FINDINGS, RECOMMENDATIONS and COMMENTS of Coroner Simon Cooper following the holding of an inquest under the *Coroners Act* 1995 into the death of:

Alexander Dale Hall

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Alexander Dale Hall with an inquest held at Hobart in Tasmania make the following findings.

Hearing Dates

9 and 10 July 2018 at Hobart in Tasmania

Representation

Mr S Thompson Counsel Assisting the Coroner

Introduction

1. Alexander Dale Hall, husband of Barbara, father of Katy, Stacey and Darren and known as Dale, died sometime between 10.00 am and 12.00 noon on Monday 26 October 2015 when the tractor he was driving crashed into the Jordan River at Bridgewater in Tasmania.

2. Mr Hall was a very experienced tractor driver. In addition, he was highly competent in the operation of associated equipment such as slashers, brush cutters, verge mowers and the like. He had worked slashing since about 1998. At the time of his death, he was employed by Peter Jones Mowing Pty Ltd on a casual basis. Peter Jones Mowing was and is the corporate alter ego (for want of a better expression) of Mr Peter Jones, Mr Hall's nephew.

3. Relevantly, Peter Jones Mowing had a contract with Brighton Council to slash and mow road verges and other areas of grass within the municipality. Mr Hall was carrying out work associated with this contract at the time of his death.

4. Mr Hall had some health issues at the time of his death. Although he was active, a non-smoker and only a social drinker, his medical records[1] indicate

[1] Exhibit C13

that he suffered from type 2 diabetes, hypertension and obesity. His diabetes appears have been reasonably well controlled by diet. Mr Hall was also being treated with an anti-depressant medication at the time of his death. His medical history is important because it may help explain why he died as he did.

The role of the Coroner

5. However, before an analysis of the circumstances surrounding Mr Hall's death is undertaken it is important to say something about the role of a coroner. A coroner in Tasmania has jurisdiction to investigate any death which appears to have been unexpected or unnatural. In this case, because Mr Hall died while at work (and his death was not due to natural causes) the *Coroners Act* 1995[2] (the *Act*) makes an inquest mandatory. An inquest is a public hearing.

6. The requirement for an inquest to be held in a case such as this is subject to the right of the Senior Next of Kin of the deceased person (in this case Mrs Hall) to request that there be no inquest[3]. Mrs Hall did not make that request, and therefore an inquest had to be held.

7. When investigating any death, whether or not an inquest is held, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. She or he is required to thoroughly investigate a death and answer the questions (if possible) that section 28 of the *Coroners Act* 1995 (the *Act*) asks. These questions include who the deceased was, the circumstances in which he or she died, the cause of the person's death and where and when the person died. This process requires the making of various findings, but without apportioning legal or moral blame for the death.[4] A coroner is required to make findings of fact from which others may draw conclusions.[5] A coroner is also able, if she or he thinks fit, to make comments about the death or, in appropriate circumstances, recommendations to prevent similar deaths in the future.

8. A coroner neither punishes nor awards compensation – that is for other proceedings in other courts, if appropriate. Nor does a coroner charge people

[2] Section 24(1)(ea) of the *Act*
[3] Section 26A of the *Act*
[4] See *R v Tennent; ex parte Jaeger* [2000] TASSC 64, per Cox CJ at paragraph 7.
[5] See *Keown v Khan* [1998] VSC 297; [1999] 1 VR 69, Calloway JA at 75 – 76.

with crimes or offences arising out of the death the subject of investigation. In fact, a coroner in Tasmania may not even say that he or she thinks someone is guilty of a crime or offence.[6] I should make it very clear that in this case there is no reason to think, at all, that anyone has committed any crime or offence in relation to Mr Hall's death.

9. As was noted above, one matter that the *Act* requires is finding how the death occurred.[7] It is well-settled that this phrase involves the application of the ordinary concepts of legal causation.[8] Any coronial inquiry necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.

10. Finally, I note that the standard of proof in coronial inquests is the civil standard. This means that where findings of fact are made a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an inquiry reaches a stage where findings being made may reflect adversely upon an individual, it is well-settled that the standard applicable is that articulated in *Briginshaw v Briginshaw*[9]. That case stands for the proposition that it is particularly important to bear in mind the seriousness of any allegation and that the task of deciding whether a serious allegation is proved should be approached with great caution.

Circumstances of Death

11. On the morning of Monday 26 October 2015 Mr Hall awoke and got ready for work, as normal. Mrs Hall, who made him lunch to take with him to work, did not notice anything unusual about her husband. Mr Hall left for work at about 7.00 am. It was his first day back at work mowing after a break.

12. After leaving his home at 3115 Tasman Highway, Orielton, Mr Hall drove a short distance to 684 Fingerpost Road, Orielton, the address of his nephew, Peter Jones. There Mr Hall collected a blue Ford 7740 tractor registered number B19MS. Mr Hall then made his way to Bridgewater where he had been assigned the job of mowing a paddock on Cove Hill Road.

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[6] Section 28 (4) of the Act.
[7] Section 28(1)(b) of the Act
[8] See *March v E. & M.H. Stramare Pty. Limited and Another* [1990 – 1991] 171 CLR 506.
[9] (1938) 60 CLR 336 (see in particular Dixon J at page 362).

13. The tractor was a four-wheel drive model manufactured in 1994. It had an enclosed cabin. On 26 October 2015, the tractor had attached to it a slasher to cut (or mow) grass. The slasher was connected to the tractor by an independent power take-off system (PTO). The evidence was that Mr Hall had driven the tractor many times in the past.

14. Sometime between shortly before 10.00 am and 12 midday, Mr Hall was mowing a steep embankment at the work site. He was working alone. Physical evidence at the scene shows clearly that the tractor deviated from its expected path and drove nearly 200 metres through tall grass and shrubbery. The tractor drove down the hill over an embankment and came to rest in the Jordan River.

15. CCTV footage taken from the Brighton Council's waste transfer station[10] depicts in part the tractor at work. The tractor is last seen on the footage at 9.56:34 am. It is likely, and I am satisfied, that shortly after this time the tractor travelled down the hill over the embankment and into the river.

16. The fact that Mr Hall's tractor had crashed into the river was not discovered for some time. Mr Hall was working alone. He had with him a mobile telephone, and the tractor was fitted with a UHF radio. Mr Jones expected the job to take Mr Hall approximately two hours. When he did not hear from Mr Hall, he tried to call him twice on his mobile phone but received no reply. Mr Jones said this was not unusual. However, he was concerned enough to arrange for one of his other employees to call Mr Hall on the UHF radio. Mr Hall did not respond to that call either.

17. At about 12 midday a passer-by noticed the tractor in the Jordan River. That person called into the nearby Brighton Council Waste Transfer Station and told the workers there that a tractor was in the river. The workers immediately contacted Mr Scott Percey, the Council work supervisor. Mr Percey gave evidence at the inquest. He said he was notified at approximately 12.05 pm and went straight to the work site with a co-worker to investigate. Mr Percey gave evidence that he found Mr Hall in the tractor which was, when he arrived, partially submerged in the river. Mr Percey called out to his co-worker to get some help. He then checked the driver's door which appeared to him to be locked but found the rear door (or window) of the tractor was unlocked. He

[10] Exhibit C15

opened it, climbed in and yelled out to Mr Hall. Mr Hall was not responsive. He said that Mr Hall's face was in the water, that he was leaning forward and he did not appear to be breathing[11].

18. Mr Percey grabbed the back of Mr Hall's shirt and pulled his face from the water. He held him until Police officers arrived a short time later to assist. One of those officers, Acting Sergeant Luke Griffiths, said that when he arrived, he did not think Mr Hall was breathing. Acting Sergeant Griffiths and Constable Lauren Hawkins took over supporting Mr Hall until the arrival of paramedics.

19. Paramedics were also shortly after on the scene but were unable to do anything to save Mr Hall. In particular, because he was partially immersed in water, they were unable to use a defibrillator. However, on all of the evidence, I am satisfied that Mr Hall was dead before Mr Percey (and therefore police and ambulance officers) arrived. Mr Percey is to be commended for his efforts to help Mr Hall in the circumstances. It is clear nothing more could have been done to try and save him.

20. Within a short time, officers from Marine Services, Forensic Services and Senior Constable Cordwell of Crash Investigation Services along with personnel from the Tasmania Fire Service were all on the scene. Tasmania Fire Service personnel extracted Mr Hall's body from the cabin of the tractor. The scene was carefully examined and photographed. The tractor was recovered from the river and taken to the Police Garage for further examination.

21. After Mr Hall's body was extracted from the cabin of the tractor and formally identified, it was transported to the mortuary at the Royal Hobart Hospital.

Forensic Pathology Evidence

22. The next day at the mortuary an autopsy was carried out upon Mr Hall's body by the State Forensic Pathologist, Dr Christopher Hamilton Lawrence. Dr Lawrence found, at autopsy, that Mr Hall had suffered a fracture dislocation through the C4/5 vertebrae and a basal subarachnoid haemorrhage. He said, and I accept, that this was the cause of Mr Hall's death. In plain English, I am satisfied that Mr Hall died of a broken neck. Dr Lawrence also noted that Mr

[11] Exhibit C20

Hall had significant bruising on his head and neck which he said was consistent with being thrown around in the cabin unrestrained whilst the tractor was out of control moving over rough ground. Dr Lawrence noted, in particular, a large bruise on the right side of Mr Hall's forehead which he said was caused by a substantial impact, most likely on the steering wheel of the tractor. Dr Lawrence expressed the opinion that Mr Hall had suffered injuries equivalent to those sustained in a car crash.

23. Samples were taken at autopsy from Mr Hall's body and subsequently analysed at the laboratory of Forensic Science Service Tasmania[12]. The results of that toxicological analysis were unremarkable. No alcohol or illicit drugs were identified as having been present in Mr Hall's body at the time of his death. Prescription drugs at therapeutic or sub-therapeutic levels were found to have been present in the samples but I am satisfied on the evidence that those drugs neither caused nor contributed to the happening of the crash.

Evidence from the scene

24. Senior Constable Cordwell conducted a comprehensive investigation of the crash. She was assisted by a number of other officers. She gave evidence at the inquest, and the report that she authored was tendered in evidence[13]. Counsel assisting submitted, and I accept, that her evidence establishes very clearly the path the tractor took. In making the following findings of fact, I rely upon the very helpful submissions of Mr Thompson.

25. Senior Constable Cordwell explained that track marks, changes in the grass and damage to shrubbery all indicate where the tractor had travelled. On the basis of her evidence, I find that Mr Hall was first cutting the grass towards the top of the paddock. The tractor was towards the top of a hill near a metal post. The tractor travelled over that metal post and cut part of it off. However, the evidence from both Senior Constable Cordwell and Mr Jones was that hitting and cutting the post was unlikely to have any impact upon the functioning of the tractor, if for no other reason than because of the relatively small size of the object. I note Mr Cameron Rae, an experienced mechanic who gave evidence about the state of the tractor after Mr Hall's death, found nothing to suggest that the post had caused any damage to the tractor.

[12] Exhibit C5
[13] Exhibit C24

26. Viewing the evidence as a whole I am satisfied that although undoubtedly striking the post would have made a loud noise, no doubt audible to Mr Hall, it did not cause the tractor to stop or its engine to stall.

27. The evidence was that a Bunnings Hardware cap, belonging to Mr Hall, and which he invariably wore, was found on the ground 7.2 metres west of a dirt track (there were several in the paddock, this was the easternmost of those tracks and lead to the bank of the river). The cap was 14 metres north-east of the protruding post and in line with it.[14] It is impossible to make any finding as to how the cap got there and whether its position was of any significance. It may be that the cap came off because Mr Hall stopped the tractor after he heard it hit the post and alighted from the cab. It may be that he dropped it at some earlier time or that it became dislodged from Mr Hall's head in some other way and ended up on the ground. There is nothing in the evidence which enables an affirmative finding to be made about the issue.

28. Senior Constable Cordwell said that the tractor then travelled down the hill, towards the Jordan River in a generally north-easterly direction. As it travelled down the hill, the tractor crossed over the dirt track.

29. Roughly 42.5 metres after crossing the dirt track the physical evidence at the scene shows that the slasher stopped cutting the grass. Senior Constable Cordwell said this is evidenced by the fact that some of the grass was uncut at that spot but flattened. Mr Thompson submitted there are two possible reasons why the tractor stopped cutting the grass. The first is excessive speed (according to Mr Rae the slasher itself will operate at any speed, but if the tractor is going too fast the slasher will not cut well). The other possible reason is some type of mechanical issue. In the circumstances of this case, it is unnecessary to make any finding as to the reason why the slasher stopping working other than to note that it is apparent that it did.

30. Shortly after the tractor stopped cutting the grass, it hit a large rock protruding from the ground and then veered into relatively thick vegetation including boxthorn bushes. The evidence was that an experienced tractor operator like Mr Hall would not deliberately drive through boxthorn bushes because of the potential for damage to the tyres of the tractor. In fact Mrs Hall and her

[14] Exhibit C24, page 2

daughter told the inquest that it was impossible that Mr Hall would have deliberately driven over boxthorn bushes. By the time the tractor reached the boxthorn bushes it was well out of the area that was to be mowed.

31. Finally, the tractor drove through some small saplings, over a bank and into the river. Senior Constable Cordwell's evidence was that the tractor had travelled a total distance of nearly 200 metres from the top of the hill to its resting place in the river. She found no brake marks, at all, anywhere on the path the tractor took from the top of the hill to the river. The physical evidence satisfies me that at no stage did Mr Hall apply the brakes of the tractor.

32. I am also satisfied with the evidence that when the tractor came to a halt in the river that was likely to have been an extremely violent stop. Logic dictates, and I find, that the impact of the tractor with the riverbed was the cause of Mr Hall's broken neck.

33. Senior Constable Cordwell's evidence was, although the day was dry (and so was the grass), that the grass was relatively slippery. She said that the drag factor of the grass was 0.20 which is to be contrasted with an 'ordinary' road drag factor of between 0.5 and 0.68.

34. It proved impossible to calculate the tractor speed although Senior Constable Cordwell performed calculations that if the tractor had been travelling 5 km an hour, then the 199 metre descent it made would have taken approximately two minutes and 40 seconds. If it had been travelling at 15 km an hour, its descent would have taken approximately 48 seconds. The point is that whatever speed the tractor was travelling at a conscious driver would have had ample time to apply the brake and bring the tractor to a halt. The fact that there is no evidence of braking at all strongly suggests that by the time the tractor made its journey from the top of the slope into the river Mr Hall was either unconscious or in a significantly reduced state of consciousness.

35. I note the evidence was that the tractor was fitted with a lap seatbelt designed to be worn across a driver's waist. It did not have a shoulder sash type restraint. I also note that Mr Hall was not wearing the lap seatbelt when he was found. I am satisfied he was not wearing it at least during the tractor's final journey down the slope into the Jordan River.

The condition of the tractor

36. Mr Rodney Hill, a qualified diesel mechanic, gave evidence at the inquest. He said that he carried out the maintenance on all three of Peter Jones Mowing tractors, including the tractor that Mr Hall was driving on the day of his death. Mr Hill said he had done this for some years. He said he last worked on the tractor on 12 December 2014. Mr Hill's evidence was that the tractor was mechanically sound at that time. His evidence was that he did not work on the tractor again after December 2014 although in about April or May 2015 he recalled helping Mr Jones (and possibly Mr Hall) "detail" the tractor in readiness for it being sold. His evidence was that he might have helped fix a couple of bolts on the seat or similar.

37. Mr Hill said that even though the tractor was "old", it was in reasonable condition. He also said Mr Jones arranged for him to service the tractors in accordance with his recommendations. Mr Hill's evidence was that all the tractors, including the tractor being driven by Mr Hall on the day of his death, were reasonably well maintained. I accept Mr Hill's evidence.

38. As noted earlier, after the tractor was recovered from the Jordan River it was transported to the police garage in Hobart. The tractor was taken from the garage to premises in Kingston where Mr Rae (who has already been mentioned in this finding) inspected it with the slasher still attached. Mr Rae provided a report and gave evidence at the inquest. His evidence was extremely helpful, and I accept it. Mr Rae said that when he inspected the tractor, he noted its rear tyres were bald. However in light of the evidence generally, in particular Mr Rae's statement that even though the tyres were bald, he would have been "comfortable" driving the tractor on that day on that hill I am satisfied that the state of the tyres neither caused nor contributed to the happening of the crash.

39. Mr Rae said that due to the fact that the tractor had been partially submerged in salt water (the Jordan River is tidal where the accident occurred) it had suffered significant corrosion. This, in turn, caused damage to both the engine block and the electrical system which made it difficult to accurately test and diagnose whether there were any problems with the electrical systems. He also observed that the brakes were corroded as a result of their immersion in salt water and that the brake pedal had seized. However, he found no evidence that the

tractor was in anything other than a reasonable mechanical condition. His evidence, and that of Mr Hill's, persuades me that nothing about the mechanical condition of the tractor caused or contributed to Mr Hall's death.

Operation of the tractor on the day

40. A considerable amount of attention at the inquest was focussed upon how the tractor was operating in the immediate lead up to the crash, whether the engine was on and what gear it was in. Mr Rae gave evidence as to the operation of the PTO. He said the PTO switch in the cabin (which can be clearly seen in the photographs tendered at inquest[15]) needed to be in the "on" or engaged position for the slasher to work. The evidence from attending police was that they found the switch to be in the "on" position. There is a theoretical possibility that the switch could have been accidentally knocked from "off" to "on" during the attempts to save Mr Hall and then the recovery of his body. However, the evidence was that in order to switch from "off" to "on" it was necessary to push down on the button and twist it. I am satisfied in the circumstances this is inherently unlikely to have occurred accidentally. I am therefore satisfied the PTO switch was engaged at the time the accident occurred. The significance of this, as Mr Thompson submitted, is that if the tractor had stalled, it could only be restarted with the PTO disengaged or in the off position. It is clear that Mr Hall, given his extensive general experience with tractors, and in particular with the tractor he was driving on the day of his death, would have known that he could not restart the tractor with the PTO engaged.

41. Mr Rae expressed the opinion in his evidence that, despite the fact the ignition of the tractor was found in the "on" position, the tractor itself was not running (or more accurately the engine was not) when it entered the water. He said this was so because the engine did not feature the sort of water damage that he would have expected had it been running when it was submerged. In addition to this, of course, the slasher had stopped cutting the grass prior to entering the water. Due to the corrosion and as the engine was not running when the tractor was recovered I can make no finding as to what gear the tractor was in. Mr Thompson submits, and I accept, that is more likely than not that the tractor was not running when it entered the water.

[15] Exhibit C8a

42. Why the tractor was not running upon entry to the water is a question that is impossible to answer. There are several possible reasons why. The reasons include mechanical ones, driver error or an intentional act on the part of Mr Hall – perhaps related to a reduced level of consciousness. Whatever the cause the evidence does not allow me to make a finding as to the reason why the engine was not running.

43. However, the fact that the engine was not running means Mr Hall, had he been conscious, would have had substantial difficulty maneuvering the tractor because the power-assisted steering relied upon the engine running. Mr Rae said in his evidence that the difficulty of steering the tractor without power assistance was considerably more than would have been experienced in say an ordinary motor vehicle. I accept Mr Rae's evidence about this point.

44. The evidence, viewed as a whole, leads to the conclusion that Mr Hall was not exercising any, or any effective, control over the tractor as it moved down the slope and entered the river. Given the absence of drugs or alcohol and the fact that the tractor itself was in a reasonable mechanical condition the most likely explanation for Mr Hall's apparent loss of control is in my view a medical episode.

45. Dr Lawrence expressed the opinion that there were two equally plausible explanations accounting for a loss or diminution of consciousness. The first was a hypoglycaemic episode and the second a cardiac arrhythmia. Either explanation is possible. The hypoglycaemic episode is a possibility given Mr Hall's weight and history of type 2 diabetes. On the other hand, he had no history of having experienced hypoglycaemia and the evidence is that he had eaten breakfast the morning of death which would tend to militate against the possibility of such an episode. However, it cannot be excluded.

46. The possibility of a cardiac arrhythmia arose in Dr Lawrence's view because Mr Hall had a mildly enlarged heart and therefore an arrhythmia could not be excluded. On the other hand, Mr Hall had no ischaemic heart disease and no history of previous syncope. Like a hypoglycaemic event or episode, a cardiac arrhythmia cannot be excluded.

47. Although I am satisfied on the balance of probabilities viewing the evidence as a whole that the most likely explanation for Mr Hall's loss of control of the

tractor is, as I have already said, some type of medical event, I cannot in the circumstances on the evidence to hand reach a concluded view as to the nature of that event. I am satisfied that the unidentified medical event (more likely than not hypoglycaemia or cardiac arrhythmia or perhaps a combination of the two) led to a loss of or a significant reduction in Mr Hall's consciousness which in turn led to the tractor crashing.

Work Practices

48. Mr Hall's family asked the court to consider four issues. Those issues were:

    a) That tractor drivers should not work alone or if they are working alone should be checked on more regularly;

    b) That tractor drivers should check the area before work commences to identify physical hazards and obstructions;

    c) That tractors should have three-point seatbelts rather than lap seatbelts; and

    d) That the pre-start checklist should include a consideration of the tread of the tyres.

49. I am satisfied that each of the issues raised for consideration is properly within a coroner's jurisdiction to consider, particularly in the context of Mr Hall's death. I consider that it is impracticable for tractor drivers to work in pairs or greater groups than that. The nature of the task undertaken by Mr Hall at the time of his death was necessarily solitary. As Mr Thompson submitted, Mr Hall was an experienced and highly regarded tractor driver who had previously mowed at the very worksite he was working at on the day of his death. I accept it would not have been reasonably practicable or necessary for Mr Jones to have checked in on Mr Hall more regularly than he did. The evidence was Mr Jones did, in fact, check upon Mr Hall, and it is difficult to conclude that had he checked more frequently the outcome would have been any different.

50. The issue of the pre-start checklist[16] is I think answered by the fact that the checklist requires the driver to "visually check tyres for pressure and damage". The example of the pre-start checklist tendered at the inquest (having been one

[16] Exhibit C30

having been completed by Mr Hall) demonstrate that this was so. I am satisfied that the pre-start checklist itself was more than adequate, as were Mr Jones' practices and procedures in a general sense. In the context of a consideration of the tractors tyres tread, it is inconceivable that an experienced operator having been required by the checklist to check tyres for pressure and damage visually would not note tyres being bald. The other point about the tyre baldness, in this case, is that I am satisfied, as I have already said, even though the tyres were to an extent bald that fact neither caused nor contributed to the happening of the crash.

51. Essentially the same point arises in relation to tractor drivers checking the physical area of their work. The Safe Work Method Statement tendered at the inquest[17] clearly directs the tractor driver's attention to issues such as "unexpected conditions in the work site that could make work unsafe or impracticable to complete" as well as the scope of the work and specifications, a consideration of whether the planned equipment is roadworthy and in sound mechanical order. These demand that a driver checks carefully the physical work area.

52. However, the point raised in relation to the three-point or shoulder sash seatbelt is in my respectful view a very good one. Dr Lawrence gave evidence about the protection afforded by a three point or shoulder sash seatbelt. He said, and the point is perhaps obvious, that such seatbelts offer far better protection than a simple lap seatbelt. Dr Lawrence said a three-point restraint might well have protected Mr Hall (assuming he was wearing it) and meant that his neck was not broken.

53. As counsel assisting submitted, Mr Hall's death is a sad reminder of the importance of wearing seatbelts. Even though the obligation to wear a seatbelt by reason of the *Road Rules* 2009 rule 264 was not engaged in this case because the worksite was not a road or road related area, the need to wear a seatbelt where fitted is in my respectful view beyond argument. In my view where it is possible to fit a three-point seatbelt to a tractor (recognising there are many variations in design some of which mean in practical terms no such seatbelt was able to be fitted) then such a seatbelt should be fitted and worn.

[17] Exhibit C31

Formal Findings

54. The evidence at the inquest allows me to make the following findings in accordance with section 28(1) of the Act:

    a) the identity of the deceased is Alexander Dale Hall;

    b) Mr Hall's death was the result of a tractor crash which happened as a result of Mr Hall experiencing a loss of consciousness, possibly after a hypoglycaemic episode or cardiac arrhythmia occurred;

    c) the cause of Mr Hall's death was a fracture dislocation through vertebrae C4/5 and a basal subarachnoid haemorrhage (in lay terms a broken neck); and

    d) Mr Hall died between shortly before 10.00 am and 12 midday on 26 October 2015 in the Jordan River, adjacent to Cove Hill Road in the Municipality of Brighton in Tasmania.

Comments and Recommendations

55. Section 28(2) of the *Act* empowers a coroner in appropriate circumstances to make recommendations in a finding with "respect to ways of preventing further deaths". It should be reasonably clear from what I have said earlier in these findings that I consider the issue of seatbelts to be extremely important. Although Mr Hall was under no legal obligation to wear a seatbelt I note that if he had been wearing a seatbelt, it is possible that the injuries he sustained may have been less and may have proved ultimately not to be fatal. It is also the case that if a three-point harness had been fitted to the tractor the possibility of Mr Hall suffering the injury which caused his death would have been lessened considerably if not avoided altogether – assuming such a seatbelt was being worn.

56. I therefore consider it important to make two recommendations, both relating to seatbelts. First, **I recommend** that seatbelts, where fitted, always be worn by tractor drivers in all circumstances. Second, **I recommend** where it is practicable to do so, three-point (shoulder sash) seatbelts, rather than lap seatbelts, should be fitted to all tractors.

57. I wish to extend my appreciation to Senior Constable Kelly Cordwell for the manner in which she conducted the investigation.

58. I extend my thanks to Mr Thompson, counsel assisting, for the extremely professional manner in which he presented the evidence at the inquest.

59. I thank Constable Luck for her contribution to the smooth running of the inquest.

60. In conclusion, I extend my condolences to the family, loved ones and friends of Mr Hall on their loss.

Dated 24 August 2018 at Hobart in Tasmania

Simon Cooper
Coroner