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 Brian Dransfield

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

(a) The identity of the deceased is Brian Dransfield;

(b) Mr Dransfield died as a result of injuries sustained by him whilst felling a tree;

(c) The cause of Mr Dransfield's death was as a result of multiple blunt force injuries; and

(d) Mr Dransfield died at 261 Millvale Road, Dromedary in Tasmania on 17 August 2014.

Brian Dransfield died as a consequence of injuries he sustained in a tree felling incident on 17 August 2014. At the time of his death Mr Dransfield had been in a relationship with Mrs Helen Dransfield for 40 years. Together they had two sons, Rodney and Matthew. Matthew predeceased his father. Mr Dransfield was also the father of three sons from a previous relationship, two of who are also deceased.

Broadly speaking given his age, Mr Dransfield was in good health. He was the owner of a small property at 261 Millvale Road, Dromedary. According to Mrs Dransfield, Mr Dransfield mainly used the property to cut down trees, something he ordinarily did on his own. Mr Dransfield had been involved in the wood cutting industry since he was a teenager. During his working life he was a truck driver but continued to cut down trees for most of his life to earn money when there was not much work driving trucks.

At about 3.00pm on Sunday 17 August 2014, Mr Dransfield said goodbye to his wife and headed to the property at 261 Millvale Road, Dromedary. He remained alone on the property felling trees with his chainsaw for a couple of hours.

At about 5.30pm Mr Dransfield was felling a large tree on the side slope of the block. The tree fell and landed on top of him pinning him down across his lower back and legs. He was trapped underneath the log. Mr Dransfield was still conscious and was able to take his mobile phone out of his pocket and call 000.

Police and fire service personnel attended initially. They were directed by radio dispatch services to not remove the tree pending the arrival of ambulance officers. Upon the arrival of police Mr Dransfield was still conscious and able to communicate.

Shortly after the arrival of Ambulance Service personnel Mr Dransfield lost consciousness and went into cardiac arrest. Fire service personnel then removed the tree from him and CPR was performed by fire service personnel whilst ambulance officers administered him medication. Unfortunately the attempts to resuscitate Mr Dransfield were not successful and after about an hour he was pronounced deceased.

Mr Dransfield's body was formally identified at the scene by his son, Rodney, and then transported by mortuary ambulance to the Royal Hobart Hospital. At the Royal Hobart Hospital an autopsy was carried out on Mr Dransfield's body by Dr Kathy Urankar, under the supervision of Dr Donald McGillivray Ritchey, Forensic Pathologist. The conclusion to be drawn from the autopsy was that the cause of Mr Dransfield's death was multiple blunt force injuries due to, or as a consequence of, a tree felling incident. I accept this opinion.

Samples were taken from Mr Dransfield's body at autopsy for subsequent analysis at the laboratory of Forensic Science Service Tasmania. No alcohol or drugs were found to be in those samples.

I have reviewed the response of emergency services. In my view the response by all emergency services was appropriate and as timely as the circumstances allowed.

What is quite clear is that Mr Dransfield died as a consequence of being crushed to death by a tree that he was felling. The circumstances surrounding the tree felling were reviewed by Mr Barry Clarke, a firewood merchant, and a man who has grown up around logging, wood cutting, tree felling and related activities. Although lacking any formal training in the felling of trees or use of chainsaws, Mr Clarke's experience and history in the timber industry is such that I accept his capacity to express an opinion about the circumstances surrounding Mr Dransfield's accident.

Mr Clarke reviewed a series of photographs provided to him by police investigators. Those photographs were of the tree under which Mr Dransfield was located and the general area surrounding the accident. Mr Clarke expressed the opinion that Mr Dransfield made cut wedges into the base of the tree, however, he did not cut the back-cut far enough on the back side of the tree. Mr Clarke's opinion was that the hinged timber therefore made the tree stump "want to fall downhill". In summary, Mr Dransfield's death was, in my opinion, a result of poor tree felling technique.

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 Dransfield is similar to the circumstances of the deaths of Mr Howard, Mr Hyland, Mr Mitchell, Mr Spanney and Mr Young, I consider it useful to address the issues arising from all of 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); 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 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 4.5.3.2, 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 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.

I thank the TFGA for its helpful submission. I acknowledge the contribution of Mr Barry Clarke to this investigation.

I commend the efforts of all emergency services personnel who attended the scene of this tragedy; in particular the efforts of Senior Station Officer, Andrew Skelly and Senior Fire Fighter, Warren Frey, performing CPR on Mr Dransfield for an extended period of time.

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 Dransfield'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 Dransfield.

Dated 11 August 2017 at Hobart in the State of Tasmania

Simon Cooper
Coroner