IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 004724

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Christopher James Wrigglesworth
Date of birth:	29 March 1961
Date of death:	27 August 2020
Cause of death:	1(a) Multiple injuries sustained from a tree falling on a motor vehicle (driver)
Place of death:	Terrys Avenue & Ena Road, Belgrave, Victoria, 3160
Keywords:	Accident; Tree fall

INTRODUCTION

1. On 27 August 2020, Christopher James Wrigglesworth was 59 years old when he died from injuries sustained from a tree falling on his motor vehicle. Christopher is survived by his partner Christina Doogood and two step-children.

THE CORONIAL INVESTIGATION

2. Christopher'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.

3. 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.

4. 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.

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

6. This finding draws on the totality of the coronial investigation into the death of Christopher 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.[1]

[1] 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.

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

Circumstances in which the death occurred

7. On the evening of 27 August 2020, Christopher left home alone to buy some champagne for his sister's birthday. He drove his partner's 2015 white Hyundai i30 and parked in the carpark near Terrys Avenue behind the Belgrave Woolworths.

8. There were significant winds at the time. Immediately over the road at the Belgrave Police Station, officers noted extensive rain and wind. At one stage, the power went out and the generator started to maintain power supply to the station.

9. Adjacent to the road from the carpark is a small reserve with several large trees. As Christopher was leaving the carpark, one of these trees fell directly onto the front of the vehicle. The fallen trunk came to a rest over the top of the car which pinned Christopher within the vehicle.

10. Nobody saw the tree fall, but a witness coming out of the supermarket noted a massive gust of wind and then 'a big boom'. The witness turned to the direction of the sound, saw the tree on the car, and attended to Christopher. They provided reassurance and held Christopher's hand until police arrived.

11. Another witness saw the tree resting on the car and ran across the road to the Belgrave Police Station to ask for help. At the same time, other witnesses starting using small chainsaws to try and cut some branches off the fallen tree.

12. When officers from Belgrave Police Station attended, they noted that the police radio was very busy at the time with multiple calls related to the significant weather—one street nearby had over ten trees fall around the same time with resulting property damage. Officers struggled to give updates over the radio throughout the evening because it was so busy.

13. Paramedics from Ambulance Victoria, members from the Country Fire Authority (**CFA**), and members from State Emergency Services (**SES**) attended the scene shortly afterwards. Given the degree of entrapment, paramedics were unable to assess Christopher below his abdomen. Christopher was trapped for approximately one hour and forty minutes before members from CFA and SES were able to extricate him from the vehicle.

14. Once extricated, paramedics assessed Christopher's injuries as severe and life threatening. While Christopher was conscious and able to respond to emergency service workers, he was

confused and repeating himself. Given the extent of the injuries, the plan was for Christopher to be transferred to hospital via the Helicopter Emergency Medical Service (**HEMS**).

15. Christopher was conveyed by ambulance to a nearby reserve where the helicopter had landed. As he was being loaded into the helicopter, Christopher deteriorated further and became unresponsive. Despite significant resuscitative efforts from paramedics including administration of CPR, Christopher died at the scene and could not be revived.

Identity of the deceased

16. On 28 August 2020, Christopher James Wrigglesworth, born 29 March 1961, was visually identified by his brother, Ian Wrigglesworth.

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

Medical cause of death

18. Forensic Pathologist Dr Gregory Young (**Dr Young**) from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 2 September 2020 and reviewed the Police Report of Death (**Form 83**), post-mortem computed tomography (**CT**) scan, three scene photos from Victoria Police, and notes from Ambulance Victoria. Dr Young provided a written report of the findings dated 8 September 2020.

19. The post-mortem examination showed abrasions and bruises to the head, torso, and limbs. There were no unexpected signs of trauma.

20. Toxicological analysis of post-mortem samples identified the presence of ondansetron. This is consistent with treatment at the scene by paramedics.

21. Dr Young provided an opinion that the medical cause of death was '*1 (a) multiple injuries sustained from a tree falling on a motor vehicle (driver).*'

22. I accept Dr Young's opinion.

FURTHER INVESTIGATIONS

23. The reserve and relevant tree are managed by the Yarra Ranges Shire Council (**Council**). As part of my investigation, the Coroner's Investigator requested the Council to provide a statement addressing the subject tree failure which was provided by the coordinator of the Tree Management Team.

24. The report identified the subject tree as *Eucalyptus cypellocarpa*, common name Mountain Grey Gum, which is a common species and is indigenous to the Yarra Ranges.

25. Trees on Council-owned parks are managed as part of the Tree Assessment Framework in the Council's Tree Policy. Each park is assigned a risk rating which determines how frequently arborists perform proactive tree inspections. The reserve where the incident occurred is classified as a moderate risk zone. This means that the area, including each tree, is inspected by arborists every two years. At last review on 30 December 2019, the arborist recommended no action for any of the trees in the reserve.

26. In addition to Christopher's death, the Coroner's Court investigated two other deaths from tree failure which occurred on the same night from the same weather event. The local councils responsible for those trees each engaged an independent arborist to identify the cause of tree failure as part of their investigation. This is not the practice of Yarra Range Shire Council.

FINDINGS AND CONCLUSION

27. Pursuant to section 67(1) of the Act I make the following findings:

    a) the identity of the deceased was Christopher James Wrigglesworth, born 29 March 1961;

    b) the death occurred on 27 August 2020 at Terrys Avenue & Ena Road, Belgrave, Victoria, 3160, from *1(a) multiple injuries sustained from a tree falling on a motor vehicle (driver)*; and

    c) the death occurred in the circumstances described above.

28. Having considered all the circumstances, I find that the death was the result of a tragic accident caused by tree failure from significant winds. However, without any report from an independent arborist, there is insufficient evidence to determine if there were any further contributing factors about the tree itself that could have made it more susceptible to failure in such conditions.

29. I find that Yarra Range Shire Council had in place appropriate processes for regular tree inspection under its Tree Assessment Framework, and that noting the outcome of the most recent inspection, the tree failure could not have been foreseen.

30. Nonetheless, I consider that the occurrence of any fatal incident should give rise to a further assessment of risk, which could be achieved by commissioning an additional, independent arborist report. Such inspections may reveal issues or problems with trees which are not appreciable on visual tree assessment alone, and thereby enable better identification of preventable causal factors and future prevention opportunities. I have included a recommendation as such below.

31. On 3 July 2023, Yarra Ranges Shire Council indicated that it agreed with the proposed recommendation and intended to incorporate the recommendation into its Tree Policy when it is reviewed over the coming year. I commend the Council on its commitment to improve its processes in this way.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendation:

(i) That Yarra Ranges Shire Council consider incorporating a requirement into the Tree Assessment Framework of the Tree Policy to obtain an independent arborist report in cases where tree failure results in death.

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

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

Christina Doogood, Senior Next of Kin

Paul Mechelen, Yarra Ranges Council

Larelle Thomas, TAC

SC Grant Harrison, Coroner's Investigator

Signature:

Coroner Leveasque Peterson

Date : 13 July 2023

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.