CORONER’S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into the death of Paul Edward Storey**
Citation:	**[2026] ACTCD 3**
Decision Date:	20 March 2026
Before:	Coroner K J Archer
Findings:	See [13] - [14], [45], [47] - [48]
Catchwords:	**CORONIAL LAW** – MANNER AND CAUSE OF DEATH – bicycle accident– multiple injuries sustained in single bicycle accident- matter of public safety
Legislation Cited:	*Coroners Act 1997* (ACT) ss 13, 34A, 52 and 55 *Tree Protection Act 2005* *Urban Forest Act 2023*
Texts Cited:	‘Risky business: A resource to help local governments manage environmental health risks’, Environmental Health Australia 2012 AS ISO 31000:2018, Risk Management Guidelines, Standards Australia, 2018 Tree Benefit-Risk Management Policy, Transport Canberra and City Services Directorate, 2023 VALID Tree Benefit-Risk Management Operations Guide, Transport Canberra and City Services Directorate, 2023
File Number:	CD 23 of 2022

CORONER ARCHER

Introduction

1. On the morning of 24 January 2022, Paul Edward Storey died from multiple injuries sustained when he was cycling and his head impacted a large tree branch which was hanging across the bicycle path at the southern end of Garryowen Drive, Acton, in the area known as Black Mountain Peninsula. I will, with respect, refer to Mr Storey as Paul in these findings. Paul was 71 years of age at the time of his death.

2. Paul was very active at the time of his death, riding his bicycle two or three times a week. He was part of a group of cyclist friends who rode together every Monday around Lake Burley Griffin. Paul was a retired public servant, and his family have reported that he was in good health.

Jurisdiction

3. Paul's death was reported to the Coroner, as it fell within the terms of s 13(1)(g) of the *Coroners Act 1997* (ACT) (the Act), being a death that "appears to be directly attributed to an accident".

4. Section 13 of the Act requires me to hold an inquest investigation into the manner and cause of Paul's death. In doing so, I must make findings as required by s 52 of the Act. I must establish the manner and cause of Paul's death and state whether a matter of public safety is found to arise in connection with my inquest.

Hearing

5. In this case I was satisfied that that the information given to me in the course of my investigation enabled me to make manner and cause of death findings without the need for a hearing: s 34A of the Act. That view was communicated to the parties in the context of the provisional findings process. The Territory and Paul's family were invited to make submissions on the issue.

Provisional Findings

6. My provisional findings were sent to the Territory and Paul's family on 5 February 2026. My proposed findings contained criticism of the Territory and, pursuant to section 55 of the Act, I was required to give the Territory a copy of the proposed comment and give the Territory an opportunity to respond to it by making a submission or giving me a statement in relation to it. I refer to the Territory's response at [46] – [47].

Part 1 – Issues Relating to Manner and Cause of Death

The Accident

7. On 24 January 2022, Paul was riding on a bike path on Black Mountain Peninsula in a group with four friends. The rider in front of Paul told investigating police that a tree had partially fallen over the bike path angling upwards from its base. That rider had appreciated that a cyclist would have to duck to avoid striking the tree. He ducked to avoid the tree. Paul either did not see the tree or miscalculated the extent to which it obstructed the path. He struck the tree with his head. Those riding with him heard a loud cracking noise. Other members of the riding group did not observe the accident. Seeing Paul lying on the ground they came to his aid. Initially after the collision, Paul told the other members of his riding group that his neck hurt. He was conscious and breathing at that time. A 000 call was made to the ACT Ambulance Service (ACTAS).

8. Between the 000 call and the ACTAS attendance, Paul lost consciousness and stopped breathing. Members of the riding group commenced CPR with the assistance of nearby lifeguards until ACTAS arrived. Upon the arrival of ACTAS, paramedics attempted to resuscitate Paul, but unfortunately those attempts were unsuccessful.

9. After the accident, an after-hours on-call arborist officer in the Urban Treescapes business unit of the Transport Canberra and City Services Directorate (TCCS) attended the site and arranged for an arborist crew to remove the lower branch of the leaning tree to make safe the path. The officer also assessed the surrounding trees to ensure the site was made safe. The arborist crew returned on 25 January 2022 to remove the rest of the tree.

Evidence

10. Photographs taken by police after the collision show a large branch hanging over the path at head height. Police measured the distance between where Paul collided with the tree and the path to be 145cm. The distance between the highest point of the tree and the path was approximately 180cm.

11. A mechanical inspection of the bicycle was not conducted, as it did not provide any further probative evidence. The bicycle did not appear to have sustained any significant damage and appeared to be in working order. The state of the bicycle did not contribute to the cause of the accident.

12. Forensic Pathologist, Professor Duflou, conducted an external examination of Paul's body on 28 January 2022 and found that Paul had sustained multiple impact related injuries to his face, and lower cervical and upper thoracic spine including fractures of the

spine. The injuries were described by Professor Duflou as being typical of hyperextension injury and consistent with the history of the accident that had been provided to him.

Formal Findings

13. Based on this evidence, I find that Paul Edward Storey died on 24 January 2022 at Black Mountain Peninsula from multiple injuries sustained in a cycling accident.

<u>Part 2 – Issues Relating to Public Safety</u>

14. On the basis of the information provided to me, I am satisfied that a public safety issue arises in connection with Paul's death.

Fix My Street Report on 10 January 2022

15. Prior to the accident, the Territory was on notice on and from 10 January 2022 of the issue with the tree branch because of an online report which had been made by a member of the public on that date via the ACT Government Fix My Street (**FMS**) portal. FMS is a public facing portal, which allows members of the public to log service requests for municipal jobs. Around 50,000 reports are made on the FMS portal each year.

16. Reports received via the FMS portal were, at the time of the accident, and continue to be, triaged at the beginning of each business day. The triaging is undertaken by field depot support officers and technical officers within the particular TCCS business unit to which the report has been automatically directed based on the category or type of issue selected by the reporter, for the purpose of either:

    a. scheduling the relevant task required to respond to the report;

    b. assignment to the correct TCCS business unit responsible for the particular task or response required if it has not been raised with the correct business unit; or

    c. referral to the relevant body if the report relates to a non-TCCS asset.

17. When a person makes a report in the FMS portal, they are required to select a category, for example "Cycle & footpaths", "Grass, trees & shrubs" or "Parks & public spaces". The report is then automatically directed to the business unit responsible for that particular area.

Fix my Street Case 151070

18. On 10 January 2022, some 14 days prior to the accident involving Paul, a report was received from a member of the public via the FMS portal (**Case 151070**). The report provided by the member of the public was:

At the end of Black Mountain Peninsula there is a large tree leaning at 45 degrees over the track. It looks as if it could fall soon, especially with more rain, and even now the trunk is almost at cyclists' head height.

19. The description and location of the tree leaning over the path in Case 151070 seems to match the description and location of the hanging branch that caused the accident and I consider that it is highly likely that the tree referred to in Case 151070 was the same tree that caused the accident.

20. I caused correspondence to be issued to the Territory requesting a response as to why Case 151070 was not responded to in a timely manner, in light of the serious hazard which is described in the report.

Part 3 - The Territory's Response

21. The Court received a response from the Deputy Director-General of the City and Environment Directorate (**CED**), in which the former TCCS Directorate now sits. That response was dated 3 December 2025 (the **Territory's Response**). The Territory's Response was further to a letter the Deputy Director-General sent to ACT Policing after the accident, dated 14 June 2022 (the **Territory's Letter to ACT Policing**).

22. Those responses suggest that Case 151070 was allocated to the incorrect business unit of TCCS. At the time of the accident, the business units of TCCS used different IT systems which were not fully integrated. Case 151070 was not redirected to the correct business area, being Urban Treescapes. As a consequence, a triaging process which would have required assessment of the risks arising from the circumstances described in Case 151070 did not take place before the accident occurred.

Allocation to Incorrect Business Unit

23. Case 151070 was automatically assigned to the Place Management business unit of TCCS on 10 January 2022 based on the category of "Cycle and Footpaths" as selected by the reporter.

24. The Place Management business unit was (and is) responsible for urban open space maintenance and management, including mowing, cleaning and maintenance of playgrounds and park furniture, public toilet blocks, and pest control.

25. When the Place Management field depot staff triaged Case 151070, they sought to reassign the case to the Urban Treescapes business unit for action as it related to a tree.

26. From 1 January 2024, and at the time of the accident, the Urban Treescapes business unit was responsible for urban tree maintenance and the administration of the *Tree Protection Act 2005*. That responsibility was exercised by that unit under the *Urban*

Forest Act 2023. Urban Treescapes triage and sort reports into types of jobs – for example, fallen trees pruning requests, storm damage, fallen branches, line of sight and tree assessment. At the time of the accident, the various business units of TCCS used different IT systems. Relevantly:

- FMS had recently migrated from the Oracle Customer Relationship Management platform to the Salesforce platform;
- The Urban Treescapes business unit used the Salesforce platform to manage FMS requests;
- The Place Management business unit used the information technology platform Assetic to record assets and manage workflows including managing FMS requests.

27. At the time, these systems were not fully integrated meaning the sharing of information between these platforms was not instantaneous nor automatic. For reasons that were not explained by the Territory, the system users in Place Management and Urban Treescapes were not aware of this lack of full integration notwithstanding that the operating procedures for both business units were predicated on an assumption the systems were fully integrated.

28. In relation to Case 151070, Place Management staff rejected the case in Assetic on the understanding that to do so would result in the matter being referred back to Access Canberra to be correctly allocated to Urban Treescapes. This rejection and assumed redirection were actioned by Place Management less than 24 hours after the case was referred to them. The outcome of the rejection, however, was for the report to be referred to a Place Management Salesforce queue. A manual redirection in the Salesforce platform was required for the case to be redirected to Urban Treescapes.

29. For this reason, Case 151070 was not actioned in a timely manner.

30. I do not propose to make a recommendation in relation to this obvious failure relating to the allocation of cases or reports. The Territory's Response provides a detailed explanation of changes that have occurred to FMS processes since the accident on 24 January 2022. The Territory has advised that the incorrect allocation of Case 151070 was one of a number of factors that have contributed to changes in FMS processes in recent years.

31. Those changes to the FMS processes are currently being considered by the Legislative Assembly Standing Committee on Transport and City Services in the context of its inquiry into the effectiveness of the FMS and whether the online tool is fulfilling its intended purpose. The Territory's Response to the Court included providing a copy of a detailed

submission made by the Territory to that inquiry. Relevant to this inquest was information provided as to what has been styled as the "2023-2025 FMS Remediation Program" (**the Program**).

32. The Territory explained that the Program was established in early 2024, in response to a large backlog of unresolved requests, and sought to address difficulties in data consistency between Access Canberra and TCCS. One of the goals of the Program was to deliver an improved experience for citizens and staff. The Territory asserted that other improvements to the FMS application were also delivered, including refinement of the web interface.

33. The Territory indicated that one of the outcomes of the Program was that the various systems used across what is now the CED are able to communicate with each other. For example, there is now integration between Salesforce, FMS, and the *Assetic* system, which manages all of TCCS'/CED's assets, including maintenance with contracted third parties.

34. The Territory's Response asserted that the practical outcome of the Program is that if a case such as Case 151070 was received today it would be referred to Urban Treescapes without issue.

35. The Territory advised that the Program also included the establishment of the City Operations Triage Team to assist line areas with administrative tasks, reduce operational staff pressures by triaging complex requests that require human intervention and reduce the number of pending jobs. The Territory said that these improvements have resulted in TCCS/CED reducing average case closure times from 99 days in 2023, to 34 days in 2024, and 16 days in 2025.

36. The Territory outlined in its Response several other changes and improvements which have taken place since the accident involving Paul. Those changes include the change in Administrative Arrangements which came into effect on 1 July 2025, which merged the former TCCS and ESPD directorates with Access Canberra to form the new CED. The Territory maintained that the restructure aligns the teams responsible for both the "FMS front-end user experience" and the "back-end service delivery" to the same directorate. I understand the "front-end user experience" refers to the experience of a member of the public in making an online complaint via the FMS portal (i.e. the accessibility of the web interface). "Back-end service delivery" is what happens once that complaint is made.

37. The Territory's Response also referred to an increased number of arborists now being rostered on after hours, and the adoption of the VALID tree benefit-risk management strategy in 2023, which is a codified methodology to manage risks associated with trees.

38. I accept from the Territory's Response, there have been improvements to the FMS allocation process since the date of Paul's accident. It seems more likely that today, a case such as Case 151070 would be assigned to the correct business unit in TCCS/CED.

Triaging of Cases

39. The Court also sought to understand how Case 151070 would have been triaged if it had been referred promptly to the correct business unit. The Territory referred the Court to specific policy that now applies in relation to how risk in relation to trees is managed: *Tree Benefit-Risk Management Policy*[1] (the Tree Management Policy). That policy is supported by the VALID Tree Benefit-Risk Management Operations Guide, which was designed to guide the implementation of the policy.

40. The Tree Management Policy is an attempt, in the tree management space, to give practical effect to AS ISO 31000:2018 *Risk Management – Principles and Guidelines*. ISO 31000 is a Guideline containing principles, framework and processes that is referenced by most municipal councils in Australia in managing risk associated with council-owned or controlled assets. Paragraph 3.2.5.1 of the Tree Management Policy suggests that TCCS will manage the risk from Canberra's urban trees and branches falling using four risk ratings, being: Not Acceptable, Not Tolerable, Tolerable, and Acceptable.

41. Paragraph 3.2.4 of the Tree Management Policy is as follows:

> *The ACT Government has a duty of care to manage the risk from urban trees, as government assets. When managing the risk, ACT Government employees must be reasonable, proportionate, and reasonably practicable. There is a balance between the many benefits trees provide, the risk, and the costs of managing this risk. In approaching the risk with this balance, resources are not wasted in attempted risk reduction and benefit losses on trees that have Acceptable or Tolerable risk levels.*

42. The Territory's Letter to ACT Policing advised that programmed works in the Urban Treescapes business unit are allocated a priority rating with a corresponding estimation of scheduled timing:

    a) Urgent – aim to be completed within 48 hours, for example where there are very dangerous trees and safety considerations.

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[1] Transport Canberra and City Services Directorate, July 2023

b) High – aim to be completed within approximately 6 weeks.

c) Medium – up to 6 months.

d) Low – up to 12 months.

43. Neither the Territory's Letter to ACT Policing nor the Territory's Response made clear how FMS cases were allocated to these categories or how cases involving potentially acute risk were identified and assessed. For instance, there is no reference to the potential severity of the consequence of an issue arising from an FMS report being identified and assessed against a risk matrix or risk likelihood guide.[2]

44. In my view, and in the circumstances described in case 151070, even if the partially fallen tree which caused the accident had been given an "Urgent" priority rating, up to 48 hours to remediate the hazard would have been a too long a period. The hazard should have been removed or other hazard reduction measures adopted (for example, the closure of that section of the bike path) within a number of hours of the Territory receiving the FMS report. The hanging branch posed a significant risk to members of the public, and it was reasonably foreseeable that the branch could cause serious injury to users of the path.

Section 55 Notice and Territory Response

45. On 4 February 2026, the Court provided provisional findings and issued the Territory with a section 55 notice identifying the criticisms likely to be made. On 4 March 2026, the Territory provided the Court with a response.

46. In response to the section 55 notice issued by the Court, the Territory conceded that taking 48 hours to remediate the hazard as described in case 151070 would have been too long a period. The Territory also submitted the following:

    20) The City and Environment Directorate confirm that in practical terms, FMS cases will be triaged by Urban Treescapes and allocated an urgent priority rating as stated within what was the rating at the time, where there are "very dangerous trees and safety considerations". Consistent with the current Policy, Guide and practice, urgent priority will be assigned where a tree poses an unacceptable or not tolerable risk to the public or there are other safety considerations.

    21) Safety considerations include branches or trees that are hanging or at risk of falling (as opposed to already fallen branches) or fallen trees or large branches

[2] See, for example, 'Risky business, A resource to help local governments manage environmental health risks', Environmental Health Australia (November 2012), sections 4.1 (Risk likelihood guide) and 4.2 (Risk matrix) https://www.eh.org.au/documents/item/502

blocking access ways such as roads, cycle paths or pedestrian access (as opposed to fallen branches in areas not regularly accessed by the public).

22) The Territory concurs with the view expressed by the Coroner that 48 hours to remediate the hazard as described in case 151070 would have been too long a period and submits that had the report been allocated to the correct business unit, an arborist would have attended as soon as possible, and on the same day. This is evidenced by the response following Mr Storey's accident and described in Mr GH's response dated 3 December 2025:

> *On 24 January 2022, a call about the incident was received by the after hours On Call Officer, Mr DG, Arborist with Urban Treescapes, who attended the site and arranged for an arborist crew to remove the lower branch of the leaning tree to make safe the path. He also assessed the surrounding trees to ensure the site was made safe. The arborist crew returned on 25 January 2025 to remove the rest of the tree.*

23) The Territory confirms that action was taken to make the site safe on the day of the incident and the total time from the report of Mr Storey's incident being received to the complete removal of the tree and remediation of the report was less than 27 hours.

24) In practice, the top range of 48 hours for completion of remediation of urgent cases is most commonly reached and is allowed for in relation to circumstances involving wide-spread damage from weather events such as storms.

47. I accept that there was a prompt response at the site by the Territory after Mr Storey's accident was reported. However, the Territory's response to the section 55 notice issued by the Court does not make clear whether the information in paragraphs [20] to [25], which are reproduced above, describe advice from the Directorate as what now happens in practice when assessing risks presented by fallen trees, or whether the Territory's response in those paragraphs is referencing publicly available risk assessment guidelines.

48. I recommend that the Territory consider publishing practical guidance as to how issues associated with Territory infrastructure that might cause serious injury or death are identified, assessed, and actioned based on such a risk.

Condolences

49. I convey my sincere condolences to Paul's family. The circumstances of his death were unfortunate and tragic and would have caused great distress to his friends and family, particularly his cycling group who rendered aid to Paul after the accident.

50. I apologise for the delay in finalising this inquest.

I certify that the preceding 50 numbered paragraphs are a true copy of the Reasons for Judgment of his Honour Coroner Archer.

Associate: Ella Mansfield

Date: 20 March 2026