VICTORIAN INSTITUTE OF FORENSIC MEDICINE

MONASH University

STOP THE COWARD PUNCH CAMPAIGN 2019

Research Update

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30 May 2019

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RESEARCH UPDATE: 127 Australians killed by a coward punch since 2000

- There were 127 one-punch deaths in Australia between 2000-2016
- 94% of victims were males; average age: 37 years
- 73% of fatalities involved alcohol
- These deaths occur on the weekend, at homes, pubs and clubs between 12pm and 3am
- Despite awareness, one-punch deaths keep happening
- **Every one of these deaths is completely preventable.**

Young Australian men are the main victims

A staggering 94% of one-punch victims were male, with only 7 cases involving females. This is consistent with research on assaults which indicate offenders are almost exclusively male. As well as the devastating effects on the one-punch victims themselves, these assaults also have a significant impact on their families, friends and the wider community. The emotional impact on emergency services treating one-punch patients every weekend around Australia is enormous and the financial burden on the Australian healthcare and justice systems cost taxpayers millions of dollars every year.

Alcohol: a key factor

Alcohol was the major factor associated with one-punch fatalities from 2000-2012, detected in almost three quarters of victims.

The average concentration of alcohol in blood was 0.16g/100mL, which is over three times the legal driving limit in Australia. Blood alcohol concentrations up to 0.2g/100mL can result in slurred speech, loss of balance and coordination, slowed reflexes, poor judgment, and a decreased ability to interpret and react to surroundings. Excessive alcohol consumption among men is also associated with increased aggression and, consequently, an increased risk of perpetrating violence against others. This study also demonstrated that alcohol increases the risk of becoming a victim of a violent assault.

The implications of drinking excessively can increase the risk of injury in a one-punch victim. When a person is intoxicated by alcohol, their ability to react to an incoming punch or attack is compromised. Alcohol intoxication impairs an individual's ability to understand social cues and

anticipate the signs of danger, especially in noisy, crowded or dark social settings. Victims may also be susceptible to greater trauma with an unexpected blow to the face. Relaxation of the muscles around the neck causes the victim to be less resistant to the punch, which can result in more significant trauma to the major arteries of the neck and can be fatal.

Alcohol is still regarded as the biggest contributor to substance-related violent deaths throughout the world. As total volume of alcohol sales increase, so does the rate of fatal assaults.

Other drugs are less prevalent- but will this change?

Involvement of other drugs was less common, with cannabis the next most prevalent (10 cases) and Methylamphetamine ('ice') or MDMA ('ecstasy') detected in only two cases. Aside from drugs administered in hospital, the only other pharmaceutical drugs detected among victims were antidepressants (3 cases).

However given the rise of methylamphetamine in forensic casework in recent years, particularly among fatal road crashes and violent assaults, it is possible that this drug features more prominently in one-punch assaults since 2012. This is something we are currently investigating.

Most cases (45) were delayed deaths occurring days, weeks or months following the initial assault, with limited toxicological analysis performed as most drugs would have been eliminated from the victim's body during this time in hospital. In 24 cases, toxicology analysis was not performed, or the report was unavailable. Therefore, the prevalence of drugs in these deaths is most likely an underrepresentation.

Weekends are prime time for these assaults

Most assaults occurred between Friday and Sunday, between midday and 3am.

This is consistent with the times of the week most Australians are out drinking alcohol. Research indicates that late night drinking presents a time of particular risk for violent assaults.

Most deaths occurred at a hotel/pub or in a public space (sidewalks, parks, camping sites or public transport stops), including 8 incidents where the assault occurred shortly after the deceased had left a licenced venue where they had been drinking. Often an argument started at the pub and resumed down the street, resulting in a one-punch assault. Most of these victims were unknown to the perpetrators prior to the assault.

Residences were also a common location for one-punch assaults, mostly involving fights among family members or friends.

An argument preceded the punch in 76 cases, but it was often unclear whether it was the victim or the perpetrator who initiated the fight. Sixteen cases were completely unprovoked without any interaction between the victim and perpetrator prior to the assault.

While the majority of deaths occurred in NSW (30), followed by Victoria (26) and Queensland (26), this is reflective of the population distribution across Australia.

These deaths represent the tip of the iceberg

While these figures are alarming, they represent only a fraction of the problem surrounding one-punch assaults in Australia.

Firstly, this study only included cases that were no longer under investigation by the Coroner. There are also numerous fatal assaults beginning with a one-punch which incapacitates the victim, but are then followed by a series of punches and kicks by the perpetrator. These cases were not included in our study either but represent a large component of forensic casework in Victoria.

There are a number of one-punch victims who do not die, but end up permanently mentally and/or physically disabled from the assault. These cases typically involve complex neurosurgery and a prolonged intensive care hospital admission, followed by rehabilitation and ongoing care to manage the physical, cognitive and emotional damage incurred with the assault.

It is highly unusual for a one-punch victim to survive without any permanent damage; typically they experience a range of cognitive impairments including difficulties with memory, concentration and learning, and most are unable to return to work. They never regain full cognitive ability again, but just learn to adapt.

These are the ‘lucky’ ones- many survivors are left with profound disabilities years after the assault and are confined to a wheelchair requiring permanent care.

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What's changed since 2012?

Research update underway

Despite greater public awareness of one-punch assaults in recent years, they continue to happen; there were a further 28 one punch fatalities between 2013 and 2016.

While most of these deaths occurred in NSW (8 deaths), it is alarming that the number of one-punch fatalities in WA was next highest (7 deaths). This is a much higher proportion of deaths in WA compared with cases prior to 2012 and also in view of population distribution across Australia. There were a further 6 deaths in Queensland, followed by 4 in Victoria.

Not surprisingly, the majority of these cases (28) were male, aged between 31 and 60. However interestingly, the highest proportion of cases (9 deaths) was aged between 51 and 60, followed by 7 deaths among 31–40-year-olds and 5 deaths in 41-50 year olds. This is a change from the pre-2012 data with an apparent trend towards older males.

Most deaths occurred on a public space, e.g. a street or side of the road (13 deaths). This was followed by 7 deaths at a person's home and 4 in a commercial area (which includes pubs and licenced venues, as well as shops and office spaces).

The prevalence of alcohol and other drugs in these recent cases is currently under investigation and may help identify further opportunities for death prevention.

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STOP THE COWARD PUNCH

COMMENTARY: Preventing one-punch deaths

What's changed since 2012?

When we first started looking into one-punch deaths in 2012, we had no idea just how serious and widespread this problem was in Australia.

Fast forward a few years and very little has changed.

A further 28 people have lost their lives to a one-punch assault between 2013 and 2016. This number is likely to rise as further cases are closed in the criminal courts. This doesn't include more recent coward's punch deaths, including the tragic death in 2017 of Patrick Pritzwald-Stegman, the cardiothoracic surgeon and father of two who was punched after telling someone to stop smoking at the entrance to a hospital where he worked.

The impact felt by the family and friends of one-punch assaults are highlighted by the devastating case of the Kelly family. Eldest son Thomas was killed by a completely unprovoked one-punch assault in 2012 and four years later, his younger brother Stuart took his own life. Their parents, who have fiercely campaigned for Sydney lockout laws and the introduction of mandatory sentencing in one punch assaults, expressed their heartbreaking guilt at the loss of their boys earlier this year.

One punch assaults do not only affect the victims. These are sons, brothers, husbands, fathers, friends and colleagues. These deaths have a real, and often permanent, ripple effect in the community. These senseless acts of violence do not discriminate. What they do seem to have in common, is alcohol.

Few would be surprised that alcohol is regarded as the biggest contributor to substance-related violent fatalities, including one-punch deaths. As total volume of alcohol sales increase, so does the rate of fatal assaults. 73% of one-punch victims had been drinking before they died and many to excess- the median blood alcohol level was over three times the legal driving limit in Australia. Hospital emergency departments are overflowing with victims of alcohol-related assaults; there are almost 6,000 deaths and 150,000 hospitalisations related to alcohol each

year in Australia. The social costs of alcohol abuse in Australia costs in excess of $15billion annually.

The question we are currently investigating is - will alcohol continue to be a major factor in one-punch fatalities? Other forensic casework may hold some clues.

For the first time ever, the prevalence of methylamphetamine ('ice') among drivers in fatal road crashes in Victoria has exceeded the number of fatal road crashes involving alcohol. Methylamphetamine also features strongly among violent offenders and has increased rapidly among deaths reported to the coroner. The methylamphetamine-associated death rate has quadrupled between 1999 and 2016. While we only identified one case in the 2000-12 study where methylamphetamine was detected, it is possible that this figure will rise in one-punch deaths since then.

But with a concerted effort towards education and awareness, we are seeing some positive trends.

The 2013-16 cases indicated a decline in one-punch fatalities occurring at licenced venues compared to pre-2012, which may indicate successful initiatives to prevent and manage alcohol-related violence at these locations. Other prevention strategies, including mandatory sentencing for perpetrators and the Sydney lockout laws which have reportedly cut assaults in Kings Cross by up to 49%, are also likely contributors. The continued public awareness and education campaigns about the risks of excessive drinking and that one punch *can* kill may also be having a positive impact. With only 4 deaths in Victoria between 2013 and 16, it appears that these messages may be reaching the public in some parts of the country. Unfortunately, in Western Australia, there were almost as many deaths between 2013 and 2016 as there were in the entire 13-year study period examined previously. Despite the introduction of coward's punch laws in WA, sentencing in some recent cases has been lenient and has not reflected the seriousness of the attack.

We have seen a decline in younger one-punch victims. The age of one-punch victims was higher in the post 2012 cases, with most victims aged between 51 and 60 years of age (our previous work demonstrated the highest risk among 20–49-year-olds). The explanation for this increase among older adults is unclear and something we intend to investigate further; but the silver lining to this may be a decline in younger one-punch victims, with the lowest proportion of deaths seen in under 30-year-olds. We know drinking rates have declined among young Australians but increased among the 30+ and especially 50+ population; so maybe this trend

in one-punch victims is alcohol related? Perhaps public health initiatives aimed at preventing violence and alcohol abuse among young people is working.

What now?

There is still more work to be done to prevent one-punch assaults. As well as laws to deter potential perpetrators and initiatives to manage alcohol-related violence, education and research are key.

Our study remains the only national review of one-punch assaults in the world. The findings of the study provided the first evidence base for the development of policy and legislation around one-punch assaults in Australia that did not exist prior to 2014, demonstrating the importance of research in underpinning Australian public health policy and practice. However, this research alone is not enough.

More research must be conducted to determine recent trends in drug use among one-punch victims. Research also needs to consider non-fatal one-punches and explore the perpetrators of these violent crimes. This is essential to paint the complete picture of cowards' punches in Australia and guide evidence-based prevention initiatives for Australians most at risk- both victims and perpetrators.

At least 127 Australians have lost their lives to a coward's punch – a figure that is both devastating and unacceptable. And this is only the fatalities- there are so many more devastating impacts of these coward punches that we are yet to understand that will be critical in helping us to stop these senseless acts of violence.

Our job is not done yet.

The impact of a one punch blow - a clinical perspective

The 'Coward Punch', 'King Hit' or single unexpected blow to the head is a critical injury that can cause immediate death. Tragically it can also cause devastating brain damage ruining the lives of both the victim, their family and the perpetrator.

A punch to the head followed by the victim crashing to the ground causes an astonishing range of injuries. The damage caused to the brain may render the victim immediately unconscious so that they are unable to protect themselves when they fall. The blow can fracture the skull, bruise the brain and tear the blood vessels over its surface. This can result in bleeding around the brain with large blood clots that can crush and tear the fragile brain tissue as it is squeezed out through the openings in the skull and the surrounding membranes leading to death.

In addition to bruising, swelling, lacerations to the face, injuries resulting from a punch to the head can fracture the jaw, the nose, the cheek bones and the eye sockets, leading to permanent loss of senses such as smell, taste and vision. Despite complicated surgical intervention these facial fractures often result in lasting loss of normal jaw and eye movement, facial sensation and result in a life of chronic pain.

Punches to the head also affect the neck as the head is whipped around by the blow. This can stretch the arteries around the cervical spine tearing them resulting in bleeding and the brain being starved of blood leading to brain death.

For those who survive such an assault they are never the same again. Survivors may be left in a vegetative state or endure lifelong severe mental and physical disabilities preventing them from working, enjoying personal interests and separating them from their family and friends. For many of the bedridden they are reduced to living away from their family in permanent care nursing homes.