IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 003072

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Jacqui Hawkins, Deputy State Coroner
Deceased:	Ian Keith Beissel
Date of birth:	12 June 1946
Date of death:	7 June 2022
Cause of death:	1(a) Traumatic brain injury sustained in a fall from a ladder
Place of death:	The Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004
Keywords:	LADDER; FALL; TRAUMATIC BRAIN INJURY; ACCIDENT

INTRODUCTION

1. On 7 June 2022, Ian Keith Beissel was 75 years old when he died at The Alfred Hospital. At the time of his death, Mr Beissel lived with his wife of 52 years, Barbara Beissel.

2. Mr Beissel worked as a carpenter throughout most of his life. He also enjoyed playing squash and golf.

3. Mr Beissel's medical history included right hip bursitis, type 2 diabetes, hyperlipidaemia, osteoarthritis, peripheral neuropathy, hypertension, severe spinal canal stenosis, vertigo, and carpal tunnel syndrome. As a result of these conditions, his movements and abilities were hampered.

4. Mrs Beissel stated that prior to her husband's death, he had difficulty straightening his back and he struggled to walk but continued to walk unaided. Mr Beissel had also been advised by his medical practitioners not to use ladders. However, Mrs Beissel was aware that he would still climb them.

THE CORONIAL INVESTIGATION

5. Mr Beissel's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural, or violent or result from accident or injury.

6. 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.

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Beissel's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of Mr Beissel including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

10. In the days prior to the incident, the Beissel's were planning a trip away in their caravan. The caravan was parked in the driveway of their home, which was on a lean, and not flat. The caravan was approximately 2-3 metres high and had a leak in its roof which needed to be fixed. Mr Beissel had stated to his wife that he would investigate the issue, and Mrs Beissel assumed that he meant solely from the inside of the caravan.

11. On 6 June 2022 at 9.30am, Mrs Beissel left the residence to attend the gym. Following her departure, Mr Beissel took a metal A frame ladder and set it up against the caravan. He also took a bucket of water with him and placed it on top of the caravan. Investigators believe that whilst Mr Beissel was standing at a height on the ladder, one of the ladder's legs failed, causing it to slide. Mr Beissel suffered an unwitnessed fall and hit his head, rendering him unconscious.

12. At approximately 11am, Mrs Beissel returned home and located her husband on the ground in the driveway. He was positioned on top of the ladder, which had buckled on the left stabiliser. Mr Beissel's breathing was laboured and there was a pool of blood around his head. Mrs Beissel contacted emergency services and commenced cardiopulmonary resuscitation. Assistance was also rendered by an off-duty nurse that was passing by.

13. Following the arrival of ambulance crews, Mr Beissel was sedated and intubated before being conveyed to The Alfred Hospital. A CT scan was conducted which revealed that he had suffered a fracture to his right clavicle, which continued into a base of skull fracture. There was extensive intracranial haemorrhage of the brain region.

14. Mr Beissel underwent emergency surgery in the form of a right-sided hemicraniectomy and evacuation of intracerebral haematoma. He was subsequently conveyed to the Intensive Care

[1] 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.

Unit, but unfortunately, continued to deteriorate. Further CT scans revealed that his injury was not survivable.

15. The medical team had discussions with Mr Beissel's family regarding his prognosis and it was determined that he be transitioned to palliative care. Mr Beissel subsequently died at 2am on 7 June 2022.

IDENTITY OF THE DECEASED

16. On 7 June 2022, Ian Keith Beissel, born 12 June 1946, was visually identified by his daughter, Melanie Beissel.

Medical cause of death

17. On 8 June 2022, Forensic Pathologist Dr Sarah Parsons from the Victorian Institute of Forensic Medicine conducted an external examination and provided a written report of her findings.

18. The post-mortem CT scan revealed right craniectomy, intracranial haemorrhage, subarachnoid haemorrhage, interventricular haemorrhage, brain swelling, base of skull fracture, and bi-basal consolidation.

19. Toxicological analysis of post-mortem samples identified the presence of morphine, citalopram, fentanyl, and midazolam. These were administered during medical intervention.

20. Dr Parsons provided an opinion that the medical cause of death was 1 (a) Traumatic brain injury sustained in a fall from a ladder. I accept Dr Parsons' opinion.

FINDINGS AND CONCLUSION

21. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Ian Keith Beissel, born 12 June 1946;

    b) the death occurred on 07 June 2022 at The Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004, from a traumatic brain injury sustained in a fall from a ladder and;

    c) the death occurred in the circumstances described above.

COMMENTS

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

22. The risks of ladder use at home are not new, but they are associated with more deaths and injuries than any other household product.[2] According to the Victorian Department of Health (**the Department**), major trauma resulting from domestic ladder falls in Victoria doubled from 2002-2013.[3] In addition, the number of deaths resulting from falls from a ladder are also significant and were most notable in males aged 75-84 years.[4]

23. During 2016, the Department developed a campaign known as *Ladder Safety Matters* which aimed to promote health and safety measures to reduce serious injuries and deaths from ladder falls. This campaign was a joint initiative of Commonwealth, state, and territory consumer affairs agencies. In the matter of *Wright*,[5] Coroner Audrey Jamieson commended the Department's efforts in developing this coordinated strategy but noted that there continued to be a significant number of deaths from ladder falls in Victoria. She made recommendations to the Department to continue and extend the campaign.

24. The Department responded to Coroner Jamieson's recommendations by committing to continue promoting the campaign in 2019/20 and 2020/21. This was to be done via an enhanced communication plan to include ladder falls and falls from heights (including roofs in the DIY context), and the distribution of advertising material.

25. On 28 December 2020, the Victorian Government's media release[6] highlighted the annual *Ladder Safety Matters* campaign in time for the Christmas and summer home maintenance holiday period. The media release provided updated statistics as follows;

    a) In Victoria alone, there are about 1200 emergency department presentations due to ladder falls each year.

    b) Around six Victorians die from a ladder fall each year.

    c) Hospital admissions have increased by 22 percent over the five years to 2018/19 (from 614 to 752).

[2] The Victorian Department of Health website https://www.health.vic.gov.au/patient-care/ladder-safety-matters
[3] Ibid.
[4] Ibid.
[5] COR 2018 0488 published 24 April 2019.
[6] Available at https://www.premier.vic.gov.au/stepping-ladder-safety-victorians

d) The number of men hospitalised increased by 16 percent from 474 to 549.

e) The number of women hospitalised jumped by 45 percent – from 140 to 203.

f) 61 percent of all hospital admissions were people aged 60 years and over.

g) Men aged 40-79 made up 55 percent of the people who presented to the hospital emergency department after falling from a ladder.

26. Notably the media release reiterated that most ladder injuries are preventable and urged older Victorians to be cautious and not take shortcuts. It highlighted the need to ensure that people maintain three points of contact when climbing a ladder, to work within their limits, and to ensure that another person is present at home to be able to help and/or hold the ladder to ensure it does not slip.

27. I commend the Victorian Government's ongoing campaign in this area. It is apparent that continued messaging is required if we are to see a decrease in these troubling statistics. I also endorse the recent recommendations made by Coroner Simon McGregor in the matter of *Disley*[7] which included;

(i) that the Australian Competition and Consumer Commission (**ACCC**) and the Victorian Department of Health continue their *Ladder Safety Matters* campaign, including the dissemination of updated messages via relevant media, including social media channels.

(ii) that the ACCC and the Victorian Department of Health review the impact and effectiveness of the *Ladder Safety Matters* campaign.

28. The Coroners Court will continue to monitor the safety data in respect of deaths of this nature and make further recommendations as required.

29. I convey my sincere condolences to Mr Beissel's family for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

[7] COR 2021 5950 published 15 August 2022

Barbara Beissel, Senior Next of Kin

Wendy Grant, Manager-The Alfred Hospital Patient Safety and Clinical Governance Unit

Constable Nicholas Wishart, Coroner's Investigator

Signature:

Jacqui Hawkins, Deputy State Coroner

Date : 16 May 2023

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.