IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2018 0488

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008 (Vic)

I, AUDREY JAMIESON, Coroner having investigated the death of DENNIS JOHN WRIGHT

without holding an inquest:

find that the identity of the deceased was DENNIS JOHN WRIGHT

born 16 September 1945

and the death occurred on 29 January 2018

at Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3050

from:

1 (a) HEAD INJURIES

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

1. Dennis John Wright was 72 years of age and resided in Loch Sport at the time of his death. He was married to Mary Wright, his wife of 50 years. His medical history included cardiac disease with an acute myocardial infarction in 2005 from which he

recovered well, hypercholesterolaemia, hypertension, degenerative arthritis, skin cancer, anxiety and depression.

2. On 29 January 2018, Mr Wright fell as he was climbing down a ladder from the roof of his home, striking his head on the concrete floor. He was transported to Royal Melbourne Hospital by helicopter, where he was found to have suffered an unsurvivable head injury with an extensive cranial fracture, subarachnoid haemorrhage and subdural haematoma. Despite medical intervention, Mr Wright's condition deteriorated and he died at 4.33pm.

INVESTIGATIONS

Forensic pathology investigation

3. Dr Gregory Young, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM), performed an external examination upon the body of Dennis John Wright, reviewed a post mortem computed tomography (CT) scan and e-Medical Deposition Form and referred to the Victoria Police Report of Death, Form 83.

4. Anatomical findings included a sagittal skull fracture, right subdural haemorrhage and subarachnoid haemorrhage. Toxicological analysis of ante mortem admission specimens identified the presence of free morphine[1] and midazolam[2] consistent with medical treatment following the fall, as well as venlafaxine[3] and desmethylvenlafaxine[4].

5. Dr Young ascribed Mr Wright's cause of death to head injuries.

Police investigation

6. Leading Senior Constable (LSC) Peter Lock was the nominated Coroner's investigator.[5] At my direction, Peter Lock investigated the circumstances surrounding Mr Wright's

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[1] Morphine is a narcotic analgesic used to treat moderate to severe pain.

[2] Midazolam is a short acting benzodiazepine used intravenously in intensive care patients.

[3] Venlafaxine is indicated for the treatment of depression.

[4] Demethylvenlafaxine is a metabolite of venlafaxine and is also an antidepressant drug available in its own right.

[5] A Coroner's Investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the Coroner to assist the coroner with his/her investigation into a reportable death. The Coroner's Investigator receives directions from a Coroner and carries out the role subject to those directions.

death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by Mary Wright and his treating General Practitioner Dr Deepthi Mudunna.

7. During the investigation, police learned that Mr Wright went on to the roof of his home several times a year as part of normal maintenance of his property. In the summer months, he went on to the roof at the back of the house to cover the laser lite roof with shade cloth to keep the entertaining area cooler. On 29 January 2018, he went up to the roof to perform this task, with his wife watching him from the patio area. Mr Wright declined Mrs Wright's offer of assistance to hold the ladder stating that he was okay and did not require the assistance. As Mr Wright was climbing down the ladder, Mrs Wright observed him slip on the ladder and appear to overbalance, before falling backwards with the ladder onto the concrete floor.

COMMENTS

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

8. I refer to my recent findings in the investigations into the death of Mr Francis Zammit (COR 2014 3728) and Mr Brian Rutherford (COR 2014 6057), in which I note a "Report on the reduction of major trauma and injury from ladder falls" (the report)[6] published by the Department of Health and Human Services. The report recognised that in recent years there has been an increase in ladder falls injury, particularly in a domestic context. It also recognised that domestic ladder falls accounted for a high proportion of all ladder falls, especially for major trauma and death cases, and that older males accounted for the majority of cases.[7] The report identified a range of evidence-based opportunities for reducing ladders falls, such as changes to Australian Standards, ladder design improvements, building design requirements and the promotion of alternative options to domestic ladder use. These opportunities required a system-wide approach, with input from a number of government agencies.

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[6] Department of Health and 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/about/publications/researchandreports/Report%20on%20the%20reduction%20of%20major%20trauma%20and%20injury%20from%20ladder%20falls on 10 April 2019.

[7] The report, page 2.

9. In my earlier findings, I supported the prevention opportunities identified in the report and made recommendations to the Department of Health and Human Services (**DHHS**) regarding the development of a coordinated program and strategy for the implementation of public health and safety measures targeted at preventing deaths from ladder falls. I also recommended commencing a public education program aimed at improving the public's awareness of the risks and dangers of domestic ladder use.

10. In December 2015, DHHS informed me that they were collaborating with the Queensland Department of Fair Trading, the Australian Competition and Consumer Commission (**ACCC**) and Consumer Affairs Victoria in the development of a national public education campaign to raise awareness of the dangers associated with using a ladder, especially among men over 60 years of age. The national education campaign *'Ladder safety matters'* commenced in September 2016 and has now run for three consecutive years. The campaign focuses on older Australian men and included educational material published on the Victorian Government Health[8], Better Health Channel[9] and ACCC Product Safety Australia[10] websites. This material included brochures, posters and videos, with case studies of men who had fallen from ladders and provision of tips on how to use ladders safely to reduce the risk of injury. I understand DHHS are exploring a possible evaluation of the campaign impact in the short term.

11. The Victorian Government has also advocated for falls prevention through Seniors Health Promotion activities, including the funding of healthy ageing advisers, workforce development strategies, and the *Victorian Active Ageing Partnership*, which promotes health and wellbeing for older people. Community awareness messages about the dangers of ladder falls have also been promoted via *Seniors Online* and the Home and Community Care program. In June 2017, WorkSafe Victoria published a brochure *'Prevention of falls – Ladders'*[11]. The brochure sets out safety measures that can be implemented to reduce the risk of falls, including recommendations to secure the top and bottom rungs of the ladder to prevent slippage or movement of the ladder.

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[8] https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/acute-care/state-trauma-system/ladder-safety

[9] https://www.betterhealth.vic.gov.au/laddersafety

[10] https://www.productsafety.gov.au/news/ladder-safety-matters-national-campaign

[11] https://prod.wsvdigital.com.au/sites/default/files/2018-06/ISBN-Prevention-of-falls-ladders-2017-06.pdf

12. In February 2017, the Coroners Prevention Unit[12] (**CPU**) reviewed statistics on the number of unintentional deaths following ladder falls. CPU identified that there were 60 deaths between 2012 and 2016, with an average of 12 deaths per year. Males aged 65 years and older accounted for 80% of deaths. Updated statistics compiled in July 2018 identified there had been 69 deaths following ladder falls in Victoria in the period 2012 to 2018.

13. I commend the efforts of DHHS and the Victorian Government in developing a coordinated strategy and program for the implementation of public health and safety measures targeted at preventing deaths from ladder falls. However, it appears that there continue to be a significant number of deaths arising from falls from ladders in Victoria.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendations:

1. With a view to promoting public health and safety and preventing like deaths, **I recommend** that DHHS continue its *'Ladder Safety Matters'* campaign and give consideration to the implementation of additional education tools such as through social media or advertising.

2. With a view to promoting public health and safety and preventing like deaths, **I recommend** that DHHS review the impact and effectiveness of the *'Ladder Safety Matters'* campaign.

FINDINGS

The investigation has identified that Mr Wright was climbing down a ladder at his home when he slipped and fell, sustaining a head injury from which he never recovered. There is no evidence of third-party involvement in his death.

I accept and adopt the opinion of Dr Gregory Young and find that Dennis John Wright died from head injuries sustained in a fall from a ladder.

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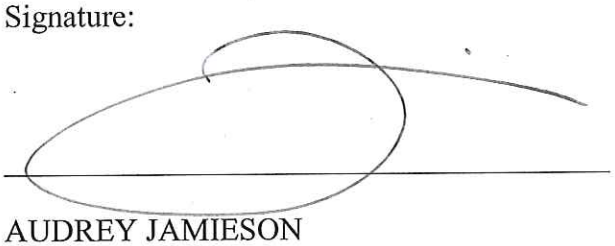
[12] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

Pursuant to section 73(1A) of the **Coroners Act 2008**, I order that this finding be published on the internet.

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

Mrs Mary Wright, Senior Next of Kin
Ms Kellie Gumm, The Royal Melbourne Hospital
Department of Health and Human Services
Leading Senior Constable Peter Lock

Signature:



AUDREY JAMIESON
CORONER
Date: **24 April 2019**