



MAGISTRATES COURT of TASMANIA
CORONIAL DIVISION



Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Braidon Lewis Fletcher

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

- a) The identity of the deceased is Braidon Lewis Fletcher;
- b) Mr Fletcher died as a result of injuries sustained by him when struck by a tree, as further detailed in the finding below;
- c) The cause of Mr Fletcher's death was blunt trauma of the head; and
- d) Mr Fletcher died on 14 January 2017 near Recherche in Tasmania.

The role of the Coroner

1. A coroner in Tasmania has jurisdiction to investigate any unexpected death which results directly or indirectly from an accident. In this case there is no doubt that Mr Fletcher died as a result of an accident, and his death was unexpected and therefore had to be investigated in the coronial jurisdiction.
2. When investigating any death, whether or not an inquest is held, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. She or he is required to thoroughly investigate a death and to make findings with respect to that death. This process requires the making of various findings, but without apportioning legal or moral blame for the death (see *R v Tennent; ex parte Jaeger* [2000] TASSC 64, per Cox CJ at paragraph 7). A coroner is required to make findings of fact from which conclusions may be drawn by others (see *Keown v Khan* [1998] VSC 297; [1999] 1 VR 69, Calloway JA at 75 - 76).
3. A coroner neither punishes nor awards compensation - that is for other proceedings in other courts, if appropriate. Nor does a coroner charge people with crimes or offences

arising out of death the subject of investigation. In fact a coroner in Tasmania may not even say that he or she thinks someone is guilty of a crime or offence (see section 28 (4) of the Coroners Act 1995).

4. One matter that the Act requires a finding to be made about is how death occurred (see section 28 (1) (b) of the Act). Any coronial inquiry necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by section 28 (1) (b) upon the coroner.

Mr Fletcher's Background

5. Mr Fletcher was born in Hobart, Tasmania, on 14 January 1996; and died on his 21st birthday. He was raised and educated in Triabunna. His mother describes him as involved in many outdoor activities growing up, something which continued into his short adult life.
6. He had some experience in the use of chainsaws, but there is no evidence he ever undertook any formal training in their use.
7. Mr Fletcher was popular and outgoing with many friends. He organised to celebrate his 21st birthday with his girlfriend, Natalie Pearce, and four other friends, Jeremy Jacobs, Jackson Sutherland, Matthew Scofield and Jonathan Ayton, camping at Cockle Creek, Recherche Bay in the far south of Tasmania.
8. The group arrived and set up camp at Gillams Beach campground, near Cockle Creek at about 9.30 pm on Friday 13 January 2017. The evidence is that Mr Fletcher went to bed around 3.00 am.

Circumstances of Death

9. At about 10.30 am on Saturday 14 January the group set off in 4-wheel drive vehicles to explore the general area and obtain some fire wood. Shortly after lunch Mr Fletcher and his friends made their way up a logging track near Spur 20, off the South Cape Road. A short distance up the track the group stopped, having found some standing dead trees identified as being suitable for fire wood.
10. Mr Fletcher, Mr Jacobs and Mr Ayton went to look at the trees, with a view to selecting a tree to fall. Ms Pearce, Mr Sutherland and Mr Schofield remained in Mr Schofield's Ute. It was very windy in the area.

11. At about 1.45 pm Mr Fletcher selected a tree to be felled and Mr Ayton, using Mr Fletcher's chainsaw, and under instruction from both Mr Fletcher and Mr Jacobs, commenced the task of attempting to fall the tree. Mr Ayton had never undertaken any formal training in the use of a chainsaw, let alone in safe tree falling techniques.
12. The chainsaw became jammed in the tree when the tree leaned onto the bar of the saw as Mr Ayton was cutting. In the circumstances the only possible explanation for that happening is poor tree falling technique, something, given Mr Ayton's inexperience with the use of chainsaws, is hardly surprising.
13. The men did not have with them wedges or an axe which are essential safety items and necessary equipment to free a jammed saw bar. In fact they had no safety equipment with them at all. Aside from Mr Jacobs, who had completed a course to trim and cross cut trees (which course makes abundantly plain that successful completion of it does not qualify a person to fall trees), no-one present seems to have had any formal qualifications in the use of chainsaws at all. And certainly no-one present had any qualifications in tree falling.
14. A decision was made collectively by Mr Fletcher, Mr Ayton and Mr Jacobs, to attempt to free the jammed saw by attaching one end of a four wheel drive vehicle recovery (or snatch) strap to the tree and the other to Mr Jacobs' Landcruiser Flat Tray ute and pulling the tree down. The evidence is that Mr Jacobs attached the strap to the tree and Mr Fletcher attached the other end to the vehicle.
15. Mr Jacobs then entered the cab of his vehicle and moved it forward, taking up the slack on the strap and pulling the tree forward. Mr Fletcher, who inexplicably remained in the area between the tree and the Ute, was struck in the head by the tree as it fell forward. He was not wearing a helmet.
16. The decision to pull the tree down using the recovery strap caused Mr Fletcher's death. That decision would have not been made by any person with even a modicum of experience in the use of a chainsaw. The decision would have been wholly unnecessary if wedges and an axe had been available to free the trapped bar of the saw.
17. His friends rushed to his assistance, called 000 for help and rendered what first aid they could.
18. Ambulance Tasmania personnel were paged at 1.54 pm and an ambulance left immediately from Huonville under lights and sirens, arriving at the accident scene at

2.42 pm. Whilst the ambulance was en route the rescue helicopter was also despatched with 2 rescue paramedics on board. Upon the arrival of the road ambulance, Intensive Care Paramedic Dale Watson observed Mr Fletcher to be unconscious, cyanosed, breathing quickly and fitting. He saw that he had lost a considerable amount of blood. In light of the fact that Mr Fletcher's condition was obviously critical and in view of the high winds in the area, a decision was taken by Paramedic Watson to load Mr Fletcher immediately into the ambulance. Once in the ambulance he was treated by Paramedic Watson and Volunteer Ambulance Officer (VAO) Ray Crowden with oxygen, a pharyngeal airway was inserted and drugs administered through an IV line. Shortly before the arrival of the helicopter with the rescue paramedics on board another Volunteer Ambulance Officer Madeleine Crawford arrived in her private vehicle to assist.

19. At about 2.53 pm, just as the helicopter was heard overhead by the ambulance officers, Mr Fletcher stopped breathing. Paramedic Watson and VAOs Crowden and Crawford immediately commenced intermittent positive-pressure ventilation using a bag and mask. The two Rescue Paramedics Andrew Summers and Andrew Johnson were lowered to the scene by winch just before 3.00 pm and assisted with resuscitation attempts. Attempts at resuscitation continued until 3.26 pm, when after consultation with Ambulance Tasmania's Clinical Coordinator, all treatment was ceased and Mr Fletcher was pronounced deceased.

The Investigation

20. Constable Paul Kruse from Geeveston, the first police officer on the scene, arrived at about 2.50 pm. Constable Tony Cooper from Huonville arrived shortly after. The two officers commenced an investigation under the *Coroners Act* 1995 as soon as they were advised that Mr Fletcher had died. Criminal Investigation Branch and Forensic Services officers were tasked to attend and assisted with the investigation.
21. The scene was examined carefully and photographed. A reconstruction of how the accident had occurred was carried out, photographed and filmed. Mr Fletcher's friends and partner were interviewed and statements taken. The chainsaw, recovery straps and a bow shackle involved in the accident were seized for subsequent examination.
22. Nothing was identified at the scene to suggest that Mr Fletcher's death was due to anything other than a tragic, but completely avoidable, accident.

23. Mr Fletcher's body was formally identified and then transported to the Royal Hobart Hospital. At the hospital an autopsy was carried out on Mr Fletcher's body by experienced forensic pathologist, Dr Donald McGillivray Ritchey. Dr Ritchey found that Mr Fletcher had a 3 cm scalp laceration overlying comminuted depressed fractures of his skull. Toxicological analysis of samples taken at autopsy were unremarkable. No alcohol or illicit drugs were identified as being present in Mr Fletcher's body. Dr Ritchey expressed the opinion, which I accept, that the cause of Mr Fletcher's death was blunt trauma to the head.
24. The chainsaw was subsequently examined by a qualified small engine mechanic in the employ of a reputable chainsaw dealership. The chainsaw was found to well maintained and in good working order. I am satisfied that nothing about it caused or contributed to Mr Fletcher's death.

Comments and Recommendations

25. 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".
26. 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"."
27. 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. Obviously not all accidental deaths are avoidable. However, Mr Fletcher's death was completely avoidable, had some extremely basic safety precautions been followed.

28. Last year I investigated 6 deaths arising out of the use of chainsaws. In each of those cases I made recommendations. Those recommendations are worth repeating.
29. I said in relation to the deaths of Kenneth Spanney, Brian Dransfield, Lawrence Howard, Toby Hyland, Kenneth Mitchell and Dylan Young:

"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... a lack of any, or any formal, training... the absence of any, or any proper personal protective equipment (PPE); ... Poor tree felling techniques; and..., 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 crosscutting 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 the 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 4.532, 4.533 and 4.534 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 4.535 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.

.....

I turn to the making of formal recommendations. I acknowledge that for the recreational or non-business chainsaw user it is important that 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 a 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 landowners 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.*

30. I can only repeat those recommendations. Once again it is necessary to comment upon a tragic but wholly avoidable death. Once again it is hoped that further unnecessary deaths arising from chainsaw use can be avoided in the future.

31. I commend the efforts of Paramedic Watson and VAOs Crowden and Crawford at the scene. I also commend the efforts of the police involved generally, but in particular those of Constable Kruse and Constable Cooper.

32. I convey my sincere condolences to the family and loved ones of Braidon Lewis Fletcher.

Dated 26 July 2018 at Hobart in the State of Tasmania.

Simon Cooper
Coroner