



**STATE CORONER'S COURT
OF NEW SOUTH WALES**

Inquest: Inquest into the death of John Lennard Erbacher

Hearing dates: 29 August 2016 – (Magistrate Burns), Port Macquarie Local Court
19-20 October 2017 – (Magistrate Grahame), Port Macquarie Local Court
6 December 2017 – (Magistrate Grahame), Glebe Coroner's Court

Date of findings: 22 December 2017

Place of findings: NSW State Coroner's Court, Glebe

Findings of: Magistrate Harriet Grahame, Deputy State Coroner

Catchwords: CORONIAL LAW – manner of death, workplace death, terraced orchard farming, use of a mobile elevated work platform (MEWP)

File numbers: 2015/258262

Representation: Mr J France (Sergeant) advocate assisting the coroner

Mr M Scott of counsel, instructed by Ms Hedger, of the Department of Finance, Services and Innovation for Safework

Mr Shume of counsel, instructed by Ms Goodhew, solicitor, Seyfarth Shaw for Gordon and Margaret Burch

Findings

Identity

The person who died was John Lennard Erbacher.

Date of death

He died on 2 September 2015.

Place of death

He died at Waterfall Farm, Stennetts Road, Comboyne, NSW.

Cause of death

He died from multiple injuries, in particular blunt force injuries to his pelvis and abdomen.

Manner of death

He died as a result of falling from a mobile elevated work platform (MEWP) while operating that equipment on a terraced avocado farm.

Recommendations

To the Executive Director, Safework NSW

I recommend,

That Safework NSW (in conjunction with corresponding agencies in other states, if applicable) convene a working party, in consultation with other relevant stakeholders (eg growers associations, farmers, and manufacturers) to

1. Develop best practice guidelines for the use of Mobile Elevated Work Platforms (MEWPS) in avocado (and other fruits with similar techniques) harvesting activities. In developing such guidelines, consideration should be given to the engineering design characteristics of MEWPS used to harvest avocados (and other fruits) and the training required for their safe use.
2. Promote awareness of the potential dangers and risks when using MEWPS to harvest avocados (and other fruits with similar harvest techniques) particularly on terraced farms.
3. Develop an educational booklet in relation to these issues specifically aimed at the avocado growing industry.
4. Develop best practice guidelines for engaging, training and supervising harvest workers, with a particular focus towards vulnerable workers,(for example, those new to the industry, youth workers and those from non-English speaking backgrounds).

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Introduction

1. On 2 September 2015, John Erbacher was at work, picking avocados at Waterfall Farm at Comboyne, NSW. That afternoon, when he did not return to the shed as expected at the end of the working day, another employee was sent to check on him. Mr Erbacher was found lying on the ground a short distance from a three wheeled Mobile Elevated Work Platform (MEWP) that he had been operating that day. It was clear that the machine had somehow tipped over and that Mr Erbacher had fallen to the ground. He was lying on his stomach, conscious, but in obvious pain. An ambulance was called and paramedics commenced treatment about 4.40pm. Mr Erbacher's condition deteriorated and his breathing became laboured. A rescue helicopter arrived around 5.17pm and a doctor continued treatment. Unfortunately, Mr Erbacher's condition worsened and he went into cardiac arrest. He was pronounced dead just before 6pm. The tragic circumstances of his death are the subject of this inquest.

The role of the Coroner and the scope of the inquest

2. The role of the coroner is to make findings as to the identity of the nominated person, and in relation to the date and place of death. The coroner is also to address issues concerning the manner and cause of the person's death.¹ In addition the coroner may make recommendations in relation to matters that have the capacity to improve public health and safety in the future.²
3. In this case there is no dispute in relation to the identity, place and medical cause of Mr Erbacher's death. For this reason the inquest focused on the manner and circumstances surrounding Mr Erbacher's death. In particular how he came to fall and whether there were gaps in the safety systems in place at the time of his death.
4. The purpose of an inquest in these tragic circumstances is not to apportion blame or criticize individuals, but rather to see if it is possible to identify opportunities to reduce the kinds of risks that are involved in day-to-day work in the avocado industry.
5. Section 81(1) of the *Coroners Act 2009* (NSW) requires that when an inquest is held, a coroner must record in writing his or her own findings in relation to various aspects of the death. These are my findings in relation to the death of John Erbacher.

The course of these proceedings

6. The proceedings commenced at Port Macquarie Local Court on 29 August 2016, before Her Honour, Magistrate Burns. Evidence was taken from the officer in charge of the investigation, Senior Constable Michael Dietrich, Michaela Nagel, Mr Erbacher's former partner, Safework Inspector Madeline Christianson and a mechanic employed at the farm, named John Ingram. At the end of the day the matter was adjourned, part-heard, for further evidence to be taken on 1 February 2017.

¹Section 81 *Coroners Act 2009* (NSW)

²Section 82 *Coroners Act 2009* (NSW)

7. For reasons unconnected with this inquest Magistrate Burns was unable to continue hearing evidence and the matter recommenced before me on 19 October 2017. The parties had formally agreed to proceed in this manner and a complete transcript of the evidence taken before Magistrate Burns was before me.
8. As well as hearing evidence on 19 and 20 October, on 18 October 2017, I attended an informal view at the farm where Mr Erbacher had died, in the company of the legal representatives of the parties, Safework inspectors and the owner of the farm, Mr Burch.
9. During the course of proceedings the court also received extensive documentary material including witness statements, expert reports, maps and photographs. I have had the opportunity to carefully consider all the evidence presented to the court.

Background

10. Mr Erbacher was 55 years of age at the time of his death. He had very recently separated from his long term partner Michaela Nagel, although they remained in close contact. Their daughter had recently commenced university and was living independently. He was apparently close to his mother and was well respected by all who knew him.
11. Mr Erbacher had worked in a variety of industries over the years. He had worked in labouring jobs and for builders and plumbers. He had worked at a large desalination plant in Sydney, where he regularly used elevated work platforms and other equipment.
12. Mr Erbacher had only been picking avocados since February 2015, firstly at another property in the local area and then for the Burch family for about six weeks prior to the accident. According to Ms Nagel he enjoyed the work and was happy in his employment at Waterfall Farm. Mr Burch described Mr Erbacher as “a very good man”, and as “a very good part of our team”³. Mr Burch explained that Mr Erbacher was “very diligent”, and that he didn’t hurry or take risks.⁴ He told the court that he had recently asked Mr Erbacher to continue as part of the permanent team at Waterfall Farm, after the 2015 picking season had concluded.
13. Mr Burch made it clear that Mr Erbacher was a careful and consistent worker. He was receptive to instruction and was considered a generally safe and responsible employee.

Waterfall Farm

14. Waterfall Farm is a family business run by Gordon and Margaret Burch. In recent years their daughter Georgia Ryan and son-in-law, David Ryan have become increasingly involved in running the operation. The property is situated at Stennetts Road, Comboyne. Originally the property was 83 hectares, but over the years further parcels have been purchased and it now stands at around 105 hectares.⁵
15. Mr Burch is a respected agricultural scientist with a master’s degree in rural science and a doctorate in agronomy. Prior to commencing farming at Comboyne, he worked for the

³ Evidence of Gordon Burch, 20/10/17, page 96, line 19 onwards

⁴ Evidence of Gordon Burch, 20/10/17, page 126, line 20 onwards

⁵ See evidence of Gordon Burch , 20/10/17, page 97, line 4 onwards

CSIRO as a principal research scientist in the ACT.⁶ Mr Burch has expertise in the area of land degradation and has a particular interest in catchment hydrology. During his career he has been involved in high level advice to government and was at one stage a director of the Australian Science and Technology Council.

16. Mr Burch had done extensive research into avocado growing prior to commencing his business. The land he purchased had been a dairy farm or vacant land and so he commenced his operation from scratch, planting trees and setting up his own systems.
17. It is clear that Mr Burch approached his operation in a scientific manner. He decided that the most efficient and sustainable method of growing avocados in Comboyne would be to use a terraced system. Drawing on P.A Yeomans' Keyline system, Mr Burch began planting his young avocado trees across the contours of his land, planning to retrofit terraces at a later date. He gave evidence that it was important to get the trees in as soon as possible as they take some time to mature. However, he explained that it took him some further time to accumulate the finances and expertise to build the terraces.⁷
18. As the years went by, the Mr Burch developed the terracing, using contract bulldozers. More recently terraces have been built prior to new planting commencing. Waterfall Farm was the first property in the local area to grow fruit, using a terraced system, but it is clear that the practise has taken hold and a number of other local operators have now commenced growing avocados using similar systems⁸. It is also clear that over the years Mr Burch has continued to perfect his own growing system and adapted his processes where necessary.
19. Mr Burch gave evidence that he now has around 10 000 trees, but as many as 4000 are immature or have been stumped or radically pruned.⁹ In 2015 the farm yielded about 450 tonnes of fruit.
20. Mr Burch demonstrated a considerable interest in and commitment to farm safety issues and he gave evidence that his business had been a finalist in Workcover's Small Business Safety Procedures Awards in 2013. I had the opportunity to observe him closely as he gave his evidence and he impressed as a highly intelligent and thoughtful man. Mr Burch gave his evidence in a clear and forthright manner and appeared to be trying to assist the court at all times. He was, in my view, an honest witness who approached the inquest with considerable integrity and knowledge.

Preparations for and commencement of the 2015 avocado harvest

21. Prior to the 2015 harvest commencing the Mr Burch assembled his crew of casual pickers. Most of the staff members were regulars and they were joined by two new pickers, one of whom was Mr Erbacher.¹⁰ Mr Erbacher had worked on a neighbouring avocado farm during the previous picking season.

⁶ Statement of Gordon Burch, Exhibit 1

⁷ For discussion of this see Mr Gordon Burch, 20/10/17, page 115, line 35 onwards

⁸ Inspector Allan noted that terracing was "a bit of a trend" in the Comboyne area and "without a doubt will occur elsewhere in the country" see his evidence on this issue 19/10/17 page 78, line 25 onwards

⁹ For discussion of this see Mr Gordon Burch, 20/10/17, page 139, line 46 onwards

¹⁰ Statement of Gordon Burch, paragraph 9 onwards - Exhibit 1

22. The harvest commenced on 14 July 2015¹¹. At the peak of the harvest there were six or seven people using mobile elevated work platforms (MEWPS) to harvest fruit. These workers picked fruit on the MEWPS and when they had filled their buckets, returned the fruit to the shed in the small utes or “mules” they had each been assigned. Each morning workers would meet at the shed and were then sent to their assigned terraces to work for the day. Each row was numbered and its inclination had been graded so that it was easy to keep track of which areas had been picked and where workers should be sent each day.
23. Mr Burch also explained that there were two regulars doing the ground picking, with family helping out. His own job was to supervise and monitor the picking staff and to do this he would travel around the farm visiting pairs of pickers throughout the day. Pickers were instructed to telephone him if there were any problems.
24. When picking commenced for the season, John Erbacher was originally working on a new self-levelling machine that had only recently been purchased. Unfortunately, the load sensors were continually malfunctioning. On one occasion Mr Erbacher had to be rescued when the machine froze in the trees. The company sent a technician who disconnected the sensors but within a week, the farm mechanic who was testing the machine broke his leg in an accident caused by the machine malfunctioning again. For this reason the machine was taken out of service and Safework became involved. John Erbacher was moved onto a different machine, an Afron HA, which had a six metre boom and four wheels.
25. Unfortunately on 28 August 2015, Mr Erbacher reversed that machine into a bank and broke one of its axles. This accident was considered out-of-character for the careful worker. The machine needed repair and as a result Mr Erbacher had to be transferred to another machine. This was a similar machine, but had only three wheels. The Afron PA 600 has two front drive wheels and a rear jockey wheel. The machine is not as stable as a four wheel machine and for this reason Mr Burch had tended to restrict its use to flatter ground and smaller trees. Mr Burch advised the court that he gave Mr Erbacher “a detailed induction on the machine and told him not to work on sloping ground when fully extending the boom”.¹²
26. It was this machine that Mr Erbacher was operating on the day of the accident.

The day of 2 September 2015 and the discovery of the tragedy

27. It appears that John Erbacher used the Afron PA 600 on 31 August 2015 and the following day without any issues. On 2 September 2015¹³ he apparently made a mistake, not closing the back door of his mule properly and as a result lost half a bin of avocados. It was out-of-character but Mr Erbacher continued working. At 2.27 pm Mr Erbacher called Gordon Burch and advised him that he was stuck and would need assistance. He had apparently bogged his MEWP. Mr Burch explained,

“I drove my ute to where he was which was row G 29. He hadn’t really moved very far. John had been doing at least 200m per day. I saw that one of the drive wheels had gone off the edge of the bank

¹¹ See statement of Gordon Burch , Exhibit 1

¹² Statement of Gordon Burch, paragraph 13 ,Exhibit 1

¹³ In his statement Mr Burch states this occurred on 1 September but elsewhere it is suggested this happened on the same day as the accident.

into a hole. He was correctly positioned but it looked like he wasn't really conscious of where his wheels were...His front left wheels were in a pit which had a sunken drum and was marked with a double white marking post. The base of the machine was caught on the ground."¹⁴

28. Mr Burch gave evidence that he assisted Mr Erbacher to get the MEWP back into a working position. Once he had helped to pull him out, Mr Burch observed that Mr Erbacher seemed a bit "distracted". He gave him the option of knocking off early but Mr Erbacher said he was good to continue. After watching him for a short time and satisfying himself that things were back on track, Mr Burch left Mr Erbacher to finish the last half hour or so of his shift.
29. However, Mr Erbacher did not return to the shed as expected and at about 3.30pm Mr Burch asked John Ingram, the farm mechanic to go down to G 29 and see what was holding him up. When he arrived he was shocked at what he saw. The machine had fallen over onto the row below and the basket and Mr Erbacher were close by. Mr Erbacher was about a metre and a half from the basket.
30. It was impossible to know if he had fallen precisely there or if he had dragged himself a small way. He was too badly injured to be able to explain properly what had happened. He was wearing his harness, but he was not attached.
31. Mr Erbacher was lying on his stomach and complaining of pain. He had trouble moving his legs. He appeared somewhat distressed and confused. According to Mr Ingram he said "What the fuck have I done?" a number of times. Mr Ingram asked Mr Erbacher if he had been wearing his safety harness as it was not connected and Mr Erbacher apparently answered that "he thought he had".¹⁵
32. At 3.42 pm John Ingram rang Mr Burch and told him that Mr Erbacher had tipped his machine and appeared to be injured. An ambulance was called and Mr Burch returned to the general area where he had left Mr Erbacher to assist while they waited for help. He was surprised to find Mr Erbacher only one tree from where he had been bogged earlier in the afternoon. Mr Burch was told to keep Mr Erbacher still and to monitor his breathing. During the wait for professional help to arrive Mr Erbacher became less responsive, but continued to breathe.
33. An ambulance arrived and officers commenced treatment, including CPR. Mr Erbacher's condition was worsening and he was having considerable trouble breathing. The Careflight crew arrived with a doctor who assumed responsibility for the patient.¹⁶
34. Unfortunately despite further treatment at the scene, Mr Erbacher could not be saved.

Cause of death

35. An autopsy was conducted on 7 September 2015 at the Department of Forensic Medicine, Newcastle. The cause of death was recorded as "Multiple Injuries (blunt force injuries to

¹⁴ Statement of Gordon Burch, paragraph 15, Exhibit 1

¹⁵ Exhibit 1, Statement of John Ingram, paragraph 18

¹⁶ Statement of Gordon Burch, paragraph 18 onwards and elsewhere

abdomen and pelvis)".¹⁷ It was noted that Mr Erbacher had multiple facial bruises and abrasions. A post mortem CT scan revealed a complex pelvic fracture and retroperitoneal haemorrhage around the right kidney. The injuries were identified as being consistent with falling from a height and impacting the ground.

36. It is most likely that Mr Erbacher was not attached by lanyard to the internal connection of the mechanical elevated work platform (MEWP) that he was using at the time of the accident.¹⁸ However, there is no evidence before me that would indicate how this would have affected his injuries or indeed his chance of survival. It is unclear whether Mr Erbacher tried to jump from the bucket or landed with it.
37. Toxicological testing showed that there was no alcohol in his system and while there was a low reading showing the presence of cannabinoids, it was not suggested that Mr Erbacher's ability to control the machine would have been impaired.

How did the accident happen?

38. The court heard considerable evidence in relation to the final resting position of the machinery in an attempt to understand exactly what happened. I have carefully examined the photographs and reviewed the expert and other evidence given at the inquest in this regard. I do not intend to repeat it now in any detail. It is clearly established that the machine tipped when it was moved onto the soft edge of the terrace. The MEWP boom was greatly extended and this would have increased its instability. It is not likely that the tipping happened very quickly, given that the basket's final resting place is no great distance from the machine itself.
39. Having said that, it is in my view impossible to determine conclusively exactly how or why the accident happened. The fall was unwitnessed and there are a number of mystifying aspects to it. Firstly, it is difficult to understand why Mr Erbacher had positioned the MEWP into that position on the row. He had already been observed by Mr Burch to have moved beyond that point and there is no known reason why he would have returned. There is no evidence that avocados had in fact been picked from that area and it was Mr Burch's evidence that Mr Erbacher had been clearly told to leave it and continue picking further along the terrace.
40. The precise positioning of the MEWP is also hard to explain. It appears that prior to tipping it had not been parallel to the edge of the terrace but at an angle facing towards the terrace¹⁹. The jockey wheel was closest to the edge, when it should have been facing the bank. There is nothing to explain why Mr Erbacher would have positioned the machine in this way, especially when he was known to be generally careful and to understand and follow safety directions.
41. The boom of the MEWP was extended to an estimate of 6 metres. This was in itself odd, given that it would not have been necessary to extend the arm to that degree to pick in the

¹⁷ "External Examination Report to the Coroner" - Dr Rexson Tse, Exhibit 3

¹⁸ Mr Ingram gave evidence that the carabiner was closed (28/8/16, page 80, line 1 onwards). This is consistent with the photograph taken on the day of the accident and the fact that it appeared to have no damage (see evidence of Inspector Allan (19/10/17, page 23, line 12). It appears to me unlikely that even if Mr Erbacher had unlatched his harness as he fell that he would have taken the time to close the carabiner, given the situation he was in.

¹⁹ See for example discussion of this issue by Inspector Allan. 19/10/17, page 62 onwards.

area, where the fruit was mostly lower down. Mr Erbacher had in any event been directed not to extend the arm in that manner or to that extent.

42. There is no doubt that the edge of the terrace was quite soft at the relevant time. Photographic evidence presented appears to show that the right hand drive wheel had subsided into the surface.²⁰ As the machine tipped the back “jockey wheel” came to rest at the base of a tree positioned at the edge of the terrace.²¹ But exactly what Mr Erbacher was doing at the time the machine tipped remains somewhat of a mystery, given his prior work history, the instructions he had been given and the position of fruit in that row.

What safety systems were in place at the farm at the time of Mr Erbacher’s death?

43. I am satisfied that safety was an important consideration for the Burch family in the operation of their farming business. They had a number of systems in place, including,
- A general safety induction for all workers including a DVD on safe picking, and the provision of safety equipment²². Harnesses were to be worn.
 - Daily pre-start meetings were held and safety issues were raised from time-to-time at morning tea
 - Written MEWP Safe Operating Guidelines were provided and signed by all employees who used those machines²³
 - A specific verbal induction was also conducted in relation to each MEWP prior to commencing operation.
 - There was a strict requirement that pickers walk each terrace prior to commencing and complete a risk assessment form
 - Workers were instructed to work in pairs or at least in adjacent rows or in close proximity. (It appears that Mr Erbacher’s pair on the day may have just finished work at the time the accident took place).
 - A system where each terrace was measured and rated in relation to hazard assessment was in place at the time and documented in a Farm Hazard Register.²⁴ Operators were required to read the risk register daily and familiarize themselves with the areas they would be working in and sign the register to indicate they understood the risk involved. John Erbacher did this on 1 September, indicating that he was aware of the risk in row G 29 W.
44. These and other measures indicate to me that the operators of Waterfall Farm took safety concerns seriously and had made significant attempts to put systems in place to reduce the risk of accidents. They were aware that each of the MEWPS had particular limitations due to their size or due to the slope they could be operated on. I am satisfied that this information was taken into account when planning the picking each day and in designating the area each picker would be sent to.

²⁰ See for example Exhibit 7, photographs 4, 6 and 12 and Exhibit 8, photographs 6 and 7

²¹ See Exhibit 7, photographs 13 and 15

²² See for example Exhibit 1, Statement of John Ingram, paragraph 20

²³ For discussion of various systems in place see the Safework’s Report to the Coroner by Madeline Christensen dated 25/11/15. It appears that detailed Operating Guidelines were signed by Mr Erbacher on 15/7/15

²⁴ Exhibit 5, “Waterfall Avocados Farm Hazard Map”. see also the evidence of Mr Burch at 20/10/17, page 127, line 5 onwards

45. The evidence also revealed that the Mr Burch and his family have continued to attempt to source new equipment which will provide increased safety for pickers. Since the accident, I note that work has also been done to raise the banks on the rows to create a stronger barrier.

Was the MEWP an appropriate machine?

46. Counsel for Safework submitted that the Afron PA 600 was an inappropriate machine to be used on terrace G 29 in or around where the machine toppled.²⁵ It is well established that the machine, having only three wheels, was less stable than others being used at the time on the property. It was only to be used on an incline of no more than eight degrees, while other machines could be used on inclines of up to 15 degrees.²⁶
47. Mr Burch gave evidence that the machine had previously been used by another worker in areas that were relatively flat.²⁷ It is also clear that it was only used by Mr Erbacher during this period because two other machines were unavailable. Mr Erbacher had most recently been using a four wheel Afron. It seems fair to assume, on the evidence before me, that while it may not have been his first choice, the machine was regarded by Mr Burch as safe and appropriate.
48. It was submitted on behalf of Safework that given the slope or incline close to where the machine tipped was measured at 10.4 degrees²⁸, it was clearly inappropriate to use that MEWP in that area. Further it was submitted that the edge of the terrace was soft and this would have also decreased stability.
49. It was Safework's submission that the unsuitability of the machine was increased given the narrowness of the terrace. The terrace was measured by Inspector Allan near where the accident occurred as being around 4.1 metres wide. The Afron PA 600, when extended was 6.88 metres in length. It follows that if an operator were to approach a tree at 90 degrees to the edge of the terrace, as was the standing instruction, the boom would need to be raised. However, once the boom was raised, the operator's ability to observe exactly where the wheels were placed in relation to the edge was greatly reduced. It was Safework's submission that this produced an unacceptable risk.
50. Mr Burch was questioned about this issue and conceded that in certain circumstances when approaching the front of a tree in a narrow terrace, an operator would have to raise the boom.²⁹ He stated that operators are shown how to do this in the induction process. He also expressed the view that this was one of the reasons why he now favoured the knuckle boom style machines over the kind of MEWP Mr Erbacher was operating on that day.

²⁵ See Outline of Submissions of Safework NSW

²⁶ See Mr Burch's evidence in this regard 20/10/17, page 142, 21 onwards

²⁷ Evidence of Gordon Burch, 20/10/17, page 142, line 9

²⁸ Evidence of measurements taken by Inspector Allan, 19/10/17, page 63 line 14 onwards. It should be noted that I accept the submission made by counsel for the Gordon and Margaret Burch that this single measurement cannot be extrapolated to suggest it accurately reflects the incline of the whole row.

²⁹ See his evidence on this point at 20/10/17, line 1 onwards.

51. However, it should be noted that Mr Burch did not concede that the Afron PA 600 was unsuitable for the work that Mr Erbacher had been asked to do. He stated that there were indeed two sections of the row which were unsuitable to be picked using the Afron PA 600, but that they constituted a small overall proportion of the length of the row. He was confident that these unsuitable areas were clearly marked and that Mr Erbacher had been firmly instructed not to pick there. Mr Burch explained that during his specific induction with Mr Erbacher he had pointed out the slope category on the compliance plate of the three wheel machine and that he had stressed to Mr Erbacher that he would need to change his work practises because he was now using a machine with different restrictions and capabilities.³⁰ On the initial walk through Mr Burch said he had pointed out the different slope category of the area where the accident actually took place.³¹ I accept the evidence Mr Burch gave in this regard.
52. On balance, I am of the view that the Afron PA 600 could have been used safely on parts of row G 29, if Mr Burch's instructions had been carefully followed. While it was not Mr Burch's first choice of machine to assign to Mr Erbacher, I accept that he genuinely believed it could be safely operated in that area. With the benefit of hindsight, it was not the best machine for the job, because even a small operator error could produce risk given the slope, the soft ground and the narrowness of at least parts of the row. However, it was not wholly inappropriate if operated carefully, within strict parameters.
53. I understand that since the accident the MEWP in question has been removed from the property, pursuant to a Safework order. I understand that Mr Burch has no intention of using three wheel machines of that nature again in like conditions. This is a sound decision and demonstrates his ongoing commitment to improving safety.

The need for recommendations

54. There is little doubt that there will be further growth of terraced avocado farms in the local Comboyne area and beyond. During the course of the informal view we passed a number of other properties using terraced systems. It appears that when Mr Burch set up his farm he had limited access to resources and expertise from other farmers and that he developed his own systems as he went. It is also clear that he had a genuine commitment to safety on his farm. That such a tragedy occurred at Waterfall Farm, demonstrates the need for further development of safety systems and controls.
55. After Mr Erbacher's death, Safework conducted a thorough investigation of the incident. A safety alert titled "Mobile Elevating Work Platforms Used in Orchards"³² dated 14 June 2016 was subsequently issued. It should also be noted that one of the key priority areas identified in the Minister for Innovation and Better Regulation's recently launched "Agricultural Work Health and Safety Plan" is "falls from height", including falls from farm machinery.
56. Inspector Allan also gave useful evidence in relation to the potential benefits of establishing a state-wide project to provide information and develop standards in relation to the use of MEWPS in the rural industry, particularly where terraced farming is occurring. It would involve the cooperation of Safework inspectors as well as industry representatives. Safework

³⁰ See for example his evidence of the specific instructions he gave at 20/10/17, page 125, line 25 onwards

³¹ 20/10/17, page 126, line 2

³² See Annexure B as attached to the Safework Submissions

is expertly placed to continue its interest and involvement in this area of work. After hearing the evidence of Inspector Allan, I was convinced that that it is an avenue that should be further explored.

Findings

57. The findings I make under section 81(1) of the Act are:

Identity

The person who died was John Lennard Erbacher

Date of death

He died on 2 September 2015.

Place of death

He died at Waterfall Farm, Stennetts Road, Comboyne, NSW

Cause of death

He died from multiple injuries, in particular blunt force injuries to his pelvis and abdomen.

Manner of death

He died as a result of falling from a mobile elevated work platform (MEWP) while operating that equipment on a terraced avocado farm.

Recommendations

58. For reason stated above I make the following recommendations pursuant to section 82 of the Act. I recommend,

To the Executive Director, Safework NSW

That Safework NSW (in conjunction with corresponding agencies in other states, if applicable) convene a working party, in consultation with other relevant stakeholders (eg growers associations, farmers, and manufacturers) to

1. Develop best practice guidelines for the use of Mobile Elevated Work Platforms (MEWPS) in avocado (and other fruits with similar techniques) harvesting activities. In developing such guidelines, consideration should be given to the engineering design characteristics of MEWPS used to harvest avocados (and other fruits) and the training required for their safe use.
2. Promote awareness of the potential dangers and risks when using MEWPS to harvest avocados (and other fruits with similar harvest techniques) particularly on terraced farms.
3. Develop an educational booklet in relation to these issues specifically aimed at the avocado growing industry.

4. Develop best practice guidelines for engaging, training and supervising harvest workers, with a particular focus towards vulnerable workers. For example, those new to the industry, youth workers and those from non-English speaking backgrounds.

Conclusion

59. Finally I offer my sincere condolences to Mr Erbacher's family. His death at work is a terrible tragedy and I have no doubt their grief and loss is ongoing. I hope they find some small comfort in the thought that these proceedings may improve safety for other farm workers in the years to come.

60. I close this inquest

Magistrate Harriet Grahame
Deputy State Coroner
22 December 2017
NSW State Coroner's Court, Glebe