IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2014 6057

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

I, AUDREY JAMIESON, Coroner having investigated the death of BRIAN GEORGE RUTHERFORD

without holding an inquest:

find that the identity of the deceased was BRIAN GEORGE RUTHERFORD

born 10 May 1940

and the death occurred on 28 November 2014

at 42 Brooks Street, Norlane 3214

from:

1 (a) BLUNT HEAD IMPACT WITH SKULL FRACTURE AND TRAUMATIC BRAIN INJURY (FALL FROM LADDER)

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Brian George Rutherford was 74 years of age at the time of his death. His medical history included extensive cardiac disease including coronary artery bypass surgery, angina, hypertension, skin cancer, depression and human immunodeficiency virus. He lived alone at 42 Brooks Street, Norlane.

2. At approximately 12.00pm on 28 November 2014, two pedestrians observed Mr Rutherford lying face up on his driveway, with a ladder entwined in his legs. Emergency services were contacted. Paramedics attended but were unable to render assistance to Mr Rutherford as it was apparent that he was deceased.

3. Police located a pair of gardening shears approximately one metre from Mr Rutherford. The ladder was located next to a large tree. A large plastic bad full of leaves was located on the ground close to the ladder.

INVESTIGATIONS

4. Dr Jacqueline Lee, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed a post mortem examination on the body of Mr Rutherford, reviewed a post mortem CT scan, and reviewed the Victorian Police Report of Death, Form 83. The autopsy confirmed a fatal head injury. Toxicological analysis of post mortem blood did not detect the presence of alcohol. The antidepressant medication venlafaxine[1] and mirtrazapine were detected.

5. Histological examination of the heart and bypass vessels showed re-canalisation of the posterior descending bypass vessel with no evidence of acute ischaemia or infarction.

6. Dr Lee opined Mr Rutherford's death was entirely the result of the sustained injury, but whether the fall was due to a misstep or collapse from a nonfatal cardiac arrhythmia could not be determined at autopsy.

7. Dr Lee ascribed the cause of Mr Rutherford's death to blunt head impact with skull fracture and traumatic brain injury.

8. Mr Rutherford's neighbours observed him to spend time tending to his garden daily. A neighbour who lives across the road from Mr Rutherford observed him alone outside his home, tending to his garden 10.15am on 28 November 2014.

COMMENTS

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

I refer to my recent findings in the investigation into the death of Mr Francis Zammit (COR 2014 3728), in which I note a "Report on the reduction of major trauma and injury from ladder falls" (the

[1] I note that therapeutic concentrations of venlafaxine range up to 0.5mg/L, and the concentration detected in post mortem blood was reported as ~ 1.4mg/L. By email dated 3 September 2015, Forensic Pathologist Dr Lee confirmed she had not highlighted this in her report due to post mortem distribution and genetic polymorphism for the metabolism of venlafaxine. Dr Lee stated that although the toxicological concentration is higher than the expected therapeutic range, it is not as high as one would expect to see with an overdose. Dr Lee was unable to say whether the concentration detected may have contributed to a cardiac arrhythmia.

report)[2] published by the Department of Health and Human Services. The report recognised ladders are a frequently used consumer product in domestic environments for everyday tasks. The report further recognised the use of ladders represents one of the highest risks of fall-related injuries and deaths, with ladders being the consumer product most often associated with DIY-related deaths and hospitalisations.[3]

The report identified a number of key opportunities for reducing ladder related falls, which I supported. I refer to and repeat the two recommendations I made to the Department of Health and Human Services, as follows:

> I **recommend** that the Department of Health and Human Services develops and coordinates a strategy and/or program with relevant stakeholders with the aim of implementing public health and safety measures targeted at preventing deaths from ladder falls such as identified in the report.
>
> AND with the aim of reducing serious injury and death from ladder falls in the domestic setting, I **recommend** that the Department of Health and Human Services commence this strategy and/or program through a public education program including but not limited to the production and dissemination of safety information material such as pamphlets aimed at improving the public's awareness of the risks and dangers of domestic ladder use.

I await a response from the Department of Health and Human Services.

FINDINGS

I accept and adopt the opinion of Dr Jacqueline Lee and find that Brian George Rutherford died from blunt head impact with skull fracture and traumatic brain injury, in circumstances that I also find that the injuries sustained were a result of a fall from a ladder.

I accordingly direct that the Registrar of Births Deaths and Marriages amend the cause of death to blunt head impact with skull fracture and traumatic brain injury (fall from ladder).

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

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[2] Department of Health & Human Services "*Report on the reduction of major trauma and injury from ladder falls*" 1 April 2015 accessed at https://www2.health.vic.gov.au/getfile/?sc_itemid=%7b4D1615A8-D17B-49F0-8F04-B66DAA877C49%7d&title=Report%20on%20the%20reduction%20of%20major%20trauma%20and%20injury%20from%20ladder%20falls 25 August 2015.

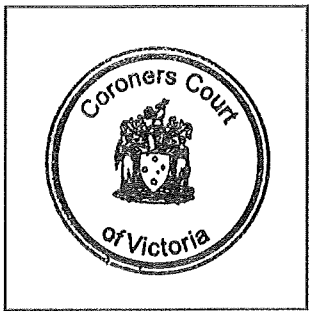
[3] The report, page 9.

Mr Colin Rutherford

Dr Pradeep Philip, Secretary, the Victorian Department of Health and Human Services

Senior Constable Paula Owen

Signature:



AUDREY JAMIESON
CORONER
Date: **3 September 2015**