IN THE CORONERS COURT
OF VICTORIA
AT SWAN HILL (KERANG)

Court Reference: COR 2012 000047

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
*Section 67 of the **Coroners Act 2008***

I, D.B.S. Cottrill, Coroner having investigated the death of SG
without holding an inquest:
find that the identity of the deceased was SG
born on 6 February 2007 aged 4 years
and the death occurred on 6 January 2012
at Kerang

from:

1 (a) Head injuries sustained from a falling piece of farm machinery

Pursuant to section 67(2) of the **Coroners Act 2008**, there is a public interest to be served in making findings regarding **the following circumstances**:

1. On 6 January 2012, SG, (born 6 February 2007) suffered fatal injuries when a hay bale spike, at the time disconnected from a front end loader and free standing weighing approximately 150kg, fell backwards. Shortly prior to the incident SG was with his father who was removing a bucket from a front end loader. SG had been moved from the bucket to sit beside his father out of harms away. As his father worked to undo nuts on the pins holding the bucket, SG moved to the bale spike where he commenced to climb to near the top of the fork in the middle. The fork then unbalanced and fell back on top of SG, with his head and body on the ground within the area covered by the fork.

2. SG was rushed by his father immediately to Kerang Base Hospital. Emergency resuscitation was undertaken with external cardiac compression, oxygen ventilation and intravenous fluids and adrenalin without response. SG's death was declared at 10.27 a.m.

3. The accident site was attended by Swan Hill C.I.U. and police members. Investigation has also been completed by Worksafe Victoria. It is not intended that any person will be charged for an offence arising from the death.

4. The statement of Wayne Brown Snr Worksafe investigator dated 15 May, 2012 details his observations at the accident site:

"the bale spike was made of a prefabricated metal of 70ml box channelling. I observed the frame laying flat on the ground and the spikes were pointing in the air. There is a total of five spikes, two long, and three shorter, which ran on the bottom rail of the frame. The frame measured 1.8m in height of which 660mm was in a bolt on extension. The width of the bale spike frame measured 1.94m. The bale spike was designed to carry two by 900mm large hay bales, but only the bottom bale would be spiked in the operation. The spikes protruded from the lower frame and had two lengths. Three spikes at 870mm and the two longer at 1140mm. The bale spike was very well made, and constructed specifically for the purpose of moving and lifting hay bales. There were two small patches of blood located on the ground within close proximity to where the top section of the bale spike was seated on the ground. It was also noted that a small round treated pine log or section of post measuring 100mm in diameter and measured around 400mm long, was located in front of the bale spike. It was laying length ways along the frame length and there were indentations in this log which where consistent with the round bale spike diameter. It was thought that at the time the bale spike may have been sitting on top of this log allowing the bale spike to be in an upright position but angled forward so as the spikes were into the ground. In this particular position it would have possibly made it safer from accidentally running into the spikes. However if the log or section of post was placed under a spike within the area of the middle spike, it may have made the frame more unstable as it could have caused rocking or side ways movement from left or right if any weight was applied to either end."

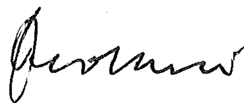
5. Detective Senior Constable Barry Gray of Swan Hill police crime department provides a statement dated 3 July, 2012 detailing his investigations. I adopt his conclusions:

   - SG died in circumstances which, at the time were unforeseeable and that no person at the time and in the circumstances could have been expected to prevent
   - The death was an unexpected and tragic misadventure which was not suspicious
   - Subsequent modifications to farm equipment and changes in farm practices, by people involved in the investigation and arising from the death have been made which would most likely, if known, prevent similar incidents of death or serious injury accruing to others in the future.

6. Detective Senior Constable Gray and Worksafe investigator Wayne Brown identify prevention issues. **I endorse the following recommendations:**

   1. That specific guidance material be published to target the hazards and risks associated with children and young persons on farms.
   2. That appropriate alerts be published regarding hazards and risks associated with children being near tractor implements and to warn of the hazards and risks associated with free standing farm implements or attachments.
   3. That the "Farmsafe" programme which concentrated on young persons in the rural and farming environment be revisited.

Signature:



D.B.S. Cottrill
Date: **9 October 2012**