IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 1715/09

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, JOHN OLLE, Coroner having investigated the death of IAN BLACK

without holding an inquest:

find that the identity of the deceased was IAN JAMES BLACK

born on 7January 1976

and the death occurred on 25 March 2009

at The Alfred Hospital, Commercial Road, Melbourne, Victoria 3004

from:

1a. INJURIES SUSTAINED IN FALL FROM HEIGHT

Pursuant to Section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances:**

1. Mr Ian Black was 33 years old at the time of his death. He resided with his wife at 8 Nekula Street, Mount Evelyn.

2. Mr Black was employed by EC Evergreen Pty Ltd (EC Evergreen) as a tree feller. He had been working for EC Evergreen for approximately three to four months, prior to his death. He was an experienced tree feller.

The Incident

3. On 25 March 2009, Mr Black attended the Tyabb Railway Station Reserve, located at Mornington-Tyabb Road, Tyabb (the site) as part of a crew of four men, to cut down and remove a large pine tree that had been deemed hazardous to passing pedestrians.

4. On arrival at the site, the crew conducted a site assessment and determined a plan to remove the tree. Mr Black's role was to climb the tree and de-limb it from the bottom up and then he would pass the wood down in manageable pieces, whilst the crew on the ground would remove and woodchip the fallen limbs. The crew and Mr Lawrence McLeod, the site manager, assessed the method of removing

the limbs of the tree as a suitable approach to the job. Mr McLeod stated that after the crew met and agreed on who would do what, he wrote up a safety sheet,[1] which was signed by all the crew.[2]

5. Mr Black was the designated person to climb and cut the tree on the day. As part of his job, Mr Black was required to wear safety equipment supplied by EC Evergreen. The climbing equipment was kept in canvas bags and was usually dismantled and assembled by the climbers themselves. Mr McLeod states that he saw Mr Black put on his harness and spikes, flip lines and life line. He explained:

> *"Spikes are connected to the side of your boots, maybe a 6 inch spike that digs into the tree and you stand on them to support yourself. A flip line is a safety line, [which] is a steel cable with a self locking system on it, and you flick it around the trunk of the tree and connect it to your harness. A life line is the main anchor rope, you use that for going up the tree and supporting yourself. It is the main climbing line. I saw Ian stand at the base of the tree, chuck his rope, his life line up and pull himself up about 20 feet. Ian then started de-limbing the tree."*[3]

6. Mr Laurence Cooke commented:

> *"The life line is a device to stop you from falling out of a tree. The life line is secured to the tree by looping it around into a fork in the tree and it is then attached to your harness. Each climber is responsible for doing that themselves."* [4]

7. Mr Black had been climbing and de-limbing the tree for approximately two and a half to three hours before he then started the last phase of removing the tree limbs. Mr Black removed the crown of the tree and started cutting the top part of the tree off and pushing the branches down to the ground.

8. According to witnesses, he had removed approximately 10 pieces of the tree trunk and was nearing the maximum diameter of the tree trunk (that he could cut with the chainsaw he had). Witnesses state that he appeared to have had some trouble pushing off the last piece of trunk he was trying to remove and had to shift his position around the tree. In order to change his position he had to remove his two safety flip lines. Witnesses say he was at a height of approximately 20 metres, when he attempted to push the piece of trunk off the tree, causing him to fall to the ground.

9. In describing the incident, Mr McLeod states:

> *"he put a step level cut in, which is cutting three quarters of the way through the tree, on one side. Then raising the saw 6 inches and cutting through the other side till they match up. Then it is ready to be pushed off. He couldn't get the leverage from where he was standing so he moved to the back side of the tree. I saw that Ian went to move and he couldn't, I didn't see him disconnect*

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1 WorkSafe Brief - p.1014
2 Statement of Lawrence McLeod- Inquest Brief p.2
3 Statement of Lawrence McLeod - Inquest Brief p.3
4 Statement of Laurence Cooke - Inquest Brief p.18

his second flip line but I suspect that is what happened. Ian moved to the back side of the tree, went to push the log and fell from the top."[5]

10. Workmates ran to assist Mr Black and called 000. A local doctor also attended the scene to assist. An ambulance and air ambulance arrived quickly and Mr Black was flown to the Alfred Hospital.

11. On arrival at the Emergency Department of the Alfred Hospital, a CT scan of Mr Black's brain revealed he had a non-survivable head injury. A decision was made between the trauma surgeon, neurosurgeon and the emergency department physician that Mr Black had non-survivable head injuries and all treatment was withdrawn.

12. Mr Black died at 6.12pm on 25 March 2009.

Review of Mr Black's work practice

13. After Mr Black was taken to hospital, Mr McLeod states:

"I had a look at his gear to find out what happened. I saw both flip lines connected to the harness by one point. On the other end of one flip line, I saw the tool strop tag that had ripped off the left hand back side of the harness. Flip lines should be connected to main anchor points on each side of the harness. It looked like Ian's flip line was connected in the wrong place."[6]

14. McLeod further opined:

"I can only assume that Ian has had at some stage whilst he was up the tree detached the flip line via the "D" shackle and re-attached it to the tool strop on the harness instead of the strong point on the harness." [7]

15. Witness, Andrew White stated:

"It is common knowledge that you don't attach a pole strap into the tool attachment of the climbing harness. It is designed to break away a lot less load than the strong static points of the harness."[8]

16. After the incident, a travel tower, also known as an elevated work platform (EWP) was hired by EC Evergreen to remove the large branch that was unsafely sitting on top of the tree. It is interesting to note that the person who was engaged to do this job stated: *"In my view the tower could have been utilised to do the whole of this tree job as I have done many of a similar nature in the past without incident."*[9]

5 Statement of Lawrence McLeod - Inquest Brief p.3
6 Statement of Laurence McLeod - Inquest brief p.4
7 Statement of Laurence McLeod - Inquest brief p.12
8 Statement of Andrew White - Inquest brief p.67
9 Statement of Dale Linaker - WorkSafe brief p.67

INVESTIGATIONS

Forensic Pathology

17. Mr Black's father lodged an objection to autopsy pursuant to section 29 of the *Coroners Act (1985)* (old Act).

18. Consequently, Dr Matthew Lynch, Senior Forensic Pathologist with the Victorian Institute of Forensic Medicine conducted an external examination of Mr Black's body on 27 March 2009 and determined a reasonable cause of death to be 1a) *Injuries sustained from height.*

19. Toxicological analysis did not detect the use of any drugs or alcohol.

WorkSafe Victoria

20. WorkSafe Victoria (WorkSafe) was notified and a number of inspectors attended the site on the day of the incident and they commenced an investigation.

21. Inspector Rachel Johnston issued an Improvement Notice to Lonewolf Australia Pty Ltd (Lonewolf) who had sub-contracted the work to EC Evergreen on 25 March 2009 requiring them to implement a higher safety control method to continue the job such as the use of an elevated work platform (EWP) or another form of mechanical plant.[10]

22. Inspector John Shephard also issued a Prohibition Notice on to EC Evergreen 25 March 2009 prohibiting them from tree felling or pruning unless they used an EWP or other suitable mechanical equipment.[11]

Mr Russell Shepherd, Northern Melbourne Institute of TAFE

23. WorkSafe engaged Mr Russell Shepherd, an experienced Arborist and Teacher with the Northern Melbourne Institute of TAFE to provide some information in relation the relevant standards and guidelines and the risks associated with this type of work.

24. Mr Shepherd found that:

> *"There are many risks associated with working at height in trees. These risks can be reduced through the implementation of controls. Through training in the use of a tree surgeon harness, flip lines, connecting links and other associated equipment some of the risks can be reduced to an acceptable level."*[12]

25. Further, he stated that:

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10 Statement of Rachel Johnston - WorkSafe brief p.149
11 Statement of John Shephard - WorkSafe brief p.158
12 Statement of Russell Shepherd - Inquest brief p.264

"Improper use of fall arrest equipment appears to have led to the climber falling from height. It appears that the failure from the attachment of a flipline into the gear loop (not rated) part of the harness is the sole reason the climber fell."[13]

26. A 'Tree surgeon' style harness is a speciality harness designed for working in trees at height."[14] Further, harnesses must be compliant with AS:1891:2007 for Fall Arrest Systems and Devises - "*the life support anchor points on the harness are the only part of the harness designed and rated for fall arrest."* [15] I note that there was no suggestion, in the evidence to demonstrate that the harness used was not compliant with this standard.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

1. In response to this incident, WorkSafe have developed a guidance note on "Working Safely with Trees" which provides suggested control measures to implement when working at height with trees. Importantly, it suggests that a designated person should be used to check a climber's safety equipment and keep an eye on the climber, whilst in the tree. I agree with these recommendations and endorse this guidance note. I further note the importance of WorkSafe in our community to assist with the reduction and prevention of workplace deaths in Victoria.

2. Finally, I acknowledge the immense anguish that Mr Black's death would have caused to those who knew him.

Finding

I find that it is a matter of speculation as to how Mr Black, an experienced tree feller, fell from the tree.

I find that Mr Black died on 25 March 2009 and the cause of death was from *injuries sustained from height.*

Pursuant to rule 64(3) of the **Coroners Court Rules 2009**, I order that this finding be published on the internet.

13 Statement of Russell Shepherd - Inquest brief p.264
14 Statement of Russell Shepherd - Inquest brief p.261
15 Statement of Russell Shepherd - Inquest brief p.261

I direct that a copy of this finding be provided to the following:

Mrs Nadine Black
WorkSafe Victoria
EC Evergreen Pty Ltd
Lonewolf Australia Pty Ltd

Signature:

JOHN OLLE
CORONER

27 February 2012