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 Rowland Michael Chilton Howe,

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

a) The identity of the deceased is Rowland Michael Chilton Howe;
b) Mr Howe died as a result of injuries sustained in a tree felling accident;
c) The cause of Mr Howe's death was hypothermia and rhabdomyolysis due to traumatic crush injuries of his back and legs; and
d) Mr Howe died on 7 April 2019 at the Royal Hobart Hospital, Hobart, Tasmania.

Introduction

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Howe's death. The evidence includes:

- Police Report of Death for the Coroner;
- Royal Hobart Hospital Death Report to Coroner;
- an opinion of the Forensic Pathologist who conducted the autopsy;
- a report from Forensic Science Service Tasmania;
- Tasmania Fire Service (TFS) incident log;
- Ambulance Tasmania patient care report;
- an affidavit of Michael Howe, Mr Howe's father;[1]
- affidavits of Frederick and Gemma Howe, Mr Howe's brother and sister;
- affidavits from attending and investigating police officers;
- body worn camera footage;
- a report from Mr Rick Birch, forestry industry trainer and assessor;
- medical records and reports; and
- forensic and photographic evidence.

[1] Tragically, Mr Howe senior died on 7 April 2020 and his death is also the subject of a Coronial Investigation.

Background

Mr Howe, born 15 April 1991, was aged 27 years, single with no children, and working as a machine operator when he died.

Mr Howe grew up at Nunamara on the family property. He often spent his weekends helping his father maintain the vegetation on the property. The evidence is that he was familiar with the use of chainsaws, having operated them since he was 14 years old. His late father described him as being proficient in their use, but that so far as he was aware, had not undertaken any training in their use.[2]

Apart from some hearing loss and the after-effects of injuries sustained in a motor vehicle crash in 2014, Mr Howe was in good health at the time of his death. He enjoyed an active lifestyle and had a good level of physical fitness.

His employment at the time of his death, although forest based, did not involve the use of a chainsaw and, specifically, did not involve tree felling. The evidence is that he had held a forest works operator license as a skidder operator but that qualification had expired a month or so prior to his death.

Circumstances of Death

At about midday on Saturday 6 April 2019, Mr Howe was at the family home and went by vehicle onto the property to cut some firewood. His parents had lunch at 1.00pm and subsequently told investigators they heard the chainsaw operating as they ate.

At about 3.00pm, one of the family dogs returned to the house. Alerted to the fact that something might be wrong, Mr Howe's parents went looking for their son. They found him at about 3.45pm[3], roughly 250 metres from the house, trapped under a tree but still conscious.

Emergency services were called at approximately 4.00pm. Ambulance and fire crews were immediately dispatched and the first crews arrived at the scene about 30 minutes later. Mr Howe was stabilised, extracted from under the tree and flown to the Royal Hobart Hospital by medivac helicopter.

He was admitted and assessed. On initial evaluation, Mr Howe was found to be suffering from hypothermia (with a body temperature of 31 degrees centigrade), metabolic acidosis, acute kidney injury and marked hypotension. He underwent an emergency laparotomy but that did not show any significant internal bleeding or particular injuries. However, he was too badly injured to survive and died the next day, 7 April 2019.

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[2] Affidavit of Michael Frederick Howe, sworn 21 July 2019, page 2 of 4.
[3] Ambulance Tasmania Patient Care Record, page 2.

Investigation

The fact of Mr Howe's death was reported in accordance with the requirements of the *Coroners Act* 1995. His body was formally identified and then transferred to the hospital's mortuary. At the mortuary, on the day after his death, a post-mortem examination of Mr Howe was conducted by experienced Forensic Pathologist, Dr Donald Ritchey.

Dr Ritchey expressed the opinion that the cause of Mr Howe's death was rhabdomyolysis (muscle tissue breakdown) and hypothermia due to traumatic crush injuries of his back and legs as a result of being crushed by a tree. Dr Ritchey said that Mr Howe's post-operative course was marked by progressive metabolic acidosis until his death.

I accept Dr Ritchey's opinion.

Toxicological analysis of *ante mortem* samples carried out at the laboratory of Forensic Science Service Tasmania was unremarkable. Specifically, there was no indication of the presence of alcohol or drugs of any kind in his system at the time of his accident.

Mr Howe's death was investigated by Tasmania Police. Evidence was collected at and from the scene by a specialist Forensic Service Officer who also photographed the scene. Both chainsaws used by Mr Howe at the time of his accident were seized and taken to Launceston Police Station. Both were subsequently examined by a small engine mechanic. That mechanic found that both chainsaws were in perfect mechanical working order. I am satisfied that the chainsaws were both in good condition, appropriately maintained and did not by reason of mechanical deficiency or defect cause or contribute to Mr Howe's death.

The evidence obtained by police, including affidavits and photographs was reviewed at my request by Mr Rick Birch, a highly experienced trainer and assessor in the forest industry. I am satisfied that Mr Birch is well qualified as an expert in the area of chainsaw use generally, and tree felling in particular. He has in excess of 35 years working as a tree feller and has been a trainer and assessor in that discipline for over 25 years. Mr Birch's opinion in relation to the circumstances surrounding Mr Howe's death has, along with all the evidence obtained, informed my finding.

I find that Mr Howe was using a chainsaw to fall a large Eucalyptus Obliqua (stringy bark) tree. The stringy bark fell in an unintended direction and lodged in the top of a smaller Acacia Mearnsii (or black wattle) tree. I find that Mr Howe then attempted to fall the black wattle tree. It is evident that the black wattle was under considerable tension due to the weight of the stringy bark. This tension caused the chain on Mr Howe's chainsaw to become lodged in a cut in the black wattle. Mr Howe apparently then used a second chainsaw to make an

additional cut in the black wattle, in an effort to free the first chainsaw. As Mr Howe did this, the base of the black wattle dislodged, 'kicked up' under the tension of the much larger stringy bark causing it to split and fall onto Mr Howe. He remained trapped under it on the ground.

Mr Birch said, and I accept, that deficient falling techniques were the reason Mr Howe became trapped under the tree.

I note Mr Howe was wearing a safety helmet at the time of the accident.

I am satisfied that there are no suspicious circumstances surrounding Mr Howe's death. There is no evidence that his death was caused or contributed to by the use of alcohol or illicit drugs. There is no evidence of the involvement of any other person in his death.

Comments and Recommendations

Sadly, tree felling accidents involving chainsaws, such as that which caused Mr Howe's death, are frequently encountered by coroners. Such incidents have been prevalent in Australia and are significantly over-represented in Tasmania, particularly within rural areas.

The investigation conducted into Mr Howe's death showed that at the time of his death he had no qualifications in respect of tree felling. Although holding a qualification as a log skidder operator, there is no evidence that Mr Howe had ever received any training in relation to tree felling.

In August 2017, I published findings in respect of six deaths associated with chainsaw use and tree felling. I published another finding in relation to a chainsaw related death in July 2018. I observed that the common factors that lead to deaths associated with the use of chainsaws and tree felling are a lack of training, failure to wear protective equipment, poor tree felling techniques and dangerous chainsaw use practices.

Several of those factors – lack of training, poor tree felling techniques and dangerous chainsaw use – were present in this case.

I also note that experience is no substitute for training. Proper training by accredited and qualified trainers is the only way to learn safe chainsaw use and tree falling techniques.

In the cases in respect of which I made findings in August 2018, I made a series of recommendations. It is worth setting those recommendations out again:

- *all chainsaw operators must undertake approved chainsaw training prior to purchasing or using a chainsaw.*
- *all persons selling chainsaws must be accredited chainsaw operators.*
- *all chainsaw operators must undergo regular practical reassessment.*
- *all landowners be required to ensure that people permitted to use chainsaws on their land be appropriately qualified.*
- *no person under the age of 16 years be permitted to own or use a chainsaw in any circumstances.*

I reiterate those recommendations within the context of this unfortunate accident. I observe that, so far as I can determine, nothing has been done by any agency or entity to take any steps to do anything, at all, to enhance the safety of chainsaw users in Tasmania.

Therefore, I consider it both necessary and appropriate to **recommend** that the responsible agency considers regulatory reform directed at preventing deaths and injuries arising from the use of chainsaws by members of the community.

The response of all emergency services personnel involved in the rescue of Mr Howe should be recognised. In particular, I consider that Brigade Chief Brian Medcalf of St Patrick's River Volunteer Fire Brigade, and his crew, should especially be acknowledged.

I also wish to thank Mr Rick Birch for his very valuable assistance in relation to this investigation.

Finally, I wish to extend my thanks to Constable Matthew Faulkner for his most competent investigation and report.

In concluding, I wish to convey my sincere and respectful condolences to the family and loved ones of Mr Howe on their loss.

Dated: 11 August 2020 at Hobart in the State of Tasmania.

Simon Cooper
Coroner