IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 000601

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Esri Lederberger
Date of birth:	27 February 1950
Date of death:	1 February 2019
Cause of death:	1(a) Injuries sustained in fall from height
Place of death:	16 Hinkler Road, Mordialloc, Victoria

INTRODUCTION

1. On 1 February 2019, Esri Lederberger was 68 years old when he fell from a height in the course of performing his work.

THE CORONIAL INVESTIGATION

2. Esri'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.

3. 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.

4. 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.

5. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Esri'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. This brief also included the totality of the related WorkSafe investigation brief.

6. This finding draws on the totality of the coronial investigation into the death of Esri Lederberger 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]

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[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.

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

Circumstances in which the death occurred

7. Esri was the owner, director and personally worked in the dairy company known as Tempo Foods in Mordialloc. He founded the business in 1984, and has been supplying Kosher products to the community ever since.

8. The business employed approximately 12 people across two facilities: the first is a warehousing and logistics site, and the second, where the manufacturing occurs, is two doors down. His son Yehuda Lederberger also works in the business as the Operations Manager.

9. At about 1.30pm on 1 February 2019, Esri decided it was time to defrost the refrigeration ducts up in the roof of the cool room at the warehousing site. He had done this many times before.[2]

10. He asked his storeman Andrew Walk to assist by raising him to the top of the warehouse shelving unit using the warehouse forklift. Walk did this by using the forklift to pick up a cage, which Esri stepped into. The cage was then raised by Walk to the third storage shelf, where Esri hopped out to commence his task, and Walk returned to his other duties. [3]

11. Sometime in the next half hour, Yehuda received a telephone call from his father asking for assistance to get down. Yehuda left the office and drove the forklift back down to the cool room, where he saw his father standing on the pallets of food products on the third storage shelf. Yehuda raised the cage to the third level but as Esri stepped into it, the cage toppled to the left and both the cage and Esri fell to the concrete floor, causing him obvious head injury and damaging the cage. Yehuda jumped out of the forklift to try and catch his father but could not get there in time. [4]

12. Yehuda immediately called the Jewish Ambulance Service, who in turn relayed this call to Ambulance Victoria due to its urgency, and Walk called 000. Despite everyone's best efforts, Esri could not be revived and was declared dead at the scene at 2.36 pm.[5]

13. When my investigator documented the scene in the aftermath, he observed an orange Linde forklift registered number ZZW299 to be positioned against the shelving unit with the mast

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[2] First Statement of Yehuda Lederberger, and Statement of Andrew Walk, Coronial Brief.
[3] Statement of Andrew Walk, Coronial Brief.
[4] First Statement of Yehuda Lederberger, Coronial Brief.
[5] Statement of Kayne Josephs, Coronial Brief.

raised to the top of the third shelf, which contained a pallet laden with buckets. At this point, the forks were measured at approximately 3.1 meters above ground level.[6] The left fork had impacted one of the buckets causing an indentation to the bucket.[7] These buckets were what Esri had been standing on immediately prior to the accident. A red hose was also running up to the top of the shelving unit which Esri had been using to defrost the air conditioning ducts.[8]

14. The steel cage had fallen to the ground to the left side of the forklift sustaining moderate impact damage. There was a yellow strap attached to the side of the cage however witnesses indicated that the cage was not secured to the forks in any manner.[9]

15. The forks of the forklift were also observed to be positioned close together approximately 30 cm apart creating a narrow platform for the cage to rest upon.[10]

16. It is not possible for me to now determine, to the requisite standard,[11] whether it was the noted impact of the forks into the bucket on the shelving unit which caused the cage to become unstable or whether Esri's significant weight (approximately 150kg) in combination with the narrow platform of the forks and the unsecured cage, caused the cage to fall as he stepped into it.

17. Either way, Esri should not have attempted this task in these circumstances, and was experienced enough that he ought to have known better.

18. For the avoidance of doubt, I cannot be satisfied to the requisite standard that any other actions by any of the other people involved in the accident on the day would have deterred Esri from attempting this task in the manner in which he did.

Identity of the deceased

19. On 1 February 2019, Esri Lederberger, born 27 February 1950, was visually identified by his son Yehuda Lederberger.

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[6] Statement of Christopher Delaney, Coronial Brief.
[7] Statement of Brett Dickson, Coronial Brief.
[8] Statement of Wayne Billing, Coronial Brief.
[9] First Statement of Yehuda Lederberger, Coronial Brief.
[10] Statement of Wayne Billing, Coronial Brief.
[11] The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* (1938) 60 CLR 336 gloss or explications. Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

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

Medical cause of death

21. Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 4 February 2019 and provided a written report of his findings dated 12 February 2019.

22. The post-mortem CT Scan and external examination revealed a left basal skull fracture, no intracranial haemorrhage, metal in the right hip, right sided rib fractures, a small right pneumothorax, fractures of pelvis, small pleural effusions and calcific coronary artery disease.

23. Dr Lynch observed blood in both external auditory canals, and formed the view that his findings were consistent with the history given.

24. Toxicological analysis of post-mortem samples identified the presence of expected prescription medications, and did not identify the presence of any alcohol or any commons drugs or poisons.

25. Dr Lynch provided an opinion that the medical cause of death was 1(a) Injuries sustained in fall from height.

26. More specific causal detail could not be obtained whilst respecting the senior next of kin's request that there not be any autopsy on cultural and religious grounds.

27. I accept Dr Lynch's opinion.

WORKSAFE INVESTIGATION

28. As this death occurred in a place of work in Victoria, WorkSafe immediately commenced an investigation, prepared a brief of evidence and ultimately issued three Improvement Notices.[12]

29. Under section 7 of the Act, Parliament has made it clear that in the exercise of my investigative jurisdiction I am to liaise with other investigative authorities, avoid unnecessary duplication of inquiries where possible and expedite the investigation of deaths.

30. With this intention in mind, I received the WorkSafe brief as a component of my own Coronial brief. Having reviewed that brief in conjunction with the further material by my investigator, I have formed the view that the Improvement Notices issued by WorkSafe, and the company's

[12] Statement of Natalie Heriot, Coronial Brief.

responses, adequately address the prevention opportunities I saw in this incident, and I will not now duplicate them.

31. For completeness, I note that on 17 December 2020, the Victorian WorkCover Authority decided not to prosecute anyone, but did issue the company, which had no prior offences, with an official caution.

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

    a) the identity of the deceased was Esri Lederberger, born 27 February 1950;

    b) the death occurred on 1 February 2019 at 16 Hinkler Road, Mordialloc, Victoria, from injuries sustained in a fall from height; and

    c) the death occurred in the circumstances described above.

COMMENT

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

> Mr Esri Lederberger's conduct contributed to his own death.

I convey my sincere condolences to Esri'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:

Esther Lederberger, Senior Next of Kin

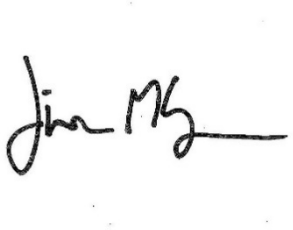
Sebastian Draga, Ambulance Victoria

Steve Jacobs, Wisewould Mahoney

Thinh Tran, WorkSafe

Senior Constable Wayne Billing, Coroner's Investigator

Signature:



CORONER SIMON McGREGOR

CORONER

Date: 29 October 2021

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.