



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 0031

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

Findings of: **MICHELLE HODGSON, CORONER**

Deceased: [REDACTED]

Date of birth: [REDACTED]

Date of death: [REDACTED]

Cause of death: **1(a) Injuries sustained in a tractor incident**

Place of death: [REDACTED] VIC [REDACTED]

HER HONOUR:

Background

1. [REDACTED] was born on [REDACTED] and was the beloved son of [REDACTED] and brother to [REDACTED]. He was [REDACTED] years old when he died on [REDACTED] following a tractor incident on his family's farm.

[REDACTED] For generations, [REDACTED] family had lived and worked on the farm at [REDACTED]
[REDACTED]
[REDACTED]

3. [REDACTED] father ([REDACTED]) was a qualified diesel agricultural mechanic. He had managed the farm's contracting business for eight years at the time of [REDACTED] death. His work included maintenance and mechanical fixing of tractors and machinery, as well as general farm duties including fertilising paddocks using a tractor and fertiliser spreader.
4. [REDACTED] father grew up on the farm and would often take his children to work there when it was not silage season. The children would generally stay with [REDACTED] on the farm for half a day, then return home for lunch or visit their grandparents who lived on the farm.

The coronial investigation

5. [REDACTED] death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008 (Vic)* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.
6. Coroners independently investigate reportable deaths to find, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.¹

¹ In the coronial jurisdiction facts must be established on the balance of probabilities 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

7. The law is clear that coroners establish facts; they do not 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 into [REDACTED] death. The Coroner's Investigator investigated the matter on my behalf and submitted a coronial brief of evidence.
10. I requested the Coroners Prevention Unit (CPU)² review the circumstances of [REDACTED] death to identify opportunities to prevent similar deaths from occurring in future.
11. I also received material from Worksafe Victoria, which investigated the fatal incident but did not commence a prosecution against any person or entity.
12. After considering all the material obtained during the coronial investigation, I determined that I had sufficient information to complete my task as coroner and that further investigation was not required.
13. 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.

Circumstances in which the death occurred

14. In the early morning of [REDACTED], [REDACTED] went to work at the farm and returned home for breakfast. After breakfast, he returned to the farm with [REDACTED] and the pair arrived at about 9:00am. [REDACTED] continued to work in the machinery shed.

a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

² The role of the Coroners Prevention Unit (CPU) is to assist coroners investigating deaths, particularly deaths that occur in a healthcare setting. It is staffed by healthcare professionals, including practising physicians and nurses, who are independent of the health professionals and institutions under consideration.

15. At about 10:15am, [REDACTED] needed to disconnect a Kubota fertiliser spreader from a John Deere 6150R tractor. The spreader weighed about 675 kilograms and was filled with an estimated two tons of urea fertiliser.
16. As was his usual practice, [REDACTED] lowered the spreader onto two wooden pallets that were stacked on the ground. He disconnected the linkage which connected the spreader to the tractor. [REDACTED] was standing to his right.
17. Once disconnected, the full weight of the spreader rested on the pallets. The pallets cracked causing the fertiliser spreader to slowly roll backwards. The rear of the spreader hit the ground. [REDACTED] was not in sight.
18. [REDACTED] ran to the back of the equipment and observed [REDACTED] under the spreader with their head and chest exposed. He yelled, which alerted [REDACTED] [REDACTED], who were also working on the farm.
19. Emergency Services were called. A forklift was used to lift the spreader and [REDACTED] was pulled from the fertiliser underneath. [REDACTED] carried [REDACTED] to his grandparents' house and administered cardiopulmonary resuscitation.
20. At about 11:10am, Victoria Police attended the scene and Ambulance Victoria paramedics arrived shortly afterwards. Sadly, [REDACTED] was unresponsive and could not be revived.

Identity of the deceased

21. On [REDACTED], [REDACTED] was visually identified by his grandfather, [REDACTED].
22. Identity is not in dispute and requires no further investigation.

Medical cause of death

23. On [REDACTED], Dr Victoria Francis, Forensic Pathologist at the Victorian Institute of Forensic Medicine conducted an external examination upon the body of [REDACTED] and reviewed a post mortem computed tomography (CT) scan.

24. The examination showed injuries to [REDACTED] head, face, torso and left leg. The CT scan confirmed that [REDACTED] suffered significant head and body injuries, including multiple fractures and a pneumocephalus.³
25. After reviewing the CT scan, a radiology report from the Royal Children's Hospital, and toxicology results, Dr Francis completed a report dated [REDACTED], in which she formulated a reasonable cause of death to be: "*1(a) Injuries sustained in a tractor incident*". I accept Dr Francis' opinion as to the medical cause of death.

Further investigation

26. Following a notification to WorkSafe Victoria, John Hambridge of John Hambridge Consulting completed an inspection on the tractor and spreader involved in the incident and prepared a report. The inspection found no apparent mechanical, hydraulic or electrical faults that could have contributed to the incident.
27. The report noted that the practice of using one or two pallets to support a spreader is not uncommon throughout the agricultural industry. However, Mr Hambridge opined this is not a safe practice.
28. According to Mr Hambridge, best practice for the connection and storage of the spreader is to establish a demarcation area with clear boundaries that is restricted to operational personnel, ideally on a level and compacted ground area. The use of a concrete apron should be considered and should allow the spreader to be placed at an appropriate height for coupling to a tractor.
29. The Victorian WorkCover Authority did not commence a prosecution against any party in relation to this matter.

Comments pursuant to section 67(2) of the Act

30. Farms can be places where Victorian families live, work and play. It is common practice for many farming families to bring children to a farm worksite, and it was not uncommon for [REDACTED] to bring his children to the farm while he was working.

³ Air in the intracranial cavity.

31. However, farm worksites present serious death and injury risks to children that other workplaces and homes do not. Children lack the physical and mental capacity to avoid many farm hazards and are therefore vulnerable to injury or death arising from exposure to dangerous machinery, livestock, grain loading areas, bodies of water and chemicals. Further, adults engaged in farm work may not be able to also adequately supervise their young children.

32. [REDACTED]
[REDACTED]⁴
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

33. Parents must weigh the risks of bringing their children onto a farm worksite with perceived benefits, which include meeting childcare needs of the family, building character in children, and continuing family farming culture.

34. It is important that Victorian farming families are fully aware of how to minimise risks to their children on farm worksites. There are public resources that provide safety tips for children on farms, including from WorkSafe Victoria and the Better Health Channel.⁵ I am mindful that various organisations, the media and other farming families and may read this finding. I therefore take the opportunity to highlight the following risk-reducing measures as recommended by WorkSafe and Better Health Channel:⁶

⁴ [REDACTED]

⁵ Better Health Channel is a website managed and authorised by the Department of Health and Human Services, Victoria.

⁶ WorkSafe Victoria, 'Children on farms', <<https://www.worksafe.vic.gov.au/children-farms>>, last accessed 24 January 2020; Better Health Channel, 'Farm safety – children', <<https://www.betterhealth.vic.gov.au/health/HealthyLiving/farm-safety-children>>, last accessed 24 January 2020.

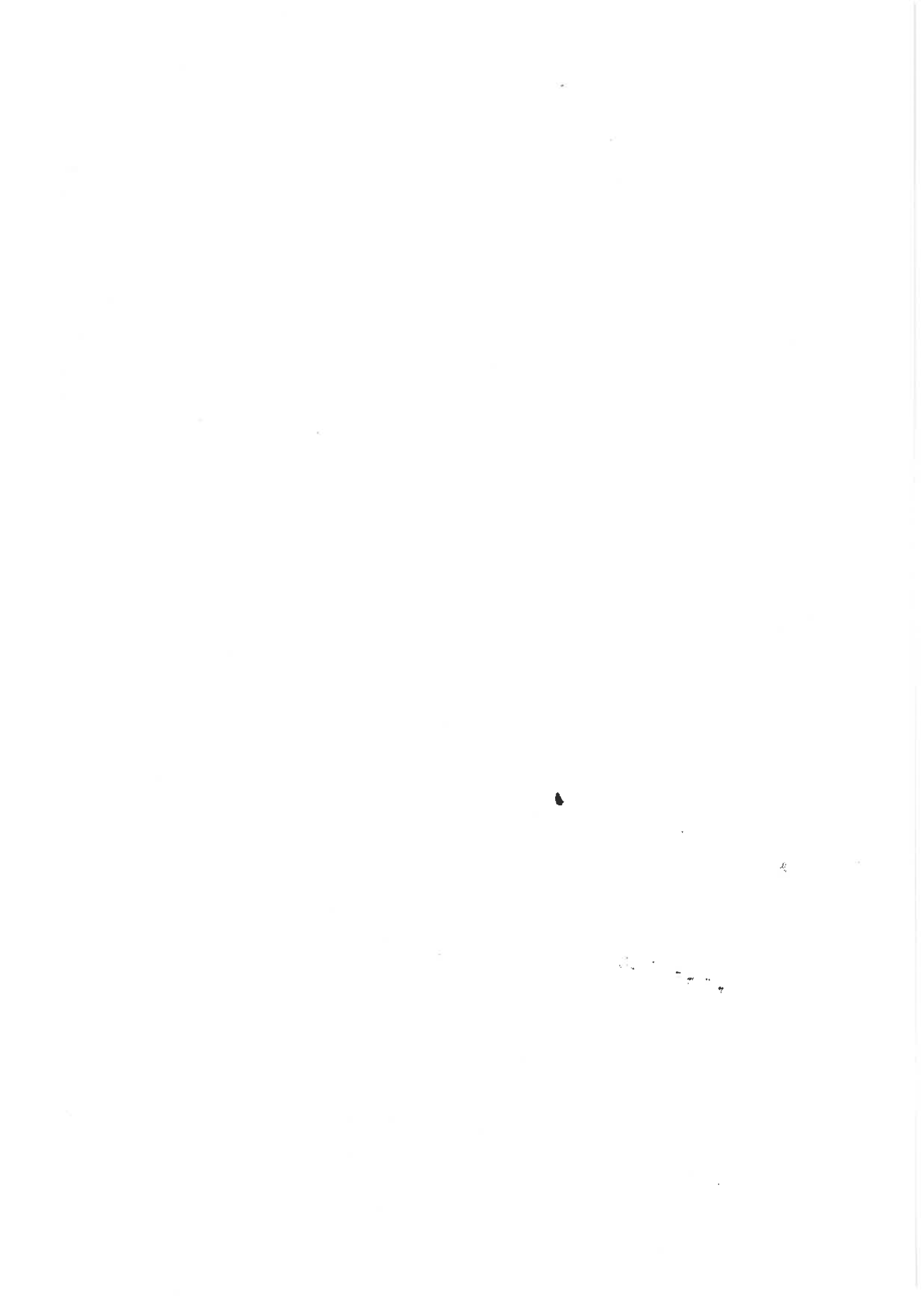
- (a) Provide young children with a safe play area such as a securely fenced house yard where there are no major hazards.
 - (b) Create 'out of bound' areas in and around silos, grain loading areas, farm machinery, power tools and animal pens.
 - (c) Teach children water safety and fence off all water sources such as dams, ponds, septic tanks, sheep dips, pools and creeks, where possible.
 - (d) Don't let a child ride on farm machinery, such as tractors, or in the back of utes.
 - (e) Lock up chemicals and guns.
 - (f) Ensure children do not have access to ladders and do not climb to heights.
 - (g) Teach children about both the positive and dangerous aspects of livestock and farm animals.
35. Above all, I note that supervision is the most important safety precaution in preventing child injuries. [REDACTED] tragic and accidental death highlights that young children require constant adult supervision, especially around farm machinery.

Recommendations pursuant to section 72(2) of the Act

36. I recommend that WorkSafe Victoria, in consultation with Victorian Farmers Federation, consider engaging with farming families and/or conducting a public awareness campaign aimed at farming families highlighting the risks of having children on the farm worksite while undertaking work and incorporating how to keep children safe on farms.

Findings and conclusion

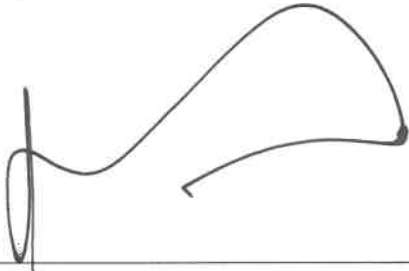
37. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008* (Vic):
- (a) the identity of the deceased was [REDACTED] born [REDACTED];
 - (b) [REDACTED] died on [REDACTED] at [REDACTED] Victoria from injuries sustained in a tractor incident; and



- (c) the death occurred in the circumstances described above.
38. I express my sincere condolences to [REDACTED] father [REDACTED] and mother [REDACTED], together with his siblings, grandparents and extended family.
39. Pursuant to section 73(1B) of the Act, I order that this finding be published on the internet.
40. However, I order that information that would identify [REDACTED] and their family be redacted prior to publication to protect family privacy.
41. I direct that a copy of this finding be provided to the following:

[REDACTED] Senior Next of Kin
Liana Buchanan, Commission for Children and Young People
WorkSafe Victoria
The Victorian Farmers Federation
Detective Senior Constable Craig Wastell, Coroner's Investigator

Signature:



MICHELLE HODGSON

CORONER

Date:

7.2.2020

