IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2009 3760

FINDING INTO DEATH WITH INQUEST[1]

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: ANDREW HEPPLE PATTISON

Hearing Dates:	1, 2, 3 and 4 May 2012
Appearances:	Mr S McGregor of Counsel on behalf of Maribyrnong City Council
	Mr D McCredden, Victorian Government Solicitor's Office, on behalf of the Victorian Commission for Gambling and Liquor Regulation
	Mr P Gamble on behalf of the Footscray Club Incorporated
Police Coronial Support Unit:	Senior Constable Tania Cristiano
Findings of:	AUDREY JAMIESON, CORONER
Delivered on:	24 February 2016
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank VIC 3006

[1] The Finding does not purport to refer to all aspects of the evidence obtained in the course of the Investigation. The material relied upon included statements and documents tendered in evidence together with the Transcript of proceedings and submissions of legal representatives/Counsel. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

I, AUDREY JAMIESON, Coroner having investigated the death of ANDREW HEPPLE PATTISON

AND having held an Inquest in relation to this death on 1, 2, 3 and 4 May 2012

at 222 Exhibition Street, Melbourne

find that the identity of the deceased was ANDREW HEPPLE PATTISON

born 30 July 1970

and the death occurred on 2 August 2009

at the Footscray Club, 43 Paisley Street, Footscray 3011

from:

1a. POSITIONAL ASPHYXIA IN A SETTING OF INTOXICATION AND MINOR HEAD INJURY

in the following summary of circumstances:

1. Mr Andrew Hepple Pattison died on 2 August 2009 from positional asphyxia in a setting of intoxication and minor head injury. The death of Mr Pattison was *reportable* as defined in the *Coroners Act* 1985 (Vic) (as it then was). An Inquest was held into the death of Mr Pattison on 1-4 May 2012 pursuant to section 52(1) *Coroners Act* 2008 (Vic).

BACKGROUND CIRCUMSTANCES:

2. Mr Pattison was born on 30 July 1970 and was 39 years old at the time of his death. He lived in Balwyn and worked as a butcher.

3. Mr Pattison was a member and patron of the Footscray Club Incorporated (**the Club**), located at 43 Paisley Street, Footscray. The Club is a social club with an annual membership fee that hosts regular events such as monthly functions, Christmas lunches, a Mother's Day luncheon; "[t]hose sort of functions that without the club…these people of Footscray wouldn't have the ability to celebrate".[2]

4. The Club is located on the second storey of the Paisley Street premises, and patrons must ascend two flights of stairs to access the Club, with approximately 14 steps per flight and a landing between the two.

[2] T, page 70.

SURROUNDING CIRCUMSTANCES:

5. Club committee member Thomas Flynn was the duty barman on 2 August 2009. He commenced work at 6.30am. Club committee member Steve Bartlett was also working on the day and the two cooked the meals for the 'Sunday Sippers' program.[3] Mr Bartlett arrived at the Club at approximately 8.30am on 2 August 2009.[4] He was cooking that day, but spent some time serving behind the bar.

6. The Club opened at approximately 10.00am.[5]

7. Mr Pattison arrived at the Club sometime between 12.00pm and 1.00pm. He sat at the bar and drank pots of "heavy beer" (Carlton Draught). Club member Nicholas Lewis arrived at the Club at approximately 2.30pm on 2 August 2009 and observed Mr Pattison playing pool with Club member, Alex Smith.[6]

8. Mr Flynn estimated Mr Pattison consumed between ten to 12 pots over the course of the afternoon.[7] Mr Flynn said this was a normal amount for Mr Pattison to consume.[8] Mr Flynn conceded he did not know whether Mr Pattison had been drinking alcohol prior to arriving at the Club, but said he did not appear intoxicated.[9]

9. To Mr Bartlett's knowledge, Mr Pattison had a meal that day.[10]

10. Mr Flynn observed Mr Pattison playing pool, and then return to the bar for a few drinks. Mr Pattison had asked Mr Flynn for two takeaway meals earlier. Mr Flynn kept them in the refrigerator for him. Mr Flynn recalls Mr Pattison asked him to call him a taxi but could not recall when this occurred. Mr Flynn said that just before this, he had formed a belief that Mr Pattison had had enough to drink and told him it was his last beer.[11] Mr Flynn said there was no disorderly behaviour, rather it was his instinct that Mr Pattison had had enough.[12]

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[3] Exhibit 5. Mr Flynn explained he and Mr Bartlett swapped duties behind the bar and in the kitchen; T, page 80. He said that although it did not always happen and was dependent on the day's planned activities, there were usually two volunteers working on Sundays; T, page 80.
[4] Exhibit 6.
[5] Exhibit 5.
[6] Exhibit 3, T, page 52.
[7] Exhibit 5, T, page 81.
[8] T, page 84.
[9] T, page 88.
[10] T, page 108.
[11] Mr Flynn considered this occurred between 15 and 25 minutes before 5.30pm; T, page 89.
[12] Exhibit 5. When asked whether it was possible that Mr Bartlett had also served beers to Mr Pattison, Mr Flynn said "no...[at the time] Steve would have been flat out with the meals and I would have been flat out behind the bar so we would have just stuck to our tasks"; T, page 81.

11. After Mr Flynn called for a taxi, he asked Mr Pattison to wait for it downstairs. Mr Pattison asked for a takeaway beer, and Mr Flynn provided him with a VB stubby. Mr Pattison left alone carrying the stubby and a plastic bag containing his two meals.[13]

12. Nicholas Lewis later observed Mr Pattison at the bar preparing to leave. Nicholas Lewis did not see Mr Pattison leave, but heard him tell other members he was leaving.

13. To exit the Club, one must walk across a landing, turn left, descend 14 steps to another landing, turn left again and descend a further 14 steps.[14]

14. Approximately 30 seconds after Mr Pattison left, Nicholas Lewis heard a loud 'thump' coming from the front entrance stairs. Nicholas Lewis communicated to Mr Bartlett that he thought Mr Pattison had fallen.[15] Mr Bartlett states "[f]rom experience of working here I figured he had fallen down the stairs..." and after looking through the window he could see Mr Pattison lying on the bottom of the stairs.[16] Mr Bartlett was the first person to reach Mr Pattison.[17]

15. Mr Bartlett checked for and located a pulse. Mr Pattison was lying with his body across the corridor, his legs folded up behind him and the first step up, his head resting against the skirting, and his face resting in blood, facing the floor. Mr Bartlett ran back up the stairs, asked that someone call for an ambulance and returned to Mr Pattison.[18] Mr Bartlett said that when he first saw Mr Pattison at the bottom of the stairs "I didn't think there was much that could be done".[19]

16. Mr Flynn telephoned emergency services and requested an ambulance. As Mr Flynn did not know what had occurred, he gave the telephone to Club Vice President Neil Lewis, who had been downstairs. Mr Flynn remained upstairs.[20] The emergency services call taker arranged to call Neil Lewis on his mobile telephone so that Neil could go to Mr Pattison and provide more information about his state.[21] Neil Lewis went downstairs to

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[13] Exhibit 5.
[14] Exhibit 14.
[15] Exhibit 3. Mr Lewis confirmed in evidence he did not witness the fall, nor did he observe Mr Pattison leave the Club, so could not comment on whether he was intoxicated; T, page 52.
[16] Exhibit 6.
[17] T, page 103.
[18] Exhibit 6.
[19] T, page 109.
[20] Exhibit 5.
[21] Exhibit 11, T, page 124.

Mr Pattison, and put his mobile telephone on speakerphone.[22] Neil Lewis observed Mr Pattison to be unconscious but breathing.[23]

17. Once Mr Bartlett asked for an ambulance, Club Secretary Robert Fisher went downstairs and cleaned the glass up. Mr Fisher then returned upstairs, as there were too many people in the small landing area. He remained upstairs.[24]

18. Whilst still on the call to emergency services, Mr Bartlett observed Mr Pattison was "convulsing" and he could not tell if he was breathing. Neil Lewis was also present. The emergency services call taker initially told them not to move Mr Pattison, however after guided Mr Bartlett and Neil Lewis in assessing his breathing, and determining that Mr Pattison was not breathing adequately, the call taker instructed them to move Mr Pattison, with one person holding his head and neck firm with the other holding the legs.[25] Mr Bartlett recalls panicking and considered he and Neil Lewis were a bit reluctant, however Neil Lewis grabbed Mr Pattison's legs and Mr Bartlett held his head and moved him to the right, away from the wall. Mr Bartlett explained that the move was "very marginal".[26] Neil Lewis states, "[w]e tried to turn Andy over but due to his position and the cramped area we were working in it was impossible".[27] The two could then hear sirens, and the ambulance arrived shortly after.[28]

19. Attending paramedics located Mr Pattison lying prone, diagonally across the bottom landing towards the bottom step. His legs extended up the bottom three steps on the opposite side of the stairwell, and his head was positioned at an extreme angle relative to his torso.[29] Paramedics were unable to revive Mr Pattison and he was declared deceased at the scene.

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[22] Exhibit 11.
[23] Neil Lewis said in evidence that he could not recall whether he explained this concern to Mr Bartlett; T, page 123.
[24] Exhibit 4.
[25] Exhibit 11.
[26] T, page 104. Mr Bartlett said this was because the 'gurgling' sound increased. He said he was panicked when he returned to Mr Pattison after calling for an ambulance, seeing a large amount of blood. Mr Gamble highlighted that the distress caused by seeing this might involve "us not reacting perhaps in the way we would like to think we could"; T, page 104. Ambulance paramedic Mr Gould later explained this 'gurgling' sound could have represented a build-up of secretions in his upper airway that he had not been clearing due to his conscious state, and it also possibly represented blood from his face that has entered his airway; T, page 187.
[27] Exhibit 7.
[28] Exhibit 6. Mr Bartlett stated he had approximately one dozen pints of light beer himself from about 2.00pm that afternoon. T, page 103. Neil Lewis, when asked about the time interval between being instructed by the call taker to move Mr Pattison and the arrival of the ambulance "It seemed like ages b[u]t it was probably only about 30 seconds..."; T, page 131.
[29] T, page 3.

20. Forensic Pathologist, Associate Professor (**A/Prof**) David Ranson, Deputy Director at the Victorian Institute of Forensic Medicine (**VIFM**) attended the scene on 2 August 2009 and observed Mr Pattison *in situ*.

INVESTIGATIONS:

Identity of the deceased

21. The identity of Andrew Hepple Pattison was without dispute and required no additional investigation.

Forensic Pathology

22. A/Prof Ranson found Mr Pattison lying supine with his feet resting on the bottom step of the entrance to the Club. His head lay towards an electricity switchbox. The switchbox was situated next to a bus shelter. His legs were slightly raised by his feet being positioned on the lower step of the entranceway. Some bloodstaining was present on his right hand however, there did not appear to be any significant injuries to either hand. No significant external injuries were noted to the back, face, shoulders or neck. Some blood was present around the face. Blood was not present deep within the ear canals. Palpation of the back of the head revealed a laceration in the form of a U shape, situated slightly to the right of the midline at the occiput. A considerable quantity of blood was present oozing from this wound.

23. A/Prof Ranson was informed that the ambulance paramedics held concerns about the nature of the injury to Mr Pattison's head. A/Prof Ranson noted that in the area of the intense blood staining at the foot of the stairs, there was a stud-like object protruding from the skirting board. The stud-like object however did not appear to have any blood on it.

24. A/Prof Ranson noted an area of scuffmark on the wall further up the first flight of stairs. He also noticed some fragments of dark brown glass present on the tiled steps in the entrance way and on the tiles at the foot of the stairs.

25. On 4 August 2009, A/Prof Ranson performed a post mortem examination on the body of Mr Pattison, reviewed a post mortem CT scan and the Form 83 Victoria Police Report of Death.

26. A/Prof Ranson prepared a Report [30] which detailed that the autopsy revealed evidence of a very small degree of natural disease of a type that A/Prof Ranson stated would not normally be expected to cause significant cardiac symptoms and was not of a degree that would be expected to have caused sudden death.

27. The autopsy revealed little in the way of significant recent trauma apart from the laceration to the back of the head. In particular, there was no evidence of any skull fracture and or damage to the cervical vertebrae or the spinal cord. Examination of the brain revealed no evidence of bruising or haemorrhages within or around it.

28. A/Prof Ranson said that it would be possible for an individual who has suffered such a scalp injury to receive a sufficient force to the head to result in a lowered state of consciousness or unconsciousness. He said that an individual who is in a lowered conscious state and positioned head-down with their head possibly trapped against the wall could have their upper airway compromised in such a way as to cause obstruction to breathing. A/Prof Ranson further said that a high level of alcohol might also contribute to failure of ventilation in difficult environmental circumstances.

29. The autopsy showed some petechial haemorrhages within the eyes together with a conjunctival haemorrhage and deep congestion of the lungs with prominent petechial haemorrhages within the interlobar fissures. A/Prof Ranson explained that while these findings are not necessarily diagnostic of asphyxia, the reported circumstances, involving potential positional airway obstruction combined with a probable lowered level of consciousness due to a head injury and alcohol ingestion, meant that positional asphyxia is a potential mechanism of Mr Pattison's death. A/Prof Ranson concluded that in the absence of other significant natural disease or trauma to explain the death, it would be reasonable to raise the significance of positional asphyxia from a probable cause of death to the cause of death.

30. Toxicological analysis of blood retrieved post mortem identified the presence of alcohol at a blood concentration of 0.31g/100mL.[31]

31. A/Prof Ranson ascribed the cause of Mr Pattison's death to positional asphyxia in a setting of intoxication and minor head injury.

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[30] Exhibit 1 – Medical Examiner's Report of A/Prof D.L. Ranson (and attaching the Toxicology Report) dated 1 May 2012.

[31] The concentration of alcohol identified in Vitreous Humour was 0.37g/100mL. The blood alcohol concentration limit for drivers in Victoria is 0.05g/100mL.

Police Investigation

32. The circumstances of Mr Pattison's death have been the subject of investigation by Victoria Police on my behalf.

33. Police attended the scene at approximately 5.55pm and initially notified the Criminal Investigation Unit and ultimately the Homicide Squad. Following the autopsy, the preliminary findings indicated no evidence of third party involvement.[32]

34. Coroner's Investigator Leading Senior Constable (LSC) Ash Barry attended the scene but did not see Mr Pattison *in situ* at the bottom of the stairs, as the paramedics had moved him before he arrived.[33]

35. A scuffmark was identified on the wall further up the lower flight of stairs,[34] however there is no evidence as to where Mr Pattison fell from, and no evidence to suggest when or how the scuffmark might have appeared.[35]

36. A camera was noted to be in place at the Club's entrance door however, Police were informed that it does not record.[36]

37. LSC Barry submitted a brief of evidence containing statements.

Coroners Prevention Unit

38. The Coroners Prevention Unit (**CPU**)[37] was requested to prepare information on the requirements for Responsible Service of Alcohol (**RSA**) training for licensed premises in Victoria on my behalf.

Expert Opinion

39. I attended a view at the Club and from my own observations of the stairs/stairwell considered them steep in appearance. In the context of the clientele seeking access to and

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[32] Exhibit 9. The notification to these police units was apparently based on the MICA paramedic's opinion that the injuries observed on Mr Pattison were not consistent with a fall.
[33] T, page 173.
[34] Exhibit 1, Exhibit 10, photographs 19 and 20.
[35] T, page 170. LSC Barry stated he did not make, nor seek to have any comparison made by attending forensic officers between the scuffmark and Mr Pattison's shoe. Neil Lewis was unable to say whether the scuff marks located after the incident at approximately step 12 or 13 was there prior to the incident; T, page 129.
[36] Exhibit 5.
[37] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

egress from the Club, I considered there was a need to obtain an expert opinion to review the stairwell design and consider the possibility that the design contributed to the incident.

40. An expert opinion was subsequently sought from Ergonomist Professor David Caple of David Caple and Associates. Professor Caple was asked to provide an opinion in the context of the health and safety of the Club patrons' access and egress to the premises.

41. Professor Caple attended the Club on 11 April 2012 and after dark on 24 April 2012. In his report dated 26 April 2012,[38] Professor Caple stated he assumed Mr Pattison exited the Club, walked along the corridor beside the balustrade to the top of the upper flight of stairs, descended the upper flight to the landing, and fell sometime after commencing his descent of the lower flight of stairs.[39]

42. Professor Caple referred to Australian Standards (**AS**) AS1657-1992, "Fixed platforms, stairways and ladders – design, construction and installation", section 4 (stairways) in considering the ergonomic risk factors associated with the particular stair design.[40]

43. Professor Caple identified the following:

    a. the carpet used on the stairs does not provide clear visual cues in relation to tread[41] depth, particularly when looking down the stairs from the top and middle landings. The carpet tends to blend into a continuous pattern rather than users being able to easily see individual treads, making it difficult to discriminate the three dimensional depth.[42] AS1657-1992 states (at 4.3.3) that the nosing should be such that the edge of the stairs is highlighted especially where the stairs may be used in a variety of lighting conditions. Professor Caple therefore determined the stairs were not compliant with the AS in this regard;

    b. there is a difference in the heights for the risers[43] between treads, with the upper flight measuring 260mm between each tread, compared with 150mm at the bottom flight. This means that the upper flight is steeper, and steeper than the recommended angle for stairs;

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[38] Exhibit 20.
[39] Exhibit 20.
[40] Exhibit 20.
[41] Tread – this is the flat surface where the foot is placed on the stair when ascending or descending; Exhibit 20.
[42] T, page 245.
[43] Riser – this is the vertical elevation distance between joining treads; Exhibit 20.

c. there is a slight 'hump' underneath the carpet on the first level landing which could increase the risk of instability or trips when descending the lower flight;

d. the lighting in the landing after dark (50Lux) falls below the recommended levels of 160-200Lux;[44] and

e. there was only one handrail for the upper flight of stairs. Although this was not stated as a strict compliance issue, Professor Caple stated "it would seem prudent that two handrails should have been provided...taking into consideration the nature of the business...and the potential demographic of people using these stairs...".[45]

44. Professor Caple concluded that his review identified non-compliant aspects of the stairway design at the Club compared with the requirements of the AS1657-1992, and that it is evident that the ergonomic requirements for such a stairway could be improved with some practical interventions, including:

a. provision of colour contrasted and tactile differential nosing treatment to the edge of each tread;

b. elimination of the 'hump' identified on first level landing;

c. provision of a handrail down both sides of both flights; and

d. provision of additional lighting of the level 1 landing.

45. Professor Caple noted the Club's provision of a sign encouraging patrons to use the handrail.[46]

JURISDICTION

46. At the time of Mr Pattison's death, the *Coroners Act 1985* (Vic) (**Old Act**) applied. From 1 November 2009, the *Coroners Act (2008)* (Vic) (**the Act**) has applied to the finalisation of investigations into deaths that occurred prior to its introduction.[47]

47. The role of the coronial system in Victoria involves the independent investigation of deaths to determine the cause of death, to contribute to the reduction of the number of

[44] AS1680.1-1990 "Interior Lighting Part 1: general principles and recommendations".
[45] Exhibit 20.
[46] Exhibit 20.
[47] The Act, section 119 and Schedule 1.

preventable deaths and for the promotion of public health and safety and the administration of justice.

48. Section 67 of the Act sets out the statutory role of the Coroner in that a Coroner must find, if possible, the identity of the deceased, the cause of death and, in some cases, the circumstances in which the death occurred.

49. A Coroner may comment on any matter connected with the death and may also report to the Attorney-General and may make recommendations to any Minister, public statutory authority or entity, on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[48]

50. Pursuant to section 52(1) of the Act, I determined that an Inquest was warranted in the circumstances, as the events leading up to Mr Pattison's death remained unclear, and I had identified a number of public health and safety issues requiring further examination, including the access and egress to the club in the context of its patronage and the responsible serving of alcohol

Directions Hearings

51. A Directions Hearing was held on 24 November 2011. Mr Pattison's family were not present. Due to late notification, the Club was not represented at that stage but manager Mr Gary Seviour attended. Mr Waters appeared on behalf of Maribyrnong City Council (**the Council**) and Mr McCredden appeared on behalf of Responsible Alcohol Victoria (**RAV**). Leading Senior Constable Tania Cristiano of the Police Coronial Support Unit acted as counsel assist and outlined the potential scope of Inquest.

52. Mr McCredden explained that RAV is a business unit within the Department of Justice, operational since late 2008, containing a number of discrete groups. Mr McCredden explained the Director of Liquor Licensing is a statutory office holder responsible for making decisions relating to licences and imposed licence conditions. He explained there is a policy unit within RAV, and a compliance enforcement directorate with the relevant responsibilities for carrying out inspections of licensed premises, either randomly or in accordance with complaints, and to enforce provisions of the *Liquor Control Reform Act 1998* (Vic) (**LCR Act**) by way of prosecuting licensees or others for offences under this

[48] The Act, section 72(1) and (2).

Act, or conducting inquiries or disciplinary proceedings in the Victoria Civil Administrative Tribunal.[49]

53. Mr McCredden flagged that the RAV was at the time undergoing some changes that were to come into effect in early 2012, including the introduction of a new commission responsible for gambling and liquor regulation generally, which would see the cessation of the Director of Liquor Licensing position.[50]

54. A further Directions Hearing was held on 2 March 2012. Mr Paul Gamble appeared on behalf of the Club, Ms Masha Lezaic appeared for the new Victorian Commission for Gambling and Liquor Regulation (**VCGLR**)[51] and Mr Waters on behalf of the Council. No family attended.

55. Mr Gamble said that since the incident, there had been some changes to the structure of the staircase at the Club with the installation of an additional rail, and a slightly higher balustrade.[52] I explained my concerns relating to the apparent steepness of the staircase, and the demographic of the people using them, that is, those drinking alcohol prior to descending.[53]

56. Mr Waters informed me that the Council had identified that existing use rights apply to the building as it has been there since 1908 and occupied by the Club since that time.[54]

Additional information

57. Following the DH and prior to Inquest, Ms Catherine Myers on behalf of the VCGLR provided a statement dated 2 May 2012.[55]

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[49] TDH1, page 5.
[50] TDH1, page 5.
[51] Formerly the RAV, name changed as of 6 February 2012.
[52] Transcript of Directions Hearing 2 March 2012 (TDH2), page 2.
[53] TDH2, page 3.
[54] TDH2, page 6.
[55] Exhibit 8.

INQUEST

58. An Inquest was conducted on 1, 2, 3 and 4 May 2012. LSC Cristiano acted as counsel assist. Mr McCredden appeared on behalf of VCGLR,[56] Mr Simon McGregor of Counsel on behalf of the Council and Mr Gamble on behalf of the Club. Mr Pattison's family did not attend.

59. The following general themes were identified to be explored at Inquest:

    a. the responsible service of alcohol;

    b. the safety of the licensed premises, including access and egress;

    c. the risks associated with serving alcohol in a licensed premises that has access and egress limitations;

    d. the lack of persons with first aid qualifications who were serving alcohol at the Club; and

    e. regulatory issues surrounding the Club.[57]

Evidence at Inquest

60. *Viva voce* evidence was obtained from the following witnesses at Inquest:

    a. Victorian Institute of Forensic Medicine Forensic Pathologist A/Prof David Ranson;[58]

    b. Club Manager Gary Seviour;

    c. Club member Nicholas Lewis;

    d. Club secretary Robert Fisher;

    e. Club committee member Thomas Flynn;

    f. Club committee member Steve Bartlett;

    g. Club Vice President Neil Lewis;

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[56] A preliminary matter was raised by Mr McCredden in that his client considered that it had canvassed the relevant regulatory framework surrounding the responsible service of alcohol in Ms Myers' statement, and did not consider it was necessary to remain an Interested Party before the Court for the duration of the Inquest. Mr McCredden therefore proposed to excuse himself from the bar table. I informed Mr McCredden it is a matter for the VCGLR as to whether they wanted to remain involved for the duration of the Inquest or only as such time as when Ms Myers gave her evidence

[57] T, page 3.

[58] Medical Examination Report of Associate Professor Ranson dated 1 May 2012.

h. Ms Catherine Myers, Acting Director of Strategy, Education and Integration at the Victoria Commission for Gambling and Liquor Regulation;

i. Leading Senior Constable Ash Barry;

j. Nigel Gould, ambulance paramedic;

k. Raymond Richards, Maribyrnong Council Building Inspector; and

l. Professor David Caple.

Cause of death

61. A/Prof Ranson was asked whether the six to seven minutes that elapsed between the ambulance being called and arriving, when Mr Pattison remained in an awkward position, had a bearing on the outcome. A/Prof Ranson responded, "Well, I think it certainly could have a bearing on the outcome".[59] A/Prof Ranson said that, given his belief that positional asphyxia played a significant role in Mr Pattison's death, his death "might well have been prevented, had his airway been able to be maintained from an early stage."[60]

62. A/Prof Ranson agreed there is a tension between moving someone with a possible neck injury and leaving them *in situ*, as moving someone with a neck injury could cause further damage, including spinal cord damage, leading to possible paraplegia or quadriplegia. Although A/Prof Ranson recognised he is not an Emergency Physician and therefore might not be best qualified to talk about the subtleties of that situation, he said "...clearly saving life is important, so in a situation where the person has to draw the risk of causing further neck injury and [assist] somebody who is unable to breathe adequately, then I think the issue of preserving life comes first in most people's minds".[61] A/Prof Ranson conceded he could understand how a non-medical person could feel conflicted in this situation.[62]

63. A/Prof Ranson said he could not say where or how Mr Pattison sustained the scalp laceration, but confirmed he did not locate any glass within the wound.[63]

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[59] T, page 13. A/Prof Ranson later said that the important period is the first three minutes; T, page 20.
[60] T, page 13. A/Prof Ranson commented that although the blood alcohol concentration (**BAC**) detected was very high and can be associated with bad outcomes, there are other individuals who can survive at those, and indeed higher levels.
[61] T, page 16.
[62] T, pages 16-17.
[63] T, page 20.

64. A/Prof Ranson commented that the act of an individual walking downstairs with a comparable BAC whilst trying to hold/carry objects, with possible distractions is a "risky activity", and that the level of alcohol detected in Mr Pattison would impair their motor skills, even if they were used to consuming a considerable amount of alcohol.[64]

Paramedic assessment

65. Ambulance paramedic Nigel Gould arrived at the scene and located Mr Pattison with his head and torso lying diagonally across the landing at the base of the stairs. He observed Mr Pattison's head wedged between the wall of the stairway and his torso. His head was positioned at a severe angle to his torso with a large pool of clotted blood surrounding it. His torso was positioned chest down, diagonally across the landing towards the bottom step, with his legs extended up the bottom three steps on the opposite side of the stairway to the position of his head.[65]

66. Mr Gould considered Mr Pattison's airway would have been occluded or blocked due to the angle of his head. He said that the first necessary action upon his arrival was to move Mr Pattison on to his back, protecting his neck as much as possible, and assess his airway to ensure it was patent given he was unconscious.[66] Mr Gould said airway protection comes before the risk of spinal injury as it presents an immediate life threat as opposed to a risk of secondary injury.[67]

67. Mr Gould recalls a male standing on the stairs who told him, in general terms, that Mr Pattison had tripped on the top step and fell forward down the stairway, and had been heavily intoxicated.[68] Mr Gould could not identify this person.[69]

68. From Mr Gould's perspective, Mr Pattison's injuries were consistent with a fall from around the top of the lower stairway.[70] Mr Gould noted that Mr Pattison's position was quite contorted and from his experience, "it would take a degree of distance to achieve that level of contortion so I, just looking at it, if it was five steps I wouldn't have thought

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[64] T, pages 14-15.
[65] Exhibit 12.
[66] T, pages 185-186.
[67] T, page 186. Mr Gould conceded that he had 10 years' experience as a paramedic and asking two untrained individuals in this situation to move Mr Pattison was a very difficult thing to ask of them and that it took, from memory, three trained personnel (MFB and paramedics) to move Mr Pattison to the supine position; T, pages 187-188.
[68] Exhibit 12; T, page 182.
[69] T, page 182.
[70] T, pages 183 - 184.

perhaps his position matched the distance of five steps".[71] Mr Gould later conceded it was also possible that Mr Pattison fell a short distance[72] and that if he had fallen a distance of approximately 14 steps, he would normally expect there would be other bodily injuries.[73] When asked whether, in general, the extent of injuries relative to the distance fallen is influenced by levels of intoxication, Mr Gould considered it is generally accepted that you do not attempt to break a fall when intoxicated and you tend to land in the position that you fall.[74]

The Club

69. Club manager Mr Seviour said the Club is run by a committee of members who are not employed by the Club and work the bar on a voluntary basis.[75]

70. Mr Seviour said that on Sundays, the Club's bar was managed by volunteer committee members, however since and in response to the incident, a full-time employee has been engaged to serve alcohol on Sundays,[76] who has a valid RSA.[77]

71. Mr Seviour said he is responsible for repairs but must consult the committee prior to arranging repairs.[78]

72. The Club premises was built in 1908, and has since, in one form or another been owned by the Club, until it sold in May 2008 and thereafter leased by the Club from the new owner.[79] Neil Lewis said the owner is responsible for the external part of the building, the Club is responsible for the internal part of the building, and that the owner need not approve internal improvements.[80]

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[71] T, page 184 and 189.
[72] T, page 188.
[73] T, page 191.
[74] T, page 193.
[75] Exhibit 2. Mr Seviour in evidence explained the Footscray Club Committee was made up of ten individuals; T, page 23.
[76] T, pages 30-31. Mr Seviour explained the change to have an employed person behind the bar as opposed to a volunteer has increased the sense of responsibility and encouraged the bar to be run more professionally; T, page 31. Mr Seviour does not usually work on Sundays but occasionally attends Sunday functions. He said volunteers had RSA certificates T, page 40.
[77] T, pages 43-44. Mr McCredden also confirmed with Mr Seviour that the Club does not have any relationships with industry or community bodies such as the Club Association of Victoria.
[78] T, page 23.
[79] T, page 37.
[80] T, page 133.

73. Mr Seviour said the Club was refurbished in approximately 2008.[81] He said enquiries were made into fitting a chairlift onto the stairs prior to the incident, to accommodate ageing members. Contact was made with a specialist company and the Metropolitan Fire Brigade. It was determined that the stairwell was too narrow to accommodate a chairlift whilst maintaining adequate access and egress for stair users.[82]

74. Enquiries were also made regarding placing a handrail on the left ascending side of the staircase. Mr Seviour said that the Council attended and determined that the stairwell was too narrow for this proposal. He said the Council has, since the incident, returned and inspected the stairwell and determined that a handrail could be installed on the left ascending side on the first flight only (the second flight is still considered too narrow). Mr Seviour said the Club installed the rail on the first flight "straight away" following this decision.[83]

75. Mr Fisher recalled he was a member of a sub-committee that was formed in relation to the renovations. The sub-committee made recommendations on behalf of Club members regarding quotes.[84] He said the sub-committee did not see any documentation regarding the renovations and was not specifically involved in matters such as obtaining council permits.[85]

76. Neil Lewis said the Club provides its members with water, tea and coffee free of charge.[86]

Club changes since the incident

77. Changes have occurred in response to Mr Pattison's death, including the installation of a handrail on the bottom flight of stairs, replacement of the right ascending balustrade on the upper flight of stairs with a taller one and the installation of recording cameras on both stairwells and outside the front of the Club. The cameras are visible from behind the

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[81] T, page 23-24. Mr Seviour confirmed the refurbishment occurred before the incident, and included new bar facilities, new carpet (including the stairwell), furniture and air conditioning; T, page 24. He said the stairs themselves remained the same; T, page 25. He said that no strips to assist with edge differentiation have been installed; T, page 35. Mr Gamble made a point that architects had been engaged prior to the renovations; T pages 38-39.

[82] T, pages 26-27. Mr Seviour explained some older Club members cannot attend as often as they would like to as they find access difficult. He has himself walked in front of older Club members as they descend the stairs, due to age-related functional limitations rather than the effects of alcohol consumption. He said to his knowledge, there have not been any "stumbles"; T, page 34. Mr Flynn said he often walks down in front of the elderly clientele to provide support; T, page 95.

[83] T, pages 27-28.

[84] T, page 56. Mr Fisher said the Club engaged a company to conduct the entire renovations and the company would then sub-contract; T, page 57. He said the lease was arranged by the Club's President, Mr Charlie Cook; T, page 57.

[85] T, pages 65-66. Mr Fisher recalled the renovations occurred over an approximate three month period; T, page 66.

[86] T, pages 127-128.

bar and operational 24 hours per day, enabling staff to ensure members leaving do not encounter problems exiting.[87]

78. Signs were installed to ensure members use the handrails. The Club also now has full time employees working behind the bar and volunteers are not used for this purpose.[88]

Club training

i. RSA certificates

79. Mr Saviour obtained a valid RSA certificate on 1 May 2004.[89] His RSA certificate was reportedly valid at the time of the incident, having completed refresher training in 2008 or 2009.

80. Mr Nicholas Lewis is a Club member and worked behind the Club's bar on occasion.[90] He had an RSA certificate before he started working behind the Club's bar, but has not undertaken a refresher course for approximately four years as he no longer works in the industry.[91]

81. Mr Fisher used to work behind the Club's bar on a voluntary basis. He no longer performs this duty.[92] He obtained an RSA certificate in approximately 2006, but has not completed refresher training.[93] He completed the RSA certificate because he was voluntarily working behind the bar approximately every eight weeks, "so it was suggested that each of our committee people that were doing that community work has their RSA in place".[94] Mr Fisher said the Club paid for the RSA to be completed.[95]

82. Mr Flynn holds an RSA certificate, but until hearing evidence at Inquest was unaware of the requirement to complete a refresher course.[96] He recalled completing the certificate in 2004 or 2005, when the Club paid for and sent approximately six members to it.[97]

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[87] T, pages 32, 84 and 95.
[88] T, page 132.
[89] Exhibit 2.
[90] Exhibit 3.
[91] T, page 49.
[92] T, page 57. Mr Fisher was not serving alcohol on 2 August 2009; T, page 68.
[93] T, pages 57-58.
[94] T, page 58.
[95] T, page 58. Mr Fisher recalled he completed the RSA course with other committee members; T, page 65.
[96] T, page 79. Mr McCredden on behalf of the VCGLR said that there is a relatively new regime in place that requires certain types of licences, but not club licences, to undertake refresher training on a cyclic three year basis; T, page 92.
[97] T, page 80.

83. Mr Bartlett had been a member of the Club for four years and employed to work behind the bar for six years before that.[98] Mr Bartlett had an RSA certificate, could not recall when he first obtained this qualification but said "...I had it while I was at the club, yes."[99] He has completed a refresher course.[100]

84. Neil Lewis has been a Club member for approximately 20 years.[101] He obtained an RSA certificate in approximately 2006. He went with the Club group (of approximately six). He said "Gary at the time...thought we had a responsibility to serve alcohol correctly so I think it became a requirement for the club that if you have to serve we have to have the RSA...".[102] Neil Lewis did not complete a refresher course.[103]

85. Mr Seviour understood that the local licensing authority has visited the Club to check compliance, and that there has been no compliance issues in relation to the Club's liquor licence or the service of alcohol.[104]

ii. First aid

86. Mr Seviour said the Club has a first aid kit, located in the kitchen, which he maintains and re-stocks as needed.[105] He has completed a first aid course but his qualifications have since lapsed.[106] He did not know if anyone else at the Club held a first aid certificate.[107] It was Mr Seviour's understanding that there is no requirement for staff at a licensed premises to have a first-aid certificate.[108]

87. Mr Nicolas Lewis completed a first aid certificate when he was younger, but did not feel confident in rendering first aid.[109] Mr Bartlett does not have first aid

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[98] T, page 98.
[99] T, page 98. Mr Bartlett later explained he had completed a cellarman course in approximately 1994 that went for approximately 14 weeks, and involved all aspects of bar service and cellar work, including recognising intoxication in patrons; T, page 105.
[100] T, page 99.
[101] T, page 121.
[102] T, page 123.
[103] T, page 123. He did not have a regular position serving behind the bar, rather would fill in occasionally when someone was running late. He said in evidence that he no longer serves behind the bar; T, pages 122-123.
[104] T, page 42.
[105] Exhibit 2.
[106] Exhibit 2. Mr Seviour confirmed in evidence that he had not since completed a refresher; T, page 32. He stated he did not consider it was a requirement for someone at the Club to be first aid qualified.
[107] T, page 22.
[108] T, page 41.
[109] T, pages 52-53.

training/qualifications.[110] Neil Lewis does not and has never held a first aid certificate, and has never received any such training.[111]

88. Mr Flynn does not have current first aid qualifications,[112] having completed a first-aid certificate approximately 30-40 years ago.[113] I asked whether Mr Flynn found it concerning that no one seemed to be trained in first aid given the Club's clientele, to which Mr Flynn responded "I suppose when you look at the Pattison case it probably would have been a help, but prior to that and since then there's been absolutely no need."[114] Mr Flynn estimated that approximately two thirds of the Club members are 'elderly', with members approximately 80 years of age. He said that on a Friday, 90 per cent of members in attendance at the Club would be over 60 years.[115]

89. Neil Lewis said that as a result of the coronial investigation, the Club intends to arrange for several committee members to receive first aid training and for "everybody to re-attend the Responsible Serving of Alcohol course because that's a failure we found...[w]e will take that as an understanding to get that rectified".[116]

Previous incidents

90. In Mr Seviour's 21 years as Club Manager, he was not aware of anyone else falling down the stairs.[117] He did not know what Mr Bartlett was referring to in his statement when he said that he heard a thump and "[f]rom experience of working here, I figured he'd fallen down the stairs".[118]

91. Mr Nicholas Lewis said he had not previously heard a similar noise at the Club, nor had he known of anyone else falling at the Club.[119] Mr Flynn said he was not aware of anyone falling down the stairs, whether from intoxication or physical/medical problems, both prior to and after the incident.[120]

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[110] T, page 99.
[111] T, page 123.
[112] T, page 80.
[113] T, page 92.
[114] T, pages 92-93.
[115] T, page 93.
[116] T, page 133. At the time of the Inquest, this had yet to be arranged; T, page 33. Mr Seviour explained the Committee members are doing the course because they are at the Club on a regular basis. Upon further questioning, Mr Seviour said that the person now employed to work Sundays will also be first aid trained
[117] T, page 28.
[118] T, page 44.
[119] T, page 51. Mr Lewis said in evidence that he did not know anyone who had trouble negotiating the stairs due to their physical state; T, pages 51-52.
[120] T, page 79.

92. Neil Lewis had never had cause to cut someone off from the bar, and was not aware of any other customers having been cut off.[121] He was not aware of anyone else falling or stumbling on the stairs in his 20 years at the Club.[122] Mr Bartlett also did not know of anyone else falling or stumbling down the stairs.[123]

93. I confirmed with Mr Seviour that there is an incident book at the Club that would contain any other incidents such as a fall down the stairs. Mr Seviour said the incident involving Mr Pattison was however not entered into the incident book.[124] Mr Flynn was not aware of an incident/injury book.[125] Mr Bartlett said he never entered any details in the incident/injury book at the club, and did not know if one existed.[126]

Mr Pattison

94. Mr Pattison regularly attended the Club on Thursday evenings and Sundays.[127] He regularly attended Sundays with his girlfriend, who did not drink alcohol.[128] Mr Pattison would drink alcohol on each attendance and regularly consumed ten to 12 pots of beer. Cutting him off was not a regular occurrence.[129] Mr Seviour recalled Mr Pattison's usual state following his ten to 12 pots as "...all right, he got up, walked out of the club, no problems".[130]

95. Mr Bartlett did not notice anything unusual about Mr Pattison on 2 August 2009 and said that he was not "sculling" his beers.[131] Mr Bartlett was working in the kitchen, but out of experience working behind the bar, told Mr Flynn that he thought Mr Pattison had had enough and should be cut off. Mr Bartlett explained that he overheard Mr Pattison cutting into conversations, getting slightly louder, whereas he was normally "a quiet sort of guy".[132] Mr Flynn apparently agreed and said he had already cut him off.[133] Mr Bartlett

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[121] T, page 125.
[122] T, page 125.
[123] T, page 110.
[124] T, page 47.
[125] T, page 96.
[126] T, page 110.
[127] T, page 29.
[128] T, page 40.
[129] T, pages 29.30. Mr Flynn confirmed he had never cut Mr Pattison off before, and believed no other member had previously cut him off; T, page 82. Mr Flynn was only aware of one other person who had ever been cut off; T, page 83.
[130] T, page 30. Mr Seviour was not working on 2 August 2009. Mr Seviour had been the Club manager for 21 years; T, page 22.
[131] Exhibit 6.
[132] T, page 100.
[133] Exhibit 6, T, page 101. Mr Bartlett said that over the years he probably had cause to cut other customers off, but could not specifically recall such a situation; T, page 101.

said that at that stage, Mr Pattison was steady on his feet and did not stumble or stagger as he walked out of the Club.[134] He could not recall which hand the stubby or the plastic meal bag were in.[135]

96. Mr Fisher arrived at the club at approximately 2.00pm on 2 August 2009.[136] Mr Fisher was sitting close to Mr Pattison and Alex Smith[137] and observed Mr Pattison to have had "the drink that broke the camel[']s back", and that bar manager Tom Flynn told him to go home.[138] Mr Fisher said there were no arguments about this and Mr Flynn telephoned a taxi.[139] Mr Fisher had not previously known Mr Pattison to be cut off from the bar.[140] Mr Pattison then said he wanted a "traveller", and purchased a VB stubby at approximately 5.30pm, and said goodbye. Mr Fisher observed Mr Pattison to be "a bit wobbly with his walking".[141]

97. Mr Flynn explained his feeling that Mr Pattison had had enough alcohol came about when he asked Mr Pattison about his girlfriend who often accompanied him to the Club on Sundays. Mr Pattison apparently responded, "we're having a blue".[142] Mr Flynn said Mr Pattison was not a "happy bloke", and started to talk about it, which is when Mr Flynn decided he had had enough, and suggested to Mr Pattison that he go home.[143]

Responsible service of alcohol

98. The *Liquor Control Reform Act 1998* (Vic) (**LCR Act**) is the primary piece of legislation regulating the supply and consumption of liquor in Victoria. It provides a regime for the

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[134] Mr Bartlett also confirmed Mr Pattison was not becoming boisterous or disorderly, argumentative, incoherent, slurring, physically violent, aggressive, using offensive language, exhibiting inappropriate sexual behaviours, that his conversation was coherent, he was holding a train of thought when talking, and appeared to understand what was being said to him; T, page 106.

[135] Exhibit 6, T, page 102. In oral evidence, Mr Bartlett could not positively recall the stubby in Mr Pattison's hands.

[136] Exhibit 4. Mr Fisher estimated observing Mr Pattison consume six pots of beer between approximately 2.30pm and 5.30pm; T, pages 59-60.

[137] T, page 69.

[138] Exhibit 4. Mr Fisher said he noticed at that stage that Mr Pattison's speech was slower and that he seemed tired; T, page 60. He said that Mr Pattison did not become loud, boisterous, disorderly or argumentative, and that he acquiesced to the suggestion that he go home. He was not incoherent or slurring his words or bothering other members, nor was he falling asleep or displaying difficulty comprehending what was being said to him. Mr Fisher could not recall observing Mr Pattison bumping into furniture or other patrons. Mr Pattison did not fall prior to the incident; T, pages 63-64. Mr Flynn also confirmed a lack of these behaviours; T, pages 89-90. Mr Fisher said it is a club rule, or code of conduct, that the barman has the capacity to cut someone off from the service of alcohol if they determine the patron has had too much to drink; T, page 68.

[139] Exhibit 4.

[140] T, page 61.

[141] Exhibit 4.

[142] T, page 85.

[143] T, pages 88 and 90. Mr Flynn confirmed Mr Pattison did not have any other witnessed falls on 2 August 2009 and he did not notice Mr Pattison swaying or staggering.

granting of licences by the VCGLR permitting the supply of liquor, and imposes obligations in respect to certain licence categories that relate to RSA training.[144]

99. The VCGLR has power to impose conditions on any form of licence and from time to time, may impose conditions relating to RSA on licences other than general licences, on-premises licences, packaged liquor licences or late night licences.[145]

100. Under section 44 of the LCR Act, applicants for a licence must demonstrate they have an adequate knowledge of the LCR Act. There are courses available that cover the obligations and liquor laws in Victoria that the VCGLR considers adequate training to satisfy them that an applicant[146] has adequate knowledge of the liquor licence laws and obligations.[147] New applicants/licensees are also required to attend an RSA training course.[148]

101. Pursuant to amendments to the LCR Act that came into operation on 1 January 2011, it is now a legislative requirement that an applicant for new general, on-premises, packaged liquor and late night licences must have completed an 'approved' RSA program.[149] It is the VCGLR's policy however to require all applicants for a licence, including a club licence, to undertake an RSA training program before a licence is granted.[150]

102. The focus of RSA training is teaching licensees and staff about how to serve alcohol responsibly at licensed premises. The training also assists them to develop appropriate policies and strategies for managing their licensed premises, to reduce the risks commonly associated with alcohol consumption. It therefore enhances their knowledge about the effects of alcohol and the requirements of the LCR Act, and raises their awareness of the types of issues that may arise for them in managing their business and

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[144] Exhibit 8.
[145] Exhibit 8.
[146] Mr Myers pointed out that an existing licence is technically not considered an application under the LCR Act; T, page 136.
[147] T, page 149. The courses are known as the 'New Entrants Course' and the 'First Steps Licensee Course', which are essential the same, but branded differently by training providers.
[148] T, page 150. Ms Myers stated that the RSA has been available since approximately the late 1990s, and although she does not believe it was mandatory, it "was general practice in the industry for staff to attend RSA training", although not something necessarily encouraged by the (then) liquor Licensing Commission.
[149] Exhibit 8.
[150] Exhibit 8. This policy has been in place since 1 January 2011. Under section 44(2) of the LCR Act, the VCGLR may refuse to grant an application for a licence in certain circumstances, including where the applicant (or the directors of an applicant in the case of a body corporate) does not have an adequate knowledge of the LCR Act.

staff. For those serving alcohol, it provides specific strategies for dealing with difficult situations that may arise when engaged in service.[151]

103. The Club's licence is a "full club licence",[152] which falls under the category of "club licences".[153] This means the Club is only permitted to provide or sell alcohol to club members or guests accompanying a member, and not to the general public.[154]

104. Ms Myers confirmed parts of her statement were not relevant to the Club's full club licence.[155] Ms Myers stated the legislation "...doesn't apply to club licence so the RSA training requirements for those who supply alcohol does not apply to a club licence."[156]

105. Ms Myers confirmed the LCR Act does not go so far as saying anyone within the Club who is working behind the bar or selling or distributing alcohol needs to have completed the [RSA] course, nor does a club licence require someone with qualifications to be present at all times when alcohol is being sold.[157]

106. Ms Myers stated there are particular industry bodies, such as Clubs Victoria, Community Clubs Association and the Community Club Managers Association of Australia (Victoria branch) that play an educative role for clubs.[158]

107. Ms Myers agreed that prior to the 1 January 2011 legislative amendments, the Club may not have had a statutory obligation to have "anybody with qualifications", because they would have had their licence in place prior to the policy or legislative changes coming through.[159]

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[151] Exhibit 8. RSA training programs are conducted by approved Registered Training Organisations accredited by the VCGLR. They are conducted in person for a four-hour durations and are presented with the assistance of material provided by the VCGLR, including audio-visual aids.
[152] T, page 134; Exhibit 21, page 96.
[153] T, page 135. Ms Myers explained that "club licences" covers full club licences, restricted club licences and renewable limited licences. She explained the full club licence allows for off premises (takeaway) sale to members.
[154] T, page 161.
[155] Exhibit 8; T, pages 135, 140, for example, the obligations on holders of other licence categories imposed under sections 108AA and 108 AH of the LCR Act, and paragraphs 11 to 13 relating to RSA training. Ms Myers also explained that a significant portion of her statement refers to applications for licences since the legislative changes came in on 1 January 2011, rather than existing licences, such as held by the Club; T, page 137. Ms Myers explained that the Club is not considered an 'applicant' according to the legislation; T, page 141. Ms Myers said that prior to the new Act, the 'club licence' category were only required to have new entrant training, which did not necessarily cover off in detail the RSA training requirements; T, page 137.
[156] T, page 141. Ms Myers was asked to explain the situation when a licence in existence before the introduction of the legislation is renewed after the introduction of the legislation, whether there is an obligation on the licence holder regarding RSA training. Ms Myers stated "Unless it was a licence type that was covered by the changed legislation so the new legislation club licence, when they brought in the stricter RSA training requirements, the club licence category was not covered by those changes in the legislation."
[157] T, page 138. Ms Myers was not aware of any impending changes in this regard at the time of Inquest.
[158] T, page 155.
[159] T, pages 137-138.

108. Currently, those obliged to hold an RSA certificate must renew it every three years via an online training program.[160] Ms Myers qualified that while RSA certificates do not technically expire, to keep one current to be able to supply alcohol, the certificate holder must have undertaken the refresher program every three years.[161] There is however no mechanism in place for the VCGLR to notify certificate holders of this anniversary, and the actual certificate does not have an expiry date on it.[162]

109. Ms Myers explained the RSA online refresher training is open to anyone, and not just those who have completed the original RSA training.[163]

110. Information available on the VCGLR's website includes fact sheets on where you can attend RSA training, and obligations on license categories.[164]

111. In referring to a new publication, "*Our Club Licensee Responsibilities*", Ms Myers stated that they were aware that the knowledge, the transfer of liquor obligations does not routinely get handed over to each successive volunteer club committee, often resulting in administrative-type breaches. The purpose of the document is to enable information to pass to new committees, to provide clubs with the information they need to provide if they are subject to an inspection.[165] Once the document is available, the VCGLR will send it to a restricted number of clubs and publish it on its website. The VCGLR also promoted it through its subscription-based electronic newsletter.[166]

112. Mr Gamble pointed out the possibility that at the time of the incident, some educational material might not have been provided to the Club.[167] Similarly, the Club would not have received the "*Guide to the Responsible Service of Alcohol*"[168] as it is distributed during RSA training.[169]

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[160] T, pages 138 and 147.
[161] T, page 154, relating to the specific categories in the legislation, which do not include the Club.
[162] T, page 138. Ms Myers was not entirely sure, but when asked how those completing au RSA certificate know to maintain their qualifications, responded that the RSA fact sheet might be in the training material provided, but would need to check. Ms Myers explained there are on average 60,000 people completing the (initial) RSA training annually; T, pages 139, 147.
[163] T, page 154.
[164] T, page 154. Ms Myers agreed that online information is a way of communicating with the some 19,000 Victoria licence holders; T, page 155.
[165] T, page 156. Ms Myers said there was at the time of Inquest no launch date and the document was "at the printers".
[166] T, pages 156-157.
[167] Such as intoxication guidelines or information relating to changes to the liquor licensing fees regime in late 2009, which was accompanied by additional materials referring licence holders to the website to keep up to date with changes; T, pages 145-146.
[168] Exhibit 8, attachment 1.
[169] T, page 146.

113. To Ms Myers' knowledge, the VCGLR had not turned their mind to including a first aid component in the RSA certificate,[170] and expressed a view in this respect that "...it's difficult to have a blanket approach to those requirements given the diversity and the complexity of the licence hospitality in[dustry]".[171] Ms Myers explained issues with the itinerant workforce, subsequent high staff turnover and the consequential business costs in maintaining first aid currency.[172] Ms Myers said in relation to the training currently provided:

> *...I guess the training is about being able to identify so that you can stop the supply of alcohol or offer alternatives, you know low alcohol, food with the supply; those sorts of things...I don't know whether, you know, I would be stretching that training to relate it to health effects so much, you know, further than the immediate effects of alcohol.*[173]

114. Ms Myers was unsure how long the Club has held its licence, but confirmed renewal occurs annually.[174] She explained the renewal process is "purely about collection of fees to maintain the currency of the licence."[175]

115. Ms Myers confirmed that there is no current legislative requirement for staff at clubs like the Club to hold an RSA certificate.[176] Ms Myers was not aware of any planned changes in this regard but noted that the VCGLR encourages organisations like the Club to participate.[177] Ms Myers agreed that she considered it appropriate and responsible that the Club staff hold/held RSAs in the context of it not being required.[178]

Council involvement with the Club

116. The Club has been in existence since 1894 and has operated from its current premises since 1909.[179] Council records reveal existing use occupancy of this building since 1908.[180]

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[170] T, page 139.
[171] T, page 148.
[172] T, page 162.
[173] T, page 162. Ms Myers said in evidence that she considered it more appropriate to call for an ambulance as it is their core business to administer first aid.
[174] T, page 140.
[175] T, page 141.
[176] T, pages 141 and 160.
[177] T, pages 160.
[178] T, page 160.
[179] Exhibit 14.
[180] T, page 214.

117. To Mr Richards' knowledge, the Council has no ongoing role to monitor the state of the building from which the Club operates. The Council's only ongoing role is in relation to the Club's requirement to remain registered as a "Food Premises" under the *Food Act 1984*.[181]

118. Mr Richards confirmed he re-checked the Council records and could not find a permit application in respect of the premises occupied by the Club.[182]

119. There was a council program to inspect for safety of all the premises in Paisley Street in 2008. As a result of that program, Mr Richards was referred to a letter dated 14 November 2008 from Mr Colin Netherclift, Municipal Building Surveyor, Maribyrnong City Council, addressed to the owner of the Club premises.[183] The letter, based on an inspection that occurred on 22 October 2008, enclosed a building notice, which was referred to as an infringement notice.[184] Mr Richards explained that during the 22 October 2008 inspection, he noticed the main egress door opened inward into the stairwell (rather than outward), and identified this as a danger in the event of a mass emergency exit from the Club.[185] Mr Richards again attended the Club on 28 April 2009, who had complied with the infringement notice.[186] Mr Richards confirmed he took measurements of the

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[181] Exhibit 14.

[182] T, page 196.

[183] Exhibit 15. Mr Richards explained Mr Netherclift is his boss, is the building surveyor and therefore the person delegated to issue these notices under the *Building Act 1993*. Mr Richards explained however that he was the one who conducted the site inspection of the Club. The Council has a policy that authorises the building department to conduct inspections of essential services, performed on a street-by-street basis for the municipality. The Club was one of the properties included in these targeted inspections; T, page 197.

[184] T, page 197. Mr Richards explained that under the *Building Act* 1993, power is given (under section 106) to issue an infringement notice if there appeared to be any works carried out within a permit. He said that during the 'spot' inspections, the renovations under way, which he had a look at, were not considered 'structural works' (which would have required a permit) but were more 'minor works' for which there is an exemption for requiring a permit under the *Building Regulations 2006*; T, pages 198-199. LSC Cristiano questioned Mr Richards regarding a checklist taken for inspections that has 41 items to tick off, the stairs NOT being one of them, and therefore asked why he inspected the stairs in his 2008 spot visit; T, pages 223-224, Exhibit 15A. He said that prior to inspections, the building owner is provided with a letter informing them of the upcoming inspection. He said the letter does not necessarily go to the tenant "because our requirements say owner must make the building comply"; T, page 207, confirmed at T, page 220.

[185] T, pages 197-198.

[186] T, page 199. The infringement notice was subsequently cancelled. Mr Richards referred to a file note in his handwriting dated 28 April 2009, which reads "Closed for renovations. All Ok.". Mr McGregor explained that when Mr Richards was told the Club was closed for renovations, he went up and looked at what was occurring and considered the renovations did not require any planning permit and it nonetheless complied with the BCode, as reflected in his notations; T, pages 114-115. Mr Richards stated that he made no further recommendations to change any part of the Club, including based on his visits/inspections that occurred after the incident; T, page 203.

carpeted stairs when he attended the Club in 2008 for the 'spot' inspection and found them to be compliant with the BCode.[187]

120. Mr Richards explained that as a building inspector, his compliance document is the Building Code of Australia (**BCode**).[188] Mr Richards agreed with Mr McGregor that the BCode "by virtue of that train of legislative documents back to Parliament represents the law in Victoria".[189] Mr Richards explained that the BCode refers to, or adopts some Australian Standards (**AS**), but not others.[190]

121. Mr Richards attended the Club on two occasions since the incident, most recently in March 2012. He considered the access to and egress from the Club. He observed that the two flights of 14 steps with a landing in between are in generally good condition, with no tripping hazards. He observed that the stairs are not too steep and comply with the BCode (at 2012) in that respect.[191] He also observed that the handrail heights comply with the Building Code. He measured the width of the stairs from handrail to handrail on the lower flights of stairs at 95cm, and noted the Building Code requires stairs to be at least one metre wide, but stated that given the age of the building, he does not consider the Building Code applies. He stated it would be practically impossible for the premises to comply with the current requirements.[192] Mr Richards also referred to point 10 of Practice Note 2007-23 supplied by the (then) Building Commission containing guidance on how building inspectors are to treat buildings of this age. I accept that the Practice Note indicates that the code in existence most applicable to a 1908 building is the *Uniform Building Regulations 1945*, specifically in this case Regulations 2710 (i), (ii) and (iii),

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[187] T, pages 206-207. Mr Richards stated he however did not record these measurements (also T, pages 225-226), but that things are done differently now at the Council, and documentation is much more prescriptive, and that back in 2008, the Council was only starting to perform these inspections; T, page 234; Exhibit 15B. Mr Richards confirmed the stairs complied with the BCode's stated ratio that is the acceptable level of steepness for stairs. He said there is no Australian Standard in relation to this, and the requirement/ratio is therefore exclusively found in the National Construction Code; T, page 208.

[188] T, page 200. The BCode has now as part of a program of nationally consistent legislation been called the National Construction Code Mr Richards agreed that the document is still however referred to as the Building Code of Australian in the *Building Act 1993* pursuant to Regulation 109 of the *Building Regulations 2006*. The BCode is in fact Volumes one and two of the National Construction Code, produced and maintained by the Australian Building Codes Board. The BCA has been given the status of building regulation by all States and Territories; http://www.abcb.gov.au/en/about-the-national-construction-code/the-building-code-of-australia.aspx accessed 29 December 2015. The BCode in place at the time of the incident was the 2011 version; T, pages 227-228.

[189] T, page 200.

[190] T, pages 200-201. Mr Richards explained the BCode refers to the Australian Standards concerning building only, and that whilst it adopts some of the Australian Standards, in some areas the BCode incorporates its own standards.

[191] Exhibit 14. He further stated that he did not agree with evidence that suggests the stairs are particularly steep; T, page 221.

[192] Exhibit 14, T, page 213. Mr Richards clarified the BCode requires one metres width for 'passageways'.

2711(a), 2712(b) and 2712 (d). According to Mr Richard's calculations, the stairs complied with these 1945 Regulations, and the standards referable to acceptable stairs in his opinion has not changed terribly much since that time.[193]

122. Mr Richards confirmed that the BCode clearly states that AS 1657-1992 (as referred to by Professor Caple) is not applicable in this case, as the Club's stairway is considered a public egress area for the building.[194] Paragraph D2.18 of the BCode reads:

> *A stairway may comply with AS1657 in lieu of various parts of the Building Code if it only serves machinery rooms and the like or non-habitable rooms not used in a frequent or daily basis.*[195]

123. Further, the scope of AS 1657 read:

> *This standard sets out requirements for the design, construction, installation of stairways which are intended to provide a means of safe access to and safe working at places normally used by operating inspection maintenance and servicing personnel. This standard does not apply to situations where special provision is made in appropriate building or other regulations.*[196]

124. Mr Richards said this is an area where the BCode has chosen to insert its own standards.[197]

125. Mr Richards estimated he has attended the Club on six or seven occasions, and had taken measurements approximately four times.[198] He explained a 'riser' is the actual height of the stair going up, and the 'going' is the tread that you actually place your foot on.[199] Mr Richards recalled, based on his measurements that the risers were consistently around 160 millimetres across the upper and lower flights, with little variation. He said that he did not see one individual riser that measured 260 millimetres,[200] but later conceded he did not measure every one.[201]

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[193] T, pages 214-215; Exhibit 19.
[194] T, page 201, referring to paragraph D2.18 of the BCode.
[195] T, page 201.
[196] T, page 202.
[197] T, page 202.
[198] T, page 202. Mr Richards later explained he had taken measurements of the stairs approximately four times that year (2012); T, page 226.
[199] T, page 203.
[200] T, pages 204 and 206; Exhibit 16 (photographs of the first and second flights of stairs at the Club taken mostly on 27 April 2012).
[201] T, page 226.

126. In relation to the 'hump' identified by Professor Caple on the landing just prior to the start of the lower flight of stairs, Mr Richards explained he had an opportunity to look underneath the carpet, and identified a 'nosing', which is a piece of wood, that is approximately five millimetres higher than the level of the landing.[202] Mr Richards stated it was pretty "standard" to find such a thing in a 100 year-old building.[203] He said that '[i]t's well within the requirements of a defect, but due to the presence of carpet and underlay, "it tends to be more like a slight hump rather than something that you would get your feet caught on...",[204] and reduces the risk of a trip.[205] He said the carpet is a non-slip variety, and therefore complies with D2.13 of the BCode (non-slip surface on stairwell).[206]

127. In relation to the level of lux (the illumination of the light) in the stairwell, Mr Richards said the BCode does not regulate lighting in this type of stairwell *per se*, and only requires emergency lighting.[207] Mr Richards said AS 1601.2006, as referred to by Professor Caple has not been incorporated into the BCode.[208]

Expert viva voce evidence

128. Professor Caple distinguished his building assessment from the role of the building inspector. The building inspector ensures the base building integrity meets the BCode safety requirements, whereas as a health and safety consultant, he looks at the space from the perspective of a risk assessment approach to hazards present in the context of what the space is being used for. He looks at the hierarchy of control to eliminate, or to reduce, as far as reasonably practicable, any identified risk factors.[209] Professor Caple considers a building occupier must complete both inspection types.[210]

129. Professor Caple explained that for the purpose of his assessment, he relies on a broad range of material such as the BCode (when relevant), guidance provided by WorkSafe Victoria and AS to reflect the state of knowledge from industry experts pertaining to

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[202] T, page 209, Exhibit 18.
[203] T, page 209.
[204] T, pages 209-210.
[205] T, pages 210-211.
[206] T, pages 209-210.
[207] T, page 211. Mr Richards agreed however that the minimum safe movement requirements in AS 1601 is 20 lux; T, page 212; Exhibit 19.
[208] T, page 211.
[209] *Occupational Health and Safety Act 2004* (Vic), section 20.
[210] T, page 239.

health and safety risks.[211] He conceded that due to clause 1.1. of the AS1657, it might have been more appropriate to look at the BCode requirements for stairs for the purpose of his assessment.[212]

130. Professor Caple attempted to reconcile the difference between his and Mr Richards' riser measurements in relation to the bottom flight. Professor Caple recalled the 260mm riser measurement related to the top four treads on the upper flight.[213] Professor Caple agreed that in one of the photographs, the straight edge ruler laid down on the top flight of stairs is in contact with every stair,[214] which would lead him to believe that height of all the stairs is consistent.[215] In consideration of Exhibit 15, which shows Mr Richards' measurements of the upper flight as being approximately 175mm, Professor Caple realised he had made a mistake, and where it said 260mm in his report, it should have read 160mm.[216]

131. Professor Caple explained that he does not have an issue with the top flight in the context of this incident, as he understands Mr Pattison fell on the bottom flight. He further said he does not have a problem with the compliance with the BCode of the bottom flight,[217] and that both flights fall within the AS insofar as they are of the prescribed rise and tread.[218] He would not describe the stairs as steep, and said "...they are fine".[219]

132. In relation to the 5mm rise observed in the 'hump', Professor Caple stated he had seen this issue in other similarly aged staircases. He further agreed that placement of carpet over the 'hump' acted to spread the [height] differential over a larger surface area.[220] He said however that the 'hump', given Mr Pattison's intoxicated state "...had the potential...to disorientate his gait from what he would have anticipated...".[221]

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[211] T, page 240. Professor Caple later explained that while he referred to the BCode, he found that the breadth of criteria in the AS covered more of the occupational health and safety elements, which is why he used that AS as the basis for compliance, as he considered the BCode was primarily looking more to the base building requirements, rather than the space's functional requirements; T, pages 248-249.
[212] T, page 250.
[213] T, page 241. Professor Caple stated he considered the lower flight treads to be very consistent, all being around 150 or 160mm in height.
[214] Exhibit 17.
[215] T, page 251.
[216] T, pages 251-252.
[217] T, page 252.
[218] T, page 256.
[219] T, page 256.
[220] T, page 253.
[221] T, page 261.

133. Professor Caple stated he checked and found a more recent AS then AS1620.1 of 1990 in relation to lighting (AS1680.1 of 2006), however was not aware of any difference between the figures in the 1990 standard as opposed to the 2006 standard, and without having gone through them exhaustively, noted that "...they're basically the same".[222] Professor Caple agreed that the BCode does not address the issue of lux requirements on staircases.[223]

134. Professor Caple remarked that if Mr Pattison fell from the landing between the upper and lower flights, where the 'hump' is located, the lack of illumination would be a potential contributing factor to his visual discrimination in the context of his intoxicated state.[224]

135. Professor Caple remarked that although the stair carpet was of a good quality, the colouring and pattern of the carpet is such that there is an issue with a lack of visual determination of the edge of the tread, which he said "...influences the gait".[225] He commented that his suggestion of retrofitting nosing treatments is simple and inexpensive.[226] Professor Caple agreed however that the BCode does not mandate there be any nosing where there is a non-slip surface such as a quality carpet.[227]

136. In Professor Caple's opinion, the lack of implementation of the practical suggestions he made in his report does not represent any breaches under the *Occupational Health and Safety Act 2004* (Vic) (**OH&S Act**).[228] He however maintained that the 'hump' does not appear to serve a purpose, and would be quite inexpensive to remove in an effort to provide an environment conducive to consistent gait patterns when descending the stairs.[229]

137. Professor Caple said he thought from a risk control perspective that it is eminently sensible to have a handrail on both sides regardless of whether the AS might dictate that or not, due to the functional appraisal of what the facility was being used for.[230]

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[222] T, pages 243-244. Mr McGregor agreed with this; T, page 245.
[223] T, page 255.
[224] T, page 246.
[225] T, page 247. Professor Caple explained that as an ergonomist, he considers the cognitive capabilities of people using the space that intoxication can affect the ability to discriminate fine details, perceive proprioceptive input, and make decisions and respond quickly; T, pages 247-248. He also noted that the features of the client demographic, including age, should be taken into account when conducting risk assessments in determining what is reasonably practicable for the environment's design ; T, page 248.
[226] T, page 247.
[227] T, page 254.
[228] T, page 260.
[229] T, pages 260-261.
[230] T, page 259.

Submissions

138. At the conclusion of the evidence, the interested parties, through their respective legal representatives, made oral submissions. I thank counsel assisting and the interested parties in this matter for their valuable contribution and submissions.

COMMENTS:

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death:

1. Mr McCredden indicated the VCGLR had considered the issue of first aid training, and would endorse first aid training as a form of best practice at any workplace, however would have some concerns about making such training mandatory under a liquor license. The concerns include the training costs (required to be regularly updated), the practical need to have a staff member present with the training (meaning multiple staff members would need to be trained), and the more appropriate regulatory forum of employer's duties or obligations under OH&S legislation, which has (non-mandatory) compliance codes on topic.[231] Mr McCredden noted that in the event of legislative changes towards mandatory first aid training, as a component of liquor licensing, significant regulatory review and the issuing of a regulatory impact statement would be needed.[232]

2. Mr McCredden however indicated the VCGLR's preparedness to consider incorporating first aid training material into some of its resources that are made available as best practice.[233]

3. I am encouraged by the VCGLR's preparedness to make first aid training material available to licensees as part of 'best practice' resources, and am also encouraged that the Club, at Inquest, indicated its intention for some employees to undertake first aid training. Whilst not within the scope of this Inquest, I note that employers' general duties and obligations to employees and other persons are contained within the OH&S Act 2004, and the WorkSafe *'First Aid in the Workplace – Compliance Code'* is relevant in this regard. In the circumstances I make no specific recommendation regarding the mandating of first aid training as part of RSA certificates.

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[231] WorkSafe, *'First Aid in the Workplace – Compliance Code'* issued 18 September 2008, available at https://www.worksafe.vic.gov.au/forms-and-publications/forms-and-publications/first-aid-in-the-workplace-compliance-code; accessed 7 January 2016.
[232] T, pages 311-312.
[233] T, page 312.

4. I accept that the lack of a requirement mandating first aid training for liquor licenses does not represent a gap in the regulation of licensed premises *per se*.

5. The changes relating to liquor licences that came into effect in January 2011 were introduced by the *Liquor Control Reform Amendment Act 2010*. The changes introduced a statutory requirement for general on premises and late night licensees to have all their staff undertake RSA training and to complete refresher training every three years.[234] These provisions do not, however, apply to a club licence unless the licence has a condition placed upon it.[235] I accept however that the VCGLR strongly encourages all licensees and applicants to undertake RSA training.[236]

6. I accept that the VCGLR has progressed historically and grown in its endeavours to expand the range of licenses and undertakings by licensees. It is clear that the VCGLR's role is growing commensurate with its responsibilities to the community. I however maintain concerns that all 'clubs' are considered clubs for the purpose of RSA training requirements under the LCR Act. This means that a football club, serving alcohol for a few hours once per week during a given season is treated the same, and subject to the same staff training requirements as a club such as the Club, which sells alcohol over a significant number of daily hours, seven days per week.

7. I commend the voluntary undertaking of RSA training by Club staff and acknowledge it is above and beyond what is required of them. I also acknowledge it is likely a reflection of the VCGLR's successful education programs, and reflective of a developing industry culture.

8. I accept that the Club, having been built in the early 1900s, is by virtue of the Building Commission's (as it then was) Practice Note 2007-23 subject to the *Uniform Building Regulations 1945*. I acknowledge the inherent difficulties in how we fit existing use with current practices and standards. I acknowledge that while looking at current standards, we must be cognisant of the building's age and the function it continues to provide. In any event, the building appears to comply with the *Uniform Building Regulations 1945*, and I make no further comment in this regard.

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[234] T, page 290. The effect of those provision coming into operation was that those effected had, under the transitional provisions, 12 months to ensure all staff were trained.
[235] T, page 291.
[236] T, page 296.

9. I accept that the Building Code is a legislated code and that the Australian Standards are not, unless otherwise incorporated by law. I accept that the Club's premises, despite its age, appears to comply with the Building Code in respect of the stairway.

10. I accept that aspects of Professor Caple's assessment of the stairs focused on Occupational Health and Safety best practice and functionality rather than minimum legal compliance. I accept that Professor Caple's focus was and is not relevant to the Council and its involvement with the Club and accordingly make no further comment.

11. Professor Caple's assessment highlighted some usability issues for which there are practical and inexpensive solutions available to improve the safety of the stairs.[237] I commend the Club for indicating its intentions to follow through with some of his suggestions.

12. I accept that on the evidence before me, the mechanism of Mr Pattison's fall remains unknown. While it is possible that he fell from further up the lower staircase, there is no definitive evidence to support this. The absence of knowing the mechanism of his fall means that I am unable to determine whether any physical aspects of the staircase were contributing factors.

13. None of the initial responders identified that Mr Pattison's position after the fall was or might have been compromising his airway. It was in excess of six minutes before the '000' call taker was able to ascertain that Mr Pattison was not breathing adequately and gave instructions that he be moved (after initially instructing he not be moved). I acknowledge the difficulties encountered by those Club members trying to render assistance to Mr Pattison in that they were not first aid trained, were working in a difficult and confined space and were hesitant due to an understandable fear of causing further injury to him. I nonetheless cannot ignore the strong probability, supported by the evidence of Associate Professor Ranson, that Mr Pattison's death was preventable.

[237] T, page 266.

FINDINGS:

1. I find that the identity of the deceased is Andrew Hepple Pattison.

2. I find that the death of Mr Pattison is directly related to his fall down the stairs at the Footscray Club.

3. I find that the Footscray Club staff acted appropriately in cutting Mr Pattison off from purchasing alcohol at the bar and arranging transport to take him home.

4. I am unable to make a finding in relation to how Mr Pattison fell down the stairs at the Footscray Club and therefore unable to identify definitive contributing factors or causal factors, apart from a finding, on the balance of probabilities, that his level of intoxication likely contributed to his mechanical fall.

5. I accept that the physical properties of the stairs at the Footscray Club comply with the relevant codes and regulations and make no adverse findings in this regard.

6. I commend the changes that have been made since, and in response to Mr Pattison's death by the Footscray Club.

7. I accept that the Footscray Club, in having employees and volunteers who at the time of the incident had completed the Responsible Service of Alcohol training, went above and beyond their statutory requirements based on their full club licence granted under the *Liquor Control Reform Act 1998* (Vic).

8. I accept that first aid training is not mandated for liquor licenses and that it would be arduous to suggest it be incorporated into Responsible Service of Alcohol Training. I note however the compliance codes relevant to the *Occupational Health and Safety Act 2004* which inform employers' duties or obligations not only to their employees, but to other people, including patrons. It is unclear why the Footscray Club did not turn their mind to their duties and obligations under the *Occupational Health and Safety Act 2004* in this regard in the context of the Club's function and members.

9. I accept that the Maribyrnong City Council were not required to conduct inspections at the Footscray Club's premises as there had been no building permit application or change to its existing use rights. I make no adverse finding in relation to Maribyrnong City Council.

10. I accept that the Victorian Commission for Gambling and Liquor Regulation have taken an active and leading role in the liquor licensing sphere in providing education material

and promoting a policy that encourages all licensees and applicants to undertake Responsible Service of Alcohol training. I make no adverse finding against the Commission.

11. I find that Andrew Hepple Pattison died from positional asphyxia in a setting of intoxication and minor head injury. I further find that his death may have been prevented if his airway had been cleared and maintained from a time proximate to being located at the base of the stairwell.

To enable compliance with sections 72(5) and 73(1) of the *Coroners Act 2008* (Vic), I direct that the Findings will be published on the internet.

I direct that a copy of these Findings be provided to the following:

- Mr David Pattison
- Mrs Pamela Pattison
- Mr Mark Waters, CIE Legal on behalf of Maribyrnong City Council
- Mr Simon McGregor of Counsel
- The Footscray Club
- Ms Masha Lezaic, Victorian Government Solicitors Office on behalf of the Victorian Commission for Gambling and Liquor Regulation
- Mr Daniel McCredden of Counsel
- Mr Colin Grant, Manager Professional Standards, Ambulance Victoria
- Associate Professor David Ranson, Victorian Institute of Forensic Medicine
- Police Coronial Support Unit
- Constable Ashley Barry

Signature:

AUDREY JAMIESON
CORONER
Date: 24 February 2016