IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 4730

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: GEOFFREY ASHTON

Delivered On:	6 March 2014
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	19 and 20 September 2013
Findings of:	JUDGE IAN L GRAY, STATE CORONER
Representation:	Mr John Kelly, counsel for the Ashton family. Ms Naomi Hodgson, counsel for the Chief Commissioner of Police.
Counsel Assisting the Coroner:	Ms Jodie Burns, Principal In House Solicitor

I, JUDGE IAN L GRAY, State Coroner having investigated the death of GEOFFREY ASHTON

AND having held an inquest in relation to this death on 19 and 20 September 2013
at the Melbourne Coroners Court
find that the identity of the deceased was GEOFFREY ASHTON
born on 24 September 1933
and the death occurred on 17 December 2011
at the Croydon Police Station, 175 Mt Dandenong Road, Croydon 3136
from:

1(a) ISCHEMIC HEART DISEASE

Pursuant to section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances:**

BACKGROUND

1. Geoffrey Ashton (Mr Ashton) was born on 24 September 1933. He died on 17 December 2011 aged 78 in the foyer of the Croydon Police Station.

2. At the time of his death Mr Ashton resided at 7 Langdale Drive, Croydon Hills, with his wife, Pamela Ashton, of 47 years. Mr Ashton and Pamela had six adult children, none of which was living with them. Timothy Ashton, Mr Ashton's son, has told me that the death has materially altered the family structure.

3. On 17 December 2011, Mr Ashton was reported by Pamela to be relaxed and in good spirits, physically looked well and had not complained of any medical conditions to her.

4. In the afternoon they both attended an 80th birthday party at Mingarra Residential Care in Croydon, which is next door to the Sacred Heart Church.

5. They left the birthday party at 4:45pm and travelled the 10-15 minutes back to their home where they prepared to return to attend the 6.00pm mass at the Sacred Heart Church.

6. Mr Ashton was actively involved with, and attended regularly, the Sacred Heart Church including helping to modify a former monastery to allow a business enterprise as a convention/conference facility. The church was a very sacred place to him.

7. At the time of his death, Mr Ashton was being treated by his general practitioner, Dr Max De Clifford, and cardiologist, Dr David Rose, for ischemic heart disease (IHD).

8. Mr Ashton was first diagnosed with IHD in 1994, at the age of 61. Mr Ashton was also being treated for other conditions including type 2 diabetes, hypertension, paroxysmal atrial fibrillation, and intermittent slow heart rates.

9. Despite these conditions Mr Ashton's cardiologist, Dr David Rose, reports that his overall health was reasonable and his IHD was managed by medication.

THE CORONIAL INVESTIGATION

10. The Corners Act 2008 (**The Act**) sets out the role of coronial system in Victoria. This role is to independently investigate certain deaths to establish, if possible, the identity of the deceased, the cause of the death and the circumstances in which the death occurred.

11. The cause of death refers to the medical cause of death. For coronial purposes, the circumstances in which a death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the medical cause of death and not merely all circumstances which might form part of a narrative culminating in death.

12. A coroner's role is also to contribute to the reduction of the number of preventable deaths and the promotion of public health and safety and the administration of justice.[1]

13. Detective Senior Constable Scott Riley from the Homicide Squad was the coroner's investigator assisting me and he prepared the coronial brief and assisted with my investigation.

WAS IT MANDATORY TO HAVE AN INQUEST

14. Section 52(2) of the Act provides that it is mandatory for a coroner to hold an inquest into a death if the death or cause of death occurred in Victoria and a coroner suspects the death was as a result of homicide, or the deceased was, immediately before death, a person placed in custody or care or the identity of the deceased is unknown.

15. Mr Ashton's death is not consistent with homicide. Identity and the medical cause of Mr Ashton's death were not in dispute. Mr Ashton was not a person placed in custody or care at the time of his death. Therefore, it was not mandatory to conduct an inquest in this matter. However, Mr Ashton's family sought an inquest and I considered it was appropriate to deal with a number of the issues in the setting of an inquest.

---

[1] Coroners Act 2008 (Vic), Preamble and s 1.

INQUEST

16. On 19 and 20 September 2013 an inquest was held where the following witnesses gave evidence:

- Dr Norman Rose, Cardiologist.
- Dr Michael Burke, Pathologist.
- Commander Cole.
- Victoria Police member, Alan Bassett.
- Victoria Police member, Stephen Young.
- Coroner's Investigator, Scott Riley.

17. Mr Timothy Ashton made a statement about his father at the conclusion of the inquest.

18. The areas of inquiry at the inquest included whether the altercation shortly before Mr Ashton's death caused or contributed to the medical cause of death of IHD, whether adequate steps were taken by Victoria Police to provide first aid to Mr Ashton, whether the Victoria Police policies and procedures adequately addressed a medical emergency for a member of the public and whether the evidence highlighted any prevention opportunities.

19. Ultimately the focus of the evidence was on police first aid training procedures and the adequacy or otherwise of the response by police at the Croydon Police Station on the evening of 17 December 2011 when Mr Ashton collapsed twice in the foyer of the police station.

20. A particular focus was the issue of defibrillators (automated external defibrillator or AED). The questions on this issue were:

- Was an AED in place at Croydon (on the evidence one was there, but the relevant police officers did not know that).
- The value of using an AED in dealing with heart attack events caused by IHD as in the case of Mr Ashton. (On that matter, I accept the evidence of both Doctors Burke and Rose. The evidence is clear that an AED, if applied within time, can significantly increase the chances of saving a life when there is sudden cardiac arrhythmia).
- Whether AED's should be placed in all police stations.

- Whether such AED's should be primarily focused on the health and safety of members of the police force or on the public or both.
- Police first aid training in the use of AED's.
- Associated first aid training in CPR techniques.

21. The evidence of Commander Cole on these matters was instructive. I accept the evidence he gave on the first aid training issue. He expressed his own opinion that the availability of an AED (when known to be and available and readily accessible at a police station) is desirable. He qualified that by referring to the incidence of heart attack events in police stations and cost. He told me that 81 AED's are in fact installed in Victorian police stations but not in 81 separate police stations – a number of locations have a number of AED's at them (for example at the Victoria Police Forensic Services Department in MacLeod).

IDENTITY

22. Mr Ashton was visually identified by his son, Timothy on 18 December 2011.

23. There is no dispute about Mr Ashton's identity. I find Mr Ashton's identity to be Geoffrey Ashton, born on 24 September 1933.

MEDICAL CAUSE OF DEATH

24. On 17 December 2011, Dr Michael Burke, Forensic Pathologist with the Victorian Institute of Forensic Medicine, was informed by the Homicide Squad that a male had presented at the Croydon Police Station alleging he had been assaulted and had an injury to his left eye and nose and subsequently died. On the same day, Dr Burke attended at the police station and viewed CCTV of Mr Ashton at the police station.

25. On 18 December 2011, at 3:45 am, Dr Michael Burke, performed an autopsy on Mr Ashton and concluded that the cause of death was IHD. Toxicological analysis also revealed the presence of ethanol (alcohol) of 0.03g/ml/100ml.

26. Dr Rose, whilst not present at the autopsy, agreed with Dr Burke's cause of death of IHD and commented:

> *"No, no, I regard this – IHD is – there's a series of levels in this. Ischemic heart disease is the underlying diseases. Then the consequence of ischemic heart disease is things like angina, myocardial infarct and then the consequence of angina, myocardial infarct may be ventricular fibrillation so it's a series of steps. I*

absolutely agree that the cause of death was ischemic heart disease, it's the upstream cause."[2]

27. Dr Burke did not find any evidence of coronary thrombosis[3] or acute myocardial infarction[4]. However, Dr Rose gave evidence that whilst the autopsy did not show evidence of coronary thrombosis or acute myocardial infarction, a thrombus[5] could have disappeared by the time of the autopsy and that changes of myocardial infarction may not have fully developed.

28. Dr Burke gave evidence at the inquest that Mr Ashton had an enlarged heart and *"Enlarged hearts are electrically unstable."*[6]

29. Dr Rose did not consider the alcohol in Mr Ashton's blood was a contributing factor to the cause of death.[7]

30. I find Mr Ashton's medical cause of death was IHD. It was well established that Mr Ashton suffered significant IHD.

Whether the temporal association between the physical altercation and the sudden cardiac event contributed to the death

31. It is not mandatory for the court to determine what, if any, events or incident contributed to the medical cause of death. However, Dr Burke, in his autopsy report commented:

> *"Given the close temporal association between the physical altercation and the sudden cardiac event, it would appear highly likely the "stress" associated with the incident has contributed to the death".*[8]

32. Both Dr Burke and Dr Rose, in essence, agreed that the stress associated with the incident was a contributor to the onset of the heart attack. Dr Rose considered that it was a "likely"[9] contributor to the stress. Dr Burke considered that the contribution to the stress

---

[2] Inquest transcript, page 55
[3] Coronary thrombosis is the medical term for the process of the body forming a blood clot in the coronary arteries
[4] A myocardial infarction is the medical term for an event commonly known as a heart attack. It happens when blood stops flowing properly to part of the heart and the heart muscle is injured due to not getting enough oxygen. Usually this is because one of the coronary arteries that supplies blood to the heart develops a blockage due to an unstable build up of white blood cells, cholesterol and fat.
[5] A thrombus is the medical term for a clot.
6 Inquest transcript, page 71.
[7] Inquest transcript, page 43.
[8] Inquest brief, page 42.
[9] Dr Rose gave evidence that, whilst he would not disagree with Dr Burke, he believed it was 'likely' but not 'highly likely' the physical altercation was a precipitating factor for the cardiac event, but for him it is a matter of degrees of certainty. Dr Rose qualified his response by stating he was not certain exactly where to draw the line.

was between "possible and probable"[10]. On this evidence, it is reasonable to conclude that the stress caused by the incident at the church played a part in the onset of Mr Ashton's heart attack.

33. At the same time, bearing in mind the whole of the medical evidence, it was clear that Mr Ashton was suffering "significant" IHD and a number of other relevant conditions including diabetes and hypertension. In combination, they placed him at risk of suffering a heart attack.

34. It is clear that Mr Ashton was somewhat agitated at the police station. The CCTV footage demonstrates this.

35. Dr Rose, agreed that it was possible the '*stress*' could include Mr Ashton being in an agitated when he first approached the vehicle in the disabled car park. Dr Rose stated that in relation to the questions of precipitating factors for sudden death and in particular the altercation in which Mr Ashton was involved before his death "*it's known that emotional stressors leading to a surge of adrenalin, sudden physiological shocks, can a promote coronary events. This may be by way of rupture of vulnerable plaque leading to coronary thrombosis or producing sudden cardiac disturbance of rhythm such as ventricular fibrillation in vulnerable patients and I made the observation there are reports of sudden cardiac death being more common in communities subjected to natural disasters. An earthquake in Los Angeles, Loma Prieta earthquake a decade ago was noted to produce an increase in the incidents of cardiac death but by the end of the month all the incidents had returned to usual, to baseline, and experts opined that the stress of the event had brought forward events that were going to occur. So the stress had led to an upsurge of events but those events had been going to occur in the fullness of time were just brought forward by that stress.*"[11]

[10] Inquest transcript, page 77, Dr Burke's evidence at inquest was "*I'm sort of at the higher end. I viewed the situation as this. That if Mr Ashton was having this altercation, whatever that altercation is, whether it was push and shove or blows thrown or just even yelling at each other and he suddenly grabbed his chest and died. I think most people would say the incident, the stress, the adrenalin coursing through the body has triggered his death. I think most people would say that. ..If he died a week later, I think most people would say it's probably got nothing to do with it. Then it becomes how long is a piece of string? How long does it have to be from the incident that one can say that it has contributed to his death and for me I think it's close enough. I think if the incident hadn't occurred he'd be walking around the next day*".

[11] Inquest transcript pages 32-33

CIRCUMSTANCES OF DEATH

Sacred Heart Church, Croydon

36. On Saturday 17 December 2011, at approximately 5.45pm, Mr Ashton attended the Sacred Heart Church in Croydon with his wife for the 6.00pm mass. Upon arrival at the church, Mr Ashton parked his car and he and his wife proceeded to enter the church.

37. At the same time, another car parked in a disabled car park nearby. Mr Ashton approached the vehicle parked in the disabled car park and advised the four occupants (comprising of Leofred (father), Steven (son), Ursula (wife/mother) and Sonia Naronha (daughter)) that they should not be parking there.

38. Leofred Naronha was driving the vehicle and had a valid parking permit, however, it is unclear whether it was displayed at the time Mr Ashton approached the vehicle. The evidence suggests that Mr Ashton was in an agitated state during this discussion.

39. There are varying accounts of what occurred after this. What is known is that whilst entering the church Mr Ashton, Leofred and Steven had an altercation, which resulted in Mr Ashton being pushed, and hit to the face after which he fell to the ground (**the church incident**).

40. There is no evidence in the inquest brief to suggest that Mr Ashton was racially intolerant to the people involved in the incident.

41. The Homicide Squad compiled a criminal brief of evidence and on 19 April 2012, it was submitted to the Director of Public Prosecutions (DPP) for advice.

42. On 2 August 2012, a representative of the Office of Public Prosecutions advised that the DPP was of the view that there was no reasonable prospect of conviction for manslaughter despite the comment made by Dr Burke that the stress related to the incident contributed to the death. Firstly, the DPP was of the view that there was real doubt as to causation. Secondly, the DPP was of the view that there is real doubt as to which acts by different persons, led to the stress that may have contributed to the death. Finally, the DPP noted there is real doubt that either of such acts was not done in self-defence.

Croydon Police Station

43. Mr Ashton subsequently went to the Croydon Police Station and attempted to report to Leading Senior Constable (LSC) Bassett (watch housekeeper) the church incident.

44. LSC Bassett asked Mr Ashton if he was alright and inquired whether he needed an ambulance, which he refused. LSC Bassett stated that his policy was when somebody alleges they have been assaulted, he always asks them if they need medical assistance or an ambulance.

45. LSC Bassett then asked Mr Ashton what had happened and he was told he was going to church when he saw a car parked in a signed area so he went over to the car and told the people inside that they should not park there, that it was for older people (i.e. disabled parking).

46. Mr Ashton provided LSC Bassett with registration numbers 0UL-499 or OUL-449. After establishing that Mr Ashton drove to the station, LSC Bassett offered him some water. At this stage, LSC Bassett formed the view that Mr Ashton was agitated.

47. LSC Bassett observed swelling above Mr Ashton's left eye and informed him that he would conduct some checks on the registration numbers and get some water for him. LSC Bassett observed Mr Ashton to sit down on the seats near the soft interview room in the foyer of the police station.

48. There was no computer at the front desk and LSC Bassett had to leave the front area to conduct the checks. The computer LSC Bassett used to conduct the checks did not allow him to see Mr Ashton in the foyer. LSC Bassett believed some of the newer stations now have a computer at the front counter.

49. Whilst conducting the checks, LSC Bassett answered a phone call that went for just over five minutes. The results of the checks showed that both of the vehicles were Fords. One of them being a silver Ford registered to an address in country Victoria, and the second being a green Ford station wagon registered to a Croydon address.

First incident – un-witnessed

50. Whilst LSC Bassett was conducting vehicle registration checks, CCTV shows Mr Ashton to collapse and recover shortly thereafter.

51. Upon LSC Bassett returning to the front counter in the foyer area, Mr Ashton got off the seat and went to him. LSC Bassett gave him a cup of water and had a further conversation with him where he asked whether he was sure of the registration numbers.

52. Dr Rose's opinion having viewed the CCTV of Mr Ashton's un-witnessed collapse was *"That would lead me to the conclusion he was probably have a myocardial infarct or at*

least an ischemic event at the time."[12] Dr Rose agreed that it was very likely that Mr Ashton's heart muscle may have commenced to die at the first un-witnessed incident.

53. Dr Rose's stated "*I think where he slumped and fell, it was a faint. A faint induced by pain and his being unwell. Not to some extent that's speculative. I can see that he's unwell. I can see that he's in pain, at least I infer that from the way he behaves, and from his grasping of his left arm, that he's in pain, he seems to be agitated. He seems to be sweating and wiping his brow, then he clearly becomes unwell and he slumps and he falls to the floor but he gets up again...I think the pain and the being unwell is due to ischemia. I think he has angina at that point or he's developing a myocardial infarct but the event that causes him to fall to the floor is not simply the myocardial infarct, it's some consequence of it and the consequence is probably a vasovagal faint. The consequence might have been ventricular fibrillation but if that had been the case I don't think he would have got up again and on the second occasion of course he didn't get up again.*"[13]

54. Dr Rose concluded un-witnessed collapse "*may have been a vasovagal event, a simple faint, due to pain and being unwell. It's unlikely to have been due to ventricular arrhythmia because he spontaneously recovered...which one doesn't usually do from ventricular fibrillation and in the circumstance of being unwell, in pain, sweating, those are often features of what we call a vagal discharge, discharge of the vagal nerve producing those symptoms and it's possible to induce a faint with that and I think that first event was probably of that sort.*"[14]

55. Dr Rose also stated in relation to the un-witnessed incident "*Had he had just a sudden ventricular arrhythmia, as in scar-based arrhythmia, I would have expected no warning. He would have simply suddenly collapsed. But on the video we see a man who seems to be in pain, distressed, unwell and – where there was no sound of course but looking at him, he looks to me like a man who's probably having an ischemic event at that time so I would lean very heavily to the notion that this was an ischemic event...Lack of blood flow to the heart producing pain.*"[15]

56. Dr Rose stated if police had been aware of the un-witnessed incident and summonsed help "*Perhaps, knowing he'd been unwell, perhaps if he told them that he had a history of heart disease, they may have induced the police to start CPR earlier but the only thing I can*

[12] Inquest transcript, page 38
[13] Inquest transcript, page 47-48.
[14] Inquest transcript, pages 38-39.
[15] Inquest transcript, page 38.

think of that could have made a difference from what we have seen was the earlier application of CPR to Mr Ashton...Effective CPR...yes defibrillation – yes."[16]

57. Dr Rose stated he did not think Mr Ashton would have had no memory of the un-witnessed collapse, *"if he made no mention to the police that he was unwell and in pain I can't explain that, I find that surprising."*[17]

58. LSC Bassett stated that if there was a computer at the front desk and had he seen Mr Ashton collapse on that floor on the first occasion, his first thought would have been to call for an ambulance straight away.

<u>*Second incident – witnessed*</u>

59. Whilst LSC Bassett enquired about vehicle registration numbers, Mr Ashton started to rub his left arm. LSC Bassett asked if he was alright and he said, *'My arm is sore, I feel like I may collapse.'*[18] LSC Bassett said, *'Go and sit down for a bit'*[19] and suggested he go and sit down on two or three occasions over a 10 to 15 second period. At this time, Mr Ashton collapsed to the floor.

60. LSC Bassett immediately called Acting Sergeant (A/Sgt) Young, in the section sergeant's office, for assistance and to call for an ambulance. A/Sgt Young was the only other police officer in the station at the time.

61. LSC Bassett stated that the first time he became alerted to Mr Ashton having a real medical problem was when he was rubbing his arm and his skin seemed to be pasty/a pale colour and it made him inquire if he was okay.

62. LSC Bassett went to the foyer area and observed Mr Ashton lying on the floor unconscious and breathing very shallowly. He rolled Mr Ashton onto his side into recovery position and used the water from the cup to sprinkle across his face in order to get some response, which had no effect.

63. Dr Rose opined that in relation to the second collapse *"I think was ventricular fibrillation, he never recovered from that. When he fell to the ground, had it been a simple faint, he would have been expected to recover quickly as he did on the first occasion but he didn't move again. He made – I think he was in ventricular fibrillation at that point."*[20]

---

[16] Inquest transcript, page 43.
[17] Inquest transcript, page 42.
[18] Inquest transcript, page 48.
[19] Inquest transcript, page 48.
[20] Inquest transcript, page 39.

Attempts to locate a resuscitation mask

64. At this point LSC Bassett returned to the watch house and looked for a resuscitation mask with the intention of performing CPR, including mouth-to-mouth. However, he was unable to locate one in that first aid kit and other areas of the station.[21] LSC Bassett stated his first aid training taught him that he should not do mouth-to-mouth without a mask for the safety of all persons. LSC Bassett stated he would always use a mask.

65. LSC Bassett stated "*I did look for a mask obviously in the first aid kit and I would have looked in some other place as well, in the sergeant's office – look, I'm not exactly sure of my movements when I was looking for that mask but I did look in other places as well in the hope of finding a mask...My movements when I left were wholly and solely to try and find a resus mask to try and offer some assistance.*"[22]

66. LSC Bassett stated that his movements over the 5 minute 49 second period from when Mr Ashton collapsed to when he first administered CPR could be accounted for because "*the entire time I was out there I was trying to find a mask or something to assist Mr Ashton, I wasn't doing anything other than that...the entire time I was out the back. That's what I was trying to try and find something which I could render some assistance*"..."*when Mr Ashton collapsed and I was trying to find that mask and I couldn't find it, it was a confronting situation and not a situation I had in my time in the police force been with before and it was – it was – for want of a better word it was a distressing situation.*"[23]

67. Whilst LSC Bassett was trying to locate a resuscitation mask A/Sgt Young was on the phone to Ambulance Victoria.

First aid training

68. During his evidence, LSC Bassett agreed he had let his first aid training lapse, as it expired in August 2008. However, he was not aware first aid training was a direct policy or that it was mandated for police officers.

69. LSC Bassett agreed that each member received a white hard cover plastic resuscitation mask when they did the St John's First Aid training; however, they were not practical to carry around.

---

[21] LSC Bassett stated "*I looked in the first aid – I looked – I had a look around, I couldn't find one – I don't know, all I know is on that day I couldn't find a mask.*"
[22] Inquest transcript, page 123.
[23] Inquest transcript, page 133.

70. LSC Bassett's evidence was that on this occasion he was looking for a plastic sheet with a small mouthpiece on it, which could be put over the mouth of Mr Ashton allowing him to blow through it with some sort of protection.

71. LSC Bassett's evidence was that on this occasion he was not aware there was an AED in the police station. However, he did state that had he known one was available "*I have to say, yes, it would have been beneficial*"[24]. LSC Bassett agreed that as part of the first aid training they were trained in the use of AED's.

First aid administered to Mr Ashton

72. LSC Bassett stated that he followed the instructions provided by the 000 operator, via A/Sgt Young, to the best of his ability. However, as a Victoria Police officer with 28 years' experience he had never been required to administer CPR to any person before.

73. Dr Rose's evidence was the 000 operator spent quite some time ascertaining whether Mr Ashton was still breathing and that he thought she was uncertain about the answers she was getting because the police themselves seemed to be uncertain as to whether Mr Ashton was actually breathing.

74. Dr Rose's observation of the CCTV was that Mr Ashton may have been taking agonal breaths, an occasional movement and a 'death gasp' and that he didn't think he was actually breathing.

75. Despite this, Dr Rose stated that once the 000 operator was convinced Mr Ashton was not breathing she asked the police to begin CPR. However, in Dr Rose's view "*I think time had gone past. I was slightly squirming as I watched it wishing that CPR would commence.*"[25]

76. In relation to when CPR should commence, Dr Rose stated "*Now we like people to do it. Anything you do is worthwhile, any effort you make may result in a save. Mr Ashton died. They did the best they could I think. It's always worthwhile doing it but the first cardiac arrest that you're giving the resuscitation it's most likely going to be a disaster...The more training the better, the more practice the better.*"[26]

77. Dr Rose's view was that the first aid administered to Mr Ashton after the second collapse was not effective because he was in ventricular fibrillation and needed CPR immediately. Dr Rose also commented *"I don't think the personnel that were attending him understood*

[24] Inquest transcript, page 95.
[25] Inquest transcript, page 49.
[26] Inquest transcript, page 53.

that or were trained in that. They turned him into a position that protected his airway and in most circumstances of fainting or being unwell that's a good thing to do but if the patient has had a cardiac arrest due to ventricular fibrillation then the rapid onset of CPR is critical. My note of the times on the video suggest it was about six minutes before an attempt was made by CPR."[27]

AED's

78. Dr Rose gave detailed evidence in relation to Mr Ashton and more generally on the issue of the use and value of defibrillation. Dr Rose, when asked the likely effect if an AED had been used, he responded:

> *"It very probably would have had a significant effect. It may well have saved his life. We were in the critical threshold for successful resuscitation. He very likely was in ventricular fibrillation. Had an automatic defibrillator been applied it very likely would have defibrillated him, given time for the ambulance to arrive and to take him to hospital, it likely would have had a significant effect...the defibrillator will actually deliver the shock, the instructions it gives you is, "Get out of the way, let go of the patient."*[28]*... "It would have been valuable to have applied the external automatic defibrillator because the external automatic defibrillator, if it detective ventricular fibrillation, would have immediately recommended a shock... That could have saved his life ...Now it is possible, when he went down, that it wasn't ventricular fibrillation but more serious than that, something that was not shockable and indeed not survivable because we're speculating about what it was. Most sudden death in circumstances like this is ventricular fibrillation, is shockable and is reversible so one assumes that in every case one ought to apply a defibrillator to someone in the circumstance and hope for the best but it's also possible that we were dealing with a major event, that there was even more serious damage done. It's possible that had a defibrillator been applied it might have found something we call asystole, no rhythm, not shockable, or something we call electromechanical dissociation, normal rhythm, no output, not shockable but the likeliest, far and away the likeliest is ventricular fibrillation, shockable."*[29]

79. Dr Rose stated:

---

[27] Inquest transcript, page 39.
[28] Inquest transcript, page 54.
[29] Inquest transcript, page 44.

"since Mr Ashton's sudden death was very likely associated with ventricular defibrillation, whether due to an acute coronary event or scar-based, it's possible that an automatic defibrillator would have made a critical difference. Out of hospital, cardiac arrest is associated with a very high mortality and in most cases a successful resuscitation cannot be achieved. The availability of rapid defibrillation as well as the ability and willingness of bystanders to undertake immediate cardiopulmonary resuscitation, CPR, can make a great difference to the prospects of survival."[30]

80. Dr Rose stated that critical changes occur in the heart within 3 minutes and death can occur within 4 minutes.[31] When asked if there was any acceptable medical literature that gives broad time frames when proper CPR should be administers, Dr Rose stated:

"Well the medical literature recommends as soon as possible. One knows the longer the time, the less likely one is get a good outcome. The difficulty always is one never can be quite certain at what time anything happened. For example, while I suggest to you Mr Ashton collapsed to the floor the second time, he was in ventricular fibrillation, one doesn't know that for certain so one cannot say with certainty just from viewing the video that circulation to the brain had ceased at that moment. So that when the ambulance arrive, even if somebody tells them the patient has been unconscious for five minutes, six minutes, they will usually start CPR in the hope that there may be a good outcome but from experience they might be pessimistic about the likelihood of a good outcome. So the medical literature is the sooner the better."[32]

81. Dr Rose qualified his evidence stating that even if someone is revived it does not mean they will be in a healthy state:

"If they have severe brain damage, there may be cause to regret the resuscitation but one never knows."[33]

"The emphasis now in CPR is on the chest compressions which need to be delivered rapidly, both hands. Actually breathing the patient, providing more oxygen is now thought less critical but as the CPR goes on that has to be done as well, that's mouth

[30] Inquest transcript, page 36.
[31] Inquest transcript pages 40.
[32] Inquest transcript, page 41.
[33] Inquest transcript, page 40.

to mouth, or if there's an instrument that can interpose that's helpful... If one is undertaking CPR, at some stage, some oxygen, some breaths will have to be given but the critical part is the chest compressions and Dr de Clifford's statement about defibrillation is true. The sooner defibrillation can be applied to the right patient the better. Lay people who are not trained in medicine are not expected to recognize rhythms that can be appropriate defibrillated hence automatic defibrillators. If one can be applied quickly, that can make all the difference." [34]

PREVENTION

Introduction

82. Dr Rose as Mr Ashton's treating cardiologist at the time of his death stated his overall health was reasonable. Whilst he had significant heart disease, as well as other conditions such as diabetes, hypertension, paroxysmal atrial fibrillation and intermittent slow heart rate sign as a brachycardia. Nonetheless, he was managing fairly well on medication, was free of symptoms and his quality of life when he last saw him seemed to be good.[35] However, he did qualify this by stating "*Everybody who has ischemic heart disease is always at risk of sudden plaque rupture and sudden events that are not predictable.*"[36]

Was Mr Ashton's death expected or anticipated?

83. Dr Rose described Mr Ashton's death as an unexpected death and he had not anticipated it.[37] Dr Rose stated:

"Mr Ashton's GP had not anticipated it and very clearly the police when Mr Ashton walked into the station had no idea as imminent. No, I regard it as sudden and unexpected... It's not surprising in the sense of knowing he was a man with ischemic heart disease who was at that risk. So in that respect it's not surprising. That it occurred at that moment without warning was surprising..."[38]

84. Dr Rose further stated:

"I think the death was preventable from the time of his second collapse in ventricular fibrillation. Had effective CPR been started immediately, possibly, and above all had the automatic defibrillator that I'm now told was present been applied, it's certainly

[34] Inquest transcript, page 41.
[35] Inquest transcript, page 36
36 Inquest brief, page 57.
37 Inquest brief, page 66
38 Inquest brief, page 66

possible that the death was preventable, not certain, only possible... Perhaps probable... It's not easy to be precise."[39]

85. Dr Burke agreed with Dr Rose that Mr Ashton's death was unexpected.[40] However, Dr Burke qualified this by stating *'I have seen people at the Institute who have seen their doctor the day before and given a clean bill of health and therefore they come to us because it's totally unexpected that they die but, from our point of view, people with ischemic heart disease can die at any time but that's because I have a skewed view because everyone I see – there are lots and lots of people out there with ischemic heart disease doing well but it is a dangerous disease."*[41]

Victoria Police's approach to first aid training

86. Commander Cole gave evidence on 20 September 2013 that he was the current Commander Director of the Health Safety and Deployment Division and his responsibilities included undertaking a risk assessment before resources were allocated, strategies and management put in place for first aid and other health and safety issues.

87. Commander Cole confirmed an AED was sourced and placed within the Croydon police station in August 2011.

88. Commander Cole explained the Victoria Police manuals to contain two parts, one the policy and the other the guidelines. The policy sets out the requirement for all employees of Victoria Police and the guidelines set out how to comply with the policy.

89. Commander Cole confirmed that the Victoria Police manual did not provide a policy or a guideline that a first aid training qualification needs to be current to a certain period.

90. Commander Cole explained that Operational Safety and Tactic training (OST) and first aid had been linked together. However, after an Office of Police Integrity inquiry into police shootings, there was criticism of Victoria Police diluting the OST training. Therefore, a decision was taken as a result of a recommendation that they un-attach the first aid training from OST and provide it as a separate training; to allow OST to focus on operational safety tactics.

39 Inquest transcript, page 67.
40 Inquest transcript, page 79.
41 Inquest transcript, page 84.

91. However, that disconnection removed the onus of first aid being required to have a current OST qualification and Victoria Police had not addressed the fact that first aid is no longer a requirement of a serving Victoria Police officer (i.e. there is no policy).

92. Commander Cole stated that in terms of first aid training, it came down to an expectation that members are first aid trained and hold a current qualification. Commander Cole noted that it is a requirement on entry to Victoria Police to have first aid training.

93. Despite there being no formal policy, Victoria Police fund St John's Ambulance to provide members of the force first aid training and restock first aid kits.

The role of the First Responder

94. Commander Cole explained that in Victoria Police terms '*first responder*' is '*first response unit*', being police first response unit and in terms of other services, it's the first qualified responding unit e.g. ambulance etc. Commander Cole stated that some police members possess higher first aid qualifications, such as Search and Rescue Squad. However, for general policing in terms of getting a first responder they would call for an ambulance.

Maintenance of first aid kits

95. Commander Cole stated that the Officer in Charge (OIC) of a police station is responsible for the audit and the maintenance of first aid kits at police stations. However, there appeared to be no coordinated approach other than leaving this task up to the OIC.

AED register

96. Commander Cole stated that his department was not aware of the existence of the AED at Croydon Police Station at the date of Mr Ashton's death. He agreed there was no official record of AED's held by Victoria Police and his department was in the process of creating a central register.

97. At the time of the inquest Commander Cole's department was aware of 81 devices across Victoria Police, not all in separate police stations. Commander Cole stated there are 326 permanent police stations in Victoria, and five seasonal police stations.

98. Commander Cole agreed that in his role as Director of Health Safety and Deployment Division, he was responsible to ensure that the Chief Commissioner of Police, in its capacity as an employer, meets its obligations under the *Occupational Health and Safety Act 2004* (**OHS Act**).

99. Section 23(1) of the OHS Act imposes a non delegable duty on employers to other persons; namely that an employer must ensure, so far as is reasonably practicable, that persons other than employees of the employer are not exposed to risks to their health or safety arising from the conduct of the undertaking of the employer.

100. In relation to section 23 of the OHS Act, Commander Cole stated:

> *"in practical terms we considered about keeping people who come in - into contact with us, safe... In terms of police stations, it's any person who comes into a police station. But typically it will be persons taken into custody, persons taken into care, persons who are in making witness statements and the like, or in - and we would accept that it's persons who come into the foyer of the police station to make reports. So it's a dual-fold process for us. It's one, about the person who's in the foyer of the police station, but it's also about protecting our own employees."*[42]

Risk assessment

101. Commander Cole referred to Attachment 7 of his statement and advised me that "*This form is used by local management in consultation with a health and safety rep to determine the number of police members to be trained, the level of first aid training required, the number, type and location of first aid kits, and the need for a first aid room.*"[43]

102. Commander Cole agreed that the assessment form does not require consideration of a need for an AED, however this did not mean consideration was not given to one, "*defibrillators are considered. Keeping in mind that this first aid risk assessment is around risk to employees and obligations by their employer, and that's how - and that is why we see defibrillator devices in some high risk areas where employees are at higher risk of heart attack.*"[44]

103. Commander Cole was asked whether there should be an AED in every police station in Victoria and he responded "*Well, I think that's an unfair question because it requires an official response and a personal response. Um, in terms of the official response, we haven't done the piece of work, so we don't fully understand the extent of um, the need. Until we've done that, I think it's unfair to say it. From a personal perspective, um, I would certainly agree that I think it would be a benefit if we had them in each work location.*"[45]

[42] Inquest transcript, page 151.
[43] Inquest transcript, page 153.
[44] Inquest transcript, page 153.
[45] Inquest transcript, page 156.

104. When asked whether Commander Cole could see any down side to having AED in the Victoria Police workplaces, he stated "*...have proper instruction about their use, I don't see a downside.*"[46]

105. Commander Cole agreed that members of the public reporting a crime was a part of the normal police business (or the **undertaking**) and that Victoria Police had an obligation under section 23 of the OHS Act to protect members of the public from risks arising from its undertaking.

106. Commander Cole said he was troubled that a significant part of the time LSC Bassett, and also A/Sgt Young, was spent attempting to locate a resuscitation mask.

107. Section 23 of OHS Act provides non-delegable duties which, if breached, attach a criminal sanction. An employer's obligation, in this case Victoria Police, cannot be delegated to St John's Ambulance and/or the OIC of the station. The task can be assigned to one or both to carry out on behalf of the employer, however, the responsibility to discharge the health and safety obligation remains with the employer. As such, an employer should have appropriate policies and supervision in place. Despite this, I do not suggest there were any OHS Act breaches in this matter.

108. Commander Cole stated that the OIC should conduct a monthly report and said there were directions around monthly inspections, but he did not point to any specific policy. It was unclear whether there was any coordinated auditing or supervision to ensure the monthly report was done.

Compliance Code – First Aid

109. The WorkSafe Compliance Code – First Aid in the Workplace, whilst not mandatory, provides valuable guidance to employers on how to discharge their first aid obligations in the workplace. At paragraph 86 it states:

> *"If life threatening injuries could result, and if time access to emergency services cannot be assured, a first aid officer trained in more advanced techniques such as defibrillators and oxygen provision, may be needed. The final decision will depend on a combination of factors such as the number of employees, the nature of the hazards present, and severity of the risks involved."*

[46] Inquest transcript, page 157.

110. Commander Cole agreed that a risk assessment was not done at Croydon and when asked why that wasn't done he responded "*No, I have not had a satisfactory response to that.*"[47]

111. Commander Cole said there "*would be a monthly inspection document for the station, certifying that the inspection of the statement and equipment has been carried out.*"[48] When asked whether the inspection was stored electronically or manually, he stated "*I don't know what system Croydon uses.*"[49]

POST INQUEST DOCUMENTS

112. After the inquest, the Chief Commissioner of Police provided the statement of Dr Foti Blaher, Senior Police Medical Officer, dated 26 October 2013. The statement states that more than 80% of sudden cardiac deaths occur in people with coronary artery disease (**CAD**), which is the number one killer in the world. In 2009, in Australia, coronary artery disease deaths (22,500) accounted for 16% of deaths from all causes. Approximately 50% of all people who die suddenly from CAD die without any previous warning symptoms of CAD. The majority of sudden cardiac arrests occur out of hospital, and many as a result of an underlying acute coronary event. It has been estimated that there are approximately 30,000 cases of sudden cardiac arrest within Australia each year. The majority of these events result in death, with fewer than 15% of people surviving beyond a month. For sudden cardiac arrest, the chance of survival decreases by 10% for every minute the victim is in ventricular fibrillation. A sudden cardiac arrest is treatable with prompt CPR and early defibrillation. Early access to defibrillation for sudden cardiac arrest is in the universally recognised 'chain of survival', as the time taken to defibrillation is a key predictor of survival.

113. In 2012, St John Ambulance Australia, the Australian Resuscitation Council and the National Heart Foundation of Australia issued a joint statement on early access to defibrillation that:

(i) Early access to defibrillation is vital to improving outcomes from sudden cardiac arrest. AEDs in the public domain (such as major airports and some sporting stadiums) have been shown to reduce time to defibrillation and save lives. Furthermore, first responder programs are effective in reducing time to

[47] Inquest transcript, page 180.
48 Inquest transcript, page 182.
49 Inquest transcript, page 182.

defibrillation and provide a smooth transition to pre-hospital emergency medical services.

(ii) St John Ambulance Australia, the Australian Resuscitation Council and the Heart Foundation call upon the Federal and State and Territory governments to take the lead in developing and implementing early access defibrillation policy, ensuring the 30,000 Australians who suffer out-of-hospital cardiac arrest every year are given the best chance of survival.

(iii) In summary, there is strong medical evidence that early cardiac defibrillation saves lives.

114. Dr Blaher stated that he made enquiries with Commander Cole and had reviewed a list of 27 incidents at Victoria Police workplaces which required Ambulance or Paramedic involvement for police employees or members of the public since May 2006, and of those incidents, 4 required CPR, indicating the incidences of sudden cardiac arrest in Victoria Police workplaces is low.

115. Despite this, Dr Blaher concedes that the medical evidence indicates that early defibrillation improves survival following sudden cardiac arrest, and as there are a number of AEDs already located in Victoria Police workplaces, in his view it is desirable to consider:

(iv) Victoria Police deploying AEDs in all workplaces and Victoria Police employees receiving training in the use of the AEDs;

(v) The continuation of a central register of AEDs and of the Victoria Police employees trained to use the AEDs; and

(vi) All usage of AEDs be recorded on a central database and reported to the Police Medical Officer for review.

SUBMISSIONS

116. At the conclusion of the inquest I invited submissions from interested parties and counsel assist. I have summarized the relevant parts of each interested party's submissions.

Submissions on behalf of the Ashton family

117. Mr Kelly, on behalf of the family, submitted the circumstances of Mr Ashton's death in the foyer of the Croydon police station raised questions about the adequacy of the care he received from the police officers attending to him; the adequacy of the training administered to those officers in order to equip them to deal with emergencies such as the

one they were obliged to deal with on 17 December 2011 and the adequacy of the equipment provided to them in order to meet their obligations pursuant to section 23 of the OHS Act, together with the procedures for ensuring that first aid training is maintained and kept current and to ensure that the first aid kit is appropriately stocked and maintained.

118. I agree with Mr Kelly's submission that the response to the witnessed collapse in the foyer of the police station was inadequate. Mr Kelly submitted that attending regular refresher courses is likely to engender greater confidence in an officer's ability to perform CPR and, in turn, lead to the more decisive and timely administering of it than occurred here. I agree with that but I do not agree with Mr Kelly's submission that LSC Bassett did not have the training, experience, initiative or confidence to make a timely, appropriate intervention and that had he done so, a life may well have been saved. I accept that LSC Bassett had a number of impediments preventing him assisting Mr Ashton in a timely manner. On the evidence, access to an AED, at an early stage, may have made a critical difference to the outcome. I also note that the commencement of CPR was delayed. This delay may also have been critical (see my later comments).

119. I agree with Mr Kelly's submission that it was difficult to divine from the evidence whose responsibility it was to ensure that the first aid kit remained adequately stocked: LSC Bassett gave evidence about St John's coming and restocking the kits; Commander Cole said the OIC of each police station was responsible for auditing and maintaining the kits.

120. I agree with Mr Kelly that the Victoria Police's policy on first aid training appeared to be somewhat perfunctory and haphazard in the circumstances and its currency is left largely to the discretion of the officers themselves or their superiors. Given the statutory obligation to ensure a safe place of employment in the context of operating a police station open to any and all members of the public, in various states of repair, health and distress, the training in CPR and the training in the use of an AED appears minimal.

121. Mr Kelly criticised the Victoria Police's response to Mr Ashton's death, as articulated by Commander Cole, as poor because he could not point to an investigation of the policies in place at the Croydon Police Station or any changes in light of Mr Ashton's death.

Chief Commissioner of Police

122. I acknowledge Ms Hodgson's submission that Dr Rose was not in the position of being an independent expert witness in this inquest, as he was a person providing care to Mr Ashton

for his coronary health prior to his death. I also acknowledge Ms Hodgson's submission that LSC Bassett had never met Mr Ashton and did not know he suffered from IHD. Nor did Mr Ashton advise him of this condition or that he had just collapsed when LSC Bassett had left the watch house. I also acknowledge that when Mr Ashton arrived at the Croydon Police Station he was agitated but not distressed and LSC Bassett appropriately offered Mr Ashton medical assistance following his report that he had been assaulted. When Mr Ashton refused medical treatment, LSC Bassett was not required to insist upon medical treatment.

123. I accept Ms Hodgson's submission that, whilst LSC Bassett had been trained by St John's Ambulance in first aid including a CPR component, there was no mandate or a policy to refresh his first aid training every three years.

124. Ms Hodgson referred to Commander Cole's evidence that the requirement was that first aid kits were audited monthly by the Officer in Charge and that this is recorded in the relevant Victoria Police Manual - Procedures and Guidelines: Safe-T-Works Management dated 22 January 2013.

125. I accept Ms Hodgson's submission that LSC Bassett and A/Sgt Young acted in accordance with their training and to the best of their abilities with good intention. Any expectation that these members should have had higher paramedic-like training is unreasonable for members undertaking general policing duties, noting that there have been only two members of the public experiencing cardiac events in police stations throughout Victoria in the last seven years.

126. Whilst I agree with this submission, in my view there should be a requirement that Victoria Police members have a current first aid qualification. I note that there was no requirement that Victoria Police members arrange their own first aid training at the time of Mr Ashton's death. In those circumstances, LSC Bassett cannot be criticised for having completed his latest first aid training three years and four months prior to Mr Ashton's death.

127. There is no evidence to suggest the outcome would have been different if LSC Bassett's first aid qualification had been current. There is, however, evidence that compressions done by 'a trained professional', being either a doctor, nurse or paramedic, who was experienced in performing CPR, *'possibly' to 'probably'* would have altered the outcome. LSC Bassett was not a 'trained professional' as defined by Dr Rose and there is no current training or expectation for members undertaking general policing duties to be so.

128. LSC Bassett and A/Sgt Young should have been able to locate a resuscitation mask at the Croydon Police Station. However, I note that the 000 operator did not advise the police members at any time to perform breaths on Mr Ashton as part of the CPR. The lack of a resuscitation mask (and therefore breaths) during the CPR performed on Mr Ashton was not causative of his death. However, the fact that LSC Bassett and A/Sgt Young were looking for a mask did potentially delay the instruction by the 000 operator to perform compressions, and the delay in compressions may have contributed to Mr Ashton's death. (However, I note the evidence that LSC Bassett's compressions were ineffective when performed.)

129. Ms Hodgson conceded, on behalf of the Chief Commissioner of Police, that the lack of a resuscitation mask in the first aid kit at the Croydon Police Station at the time, although not causative of Mr Ashton's death, is not best practice.

130. Ms Hodgson submitted that the location of an AED at all police premises is determined following an informal assessment of higher risk areas for employees experiencing a heart attack. These areas include police training areas, some frontline policing resources and in some police stations where prisoners are able to be held.

131. I am advised by Ms Hodgson that, as at 3 September 2013, a central register now exists for AED units located State-wide.

132. Ms Hodgson submitted that there could be no criticism of LSC Bassett and A/Sgt Young in their conduct, as they acted in accordance with their training and the resources available to them or known to them at the time. However, in my opinion either the absence of, or inability to locate, a resuscitation mask is an important deficiency in the necessary maintenance of the first aid kit at Croydon Police Station.

133. Ms Hodgson submitted that the fact that an AED was at Croydon Police Station at the time of Mr Ashton's death and was not known to the police members attending him was unfortunate. I agree. Clearly members at Croydon should have known of its existence, exactly where it was kept, and how to use it.

Counsel Assist submissions

134. I agree with Counsel Assist's submission that the OHS Act provides a number of non-delegable duties, mainly to employers. The Chief Commissioner of Police is an employer for the purpose of the OHS Act. Therefore, whilst the task of maintaining first aid kits can be assigned to a Senior Sergeant, the responsibility to discharge the obligation under the

OHS Act remains with the employer at all times. Therefore, the employer must ensure there are sufficient systems in place to discharge their obligations.

135. I accept Counsel Assist's submission that the evidence reveals that there were inadequate policies and procedures for maintenance of first aid kits, first aid training and use of AED's.

136. Counsel Assist also submitted that having regard to the High Court case of *Briginshaw v Briginshaw* (1938) 60 CLR 336, criticism should not be made of individual members in this matter because it was their employers responsibility to ensure there were adequate first aid resources at the station; including clear and adequate policies on first aid. I agree.

137. I note Counsel Assist's submission that a possible comment would be that St John Ambulance provide disposable resuscitation masks in a clearly recognizable packet (i.e. fluorescent orange) to make them readily identifiable in an emergency.

CONCLUSIONS

138. Having considered all of the evidence, I find that Geoffrey Ashton died on 17 December 2011, aged 78, as a result of ischemic heart disease.

COMMENTS

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

139. Valuable time was lost trying to locate a resuscitation mask. The evidence of LSC Bassett and A/Sgt Young was that when Mr Ashton collapsed a second time, not only was it necessary for them to ring 000 (which A/Sgt Young did) but they were also looking a resuscitation mask so that mouth-to-mouth could be performed. Neither fully understood the role of mouth-to-mouth in the context of CPR. It seems clear that the knowledge and training in respect of CPR was deficient. On the medical evidence, mouth-to-mouth is one part of a CPR process. The medical evidence is clear that chest compressions should always come first and as quickly as possible. Unless it is commenced within about 3 minutes it is unlikely to succeed. The evidence (including the CCTV footage) is that LSC Bassett was pre-occupied with trying to find a mask so he could do mouth-to-mouth. He had placed Mr Ashton in a position on his side, and taken other measures to check his immediate state of health (checked pulse, removed dentures, cleared the airway etc). LSC Bassett's actions, taken undoubtedly in good faith and with every intention of trying to

help Mr Ashton, were the actions of a person not at all confident as to what was immediately required.

140. First aid training in relation to the necessity for CPR as early as possible appears to be deficient.

141. Commander Cole's evidence in relation to first aid training was important. It is clear that there is insufficient emphasis on chest compression CPR. It clear from the footage that LSC Bassett was not confident in CPR chest compression. (I note Dr Burke's evidence that even he would struggle, at least in the moment, with dealing with such a challenge and I do not criticise LSC Bassett).

142. In any event, it was 5 minutes 49 seconds between Mr Ashton's second collapse and the first chest compression being applied by LSC Bassett. This was a delayed response and unlikely to succeed. It was also necessary that it be a very firm chest compression.

143. A/Sgt Young acted correctly in telephoning 000 and in obtaining instructions on the application of CPR. He acted correctly in conveying these to LSC Bassett who also then commenced to engage in chest compressions. But it was too late in all probability. In any event, it is impossible to know whether chest compression CPR, even if administered effectively and earlier, would have saved Mr Ashton's life, particularly given his "*significant*" IHD.

144. Given the information provided by the Victoria Police medical officer it appears to be appropriate to make a recommendation in relation to AED's.

145. AED's have a higher success rate than untrained manual chest compressions (the evidence of Dr Rose and Dr Burke). Most incidents of sudden heart attack outside hospitals are a result of arrhythmia. This condition is susceptible to correction by a defibrillator. It follows that rapid effective defibrillation is likely to save lives in incidents such as this when they occur. From that point of view, it is necessary to make a recommendation on the point.

146. Obviously cost will be a factor, but I recommend that Victoria Police investigate the cost and feasibility of installing an AED in an accessible part of all police stations which are open on a 24/7 or 5 day or 7 day a week basis and into which members of the public come for the purposes of general business. It was the evidence that a number of members of the public are in police station foyers, often in state of anxiety, anger or ill health.

147. The obligations of Victoria Police under s.23 of the OHS Act are important. These were highlighted by Ms Burns. They need to be taken into account by Victoria Police in responding to the recommendations I make.

148. Ultimately, whether Mr Ashton's death was "preventable" will never be known. What is clear is that the availability of an AED, which are readily available, properly serviced and which can be rapidly deployed, will maximise the prospect of saving lives in circumstances such as this. Modern AED's (automatic defibrillators which speak to the operator) are clearly an excellent innovation and require almost no training for effective use.

149. I note that the AED which was at the Croydon Police station at the time (and kept under the desk of a police officer) has now been placed on a wall and is readily available to police. It should never have been otherwise. However I note Commander Cole's evidence that this particular AED, and others also, have been provided by service clubs and similar organisations, and funded by them, and have been intended for their use and not for the use of the general public in a police station foyer. This appears to have been corrected.

RECOMMENDATIONS

1. That the Chief Commissioner of Police implements a first aid policy requiring first aid and refresher training be mandatory rather than discretionary. Also, that the first aid policy detail to members of the police force their first aid responsibilities in the case of a medical emergency.

2. That the Chief Commissioner of Police ensure that the computers in each watch house are located to enable the user to view the public in the watch house.

3. That the Chief Commissioner of Police deploy AEDs in all workplaces under its management and control.

4. That the Chief Commissioner of Police maintain a central register of AEDs in Victoria Police workplaces. All AEDs should be clearly identified for members of the force and the public to locate.

5. That the Chief Commissioner of Police ensure members of the police force are trained to use AEDs and are informed as to their locations.

6. That the Chief Commissioner of Police maintain a register of all usage of AEDs recording on a central database and reported to the Police Medical Officer for review.

7. That the Chief Commissioner of Police use the facts of this case to highlight and emphasise for all police officers the importance of CPR training. In particular, the training in the necessity of chest compressions quickly, before considering mouth to mouth.

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that this Finding be published as part of the Court record.

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

Family of Geoffrey Ashton.

Chief Commissioner Ken Lay APM, Chief Commissioner of Victoria Police.

Coroner's Investigator, Detective Senior Constable Scott Riley.

Signature

JUDGE IAN GRAY

STATE CORONER

Date: 5/3/14