MAGISTRATES COURT TASMANIA

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Madeleine Wilson, Coroner, having investigated the death of Karl Wayne Stokes.

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

a) The identity of the deceased is Karl Wayne Stokes, date of birth 24 December 1973.

b) Mr Stokes, 50, was born in Te Kuiti, New Zealand and moved to Tasmania in 1995. He settled in Smithton and worked on local dairy farms as a general farm hand, working his way up to being a technical farm consultant and farm manager.

Mr Stokes's first marriage to Janelle Ward, produced four children, Arleigh (b. 2000), who died in infancy, Ryley (b. 2001) and twin daughters Montaya and Zavarnah (b. 2003). This marriage ended in about 2008. Mr Stokes commenced a relationship with Jane Leeder in 2011 and they were married in 2015.

Mr Stokes was engaged by Beattie-Lester Beef at Lileah, south of Smithton as an independent contractor and consultant, providing advice and assistance to the owners to run the dairy farm. At the time of his death, he and Jane lived in a house they had bought, on the boundary of the farm, with Riley, Montaya and Zavarnah.

On Thursday 1 August 2024 Mr Stokes was working on the dairy farm. He returned home briefly for lunch. He was riding his All-Terrain Vehicle (ATV) and wearing a full-face helmet, which he left on the church pew outside the front door, as was his habit. His daughter swore an affidavit to the effect that he had stayed for about ten minutes and seemed to be in a rush. He told his daughters that he had slept poorly and had been awake since 2.00am. He said that his day had been hectic and he had a long list of jobs

to do. Mr Stokes made some toast and left the house eating it. He did not collect his helmet.

At about 3.20pm, Mr Stokes phoned Toni Fagan, a farm hand, and told her that he was on his way to the dairy with some cows and would like some assistance putting them into the yard at the dairy. Mr Stokes arrived at the dairy on his ATV, he was not wearing a helmet. He was travelling very slowly, at walking pace behind the cows.

Mr Stokes got off the ATV and he and Ms Fagan began to usher the cows into the yard when one of the cows began to wander off down a laneway. Mr Stokes told Ms Fagan that he would "just grab her (the stray cow) and then we can lock them in". Mr Stokes got back onto the ATV and drove towards the cow which was about one hundred meters away and walking very slowly. Mr Stokes was not going very fast but caught up to the cow. He pulled up on the right-hand side of the cow, between it and the fence. As he did so the cow began to quicken its pace. Mr Stokes went to drive past the cow, but it turned towards him and struck him to the head with her head. Mr Stokes fell from the ATV, he did not attempt to break his fall and landed flat, face down and did not move. Mr Stokes did not respond to Ms Fagan's calls. Mr Stokes was placed in the recovery position and emergency services were called. Prior to the ambulance arriving Mr Stokes had a seizure. Ambulance Tasmania attended the scene and transported Mr Stokes to Smithton aerodrome where he was taken to the Royal Hobart Hospital by air ambulance.

Upon admission at Royal Hobart Hospital (RHH), there were no significant injuries on external examination. However, Computed Tomography (CT) scans showed severe traumatic brain injury with multi-compartmental (epidural, subdural, subarachnoid and parenchymal) haemorrhages and comminuted, depressed fractures of the left parietal and occipital bones. There was suspected left transverse sinus thrombosis (stroke) and oedema (swelling). Aspiration was suspected. A remote lumbar compression fracture was identified. Mr Stokes was noted to have bleeding from the left external auditory canal, in keeping with the skull fractures.

A consultant neurosurgeon considered that neurosurgical intervention would be inappropriate as the injuries were not survivable. Brain death was verified on 3 August 2024 by clinical criteria, and his treatment was changed to comfort care.

Toxicological testing of antemortem blood, showed the presence of drugs associated with medical management. Specifically, alcohol was not detected.

Tasmania Police and WorkSafe Tasmania commenced investigations into the accident.

c) Mr Stokes' cause of death was complications of blunt force injuries of the head.

d) Mr Stokes died on 3 August 2024 at Hobart, Tasmania.

In making the above findings I have had regard to the evidence gained in the investigation into Mr Stokes' death. The evidence includes:

- The Police Report of Death for the Coroner;
- The Hospital Death Report to the Coroner;
- Affidavit confirming identity;
- Affidavit of Jane Stokes;
- Affidavit of Toni Fagan;
- Affidavit of Montaya Stokes;
- Affidavit of James Showell;
- Affidavit of Constable Steven Holcombe;
- Affidavit of Constable Robert Oberrauter;
- Affidavit of Philip Evans;
- Medical records;
- WorkSafe Tasmania investigation report; and
- Report of the forensic pathologist Dr Rebecca Irvine regarding cause of death.

Comments and Recommendations

Mr Stokes's work experience

Mr Stokes completed a dairy farm cadetship and was a past winner of the Regional Young Farmer of the Year competition. He had approximately 35 years of experience working on and managing farms. Mr Stokes developed a passion for biological farming practices and organic farming. He became a technical consultant for biological and

organic agronomy consultancies. Mr Stokes was a skilled and knowledgeable dairy farmer and was well respected in New Zealand and the Circular Head area. In 2020 he was appointed the Operations Manager for a company operating dairy farms in Tasmania and Victoria. He started working for himself in 2022 as a highly skilled farm management contractor, working in beef, dairy and cropping. In 2024 Mr Stokes began working with the owners of Beattie-Lester Beef to provide them with valuable advice about farm management. Together they reviewed the Beattie-Lester Beef's policies. At the time of his death Mr Stokes had been in the process of updating the company's policies and procedures.

Mr Stokes was an experienced rider of motorbikes and ATV's. Mr Stokes was known to enforce the requirement to wear helmets when using ATVs and up until the date of his death, had been known to be very safety conscious and to always wear a helmet. His helmet was inspected by WorkSafe Tasmania who noted that it provided adequate protection as required for quad bike operators and met the relevant Australian Standard.

Beattie- Lester Beef work practices

Susan Parker responded to a Notice to Produce Documents issued to Beattie-Lester Beef by WorkSafe Tasmania. She produced a "Work Health and Safety Manual" and a handbook containing relevant policies and responded that these documents were given to employees to sign before they commenced work. She said that a copy of the manual and policies had been given to Mr Stokes but he had declined to sign it at the time as he was covered in mud. At the time of his death, he had still not signed and returned the documentation. The folder given to Mr Stokes was seized as an exhibit. The manual provided to Mr Stokes included directions about riding motorcycles and quad bikes. A separate quad bike policy was also included. Both documents referenced the requirement to wear an approved safety helmet when riding a quad bike. The only policy applicable to the movement of cattle provided to Mr Stokes was a reference to moving cows across a public road and the requirement to ensure stock crossing signs were in place, the gates opened and the cows moved as quickly as possible.

Another folder was produced containing the complete Beattie-Lester Beef Work Health and Safety Manual which referenced handling cattle and stated "extreme care should be taken when working with cattle in confined areas to avoid being charged as cattle can be unpredictable". The Employment Agreement/Conditions of Employment document warned that when working with livestock, the worker should take care to "avoid being butted or kicked" and that "extreme care should be taken when working

with confined areas to avoid being charged or crushed". Neither of these documents were included in the folder given to Mr Stokes.

Ms Parker stated that Beattie-Lester Beef did not have "a stand alone operating procedure for cattle management, mustering and handling" at the relevant time.

Safe Work Australia produced a "Guide to managing risks in cattle handling "in 2020. The guide addresses cattle behaviour , their field of vision and techniques to be applied to manoeuvre cattle. It also warns that cattle do not like being singled out in the paddock or in yards and can become extremely agitated and unpredictable. There is no mandatory requirement to follow the instructions or to use the information to dictate procedures regarding cattle handling. The information contained in the guide is generally accepted practice in the farming industry and provides clear practicable techniques and control measures which can be implemented to protect workers and livestock.

I find that Mr Stokes was a very experienced dairy farmer and farm manager who had extensive experience working with, and mustering, cattle on dairy farms. I also find that Beattie-Lester Beef had clear work health and safety policies requiring riders of ATVs to wear an approved safety helmet and that Mr Stokes's helmet met those standards. I am satisfied that Mr Stokes was usually safety conscious when riding ATV's and his failure to wear a helmet on this occasion was an aberration.

I find that Beattie-Lester Beef provided limited instruction to staff about cattle handling but did not specifically refer them to the Work Safe Guide to managing risks in cattle handling. However, I find that Mr Stokes had been farming for 35 years and was very experienced in mustering cattle and riding ATV's. The owner of Beattie-Lester Beef had observed Mr Stokes using the ATV and mustering cattle on the farm and deemed him to be a very competent cattle handler. I do not consider that the failure to refer Mr Stokes to the Work Safe Guide to managing risks in cattle handling contributed to his death and find that it is probable that Mr Stokes was aware of the risks of approaching the dairy cow in the way that he did.

The evidence obtained in the course of the investigation satisfies me that it was Mr Stokes's practice to wear a helmet when he was riding an ATV. Witnesses attest to him being a patient and safety conscious worker. It was usual for him to leave his helmet on an old church pew by the front door when returning home. I find that Mr Stokes's failure to collect his helmet after returning home for lunch was uncharacteristic and likely an oversight, due to him rushing to return to his work duties. His subsequent

failure to wear the helmet when riding his ATV was an aberration but one which likely increased the chance of injury to his head from being butted by a cow.

Decision not to hold an inquest

A death that occurs at, or as a result of an accident or injury that occurs at, the deceased's place of work is a reportable death, unless it appears that the death is due to natural causes.[1]

In such cases a coroner must hold an inquest into the death.[2] However, if the senior next of kin requests the coroner not to hold the inquest, the coroner may decline to hold the inquest if satisfied that it would not be contrary to the public interest or the interests of justice if the inquest were not held[3]. In the present case, such a request was received. I am satisfied that based on the comprehensive brief of evidence received, that no further evidence or information would be likely to result from holding a public inquest and that it would not be contrary to the public interest or interests of justice if no inquest was held.

I am satisfied that Mr Stokes's tragic death was the result of head injuries he sustained when hit in the head by a dairy cow. At the time Mr Stokes was not wearing a helmet and this likely increased the extent of the injuries he sustained. However, unlike other coronial decisions dealing with deaths related to the use of ATV's (in particular those related to the failure to wear a helmet), the fact that Mr Stokes was riding an ATV at the time of his death was incidental to the circumstances of his death.

The circumstances of Mr Stokes' death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

Mr Stokes was a registered organ donor and his family generously consented to postmortem organ donation.

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[1] Section 3, *Coroners Act 1995*
[2] Section 24, *Coroners Act 1995.*
[3] Section 26A, *Coroners Act 1995.*

I extend my appreciation to investigating officer Constable Thomas Donnellan for his investigation and report.

I convey my sincere condolences to the family and loved ones of Mr Stokes.

Dated: 3 July 2026 at Hobart, in the State of Tasmania.

Madeleine Wilson
Coroner