IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 5171

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	Caitlin English, Coroner
Deceased:	Leli Pulis
Date of birth:	17 August 1961
Date of death:	31 October 2016
Cause of death:	I(a) Multiple injuries sustained in a fall from a height
Place of death:	The Royal Melbourne Hospital 300 Grattan Street, Parkville, Victoria

INTRODUCTION

1. Leli Pulis was a 55-year-old man who lived in St Albans at the time of his death.

2. On 23 October 2016 he was injured in a fall from his carport. He was taken to hospital but did not recover and he died on 1 November.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. Mr Pulis' death was reported to the Coroner as it appeared to have resulted directly or indirectly from an accident or injury and so fell within the definition of a reportable death in the *Coroners Act 2008.*

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. Leading Senior Constable Kelly Ramsey of the Police Coronial Support Unit prepared a coronial brief in this matter. The brief includes statements from witnesses, including family, the forensic pathologist who examined Mr Pulis and treating clinicians.

6. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established on the balance of probabilities.[1]

IDENTITY

7. On 1 November 2016, Charlie Pulis visually identified his father Leli Pulis, born 17 August 1961.

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

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[1] This is 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.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

9. Mr Pulis had no known significant health issues apart from high cholesterol, gastritis with gastro-oesophageal reflux disease and glaucoma.[2] However, his son Charlie reports that '*if [Mr Pulis] was hungry, he may get a little bit dizzy*'.[3]

10. At around 9.00am on 23 October 2016 Mr Pulis was at home with his son Tony, clearing the house's guttering while his wife Rita was at the shops. According to Charlie, in order to reach the guttering it is necessary to climb onto the garage roof then walk over the carport onto the house's roof.

11. Charlie describes the carport as '*made up of corrugated iron with clear hard plastic that would be about a metre wide and in between the metal at every 3-4 metres*'.[4]

12. Mr Pulis climbed onto the garage using a ladder while his son Tony stayed at the base of the ladder. Mr Pulis moved across the carport toward a corner of the house where the gutter was blocked. Charlie notes that Mr Pulis had done this in the past.

13. Tony then heard Mr Pulis '*come through the hard plastic section of the carport*' and fall onto concrete. Tony found Mr Pulis '*trying to get up*' and he reportedly '*seemed okay for a couple of minutes*'. Tony and Mrs Pulis contacted emergency services as well as Charlie to attend.[5]

14. Ambulance paramedics arrived at 9.11am. They found Mr Pulis conscious but distressed and uncooperative. Paramedic Hayden Astbury noted '*an abrasion to the occipital region of his head*' and '*a haemorrhage from his nose*'.[6]

15. Paramedics attempted to immobilise Mr Pulis' spine then administered oxygen as well as an anti-nausea medication and the pain reliever fentanyl. At 9.31am Mr Pulis was transported to Royal Melbourne Hospital.[7]

16. He arrived at the Emergency Department at 10.08am. Following CT scans, Mr Pulis was '*taken to emergency theatre ... for significant brain injuries, drainage of a subdural*

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[2] Statement of Dr Suman Prakash dated 13 April 2018, Coronial Brief.
[3] Statement of Charlie Pulis dated 1 March 2018, Coronial Brief.
[4] Ibid.
[5] Ibid.
[6] Statement of Ambulance Paramedic Hayden Astbury dated 17 March 2018, Coronial Brief.
[7] Ibid.

haematoma (Neurosurgical consultant Mr B Kavar) and subsequently for then thoracic spine fixation (Orthopaedic consultant Emily Kong).'[8]

17. Mr Pulis was treated in the Intensive Care Unit for several days but showed poor progress. On 29 October 2016 a CT brain scan showed very significant left-sided brain injuries, on 30 October 2016 there was an increase in intracranial pressures and on 31 October 2016 pupil dilation was noted which suggested new uncontrolled swelling on the left side of the brain.[9]

18. After discussion with Mr Pulis' family regarding his poor prognosis, his medical team withdrew support.[10] Charlie Pulis recalls that '*he stayed with us for quite some time*' and took his last breath at 6.19pm on 1 November 2016.[11]

CAUSE OF DEATH

19. On 3 November 2016, Dr Sarah Parsons, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an inspection of Mr Pulis' body and provided a written report, dated 9 November 2016. In that report, Dr Parsons concluded that a reasonable cause of death was '*I(a) Multiple injuries sustained in a fall from a height*'.

20. I accept Dr Parsons' opinion as to cause of death.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

21. The Coroners Prevention Unit (CPU)[12] has conducted a review of Victorian deaths following falls from roofs. The review identified that, between 1 January 2006 and 31 December 2016, 24 people died in Victoria as a result of roof falls while engaged in do it yourself (DIY) work.

22. Four of these deaths involved falling through a skylight, seven through a roof and 13 falling off a roof. There was no evidence that any of these people were using safety equipment at the time of their deaths.

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[8] Statement of Dr James Anstey dated 14 April 2018, Coronial Brief.
[9] Ibid.
[10] E-Medical Deposition of Dr Brigid Wolf dated 31 October 2016.
[11] Statement of Charlie Pulis dated 1 March 2018, Coronial Brief.
[12] The Coroners Prevention Unit (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.

23. During the same time period, nine people died following roof falls while undertaking paid employment.

24. The review discussed prevention initiatives aimed at reducing the likelihood of roof falls. Relevantly, the Australian Competition and Consumer Commission was noted to provide basic information about completing DIY activities at home. WorkSafe Victoria provides information for employers and employees on preventing falls in work environments, including roof falls,[13] and both WorkSafe Victoria and Safe Work Australia have published codes for falls prevention.

25. The WorkSafe initiatives by their nature do not address 'DIY' work at home, the context in which the greater number of fatal roof falls occur.

Ladder safety initiatives

26. Deaths following falls from ladders have a similar distinction between workplace and domestic contexts. A 2014 report from the Department of Health & Human Services entitled '*Report on the reduction of major trauma and injury from ladder falls*' found:

> '*In recent years there has been an increase in ladders falls injury, particularly in the domestic context, and the injuries resulting from these falls have not been the subject of any injury prevention initiative, despite the clear gains in reducing ladder-related falls and injuries in the workplace through strict regulations and preventative action.*'[14]

27. In her finding into the death of Francis Zammit dated 27 August 2015,[15] Coroner Audrey Jamieson recommended (in summary) that the Department of Health and Human Services develop a program with the aim of implementing public health and safety measures targeted at preventing deaths from ladder falls, including a public education program.

28. Acting Secretary of the Department of Health and Human Services, Kym Peake responded on 6 October 2015[16] outlining the Department's current initiatives on this issue and stating that Coroner Jamieson's recommendations would be considered and would inform the development of a national education campaign.

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[13] See, eg, 'A guide to: Falls Prevention', WorkSafe Victoria (2nd edition, June 2017), 'Prevention of falls – working on roofs', WorkSafe Victoria (1st edition, June 2005).
[14] Department of Health & Human Services, '*Report on the reduction of major trauma and injury from ladder falls*', October 2014.
[15] Finding available on the Coroners Court of Victoria website, Case Number 372814.
[16] Response available on the Coroners Court of Victoria website, Case Number 372814.

29. In September 2016, a national '*Ladder Safety Matters*' campaign began to reduce serious injury and deaths from ladder falls as a joint initiative of Australian, state and territory consumer affairs agencies and the Victorian Department of Health and Human services.[17]

30. I repeat the still relevant comment made by Coroner Spanos in the finding for the death of Fritz Hoefer: [18]

'It is appropriate to repeat here the need for a public awareness campaign highlighting the dangers involved, and educating the public about safer practices involving ladders and or working at a height. The statistics suggest that such a campaign should be particularly aimed at males over the age of sixty who are minded to do their own home maintenance.'

31. I am of the view this campaign could be extended to include falls from heights, including roofs, in the DIY context.

FINDINGS

32. Having investigated the death, without holding an inquest, I find pursuant to section 67(1) of the *Coroners Act 2008* that Leli Pulis, born 17 August 1961, died on 31 October 2016 at Parkville, Victoria, from I(a) Multiple injuries sustained in a fall from a height in the circumstances described above.

RECOMMENDATION

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

1. That the **Victorian Department of Health and Human Services** consider extending the national 'Ladder Safety Matters' public education initiative to include falls from heights, including roofs, in the DIY context.

I direct that this finding be published on the Internet.

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

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[17] See Product Safety Australia publications at www.productsafety.gov.au/publication/ladder-safety-matters and a media release of Minister for Health the Hon Jill Hennessy MP '*Stepping up for ladder safety*' dated 13 September 2016.

[18] [COR 2008 114]

Mrs Rita Pulis, senior next of kin.

Ms Kym Peake, Secretary, Department of Health and Human Services.

Ms Kellie Gumm, Trauma Program Manager, The Royal Melbourne Hospital.

Leading Senior Constable Kelly Ramsey, Victoria Police, Coroner's Investigator.

Signature:

CAITLIN ENGLISH

CORONER

Date: 16 October 2018