IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 5607

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	Caitlin English, Coroner
Deceased:	Henry Charles Ackerman
Date of birth:	26 September 1938
Date of death:	25 November 2016
Cause of death:	I(a) Neck injuries received in a fall
Place of death:	6 Grieve Avenue, Indented Head, Victoria

BACKGROUND

1. Henry Charles Ackerman was a 78-year-old man who lived in Indented Head at the time of his death.

2. After Mr Ackerman did not attend a regular lunch with his friend Kenneth McDonald on 26 November 2016, Mr McDonald went to Mr Ackerman's house and found him lying deceased in a garden bed in his yard.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. Mr Ackerman's death was reported to the Coroner as it appeared to have resulted, directly or indirectly, from an accident or injury and so fell within the definition of a reportable death in the *Coroners Act 2008.*

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. The Coroner's Investigator prepared a coronial brief in this matter. The brief includes statements from witnesses, including the forensic pathologist who examined Mr Ackerman, a treating clinician and investigating officers.

6. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established to the standard of proof of the balance of probabilities.[1]

IDENTIFICATION OF THE DECEASED

7. On 26 November 2016, Kenneth McDonald visually identified Mr Ackerman's body as being that of his friend Henry Charles Ackerman, born 26 September 1938.

8. Identity is not in dispute and requires no further investigation.

[1] This is subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

9. Mr Ackerman had lived alone at 6 Grieve Avenue, Indented Head, since his wife Barbara moved into permanent care in late 2014. He regularly attended the Drysdale Village Medical Centre.

10. His medical history included depression (for which he was treated with the antidepressant sertraline) and Ménière's Disease, a disorder of the inner ear which can cause bouts of severe dizziness.

Events proximate to death

11. At around 10.08am on 25 November 2017, Mr Ackerman's friend Victor Gatt called him to discuss Mr Ackerman picking up a trailer from his property. Mr Ackerman stated he would do so on the following morning. According to Mr Gatt, Mr Ackerman '*sounded alright*'.[2]

12. Mr Ackerman's medication pack indicates that he last took his regular medications on that morning and did not take those marked for 'Noon'. A neighbour noticed at 6.00pm on 25 November 2016 that Mr Ackerman's front gate was still open.

13. Mr Ackerman had a regular arrangement to visit his friend Kenneth McDonald for lunch at around 12.30pm on Saturdays. After Mr Ackerman had not arrived by 1.00pm on 26 November 2016, Mr McDonald attempted to phone him at his house but received no response.

14. At around 1.15pm Mr McDonald went to Mr Ackerman's house to see if he was there. Mr McDonald saw an electrical cord leading out of the garage and followed the cord into the adjacent yard.

15. Mr McDonald then found Mr Ackerman laying on the ground in a garden bed. Mr McDonald contacted emergency services, but Mr Ackerman was already deceased.

16. Mr Ackerman's body was near the base of a wooden framed fence approximately 1.67m in height. A double-sided aluminium ladder in the fully open position was laying across the top of the fence with its feet off the ground, and an electric hedge trimmer (to which the electrical cord was connected) was hanging by the cord from the end of the ladder.

[2] Statement of Victor Gatt dated 13 March 2017, Coronial Brief.

17. The ladder was placed near some tall vegetation and cuttings were found on the ground on both sides of the fence. The height of the fence was approximately half the length of the ladder.

18. The hedge trimmer required two hands to operate.[3] It appears that Mr Ackerman was standing on the ladder and using the hedge trimmer before suffering a fatal fall.

CAUSE OF DEATH

19. On 28 November 2016, Dr Gregory Young, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an inspection of Mr Ackerman's body and provided a written report, dated 29 November 2016. In that report, Dr Young concluded that a reasonable cause of death was '*I(a) Neck injuries received in a fall*'.

20. Dr Young commented that '*the injury to the neck would have resulted in significant injury to the spinal cord at that level, thus death would have occurred quickly*'.

21. I accept Dr Young's opinion as to cause of death.

22. Toxicological analysis of the post mortem samples taken from Mr Ackerman identified the presence of sertraline and paracetamol. No ethanol (alcohol) was detected.

23. It is possible that Mr Ackerman's fall was caused by dizziness induced by Ménière's Disease, but his fall could also be explained by tilting of the ladder which was not securely placed against the fence.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

24. This Court has previously investigated deaths occurring in falls from ladder among older males engaged in home maintenance. I refer in particular to Coroner Jamieson's finding into the death of Francis Zammit dated 27 August 2015.[4] That finding referred to a recent report from the Department of Health & Human Services entitled '*Report on the reduction of major trauma and injury from ladder falls*'.[5]

25. The report identified that the frequency of ladder falls resulting in serious injury in Victoria had doubled between 2002 and 2013.[6]

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[3] Ozito HT-501 Hedge Trimmer Operation Manual, Coronial Brief, p 7.
[4] Available on the Coroners Court of Victoria website, Case Number 372814.
[5] Department of Health & Human Services, '*Report on the reduction of major trauma and injury from ladder falls*', April 2015.
[6] Ibid 9.

26. The report identified that between 2001 and 2012, 276 deaths were reported to an Australian Coroner involving fatalities resulting from people falling off ladders, 89 of which occurred in Victoria.[7] Approximately seven Victorians died each year in that period as a result of injuries sustained in domestic ladder falls.

27. The report found that males and persons over 60 were overrepresented in falls from conventional ladders, representing up to 81% of all hospital-treated ladder injuries, the majority occurring at home when the householder was doing home maintenance.[8]

28. I endorse Coroner Jamieson recommendations (in summary) that the Department of Health and Human Services develop a program with the aim of implementing public health and safety measures targeted at preventing deaths from ladder falls, including a public education program.

29. Acting Secretary of the Department of Health and Human Services, Kym Peake responded on 6 October 2015[9] outlining the Department's current initiatives on this issue and stating that Coroner Jamieson's recommendations would be considered and would inform the development of a national education campaign.

30. In September 2016, a national '*Ladder Safety Matters*' campaign began to reduce serious injury and deaths from ladder falls as a joint initiative of Australian, state and territory consumer affairs agencies and the Victorian Department of Health and Human services.[10]

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[7] Ibid 45.
[8] Ibid 13.
[9] Available on the Coroners Court of Victoria website, Case Number 372814.
[10] See Product Safety Australia publications at www.productsafety.gov.au/publication/ladder-safety-matters and a media release of Minister for Health the Hon Jill Hennessy MP '*Stepping up for ladder safety*' dated 13 September 2016.

FINDINGS AND CONCLUSION

31. Having investigated the death, without holding an inquest, I find pursuant to section 67(1) of the *Coroners Act 2008* that Henry Charles Ackerman, born 26 September 1938, died on 25 November 2016 at Indented Head, Victoria, from I(a) Neck injuries received in a fall in the circumstances described above.

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

Ms Robyn Saxon, senior next of kin.

Ms Kym Peake, Secretary, Department of Health and Human Services, Victoria.

Leading Senior Constable Chris Anderson, Victoria Police, Coroner's Investigator.

Signature:

CAITLIN ENGLISH

CORONER

Date: 31 October 2017