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 Neil Robert Kingston

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

a) The identity of the deceased is Neil Robert Kingston;
b) Mr Kingston died as a result of being struck by a tree branch whilst engaged in falling a tree;
c) The cause of Mr Kingston's death was acute intracranial (subarachnoid) heamorrhage; and
d) Mr Kingston died on 27 November 2016 at 293 Cuba Road, Smithton in Tasmania.

In making the above findings I have had regard to the evidence gained in the investigation into Mr Kingston's death. The evidence comprises an opinion of the pathologist who conducted the autopsy on Mr Kingston's body; the results of toxicological analysis of samples taken at autopsy; an affidavit of his partner Ms Julie Greene; and relevant police and forensic evidence.

The evidence satisfies me that Mr Kingston died in the following circumstances. In the afternoon of Sunday 27 November 2016 Mr Kingston and Ms Greene were in the bush roughly 500 metres from his residence.

Mr Kingston located a tree he intended to fall. As was his normal practice, for safety reasons, he sent Ms Greene a distance away. Mr Kingston then proceeded to fall the tree he had selected. Subsequent investigation makes it apparent that the tree he felled hit the branch of another tree causing that branch to snap off, fly clear, and strike Mr Kingston in the back of his head.

Ms Greene was quickly upon the scene. She attempted to render assistance to Mr Kingston and also used her mobile telephone to call for help. Ambulance Tasmania personnel and a police officer were quickly on the scene but nothing was able to be done for Mr Kingston.

I am satisfied that there are no circumstances of suspicion attending Mr Kingston's death. I note that whilst he was wearing protective chaps, work boots and earplugs, as

well as being equipped with an axe and plastic wedges in addition to his chainsaw, Mr Kingston was not wearing a helmet.

After identification, Mr Kingston's body was removed from the scene by mortuary ambulance and transported to the mortuary at the Launceston General Hospital. At the Launceston General Hospital an autopsy was carried out by Dr Roseanne Devadas, pathologist. Dr Devadas concluded that the cause of Mr Kingston's death was acute intracranial (subarachnoid) haemorrhage which resulted from a blunt force trauma to his head resulting in a skull fracture. Dr Devadas expressed the opinion that had Mr Kingston been wearing a helmet, although he would have undoubtedly suffered a serious head injury, that injury would likely have been survivable.

I am satisfied that Mr Kingston's death directly resulted from poor tree felling technique and his failure to wear appropriate personal protective equipment.

I note the evidence was that Mr Kingston had apparently never undertaken any formal training in relation to tree felling techniques but had been falling trees for over 40 years seemingly without incident.

Comments and Recommendations

I have recently had occasion to make recommendations and comments in relation to six other deaths associated with tree falling and chainsaw use.

As was pointed out in those findings, 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.

In this case, as with the 6 other deaths recently dealt with, it is also quite apparent that death was completely avoidable had proper precautions been taken and safety equipment used.

It is important to ensure, to the extent possible, that lessons are learned from any death that is the subject of investigation so as to prevent, also to the extent possible, people making the same basic and deadly mistakes in the future. To that end it is appropriate to repeat the recommendations recently made.

- 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 ideally every three years.

- I **recommend** that all land owners and managers 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.

In concluding, I convey my sincere condolences to the family of Mr Kingston.

Dated: 23 October 2017 at Hobart in the State of Tasmania.

Simon Cooper
CORONER