



MAGISTRATES COURT of TASMANIA  
CORONIAL DIVISION



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## Record of Investigation into Death (Without Inquest)

*Coroners Act 1995*  
*Coroners Rules 2006*  
*Rule 11*

I, Simon Cooper, Coroner, having investigated a death of Ian McLean MacKinnon

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

- a) The identity of the deceased is Ian McLean MacKinnon;
- b) Mr MacKinnon died as a result of injuries received when, in the course of his employment, he was crushed in an agricultural machine;
- c) The cause of Mr MacKinnon's death was chest injuries; and
- d) Mr MacKinnon died on 11 March 2016 at 'Brambletye', 1014 Glen Esk Road, Conara, in Tasmania.

### **Introduction**

1. In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr MacKinnon's death. The evidence comprises the affidavits from a number of relevant witnesses (including attending police), a report from the State Forensic Pathologist, the results of toxicological analysis of samples taken from Mr MacKinnon's body at autopsy, a report from Ambulance Tasmania, reports from Mr MacKinnon's general practitioner, orthopaedic surgeon, cardiologist and neurologist, an analysis of records held by the National Coronial Information Service and a report from WorkSafe Tasmania.

### **Jurisdiction**

2. The *Coroners Act 1995* ('the *Act*') provides that an inquest must be held where a person dies as a result of an accident or injury that occurred at his or her place of work<sup>1</sup>. The same act defines 'inquest' as a public hearing.

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<sup>1</sup> See section 24 (1) (ea)

3. However, the Coroner does not have to hold an inquest if the Senior Next of Kin requests her or him not to do so, provided that the Coroner is satisfied it would not be contrary to the public interest or the interest of justice not to hold an inquest<sup>2</sup>.
4. Mr MacKinnon's widow Dianne MacKinnon, the Senior Next of Kin in terms of the *Act*, requested that no inquest be held.
5. I reached the view that it would not be contrary to the public interest or the interest of justice if an inquest were not held in relation to Mr MacKinnon's death. There are a number of reasons for this. In reaching that view I had regard to the material set out in paragraph 1, above. The reasons include that the circumstances surrounding Mr MacKinnon's death are very clear indeed and I am of the view that no further information will be forthcoming as a result of holding an inquest. Perhaps most importantly, there is no evidence in Australia or New Zealand that the particular machine that caused Mr MacKinnon's death has been responsible for other deaths. In fact, the National Coronial Information Service database records no deaths in similar circumstances in either Australia or New Zealand. This strongly suggests that Mr MacKinnon's death resulted from an extremely rare, isolated and tragic accident.

### **Mr MacKinnon's Background**

6. Mr MacKinnon was 66 years of age at the time of his death. He had been married to Dianne for 40 years and he lived the majority of his life in the Northern Midlands of Tasmania. He grew up on the property 'Glen Esk' which had been in his family for many years. Mr and Mrs MacKinnon have three adult daughters.
7. Mr MacKinnon was a farmer throughout his life. In addition to 'Glen Esk', he also farmed the next-door property 'Brambletye'. 'Glen Esk' and 'Brambletye' each comprise approximately 10,000 acres or 4,000 hectares of diverse farmland. At the time both properties had stock and crops.
8. In 2014 Mr MacKinnon and his wife moved from 'Glen Esk' to live at 179 St John Street, Launceston as they transitioned to retired life. Mr MacKinnon continued to travel back to Conara to work both properties. In September 2015 'Brambletye' was put on the market. 'Glen Esk' was sold just prior to Mr MacKinnon's death and 'Brambletye' sold shortly after his death.
9. Mr MacKinnon was generally a healthy man; however, he was diagnosed with

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<sup>2</sup> Section 26A

gastro-oesophageal reflux disease in 2003, Parkinson's disease in 2013 and he had a lateral meniscus tear of the right knee in 2015. His Parkinson's disease was being managed by Dr Richard Gerraty, a neurologist based in Melbourne whom Mr MacKinnon saw on a six-monthly basis.

10. Mr MacKinnon had been a patient of General Practitioner Dr Timothy Shaw since November 2009 and he last visited his doctor on 1 March 2016.

11. At the time of his death Mr MacKinnon was taking the following medication:

- Azilect, 1mg, x1 daily (Parkinson's Disease);
- Betnovate 1/5 cream, 0.02%, applied daily;
- Crestor, 10mgs, x1 daily (Hypercholesterolaemia);
- Madopar, 100mgs/25mgs, 3 times daily (Parkinson's Disease);
- Omeprazole EC, 20mgs, x1 daily; and
- Panadol osteo SR, 665mgs, x2 three times daily.

12. Mrs MacKinnon said in her affidavit made as part of the investigation that the effect of Parkinson's disease upon her husband was that he had 'difficulty with his hands shaking... [which]...made it hard for him to do things like writing or signing his name'. She said he was generally 'pretty good' at taking his prescribed medication.

### **Circumstances of Death**

13. On the day of his death, 11 March 2016, Mr MacKinnon was working on 'Brambletye' and operating a John Deere tractor pulling a Highline XL-78 rock picker. The rock picker had been purchased in 2008 or 2009 and had been regularly used by Mr MacKinnon. The evidence is that the machine was in good working order and properly maintained.

14. The rock picker was towed behind a tractor at a low speed. When operating, hydraulic powered rotating metal arms in the rock picker swept across the surface of the ground and scooped up rocks depositing them in a bucket (or basket) at the back of the machine. When the bucket was full, it was necessary to tow the rock picker to another area to dump the rocks and then continue.

15. In the morning starting at about 7.45am, Mr MacKinnon and farm employee Mr Cardi Barker completed some maintenance work on the rock picker. Mr Barker described Mr MacKinnon as being 'pretty happy' that day.

16. The maintenance work was carried out in a paddock on 'Brambletye' approximately seven kilometres south of the Glen Esk Road at Conara to commence clearing rocks. It took the two men approximately three hours. Mr Barker later told investigators that the maintenance included greasing the bearings on either side of the rotating arms of the rock picker. In addition to this routine maintenance, Mr MacKinnon wanted to fix a bend in one of the rotating arms. Reportedly, it was not critical to repair the bend, in the sense that the rock picker was still capable of operating properly. However, Mr MacKinnon wanted it fixed to stop any further wear and tear. Mr MacKinnon and Mr Barker used oxyacetylene equipment to heat up the metal arm which they then straightened by pressure from a chain attached to the back of a utility.
17. After the maintenance was completed, Mr MacKinnon commenced using the rock picker in the paddock. Mr Barker went to 'Glen Esk' to cut lucerne.
18. The paddock was one of several on 'Brambletye' being prepared for ploughing. The area where Mr MacKinnon was working required surface rocks to be removed prior to a plough being able to move across the ground.
19. Mrs MacKinnon said that as 'Brambletye' was on the market, Mr MacKinnon wanted things 'to be right'. Amongst many other things, this involved ensuring that some of the property's paddocks were cleared of rock so they could be sown if needed.
20. At the time of the accident which caused his death, Mr MacKinnon was working in the same paddock as a contracted farm worker Mr Jeremy Bryant. Mr Bryant was contracted to carry out ploughing. He was towing a disc plough behind a tractor. Earlier in the day he had finished ploughing in another paddock. Between about 10.30am and 11.00am, Mr Bryant started working in the same paddock as Mr MacKinnon. The two men did not interact in any way; working as they were in different areas of what was a very large paddock.
21. Mr MacKinnon moved along the paddock picking up rocks. After the rocks were removed, Mr Bryant was able to plough. Both men were some distance apart.
22. At approximately 2.00pm, Mr Bryant saw the John Deere tractor towing the rock picker machine moving up the hill of the paddock. He said that it appeared to have a bucket full of rocks which he thought would likely require emptying. Mr Bryant was ploughing down the hill at the time so continued on before doing another run back up the hill.

23. Mr Bryant later told investigators that when he reached the top of the hill he saw the John Deere tractor and rock picker reversed near where the rocks were being dumped. He said the bucket was empty of rocks and had been lowered back into its operating position. Mr Bryant saw the tractor door open and the rotating arms of the rock picker stopped. He was unable to hear if the tractor was operating or not. He did not see anyone near the tractor and told investigating police that he thought perhaps that the operator (who he did not yet know was actually Mr MacKinnon) may have stopped for a toilet break. Mr Bryant continued on and completed another run down and back up the hill, taking approximately two minutes to complete.
24. On his return to the top of the hill, Mr Bryant saw that both the tractor and rock picker had not moved. When he was closer to the tractor he could see that the rotating arms of the rock picker were rotating and he realised something was wrong. He stopped his own tractor and walked toward the John Deere tractor. As he got closer, Mr Bryant saw legs coming out of the bucket at the back of the rock picker. He immediately went to the tractor which was still running and shut it down. In addition, Mr Bryant saw that the rock picker arms were still rotating forward.
25. Mr Bryant moved back to the rock picker bucket and found Mr MacKinnon caught in the rear area of the rock picker. He was conscious and asking for help. Mr Bryant described Mr MacKinnon as being in the corner of the bucket with his head at the bottom of the bucket. Mr Bryant placed his own shirt under Mr MacKinnon's head and then called Mr Barker for help – asking him to call an ambulance. Mr Bryant then went back to Mr MacKinnon, climbed into the bucket and did what he could to comfort him. As he returned to the bucket, he noticed a sledge hammer on the ground on the outside of the rock picker.
26. Mr Barker called an ambulance (Ambulance Tasmania records indicate this occurred at 2.05pm) and then rushed to the scene of the accident. Mr MacKinnon was still conscious. He recognised Mr Barker and spoke to him. Mr Barker climbed into the bucket with Mr MacKinnon and Mr Bryant. Both men tried to make Mr MacKinnon comfortable.
27. Mr Barker then called Mrs MacKinnon and told her what had happened. He and Mr Bryant stayed with Mr MacKinnon until the arrival of the ambulance at 2.32pm. Mr MacKinnon was treated for approximately 20 minutes before he could be extracted from the rock picker. He was placed in the ambulance where attempts were made to stabilise him. Mr MacKinnon went into cardiac arrest and CPR was commenced.

28. The rescue helicopter was dispatched from Hobart at 2.58pm and arrived at the accident scene 3.56pm. However, as it arrived Mr MacKinnon died and all attempts at resuscitation ceased.

### **Investigation**

29. Police officers arrived the scene while Mr MacKinnon was still being treated by Ambulance Tasmania. A Tasmania Police Forensic Services officer attended to assist with the investigation. Amongst other things, that officer photographed Mr MacKinnon's body. The photographs graphically illustrate the nature and extent of Mr MacKinnon's injuries. WorkSafe Tasmania investigators attended the scene shortly after Mr MacKinnon's death.

30. Photographs taken, exhibits seized and video footage taken of the rock picker in operation, all formed part of the material provided to me.

31. After formal identification, Mr MacKinnon's body was transported to the mortuary at the Royal Hobart Hospital. At the mortuary an autopsy was carried out by Dr Christopher Hamilton Lawrence MB BS FRCPA, the State Forensic Pathologist. The autopsy revealed that Mr MacKinnon had sustained significant rib fractures with laceration of his lungs. One litre of blood was found in his right pleural cavity. Although Mr MacKinnon was noted to have superficial bruising on his scalp, he had no deeper head injuries. Dr Lawrence expressed the opinion, which I accept, that the principle cause of Mr MacKinnon's death were the chest injuries sustained by him whilst entrapped in the rock picker.

32. Samples taken at autopsy were subsequently toxicologically analysed. No alcohol or illicit drugs were found to be present in those samples.

33. WorkSafe Tasmania investigators examined the rock picker. They concluded that the machine itself was in good mechanical condition and that no mechanical defect caused Mr MacKinnon's death.

### **Conclusion**

34. The evidence leads me to conclude that Mr MacKinnon stopped the tractor and rock picker as a result of a rock being becoming trapped in the arms of the picker. It would appear that he left the tractor cab but failed to turn the rock picker hydraulics off. The evidence suggests that Mr MacKinnon attempted to remove the rock by

striking it with the sledge hammer found next to the picker. Once the rock has been cleared the rotating arms of the rock picker have re-engaged (which could not have occurred had it been switched off), picked up Mr MacKinnon and thrown him into the rear bucket where he was crushed, sustaining fatal injuries.

35. I am satisfied on the evidence that there are no suspicious circumstances surrounding Mr MacKinnon's death. The most likely explanation for the accident is inattention on Mr MacKinnon's part in failing to turn off the rock picker hydraulics before he attempted to free a trapped rock. I am satisfied that neither drugs nor alcohol played any role in the happening of the accident. I am also satisfied that the rock picker was mechanically sound. Finally, I am satisfied that no other person caused or contributed to Mr MacKinnon's death.

#### **Comments and Recommendations**

36. I extend my appreciation to investigating officer Senior Constable Fysh for her competent investigation and report.
37. The circumstances of Mr MacKinnon's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.
38. In concluding, I convey my sincere condolences to the family of Mr MacKinnon on their tragic loss.

**Dated** 17 October 2018 at Hobart, Tasmania.

**Simon Cooper**  
**Coroner**