IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 3580

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of ED

Delivered On:	29 JUNE 2021
Delivered At:	THE CORONERS COURT OF VICTORIA 65 KAVANAGH STREET, SOUTHBANK
Hearing Dates:	16, 17 AND 18 JUNE 2021
Findings of:	CORONER PHILLIP BYRNE
Counsel Assisting the Coroner:	ACTING SERGEANT JEFFREY DART, POLICE CORONIAL SUPPORT UNIT
Representation:	MR STEPHEN RUSSELL OF COUNSEL APPEARED ON BEHALF OF MR GIANFORTE

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OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2019 3580**

FINDING INTO DEATH WITH INQUEST

Form 38 Rule 63(2)
Section 67 of the ***Coroners Act 2008***

I, PHILLIP BYRNE, Coroner having investigated the death of ED
AND having held an inquest in relation to this death on
find that the identity of the deceased was ED
born on 6 May 1960
and the death occurred on 10 July 2019
at the Alfred Hospital, 55 Commercial Road, Melbourne, Victoria 3004

from:

I (a) HEAD INJURIES

Pursuant to section 67(1) of the **Coroners Act 2008** I make findings with respect to **the following circumstances**:

BACKGROUND

1. ED, who at Mrs D's request I will refer to as ED, was 59 years of age at the time of his death. ED resided with his wife of almost 40 years Mrs D at 6629 Maroondah Highway, Yarck. ED was a well-regarded, hard-working man, proud of his Aboriginal heritage.
2. ED worked for Mr Lewis Gianforte, an agricultural contractor, initially on a casual basis but on a full-time basis for about 12 months up until his untimely death in July 2019. ED and Mr Gianforte were not only employee and employer, but also enjoyed a friendship.

BROAD CIRCUMSTANCES SURROUNDING DEATH

3. On Wednesday 10 July 2019 at about 8am ED attended Mr Gianforte's property at 21 Mt Margaret Road, Marysville. After feeding cattle and taking a mid-morning "smoko," Mr Gianforte and ED attended a paddock on the property known as "Lane Gully" paddock to clear up a fallen tree. The fallen gum tree was cut up and a fire started to burn the fallen tree. At that time it was decided to fell two standing dead trees proximate to the fallen tree and

add them to the fire. It was decided the standing dead trees would be pushed over onto the fire utilising the bucket of Mr Gianforte's John Deere tractor. The felled trees were then to be cut up by ED using a chainsaw, with Mr Gianforte cleaning up the off-cuts with the tractor, pushing them onto the fire.

4. Believing ED was positioned some distance from the fire away from the area where the trees were to be felled, Mr Gianforte pushed the first tree over with it landing where expected. He then commenced pushing the second tree over. The second felled tree landed to the right of the first felled tree, not on the fire. Mr Gianforte then drove the tractor to where the felled tree landed where, no doubt to his horror, he located ED face-down on the ground. It soon became apparent to Mr Gianforte that ED had sustained a significant head injury. Mr Gianforte immediately rang the 000 emergency number and received instructions on how to provide care to ED until the arrival of ambulance paramedics.

5. The 000 emergency call resulted in the attendance first of ambulance paramedics followed by Victoria Police members including, following protocol, members of the Alexandra Crime Investigation Unit, and an Ambulance Victoria air ambulance with a MICA flight paramedic.

6. ED was assessed as suffering an extremely serious head injury. He was placed in an induced coma, intubated and conveyed to the Alfred Hospital in Melbourne at 1:55pm. After resuscitation, assessment and treatment in the Emergency Department, review of radiology and CT scans, and in consultation with members of the neurological team it was concluded ED's injuries were "catastrophic;" it was considered ED's condition was unsalvageable. In consultation with the family, end of life care was initiated and ED passed away at 6:10pm that evening.

REPORT TO THE CORONER

7. ED's death was reported to the coroner. Having examined the Form 83 Police Report of Death for the Coroner and the e-Medical Deposition submitted by the Alfred Hospital, having considered the circumstances as reported, and having conferred with a forensic pathologist, I directed an external only post mortem examination and ancillary tests.

8. The directed post mortem examination was undertaken at the Victorian Institute of Forensic Medicine (**VIFM**) by Forensic Pathologist Dr Joanna Glengarry. Dr Glengarry advised ED's death was due to:

   I(a) HEAD INJURIES

By way of comment she advised post mortem imaging at VIFM demonstrated ED had suffered a "severe traumatic brain injury" and other injuries, including a skull base fracture and cervical spine fractures. Toxicological analysis of a post mortem blood sample demonstrated Delta-9-tertahydrocannibol (cannabis) at ~5 ng/mL.

FURTHER INVESTIGATION

9. On receipt of Dr Glengarry's medical examiner's report, on 27 August I had my registrar request the coroner's investigator prepare a full coronial brief of evidence. On the same day my registrar provided to Mrs D a copy of the medical examiner's report and advised I had requested a brief of evidence to assist my investigation. Having regard to the circumstances I was aware the matter would be reported to WorkSafe and they would also conduct an investigation. It should be understood that the WorkSafe investigation is distinct/separate to my coronial investigation; the separate investigations have a somewhat different focus. My primary focus is to endeavour to establish the facts surrounding the death without laying or apportioning blame; whereas my understanding is that the primary focus of the WorkSafe investigation is to examine whether there has been any breach of the *Occupational Health and Safety Act 2004*, together with a focus on seeking to prevent workplace deaths.

10. A comprehensive coronial brief of evidence was submitted to the Court on 30 October 2019 by the coroner's investigator Detective Sergeant Michael Engel of Alexandra Crime Investigation Unit. I commend Detective Sergeant Engel on the quality of the investigation and brief. As is often the case in matters such as this the coroner's investigator's brief contains material extracted from the WorkSafe brief.

11. In late July 2019 WorkSafe advised they were investigating the circumstances of ED's death for "… possible breaches of the *Occupational Health and Safety Act 2004*." In those circumstances, following my normal practice, I decided to leave my investigation in abeyance.

12. In June 2020 Piper Alderman Solicitors advised they now act for Mr Gianforte. A copy of the initial brief lodged by the coroner's investigator was provided. Subsequently further photographs were provided.

13. In January 2021 WorkSafe provided to the Court a copy of their brief of evidence; extremely comprehensive material on a USB. Included was a statement by Senior WorkSafe Investigator Kevin Falkenbach, a copy of which I had my registrar extract from the USB material. I noted that at the conclusion of his investigation Mr Falkenbach formed the view

that the work practice in place at the property on the fateful day was deficient on a number of bases. When my registrar enquired of WorkSafe she was advised the matter had been "moved to legal review."

14. In an email of 3 February 2021WorkSafe advised they did not commence a prosecution "due to insufficient evidence and public interest considerations." In light of that advice I no longer needed to leave my investigation in abeyance; it was therefore enlivened.

15. Having examined the body of material I formed the view it would not be appropriate to proceed to finalisation "on the papers" by way of a Finding Without Inquest. I decided the best way to progress my investigation was to list the matter for a Mention/Directions hearing. Mrs D was advised of my proposal and invited to submit any further material she would have me consider. The primary reason I took that decision was on the material I had at that point there was a prospect, and I put it no higher than that, that an adverse finding against Mr Gianforte would be a possibility in relation to unsafe workplace practices on the day. On 25 February 2021 I requested my registrar list the matter for a Mention/Directions hearing with a view to considering whether to list for formal inquest, determine the scope/parameters of an inquest if one were to proceed, and to settle a list of witnesses. At that hearing the interested parties, Mrs D and Mr Gianforte, would be invited to make submissions on those issues.

16. Through Mr Troy Williamson, the Koori Family Engagement Coordinator at the Court, Mrs D indicated she did not wish to be formally engaged in the preliminary hearing, but wanted to observe and listen to the proceeding.

17. A Mention/Directions hearing proceeded on 20 April 2021 at which Ms Rachel Quinn, my coroner's solicitor, appeared to assist, Mr Stephen Russell of counsel appeared on behalf of Mr Gianforte, and Mrs D was "linked in" via Webex. Ms Cara Foot and Ms Penelope Corns appeared for WorkSafe and Alfred Health respectively. At the outset I advised Ms Foot and Ms Corns I had no issues with their respective clients and anticipated their roles would merely be keeping a "watching brief."

18. In this formal finding I do not propose to relate "chapter and verse" Mr Russell's submissions, but merely say he submitted there was no reasonable basis to be critical of Mr Gianforte and it would be appropriate for me to finalise the matter "on the papers." Again through Mr Williamson, Mrs D indicated she did not want the matter to proceed to inquest and did not at that point seek further input.

19. At the completion of the Mention/Directions hearing I advised the interested parties I proposed to take the matter to formal inquest. I indicated my focus at inquest would be narrow: whether an appropriate risk assessment was undertaken and whether there was some form of "plan," for want of a better word, to ensure the safety of ED during the process of felling the two dead trees. I also tentatively settled a list of witnesses I would call at the formal inquest hearing. Mr Gianforte was included in that tentative list, but more on that issue later in this finding.

INQUEST FINDING

20. The matter proceeded to inquest on Wednesday 16 June 2021. Acting Sergeant Jeffrey Dart of the Police Coronial Support Unit appeared to assist, and Mr Russell again appeared for Mr Gianforte. I made it clear I had no issues with WorkSafe so that Ms Foot merely had a "watching brief." Prior to the hearing I had Acting Sergeant Dart contact Mrs D to confirm she did not wish to directly engage in the inquest, but wished to again merely observe the proceedings as an attendee via WebEx. I advised Mrs D that adopting that course she would be unable to make a submission at the conclusion of the evidence, but if she wished to make comment at the end of the proceedings I would stand down for a short while during which she could contact Acting Sergeant Dart who would put any matter to me on her behalf.

21. I heard viva voce evidence from Leading Senior Constable Peter Collyer, the first police member to attend the scene, Detective Leading Senior Constable Cusack, and Senior WorkSafe Inspector Mr Kevin Falkenbach. I do not propose to relate in detail their evidence as it is contained in their formal statements which were received into evidence as exhibits.

22. The detail of the examination by Acting Sergeant Dart and Mr Russell is contained in the formal transcript of the proceedings so that again I do not propose to relate it fully "chapter and verse" in this finding. However, I refer to several matters which are in my view significant:

    - No piece of the fallen tree was in the near vicinity of blood on the grass which would explain the significant physical injuries ED sustained.
    - Where <u>precisely</u> ED was when the impact occurred, nor the exact spot when first located on the ground by Mr Gianforte.
    - It was conceded there is a prospect ED moved a short distance before falling to the ground after being struck by part of the tree.

In response to a question by Mr Russell, Detective Leading Senior Constable Cusack conceded there were a lot of "unknowns" after the second tree was felled.

23. Mr Gianforte was the final witness to be called. Mr Russell had earlier indicated Mr Gianforte would likely seek to be excused from giving evidence on the basis to do so would possibly lead to self-incrimination. Of course in common law rule against self-incrimination is a basic, centuries old tenet of our judicial system. However, in the coronial jurisdiction there is a legislative exception to the age-old rule. Section 57 of the *Coroners Act 2008* gives a coroner power to compel a witness to give evidence even though the witness has sought to be excused from doing so.

24. Mr Gianforte entered the witness box, was sworn, then formally sought to be excused from giving evidence on the basis of the privilege against self-incrimination. Mr Russell made a short submission in relation to Mr Gianforte's application. Having considered the relevant issues, including enquiring whether Mr Gianforte was prepared to give evidence under the protection of an s 57 Certificate, and particularly noting the limitation of actions period had not expired, I took the decision <u>not</u> to require Mr Gianforte to give viva voce evidence either with or without the protection of s 57 and he was excused.

25. Acting Sergeant Dart then tendered into evidence the balance of the coronial brief of evidence.

26. Mr Russell made a short submission to the effect there was no basis to make any adverse finding or comment against Mr Gianforte. Mr Russell submitted ED and Mr Gianforte had discussed what was proposed, prior to pushing the second tree over Mr Gianforte had observed ED some distance away from where the tree was to be felled. He further submitted that as Mr Falkenbach had in evidence conceded, no formal standard was applicable. I was advised Mrs D did not wish to add anything.

CONCLUSIONS

27. Before announcing the conclusions I have reached, I think it important to make several comments in relation to the role of the coroner, which is often misunderstood in the broader community.

28. <u>Keown v Khan</u> (1999 1 VR 69), a decision of the Victorian Court of Appeal, represents a landmark judgement which, in my opinion, provided much needed guidance to Victorian (and other) coroners. His Honour Mr Justice Callaway, adopting a statement contained in

the report of the Brodrick Committee (UK) Report of the Committee on Death Certification And Coroners (1971), said:

> *"In future the function of an inquest should be simply to seek out and record as many of the facts concerning the death as public interest required, without deducing from those facts any determination of blame."*

29. Again quoting the Brodrick Committee (UK) Report, His Honour noted:

> *"In many cases, perhaps the majority, the facts themselves will demonstrate quite clearly whether anyone bears any responsibility for the death; there is a difference between a form of proceeding which affords to others the opportunity to judge an issue and one which appears to judge the issue itself."*

30. The apparent contradiction, which I find somewhat difficult to articulate, was discussed in the New Zealand case of Coroners Court v Susan Newton and Fairfax New Zealand Ltd (2006 NZAR 312, 320). Referring to Laws New Zealand Coroners under the heading of "Blame" the Court said:

> *"It is no part of the coroner's function to apportion blame for the death. The coroner must however be able to go beyond the mere cause of death if the coroner is to serve a useful social function, and must establish so far as is possible, the circumstances of the death. The implicit attribution of blame may be unavoidable in order for the coroner to ascertain or explain how the death occurred in the wider events that were the real cause."* (my emphasis)

31. I am satisfied ED was struck a powerful blow likely by a branch of the second falling tree, not the truck. Whatever part of the tree ED was stuck by, the injuries shown at autopsy demonstrate it was on any reasonable definition, not a "stick." Having said that, it is possible, but in my view less likely, the fatal blow was caused by a significant branch which had disconnected when the falling tree impacted the ground.

32. It is true ED and Mr Gianforte had a discussion prior to felling the dead trees, but that was just in relation to how the job was to be done. I am satisfied there was no risk assessment discussed or undertaken, nor was a plan formulated, even an unformal one. It is clear neither ED nor Mr Gianforte turned their minds to the prospect the job may result in injury, let alone death. Mr Gianforte and ED had previously undertaken dead tree felling without incident, which in all likelihood had led to a level of complacency.

33. In my considered view the failure to jointly undertake a risk assessment and formulate a plan to ensure ED's welfare was an omission in breach of a recognised duty, and consequently a causal or at least contributing factor in ED's death.

34. I am unable to reach any firm conclusion as to the relevance, if any, of ED's use of cannabis prior to the fateful incident.

FINDING

35. I formally find ED died in the Alfred Hospital, Melbourne, on 10 July 2019 as a result of head and other injuries sustained earlier that day when struck by a part of a tree being felled at a local property at 21 Mt Margaret Road, Marysville.

DISTRIBUTION OF FINDING

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

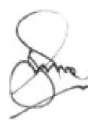
Mrs D, Senior Next of Kin

Sergeant Michael Engel, Victoria Police

Matthew Read, WorkSafe Victoria

Bruce Crosthwaite, Thomson Geer on behalf of WorkSafe Victoria

Keren Day, Alfred Health



PHILLIP BYRNE
CORONER
Date: 30 June 2021