IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 002182

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, CORONER
Deceased:	Constantin Daoussianis
Date of birth:	12 November 1942
Date of death:	26 April 2023
Cause of death:	1(a) Complications post fall from ladder sustaining multiple injuries including to the head and chest
Place of death:	The Alfred, 55 Commercial Road, Melbourne, Victoria, 3004

INTRODUCTION

1. On 26 April 2023, Constantin Daoussianis (**Constantin**) was 80 years old when he died in hospital following a suspected, unwitnessed fall from a ladder. At the time of his death, Constantin lived in Coburg with his wife of 51 years, Dina Daoussianis (**Ms Daoussianis**). The couple shared two daughters, Helen and Maria.

Background

2. Constantin and Ms Daoussianis owned a holiday property in Dromana (**the Dromana property**), which they would attend *'on a regular basis for general upkeep, gardening and maintenance'.*

3. Ms Daoussianis recalls that Constantin would frequently garden as *'one of his regular chores'*, that they were *'self-sufficient'* and lived *'without the need of any assistance for our day-to-day needs'.* Their daughter, Maria, recalls that Constantin was frustrated that his declining fitness levels prevented him from undertaking all his usual tasks.

Medical History

4. Constantin had a medical history of diabetes, hypertension, chronic depression and benign paroxysmal positional vertigo. His General Practitioner (**GP**) stated that in the few years prior to his death, Constantin *'had low mood, poor sleep and a high anxiety level'.* He was trialled on various anti-depressant medications, however, did not experience any improvement.

THE CORONIAL INVESTIGATION

5. Constantin'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. This finding draws on the totality of the coronial investigation into the death of Constantin Daoussianis. 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]

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

Circumstances in which the death occurred

9. On 4 April 2023, at approximately 1:45pm, Constantin and Ms Daoussianis arrived at the Dromana property. Constantin started *'to do some gardening and mow the lawns'* while Ms Daoussianis travelled to the local shops to purchase some groceries. She recalls she left the Dromana property between 2 and 3pm, at which time Constantin was mowing the front lawn.

10. Upon her return, approximately one hour later, Ms Daoussianis located Constantin lying on the concrete paving at the property's left-hand fence line. She observed blood coming from Constantin's ear and sought assistance from their neighbour, Jamie Passick (**Mr Passick**).

11. Mr Passick observed Constantin to be *'conscious and breathing'* and contacted emergency services. Ms Daoussianis and Mr Passick noticed an A-frame ladder and pair of secateurs nearby. Ms Daoussianis stated, *'it looked like he was pruning the plants along the fence line and fell from the ladder'*, which is echoed by Mr Passick's recollection that *'it appeared to [him] that [Constantin] had been up the ladder trimming back an overgrown plant. Judging by the height of what was noticeably trimmed I would surmise [he] was close to the top of the ladder'.*

12. Constantin was transported via ambulance to the Alfred Hospital. He was assessed to have multiple injuries including rib fractures, a small left haemopneumothorax, a subarachnoid haemorrhage and a likely-extra dural hematoma. He was admitted to the Intensive Care Unit (**ICU**).

[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.

13. The following day, on 5 April 2023, Constantin's condition deteriorated; medical practitioners believed this was due to the progression of his intracerebral bleeds and associated swelling. Constantin's condition continued to decline and following a meeting between medical practitioners and his family, it was determined to transition him to a palliative pathway.

14. Constantin passed away, surrounded by family, at 11:55am on 26 April 2023.

Identity of the deceased

15. On 26 April 2023, Constantin Daoussianis, born 12 November 1942, was visually identified by his daughter, Helen Skliros, who completed a Statement of Identification to this effect.

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

Medical cause of death

17. Forensic Pathologist Dr Paul Bedford (**Dr Bedford**) from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on the body of Constantin Daoussianis on 27 April 2023. Dr Bedford considered the e-Medical Deposition Form of Alfred Hospital, the post-mortem computed tomography (**CT**) scan and the Victoria Police Report of Death to the Coroner (**Form 83**) and provided a written report of his findings dated 28 April 2023.

18. The post-mortem CT scan revealed focal right frontal changes, a left temporal skull fracture and multiple rib fractures. Physical examination was consistent with the recorded medical intervention.

19. Dr Bedford provided an opinion that the medical cause of death was 1 (a) COMPLICATIONS POST FALL FROM LADDER SUSTAINING MULTIPLE INJURIES INCLUDING TO THE HEAD AND CHEST.

COMMENTS

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

21. The dangers of elderly people working on ladders is not to be underestimated. I directed the Coroners Prevention Unit (**CPU**) to identify the frequency of deaths involving a fall from a ladder in a domestic setting in recent years. The CPU identified 85 deaths that occurred between 1 January 2014 and 30 June 2023. Over the period of analysis, the majority of

deceased were male (91.8%) and the highest frequency of deaths occurred in those aged between 70-79 (38.8%), followed by those aged 80-89 (34.1%).

22. It is concerning that elderly Victorians constitute the highest frequency of deaths due to falls from ladders, however, it not entirely surprising. I acknowledge the difficulty, both physically and mentally, faced by the elderly population as they become less able-bodied, and that they often seek to maintain their independence and autonomy. Indeed, to preserve their independence, elderly individuals may continue to engage in activities which place them at an appreciable risk of injury or death.

23. In 2020, then-Minister for Health, the Honourable Martin Foley, released a media release entitled *'Stepping Up Ladder Safety for Victorians'*. In it, the Hon Martin Foley identified that Victorian hospital emergency departments receive 1,200 admissions annually due to ladder falls, and that 61% of these admissions were persons over 60 years of age.

24. The media release contained a statement by then-Deputy Director of The Alfred Emergency and Trauma Centre, Dr Carl Luckhoff, which read:

> *'That data shows just how serious a fall from a ladder can be and it should be a reminder for older Victorians to stop and think before doing something risky on a ladder'.*

25. Victorian coroners have long been engaged in efforts to reduce domestic fall from ladder fatalities. In the matters of Brian Rutherford and Francis Zammit, I first made recommendations to the Department of Health that the it develop and coordinate 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.[2] The '*Ladder Safety Matters'* campaign came from this recommendation and was a joint initiative of Commonwealth, State, and territory consumer affairs agencies. In addition, I further note that the Ladder Safety Matters campaign was disseminated via the Better Health

[2] Form 38 Finding into Death Without Inquest in the matter of Brian Rutherford, dated September 2015 and available at https://www.coronerscourt.vic.gov.au/sites/default/files/2018-12/20146057_bryangeorgerutherford.pdf; Form 38 Finding into Death Without Inquest in the matter of Francis Zammit, dated 27 August 2015 and available at https://www.coronerscourt.vic.gov.au/sites/default/files/2018-12/francisxavierzammit_372814.pdf.

Channel and includes helpful safety hints to avoid individuals sustaining injuries whilst working on ladders.

26. More recently, my colleague, Coroner Simon McGregor, recommended in his Findings into the death of John Disley 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; and that the ACCC and the Victorian Department of Health review the continued impact and effectiveness of the Ladder Safety Matters campaign.[3]

27. In December 2021, the ACCC responded to the recommendation advising of a recent social media campaign called '*Spring has Sprung*'. It included specific content to remind consumers of the hazards of using ladders that are unsafe, or of using ladders incorrectly, with tips on how to stay safe. The content was delivered on 18 November 2022 through social media posts from the ACCC Product Safety Facebook and X (formerly 'Twitter') accounts, linking directly to the ladder safety content on the Product Safety Australia website.

28. Since then and despite these annual public awareness campaigns, Victorian coroners continue to investigate an increasing number of fatalities involving ladder falls each year. I echo Coroner McGregor's recommendation, and direct for this Finding to be distributed to the ACCC. I encourage the ACCC to continue their efforts in prevention and education campaigns targeting the fatal risk of ladder falls, particularly amongst older Victorians.

FINDINGS AND CONCLUSION

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

    a. the identity of the deceased was Constantin Daoussianis, born 12 November 1942;

    b. the death occurred on 26 April 2023 at The Alfred, 55 Commercial Road, Melbourne, Victoria, 3004, from; and,

    c. I accept and adopt the medical cause of death as ascribed by Dr Paul Bedford and find that Constantin Daoussianis died from complications post fall from ladder sustaining multiple injuries including to the head and chest.

[3] Form 38 Finding into Death Without Inquest in the matter of John Disley, dated 15 August 2022 and available at https://www.coronerscourt.vic.gov.au/sites/default/files/Coroners%20Finding%20-%20John%20Disley%20-%20COR%202021%20005950.pdf.

2. AND, I find that, the cogency of the evidence, including a nearby ladder and secateurs, permit me to make a finding that Constantin Daoussianis was pruning vegetation when he fell from the ladder. I note that Constantin Daoussianis had a history of benign paroxysmal positional vertigo, however, the weight of the evidence does not support a conclusion that this caused him to lose his balance. I acknowledge that he experienced mental ill health, however, there is no evidence to suggest that his fall was an intentional act.

3. Constantin Daoussianis' death is a tragic reminder of the danger associated with ladders in domestic settings, particularly amongst older demographics who face an increased risk of falls and of associated serious injuries or death. I reiterate the comments and recommendations which I have previously made, and which have been made by my colleagues and the Victorian Government and emphasise the importance of public campaigns on the issue.

I convey my sincere condolences to Constantin'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:

Dina Daoussianis, Senior Next of Kin

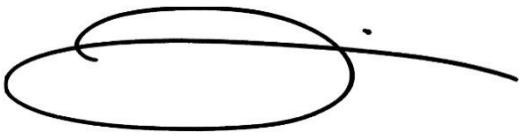
The Honourable Mary-Anne Thomas, Victorian Minister for Health

Australian Competition and Consumer Commission

Alfred Health

Constable Alice Bussey, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 24 October 2024

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.