MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Stephen Carey, Coroner, having investigated the death of Darryl Arthur Adamson

Find That:

(a) The identity of the deceased is Darryl Arthur Adamson;

(b) Mr Adamson died in the circumstances described in this finding;

(c) Mr Adamson died as a result of traumatic amputation of his right lower leg due to it being trapped under a moving tractor wheel;

(d) Mr Adamson died on 7 November 2014 at Scotts Road, Geeveston, Tasmania; and

(e) Mr Adamson was born in Perth, Western Australia on 13 November 1964 and was aged 49 years; he was living in a de facto relationship and was receiving a disability pension at the date of his death.

Circumstances Surrounding Death:

Mr Adamson had been in a de facto relationship with Heather Louise Gunston for approximately 16 years. Mr Adamson was a qualified aircraft engineer and had extensive knowledge of various forms of machinery. Unfortunately, Mr Adamson suffered significant mental health issues, believed to be acute post-traumatic stress disorder, depression and anxiety as a result of being sexually abused as a child. These mental health issues, however, are not considered to have in any way contributed to his tragic death.

Ms Gunston purchased a farm at 62 Scotts Road, Geeveston and Mr Adamson moved there in February 2010. Ms Gunston joined him in Tasmania in August 2010.

Mr Adamson was not on any prescribed medication, however he would consume alcohol on a regular basis and also smoke cannabis as a form of self-medication as it assisted to control his anxiety.

Approximately 6 months before his death, Mr Adamson had begun to suffer seizures and investigations in relation to this involved blood testing which also led to a diagnosis of hepatitis C. This diagnosis exacerbated his anxiety and depression.

Mr Adamson had at least two notable seizures as recalled by Ms Gunston. The first on 31 May 2014 which resulted in a brief admission to Royal Hobart Hospital, and the second on 4 November 2014. No diagnosis as to the cause of these seizures had been made prior to his death with investigations planned but not carried out before his death. He had not been prescribed any medication for these seizures.

On 7 November 2014 Mr Adamson was using a Massey Fergusson tractor with grass slasher attached to clear grass in an apple orchard at the property at 62 Scotts Road, Geeveston. The only other person present at the address at that time was Mr Angus Sim who was a friend of Mr Adamson and who at that time resided at that address. Mr Adamson began slashing at approximately 11:00am and Mr Sim would check on his progress, observing him from time to time. Mr Sim maintained his observation either by going outside the house or by listening to the sound of the tractor to make sure it was still running. He realised that there was a period of approximately 20 minutes during which the tractor sounded as though it was stationary although the motor still operating. He went to investigate and observed that Mr Adamson was lying on the ground with both of his legs trapped under the rear right hand tyre of the tractor. The tyre was still turning and the tractor was in forward gear. He turned the tractor off and ran out onto Scotts Road, waving down a passing vehicle, requesting that the occupants call the ambulance service. The ambulance service logged a call at 11:57am.

When first observed, Mr Adamson was unresponsive; however the occupant of the motor vehicle, Mr Robert Scharkie, attended Mr Adamson commencing CPR which he continued until the ambulance arrived at 12:20pm. Unfortunately an assessment by attending paramedics determined that resuscitation endeavours would not assist as Mr Adamson was deceased.

Police arrived at the scene at 12:24pm and an investigation commenced. Initially Workplace Standards Tasmania were advised but their involvement was ceased when it was determined that Mr Adamson was not employed to do the work he was doing at the time of his death.

An examination of the scene disclosed that the ground in the orchard was uneven, there being only just enough room to manoeuvre the tractor and slasher between the rows of trees. The tractor had collided into an apple tree, the apple trees were not heavily pruned and there were several branches which could have dislodged Mr Adamson from the seat of the tractor if he was still driving it when it came in contact with the apple tree. Both of Mr Adamson's legs were noted to have been severely damaged. His right leg was crushed and severed just below the knee. The left leg was also damaged but not as severely. Mr Adamson also had grazing to his right arm. The tyre which had trapped Mr Adamson appears to have continued to rotate for quite some time as there was a large depression in the ground, approximately 75cm deep. Mr Adamson was observed to be barefoot; according to Ms Gunston this was not unusual. The foot pedals of the tractor were metal and to operate that tractor barefoot would have increased the difficulty of operating the foot controls, including the brakes. The tractor was believed to be approximately 50 years old and did not have any safety features incorporated; in particular a cut out switch which activates when the weight of the operator is released from the driving seat.

The autopsy findings at post-mortem revealed extensive traumatic damage to the right lower leg but also severe ischaemic heart disease.

Although the cause of death is clearly established, the investigation was unable to identify how Mr Adamson came to be in a position where he was caught under the operating tyre of the tractor. In that regard there are a number of possibilities. Given that Mr Adamson was known to have been suffering seizures in the months preceding his death, the most recent being 3 days prior, it is possible that he has suffered a seizure and fell from the tractor, thereby becoming trapped underneath the wheel. Given the identification of severe ischaemic heart disease with a 70% narrowing of the left anterior descending coronary artery, he may have had a cardiac incident which has precipitated a fall from the tractor. Another possibility is that noting the ground in the orchard was uneven and there were low hanging branches on the apple trees, he may have been dislodged by contacting one of the trees, and possibly this may have been combined with some incident occurring whereby his ability to operate the tractor was affected by him being barefoot.

The post-mortem toxicology reports alcohol and THC in his system. There is a possibility that these substances may have affected his ability to operate the tractor at the time, although there is no clear indication of this.

Comments and Recommendations:

Due to the age of the tractor being operated by Mr Adamson it was not fitted with accepted safety mechanisms now common on such equipment. The existence of a cut-off switch that would stop the engine once weight was lifted from the driver's seat could have avoided this tragic accident. I am unaware of the cost of retrofitting such a device to older style tractors, however it would be my recommendation that persons operating this type of equipment, especially in circumstances where there is an increased risk of falling from the tractor, consider fitting such a safety device.

The circumstances of Mr Adamson's death do not require me to make any comments or recommendations pursuant to section 28 of the *Coroners Act* 1995.

I wish to convey my sincere condolences to the family of Mr Adamson.

Dated: 1 October 2015 at Hobart in the state of Tasmania.

Stephen Carey
Coroner