



# MAGISTRATES COURT *of* TASMANIA

## CORONIAL DIVISION

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### **Record of Investigation into Death (Without Inquest)**

*Coroners Act 1995  
Coroners Rules 2006  
Rule 11*

I, Olivia McTaggart, Coroner, having investigated the death of Colin George Williamson,

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

- a) The identity of the deceased is Mr Colin George Williamson;
- b) Mr Williamson died as a result of injuries sustained in a tree felling accident;
- c) The cause of death is severe head and chest trauma; and
- d) Mr Williamson died on 23 January 2018 at Forthside, Tasmania.

#### **Introduction**

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

- The Police Report of Death;
- An opinion of the pathologist who conducted the autopsy;
- Affidavit of Kathleen Williamson, wife of Mr Williamson;
- Affidavits of Warren Parker and James Morris, who were felling trees with Mr Williamson at the time of his death;
- Affidavits from attending and investigating police officers;
- Expert report from Rick Birch, Industry Trainer and Assessor;
- Medical records and reports; and
- Forensic and photographic evidence.

#### **Background**

Colin George Williamson was born on 8 September 1945 in Manchester, United Kingdom. He was aged 72 years at the time of his death. During his working life, he had predominantly been employed as an insurance inspector.

Mr Williamson met his wife, Kathleen, in England in 1964 and they had been married for 50 years. They have two children together. In 1981, the family migrated to Australia and moved to Devonport.

Mr Williamson was in good health at the time of his death and had no known medical issues. He maintained an active and healthy lifestyle and had a good level of physical fitness.

Mr Williamson maintained an active hobby in woodcutting. According to Mrs Williamson, who provided an affidavit for the investigation, her husband had extensive experience, having been involved in woodcutting for around 30 years in various capacities with his friend, John Morris.

Mr Williamson previously held an Operator's Licence which was issued in 2008 by the Tasmanian Forest Industries Training Board Inc. categorised for chainsaw use and non-forest harvesting. This licence expired in 2011 and Mr Williamson did not subsequently renew it. Mrs Williamson notes that Mr Williamson always wore a protective helmet and a high visibility vest when woodcutting.

Prior to Mr Williamson's death, he and Mr Morris had an arrangement to assist Warren Parker with clearing a number of large trees on Mr Parker's property at 117 Forthside Road, Forthside in order to sell the wood as a small business opportunity.

At 8.00am on 23 January 2018, Mr Williamson arrived at 117 Forthside Road with Mr Morris to meet with Mr Parker. They had been clearing trees in this area for a number of weeks and, on this day, there were three more trees they intended to fall. The party of three took turns as to who performed particular tasks on this day.

During the morning they felled two trees. When it came time to fall the third and final tree, Mr Parker was tasked to operate the chainsaw, Mr Williamson was tasked to operate the log splitter and wedges, and Mr Morris was tasked to stand at the top of the hill to keep watch for safety purposes. Mr Williamson was wearing a protective helmet and a high visibility vest at this time.

After working on the third tree for "a couple" of minutes, the tree began to move in a downhill direction and Mr Williamson and Mr Parker stopped working on the tree. At this time, one of the branches on the tree became caught on another tree's branch. This caused the tree to begin to twist at the cut in the trunk and fall in an unintended uphill direction. Due to the branch on the felled tree being caught, it snapped off. The branch fell and hit Mr Williamson directly on his head.

Mr Williamson fell to the ground as a result of this impact and was unresponsive. Mr Morris called the ambulance and Mr Parker went to the bottom of his driveway to direct the ambulance.

Tasmania Ambulance Service and Tasmania Police arrived at the scene. Paramedics attempted CPR on Mr Williamson, with no response. After a period of 15 minutes, paramedics ceased CPR and Mr Williamson was declared deceased at the scene.

Police officers examined the scene before Mr Williamson's body was conveyed to the Launceston General Hospital by mortuary ambulance. Police observed Mr Williamson's orange safety hat at his feet. The strap to the safety hat was broken, and its internal straps were torn. Blood was on the inside of the hat and green bark was on top of the hat.

A large branch was lying by Mr Williamson's feet beside the cut stump of the tree. The bark of the branch was shredded near the safety hat. The branch was 15.5 metres in length, and 11.5 metres from its base to the area of damaged bark beside the helmet. The diameter of the branch at this point was approximately 10 centimetres. The cut tree stump was approximately 1 metre high and 0.5 metres in diameter. The fallen tree was approximately 27 metres long, and its broken limb was 10.4 metres from the sawn base of the trunk.

On 24 January 2018, a post-mortem examination of Mr Williamson was conducted by pathologist, Dr Terry Brain. Dr Brain concluded that death was due to multiple severe traumatic injuries as a result of the impact of the tree branch. Dr Brain particularly noted the presence of a flailed chest, two significant cranial fractures and a subarachnoid haemorrhage.

Toxicological testing revealed that Mr Williamson had no alcohol or drugs of any kind in his system at the time of his death.

I am satisfied that Mr Williamson died from severe head and chest trauma in the accident. I am further satisfied that no suspicious circumstances existed.

### **Comments and Recommendations**

Unfortunately, tree felling accidents involving chainsaws, such as that causing Mr Williamson's sudden death, are frequently encountered by coroners. Such incidents have been prevalent in Australia and are over-represented in Tasmania, particularly within rural areas.

In August 2017, Coroner Cooper published findings in respect of six deaths associated with chainsaw use and tree felling.<sup>1</sup> It was observed by Coroner Cooper that the common factors that lead to deaths associated with the use of chainsaws and tree felling are a lack of training, failure to wear protective equipment, poor tree felling techniques and dangerous chainsaw use practices.

In this case, Mr Rick Birch, Industry Trainer and Assessor, reviewed the evidence at my request. Mr Birch noted that Mr Williamson had previously held a Forest Works Licence issued by the Tasmanian Forest Industries Training Board but that it had lapsed. He noted that this licence was only issued for the trimming and cross cutting of fallen trees and timber and it did not cover tree felling techniques or practices at all.

Mr Birch, in his report, set out the five nationally recognised training units of competency covering tree felling. These range from the basic non-commercial training unit through to the advanced commercial operator's unit. I am satisfied that Mr Williamson had not undertaken any of these units. I have no evidence that Mr Parker or Mr Morris held current competencies in these training units.

Mr Birch, in reviewing the evidence, formed the view that there were numerous mistakes made by Mr Williamson, Mr Parker and Mr Morris in felling the tree that caused Mr Williamson's death. These mistakes included a scarf cut of insufficient depth and which was internally uneven and a back cut that was not level and which left no hingewood at all (therefore losing control of the direction of the fall). He also noted that Mr Williamson himself failed to leave the base of the tree via a safe escape route. He provided with his report a copy of the *Forest Works Tree Fallers Manual*, supporting the National Training Competencies, in support of his analysis. Mr Birch was of the view that if any of the training units referred to above had been completed by Mr Williamson and Mr Parker, the mistakes that were made would have been addressed during the training and assessment process.

Whilst Mr Williamson wore a safety helmet, the helmet straps appear to have failed in the incident or, alternatively, the strap was not properly fastened. The helmet was therefore dislodged and the branch impacted directly with his unprotected head. Additionally, the helmet bore a stamp indicating that it was manufactured in 1994. Its age alone means that it was not

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<sup>1</sup> See *Dransfield, Brian* 2017 TASCDC 323; *Howard, Lawrence Alan* 2017 TASCDC 324; *Hyland, Tobias Joseph* 2017 TASCDC 325; *Mitchell, Kenneth Hudson* 2017 TASCDC 326; *Spanney, Kenneth David* 2017 TASCDC 327; *Young, Dylan Broderick* 2017 TASCDC 328.

compliant with the applicable Australian Standard. If it had remained upon Mr Williamson's head it may have prevented his head injury.

In the findings of Coroner Cooper in 2017, he made the following recommendations:

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

These recommendations were repeated by Coroner Cooper in two further findings.<sup>2</sup> I am not aware that any agency or body has taken steps to implement these recommendations. There is force in the recommendations in light of the prevalence of deaths in this state.

I **recommend** that the responsible agency considers regulatory reform directed at preventing deaths and injuries arising from the use of chainsaws by members of the community.

I convey my sincere condolences to the family and loved ones of Mr Colin George Williamson.

**Dated** 10 August 2020 at Hobart Coroners Court in the State of Tasmania.

**Olivia McTaggart**  
**Coroner**

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<sup>2</sup> See *Kingston, Neil Robert* 2017 TASCDC 439; *Fletcher, Braidon Lewis* 2018 TASCDC 300.