



# 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 the death of Bastiaan Kleijnendorst

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

- a) The identity of the deceased is Bastiaan Kleijnendorst;
- b) Mr Kleijnendorst died in the circumstances set out further in this finding;
- c) The cause of Mr Kleijnendorst's death was multiple chest injuries; and
- d) Mr Kleijnendorst died, aged 77 years, on 30 May 2023 at Staverton Road, Promised Land, Tasmania.

In making the findings above and those that follow I have had regard to the evidence obtained in the investigation into Mr Kleijnendorst's death which includes:

- Police Report of Death for the Coroner;
- Affidavits confirming identity;
- Report – Doctor Andrew Reid, Forensic Pathologist;
- Report – Forensic Science Service Tasmania;
- Records – Ambulance Tasmania;
- Medical Records – Tasmanian Health Service;
- Affidavit – Maraea Kleynendorst, sworn 8 January 2024;
- Affidavit – David Crowdsdale, sworn 7 January 2024;
- Affidavit – Richard Elliott, sworn 22 December 2023;
- Affidavit – Ioannis Mallios, sworn 10 May 2024;
- Affidavit – First Class Constable Rachael Fitzsimmons, sworn 11 December 2023 (and body worn camera footage);
- Affidavit – First Class Constable Dean Wotherspoon, sworn 23 July 2023 (and scene photographs; and
- WorkSafe Tasmania investigation file.

## Introduction

1. Mr Kleijnendorst (known as Basil) was born in Dordrecht, Netherlands on 25 November 1945. He was aged 77 years at the time of his death and married to Maraea.
2. As at 30 May 2023 he was working at Tasmazia, Promised Land, in North Western Tasmania. Tasmazia is and was a tourist attraction which included a large hedge maze, a model town, a gift shop, pancake parlour and honey tasting facility.
3. Mr Kleijnendorst died as a result of massive injuries sustained by him while he was operating a Mini Loader in the course of his employment at Tasmazia on that day.

## The Coroner's Jurisdiction

4. Before considering the circumstances of Mr Kleijnendorst's death in further detail, it is necessary to say something about the general role of the coroner. In Tasmania, a coroner has jurisdiction to investigate any death, and hold an inquest, in relation to that death if it that appears that "*the deceased died at, or as a result of an accident or injury that occurred at, his or her place of work and the coroner is not satisfied that the death was due to natural causes*".<sup>1</sup> The circumstances of Mr Kleijnendorst's death meet this definition.
5. The requirement to hold an inquest (which is a public hearing) is subject to section 26A of the *Coroners Act 1995*. That section provides that if the senior next of kin requests the coroner not to hold an inquest and the coroner is satisfied that it would not be contrary to the public interest or the interests of justice not to hold an inquest, then no inquest need be held. In this case Mr Kleijnendorst's widow, the senior next of kin under the *Coroners Act 1995*, made such a request and I was satisfied, having regard to the extensive investigation that it was appropriate to dispense with the holding of an inquest.
6. When investigating any death, whether holding an inquest or not, a coroner performs a role different to other judicial officers. The coroner's role is inquisitorial. A coroner is required to thoroughly investigate the death and answer the questions (if possible) that section 28(1) of the *Coroners Act 1995* (the "Act") asks. Those questions include who the deceased was, how they died, the cause of the person's death, and where and when the person died. It is settled law that this process requires a coroner to make various findings, but without apportioning legal or moral blame for the death.
7. A coroner is required to make findings of fact about the death from which others may draw conclusions. A coroner may, if she or he thinks fit, make comments about the

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<sup>1</sup> Section 24(1)(ea) of the *Coroners Act 1995*.

death or, in appropriate circumstances, recommendations to prevent similar deaths in the future.

8. It is important to recognise that a coroner does not punish or award compensation to anyone. Punishment and/or compensation are for other proceedings, in other courts, if appropriate. Nor does a coroner charge people with crimes or offences arising out of a death that is the subject of investigation.
9. As was noted above, one matter that the *Act* requires, is a finding (if possible) as to how the death occurred.<sup>2</sup> 'How' has been determined to mean 'by what means and in what circumstances',<sup>3</sup> a phrase which involves the application of the ordinary concepts of legal causation.<sup>4</sup> Any coronial investigation necessarily involves a consideration of the particular circumstances surrounding the death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.
10. The standard of proof that a coroner applies 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. A coroner is not bound by the rules of evidence and may be informed in any manner the coroner reasonably thinks fit. The evidence must be capable in some way of assisting the coroner to determine the matters under section 28(1) or, in appropriate circumstances, to assist in making a comment or recommendation.

### **Circumstances of death**

11. Mr Kleijnendorst arrived at work at Tasmazia at about 7.00am on Tuesday, 30 May 2023. He was employed on a part time or casual basis to lead the team carrying out maintenance at the site. His role on the day was to operate the Mini Loader as well as direct other workers as to the tasks they were to perform. Essentially, the focus of the team was trimming the maze and clearing away debris.
12. The Mini Loader Mr Kleijnendorst was using is and was an articulated hydrostatically driven machine with foot controls. One foot controls forward; the other reverse. Speed is controlled by the use of the same pedals. To apply the brakes or to stop the Mini Loader the operator must retract the drive pedals slowly so as to remove both feet from the pedals entirely.

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<sup>2</sup> Section 28(1)(b) of the *Coroners Act* 1995.

<sup>3</sup> *Atkinson v Morrow* [2005] QCA 353.

<sup>4</sup> *March v MH Stramare Pty Ltd and Another* [1990 – 1991] 171 CLR 506.

13. At about 1.50pm a fellow employee Mr David Crowdsdale found Mr Kleijnendorst trapped under the Mini Loader. The Mini Loader was laying on its left side and Mr Kleijnendorst was on his back, pinned by the machines role over protective structure. The role over protective structure was resting on the area of his body approximately from his right hip to his upper left shoulder.
14. Mr Crowdsdale tried to lift the machine but could not do so. Another person present, Mr Richard Elliott, tried to help Mr Crowdsdale, but both were unable to move the loader. It was apparent to both men that Mr Kleijnendorst was deceased.
15. Police and emergency services were called at about 2.10pm. Police, SES personnel and a paramedic from Ambulance Tasmania all attended the scene. It was evident immediately Mr Kleijnendorst was deceased and a decision was made to preserve the scene in situ pending the arrival of officers from forensic services and investigating officers from WorkSafe Tasmania.

### **Investigation**

16. The fact of Mr Kleijnendorst's death was reported in accordance with the requirements of the *Coroners Act 1995*. Police officers including officers from forensic services and the Criminal Investigation Branch attended the scene and carried out enquiries. WorkSafe Tasmania were notified of the fact of the accident and attended and carried out investigations under their legislation.
17. Mr Kleijnendorst's body was formally identified at the scene<sup>5</sup> before being taken by mortuary ambulance to the Royal Hobart Hospital. At the mortuary, the Tasmanian State Forensic Pathologist Dr Andrew Reid performed an autopsy. After that procedure he provided a report in which he expressed the opinion that the cause of Mr Kleijnendorst's death was multiple chest injuries. The autopsy showed that Mr Kleijnendorst had suffered an oblique chest injury involving both sides of the chest but predominantly the midline sternum and lower right ribs. The oblique chest injury identified by Dr Reid is completely consistent with the observations of witnesses at the scene as to the manner in which Mr Kleijnendorst was trapped under the loader.
18. Dr Reid found underlying air in the pleural cavity (pneumothorax) combined with haemorrhage into the chest cavity (haemothorax). Dr Reid said in his report that "the combination of both blood and air, haemopneumothorax, indicates a penetrating lung injury probably due to rib fractures or pressure causing air and blood to escape into

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<sup>5</sup> Affidavit – First Class Constable Rachael Fitzsimmons, sworn 30 May 2023.

the pleural cavity.”<sup>6</sup> I accept Dr Reid’s opinion. The mode of Mr Kleijnendorst’s death was probably exsanguination but the cause was his multiple chest injuries, which caused that bleeding.

19. The injuries he sustained were so severe as to have been unsurvivable. I am satisfied he died almost instantaneously.
20. Toxicological analysis of samples taken at autopsy were subsequently carried out at the laboratory of Forensic Science Service Tasmania. No alcohol or illicit drugs were located as having been present in those samples. I am satisfied that neither drugs nor alcohol played any role in Mr Kleijnendorst’s death.
21. Contemporaneous with the investigation carried out by police officers pursuant to the *Coroners Act 1995*, which revealed no evidence of the involvement of any other person in Mr Kleijnendorst’s death nor of any suspicious circumstances at all, WorksSafe Tasmania carried out an extensive investigation. The result of that investigation has helped inform my finding.

### **Discussion**

22. The evidence viewed as a whole persuades me that there are no suspicious circumstances whatsoever associated with Mr Kleijnendorst’s death. He died from injuries sustained as a result of being crushed by the Mini Loader he was using in the course of his employment.
23. There is no evidence that Mr Kleijnendorst had any experience or training in the operation of any plant at all before working at Tasmazia. Mr Kleijnendorst’s employment background was in the building industry and particularly as a house painter. I have touched already upon the complexities associated with the operation of the particular Mini Loader. A lack of familiarity and experience with the machine would, to my mind, mean it would be difficult to maintain effective control of the machine. Proper training in the operation of the plant could have ameliorated the risk associated with that lack of familiarity and experience.
24. I note that there is no evidence that he had a job description of any type or was subject to a contract.
25. There is no evidence that Mr Kleijnendorst received an induction or any training at all in his employment at Tasmazia.
26. I am satisfied that the Mini Loader was in good mechanical condition. Mr Kleijnendorst had been responsible for purchasing it on behalf of Tasmazia. It was delivered on 18

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<sup>6</sup> Report Dr Andrew Reid 5 September 2023, page 10 of 12.

April 2023. After its delivery, Mr Kleijnendorst was provided with a hand over checklist (which he signed) along with the operators manual, warranty, hedge cutting operators manual, a service schedule, documents relating to risk assessment, a document stating that a seatbelt must be fitted and worn in conjunction with the rollover protection system and other related documentation.

27. In addition to the documentation provided with the Mini Loader a disk cutting bar was provided. Mr Kleijnendorst received instruction in basic safe operation and best practices in the use of the Mini Loader and the hedge cutting attachment from the salesman of the company from whom the Mini Loader was purchased.
28. After 18 April 2023, and until his death on 30 May 2023, the evidence is that Mr Kleijnendorst used the Mini Loader regularly to carry out hedge trimming. He was the only worker using that use of the machine. The work primarily was carried out on a mostly flat level surface within the maze itself.
29. During the morning of 30 May 2023, a matter of hours before the incident which caused his death, a 4-in-1 bucket attachment was delivered to Tasmazia. I am satisfied that Mr Kleijnendorst received some training from the salesperson who delivered that bucket that was relevant to its use. Mr Kleijnendorst then proceeded to use the 4-in-1 bucket immediately. That was the only time he had used it. His previous use of the Mini Loader using the hedge pruning attachment did not and could not, in my view, provide him with sufficient, or any, experience relevant to the use of the 4-in-1 bucket.
30. I am satisfied on the evidence that Mr Kleijnendorst was instructed not to operate the Mini Loader under any circumstances with the mast elevated.
31. I am satisfied that, unfortunately, for whatever reason, he did operate the Mini Loader with the mast elevated which caused it to over balance.
32. The Mini Loader was fitted with a seatbelt. Although the wearing of a seatbelt is, to my mind, something about which advice really need not be given, documentation supplied when the Mini Loader was purchased emphasises the need to wear a seatbelt. Mr Kleijnendorst was not wearing a seatbelt on the day he was killed. I am quite satisfied that had he been wearing a seatbelt then he would not have been ejected from the protection of the rollover protection system and crushed by it.
33. Mr Kleijnendorst's death was, to my mind, entirely avoidable.

**Comments and Recommendations**

34. The circumstances of Mr Kleijnendorst's death require me to **comment** that it is essential that all plant and equipment be operated in accordance with manufacturers specifications and recommendations. I also **comment** that when operating any plant and equipment fitted with a seatbelt the seatbelt must be worn.
35. I convey my sincere condolences to the family and loved ones of Mr Kleijnendorst.

**Dated:** 18 December 2024 at Hobart, in the State of Tasmania.

**Simon Cooper**  
**Coroner**