsory for junior rugby league players as a way of encouraging players as they move forward to continue to wear head gear. As I have found it is by no means

certain direct contact to the head or neck was involved in this case and I agree with Counsel Assisting it would be outside of the scope of this inquest to proceed that far. As well the efficacy of the use head gear in contact sport has been spoken about for decades and it is for the respective sports to continue that research and decide the benefits and disadvantages and make their own decision.

149. The issue of reducing the potential for significant impact of bodies by removing kick-starts or line drop outs was also suggested. I accept such a removal would not necessarily reduce such impacts in other stages of the game. It would be a significant change to the game's appeal and would have little support.

Conclusions and Comments

150. There was evidence led from a number of witnesses that James Ackerman relished the hard contact of Rugby League. Francis Molo was a larger and heavier person than James. Francis was described by some as a gentle and quiet person off the field but he also played hard on the field. The incident causing the tragic death occurred early in the game when it was usual for players, particularly forwards, to attempt to assert some physical and psychological dominance over their opponents. James ran at speed directly towards and into his opposing forward, Francis Molo. Francis braced himself for the impact, bending his knees and pushing forward and slightly upwards into James as the two collided. Up to the point of impact both players were simply 'playing hard' and 'doing their job'.

151. Francis does not believe that he impacted James with his shoulder with his arms tucked into the side, as was the offence for a shoulder charge at the time and that the impact was front on to the chest area. I have found that the impact was more side on and certainly the front right side of Francis' shoulder came into contact with the upper part of James chest/shoulder area. There was no attempt by Francis to wrap his arms as part of a legitimate tackle and although Francis says he did not have time to do so, in my view it never looked like that would occur. Francis was suspended for nine matches for a Grade 5 Shoulder charge and I have concluded the process that eventuated in that penalty was appropriate and legitimised the finding that this was a shoulder charge.

152. Francis may not have made direct contact with the head or neck but it is more likely than not the on field collision and resultant rapid deceleration caused James' head and neck to move in such a way and with such force his right intracranial internal carotid

artery was stretched and torn. This resulted in intracranial bleeding and pressure causing injury to James' brain incompatible with life.

153. The game of Rugby League banned the shoulder charge form of tackle in 2013 because of safety concerns. The game has taken steps since that time to strengthen the ban by simplifying the rule. The ban was not universally applauded by some, but I accept the ARLC, NRL and QRL have been resolute in their approach to banning this clearly dangerous form of tackle. The subsequent rule changes have been responsive to concerns the ban had not gone far enough and have simplified the rule and made the ban more effective. The rule changes reflect the fact that death or serious injury can occur from the significant forces and impacts that modern players can impose on each other even where there is no direct contact with the head or neck.

154. Of course it is apparent shoulder charges are still being carried out, as is the case with other banned tackling techniques such as high tackles. There are a number of strategies available to the game to deal with such breaches of the rules including penalties, send offs, placing players on report and suspensions. There was evidence the NRL/QRL provides training relating to rule changes. I accept the evidence that on field training would not teach illegal techniques for safety reasons as well as a pragmatic reason being they will result in penalties.

155. I have commented that the reluctance to use the send-off process as an aspect of deterrence should be relooked at by the NRL/QRL but I accept a mandatory send off for any grade of shoulder charge is not warranted and likely to produce unfair results.

156. The penalty regime has also been considered and I received evidence about how the impact of the changes to the penalty regime is that more serious charges will now be heard by the judiciary where more appropriate penalties can be given. It should be noted that criminal law sanctions can still apply to illegal acts occurring on a football field, and in recent times I am aware charges have been brought.

157. I have also suggested that the NRL and QRL should look at the three way categorisation for high tackles and why this would not also be applicable to shoulder charges, but as I stated this is not a strong view of mine.

158. James died playing the game he loved. He is clearly sadly missed by his wife, his parents and other family members and his friends and teammates.

Findings required by s. 45

Identity of the deceased – James William Ackerman

How he died – At the time of his death, James William Ackerman was 25 years old and a semi-professional rugby league player with the Sunshine Coast Falcons. On 20 June 2015 Sunshine Coast were playing against the Norths Devils at Norths' home ground at Bishop Park in Nundah as part of the Intrust Super Cup competition. James was playing in the front row. Sunshine Coast scored a try in the very early minutes of the game, and Norths then kicked the ball from half-way to restart the game. A Sunshine Coast player received the ball from the kick-off and passed it to James, who ran at the defensive line. Within that defensive line was player Francis Molo. James and Francis collided with each other and James immediately fell to the ground, dropping the ball. James remained on the ground, unresponsive, and it appeared he was struggling to breathe. Emergency medical treatment was provided on the ground and then at the Royal Brisbane and Women's Hospital where James was taken. James was experiencing bleeding to the brain and was placed in an induced coma. Over the next two days it became apparent James' condition was incompatible with life and a decision was made, in consultation with James' family, to terminate his life support. James passed away on 22 June 2015. An autopsy was conducted on 26 June 2015 and James' cause of death was determined to be a '*traumatic subarachnoid haemorrhage*' resulting from a '*right intracranial internal carotid artery dissection*'. It is more likely than not the on field collision and resultant rapid deceleration caused James' head and neck to move in such a way and with such force his right intracranial internal carotid artery was stretched and torn. This resulted in intracranial bleeding and pressure causing injury to James' brain incompatible with life.

Place of death – Royal Brisbane & Womens' Hospital BRISBANE QLD 4001 AUSTRALIA

Date of death– 22 June 2015

Cause of death – 1(a) Traumatic subarachnoid haemorrhage
1(b) Right intracranial internal carotid artery dissection

I close the inquest.

John Lock
Deputy State Coroner
BRISBANE
9 November 2017