IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 000195

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	William John Slade
Date of birth:	08 July 1959
Date of death:	11 January 2020
Cause of death:	1(a) INJURIES SUSTAINED IN TREE FALL INCIDENT
Place of death:	Bingo Coach Track, Anglers Rest, Victoria, 3898

INTRODUCTION

1. On 11 January 2020, William John Slade (**Bill**) was 60 years old when he was struck by a tree while undertaking firefighting and containment work on the Bingo Coach Track and at Anglers Rest, which resulted in his death.

2. Bill was born on 8 July 1959 in Wonthaggi on a 400-care dairy farm at Archies Creek. He is survived by his wife Carol Slade, and their two children.

3. Bill was described as being generally fit and healthy. He had previously suffered from Crohn's and Colitis diseases and was only one percent of people who are cured of the disease. Bill was involved in local community sport, including football and cricket. He was also the recipient of several best and fairest awards for overall local football league.

4. At the time of his death, Bill was employed by Parks Victoria as a Field Service Officer at the Wonthaggi Depot, a role that he held for 40 years. Bill and Carol also ran a farm management business together and looked after several small farms in the Glen Forbes area. Carol described Bill's work and family as his life.

5. Bill was a highly experienced and safety conscious fire fighter and had 37 fire seasons with Parks Victoria. Carol recalled that Bill was safety conscious and that his employer would '*send the younger workers away with Bill because he was responsible and would look after everyone else*'.[1] He was involved in fire-fighting activities in the Ash Wednesday, Black Saturday and Alpine and Great Divide fires. Due to the strenuous nature of the fitness training required to maintain his accreditation, Bill was due to retire from his firefighting duties at the end of the 2020 fire season.

THE CORONIAL INVESTIGATION

6. Bill'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.

7. 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

[1] Coronial Brief (**CB**), pg 49.

purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

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

9. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Bill's death. The Coroner's Investigator, Sergeant Rodney Smith conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

10. This finding draws on the totality of the coronial investigation into the death of William John Slade 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]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased, pursuant to section 67(1)(a)

11. On 14 January 2020, William John Slade, born 8 July 1959, was visually identified by his colleague, Jarrod Frogley.

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

Medical cause of death, pursuant to section 67(1)(b)

13. On 13 January 2020, Specialist Forensic Pathologist, Dr Matthew Lynch from the Victorian Institute of Forensic Medicine, conducted an external examination on the body of William Slade and provided a written report of his dated 16 January 2020.

[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.

14. The post-mortem examination revealed evidence of head and chest trauma. These findings are consistent with injuries resulting from a tree fall incident.

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

16. Dr Lynch provided an opinion that the medical cause of death was:

1 (a) INJURIES SUSTAINED IN TREE FALL INCIDENT

17. I accept Dr Lynch's opinion as to the cause of death.

Circumstances in which the death occurred, pursuant to section 67(1)(c)

18. The state of Victoria is divided into districts under the control of Department of Environment, Land, Water and Planning personnel (**DELWP**). The Tambo District in East Gippsland is the largest of all Districts, being approximately 600 thousand hectares.[3]

19. On 21 November 2019, twenty lightning strike fires were recorded in the Tambo District resulting in a number of fires.[4] By the morning of 22 November 2019, several fires had been contained, while others continued to burn. These fires eventually grew to become the Tambo Complex Fires over the following weeks.

20. Between 1 and 10 January 2020, significant fire activity increased in Anglers Rest and East Gippsland stretching existing firefighting resources and preventing further resources gaining access to the area.

21. On 10 January 2020, Bill was deployed to the Tambo District as part of a Forest Fire Management Victoria (**FFMVic**) taskforce from La Trobe District to assist with the Tambo Complex Fires.

22. On 11 January 2020, Bill was performing firefighting and containment duties at Anglers Rest, an area within the Tambo District. Anglers Rest is located on the Omeo Highway, north of the Omea Shire of East Gippsland. It is a remote location and is surrounded by the Alpine National Park.

[3] CB, pg 52.
[4] CB, pg 23.

23. At 8:00am on the morning of 11 January 2020, Bill attended a morning briefing which was conducted at the Swifts Creek Incident Control Centre (**ICC**) by leads of the Incident Management Team. The briefing provided a situational overview and objectives for the day, specific execution or deployment orders, as well as logistical arrangements, and safety items.[5] Mr Peter Brick, Operations Manager for the Tambo District, stated that during the briefing meetings, firefighting crews are reminded to be aware of the dangers posed by trees and the importance of undertaking risk assessments.[6]

24. Bill had been allocated to the Glen Valley Sector and attended an additional detailed briefing at 9:15am with the crew who would be working in that sector. The briefing included safety messages about hazardous trees, overnight rain and specific taskings. The strategy for the Glen Valley Sector, as described by Mr Brick, '*was to contain the fire at the edge of the private property around Anglers Rest*'.[7]

25. Bill was working with his colleague, Jarrod Frogley, a General Fire Fighter from Parks Victoria, patrolling and blacking out along the Bingo Coach Track.[8] Blacking out is the process of extinguishing or removing burning material along or near the fire control line to make the fire safe. The fire had crossed over the Bingo Coach Track of its own accord, and the incident site was a spot over, this meant that it was not part of a backburning operation and a hazardous tree assessment had not been completed.

26. At or around 4:55pm, two Forest and Fire Operations Officers, Mr Brendan Purcell and Mr Gareth Story, commenced blacking out within the incident spot. The site then became a work area and required a hazard tree assessment. Mr Purcell and Mr Story briefly discussed a tree which was identified as a '*stag*' which is usually, '*a dead standing tree that may have been fire affected or…it could have died from other reasons, but is still standing*'.[9] Mr Purcell recalled that the dead tree had no holes in the base and few spots around the surface. The top of the tree had broken off around 3 metres up, however the tree was standing upright, with no fire coming from the top and no visible burnt roots.[10] Following the hazardous tree assessment, Brendan began chipping small pieces of smouldering bark from the base of the tree.

[5] CB, pg 58.
[6] CB, pg 59.
[7] Ibid.
[8] DELWP investigation report, pg 3.
[9] CB, pg 60.
[10] CB, pg 91.

27. At approximately 5:10pm, Bill and Mr Frogley arrived at the location and assisted Mr Purcell and Mr Story. At or around 5:25pm, Bill was working on the eastern side of Bingo Coach Track at Anglers Rest when he was struck by the falling tree.

28. The tree was rolled off Bill and CPR was commenced until a member of the County Fire Authority arrived, who identified as a nurse and took over the medical response.[11]

29. Following a radio call about the accident, Mr Brad Fisher, the District Manager of the Tambo District stated that he set up an '*incident within an incident*' to manage the response to the incident separately to the firefight. Due to the steep mountainous terrain, the communications between the ICC and accident site were poor. Once it was established that CPR was being performed and it was a significant tree strike, steps were taken to urgently organise medical assistance.

30. Mr Fisher recalled that Ambulance Victoria and Helimed (air ambulance) requested a lot of information regarding the incident site, including whether it was an active fire site. Due to this, Mr Fisher stated that organising medical assistance took longer than usual which '*caused a high level of anxiety and frustration*'.[12] Ambulance Victoria members subsequently attended the scene and Bill was declared deceased at 6:58pm.

FURTHER INVESTIGATIONS

Investigation by WorkSafe Victoria

31. Following Bill's death, WorkSafe Victoria (**WSV**) conducted an independent investigation into the circumstances surrounding the incident.

32. On 26 April 2021, the Coroners Court was provided with a copy of the WSV brief of evidence. The WSV investigation focused on the circumstances surrounding Bill's death and the response to the incident by the emergency management agencies. The WSV brief of evidence included statements from number of personnel who witnessed or were involved in the response to the incident, as well an independent investigation report from DEWLP.

33. After undertaking a comprehensive investigation into Bill's death, WSV decided to take no further action in relation to the incident.

[11] CB, pg 96.
[12] CB, pg 79.

Investigation by DELWP

34. Following Bill's death, DELWP conducted an independent investigation into the circumstances surrounding the incident. The DELWP investigation focused hazardous tree management and training by Forest Fire Management Victoria and the general circumstances surrounding the tree fall incident.

35. On 2 June 2020, the Coroners Court was provided with a copy of the DELWP investigation report by the Coroner's Investigator. The DELWP investigation report outlined the FFMVic guidelines and procedures for hazardous tree management, including the relevant steps taken to identify and establish control for the risks associated with trees in fire management operations.[13]

36. The DELWP investigation report also outlined training available to firefighting personnel, including 'Tree Hazard Awareness' training a mandatory requirement of the 'Basic Wilderness Awareness' and 'Tree Hazard Assessor' specialist training, which provides more in-depth instructions on the systems of work that are used.

37. Tree Hazard Assessor' training provides personnel with the requisite skills to assess trees on their risk, likelihood of collapse, and what control measures can be implemented. Once an individual completes the training, they become an Accredited Tree Hazard Assessor, who provides the formal assessment for hazardous trees in practice.

38. During the course of the investigation, DELWP found that:

    - Bill was appropriately trained to undertake the role in which he was deployed having completed a General Firefighter reaccreditation on 8 January 2020 (this would have included Tree Hazard Awareness) and an online Tree Hazard course on 20 January 2017.[14]

    - Mr Purcell had completed General Firefighter accreditation on 12 March 2010 and Mr Frogley on 23 November 2018, which would have included Tree Hazard Awareness.

    - Mr Story was the only firefighter present at the incident site able to assess and mark hazardous trees, as he was the only one to have completed 'Tree Hazardous Assessor

[13] See Joint Standard Operating Procedures 08.03 Tree Hazard – Bushfire Responses (supported by the Hazardous Tree Management Pictorial Guide).
[14] WSV report, pg 23.

Training'. While the guidelines state that others can assess and mark a tree as hazardous if they have '*sufficient experience*' but does not state what the experience should be.[15]

39. Further, during the course of the DELWP investigation, Mr Les Vearing attended the incident site on 27 January 2020 with Mr Purcell to inspect the tree as a subject matter expert. Mr Vearing did not believe that Mr Purcell contributed to the tree falling by chipping the pieces of smouldering wood from the base of the tree and found that the tree had not been affected by the fire and fell from natural causes. Mr Vearing found that this was likely exacerbated by the top falling out of the tree and/or bulldozer constructing a track near it which weakened the roots.[16]

40. The outcome of the DELWP investigation was that the correct process for identifying and managing hazardous trees was followed, notwithstanding the tree in question was not identified as being hazardous.

41. The DELWP investigation report identified three contributing factors relevant to Bill's death:

Contributing factors

- The tree that fell was not identified as being hazardous and therefore was not treated.
- The impact on the tree from the top section of the tree breaking off.
- Fires had burnt through the area where the tree fell at least three times in the last 100 years. Given the level of rot and decay in the roots and trunk of the tree, it is possible that it had been dead since one of these previous fires. As such, it had a high likelihood of falling even with minor intervention (i.e vibrations from the bulldozers and impact from hand tools).

42. The DELWP investigation report also identified one non-contributing factor relevant to Bill's death:

Non-contributing factor

- The Ambulance Victoria response time was approximately 1 hour and 20 minutes. It took approximately 20 minutes for Ambulance Victoria to confirm that Helimed had

[15] DEWLP report, pg 22.
[16] DEWLP report, pgs 22 – 23.

been dispatched. It is understood that the additional procedural requirements for Ambulance Victoria to attend an active fire resulted in a delay to the response time.

43. The DELWP investigation report also made three (3) recommendations:

- Recommendation 1 - FFMVic work with Ambulance Victoria to determine what blockages exist in dispatching road and air ambulance to active fire areas and establish protocols to minimise them in order to reduce response times.

- Recommendation 2 - Explore options to provide additional defibrillators on the fire line to be available to crews working in remote locations.

- Recommendation 3 - Review hazardous tree assessment criteria to determine if risk assessments adequately incorporate consideration of recent disturbances (such as heavy plant driving past or a section of three breaking off). If these factors are not adequately considered, then the assessment criteria and associated processes should be enhanced to ensure that they are.

44. Being mindful of section 7 of the Act which makes it clear that I should 'avoid unnecessary duplication of inquiries and investigations' and having reviewed the material and information provided by DEWLP, I am satisfied that no further investigation of the circumstances surrounding Bill's death is required.

45. The focus of my investigation then then to what steps had been taken to adopt and implement the recommendations in the DEWLP investigation report.

46. DEWLP were asked to respond to the following questions:

a) Please confirm whether DELWP and FFMVic accept the incident cause and factors detailed on page 27 of the DELWP investigation report. If not, please explain why.

b) With reference to page 28 of the DELWP investigation report:

- please confirm whether DELWP and FFMVic have adopted or intend to adopt the three (3) recommendations, and if so,

- provide an update in respect of the progress of implementing the recommendations.

c) If the three (3) recommendations have not been adopted or implemented, please provide reasons for this decision.

d) whether FFMVic and Ambulance Victoria have adopted or intend to adopt the recommendations in the DEWLP investigation report and if so, provide an update in respect of the progress of implementing these recommendations.

47. On 9 June 2022, Mr Chris Hardman, Chief Fire Officer, Forest Fire Management Victoria provided a response to these questions.

Response from DELWP

48. In his letter to the Court, Mr Hardman stated that when significant workplace safety incidents occur, DELWP applies a safety investigation approach, managed by an independent team, and a monitoring and auditing process to ensure management actions are implemented.

49. As Bill was deployed with a FFMVic taskforce at the time of the incident, DELWP conducted the safety investigation, with Parks Victoria being represented on the panel of investigators.

50. Mr Hardman stated that the Forest and Fire Operations Division Leadership Team, on behalf of DELWP and FFMVic, accepted all incident causes and factors presented in the DELWP investigation report. The recommendations in the DELWP investigation report were accepted in principle and agreed management actions were developed to ensure the learnings identified in the recommendations could be implemented within FFMVic's operational context.

Recommendation 1[17]

51. In 2020, the Medical Evacuation State-wide Working Group (**MESW**) was established, under the oversight of the Deputy Chief Fire Officer Grampians. The MESW identified that, due to competing operational demands in regional and the logistical challenges associated with accessing some FFMVic work locations, Ambulance Victoria is not always able to provide rapid first response to firegrounds. Additional capability was required to ensure FFMVic staff working in remote locations had access to rapid first aid response services.

52. In November 2021, the Enhanced Medical Services Trial (**EMST**) was initiated to explore the administrative, logistical and operational challenges associated with providing enhanced

[17] Letter from Chris Hardman to Coroners Court dated 9 June 2021, p 3.

medical services during fireground operations. Ambulance Victoria was briefed on the EMST during the development of the scope and approach and supported its delivery.

53. LifeAid and Medical Edge were engaged as providers for EMST and deployed during the 2021-22 bushfire season. The field testing is now complete, and a report is being prepared for the Chief Fire Officer, which will evaluate the EMST, identify capability requirements for rapid first aid response and make any necessary recommendations. Ambulance Victoria is engaged in the evaluation of EMST.

54. With the establishment of MESW and EMST, this recommendation was completed on 17 November 2021. DELWP continues to engage with Ambulance Victoria on the delivery of remote rapid first aid.

Recommendation 2[18]

55. DELWP acquires and distributes Automatic External Defibrillators (**AEDs**) to work locations as required, based on local assessments of first aid and AED requirements. There are portable AEDs located across the DELWP districts, which can be deployed to accompany people working in remote areas, or as part of emergency deployments.

56. In Gippsland, portable AEDs are deployed based on an endorsed risk assessment tool. This tool is used by work centres to determine the optimal allocation of portable AEDs to remote work locations on a day-to-day basis.

57. In June 2019 and May 2020, DELWP facilitated two state-wide procurement and allocation processes for AEDs. As at 1 May 2022, there were 27 portable AEDs across the Gippsland region.

58. The process for regions/state teams to assess the need for, and purchase and deploy, AEDs was developed and communicated to all FFMVic management teams, and is now in operation across all FFMVic Work Centres

59. This recommendation was completed on 5 March 2021.

[18] Letter from Chris Hardman to Coroners Court dated 9 June 2022, p 4.

Recommendation 3[19]

60. In 2021, the 'Joint Standard Operating Procedure, JO 8.03 *Tree Hazard – Fire*' was reviewed and updated to allow only qualified and agency endorsed personnel to assess trees for hazard. DELWP has also updated its hazardous tree symbology, in line with the new national symbology, with all personnel (including contractors) being required to undertake the 'Tree Hazard Awareness Refresher' training ahead of the 2021-22 bushfire season.

61. The DELWP training materials were also reviewed and found to adequately capture the assessment of recent disturbances from machinery and limbs.

62. This recommendation was completed on 5 March 2021.

FINDINGS AND CONCLUSION

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

- the identity of the deceased was William John Slade, born 8 July 1959;
- the death occurred on 11 January 2020 at Bingo Coach Track, Anglers Rest, Victoria, 3898, from INJURIES SUSTAINED IN TREE FALL INCIDENT; and
- the death occurred in the circumstances described above.

COMMENTS

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

64. DEWLP have completed a comprehensive review of the issues arising from Bill's death. I am satisfied that DELWP, with the assistance of other agencies, have taken the necessary steps to adopt and implement the recommendations in the DEWLP investigation report. I support the recommendations and findings in the DEWLP investigation report and that they will improve procedures and responses to similar situations in the future.

65. From the DELWP investigation report, it is clear that there were performance issues with the systems and processes in place for incidents in remote locations requiring rapid first aid assistance. Having regard to the information provided by DELWP, I am satisfied that adequate steps have been taken these improve systems and processes. I am also satisfied that the

[19] Letter from Chris Hardman to Coroners Court dated 9 June 2022, p 4.

DELWP hazardous trees assessment criteria and training programs have been reviewed and the required policy changes have been made,

66. To reduce the likelihood of the issues associated with this incident reoccurring, I support the ongoing work between DELWP, FFMVic and Ambulance Victoria to maintain their commitment to continuous improvement of the procedures and initiatives that have been implemented in response to the recommendations in the DELWP investigation report.

67. I thank DELWP for its thorough response and the work that has been done to adopt and implement the recommendations in the DELWP investigation report.

I convey my sincere condolences to Bill's family for their loss.

Pursuant to section 73(1B) 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:

Carol Slade, Senior Next of Kin

Sergeant Rodney Smith, Coroner's Investigator

Mr Chris Hardman, Chief Fire Officer, Forest Fire Management Victoria

Signature:

Judge John Cain
STATE CORONER
Date: 15 August 2022

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.