IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 4919

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Darren J Bracken, Coroner
Deceased:	MRE
Date of birth:	31 March 2006
Date of death:	30 September 2018
Cause of death:	1(a) Traumatic head injuries
Place of death:	Leitchville, Victoria 3576

INTRODUCTION

1. MRE was only 12 years old when he died from traumatic head injuries sustained while he was operating a tractor and 'spreader' near Munroe Track in Leitchville. At the time of his death, MRE lived with his father RE (**Mr RE**); Mr E's partner, KD (**Ms KD)**; her child, DD; and his two siblings MaE and MiE, at Gunbower. MRE's mother, DM, lives in Wallan.

2. MRE's father owned and operated an excavation and bulk haulage business. In his statement to the Coroner's Investigator (CI), Mr RE said that MRE had been around heavy machinery from a very young age: "*when MRE was about four years of age, I would have him sit in the cabin of the excavator with me and he loved it*." Mr RE elaborated:

> "*When he was about 10 years of age, he was driving excavators. He was fully operating a 20 ton* [sic] *machine by himself*."
>
> "*Because MRE was around machinery all the time I instilled in him the need for safety. I went out of my way to make sure that he understood that the type of machinery that he enjoyed with, could cause harm*."[1]

3. Mr RE met Ms KD when MRE was about 9 years old. Ms KD's brother, JD (**Mr JD)** and sister-in-law, BD **(Ms BD)** operate a dairy farm **(the farm)** on Greens Road in Cohuna. MRE and his family visited regularly, and MRE loved working on the farm. Mr JD provided a statement to the CI in which he explained that:

> *"*[He] *just loved coming to the farm and driving machinery. He was very good at it*…."[MRE] *loved the farm work and the machinery. Eventually he was so good at what he did he operated most machinery on the farm*."[2]

THE CORONIAL INVESTIGATION

4. MRE's death was reported to the Coroner and fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The

[1] Statement of RE dated 6 November 2018; Coronial Brief.
[2] Statement of JD dated 21 October 2018; Coronial Brief.

purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

6. 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.

7. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of MRE's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, treating clinicians and other police – and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of MRE, including evidence contained in the coronial brief.

9. 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. In the coronial jurisdiction, facts must be established on the balance of probabilities. [3]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

10. On 29 September 2018 at approximately 7.15am, Mr RE had breakfast with MRE at the family home in Gunbower. Mr RE said that MRE was "*on top of the world, dressed in his work gear and ready for the day at JD's farm*." At about 7.30am Ms BD took MRE to the farm for the weekend.

11. At about 5.30pm, MRE and Mr JD filled the Grizzly spreader, attached to a Massey Ferguson 7485 **("the tractor"),** with fertilizer. Shortly afterwards, Mr JD; his wife and MRE discussed the "*following day's work*". Mr JD elaborated:

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

"…*we were going to travel to Red Rise block* [paddock]. *BD and I were going to be in the truck as I had to drop her at my cousin's house to get the tractor to load hay. His house is about four kilometres from the Red Rise block."*

"MRE was going to drive the tractor towing the spreader. We were meant to travel together in convoy I knew MRE was not licenced, but we were staying of [sic] the main roads and taking the back roads. This was the plan."[4]

12. Mrs BD told the coronial investigator (CI) that "*MRE had mentioned that he was going to set his alarm and head out to do the fertilizer in the morning. He was eager to do it.* [Mr JD] *had just said ok* [sic]."[5]

13. At about 8.00pm, Mr JD and his wife retired to the bed. MRE stayed up to watch television.

14. On 30 September 2018 at about 5.45am, Mr JD said he was in bed when he "*heard the tractor start and drive off. I assumed it was MRE*." Shortly afterward, Mr JD drove his wife to his cousin's house nearby to collect another tractor before heading towards "**the paddock**" in Leitchville.

15. At about 6.10am, witness Mr JL who was herding his cattle observed the tractor (which he recognised as belonging to the farm) travelling along Frees Road, Leitchville. Mr JL said that he "*saw no other vehicles on the road at the time and I could see for miles each way…I was unable to see who was driving the tractor*."[6]

16. When Mr JD and his wife arrived at the paddock, '*JD's farm'* in their respective vehicles at approximately 7.25am, Mr JD saw the tractor on a levy bank where it had come to rest against a tree stump. He said that "*from my position seated high up in the truck I could see MRE laying in the grass*. *He was about 30-40 metres from the* [paddock] *gate*."

17. When Mr JD approached MRE, he said that, "*it was obvious to me that MRE was dead. He had been run over by the machinery*." Mr JD notified his wife who then contacted emergency services.

18. Ambulance Victoria (**AV**) paramedics arrived shortly thereafter, and MRE was declared deceased at the scene.

[4] Statement of JD dated 21 October 2018; Coronial Brief.
[5] Statement of BD dated 9 January 2019; Coronial Brief.
[6] Statement of JL dated 10 January 2019; Coronial Brief.

19. Shortly thereafter, members of Victoria police arrived. Police members observed MRE's body lying in the middle of the first bay of an irrigated paddock about 50 metres from the entrance gate to the paddock. The tractor was resting against stumps near a levy bank about 100 metres from the paddock. Approximately 12.1 metres from MRE's body police located a smooth metal bar about 340 mm long which Mr RE had found in his son's right hand and had subsequently thrown.

20. On 12 October 2018, Craig Smart, a qualified mechanical investigator working with Victoria Police Collision Reconstruction and Mechanical Investigation Unit (**CRMIU**), completed a mechanical examination of the tractor and spreader. In his statement dated 17 October 2018, Mr Smart concluded that the tractor was in good working condition and operated as intended. The physical controls of the spreader within the tractor cabin were operational, however the conveyor drive mechanism did not operate as intended due to the positioning of a belt on the drive pulley. This required physical intervention in order to correct the issue and have the conveyor belt operating as intended.

21. Detective Sergeant Robert Hay of the CRMIU reconstructed the collision and provided a statement dated 15 October 2018, in which he concluded that, based on the circumstances of the collision, the proximity of the metal bar when located; marking on the V belt; the scrape in the spreader frame and that MRE had not been driven over by the rear tyre of the tractor, at the time of the incident but of the spreader when MRE was attempting to replace or repair a V belt on the spreader, with the small metal bar whilst the tractor and spreader were in motion. For an unknown reason MRE fell under a wheel of the spreader.

22. Detective Sergeant Hay noted that in order for MRE to put a V belt on the spreader he would have used a tool such as a metal bar and have the spreader in motion.

23. Pursuant to section 95(3) of the *Occupational Health and Safety Act 2004,* section 12(2) of *the Equipment (Public Safety) Act 1994* and section 11 (3) of the *Dangerous Goods Act 1985* WorkSafe Victoria investigated the incident. WorkSafe Victoria subsequently provided the Court with a letter dated 14 November 2019 advising that the Victorian WorkCover Authority had not commenced a prosecution against any party in relation to this matter due to insufficient evidence and public interest considerations.

24. During the course of the coronial investigation, Mr JD told the CI that the farm is about 25 kilometres from the paddock in Leitchville meaning that MRE would have driven the tractor using the road network to get to the paddock.

Identity of the deceased

25. On 30 September 2018, RE identified the deceased as his son MRE, born 31 March 2006.

26. Identity is not in dispute and requires no further investigation.

Medical cause of death

27. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 1 October 2018 and provided a written report of his finding dated 10 October 2018.

28. In his report Dr Bedford opined that the medical cause of death was '*1(a) Traumatic head injuries'.*

29. I accept Dr Bedford's opinion.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

30. According to Kidsafe Victoria,[7] seven Victorian children aged between 0-14 are treated in hospital every week for farm injuries (a total of 364 per annum). They are the ones who survive.

31. I referred this matter to the Coroners Prevention Unit[8] **(CPU)** and requested that it identify from the Coroners Court of Victoria surveillance database all deaths of children using farm machinery in the last five years (i.e between 1 January 2016 and 31 December 2020).

32. The CPU identified the deaths of six children, in addition to MRE, who had died during this period. All the deceased were males aged between 2 and 14 years. Three deaths related to use of quadbikes; one a ride-on lawnmower; one a motorbike; and another related to the death of two year old Darcy Membrey who was found under a fertiliser spreader which his father had disconnected from a tractor and lowered onto pallets.

33. In her findings into the death of Darcy Membrey,[9] Coroner Hodgson made a recommendation that WorkSafe Victoria, in consultation with the Victorian Farmers' Federation, consider

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[7] Kidsafe Victoria website; News 23 July 2020

[8] The Coroners Prevention Unit is a business unit in the Coroners Court of Victoria, whose staff support coroners' investigations through activities such as collating data, reviewing evidence, compiling literature reviews, and consulting with relevant experts and organisations. The CPU's central purpose is to identify opportunities to reduce preventable deaths investigated by coroners.

[9] Coroners Court Reference COR 2019 0031; date of decision 11 February 2020.

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.

34. Given the circumstances of MRE's death and noting that it involved the use of a registered motor vehicle (the tractor) I make a similar recommendation below expanding distribution to include the Transport Accident Commission and Kidsafe Victoria.

35. Active adult supervision is the most important safety precaution in preventing child injuries and is particularly so on family farms. MRE's tragic accidental death highlights that children require constant adult supervision, especially around farm machinery.

36. It may be said to go without out saying and so say it I do. MRE should never have been permitted to drive the tractor as he did or to have operated it and the spreader unsupervised as he did. I well understand the anguish his death has caused his family and the likely self-recrimination they are visiting on themselves.

RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroners Act 2008* (Vic), I recommend that:

(1) WorkSafe Victoria and the Transport Accident Commission, in consultation with the Victorian Farmers' Federation and Kidsafe Victoria, consider engaging farming families and/or conducting a public awareness campaign aimed at farming families highlighting the risks of allowing children to operate farm machinery and/or drive vehicles such as tractors and incorporating how to keep children safe on farms.

37. I am satisfied that MRE died as a result of injuries sustained when, as a result of attempting to repair the spreader, he was run over by it.

38. Pursuant to section 73(1) of the *Coroners Act 2008* (Vic). I order that this Finding be published on the internet.

FINDINGS AND CONCLUSION

39. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

(a) the identity of the deceased was MRE, born 3 March 2006;

(b) the death occurred on 30 September 2018 at the, Leitchville, Victoria 3576 from traumatic head injuries; and

(c) the death occurred in the circumstances set out in paragraphs 10-24 above.

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

Mr RE, Senior Next of Kin;

Mrs DM, Senior Next of Kin;

Mrs Lauren Copeland, Worksafe Victoria;

Mr Joe Calafiore, CEO, Transport Accident Commission;

Ms Melanie Courtney, CEO, Kidsafe Victoria;

Ms Jane Lovell, CEO, Victorian Farmers' Federation;

Adjunct Professor Tanya Farrell, Chair, The Consultative Council on Obstetric and Paediatric Mortality and Morbidity; and

Detective Leading Senior Constable Adrian Gordon, Victoria Police, Coroner's Investigator.

Signature:

DARREN J BRACKEN

CORONER

Date: 30 March 2021

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.