IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 002292

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Renato Ettore Poletti
Date of birth:	03 September 1948
Date of death:	02 May 2021
Cause of death:	1(a) Upper cervical spine injury sustained in a fall from a ladder
Place of death:	Alfred Health, The Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004
Keywords:	LADDER, FALL, ACCIDENT, CERVICAL SPINE INJURY

INTRODUCTION

1. On 02 May 2021, Renato Ettore Poletti **(Mr Poletti)** was 72 years old when he died from injuries that he sustained in a fall from a ladder. At the time of his death, Mr Poletti resided in Glen Iris with his wife of 46 years, Lucy Poletti. He is also survived by their two daughters.

2. Mr Poletti's medical history included type 2 diabetes and hypertension.[1] He was described by his family as living a healthy lifestyle and enjoyed nightly walks for physical activity.

THE CORONIAL INVESTIGATION

3. Mr Poletti'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.

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. 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.

6. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Poletti's death. The Coroner's Investigator, Senior Constable Harriette Lukaitis, conducted inquiries on my behalf and provided this evidence to the Court.

7. This finding draws on the totality of the coronial investigation into the death of Renato Ettore Poletti including evidence provided to the Court. Whilst I have reviewed all the material provided to the Court, I will only refer to that which is directly relevant to my findings or

[1] E-Medical Deposition Form from The Alfred Hospital dated 2 May 2021.

necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

8. On 30 April 2021, Mr Poletti attended his holiday home in Tootgarook to complete some garden maintenance. During the afternoon, he suffered an unwitnessed fall from a ladder at a height of approximately three metres. He was located by a bystander who commenced cardiopulmonary resuscitation. Emergency services were contacted at 4.38pm.[3]

9. On initial ambulance arrival, Mr Poletti was noted to be in PEA cardiac arrest. He was intubated and ventilated at the scene and transferred to Peninsula Health. At Frankston Hospital, CT imaging revealed a complex fracture of C2, vertebral body fracture at T3, chance fracture at T4, multiple bilateral rib fractures, mediastinal hematoma, and pulmonary contusions.[4]

10. On 1 May 2021, Mr Poletti was transferred to the Intensive Care Ward at The Alfred Hospital. A further MRI of the spine revealed that he had suffered a severe high spinal cord injury with haemorrhage. As this injury was deemed to be non-survivable, the treating team discussed the matter with Mr Poletti's family, and he was subsequently palliated. Mr Poletti was declared deceased on 2 May 2021 at 6.15pm.[5]

Identity of the deceased

11. On 2 May 2021, Renato Ettore Poletti, born 03 September 1948, was visually identified by his wife, Lucy Poletti.

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

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[2] 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.

[3] Form 83 Police Report of Death for the Coroner dated 3 May 2021

[4] E-Medical Deposition Form from The Alfred Hospital dated 2 May 2021.

[5] E-Medical Deposition Form from The Alfred Hospital dated 2 May 2021.

Medical cause of death

13. Forensic Pathologist Dr Sarah Parsons from the Victorian Institute of Forensic Medicine conducted an external examination on 4 May 2021 and provided a written report of her findings dated 7 May 2021.

14. The post-mortem examination revealed fracture through the body of C2, coronary artery calcification, and increased lung markings.

15. Toxicological analysis of post-mortem samples identified the presence of Midazolam[6] and Amlodipine.[7]

16. Dr Parsons provided an opinion that the medical cause of death was *1 (a) Upper cervical spine injury sustained in a fall from a ladder.*

17. I accept Dr Parsons' opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Renato Ettore Poletti, born 03 September 1948;

    b) the death occurred on 02 May 2021 at Alfred Health, The Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004, from *upper cervical spine 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.

19. Injuries sustained from falls involving ladders are a common cause of hospitalisations and deaths, particularly amongst older men. The Coroners Prevention Unit **(CPU)**[8] identified that

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[6] Used as a pre-operative medication, antiepileptic, sedative-hypnotic and anaesthetic induction agent.

[7] Used for hypertension and angina.

[8] The 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. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health, and mental health.

72 domestic ladder fall fatalities occurred in Victoria between January 2013 to September 2021. The number of deaths per year ranged from 5 to 12 and the majority of the deceased were men (91.7%). The age group with the highest number of deceased were between 75 to 79 years of age (27.8%).

20. The CPU noted that the frequency of fatal domestic latter falls to date in 2021 was higher than in any of the other previous years examined. This may potentially reflect the increased domestic maintenance or DIY activity around the home during the COVID-19 lockdowns.

21. It is apparent that ladder related incidents and injuries continue to contribute to the number of preventable deaths. The issue of ladder safety remains an ongoing issue for public health considerations.

The Ladder Safety Matters campaign

22. During 2016, the Victorian Department of Health **(the Department**) developed the *Ladder Safety Matters* campaign, 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.

23. In the matter of *Wright*,[9] I 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. Consequently, I made several recommendations to the Department to review the impact and effectiveness of the campaign and to continue to extend its implementation.

24. The Department responded to my 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[10] highlighted the annual *Ladder Safety Matters* campaign in time for the Christmas and summer home maintenance holiday period. The media release provided the following updated statistics:

[9] COR 2018 0488 published 24 April 2019.
[10] Available at https://www.premier.vic.gov.au/stepping-ladder-safety-victorians

a) There are about 1200 emergency department presentations in Victoria due to ladder falls each year.

b) Around six Victorians die yearly from a ladder fall.

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

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

26. The media release also reinforced 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. In the recent matter of *Disley*[11], Coroner Simon McGregor recommended that both the Australian Competition and Consumer Commission (**ACCC**) and the Department continue the *Ladder Safety Matters* campaign and review its effectiveness once again.

28. In a response to the Court dated 2 December 2022,[12] the ACCC advised that;

a) They had recently undertaken a social media campaign called '*Spring has Sprung*' which contained specific information regarding the hazards of using ladders, and tips on how to remain safe. These were delivered via social media posts from the ACCC's Facebook and Twitter accounts and linked directly to the ladder safety content on the Product Safety Australia website.

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[11] COR 2021 5950 published 15 August 2022

[12] Response of the ACCC to the Investigation into the death of John Disley dated 2 December 2022 at https://www.coronerscourt.vic.gov.au/sites/default/files/2022-12/2021%205950%20Response%20to%20recommendations%20from%20Australian%20Competition%20%26%20Consumer%20Commission_DISLEY.pdf

b) They would be considering reviewing and where necessary, updating consumer safety education materials relating to ladders on the Product Safety Australia website.

c) They would incorporate ladder safety use messaging for consumers into further cyclical education campaigns (e.g.: campaigns relating to safety over the summer period and Easter holiday periods).

d) They would explore options for amplification and further dissemination of the *Ladder Safety Matters* campaign and safety information, and/or updated ladder safety materials, through the ACCC's channels and other trusted organisations.

e) They would explore options to increase the reach of consumer messaging, including via the Consumer Education Network (including Commonwealth, state and territory consumer law regulators) and engagement with other relevant organisations.

f) That they would continue to engage with the Department for information and opportunities to align their messaging.

29. The Court also received a response from The Minister for Health, Mary-Anne Thomas dated 30 October 2022,[13] who also reiterated that the Department would continue to promote the *Ladder Safety Matters* campaign via websites and associated social media such as the Better Health Channel, Seniors Online Victoria, and Health Translations Victoria.

30. The Hon. Ms Thomas noted that *"key stakeholders, including the Victorian Men's Shed Association, Consumer Affairs Victoria, Neighbourhood Houses Victoria and Council of the Ageing Victoria also contribute to raising community awareness, particularly among people over the age of 60 years living independently in their own homes."*

31. Both the ACCC and the Department outlined that the *Ladder Safety Matters* campaign had been evaluated as being *"relevant, memorable and motivating."* The ACCC indicated that they were committed to evaluating recent and future ladder safety messaging disseminated through ACCC channels to assess reach and engagement. The Department further noted that

[13] Response from The Hon. Mary-Anne Thomas MP into the Investigation into the death of John Disley dated 30 October 2022 at https://www.coronerscourt.vic.gov.au/sites/default/files/2022-11/2021%205950%20Response%20to%20recommendations%20from%20The%20Hon.%20Mary-Anne%20Thomas%2C%20MP%2C%20Minister%20for%20Health_DISLEY.pdf

the safety messaging within the campaign is *"updated every 1-2 years to align with the latest evidence, data, and stakeholder interest."*

32. I commend and endorse the efforts of the ACCC and the Department in this area.

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

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

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

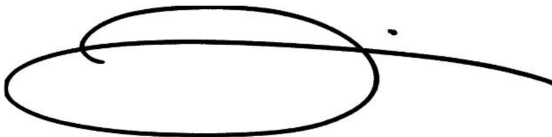
I direct that a copy of this finding be provided to the following:

Mrs Lucy Poletti, Senior Next of Kin

Ms Karen Day, Director Clinical & Enterprise Risk Management at Alfred Health

Senior Constable Harriette Lukaitis, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 2 November 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.