IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2018 2151

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008 (Vic)

I, AUDREY JAMIESON, Coroner having investigated the death of FRANK JOHN HULLAND

without holding an inquest:

find that the identity of the deceased was FRANK JOHN HULLAND

born 16 September 1940

and the death occurred on 7 May 2018

at 66 Ross Road, Patchewollock, Victoria 3491

from:

1 (a) CHEST AND PELVIC INJURIES SUSTAINED IN A FARMING INCIDENT

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

1. Frank John Hulland was 77 years of age and had been married to Noela Hulland for 51 years at the time of his death. Mr Hulland and Mrs Hulland resided in Murray Downs, but he frequently returned to the Patchewollock area to assist their children on

family-owned properties. Mr Hulland had a medical history of scoliosis, which developed as a complication of a thigh fracture and limb shortening, and one fainting episode associated with supraventricular tachycardia which was attributed to severe dehydration.

2. On 6 May 2018, Mr Hulland came to Patchewollock, intending to stay for one week to help his sons Ashley and Nicholas with farm-work. At approximately 1.00pm on 7 May 2018, Nicholas Hulland helped his father load hay bales onto a hydraulic trailer attached to Mr Hulland's Ford utility. Between 3.30pm and 4.00pm, a friend of the family saw Mr Hulland driving through Patchewollock township. He subsequently drove to a family property on Ross Road to feed livestock.

3. Between 8.30pm and 8.45pm, Nicholas Hulland drove down Ross Road toward the paddock where his father was working. He saw Mr Hulland's Ford utility was in the trees with the brake lights on and immediately perceived that something was wrong. Nicholas Hulland searched the area, but it was very dark, and he could not find his father.

4. At approximately 8.45pm, Nicholas Hulland used a two-way radio to contact his brother to ask him for assistance. Ashley Hulland asked his wife to contact an ambulance as he was concerned for his father's welfare, and then he drove down to the paddock. The two brothers found their father by retracing tyre marks. Mr Hulland was on his back and had his arm in the air. He was conscious and told his sons that he felt pain in his ribs and pelvis. Mr Hulland's stomach had red marks across his waist and he felt cold to the touch.

5. At approximately 10.30pm, Ambulance Victoria paramedics arrived and Mr Hulland's condition rapidly deteriorated. Despite resuscitative efforts, Mr Hulland's condition continued to deteriorate and he was declared deceased at approximately 11.20pm.

INVESTIGATIONS

Forensic pathology investigation

6. Dr Heinrich Bouwer, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM), performed an external examination upon the body of Frank John

Hulland, reviewed a post mortem computed tomography (CT) scan and referred to the Victoria Police Report of Death, Form 83. Dr Bouwer commented that external examination findings were consistent with the known mechanism of injury.

7. CT scanning identified multiple rib fractures, bilateral pubic fractures, a right haemothorax,[1] a bilateral pneumothorax,[2] subcutaneous emphysema in the left posterolateral chest wall,[3] blood in the subcutaneous tissue of the right thigh and a cystic lesion adjacent to the bladder. No significant cranial injuries were detected. Patchy coronary artery calcifications were identified, however, Dr Bouwer commented that it was not possible to determine conclusively whether naturally occurring disease may have contributed to Mr Hulland's death without conducting an autopsy. Toxicological analysis of post mortem blood did not identify any common drugs or poisons.

8. Dr Bouwer formulated the medical cause of Mr Hulland's death as chest and pelvic injuries sustained in a farming incident.

Police investigation

9. Upon attending the Patchewollock property after Mr Hulland's death, Victoria Police located a Ford utility (WGY373) with an attached hydraulic "tipper" trailer wedged in trees approximately eight to 10 metres from where Mr Hulland had been found. The vehicle had apparently driven through a broken, wire stock-fence. Tyre marks in the wheat stubble and earth suggested that the vehicle had driven in a straight line from the position where Mr Hulland was found, through a stock-fence and down a gentle slope before stopping in a copse of trees. There was a pile of hay on the ground nearby.

10. Leading Senior Constable (LSC) Rod Charman was the nominated Coroner's investigator.[4] At my direction, LSC Charman investigated the circumstances surrounding

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[1] Haemothoraces are collections of blood in the pleural space of the body. They may be caused by trauma and are more commonly caused by rib fractures.

[2] Pneumothorax is a collapsed lung.

[3] Subcutaneous emphysema is where air has left the lungs and travelled to muscles and tissue of the chest wall. It is caused by chest trauma.

[4] A Coroner's Investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the Coroner to assist the coroner with his/her investigation into a reportable death. The Coroner's Investigator receives directions from a Coroner and carries out the role subject to those directions.

Mr Hulland's death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by Ashley and Nicholas Hulland, Paramedic Brian Ladds, General Practitioner Dr Stephen Brand of Drysdale Medical Centre and Work Cover Authority (WorkSafe) Inspectors.

11. During the investigation, LSC Charman learned that Nicholas Hulland had turned off the Ford utility's ignition and put it into park when he located the vehicle. My investigator stated that tyre marks in the ground and crushed vegetation suggested that the vehicle had been in gear but had been stopped once it wedged in the trees. LSC Charman stated that the vehicle's driver-side door-handle was missing and the window was wound down. The hydraulic trailer was tipped to its highest point and the hydraulics box was closed. There was yellow and blue bale yarn tied to the spare wheel at the front of the trailer and it was wrapped around the right-hand axel. There was a foot print in the dust on the trailer lid, facing toward the left. LSC Charman could not see any other factors which may have contributed to the incident.

12. LSC Charman informed me that he notified Police Communications as soon as Ambulance Victoria paramedics declared Mr Hulland deceased. This prompted a call from the WorkSafe notifications online Supervisor at Emergency Services Telecommunications Authority (ESTA). At 11.53pm, LSC Charman received a call from WorkSafe representative John Davies who indicated that a WorkSafe Inspector would attend the scene to conduct their investigation and that they would inform LSC Charman when they were on their way.

13. LSC Charman photographed the scene and Mr Hulland's body in situ. At 3.10am on 8 May 2018, WorkSafe Inspector Peter Sullivan arrived at the scene and requested that Mr Hulland's body remain for the purposes of the WorkSafe investigation. LSC Charman determined that this was not necessary or appropriate and Mr Hulland's body was conveyed to the Victorian Institute of Forensic Medicine.

14. At approximately 5.30am on 8 May 2018, Senior Investigator Ross Clayton and Inspector Christopher Bull of WorkSafe joined Inspector Sullivan at the scene. The WorkSafe representatives noted that an almost intact bale of hay was resting on the ground; hay is usually distributed in smaller "biscuits" to allow livestock to access the feed without soiling it. There were no marks in the soil or wheat stubble which would

indicate that Mr Hulland had been dragged or had moved himself along the ground. The WorkSafe representatives also established that a tool had been placed between the underside of the dashboard and accelerator, effectively ensuring that the vehicle could continue to move without the need for a driver.

15. In his statement, Inspector Bull opined that it was possible Mr Hulland had fallen and been struck by either his vehicle or the attached trailer while attempting to get into the Ford utility by reaching through the driver-side window to stop the vehicle after the bale of hay has fallen from the trailer. On 8 November 2018, WorkSafe informed the Court that it did not intend to prosecute in relation to the incident due to public interest considerations.

16. Ashley Hulland confirmed that, when stock feeding, they would often put a vehicle into first gear and put the four-wheel-drive gearbox into low range. This would allow one person to break biscuits of hay off a bale and throw them to the ground while the vehicle slowly moved along without a driver. Ashley Hulland stated his father had only recently purchased the hydraulics trailer and that he had used a manually cranked trailer in the past. He did not believe his father had any ongoing, significant health conditions and was unsure how his father had gotten onto the ground.

17. General Practitioner Dr Stephen Brand stated that Mr Hulland had been prescribed betablocker medication by Cardiologist Dr Chris Lim subsequent to the fainting episode associated with supraventricular tachycardia in 2010. Dr Brand commented that Mr Hulland had not had a review in a prolonged period of time and that he did not receive repeat prescriptions of this medication. At that time, an electrocardiogram and echocardiogram showed normal results. In 2015, Mr Hulland was treated for an enlarged prostate, which proved to be benign, and urinary retention.

18. Dr Brand stated that Mr Hulland's blood pressure was in normal range, he had normal results from routine blood tests and there was no suggestion of cardiac disease, abnormalities or diabetes during the six years prior to his death. Dr Brand commented that he was unable to provide any medical context that may relate to the accident and Mr Hulland's subsequent death.

Safe Work Australia & Agricultural Work Hazards

19. The Safe Work Australia website states:

> *Agriculture is one of the most dangerous industries to work in due to the combination of hazards. These include plant, chemicals, noise, dust, sun exposure, working with animals as well as the fact many in the industry work alone or in remote locations.*[5]

20. The website further indicates that the agricultural industry has the highest fatality rate of any Australian industry. Agricultural vehicles, including tractors and quad bikes account for 37% of all fatalities. Other risk factors indicated for workers in the agricultural industries include that the cohort:

    a. Has the highest proportion of self-employed workers;

    b. Has the highest proportion of workers aged over 65;

    c. Has many hazards which are uncommon to other workplaces, such as use of chemicals, work with animals and farm-specific-vehicles;

21. Finally, the website further indicates that a large proportion of risk is in relation to the fact that farmers often work alone, and:

    a. Lift heavy loads or operate machinery by themselves;

    b. help or first aid is not always nearby if an incident occurs, and

    c. farms may be remote, without mobile phone coverage.

22. The statistical data found on the website was originally contained in the Safe Work Australia Priority Industry Snapshot: Agriculture of June 2018. The website was last updated on 25 January 2019.

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[5] Safe Work Australia, *Agriculture*, <*https://www.safeworkaustralia.gov.au/agriculture*>, updated 25 January 2019, date accessed 28/03/2019.

COMMENTS

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comments connected with the death:

1. Although Mr Hulland's death appears to be from misadventure, the evidence reflects that he was involved in a high-risk activity: the vehicle was purposely stuck in gear, so it moved forward without a driver; the unmanned vehicle hauled a new hydraulic tipper trailer; Mr Hulland was working on his own.

2. The Safe Work Australia injury and fatality data indicate that agricultural work is one of the highest risk industries in the nation. Although WorkSafe Victoria have created information pages in relation to some safety hazards for farmers, it would be appropriate to create and publish safety information about the risks associated with the use of machinery and equipment on farms where a person is working alone.

RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroners Act 2008* (Vic), I make the following recommendation:

1. In the interests of increasing public health and safety and preventing like deaths, I recommend that WorkSafe Victoria create and publish safety information about the risks associated with the use of machinery and equipment on farms where a person is working alone.

FINDINGS

The investigation has identified that Mr Hulland was stock-feeding alone on a family owned farm and his Ford utility and attached hydraulics trailer were moving independently while he distributed biscuits of hay to the ground from a bale attached to the trailer.

Although the investigation has failed to definitively identify the exact circumstances of the incident, I find on the balance of probabilities that Mr Hulland has fallen to the ground and been run-over by his vehicle and/or the attached trailer, while adopting unsafe work practices.

I accept and adopt the cause of death formulated by Dr Heinrich Bouwer and I find that Frank John Hulland died from chest and pelvic injuries sustained in a farming incident.

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

Noela Hulland
Ross Clayton of the Victorian WorkCover Authority
Leading Senior Constable Rod Charman

Signature:

AUDREY JAMIESON
CORONER
Date: **3 April 2019**