MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Stavros Mitsakis,

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that:

a) The identity of the deceased is Stavros Mitsakis;
b) Mr Mitsakis died from injuries resulting from a fall from a ladder;
c) The cause of death was a displaced cervical vertebral fracture with secondary carotid artery dissection resulting in left middle cerebral artery and posterior cerebral artery infarcts; and
d) Mr Mitsakis died 18 September 2020 in the Whittle Ward, Royal Hobart Hospital, Hobart, Tasmania.

Introduction

In making the above findings, I have had regard to the evidence gained in the comprehensive investigation into Mr Mitsakis' death. The evidence includes:

- The Police Report of Death for the Coroner;
- Royal Hobart Hospital Report of Death;
- Opinion of the State Forensic Pathologist regarding cause of death;
- Affidavits confirming identification and life extinct;
- Affidavit of Dorothy Margaret Mitsakis, wife of Mr Mitsakis;
- Affidavit of Detective Senior Constable Michael Manning and accompanying video footage of the ladder; and
- Affidavit of Russell Holywell, son-in-law of Mr Mitsakis.

Background

Stavros Mitsakis was born in Megalakos, in the mountains of Greece, on 8 February 1941. At the time of his death he was 79 years of age and was living with his wife, Dorothy Mitsakis, on their 10 acre property at 10 Proctors Road, Kingston, where they lived with other members of their family. There are three adult children of the marriage.

In 1960, Mr Mitsakis migrated to Tasmania and, over many years, he engaged in many forms of employment and operated numerous businesses. Ultimately, Mr and Mrs Mitsakis successfully operated a commercial business growing tomatoes and cucumbers on their property at Proctors Road.

Over the years, Mr Mitsakis learned building and construction skills. He performed his own maintenance upon his shops, built a house at Bruny Island and then built his own house at Proctors Road. He also constructed the commercial greenhouse at that site.

Mrs Mitsakis said that her husband had always been *"as strong as an ox"* throughout his life. However, he suffered a stroke in October 2019, which caused some physical and cognitive deficits. Whilst his physical recovery was prompt, he struggled to retain information and plan how to complete tasks for several months, before showing signs of improvement. As he improved mentally, he had the idea of building an extension on their house. Mrs Mitsakis said that *"it was impossible to stop him"*. Therefore, in early August 2020 Mr Mitsakis started building the extension.

Circumstances of Death

During the morning of 16 September 2020, Mr Mitsakis was working outside the house, using floating floorboards to block up areas under the eaves, between the wall and roof, to prevent the entry of birds. For this task, Mr Mitsakis was working at height upon an aluminium ladder, approximately 3.5 metres in length. The ladder was leaning against the house whilst he was working.

Mr Mitsakis had one section to complete, and he had already cut out these boards to fit around the rafters. Mr Mitsakis stopped for a lunch break with his wife between 12.30 and 1.00pm, and then returned to finish the task.

At 2.10pm, Mr Mitsakis entered the house, wearing his tool belt. Mrs Mitsakis reported that his face was covered in blood and he was requesting help, saying he just needed to get to bed. He did not want his wife to call an ambulance. Mrs Mitsakis assisted him to lie down and began to tend to his face. She noticed that he had a wound high on the left side of his head, and, at about 2.30pm, called an ambulance. Mrs Mitsakis reported that Mr Mitsakis said to her, *"The bloody thing. I didn't bother to put the chock under the ladder."* He stated that the ladder had slipped one way and he had fallen off the other way. He was complaining of a sore shoulder and neck, and Mrs Mitsakis noticed that his arm was sitting in an unusual position, making her think he may have a broken collar bone.

Ambulance Tasmania paramedics arrived at 2.50pm. Mr Mitsakis was noted to be lucid at that stage but becoming more vague and complaining of a very sore neck.

A CT scan conducted at the Royal Hobart Hospital revealed a burst fracture of the first cervical vertebra, at the base of the neck and skull. A CT carotid angiogram then showed there had been a traumatic dissection of the left internal carotid artery resulting in left middle cerebral artery and posterior cerebral artery infarcts. These results revealed non-survivable injuries, for which surgery was not appropriate.

On the night of 16 September 2020, Mr Mitsakis suffered a major stroke, became paralysed down his right side, and was unable to speak. He was responsive, but was not able to be treated due to the severity of the injuries he sustained. Mrs Mitsakis requested that Mr Mitsakis not be resuscitated or actively treated, in accordance with his wishes. He was transferred to the Intensive Care Unit and then to the Whittle Ward for palliative care. He was administered medication to relieve pain. He passed away on 18 September 2020.

Investigation

Mr Mitsakis' fall from the ladder was unwitnessed, and it is not clear whether he lost consciousness initially before returning into the house. Examination of the site revealed that Mr Mitsakis likely fell five metres to the ground, possibly rolling down an embankment and coming to a stop on the concrete driveway.

It was observed by Mr Mitsakis' son-in-law, Russell Holywell, that the ladder had been set up in a relatively level area but that this area was at the top of a slope. There were indentations in the ground from the ladder. The right side was damp and had moss under it, and the foot of the ladder had sunken in further on this side than on the other one. The ladder had slipped to the right but landed against shrubbery which prevented it from falling completely. It was still resting against the side of the house after the fall. There were two pieces of blue twine in frayed and poor condition attached to the top of the ladder by Mr Mitsakis for the purpose of tying off the ladder to the house. Photographic and video evidence shows that one of the pieces of twine had been cut, and the other appeared frayed. It is unclear if this occurred after the accident to assist with the removal of the ladder. It may have been that the twine failed or that Mr Mitsakis did not tie off the ladder.

There were blocks of wood on the ground near the ladder, likely those normally used by Mr Mitsakis, to 'chock' the ladder. Mr Holywell had no knowledge of how Mr Mitsakis used these blocks to safely secure the feet of the ladder. Mrs Mitsakis stated Mr Mitsakis was usually *"religious about chocking the ladder in the past as he was terrified of falling off"*.

Unfortunately, it appears that Mr Mitsakis did not chock the feet of the ladder as was his usual practice and did not tie off the top of the ladder securely or at all. The twine attached to the ladder for this purpose was in poor condition. Whilst he was working, the ladder was not stable or secure and slipped sideways causing Mr Mitsakis to fall.

Comments and Recommendations

Over the years, there have been many instances of people suffering catastrophic injuries, sometimes not infrequently resulting in death, while performing home maintenance tasks using ladders. Often, these tasks are very familiar to the person who has engaged in them many times throughout their lives. Older males are over-represented in the deaths occurring in this manner.

Coroners in Tasmania have previously outlined basic safety precautions to be taken for the safe use of ladders.[1] I take this opportunity to repeat these as follows:

1. Take basic precautions before using the ladder:

    (a) Ensure the ladder is in good condition and set up on firm and stable ground.
    (b) Ensure the ladder is positioned so that it is neither too far from, nor too close to, the support structure.
    (c) 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).
    (d) Only ever undertake light work while on the ladder and then ensure three points of contact with the ladder are maintained at all times.

2. Realistically assess physical capability to perform the work. Consider whether any particular physical or mental limitations or disabilities may give rise to safety concerns or risk of injury in any given task. Review carefully whether the work can or should proceed safely in light of any such limitations.

3. Conduct a risk assessment. That is, take time before commencing to identify potential safety hazards in the proposed work. It is important to also consider in this assessment the 'worst case scenario' in respect of potential for injury. Steps should then be taken to minimise the risks of the occurrence of those events.

[1] 2014 TASCD 318, 2007 TASCD 004.

4. Take regular breaks from the work. As a general rule, a break of approximately 10 minutes every hour is advisable. This could vary depending on many factors such as age and physical make up. Many persons working on or around their homes are prone to work for long periods to achieve their desired objective. Regular breaks reduce the fatigue that may cause a loss of concentration. This precaution becomes more important for persons in the older age group.

5. Take care to comply as far as possible with any Australian Standard or other Code of Practice approved under s274 of the *Workplace Health and Safety Act* 2012 applicable to the task at hand so as to reduce the risk of injury or death. Members of the public are encouraged to seek advice by telephoning the WorkSafe Helpline on 1300 366 322. Copies of publications to assist with safety, such as use of ladders and working at heights, are available by request through the helpline or via the WorkSafe website at www.wst.tas.gov.au.

I convey my sincere condolences to the family and loved ones of Mr Mitsakis.

Dated: 17 December 2020 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner