



MAGISTRATES COURT of TASMANIA  
CORONIAL DIVISION



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## Record Investigation of into Death (Without Inquest)

*Coroners Act 1995*  
*Coroners Rules 2006*  
*Rule 11*

I, Simon Cooper, Coroner, having investigated the death of Lawrence Alan Howard

**Find, pursuant to section 28 (1) of the *Coroners Act 1995*, as follows**

- (a) The identity of the deceased is Lawrence Alan Howard;
- (b) Mr Howard died as a result of injuries sustained by him whilst felling a tree;
- (c) The cause of Mr Howard's death was multiple injuries, including vertebral fracture, erratic compression with rib fractures, lung collapse, haemorrhage, and liver laceration; and
- (d) Mr Howard died at Webberleys Road, Forthside in Tasmania.

Mr Howard lived at his home in Ulverstone with his wife of 38 years, Lorraine. The couple also owned a 60-acre block at Webberleys Road, Forthside. The block is, and was, a mixture of pasture and native bush.

Mr Howard's health was, given his age, very good. Apart from suffering mildly high blood pressure which was controlled with medication and a minor skin irritation at the time of his death, there were no medical issues of any concern.

He was happy and healthy at the time of his death.

It was Mr Howard's practice to spend many hours tending cattle, shearing, woodcutting and the like on the block at Forthside.

On the day of his death, Tuesday 23 July 2013, Mr Howard rose and had breakfast with his wife Lorraine. Lorraine left for work at about 7.15am. Mr Howard then travelled to the block to help the next-door neighbour lay some irrigation pipes. He spoke that morning to his son-in-law, Kevin Knowles, and told him that he was going to fall a tree. Mr Howard also told Mr Knowles it would be dangerous.

After helping his neighbour, Mr Jason McNeill, at Webberleys Road to lay the irrigation pipes (during which time he also told Mr McNeill that it was his intention to go to his own property to fall a tree), it is clear on the evidence that Mr Howard travelled the short distance to his block and attempted to fall a tree. In doing so, he was hit by the tree and suffered massive, fatal injuries.

Mr Howard was alone at the time of the accident which caused his death. At about 2.30pm, Mr Knowles, his son-in-law, headed up to the block to see how Mr Howard was getting on. He found Mr Howard, clearly deceased, underneath a tree some distance from that tree's stump. Mr Knowles telephoned emergency services who attended and commenced the management of the scene. It was quite apparent to both police and ambulance personnel, that Mr Howard was deceased and no attempts were made to resuscitate him. In the circumstances, this is a perfectly reasonable decision.

An investigation was commenced at the scene pursuant to provisions of the *Coroners Act* 1995. That investigation involved the attendance of uniform and forensic officers and, significantly, an expert in forest industry practices who was able to carry out an assessment of the scene.

Various exhibits including the chainsaw that Mr Howard was using, a blockbuster, safety helmet and hearing protection were seized under the provisions of the *Coroners Act* 1995.

Mr Howard's body was transported from the scene to the mortuary at the Launceston General Hospital, where Dr Fernando, Forensic Pathologist, carried out an autopsy. Dr Fernando expressed the view that the cause of Mr Howard's death was multiple fatal injuries due to a tree falling on his body. I accept this opinion.

The investigation leads me to conclude that Mr Howard died as a result of multiple injuries sustained when a tree he was felling on his property at Webberleys Road, Forthside struck him. The time of the accident was sometime between 11.30am (when he left Mr McNeill's property) and 2.30pm when his son-in-law, Mr Knowles, found him.

Mr Keith Eastley, who I accept as an expert in forest practices, furnished a comprehensive report as part of the investigation. He outlined a number of matters that contributed to the happening of the accident which caused Mr Howard's death. Fundamentally, the tree that Mr Howard chose to attempt to fall was very hazardous in that it was burnt and a double header, and situated on sloping ground. It is apparent that the techniques utilised by Mr Howard were not of an acceptable standard. Both scarf cuts did not meet, there was significant undercutting and the top cut was not of an adequate depth to the size of the tree. In addition, Mr Eastley identified that the back cut was not level and the cut had no hinge wood.

In addition, the circumstances surrounding Mr Howard's death, along with the circumstances surrounding five other recent chainsaw-related deaths, were reviewed as part of the coronial investigation by Mr Rick Birch, a forester who has been an accredited assessor and trainer in forest industry-related programs since 1999.

The chainsaw used by Mr Howard, a Stihl 039, was in good condition and was fitted with a new 24 inch bar and new chain. All safety features were fitted to the chainsaw and were operating. I am satisfied that the chainsaw in no way caused or contributed to the happening of the accident.

The investigation revealed that Mr Howard had been felling trees on a casual basis for some years. However, it is apparent that techniques adopted by him, at least on the occasion the

subject of this investigation, fell well short of basic safety techniques. There was no evidence that he underwent any formal training in relation to safe tree felling techniques. It is clear, and I find, that the lack of training and the poor techniques adopted by Mr Howard regrettably caused the accident which led to his death. His death was entirely avoidable.

### Comments and Recommendations

Section 28 (2) of the *Coroners Act* 1995 provides that a “coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate”.

The power to make recommendations pursuant to this provision is not one to be exercised at large but rather by reference to matters associated with, relating to or connected with the death the subject of inquiry. Nathan J said in *Harmsworth v The State Coroner* [1989] VR 989 at 996:

*“the power to comment, arises as a consequence of the obligation to make findings... It is not free ranging. It must be comment “on any matter connected with the death”. The powers to comment and also to make recommendations.... are inextricably connected with, but not independent of the power to enquire into a death or fire for the purposes of making findings. They are not separate or distinct sources of power enabling a coroner to enquire for the sole or dominant reason of making comment or recommendation. It arises as a consequence of the exercise of a coroner’s prime function, that is to make findings.”*

It is important also to recognise that the power reposed in a coroner by section 28 (2) is to be exercised primarily to attempt to prevent further deaths.

Given the circumstances of the death of Mr Howard is similar to the circumstances of the deaths of Mr Dransfield, Mr Hyland, Mr Mitchell, Mr Spanney and Mr Young, I consider it useful to address the issues arising from all the deaths at the same time.

Clearly, if safely used, a chainsaw is a very useful tool with a multiplicity of applications, especially in the rural sector. On the other hand if not used safely, a chainsaw, especially when felling trees, is inherently extremely dangerous.

Death as a result of the use of chainsaws and tree felling is prevalent in Australia and disproportionately so in Tasmania. Data kept by the National Coronial Information Service indicates that at least 99 deaths occurred in Australia between 2000 and 2016 as a result of chainsaw use and tree felling. Of those deaths 23, or roughly a quarter, occurred in Tasmania. Tasmania’s population is just 2.15 % of the national population. It is also very apparent that deaths arising out of chainsaw use in general and tree felling in particular account for a considerable percentage of accidental deaths occurring in rural areas of Tasmania.

It is also quite apparent that there are a number of common factors which caused or contributed to the deaths of each of these men mentioned above. Those factors include (except for Mr Mitchell) a lack of any, or any formal, training. In the cases of Mr Mitchell, Mr

Dransfield and Mr Hyland the absence of any, or any proper personal protective equipment (PPE); and in the cases of Mr Howard, Mr Young, Mr Dransfield and Mr Mitchell poor tree felling techniques; and in the cases of Mr Spanney very dangerous chainsaw use practices. In every case death was, tragically, entirely avoidable had proper precautions been taken, tree felling techniques adopted and/or PPE used and worn. Given these factors I have determined that it is appropriate to consider the issue of whether to make recommendations, and if so what recommendations, in relation to each of the 6 deaths collectively.

In my view the circumstances of each death calls for the making of recommendations to attempt to prevent similar deaths from occurring in future. Each death was completely avoidable. It is important to ensure, to the extent possible, that lessons are learned from each death the subject of investigation so as to prevent, also to the extent possible, people making the same basic and deadly mistakes in the future.

Two very useful starting points for a consideration of the best safety practices in relation to chainsaw use are Forest Safety Code and the applicable Australian Standards.

The Safety Standards Committee of the Tasmanian Forest Industries Training Board Inc. published in 2007 the Forest Safety Code (Tasmania) 2007. The Code deals with all aspects of safety and hazards in forestry operations. Especially relevant in the current context are parts 4 and 5 which deal with Chainsaw operation and manual tree felling respectively. The code outlines safe methods of chainsaw operation and manual tree felling and references Australian Standard 2727 – Safe Chainsaw Operations (AS 2727). The code outlines the importance of risk assessment, the basic equipment required, and mandates that ‘all manual tree felling operations are to be carried out in accordance with AS 2727’. It depicts both the proper positioning of cuts (Figure 3) and appropriate, alternative and cleared escape paths (Figure 4).

The Code also provides (at 5.8) that de-limbing or cross cutting should not be carried out from the downhill side of the log if the log has the potential to roll. Great emphasis is placed on appropriate safety procedures. The code, although directed towards forest industry, is directly relevant to non-industry use of chainsaws as well. It is easy to understand. It should be followed by non-professional chainsaw operators and tree fellers.

Section 4 of Australian Standard 2727 deals in much more detail with the safe operation of chainsaws. It recommends the use of helmets (see 4.4(c)). It deals with site evaluation, tree assessment and worksite preparation before tree felling is attempted (see 4.5.3.2, 4.5.3.3 and 4.5.3.4 respectively). Those parts of the standard provide an easily understood guide to safety which, if followed, would likely have avoided several of the deaths the subject of these enquiries.

Section 4.5.3.5 of AS 2727 deals with the process of actually felling trees. It is worth setting out in full.

*“The felling operation - All trees should be felled using a scarf and back cut.*

*The basic requirements for tree felling are shown in Figure 4.10 and are described as follows:*

*(a) Scarf - The principal function of the scarf is to direct the falling tree in the desired direction. The scarf should determine the direction of the fall. Cuts used to form the scarf should meet with no overcutting or undercutting and should be cleaned out. There are several types of scarf.*

*(b) Back cut - The back cut releases the tree, allowing it to fall, and is made after the scarf has been cut. The back cut should be horizontal and placed above the bottom of the scarf, forming a step which is intended to prevent the tree from sliding back over the stump during the fall.*

*(c) Holding wood - The holding wood acts as a hinge which controls the tree's fall. The holding wood should be intact across the stump to maintain the direction of fall."*

It is apparent that compliance with the basic safety requirements set out in the Code and the AS 2727 will prevent fatalities in the future and would have prevented most of the fatalities the subject of these investigations.

I also observe that a fundamental issue in each case (except possibly Mr Mitchell's death) was the absence of training. It is no answer to an absence of formal training to say that a person has been using a chainsaw for 'years' without incident. All that this means is that a person has practical experience; it in no way ensures correct techniques are used, because those techniques must be properly learnt in the first place. Training and at least some basic level of competency assessment is, in my view, essential. Training and assessment is of limited value if skills and techniques are not reasonably regularly reviewed.

In addition, as part of the investigation into these deaths, comment and assistance was sought from the three bodies identified as likely having the most contribution in relation to chainsaw and tree felling safety; namely the Forest Industries Association of Tasmania, WorkSafe Tasmania and the Tasmanian Farmers and Graziers Association (TFGA). Only the TFGA responded to the invitation to make a submission. No response, or even acknowledgement of the invitation, was received, at all, from either the Forest Industries Association of Tasmania or WorkSafe Tasmania.

The TFGA acknowledged that deaths relating to the use of chainsaws occur all too frequently and are a matter of great concern to the association and its members. The association observed that it was notable that persons who had received training were significantly under-represented amongst those suffering fatal injuries from chainsaw uses. This is undoubtedly correct and serves to highlight the importance of training to assist to avoid preventable deaths in the future.

I turn to the making of formal recommendations. I acknowledge that for the recreational or non-business chainsaw user it is important regulatory requirements are not unduly onerous. However presently there is no regulation, at all, of the non-work related chainsaw use, and particularly tree felling. This is in contrast to boat and firearm use. I note that currently it is possible to purchase a chainsaw from retail outlet other than specialist dealers, a situation that is very similar to the pre-firearm regulation position with respect to weapons and ammunition. I also note that there is no age limit, at all, on the use of a chainsaw for any

purpose, including tree felling. It is acknowledged that none of the men whose deaths have been investigated were children, but that is, in my view not to the point.

I make the following recommendations:

- I **recommend** that all chainsaw operators must undertake approved chainsaw training prior to purchasing or using a chainsaw.
- I **recommend** that all persons selling chainsaws must be accredited chainsaw operators.
- I **recommend** that all chainsaw operators must undergo regular practical reassessment.
- I **recommend** that all land owners be required to ensure that people permitted to use chainsaws on their land be appropriately qualified.
- I **recommend** that no person under the age of 16 years be permitted to own or use a chainsaw in any circumstances.

I thank the TFGA for its helpful submission. I acknowledge the contribution of Mr Keith Eastley to this investigation.

I express my sincere thanks to Mr Rick Birch for the very great assistance he provided to the Coronial Division in relation to the investigation of Mr Howard's death as well as the 5 other deaths referred to in these recommendations and comments.

In conclusion I convey my sincere condolences to the family and loved ones of Mr Howard.

**Dated** 11 August 2017 at Hobart in the State of Tasmania.

**Simon Cooper**  
**Coroner**