IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2014 3728

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

I, AUDREY JAMIESON, Coroner having investigated the death of FRANCIS XAVIER ZAMMIT

without holding an inquest:
find that the identity of the deceased was FRANCIS XAVIER ZAMMIT
born 5 July 1926
and the death occurred between 21 and 23 July 2014
at 6 Fir Street, Blackburn 3130
from:

1 (a) BLUNT HEAD TRAUMA SUSTAINED IN A FALL FROM A LADDER

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

1. Francis Xavier Zammit was 88 years of age at the time of his death. He was born in Malta and travelled to Libya at 17 years of age. He married in Libya at the age of 19. The marriage bore a child in 1947, and he and his family relocated to Malta in 1950, before he immigrated to Australia later that year, followed by his wife and child in 1951. Mr Zammit had regular employment from that time until his retirement in 1986. Mr Zammit's wife passed away in 2000.

2. Mr Zammit lived alone at 6 Fir Street, Blackburn. His medical history included hypertension, dyslipidaemia, chronic lower back pain secondary to lumbar spine osteoarthritis and a lumbar laminectomy with emergency decompression of L3-L5 (2003), from which he recovered well.

3. At approximately 10.30pm on Tuesday, 22 July 2014, Mr Zammit's daughter, Ms Lucy Morgan, and her son attended Mr Zammit's home after multiple unsuccessful attempts to contact him. They noticed the lights were off and the daily newspaper was still outside, which was considered unusual. They contacted police who attended at approximately 11.50pm. Police searched the house and could not locate Mr Zammit. Upon a search of the back garden, police located Mr Zammit lying on the footpath underneath a tree, beside a ladder which was lying on its side. Secateurs were located nearby. It was apparent that Mr Zammit was deceased.

INVESTIGATIONS

4. Dr Linda Iles, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an external examination on the body of Mr Zammit, reviewed a post mortem CT scan, and reviewed the Victorian Police Report of Death, Form 83. Anatomical findings included a depressed and comminuted occipital skull fracture, right sided subgaleal bruising overlying the depressed skull fracture, left sided acute subdural haematoma with associated mass effect, anterior frontal contrecoup type contusion, subdural haemorrhage and non-specific congestive changes within the left lung. Incidental findings included mild coronary artery calcification and degenerative changes of the lumbar spine. Dr Iles considered the injuries identified, together with the scene description were consistent with Mr Zammit having stuck his head on the edge of the concrete path. No alcohol or common drugs or poisons were detected in post mortem blood samples.

5. Dr Iles ascribed the cause of Mr Zammit's death to blunt head trauma sustained in a fall from a ladder.

6. The circumstances of Mr Zammit's death have been the subject of investigation by Victoria Police on my behalf. Police did not indentify evidence of third party involvement.

7. Police obtained statements from Ms Morgan and General Practitioner Dr Steven Bechervaise,

8. Mr Zammit enjoyed an activity-filled lifestyle until his death. He undertook regular gardening activities and regularly attended social gatherings.

9. It appears that Mr Zammit had been pruning a hedge approximately 2.0 metres from ground level when he fell off the ladder onto the concrete footpath. The ladder was old and wooden, was approximately 2.0 metres in height and had no stops protecting the ladder's feet. Located

in the garden bed was a plank of wood approximately 80cm in length. It appears that Mr Zammit had used the plank to balance half of the ladder on the garden bed and the other half of the ladder on the concrete footpath.

Ladder related deaths in Victoria

10. The Department of Health and Human Services published a "Report on the reduction of major trauma and injury from ladder falls" (the report).[1] The report recognised ladders are a frequently used consumer product in domestic environments for everyday tasks. The report further recognised the use of ladders represents one of the highest risks of fall-related injuries and deaths, with ladders being the consumer product most often associated with DIY-related deaths and hospitalisations.[2]

11. The report identified the Victorian frequency of ladder falls resulting in serious injury has doubled between 2002 and 2013.[3] While previous research has found that between 60 and 80 percent of ladder injuries requiring hospitalisation occur in domestic settings, recent data indicates there are at least six fatalities and 2,500 hospital-treated occupational and domestic ladder injuries each year in Victoria.[4] Further findings suggest that males and the elderly (persons over 60 years of age) are over-represented when considering falls from conventional ladders, representing up to 81 percent of all hospital-treated ladder injuries, with a significantly higher mean age of those injured in domestic environments.[5] The vast majority of older person ladder injuries have been found to occur in the home, mostly when the householder was doing indoor and outdoor home maintenance.[6]

12. 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. The majority (78) of the Victorian matters involved fatalities that occurred in the

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[1] Department of Health & 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/getfile/?sc_itemid=%7b4D1615A8-D17B-49F0-8F04-B66DAA877C49%7d&title=Report%20on%20the%20reduction%20of%20major%20trauma%20and%20injury%20from%20ladder%20falls 25 August 2015.

[2] The report, page 9.

[3] The report, page 9.

[4] The report, page 13.

[5] The report, page 13.

[6] The report, page 13.

domestic environment.[7] Similarly, most of the Victorian cohort (71) represented males involved in non work-related deaths.[8]

13. Injuries to older persons have been associated with reduced mobility, flexibility, reaction time and balance. The most common mechanisms of injury associated with ladder use are falls from heights and ladders sliding away from under the user. It is noted that even falls from small heights (less than one metre) can potentially results in serious injuries.[9]

14. To date, it appears very little has been done to establish preventative strategies to support safe ladder use outside the workplace, with limited information provided for home and personal ladder use. Most initiatives have been directed towards occupational settings.[10]

15. There is currently little community knowledge regarding ladder safety in domestic environments. In a small survey of hardware store staff, the majority of staff were unaware of any courses, training or other information that could be obtained prior to using a ladder.[11]

16. A literature review identified programs in place in the United States. The American Ladder Safety Institute's website (www.laddersafety.org) provides information on basic ladder safety techniques and online training videos.[12]

17. The report provides relevant and valuable injury information, including attitudes and behaviours of the general public and information on initiatives and standards to assist in the development and evaluation of community health, safety and injury prevention strategies, such as community awareness initiatives and education, legislation and regulatory changes, and safety-related environmental, equipment and product design improvements.[13]

18. The report identified key opportunities for reducing ladder falls, including:

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[7] The report, page 45.

[8] The report, page 45.

[9] The report, page 13.

[10] For example, the Australian Standards, the implementation of *Occupational Health and Safety* Regulations and information available through WorkSafe; the report, page 15. The Australian Competition and Consumer Commission also produced two publications in 2006 but no ongoing campaign or active distribution of information is apparent; the report, page 20.

[11] The report, page 16.

[12] The report, page 15.

[13] The report, page 4.

a. improving the design and mechanism of ladders for safe consumer use through reviewing the strength and stability of ladder design;

b. supporting ladder standard and regulation improvements and enhancements for improved compliance and ladder manufacture;

c. supporting safe ladder use through building design innovation and features such as gutter guards and anchor points;

d. improving surfaces around ladders, such as the use of anti-slop floor coverings and surface treatments to reduce injury risk from falls;

e. promoting the use of protective equipment when using ladders in the domestic environment;

f. supporting public awareness of the risks and dangers of ladder use in the domestic environment through public education and resources on ladder fall prevention;

g. promoting alternatives to ladder use such as services and resources available to domestic ladder users within the community; and

h. addressing the prevention of domestic ladder falls and fall injuries through multi-sectorial collaboration and further research as required.[14]

COMMENTS

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

I support the aforementioned key opportunities for reducing ladder falls identified in the report. Unfortunately, outside of the occupational setting, no one body or entity assumes responsibility for the implementation of these prevention strategies. A public health and safety program targeted at preventing a not insignificant number of potential deaths should be coordinated by the Department of Health and Human Services.

[14] The report, page 4.

RECOMMENDATIONS

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

I **recommend** that the Department of Health and Human Services develops and coordinates a strategy and/or program with relevant stakeholders with the aim of implementing public health and safety measures targeted at preventing deaths from ladder falls such as identified in the report.

AND with the aim of reducing serious injury and death from ladder falls in the domestic setting, I **recommend** that the Department of Health and Human Services commence this strategy and/or program through a public education program including but not limited to the production and dissemination of safety information material such as pamphlets aimed at improving the public's awareness of the risks and dangers of domestic ladder use.

FINDINGSs

I accept and adopt the opinion of Dr Linda Iles and find that Francis Xavier Zammit died from blunt head trauma sustained in a fall from a ladder.

Pursuant to section 73(1) 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:

Ms Lucy Morgan

Dr Pradeep Philip, Secretary, the Victorian Department of Health and Human Services

First Constable Ian Turner

Signature:

AUDREY JAMIESON
CORONER
Date: **27 August 2015**