IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 000077

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the ***Coroners Act 2008***

Findings of:	Coroner Ingrid Giles
Deceased:	Mark Brian Lowther
Date of birth:	3 May 1966
Date of death:	4 January 2023
Cause of death:	1a: HEAD INJURIES
Place of death:	63 Ennismore Crescent, Park Orchards, Victoria, 3114
Keywords:	Accidental death, DIY, at-home work, tree felling, excavator, chainsaw

INTRODUCTION

1. On 4 January 2023, Mark Brian Lowther[1] was 56 years old when he died at home when a tree he was cutting down struck him on the head. At the time of his death, Mark lived in Park Orchards. He is survived by his three children.

Background

2. Since completing an apprenticeship as a teenager, Mark worked as a plumber. He enjoyed undertaking 'Do It Yourself' (**DIY**) works around the house and owned a Wacker Neuson excavator. He had often used the excavator for plumbing, including digging trenches and levelling ground.

3. Mark also used the excavator for undertaking DIY jobs. According to his daughter, Emma Lowther (**Emma**), he *'had used it many times before'* including in conjunction with a chainsaw to fell trees.

4. Mark had an unremarkable medical history. He was diagnosed with high cholesterol but otherwise was in *'good physical health'*. He was not known to suffer from mental ill health and was considered a *'happy go lucky'* individual.

THE CORONIAL INVESTIGATION

5. Mark's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of

---

[1] Referred to throughout this Finding as 'Mark', unless more formality is required.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Mark's death. The Coronial Investigator conducted inquiries on the Court's behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

9. Then-Deputy State Coroner Jacqui Hawkins initially held carriage of the investigation into Mark's death until it came under my purview in July 2023 for the purposes of obtaining additional material, finalising the investigation and handing down this finding.

10. This finding draws on the totality of the coronial investigation into the death of Mark Brian Lowther including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

11. On 4 January 2023, Mark was undertaking various jobs around his property. He told his daughter, Emma, that he was planning to clear some trees in the yard. Emma was not surprised by this as Mark *'loved using the excavator'*. Emma then left the house.

12. At approximately 11:30am, Mark drove his mother to a doctor's appointment and returned home around 1:30pm. His son, Max Lowther (**Max**), then left the house.

13. At some time between 2:30pm and 4:30pm, Mark began using his excavator to clear some trees in the front garden. He was the only person home at the time and his actions were not witnessed by any neighbours.

14. At approximately 4:40pm, Emma returned home. She walked through the front yard to the house and *'saw a tree down over the driveway, and heard the excavator was on'*. She began

[2] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

searching for Mark, and at 4:44pm, attempted to telephone him with no success. She noticed his work and personal vehicles in the driveway, so deduced he was still at home.

15. At 4:46pm, Emma re-attempted to telephone Mark, to no avail. She telephoned her brother, Max, who told her Mark had been working in the garden earlier in the afternoon. Emma returned to the front yard and located Mark lying face down, with a tree on top of him. She contacted emergency services.

16. At approximately 5pm, firefighters arrived and observed that the tree was lying over Mark but was not touching him. Firefighters moved the tree. They attached defibrillator pads and commenced cardiopulmonary resuscitation (**CPR**). Ambulance Victoria paramedics arrived and assessed that Mark was non-responsive, pulseless and hypothermic. The paramedics directed to cease CPR and declared Mark deceased.

IDENTITY OF THE DECEASED

17. On 4 January 2023, Mark Brian Lowther, born 3 May 1966, was visually identified by his son, Sam Lowther, who completed a formal Statement of Identification.

18. Identity is not in dispute and requires no further investigation.

MEDICAL CAUSE OF DEATH

19. Forensic Pathologist Dr Brian Beer (**Dr Beer**) of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on the body of Mark Lowther on 6 January 2023. Dr Beer considered the Victoria Police Report of Death for the Coroner (**Form 83**) and the post-mortem computed tomography (**CT**) scan and provided a written report of his findings dated 11 January 2023.

20. The post-mortem CT scan demonstrated a right frontal skull fracture, subarachnoid haemorrhage, cerebral oedema and left haemothorax. The external examination identified injuries to the head – bilateral periorbital haematomas and palpable nasal fractures.

21. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or other common drugs or poisons.

22. Dr Beer provided an opinion that the medical cause of death was 1(a) *head injuries*.

23. I accept Dr Beer's opinion.

RECONSTRUCTION OF THE INCIDENT

24. Victoria Police members arrived at the Lowther residence and made observations of the tree stump and trunk which they believed Mark was cutting at the time of his death. Senior Constable David Slater (**SC Slater**) used these observations to reconstruct the scene and provided me with his theory of what occurred.

25. SC Slater opined that Mark had made a cut in a tree on the property with a chainsaw, then used his excavator in an attempt to knock it over. SC Slater noted the chainsaw cut of the tree stump was made at a slightly upwards angle from west to east. From the position of the excavator, SC Slater believes Mark was using the machine's bucket to push the trunk in an east to west direction and therefore *'going against the natural fall of the tree made by the cut'*. He suggested this *'may have caused the tree to suddenly snap off the remaining stump and fall back toward the excavator'*.

26. I note that by the time SC Slater recorded his observations of the scene, firefighters had moved the tree from its original position to allow paramedics to access Mark. SC Slater compared his hypothesis against the firefighters' recollections prior to moving the tree, and believed they were consistent.

27. SC Slater considered Dr Beer's post-mortem report and posited the head injuries may have been caused when Mark was struck on the head by the falling tree. There was blood located on the tree trunk, supporting SC Slater's hypothesis.

USE OF EXCAVATORS AND SAFETY CONSIDERATIONS

28. Evidence supports that on 31 March 2015, Mark had purchased the excavator, a Wacker Neuson Track Excavator EZ17 (E13-01), via a distributor located in Kilsyth. Evidence provided to the Court indicates that the excavator would have been sold with Roll Over Protection (**ROP**) fitted, as is consistent with all Wacker Neuson excavator models. I accept that evidence.

Roll Over Protection

29. ROPs form an important safety component of all excavators. ROPs can be an enclosed cabin, or open metal frame, which surrounds the driver's seat. ROPs protect the operator in the event that the machine rolls over, as well as providing protection against falling objects. The ROP on a Track Excavator EZ17 (E13-01) appears as follows in Figure 1:

Figure 1

---

30. The ROP from Mark's excavator could not be located by Victoria Police on the day of his death. However, Emma confirmed to SC Slater that a ROP did exist, but that it had *'recently been refitted by a family friend who had borrowed the excavator'*.

31. It was therefore posited by SC Slater that the ROP had been removed by Mark at some point prior to his attempt to fell the tree. As a consequence, the operator's seat was left exposed to any falling objects and Mark was left with no protection when the tree came down towards him.

Training and safety guidance for operation of excavators

32. Individuals are not required to hold a specific licence or formal qualifications to purchase or operate small excavators in a home setting. Upon the purchase of an excavator, the customer is not required to undertake any safety training. Wacker Neuson informed the Court via SC Slater that all customers are provided with operating and safety information via the specific model's Operator's Manual, '*where the primary focus and instruction is on digging, by its very name as an excavator indicates, the main function of this type of machine*'.

33. The Operator's Manual relevant to Mark's excavator contained warnings including: *'do not operate the machine if the standard protective equipment (for example the cabin) has been removed'* and *'operate the machine only if all protective and safety-oriented equipment (for*

example protective structures such as a cabin or rollbar, removable safety devices) is installed and functional'. These manuals are also available for download via the Wacker Neuson website as well as being provided to customers with the excavators when sold.

34. The proprietor of the business which sold Mark the excavator in 2015 noted to the Court, via SC Slater, that he is aware of customers who remove the ROP for various reasons, including for storage in low ceiling sheds or garages or driving underneath gates at residential properties. However, operators are encouraged to refit the ROP prior to any use of the excavator.

THE PREVALENCE OF 'DIY' TREE FELLING DEATHS

35. The circumstances of Mark's death form part of a broader pattern of deaths which occur in the course of DIY work, specifically related to tree felling. To better understand the prevalence of these deaths, and to determine whether excavators pose particular risks to members of the public who use them in a DIY setting, I sought the assistance of the Coroners Prevention Unit (**CPU**) to collate relevant data and statistics.[3]

36. The CPU searched its available databases and identified that between the period of 1 January 2013 and 31 October 2023, 62 fatalities occurred as a result of tree felling in Australia (excluding Western Australia). 18 of these deaths occurred in Victoria.

37. The CPU provided greater detail regarding the 62 deaths and the demographics most highly represented. All 62 deaths were of males, with an age range of 21 to 83 years. 50 of the deaths (approximately 80%) occurred in a DIY context.

38. It was common that these fatalities occurred while the deceased was only using a chainsaw (75.8% of deaths) or were using a chainsaw in conjunction with another piece of equipment (19.3%). In one other instance, the deceased was using a chainsaw and an excavator to fell a tree, as Mark had been. Other equipment frequently used in conjunction with a chainsaw included a tractor, cherry-picker or ride-on lawn mower.

[3] The Coroners Prevention Unit (**CPU**) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health. The CPU also provides coroners with data and statistics regarding patterns and trends in categories of deaths.

FINDINGS AND CONCLUSION

39. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Mark Brian Lowther, born 3 May 1966;

    b) the death occurred on 4 January 2023 at 63 Ennismore Crescent, Park Orchards, Victoria, 3114 from *head injuries;* and

    c) the death occurred in the circumstances described above.

40. I have considered the circumstances and find that Mark Brian Lowther died as a result of a head strike from a falling tree, which he had been trying to fell with the assistance of both a chainsaw and an excavator. I have considered the theory presented by Senior Constable David Slater and find it to be a compelling reconstruction of the unwitnessed events which occurred on 4 January 2023.

41. I find that Mark Brian Lowther attempted to cut down the tree despite that the safety apparatus of the excavator had been removed, which was against the manufacturer's advice, and as a result, placed him at an appreciable risk of being seriously injured or killed by falling objects.

42. While Mark Brian Lowther had owned the excavator for several years, had used it in his profession as a plumber and had used it (along with a chainsaw) to cut down trees in the past without any reported incidents, his use of the excavator without Roll Over Protection, and contrary to the intended purpose of the excavator, contributed to his very tragic death.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

1. Mark's tragic death brings into sharp relief the dangers of DIY work and of using machinery outside of its intended purpose (in this case, using an excavator intended for digging for the purpose of felling trees).

2. This is particularly tragic given that the evidence suggests that Mark was otherwise a fairly experienced excavator operator and, according to his daughter, had felled trees with the aid of an excavator many times previously without incident.

3. While the death of Mark Lowther occurred in a DIY context, Safe Work Australia[4] and WorkSafe Victoria[5] have guidelines on managing the risks of tree work that are publicly available. Both guidelines outline the common hazards and how workers can manage and reduce risks when working with trees.

4. Safe Work Australia's guidelines for felling trees state a powered mobile plant, for example excavators, can be used provided that, among other things, they are fitted with operator protective structures like a falling object protective structure suitable for tree trimming and removal work, and are able to safely control the fall direction of the tree. It also states, the pushing attachment on the mobile plant should be in contact with the trunk of the tree with only enough push force applied to prevent the tree sitting back during the felling operation, and high enough above the ground so it can provide enough force to push the tree after the felling cuts are made.

5. The evidence suggests, and SC Slater has posited, that Mark Lowther made the cut to the tree trunk at a slightly upward angle from west to east. If this were the case and Mark commenced using the excavator bucket to push east to west, he would be going against the natural fall of the tree made by the cut, which may have caused the tree to suddenly snap off the remaining stump and fall back toward the excavator. It appears that this strategy placed him at further risk in circumstances where there was no Roll Over Protection on the excavator.

6. From a prevention perspective, curbing the deaths of DIY-associated deaths is challenging as it requires the optional uptake, on the individuals' behalf, of the safety warnings and messaging provided by organisations such as Safe Work Australia.

7. I consider that there are no specific recommendations that ought to flow from this case, noting that DIY tasks are not subject to the same level of regulation as those occurring in a public context, and that the reasons for undertaking DIY are quite varied.

8. However, I consider that it is strongly advisable for members of the public engaging in DIY work with potentially dangerous machinery to ensure that they are using machinery in a safe manner, including, in respect of excavators and similar machines:

---

[4] Safe Work, 'Guide to managing risks of tree trimming and removal work', https://www.safeworkaustralia.gov.au/system/files/documents/1702/guide-to-managing-risks-tree-trimming-removal-01082016.pdf.

[5] Work Safe Victoria, 'Working safely with trees', https://www.worksafe.vic.gov.au/resources/working-safely-trees.

a) Always operating the machine with standard protective equipment in place, including Roll Over Protection; and
b) Always operating machinery in a manner that is consistent with its intended purpose.

I convey my sincere condolences to Mark's family for their loss and I acknowledge the sudden and traumatic circumstances of his death.

I thank Senior Constable Slater for his very extensive and responsive assistance in this investigation.

ORDERS AND DIRECTIONS

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Ondine Lowther, Senior Next of Kin

Wacker Neuson

WorkSafe Victoria

Safe Work Australia

Senior Constable David Slater, Coronial Investigator

Signature:

____

Coroner Ingrid Giles

Date: 28 January 2025

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.