MAGISTRATES COURT TASMANIA

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Office of the Coroner

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Andrew McKee, Coroner, having investigated the death of Janelle Lee White

Find, pursuant to section 28(1) of the *coroners act* 1995, that

a) The identity of the deceased is Janelle Lee White;
b) Ms White died as a result of traumatic closed head injuries due to a fall from a ladder;
c) Ms White's cause of death was traumatic closed head injuries; and
d) Ms White died on 5 November 2017 at Hobart, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Ms White's death. That evidence is comprised of the following:

a) an opinion of the forensic pathologist who conducted the autopsy;
b) numerous affidavits of Stewart Bruce McBride, Ms White's de-facto partner;
c) relevant police and witness affidavits;
d) a toxicology report from Forensic Science Services Tasmania;
e) medical records and reports; and
f) forensic evidence.

Janelle Lee White was born in Liverpool, New South Wales on 29 January 1971. She was 46 years old at the date of her death. She was the eldest of three children born to the marriage of Peter and Lynette White.

Ms White was educated at Deer Park Primary School and completed her secondary education at Montmorency High School.

Ms White held various forms of employment during her working life and prior to her death was employed by Coles in the Kings Meadows store in the meat department.

Ms White commenced a de-facto relationship with Stewart Bruce McBride in October 2002. The couple had previously resided in Queensland and New Zealand and had relocated to

Tasmania in 2015. The couple had renovated a number of houses together. Their relationship was described by Ms White's relatives as loving and committed.

Circumstances Surrounding the Death

On Saturday, 4 November 2017, Mr McBride and Ms White were undertaking works on a garden shed that they were constructing on their property.

The garden shed was partially constructed and had reached the framing stage. Mr McBride and Ms White were about to start putting the roof on the garden shed.

Mr McBride was the only person present with Ms White when she fell from the ladder. He did not witness Ms White fall from the ladder. In an affidavit sworn on 21 December 2017 Mr McBride gave the following description of the incidents leading up to Ms White's fall.

"It was dry outside and the sun was out when we went out. Janelle was wearing steel cap work boots, her blue work pants, and a black vest with a shirt underneath. She had sunglasses and a hat on.

We had been outside around a few hours when Janelle got up on the ladder which was situated on a flat concrete surface. It (sic) a 4×3 m surface which was clean with no offcuts or anything lying around. The ladder is about 2.4 m high. It is relatively new, probably around five years old but we hardly use it. I don't know what brand it is but it is an A-frame aluminium ladder.

Janelle was getting onto the ladder to nail a metal brace across the top of the rafters. She had a hammer in her hand and probably would have had some nails in her hand too but I didn't see. I never saw her get onto the ladder as I had turned around to nail the other side and had my back to her. A few seconds after I had turned my back to her, I heard a loud crash. I turned around again and I saw Janelle and the ladder on the ground which is concrete. Janelle was situated in the A-frame part of the ladder on her right hand side I think. The ladder had become jammed into the wall and the scaffold."

Mr McBride provided assistance to Ms White immediately after the fall. To enable him to do so he was required to move the ladder and scaffold.

Mr McBride ran into his home obtained a telephone and called 000. From the time the call was made to 000 and the ambulance's arrival at the property, Mr McBride remained on the telephone with the 000 operator.

The two attending paramedics provided treatment at the scene and transported Ms White to the Launceston General Hospital. Ms White was transferred from the Launceston General Hospital to the Royal Hobart Hospital.

Mr McBride followed in his personal vehicle. On his way to the Royal Hobart Hospital he was contacted by a neurologist who indicated to him that Ms White would not recover from the injuries she suffered in the fall. Mr McBride made a decision not to subject Ms White to an operation.

Ms White was declared brain-dead on 5 November 2017. She remained on life support until 7 November 2017 as she was an organ donor.

A post-mortem examination was undertaken by forensic pathologist Dr Donald Ritchey.

Dr Ritchey opined that the cause of Ms White's death were traumatic closed head injuries sustained in a fall from a ladder. I accept Dr Ritchey's opinion.

Ms White's Training in the Use of Ladders and Working at Height

Mr McBride is a qualified builder. He obtained his qualifications in 1985. He has received extensive training in the use of ladders and working at heights. He completed a polytech course whilst a resident of New Zealand. He holds a white construction card. He completed a course to enable him to be a home owner builder with the Queensland Building Authority. Mr McBride is currently employed as a branch manager at Wilson Homes and continues to undergo training for ladder work and working at heights.

I am satisfied on the materials provided to me that Mr McBride was competent in the safe use of ladders and working at heights.

Ms White also held a white card and had completed the Queensland Building Authority Course. She had also received training from Mr McBride in the safe use of ladders. Mr McBride in his affidavit dated 28 May 2019 described that training as follows:

"I had trained Janelle on the individual ladders we had. This included how they worked and how to lock them in and how to use them. Janelle was a very cautious person and did not take risks when using the ladders. She was always very wary about using ladders. I don't recall her ever falling off a ladder before."

During the course of their relationship, Mr McBride had observed Ms White using ladders when they were renovating houses and in his opinion she understood the dangers associated with using ladders and working at heights.

Based on Mr McBride's affidavits I am satisfied that Ms White was competent in the safe use of ladders and was by nature a cautious person.

Investigations at Building Site

Constables Cashion and Heron attended Mr McBride's property on 4 November 2017. Constable Heron took photographs of the scene. Constable Cashion has sworn an affidavit indicating that the photographs accurately depict the scene as observed by her and Constable Heron when they attended the property on 4 November 2017.

Neither Constable Cashion nor Heron moved the ladder or scaffold depicted in the photographs.

The photographs taken of the ladder depicts four latches, two at the top of the ladder and two attached to the cross bar of the ladder. The top latches were not in place because they were only used when the ladder was fully extended.

The latches attached to the cross bar provide stability to the ladder and according to Mr McBride at least one latch had to be engaged for the ladder to be used.

The photographs establish that post the ladder falling the left hand side latch was not engaged. I cannot rule out that the latch did not become dislodged in the process of the ladder falling. The photographs do not show the right hand side latch so I cannot make any finding as to whether it was engaged or not based on the photographs.

Mr McBride is certain that the right hand latch was engaged. He believes that Ms White would have made sure that the latches on the ladder were engaged or at least one was engaged prior to using the ladder.

I have no reason not to accept Mr McBride's evidence relating to his belief that at least one latch on the cross bar of the ladder was engaged. I am therefore satisfied on the balance of probabilities that at a minimum the right hand side latch on the cross bar was engaged.

Mr McBride in his various affidavits has considered two hypothesis as to what may have caused Ms White to fall from the ladder. The first is that the ladder "walked" because one of the latches was not secured in place.

Mr McBride noted that the ladder had a tendency to "walk" if the latches were not properly engaged on both sides. By "walk" he means the ladder would make a side to side movement. He stated the side to side movement had the potential to cause the user to lose their balance.

A video of the ladder "walking" was provided to me by the investigating officers. That video depicts the slight movements of the ladder as described by Mr McBride.

The second hypothesis is that Ms White has gone up the ladder quickly and has lost her balance, causing her to fall.

Based on the evidence before me I am not in a position to make a finding that the ladder "walked" and this is what caused Ms White to lose her balance and fall from the ladder.

Neither am I in a position to make a finding that Ms White has gone up the ladder quickly and lost her balance.

The only finding I can make is that Ms White fell from the ladder. I am not able to make a finding as to what caused her to fall from the ladder.

Comments and Recommendations

I extend my appreciation to investigating officer Constable Caitlin Cashion for her investigation and report.

I note that Coroner Cooper in his finding into the death of Mr H. dated 3 September 2014 has previously made recommendations regarding individuals utilising ladders to perform works in a home environment. I repeat his recommendations:

"I recommend that the following basic safety precautions are taken when using a ladder at home:

1. Take care to comply as far as possible with either the Australian Standard applicable to the task at hand or the Code of Practice approved under section 274 for the *Workplace Health and Safety Act* 2012;

2. Ensure the ladder is in good condition and set up on firm and stable ground;

3. Ensure the ladder is positioned so that it is neither too far from, nor too close to, the support structure;

4. Always ensure when using a ladder that it is secured either by being properly "footed" by another person or tied off at the top (or both); and

5. Only ever undertake light work while on the ladder-and then ensure that three (3) points of contact with the ladder are maintained at all times."

I convey my sincere condolences to the family and loved ones of Ms White.

Dated: 16 December 2019 at Hobart Coroners Court in the State of Tasmania.

Andrew McKee
Coroner