IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2020 5113

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	Peter George Starkie
Date of birth:	21 August 1948
Date of death:	14 September 2020
Cause of death:	1(a) Multiple injuries sustained in a fall from a height
Place of death:	Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria

INTRODUCTION

1. On 14 September 2020, Peter George Starkie was 72 years old when he died following a fall from a roof. At the time of his death, Mr Starkie lived at Shepparton with his long-term partner.

THE CORONIAL INVESTIGATION

2. Mr Starkie'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.

3. 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.

4. 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.

5. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Starkie'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.

6. This finding draws on the totality of the coronial investigation into Mr Starkie's death, 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.[1]

[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.

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

Identity of the deceased

7. On 15 September 2020, Peter George Starkie, born 21 August 1948, was visually identified by his partner.

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

Medical cause of death

9. Forensic Pathologist, Dr Melanie Archer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 17 September 2020 and provided a written report of her findings dated 6 October 2020.

10. Dr Archer noted that examination of the post-mortem CT scan showed a left subdural haemorrhage, generalised subarachnoid haemorrhage, a left scalp haematoma, and a possible left parietal fracture. The base of skull fracture could not be visualised. There were fractures of right lateral rib 5 and left lateral rib 3. The vertebral bodies of the 11th and 12th thoracic vertebrae appeared fractured, and there was a right scapula fracture. Pleural fluid was seen, although there was no pneumothorax.

11. Dr Archer provided an opinion that the medical cause of death was *"1(a) Multiple injuries sustained in a fall from a height"*.

12. I accept Dr Archer's opinion.

Circumstances in which the death occurred

13. Mr Starkie is the much-loved father of two daughters and a beloved partner.

14. Mr Starkie had colourful and varied life: he worked as a musician and was a founding member of the Melbourne band, Skyhooks. After Mr Starkie's retirement, he and his partner purchased and renovated investment properties. The couple also had a property in Kalgoorlie, to which they travelled regularly to maintain, spending half the year there.

15. Mr Starkie appears to have been in relatively good health. He had a non-malignant skin cancer removed in 2013 and two episodes of stroke-like symptoms in 2014 and 2017 (the latter was confirmed to be a stroke). He was taking medication for high blood pressure.

16. At the beginning of 2019, Mr Starkie's and his partner's apartment in St Kilda flooded and required repairs. They decided to move to his mother-in-law's property in Shepparton while repair work was done to the apartment. After some time, COVID-19 restrictions were imposed, and the couple decided to stay at the property until restrictions in Melbourne lifted. While at the property, they both maintained the house by undertaking upgrades and repairs and considered purchasing the property.

17. On 13 December 2020, Mr Starkie was already awake when his partner awoke. She noted that Mr Starkie had always had trouble sleeping. She went on to describe that day as a normal day, but Mr Starkie had not had a shower before getting dressed, which was unusual, and later appeared a bit weak, tired, and quiet.

18. In the later afternoon, she noticed Mr Starkie exhibiting some further unusual behaviour when he threw away a meal he prepared and used a lot of saucepans in its preparation. He later gave short monosyllabic answers to her questions and had not awoken her when her sister-in-law had visited, despite her request that he do so.

19. Mr Starkie's partner finished washing the dishes and went to the loungeroom to rest. At this time, she saw Mr Starkie climbing or heading toward a ladder leaning against the back veranda to clean the roof – a chore for which he had purchased special brooms and cleaning products. She then heard a 'clunk and a roll' sound. She subsequently found Mr Starkie on the ground with a broken plastic roof skylight above. The fall from the roof to the concrete ground was approximately three metres.

20. She contacted emergency services and Mr Starkie was flown to the Royal Melbourne Hospital for treatment. CT scans later revealed serious injuries including a large acute left subdural/subarachnoid haemorrhage, spinal fractures, rib fractures, and a lung laceration. The brain injury was not survivable, and he passed away on 14 September 2020. Mr Starkie's family generously consented to organ donation.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Peter George Starkie, born 21 August 1948;

    (b) the death occurred on 14 September 2020 at Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, from multiple injuries sustained in a fall from a height; and

(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.

1. I have previously made findings about safety issues related to ladder use at home.

2. In the *Finding into without inquest regarding Leli Pulis*,[2] Mr Pulis died following a fall from a roof whilst cleaning the gutters. In a remarkably similar set of circumstances, he fell through a hard plastic roof onto concrete. As part of my investigation, I requested the Coroners Prevention Unit[3] (**CPU**) to conduct a review of Victorian deaths following falls from roofs.

3. The review found that 24 people had died in Victoria as a result of falls from roofs while engaged in do-it-yourself (**DIY**) work during the period 1 January 2006 to 31 December 2016. Four of the deaths involved falling through a skylight, seven through a roof, and 13 falling from a roof. There was no evidence that any of the deceased were using safety equipment at the time of their falls.

4. In the that finding, I also noted the then Department of Health and Human Services' 2014 report titled *Report on the reduction of major trauma and injury from ladder falls*,[4] which found:[5]

> *... in recent years there has been an increase in ladder 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.*

5. I also referred to previous similar findings and recommendations and noted the national *Ladder Safety Matters* campaign, which was aimed at reducing serious injury and deaths from

[2] Published 16 October 2018.
[3] 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.
[4] The report is available at: https://www2.health.vic.gov.au/about/publications/researchandreports/Report-on-the-reduction-of-major-trauma-and-injury-from-ladder-falls.
[5] Department of Health, Report on the reduction of major trauma and injury from ladder falls, published 1 April 2015, page 2.

ladder falls. This campaign was a joint initiative of Australia, state, and territory consumer affairs agencies and the Victorian Department of Health and Human Services.

6. In the matter of *Leli Pulis,* I went on to make recommendation for the Department of Health and Human Services to consider extending the national *Ladder Safety Matters* public education initiative to include falls from heights, including roofs, in the DIY context.

7. In response to my recommendation, Kym Peake, Secretary, noted that the 2018 Victorian campaign included the dissemination of hardcopy safety pamphlets to older people in the community and electronic dissemination of ladder safety information and case-studies via a dedicated social medical schedule of the Victoria Government's *Better Health Channel* website. The Department planned to review the campaign in early-mid 2019 to determine whether it would be appropriate to expand the scope of the campaign to include falls from heights in the DIY context.

8. In the *Finding into death without inquest regarding Dennis John Wright*,[6] Her Honour Coroner Audrey Jamieson commended the Department'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. Her Honour noted updated CPU data compiled in July 2018, which identified that there had been 69 deaths following ladder falls in Victoria in the period 2012 to 2018.

9. I note that the CPU recently updated its data, which showed:

   (a) there were 60 ladder falls leading to death between 1 January 2013 and 31 December 2020;

   (b) the number of deaths per year ranged from five to 10 (with 10 occurring in 2019);

   (c) the majority of deceased were men – 91.7 percent; and

   (d) the age group with the highest number of deceased was 75 to 79 years – 25 percent.

10. In her finding, Coroner Jamieson went on to make recommendations to the Department to continue and extend the *Ladder Safety Matters* campaign.

[6] Published 24 April 2019.

11. In response to Coroner Jamieson's recommendations, Ms Peake noted that the Department would 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.

12. I note the Victorian Government's media release of 28 December 2020,[7] which highlighted the annual *Ladder Safety Matters* campaign in time for the 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.

13. 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.*

14. I commend the Victorian Government's ongoing campaign in this area. Given the Government's ongoing efforts, I do not intend to make a formal recommendation but I will direct a copy of this finding be provided to the Secretary of the Department of Health for his

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

consideration and review in determining the messaging and communication methods of future campaigns.

15. Through his music and membership of the band Skyhooks, Mr Starkie brought joy to fans and enriched the lives of many. As a matter of public interest in order to raise public awareness of the dangers of using a ladder at home and deaths from ladder falls, which average between five and ten a year, I intend to publish this Finding.

I convey my sincere condolences to Mr Starkie'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:

Senior next of kin
Royal Melbourne Hospital
Professor Euan Wallace, Secretary, Department of Health
First Constable Joshua Benson, Victoria Police, Coroner's Investigator

Signature:

CAITLIN ENGLISH
DEPUTY STATE CORONER
Date: 2 August 2021

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 six 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.