



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 Tobias Joseph Hyland

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

- a) The identity of the deceased is Tobias Joseph Hyland;
- b) Mr Hyland died as a result of injuries received by him when struck by a falling tree;
- c) The cause of Mr Hyland's death was blunt traumatic injuries of the head; and
- d) Mr Hyland died at Diamond Tier, in the Central Highlands of Tasmania, on 15 November 2015.

Tobias Joseph Hyland, always known as Toby, was born on 4 December 1992 at the Royal Hobart Hospital to Robert and Shirley Hyland. He had an older brother, James. He was educated at St Virgil's College and a fully qualified sprinkler fitter by trade. Close to his family, he was still living at home at the time of his death. His father and he would often spend time together in the bush and had been doing so since Mr Toby Hyland was a young boy.

Mr Hyland was a healthy, happy and popular young man with no illnesses or medical conditions.

On the morning of Sunday 15 November 2015, having spent the night at a shooter's camp on a property known as Diamond Tier, Mr Hyland and his father travelled by four-wheel-drive to a remote area of bushland on the property to cut wood. Mr Robert Hyland felled a tree using his chainsaw, and he and his son waited for five minutes for any limbs to fall out of surrounding trees. None did. Being satisfied that it was safe they began to cut and split wood from the fallen tree. Neither were wearing any safety equipment, although I am satisfied the absence of any safety equipment had no bearing upon the tragedy which ensued.

After about 15 minutes cutting wood and filling the back of the four-wheel-drive Toyota LandCruiser ute, Mr Robert Hyland reported hearing a loud crack. He looked around in the direction of the noise and saw a limb falling slowly high up in one of the surrounding trees. He described seeing it falling through another limb in the direction of Mr Toby Hyland who was facing his father and heading back to the ute. Mr Robert Hyland warned his son to run.

He did so. After approximately two steps the limb struck him on the head, up the back area and shoulders, which caused him to fall face first onto the ground and then roll onto his back.

Mr Toby Hyland suffered terrible injuries to his head which caused him to die almost instantaneously. His father attempted CPR but was unable to save him.

Mr Robert Hyland tried to call for help but had no mobile phone reception. He sat with his son for a time and eventually left and drove away from the accident scene so he could call for help.

Police and paramedics made their way to the scene. There was nothing that could be done for Mr Toby Hyland. After formal identification his body was removed from the scene by mortuary ambulance and transported to the Royal Hobart Hospital. There forensic pathologist, Dr Donald McGillivray Ritchey, in accordance with the wishes of Mr Toby Hyland's family, performed an external examination on his body. Dr Ritchey expressed the opinion after that examination that the cause of Mr Toby Hyland's death was blunt traumatic injuries of the head. I accept this opinion.

A blood sample taken by Dr Ritchey when he examined the body was subsequently analysed at the laboratory of the Forensic Science Service Tasmania. No significant toxicology was identified as being present in that sample.

There is nothing to suggest that Toby's death was in any way suspicious or anything other than a terrible accident.

Mr Toby Hyland and his father took precautions prior to felling the tree, including studying the tree they intended to fall, determining which way it would fall, checking the surrounding trees that would be in the path of the falling tree, and waiting for a period of time to pass prior to moving into the area in which the tree had fallen to cut and split it. It is noted however that neither were wearing any personal protective equipment and in particular Mr Toby Hyland did not have a helmet on. Dr Ritchey has expressed the opinion, which I accept, that Mr Toby Hyland's "skull and brain took the force of the impact [of the tree which struck him] and dissipated much of the kinetic energy of impact. If wearing a helmet it is likely the skull and brain trauma may have been less severe and may have saved his life although it is unlikely he would have escaped injury; possibly disabling injury".

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 Hyland is similar to the circumstances of the deaths of Mr Dransfield, Mr Howard, 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 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 Hyland'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 Hyland.

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

Simon Cooper
Coroner