IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 005950

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	John Disley
Date of birth:	12 October 1941
Date of death:	6 November 2021
Cause of death:	1(a) Multiple injuries post fall from a roof
Place of death:	Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3052
Keywords:	Fall, Ladder

INTRODUCTION

1. On 6 November 2021, John Disley was 80 years old when he died at the Royal Melbourne Hospital (**RMH**) as result of injuries sustained in a fall. At the time of his death, John lived at 20 Penguin Street, Melton.

2. John's medical history included reflux, hypercholesteraemia, and hypertension.[1] He had also suffered a mild stroke in May 2021 however John completely recovered from this.[2] At the time of his death, John was prescribed aspirin, clopidogrel, and atorvastatin.[3]

3. John worked as an engineer in England before emigrating to Australia in 1964 with his wife, Helen Disley. They initially lived in Sunshine West before eventually moving to Melton where they lived until John's death.[4]

4. John was a very independent man and always insisted on doing things himself around the house, such as cleaning the guttering which he would do once or twice a year. Helen often worried that he would hurt himself.[5]

THE CORONIAL INVESTIGATION

5. John'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.

---

[1] Coronial brief, statement of Dr Siva Sooknandan dated 24 February 2022, page 28.
[2] Coronial brief, statement of Helen Disley dated 23 March 2022, page 12.
[3] Coronial brief, statement of Celina Kaiser dated 11 August 2021, page 30.
[4] Coronial brief, statement of Helen Disley dated 23 March 2022, pages 11-12.
[5] Coronial brief, statement of Helen Disley dated 23 March 2022, pages 12-13.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of John'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.

9. This finding draws on the totality of the coronial investigation into the death of John Disley 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.[6]

10. In considering the issues associated with this finding, I have been mindful of John's basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006* (Vic), in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

11. During the week prior to John's accident, there had been large amounts of rain that had caused the downpipes at John and Helen's residence to start overflowing. John's daughter, Sandra, told her parents that she would come out and clean the gutters for them however John did not want anyone else to have to do the job for him.

12. On 22 October 2021, John went outside. Helen stated that she heard a loud noise and went outside to find John lying on the ground next to a ladder which he had been using to clean the guttering and unblock a downpipe.[7] He had fallen approximately two metres to the ground.[8]

13. John was transported to RMH by ambulance, arriving at 1.48pm. On arrival, he was found to have suffered multiple fractures of his ribs, pelvis, and spine, as well as a vertebral artery dissection and injuries to his teeth. During his time at RMH, his injuries were complicated by a diagnosis of hospital-acquired pneumonia which was treated with intravenous antibiotics.[9]

---

[6] 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.

[7] Coronial brief, statement of Helen Disley dated 23 March 2022, pages 13-14.

[8] Coronial brief, statement of Dr David Read dated 12 April 2022, page 22.

[9] Coronial brief, statement of Dr David Read dated 12 April 2022, page 22.

14. On 6 November 2021, despite intensive treatment, John's condition deteriorated, and he suffered a cardiac arrest whilst on the ward. A Medical Emergency Team alert was activated however resuscitation was not commenced, consistent with John's Goals of Care.[10]

15. On 6 November 2021 at 9.59pm, John passed away.[11]

Identity of the deceased

16. On 6 November 2021, John Disley, born 12 October 1941, was visually identified by his daughter, Sandra Disley.

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

Medical cause of death

18. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 8 November 2021 and provided a written report of his findings dated 12 November 2021.

19. The post-mortem examination revealed significant traumatic injuries consistent with the history given. Bilateral lung changes with emphysema were also noted.

20. Toxicological analysis was not indicated and was not performed.

21. Dr Bedford provided an opinion that the medical cause of death was 1 (a) multiple injuries post fall from a roof.

22. I accept Dr Bedford's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was John Disley, born 12 October 1941;

    b) the death occurred on 6 November 2021 at Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3052, from *multiple injuries post fall from a roof*; and

[10] Coronial brief, statement of Dr David Read dated 12 April 2022, pages 22-23.
[11] Melbourne Health Medical E-Deposition dated 6 November 2021, page 1.

c) the death occurred in the circumstances described above.

COMMENTS

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

24. The dangers of elderly individuals working on ladders is not to be underestimated. I note the comments of former Deputy State Coroner Caitlin English in the matter of *Starkie*[12] in which Her Honour referred to a review conducted by the Coroners Prevention Unit (**CPU**)[13] which found that, from 2013 to 2020, 60 individuals had died in Victoria following falls from roofs whilst engaged in manual labour, with a majority of individuals being male (91.7 per cent), and those aged 75-79 years accounting for 25 per cent of deaths which represented the largest cohort in the study. There was no evidence that any of the deceased were using safety equipment at the time of their falls.

25. Her Honour also drew attention to the Department of Health's 2014 report titled *Report on the reduction of major trauma and injury from ladder falls* which showed that, at the time, there had been an increase in injuries from falls from ladders in the domestic sphere, and that, despite these injuries, there had not been any prevention initiatives despite clear gains in injury reduction through strict workplace regulations and preventative actions.

26. I note the Department of Health campaign *Ladder safety matters*, aimed at reducing serious injury and deaths from ladder falls. This was a joint initiative of Commonwealth, state, and territory consume affairs agencies. In addition, I further note that the *Ladder safety matters* campaign was disseminated via the *Better Health Channel* and includes helpful safety hints to avoid individuals sustaining injuries whilst working on ladders.[14]

27. In the matter of *Wright*,[15] Coroner Audrey Jamieson commended the Department of Health's efforts in developing a coordinated strategy and program for the implementation of public health and safety measures targeted at preventing deaths from ladder falls but noted that there continued to be a significant number of deaths related to falls from ladders in Victoria.

[12] COR 2020 5113.
[13] 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.
[14] Available at https://www.betterhealth.vic.gov.au/health/healthyliving/ladder-safety
[15] COR 2018 0488.

28. Her Honour went on to make recommendations to the Department to continue and extend the *Ladder Safety Matters* campaign.

29. The Department of Health responded to Coroner Jamieson's recommendations by committing to continue promoting the campaign in 2019/20 and 2020/21 with an enhanced communication plan to include ladder falls and falls from heights, including roofs, in the DIY context, an expanded social medical schedule, and distribution of advertising material.

30. I note the Victorian Government's media release of 28 December 2020,[16] which highlighted the annual *Ladder Safety Matters* campaign in time for the 2020 Christmas and summer home maintenance holiday period. Relevantly, the media release provided the following updated statistics:

    a) there are about 1200 emergency department presentations due to ladder falls and about six Victorians die as a result of falling from a ladder at home each year;

    b) hospital admissions for ladder falls around the home have gone up by 22 percent over the five years to 2018/19 – from 614 to 752;

    c) the number of men hospitalised increased by 16 percent from 474 to 549;

    d) the number of women jumped by 45 percent – from 140 to 203; and

    e) 61 percent of all hospital admissions were people aged 60 years and over, and men aged from 40 to 79 years made up more than half (55 percent) of the people who presented to hospital emergency departments after falling off a ladder.

31. Notably, the media release provided the following cautionary advice:

> *Most ladder injuries are preventable, which is why older Victorians should be cautious and not take shortcuts. People should always maintain three points of contact, use two hands when climbing and when using a tool, make sure both feet and your other hand are secure on the ladder.*
>
> *It is important to work within your limits and make sure another person is at home while you are on a ladder, in case you need help. Having another person around can hold the ladder to ensure it doesn't slip.*

[16] Available at: https://www.premier.vic.gov.au/stepping-ladder-safety-victorians

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

(i) In light of the continuing dangers posed by individuals working on ladders in the domestic context, especially amongst the elderly, **I recommend** 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.

(ii) With a view to promoting public health and safety and preventing like deaths, **I recommend** that the ACCC and the Victorian Department of Health review the impact and effectiveness of the *Ladder Safety Matters* campaign

I convey my sincere condolences to John's family for their loss.

Pursuant to section 73(1A) 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:

Helen Disley, Senior Next of Kin

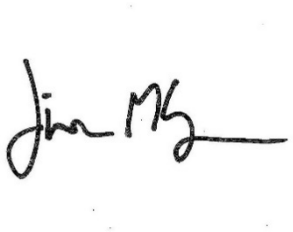
Kellie Gumm, RMH

Gina Cass-Gottlieb, Chair, ACCC

The Hon. Mary-Anne Thomas, MP, Minister for Health (Vic)

First Constable Michael Pernar, Victoria Police, Coroner's Investigator

Signature:



CORONER SIMON McGREGOR

CORONER

Date: 15 August 2022

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.