IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2013/0867

FINDING INTO DEATH WITHOUT INQUEST

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

I, AUDREY JAMIESON, Coroner having investigated the death of MERVYN BARRY MASLIN

without holding an inquest:
find that the identity of the deceased was MERVYN BARRY MASLIN
born on 18 July 1945
and the death occurred on 26 February 2013
at the Austin Hospital, 145 Studley Road, Heidelberg 3084
from:

1 (a) COMPLICATIONS ARISING FROM MULTIPLE INJURIES – FALL FROM A HEIGHT

Pursuant to section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Mr Mervyn Maslin was 67 years of age at the time of his death. He resided at 31 Maxine Drive, St Helena with his wife. He was retired. On 31 January 2013, Mr Maslin travelled to Tasmania with his friend, Mr Russell Adams. The purpose of the trip was to visit Mr Adams' son, and help him with repairs to the roof of his house situated at 124 Main Road, Penguin.

2. On 4 February 2013, Mr Maslin, Mr Russell Adams, his son Mr Robin Adams, and his son's friend, Pascal, were working carrying out repairs on the roof. It was a hot and sunny day, and where possible, Mr Maslin and Mr Russell Adams stood in the shade. There were two points of access to the roof, the first being via an internal staircase, which led to the inside of the roof. Access to the outside of the roof was by an extension ladder anchored against the veranda wall. The height of that part of the roof was approximately three metres, and it was covered by polycarbonate sheeting. Mr Maslin and Mr Russell Adams mainly worked on the

ground, cutting Colourbond sheets to length, and handing it up to Mr Robin Adams and Pascal, who were installing it on the roof. At approximately 4.00pm, Mr Robin Adams asked them if they could cut two more sheets. They cut the first sheet, and Mr Russell Adams took the sheet up the ladder and handed it to his son. They cut the second sheet, and Mr Maslin climbed the ladder and passed the sheet to Mr Robin Adams. Mr Russell Adams was looking up at Mr Maslin on the ladder and noticed he was at the top of the ladder. Mr Russell Adams turned away to pick up some tools, when he heard as loud noise. He looked up and saw that Mr Maslin was no longer on the ladder. Mr Maslin had fallen forward through the polycarbonate roof onto the paved floor of the veranda. Mr Russell Adams and his son immediately went to assist. They found Mr Maslin on the floor unconscious, but breathing. Mr Robin Adams immediately commenced mouth-to-mouth resuscitation. Emergency services were called, and they transported Mr Maslin to North West Regional Hospital before being transferred to Hobart Hospital. Due to the complexity of his injuries, Mr Maslin was flown to Melbourne on 8 February 2013, and admitted to the Austin Hospital.

3. Mr Maslin was diagnosed with severe spinal and head injuries. Due to the poor prospect of recovery, and his previous indication that he not wish to live with a severe disability, the decision was made to administer palliative care only. Mr Maslin passed away at 11.05 am on 26 February 2013.

Investigation

4. Dr Malcolm Dodd, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an external examination of the body of Mr Maslin, reviewed a post mortem CT scan, and the Form 83 Victorian Police Report of Death. Anatomical findings included multiple injuries consistent with a fall from a height. Dr Dodd ascribed the cause of Mr Maslin's death to complications arising from multiple injuries.

5. The circumstances of Mr Maslin's death have been the subject of investigation by Victoria Police. The Police investigation did not identify any suspicious circumstances.

6. The police obtained statements from Mr Maslin's friend, Mr Russell Adams; Mr Adams' son and owner of the residence, Mr Robin Adams; Mr Maslin's wife, Mrs Joy Maslin; Neurosurgical Registrar of Royal Hobart Hospital, Dr Kate Poulgrain; Rehabilitation Physician of the Austin Hospital, Dr Richard Clements; and his General Practitioner, Dr

Greg Moritz. They also obtained a report from Worksafe Tasmania, and medical reports from The Royal Hobart Hospital and the North West Regional Hospital in Burnie, Tasmania.

7. Mr Russell Adams reported that Mr Maslin had been feeling unwell that day. His wife, Mrs Joy Maslin reported that Mr Maslin was relatively healthy, but sometimes he felt light-headed in the hot weather when he stood up, and it could be the case that he had a dizzy spell in the heat. Mr Russell Adams also reported that he had worked on many projects with Mr Maslin over the years, he was familiar with building sites, and always took safety precautions. Mr Russell Adams is also of the opinion that Mr Maslin may have felt dizzy in the heat.

8. Worksafe Tasmania undertook an investigation of the site and observed poor safety standards. As it was a private residence and not a workplace, no further action could be taken. They did however, give Mr Robin Adams some advice on how to make the site safer during the renovations.

Finding

I accept and adopt the medical cause of death as identified by Dr. Dodds and find that Mr Mervyn Barry Maslin died from complications arising from multiple injuries consistent with a fall from a height.

Comments

Pursuant to Section 67(3) of the **Coroners Act 2008**, I make the following comment connected with the death:

The Coroner's Prevention Unit (CPU)[1] have previously reviewed prevention lessons in respect to falls from ladders at home and identified the following:

- there have been 82 deaths from falling from a ladder in Victoria between 2000 and 2011:
    - most deaths were persons over the age of 65;
    - many were engaged in home maintenance activities; and

[1] 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, as well as assisting in monitoring and evaluating the effectiveness of the recommendations.

- the ladder-related injury rate is increasing for home ladder use but is stable in the work-related context.

- the risks associated with ladders are well understood and information on the correct use of ladders is widely available.

Previous Victorian coronial findings in relation to deaths resulting from falls from ladders in have included the following relevant recommendations/comments:

- research the possible links between men's health, prescribed medications and risk factors for falls from heights;[2]
- reinforce the need to secure ladders to make them safe from slipping and to use falls restraint systems;[3]
- when using ladders at home, people tend to take risks that would never be tolerated in a well-controlled workplace and that a public awareness campaign highlighting the dangers involved in unsafe ladder use would seem to be justified;[4] and
- information relating to safe ladder usage could be distributed through various retail hardware and trade centres or through the auspice of retirement and pensioner association magazines and/or domestic/life insurance information.[5]

These recommendations and comments were made prior to the introduction of the *Coroners Act 2008* (Vic) and accordingly, there was no legislative requirement to respond to recommendations.

The previous CPU research comprehensively looked at issues relating to falls from ladders both nationally and internationally. It identified a lack of a strategic approach to prevent ladder related falls in the home.

The research recognised that while WorkSafe produce guidance materials, training and enforce regulations for ladder safety in Victorian workplaces, there is however no strategic approach to prevent injuries associated with unpaid home maintenance and ladder related falls in Australia. Very little has been done to address ladder safety in homes.

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[2] COR 2004/3865.

[3] Ibid.

[4] COR 2006/4106.

[5] COR 2007/1743.

The CPU examined the international approaches to ladder safety and found that the UK and Canada also focus on workplaces. The USA has a website for all ladder uses including detailed guidance and training material. In the UK and the USA, the ladder industry lead safety initiatives.

The CPU research identified potential hindrances to the development of a prevention strategy for ladder safety at home in Australia, including:

- there is no responsible organisation or department;
- many of the injuries occur on private property not in the course of employment;
- people take pride in doing their own home-maintenance and may be resistant to change;
- there is an apparent underestimation of the risk of ladder use, and consequent failure to take precautions or seek information; and
- possible contribution to falls, posed by damaged and/or unsuitable ladders, is difficult to measure, due to a paucity of available data.

Nonetheless, the rate of death from ladder falls at home, is alarming.

While I recognise the practical challenges in effecting change in this area due to the factors identified above, I wish to bring the unacceptable number of preventable fatalities and hospitalisation associated with ladder falls to the attention of the Victorian Minister of Health and the Secretary of the Department of Health.

I direct that the Finding be published on the internet.

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

Mrs Joy Maslin

Ms Lynette Russell, on behalf of Austin Health

The Hon David Davis MLC, Victorian Minister for Health

Professor Jane Halton PSM, Secretary, Department of Health

The Hon Petter Dutton, MP, Commonwealth Minister for Health

Dr Claire Noone, Executive Director, Consumer Affairs Victoria

Director, Professor Lesley Day, Deputy Director, Monash Injury Research Institute, Fall Prevention Research Unit and Director, Victorian Injury Surveillance Unit

Mr Nick Rushworth, Executive Officer, Brain Injury Australia

Ms Ann Sherry AO, Chair, Safe Work Australia

WorkSafe Victoria

WorkSafe Tasmania

Ms Jenny Scott, Magistrates Court of Tasmania, Coronial Division

Constable Hanna Parker

Signature:

AUDREY JAMIESON
Coroner
Date: **17 March 2014**