MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Lawrence William Phillips,

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is Lawrence William Phillips;

b) Mr Phillips died as a result of injuries sustained in a tree felling accident;

c) The cause of Mr Phillips' death was electrocution; and

d) Mr Phillips died, aged 62 years, on 6 November 2019 at 116 Stewarts Road, Winkleigh, Tasmania.

Introduction

1. In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Phillips's death. The evidence includes:
   - Police Report of Death for the Coroner;
   - Affidavits establishing identity and life extinct;
   - Report – Dr Terry Brain, Pathologist;
   - Affidavits – Mrs Janis Phillips, sworn 6 November and 3 December 2019;
   - Affidavit - Mr Raymond Simson, sworn 6 November 2019;
   - Affidavit – Senior Constable Dean Purdy, sworn 18 February 2020;
   - Affidavit – Constable David Eaton, sworn 14 November 2019;
   - Affidavit – Senior Constable Maree Fish, sworn 2 December 2019 (and scene photographs);
   - Affidavit – Senior Inspector Sara Richards, WorkSafe Tasmania, sworn 21 January 2020;
   - Affidavit – Senior Inspector Stuart Beams, WorkSafe Tasmania, sworn 20 January 2020;
   - Scene photographs – WorkSafe Tasmania;

- Report to Coroner – Mr Rick Birch, RB Forestry Services, 28 July 2020; and
- Letters – TasNetworks to Mr Raymond Simson dated 7 August and 24 September 2019.

Introduction

2. Mr Phillips was born on 17 September 1957 in Newcastle, New South Wales. He was aged 62 years at the time of his death. During his working life he had been employed as a linesman by an electrical company. In that capacity, and while working for Parks and Wildlife in NSW, he was said to have had experience felling trees, particularly around power lines.[1] He also had private experience using a chainsaw.

3. Mr Phillips was in reasonably good health at the time of his death, although reportedly experienced back issues and was awaiting a knee replacement. Although these injuries caused him pain, they appear not to have affected his daily activities.

The role of the coroner

4. Before considering the circumstances of Mr Phillips' death further it is necessary to say something about the role of the coroner, and the attendant powers and obligations. In Tasmania, a coroner has jurisdiction to investigate any death that "appears to have been unexpected, unnatural or violent or to have resulted directly or indirectly from an accident or injury". [2] Mr Phillips' death obviously meets this definition.

5. When conducting an investigation into a death (whether with or without holding an inquest), a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. A coronial investigation might be described as a quest for the truth. The coroner is required to thoroughly investigate the death and answer the questions (if possible) that section 28(1) of the *Coroners Act* 1995 asks. These questions include who the deceased was, how they died, the cause of the person's death and where and when the person died. This process requires the making of various findings, but without apportioning legal or moral blame for the death. The job of the coroner is to make findings of fact about the death from which others may draw conclusions. A very important aspect of the role of the coroner is to make comments about the death or, in appropriate circumstances, recommendations to prevent similar deaths in the future.

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[1] Affidavit of Janis Pamela Phillips, sworn 6 November 2019.
[2] Section 3 of the *Coroners Act* 1995.

6. It is important to recognise that a coroner does not punish or award compensation to anyone. Punishment and compensation are for other proceedings in other courts, if appropriate. Nor does a coroner charge people with crimes or offences arising out of a death that is the subject of investigation.

7. As was noted above, one matter that the *Coroners Act* 1995 requires, is a finding (if possible) as to how the death occurred. 'How' has been determined to mean "by what means and in what circumstances"[3], a phrase which involves the application of the ordinary concepts of legal causation. Any coronial investigation necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.

Background

8. The owner of the property on which Mr Phillips died, Mr Raymond Simson, received a letter from TasNetworks dated 7 August 2019 advising him that TasNetworks had identified that vegetation was growing too close to an electricity service line on his property. The letter indicated that it was "essential that [the] vegetation [be] cleared within 5 weeks from the date of this letter". The letter went on to indicate that there were two ways the vegetation could be cleared namely by:
    - Engaging a contractor authorised to carry out work within close proximity to power lines to clear the vegetation on Mr Simson's behalf; or
    - Calling TasNetworks for information about the process to have the service line temporarily disconnected (noting that a fee would apply) to allow the vegetation to be cleared, should Mr Simson choose not to engage an accredited contractor.

9. Enclosed with the letter was a list of approved contractors. The letter also included details of how to advise TasNetworks once the clearing of the vegetation had been carried out.

10. Mr Simson does not appear to have responded to that letter and so on 24 September 2019 TasNetworks sent a follow-up letter entitled "Final Reminder – Vegetation Clearance Required". The letter, which erroneously referred to a letter dated 8 August 2019,[4] reminded Mr Simson of his obligation to clear vegetation and told him that if the vegetation had not been cleared and TasNetworks did not hear from him within seven days, he was at risk of disconnection of his electricity supply.

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[3] *Atkinson v Morrow* [2005] QCA 353 at par 13.
[4] Which contextually can only have been the letter of 7 August 2019 referred to above.

Circumstances of death

11. Mr Simson does not appear to have responded to either letter. And rather than engaging an accredited contractor or having TasNetworks remove the vegetation encroaching on the power line Mr Simson decided to undertake the task, on 6 November 2019, with his friend Mr Phillips. Mr Phillips and his wife were at the time visiting Mr and Mrs Simson, and had been staying with them for a few days.

12. I note that there is no evidence that TasNetworks was contacted and thus the power line the subject of encroachment by vegetation remained at all relevant times 'live'.

13. The evidence is that in fact two trees needed to be removed to make the power line safe. The first, a large wattle tree, was blocking access to a dead tree behind it, which in turn needed to be removed as it was the one too close to the power line. Mr Simson and Mr Phillips attempted to push the wattle tree over with a backhoe, but were unable to do so. Accordingly, Mr Simson said that Mr Phillips suggested that he cut it down and Mr Simson agreed knowing, he later told investigators, of Mr Phillips experience with tree felling.[5]

14. Mr Phillips had a Rockwell brand chainsaw (with an 18 inch bar) with him. He got it from his vehicle and commenced to cut down the wattle tree, making cuts in the trunk of the tree close to ground level and from both sides of the tree. He had almost completely cut through the trunk when the tree began to spin. Mr Phillips yelled a warning, after which the tree began to fall, the top canopy of the tree catching on the live power line with the weight of the tree causing the line to sag.[6]

15. Mr Simson described seeing Mr Phillips move around the front of the tree (which it will be remembered was now hanging from a live power line) and beginning to cut through a branch, perhaps with the intention of reducing the weight of the tree on the power line. The chainsaw appears to have jammed before Mr Phillips yelled out a warning to Mr Simson not to touch him and collapsed to the ground. He had been electrocuted. Mr Simson was able to pull Mr Phillips away from the tree as their wives arrived.

16. Mrs Phillips and Mr Simson commenced CPR immediately. Emergency services were called and attended in a timely manner with Ambulance Tasmania personnel and the Tasmanian Police arriving at the scene. Paramedics attempted CPR on Mr Phillips, with

[5] Affidavit – Raymond Charles Simson, sworn 6 November 2019, page 1.
[6] *Supra*, generally.

no response and Mr Phillips was declared deceased at the scene. TasNetworks personnel also arrived to make the scene safe.

Investigation

17. An investigation was commenced at the scene. Mr Phillips' body and the scene were photographed and examined by attending police. They saw that the tree had numerous burn marks on it. Mr Phillips was noted to be wearing gloves, trousers, heavy duty steel boot caps and a long sleeved high visibility top. He had been using ear protection but was not wearing a helmet. I do not consider the absence of a helmet made any difference in this case.

18. Police saw, and photographed, burn marks on the left index finger of Mr Phillips' body and the boot on his left foot, indicating the entry and exit points for the passage of electricity through his body. Relevant witnesses including Mrs Janis Phillips (Mr Phillips wife) and Mr Simson were interviewed at the scene.

19. Mr Phillips' body was formally identified by his wife, before being removed from the scene and taken by mortuary ambulance to the Launceston General Hospital.

20. Two inspectors from WorkSafe Tasmania also attended the scene and carried out investigations, essentially directed to determining whether Mr Phillips' death was one which occurred in circumstances which fell under that agency's jurisdiction (i.e. what might be called a workplace or work related death). As part of that preliminary investigation the investigators examined the chainsaw and also photographed the scene, before determining that they had no jurisdiction to continue to investigate. Nonetheless, their presence at the scene and the evidence they provided to the Coronial investigation was very helpful.

21. The chainsaw was examined and appeared to have no mechanical defect or deficiency which caused or contributed to the happening of the accident which caused Mr Phillips' death. Relevantly, the chain appeared relatively new and in good order.

22. On the following day, 7 November 2019, a post-mortem examination of Mr Phillips was conducted by experienced pathologist, Dr Terry Brain. Dr Brain provided a report in which he expressed the opinion that the cause of Mr Philips' death was due to electrocution. I accept Dr Brain's opinion.

23. Toxicological analysis of samples taken by Dr Brain were subsequently analysed at the laboratory of Forensic Science Service Tasmania. That analysis indicated that

Mr Phillips had no alcohol or illicit drugs of any kind in his system at the time of his death.

24. The investigation under the *Coroners Act* 1995 was unable to determine what formal training, if any, Mr Phillips had received in relation to chainsaw use during his time in New South Wales as the relevant training authority at no stage kept training records for linesmen, electrical company or National Parks' employees. As such, it cannot be determined whether in fact Mr Phillips received any, and if so what, training in chainsaw use.

25. In this case, Mr Rick Birch, Industry Trainer and Assessor reviewed the evidence at the request of the Coronial Division. He provided a helpful report in which he identified that there were numerous mistakes made by Mr Phillips in falling the tree that caused his death. These mistakes included that:
    - The scarf/face/front cut and back cut were not to an acceptable standard;
    - There was no step up between them; and
    - No felling wedge was used resulting in the tree felling in a direction not intended by Mr Phillips.

26. He provided with his report a copy of the Forest Safety Code, in support of his analysis. Mr Birch was of the view that if the tree had been felled in accordance with the procedures outlined in that Code, the tree would have fallen in the intended direction and not over the live power line. I accept Mr Birch's opinion. I consider he is well qualified to express the opinions that he did.

27. All of this material has informed my conclusions and the comments and recommendations which follow below.

Discussion

28. I very much regret to say that I have concluded that in this instance almost all that could be done wrong by Mr Phillips was done wrong. His death was completely avoidable. He used completely inadequate chainsaw techniques to attempt to fell a tree adjacent a live power line. Having lost control of the tree (due to those poor techniques) he continued to use the chainsaw on a tree he must have known was in direct contact with a live power line.

29. Unfortunately, tree felling accidents involving chainsaws, such as that causing Mr Phillips' death, are frequently encountered by coroners. Such incidents are

common in Australia and are significantly over-represented in Tasmania, particularly within rural areas.

30. In the last five years I have investigated eight deaths arising from, or associated with, the use of chainsaws in this state. All of the deceased were men. They ranged in age from 21 to 75. They died in different rural localities – Cockle Creek, Smithton, Hastings, Somerset, Forthside, Dulverton, and in the Central Highlands – all over the state. Like Mr Phillips' death, all of their deaths were avoidable in different ways.

31. In August 2017, I published findings in respect of six of those deaths.[7] I said that the common factors that lead to deaths associated with the use of chainsaws and tree felling are a lack of training, failure to wear protective equipment, poor tree felling techniques and dangerous chainsaw use practices.

32. I consider that all of those factors (except deficient of absent PPE) contributed to Mr Phillips' death.

33. In my previous findings I made the following recommendations:
    - *That all chainsaw operators must undertake approved chainsaw training prior to purchasing or using a chainsaw.*
    - *That all persons selling chainsaws must be accredited chainsaw operators.*
    - *That all chainsaw operators must undergo regular practical reassessment.*
    - *That all landowners be required to ensure that people permitted to use chainsaws on their land be appropriately qualified.*
    - *That no person under the age of 16 years be permitted to own or use a chainsaw in any circumstances.*

34. I repeated and emphasised those recommendations in two further findings.[8] The recommendations have also been endorsed by Coroner McTaggart.[9] Despite this, I am not aware that any agency or body has taken steps to implement any or all of the recommendations. In fact, the only response by the Executive Branch of Government of which I am aware is a detailed explanation by the Department of Primary Industries, Parks, Water & [*sic*] Environment as to why it is not responsible for the regulation of chainsaw safety. That may be correct; but I must observe that after eight deaths from inappropriate or downright dangerous chainsaw use in five years it is disappointing

[7] See *Dransfield, Brian* 2017 TASCD 323; *Howard, Lawrence Alan* 2017 TASCD 324; *Hyland, Tobias Joseph* 2017 TASCD 325; *Mitchell, Kenneth Hudson* 2017 TASCD 326; *Spanney, Kenneth David* 2017 TASCD 327; *Young, Dylan Broderick* 2017 TASCD 328.
[8] See *Kingston, Neil Robert* 2017 TASCD 439; *Fletcher, Braidon Lewis* 2018 TASCD 300.
[9] See *Williamson, Colin George* 2020 TASCD 463.

that the only response has been a lengthy explanation as to why one government department is apparently not responsible to respond to recommendations.

Comments and recommendations

35. In the circumstances, I consider that it is necessary to urgently **recommend** that the appropriate government agency commence immediate steps to ensure regulatory reform is undertaken directed at preventing deaths and injuries arising from the use of chainsaws in the Tasmanian community.

36. In conclusion I convey my sincere condolences to the family and loved ones of Mr Phillips.

Dated: 22 February 2023 at Hobart in the State of Tasmania.

Simon Cooper
Coroner