MAGISTRATES COURT TASMANIA

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## CORONIAL DIVISION

# Record of Investigation into Death (Without Inquest)

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

**(These findings have been de-identified in relation to the name of the deceased and family by the direction of the Coroner pursuant to s 57(1)(c) of the Coroners Act 1995)**

I, Leigh Mackey, Coroner, having investigated the death of LO

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

a) The identity of the deceased is LO (date of birth 1 March 1960).

b) LO was married to NQ. In early 2008 they moved to Tasmania from Sydney eventually settling on acreage at Gunns Plains in the state's northwest. He held bachelor's and master's degrees in nursing and diplomas in other disciplines including counselling. He worked as a senior nurse at the North West Regional Hospital until his retirement in 2021.

LO did not smoke or regularly consume alcohol. Whilst he experienced some issues of pain and swelling in his knees he was physically fit and in good health. During his retirement LO enjoyed maintaining his rural property, including regular tree clearing, and was an active member of the Central Coast State Emergency Service (SES).

LO joined the SES on 6 February 2023 and was a member of its Central Coast Unit. He undertook training in several competencies including Bushfire Awareness, Rapid Impact Assessment, Traffic Control, Core Training, Rescue Skills and first Aid. LO participated in an SES delivered "trim and crosscut" chainsaw course and was assessed as competent in that course on 28 October 2023. The course focused on the use of chainsaws to "*cut storm damaged and fallen trees or branches"* and included training on creating a safe work area and undertaking risk assessments. The training specified that it did not equip or authorise a member to fell trees.[1] SES members do not fell trees as part of their duties

[1] SES Chainsaw operators Learner Guide (version 1.0 February 2020) p11.

and have a protocol to follow when engaging with private or public property owners regarding the felling of trees when responding to emergency events. The protocol places the obligation on property owners to make private arrangements for the felling of trees.

LO had significant experience operating a chainsaw whilst maintaining his property at Gunns Plains including using a chainsaw to fell trees. He demonstrated some awareness of his limitations as evident in his decision to engage a specialist to remove a tree from his property that he considered unsafe to manage himself. He was usually a cautious and meticulous planner.

Ms Netra Free operates a Buddhist monastery in Golden Valley located in the Western Tiers region of northern Tasmania approximately 100 km southeast of Gunns Plains. LO attended the property at times for meditation. LO offered to undertake work on the property including the felling of trees. LO assured Netra that he was competent and careful. On 2 November 2023 he felled a gum tree on the property without incident.

On the morning of 23 November 2023, LO returned to the property to complete further work including the felling of a tree. He arrived after Netra had left and was alone at the property. The tree to be felled, a black wattle, was large and twisted. The tree was approximately 18 m tall, with a 40 cm – 50 cm diameter and was located near a dwelling. LO utilised wedges and a system of rope pulleys and ratchet to direct the fall of the tree away from the dwelling. He was wearing a hard hat and safety googles as he felled the tree.

Based on the physical evidence at the scene, LO rigged up ropes and ratchet and tightened the ratchet to cause the tree to fall. As the tree fell he attempted to move out of its way from where he stood at the ratchet, approximately 2.5 m along the path of its fall, towards the tree's head. He failed to clear the tree and the head of it fell on his back crushing him.

Netra returned to the property between 4.30pm and 5.00pm. She prepared food for LO and took it to where she believed he was working in a paddock approximately 500 m from the main residence. When she arrived at the paddock, she found him deceased underneath the fallen tree. She contacted emergency services.

c) Post-mortem examination identified LO sustained traumatic abdominal wall hernia, bilateral rib fractures crush injuries of the pelvis, fractures of right radius and ulna, and open displaced right ankle fracture as a result of being crushed by the tree. Toxicological analysis of a postmortem sample of LO's blood revealed the presence only of caffeine.

LO's death was accidental. The weather and environmental conditions in which he was working did not contribute to the accident. The tree fell on him as he was attempting to cut it down causing a significant crushing injury which was not survivable. I find that the tree fell on LO because it had fallen unpredictably either as to the timing of or direction of its fall.

d) LO died on 23 November 2023 at Golden Valley, Tasmania.

In making the above findings I have had regard to the evidence gained in the investigation into LO's death. The evidence includes:

- The Police Report of Death for the Coroner;
- Affidavits confirming identity;
- Opinion of the forensic pathologist regarding cause of death;
- Affidavit of NQ, sworn on 22 March 2024;
- Affidavit of Netra Free, sworn on 5 April 2024;
- Tasmanian Family Medical and Tasmanian Health Service records;
- Police investigation and corresponding affidavits; and
- Brief, training materials and email provided by State Emergency Services (SES).

**Comments and Recommendations**

I extend my appreciation to investigating officers First Class Constable Jessica Weston and Constable Jorge Amaya for their investigation and report.

LO was by all accounts fit, resourceful, intelligent and safety conscious. He ensured the weather conditions were appropriate for the task of felling the tree. He utilised appropriate equipment in an to attempt to steer the fall of the tree in a safe direction.

On 11 August 2017 Coroner Cooper, made recommendations regarding the deaths of six men, Kenneth Spanney, Dylan Young, Lawrence Howard, Kenneth Mitchell, Tobias Hyland and Brian Dransfield all of whom had died whilst privately felling

trees.[2] He observed that deaths resulting from chainsaw use generally and tree felling particularly, were statistically prevalent in Australia and disproportionally so in rural Tasmania. This observation could equally be made today as the number of deaths resulting from chainsaw use and tree felling remains significant.

One of the factors Coroner Cooper identified as common to the deaths he investigated was the absence of training. This factor is relevant to the death of LO. LO's death, like those six investigated by Coroner Cooper, was avoidable. In the exercise of his function to prevent future deaths Coroner Cooper made recommendations directed toward the training and accreditation of private operators of chainsaws. None of the recommendations have been adopted in the nine years since they were made. In 2023 the Executive Director of the Consumer Building and Occupational Services (CBOS) advised that CBOS, because of Coroner Cooper's investigation and recommendations and at the request of the former Minister for Workplace Safety and Consumer Affairs, engaged with jurisdictions Australia wide to investigate what is done in those jurisdictions regarding chainsaw licencing and use. It was found that no other jurisdiction required training or licensing for the private use of chainsaws and nor was regulation being then considered. CBOS concluded that the regulation of the private use of chainsaws fell outside its legislative framework.

No regulatory barriers or requirements apply to operating a chainsaw and cutting down a tree privately, whilst, in a commercial and industrial setting, given the intrinsic dangers of chainsaw operation and tree felling, significant regulation and controls apply. The circumstances of LO's death highlights that felling trees is dangerous and unpredictable. Only those that possess specific training and expertise in the skill of tree felling ought to undertake the task. Whilst cognisant of the difficulties of regulating a private activity, the foreseeable and avoidable dangers of those untrained in the intricacies of tree felling and the ongoing occurrences of such deaths causes me, pursuant to Section 28 of the *Coroners Act* 1995, to **recommend**:

1. The Tasmanian government investigate and implement regulating private tree felling activities in Tasmania such that tree felling is only undertaken by persons trained and accredited in that activity.

[2] Spanney, Kenneth David (2017 TASCD 327) [2017] TasCorC 45; Young, Dylan Broderick Ernest (2017 TASCD 328) [2017] TasCorC 44; Howard, Lawrence Alan (2017 TASCD 324) [2017] TasCorC 43; Mitchell, Kenneth Hudson (2017 TASCD 326) [2017] TasCorC 42; Hyland, Tobias Joseph (2017 TASCD 325) [2017] TasCorC 41; Dransfield, Brian (2017 TASCD 323) [2017] TasCorC 46.

2. The Tasmanian government create and promulgate education to increase public awareness of the dangers of tree felling by those who lack specialised training.

3. The Tasmanian government investigate further the implementation of the recommendations made by Coroner Cooper in his investigation of the six deaths referred to in these findings.

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

**Dated**: 14 July 2026 at Hobart, in the State of Tasmania.

**Leigh Mackey**
**Coroner**