QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

Non-inquest findings of the investigation into the death of Bay Roxas Peuckert

CITATION:	**Investigation into the death of Bay Roxas Peuckert**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Southport
FINDINGS OF:	Mr James McDougall, Coroner
CATCHWORDS:	CORONERS: Farming incident, unsafe work practices, cherry picker.

Counsel Assisting:	Ms Rhiannon Helsen, Office of the State Coroner

Ms Bay Roxas Peuckert was 48 years of age at the time of her death. For 12 years, she had worked as a farm hand on Mr Charles and Mrs Margaret Eden's avocado, kiwi fruit and rhubarb 80 acre farm located at 272 Main Western Road, Mount Tamborine.

At around 2:00 pm on 1 September 2011, Ms Peuckert was directed by Mr Eden to drive the elevating work platform (EWP) to the machinery shed and use it to upright a 400 litre boom spray unit, which was lying on its side. The EWP was an Afron HAS-650 cherry picker, which had an 8 metre boom with a platform load capacity of 150kg. The spray unit weighed approximately 590kg. Mr Eden directed two other employees, Mr Mykko Karhula and Ms Brenda Karhula to assist Ms Peuckert. One end of the rope was subsequently tied to the spray unit and the other end of the rope was tied to the basket of the EWP. The intention was to use the EWP as a crane to lift the spray unit.

Mr Eden then directed Ms Peuckert to operate the EWP to raise the spray unit upright. Ms Peuckert complied with this direction and started to raise the boom of the EWP, whilst she was in the basket, operating it from controls within. Ms Peuckert started to raise the boom of the EWP until the unit had risen to a position where her head came into contact with the roof of the machinery shed. The boom raised and continued to rise forcing Ms Peuckert's neck into the beam of the shed. The boom then lowered before rising again, trapping Ms Peuckert between the boom basket handrail and the beam. The EWP continued to rise causing it to overbalance. This caused the plant to fall to the ground in an uncontrolled manner.

Ms Peuckert suffered neck and chest injuries. The Queensland Ambulance Service attended the scene and provided initial treatment. Ms Peuckert was subsequently airlifted to the Gold Coast Hospital (GCH) by a Care Flight helicopter. Despite extensive resuscitation measures and emergency surgery, Ms Peuckert was declared deceased at 4:25 pm.

Post-mortem findings

An external and full internal post-mortem examination was performed by Pathologist, Dr Dianne Little, on 6 September 2011. A number of histology and toxicology tests were also performed.

The internal and external examinations revealed severe neck and chest injuries. There were abrasions on the anterior of the mid-neck with bruising in the underlying strap muscles of the neck and thyroid gland. Petechial haemorrhages were also noted in the lining of both eyes. A band of abrasions across the anterior upper chest in the midline were observed as well as on the right hand side of the chest and focally on the right upper arm. There was extensive bruising in the underlying tissues of the chest with multiple rib fractures on both sides. Clinically, there was evidence of blood collection around the heart, which was relieved surgically revealing a tear in the right atrial appendage (part of the heart) with associated surrounding laceration of the heart muscle and bruising of the muscle of the right atrium of the heart.

Dr Little is of the view that the mechanism of death was likely multi-factorial. There was a crush injury to the chest with pericardial tamponade due to the lacerated right atrial appendage in the heart, which allowed blood to leak into the sac surrounding the heart, compressing it and preventing it from beating adequately. There were also multiple rib fractures with bruising of the lungs, which in addition to causing direct impairment of respiration, were associated with fat embolism. Additionally, the presence of the petechial haemorrhage and the description of her being found in a

slumped state with poor vital signs by the ambulance crew, as well as the bruising and abrasion across the front of the neck, are also suggestive of a component of crush asphyxia.

The cause of death was found to be the neck and chest injuries. There was no evidence of any significant natural disease, which could have caused or accelerated her death.

Police investigation

Following Ms Peuckert's death, a Coronial Report was prepared by Senior Constable NJ Campbell from the Logan Forensic Crash Unit. The following information has been derived from the Coronial Report and investigation material, which includes statements from various witnesses, audio exhibits, photographs and transcripts of the interviews conducted.

Incident location

The incident occurred on an 80 acre property, which is primarily used for cultivation of avocados, kiwi fruits and rhubarb. The property is owned by Mr and Mrs Eden.

The incident occurred at the entrance of a machinery shed located toward the rear of the property at the end of the access road. This shed was used to accommodate tractors, farm implements and other farming paraphernalia. The shed consisted of a timber frame, to which corrugated iron sheeting was affixed to form the shed roof and sides.

First response observations

At around 3:50 pm on 1 September 2011, Sergeant Josling and Senior Constable Calvert of the Canungra Police Station attended the incident location after being notified of the incident. They were advised by Queensland Fire Service officers who were in attendance that Ms Peuckert had been conveyed to the Gold Coast Hospital. They were directed to the machinery shed and the Afron HAS-650 yellow cherry picker.

The Afron cherry picker machine is an EWP intended for use by orchardists for the harvesting and maintenance of fruit trees. The machine is designed so that the operator can easily move around an orchard and work at varying heights. By virtue of its design, the machine is capable of working on sloping and uneven ground. The machine itself consisted of a fabricated steel base section in which the engine was located. The operator's platform was attached to the end of the fixed length fabricated steel boom that is raised and lowered by a single hydraulic cylinder mounted on the base of the machine. Although the boom can be lowered via a hydraulic control on the base section of the machine, the cherry picker is operated fully from the operator's platform. The manufacturers placard attached to the control panel in the operator's platform stated that the maximum platform load was 150 kg.

At around 5:40 pm, Senior Constable Campbell and Sergeant Jim Hickey of the Logan Forensic Crash Unit were notified of the incident. They arrived at the scene at around 6:55 pm. WH&S Inspector, Mr Pat Stevens also attended the scene.

Senior Constable Campbell observed that the yellow cherry picker had fallen forward into the entrance of the shed. The operator's platform of this machine was resting on top of a red Hardi boom spray unit. A closer inspection of the cherry picker revealed that the spray unit was attached to the platform of the cherry picker by a short length

of nylon rope. This rope was looped around the upper crossbar of the mainframe that supports the spray unit tank and the spray pump/blower mechanism. The rope had been tied off around the side panel of the operator platform foot well. He also noticed that there were two short, largely parallel, slightly curved tyre marks on the grass area at the front of the shed.

Senior Constable Campbell also conducted an inspection of the shed, where he noticed that there was a transfer of yellow paint similar in colour to that of the cherry picker on the underside of the timber roof bearer above the boom of the machine. There were also fresh rub marks on the underside of the timber bearer next to the yellow paint mark. The paint transfer and rub mark were at an angle across the underside of the timber roof bearer. This suggested that part of the cherry picker had struck the underside of the timber bearer. Fresh impact damage was also observed to the adjacent parallel roof batten. Scuff marks were also found on the top of the fabricated steel safety rail attached to the operator's platform. Recent scuff marks were also observed on the paintwork on the top side of the upper section of the steel boom. Senior Constable Campbell considered it was likely that the scuff marks on the upper section of the lifting boom were as a result of the impact with the roof bearer, while the marks on the safety platform rail were likely as a result of the impact with the roof batten.

The cherry picker was recovered the following day to allow for further inspection. When the machine was moved it was ascertained that the platform safety rail height was 3.65 metes, which exceeded the height of the shed entrance by 0.840 metres. It was clear, therefore, that it would not have been possible to lift the Hardi spray unit using the cherry picker, as intended, inside the shed entrance due to the height limitations.

Following the inspection of the equipment, Senior Constable Campbell concluded that the operator's platform was positioned inside the shed over the spray unit when the lifting attempt commenced. It is probable that the cherry picker began to lift the spray unit from its rest position while the operator was standing on the operator's platform, despite the excessive loading. As the operator of the cherry picker continued with the attempt to lift the spray unit, the boom angle has increased. However, at some point after the lift commenced, the rear wheel of the machine has lifted off the ground. The machine has initially balanced on the front wheels which acted as a fulcrum. At some point, the upper section of the lifting boom of the cherry picker has struck the underside of the timber roof bearer at the entrance to the shed with considerable force. Similarly, the top of the fabricated steel safety rail attached to the operator's platform has struck the adjacent and parallel roof batten. With the excessive load of the platform, the cherry picker has then toppled forward. The spray unit has then fallen over near its original position while the operator's platform of the cherry picker has come to rest over the top of the spray unit.

Machine operation test

Senior Constable Campbell performed a test operation of the cherry picker to establish whether there were any defects or operating faults. When he raised the platform using the foot pedal he found that the pedal would stick in the 'raise position' thus permitting the platform to continue to rise without applying any pressure to the pedal. To stop the platform from rising, it was necessary to apply foot pressure to return the pedal to the 'neutral position'. Similarly, the foot pedal was found to remain in the 'lower position' once the pedal pressure had been removed. By design, the foot pedal is meant to 'self centre' in the neutral position so that the platform will not raise

or lower without the application of foot pressure on the pedal by the operator in the desired direction.

Despite these identified faults with the raise/lower pedal, Senior Constable Campbell found that the machine operated satisfactorily and the application of the hydraulic power was smooth and precise.

Seizure and inspection of Afron cherry picker

The cherry picker was subsequently seized by Workplace Health & safety Queensland (WH&SQ) inspectors to allow it to be formally inspected and tested.

Witness statements

During the course of the investigation, Senior Constable Campbell obtained statements from the two independent witnesses to the incident, Ms Brenda Karhula and Mr Mikko Karhula. Both witnesses were also subsequently interviewed by WH&SQ inspectors.

Ms Brenda Karhula

According to Ms Karhula, Mr Eden requested that Ms Peuckert use the cherry picker, which she often operated, and bring it to the machinery shed. Mr Karhula was with Mr Eden at the time and they were inspecting the spray unit in the machinery shed. Ms Karhula saw the men trying to tie a rope from the spray unit to the bottom of the cherry picker basket where Ms Peuckert was standing. Ms Karhula was of the view that the rope being used was rotten. She suggested that if the spray unit could be lifted slightly, she may be able to get a better rope, which was stuck under the spray unit, to be used. Ms Karhula was concerned about Ms Peuckert operating the cherry picker under the shed as she did not think it was safe.

Ms Karhula grabbed the rope under the spray unit so she could pull it once the spray unit was lifted. She told Ms Peuckert to lift the spray unit about an inch. She recalls seeing the cherry picker basket raise very slowly and steady, however, the spray unit did not rise at all. Ms Karhula then recalls seeing the cherry picker basket fly up towards the roof of the shed, at which time Ms Peuckert's head hit the timber roof beam. She yelled out to Ms Peuckert to bring the basket down. She then saw the basket bounce up and down a couple of times during which she saw the beam hit Ms Peuckert's neck and then chest. After that, the basket came down quickly, as though Ms Peuckert was operating it. As the basket came down over the spray unit, it stopped and Ms Peuckert fell over to the side of the basket towards Ms Karhula.

Mr Eden instructed Ms Karhula to support Ms Peuckert's head as she had collapsed head first at the side of the spray unit. Ms Peuckert was unconscious at this time, however, she was not bleeding. Ms Karhula called 000 and requested an ambulance.

Mr Mykko Karhula

Mr Karhula recalls that Mr Eden told him that he wanted to stand the spray unit up, which was lying down in the machinery shed, so that it could be used. When Mr Karhula looked at the unit, he realised that a block and tackle would be needed to lift it up. He asked Mr Eden if he had one so it could be hung from the shed roof bearer above the spray unit. Mr Eden stated that he would get the cherry picker to lift the spray unit up. He then called out to Ms Peuckert to bring the cherry picker over to the machinery shed.

Once Ms Peuckert had the cherry picker basket in position over the spray unit, Mr Karhula got a rope and passed it through the foot on the basket before it was

attached to the unit. Ms Karhula suggested that a stronger rope, which was under the spray unit, be used .She told Ms Peuckert to lift the spray unit slightly so that she could pull the rope out from underneath it.

Mr Karhula recalls that the cherry picker basket went up slowly before Ms Peuckert hit her head on the timber beam or roof of the machinery shed. The cherry picker continued to keep rising. The cherry picker basket then came down fairly quickly before bouncing back up again. On this occasion, Ms Peuckert appeared to have been flung backwards and her chest was crushed against the timber beam. The basket then came down. Mr Karhula recalls yelling at Ms Karhula to call an ambulance.

Interview with property owner, Mr Charles Eden

Police attempted to obtain a statement from Mr Eden during the course of the investigation. On 7 March 2012, Mr Eden advised police that based upon legal advice he was unwilling to provide a statement. He formally declined to make a statement during a digital recording on 26 June 2012.

Opinions and conclusions

Having considered the information obtained during the course of the police investigation, Senior Constable Campbell drew a number of conclusions about the workplace incident supported by the evidence obtained:

- The incident occurred at approximately 2:30 pm on 1 September 2011 on an 80 acre rural property on Mount Tamborine, which is primarily used for the cultivation of avocados, kiwi fruits and rhubarb. The incident took place at the entrance to a machinery shed located toward the rear of the property at the end of the property access road. Mr Charlie Eden is the owner of the property.

- The machinery involved in the incident was a yellow Afron HAS 650 Elevating work platform, commonly referred to as a cherry picker. The machine was being operated by Ms Peuckert at the time of the incident. Ms Peuckert was employed on the property as a farm hand.

- Prior to the incident, Mr Eden had decided to stand the boom spray unit up so that it could be utilised. He requested that Ms Peuckert manoeuvre the cherry picker inside the shed to lift up the boom spray unit. Ms Peuckert operated the machine, as requested. A rope was attached to the boom spray unit and the cherry picker. The operator's platform of the cherry picker was raised slowly which partially lifted the spray unit from its resting position. All of a sudden, the operator's platform of the cherry picker has elevated rapidly causing Ms Peuckert's body to be crushed between the safety rail of the operator's platform and the underside of the shed roof. The platform then dropped suddenly before bouncing up into the roof again. The platform then came to rest across the spray unit.

- An ambulance was immediately called for Ms Peuckert, who was transported to the Gold Coast Hospital at 3:16 pm. Unfortunately, Ms Peuckert died during emergency surgery at around 4:25 pm.

- An operational test and inspection of the cherry picker established that there was a fault in the operation of the raise and lower foot and hand controls. The cherry picker is not designed or intended for use as a crane.

- The incident occurred as a direct result of the cherry picker being used to lift a load that was well in excess of its lifting capability causing the machine to become unstable during the lifting manoeuvre.

Based upon the evidence obtained, Senior Constable Campbell formed the view that there was insufficient evidence to substantiate any criminal proceedings against any person in relation to the circumstances of the incident.

Workplace Health and Safety Queensland Investigation

WH&SQ were notified of the incident by the Queensland Fire and Rescue Service on 1 September 2011 and immediately commenced an investigation. A coronial report detailing WH&SQ findings was subsequently provided.

On 1 September 2011, Principal Investigators, Mr Darren Tapper and Mr Peter Stevens attended the scene to inspect the relevant work areas. In January 2012, Principal Inspector, Mr Steve Underwood continued investigations into the incident.

During the course of the extensive and thorough WH&SQ investigation, inspectors took photographic evidence of the incident scene and relevant work area, obtained relevant witness statements, issued statutory notices, seized plant and property, obtained and analysed relevant documentation from Mr and Mrs Eden and sourced and referenced relevant legislation.

From the enquiries conducted, it was established that:

- Ms Peuckert had worked as a farm hand at 'Tamborine Mountain Rhubarb' for at least 12 years. Mr and Mrs Charles and Margaret Eden (the obligation holders) operated the business of growing rhubarb and avocadoes on an 80 acre farm at Mount Tamborine.

- The obligation holders employed a number of workers, including Ms Peuckert, to work on their farm. Mr Eden was the manager/person in control of the obligation holder's undertaking. The obligation holder was an employer within the meaning of that term under the *Workplace Health and Safety Act 1995* (the Act). Ms Peuckert was an employee under the provisions of the Act.

- As a result of this incident, Ms Peuckert sustained extensive chest and neck injuries and died as a result.

- The time and date of the incident was confirmed in witness statements from Ms Karhula and Mr Karhula.

- Pay/wage books obtained from the obligation holders indicated that Ms Peuckert was being paid wages as far back as 2003. These records also indicated that Ms Peuckert was being paid fortnightly all through 2011 until the date of the incident.

- Witness statements and photographs confirm that the incident involved a powered mobile plant, namely a EWP Model number Afron HAS-650 cherry picker.

- The obligation holder had no previous workplace enforcement history under the Act.

Witness statements

Witness statements were obtained by WH&SQ investigators from Mr and Ms Karhula on 6 September 2011.

According to Ms Karhula, she had worked for Mr and Mrs Eden six or seven times over a period of approximately six years. She was compensated in the form of petrol and avocadoes for the work she performed. Ms Karhula had never attended any training sessions, including induction training with Mr and Mrs Eden. She stated that Mr Eden was the boss and gave orders and instructions, however, in the past Ms Peuckert had also issued directions. There were no operator's manuals for any of the plant equipment available for viewing. Ms Karhula recalled that she had seen Ms Peuckert operate the EWP on numerous occasions, however, had never seen her wear a harness.

In relation to the incident, Ms Karhula stated that, *Charlie came down, asked Myk if he would go down to the shed, which was a few feet away from us, to try and stand up a spray machine. He couldn't shift it and move it and he asked Bay to come down and get the cherry picker and to come over with it.* She confirmed that it was Mr Eden's idea to use the EWP to upright the spray unit. Ms Karhula stated that she saw the machine go up and Ms Peuckert got hit. The machine then began to come down before it flung back up again.

According to Mr Karhula, he had worked for Mr and Mrs Eden on and off for the past 30 to 40 years as required on a volunteer basis. He was occasionally paid some petrol money. Mr Karhula had previously operated the EWP, as well as various other pieces of farming equipment. He had never seen any operator's manuals or pre-start checklists for the EWP. He also never wore a harness when he operated the EWP.

In relation to the incident, Mr Karhula recalls that Mr Eden directed him to assist in lifting the spray unit, which was lying horizontally. Mr Karhula asked Mr Eden, *have you got a block and tackle, we can hook it up the top there and lift it.* Mr Eden then directed Ms Peuckert to bring the EWP over to assist. He recalls that it was Mr Eden's idea to use the EWP to lift the spray unit. Mr Eden tied one end of the rope to the bottom of the EWP and Mr Karhula tied the other end of the rope to the spray unit.

The obligation holders declined to be interviewed by WH&SQ.

Operation, maintenance and parts manual – Afron HAS-650 cherry picker (EWP)

The operation, maintenance and parts manual were provided to WH&SQ inspectors by the obligation holders. The manual set out a number of guidelines. Witness statements, photos and the expert report obtained by WH&SQ, confirm that the following guidelines were not followed:

- Page 9 of the manual stated: *it is most important that the operator be well trained, instructed and warned of the danger involved in careless operation.*

- Page 10 of the manual stated: *for your own or operator's safety, the Afron HAS should be checked daily before attempting to use it.*

- Page 11 of the manual stated: *only trained operators must be assigned to operate this machine…Never exceed the manufacturers recommended platform load capacity…Maximum platform load 150 kg…a body belt for each person must be worn with the safety strap attached.*

- Page 12 of the manual stated: *it is recommended that head gear (hard hats) be worn by all personnel on the work platform…Before attempting to use your Afron in any job, check the area carefully for any obstructions…Do not drive carriage or platform into stationary objects or pull from platform or lift objects with the platform.*

- Page 13 of the manual stated: *It is necessary for the employer to train the employee in the safe operation of this machine and the safety procedures required.* A training sign off sheet is provided in the manual. It was noted that there were no signatures on Mr and Mrs Eden's training sheet.

The Afron HAS-650 had a large danger sign attached to it outlining most of the points described in the manual. It also clearly showed that the maximum platform load of the machine was 150 kg and it was not to be used to lift objects with the platform.

WH&SQ Inspectors asked the obligation holders to provide documents outlining any training or induction provided to staff. No training, induction documents or sign off sheets were provided.

Notices Issued

WH&SQ Inspectors issued the following notices immediately:

- Prohibition Notice no: P761868 – Directing the person in control of the plant being the Afron HAS-650 (serial no: 200107) cherry picker, to stop allowing the plant to be used until it has been repaired and inspected by a competent person.

- Improvement Notice no: I752018 – The relevant person must develop, implement and maintain a safe system of work to ensure the plant is maintained on a regular basis, as per manufacturers specifications…

Inspectors also seized the Afron HAS-650 cherry picker and the 400 litre boom spray unit.

Other issues

The Afron HAs-650 cherry picker was inspected by a technician from Lincoln Hire who provided a report indicating that there were a number of faults with the cherry picker. He noted that, *the controls from the basket for the EWP raise and lower stick stay on when the lever is released in some situations. When pushed firmly the*

controls remained in a locked in position…and the platform either continued to raise or lower. This fault may have contributed to the incident.

A detailed report was also prepared by Principal Advisor, Mr Stuart Davis, from WH&SQ Engineering Services Unit. The conclusions reached by Mr Davis are as follows:

> *The work system and mobile plant associated with the fatal incident Bay Roxas Peuckert on 1 September 2011 were unsafe and totally unacceptable for the following reasons:*
>
> (a) The Afron HAS-650 EWP was severely overloaded and had inadequate stability to be able to lift the spray unit from its position on the ground to a vertical position. The EWP was overloaded by a factor of 161% based on a force to cause overturning at more than three and half times based on the manufacturer's rated capacity of 150 kg.
>
> (b) The area where the spray unit was being lifted had inadequate vertical clearance to safely lift the unit to its vertical position. The use of the EWP to lift the unit caused the platform to strike the underside of the timber beam supporting the inside part of the shed roof.
>
> (c) The manufacturer of the Afron HAS-650 EWP states, *Do not push tower against solid objects or use the tower as a crane.*
>
> (d) The raise and lower foot and hand controls could be locked so that both the raise and lower functions would operate when the operator's hand or foot was removed. This was a fault of the unit and not how the unit was originally intended to operate.
>
> In addition to the above, the inspection of the EWP showed the following faults:
>
> - The control decal for the raise and lower hand lever was missing the word 'up'.
>
> - One of the hydraulic hoses attached to the luff cylinder had a damaged outer sheath that required replacing.
>
> - Relatively minor areas of rust were found at various places on the unit.

Conclusions

Upon considering all the evidence obtained during the course of the investigation, it was determined by WH&SQ that the hazards requiring management in this case were:

- Powered mobile plant being Afron Has-650 EWP; and

- The systems of work for operating the Afron HAS-650 EWP

The risk that emanated from the hazards was held to be the risk of death/injury or illness, including the risk of fatal injuries, as occurred in this case.

It was concluded that, as of 1 September 2011, Mr and Mrs Eden owed an obligation under s. 28 of the Act, in that:

- Charles and Margaret Eden ran a family partnership trading as Tamborine Mountain Rhubarb.

- Ms Peuckert was a worker and carried out work for and at the direction of the family partnership.

In the course of carrying out work for, and at the direction of Mr and Mrs Eden, Ms Peuckert was exposed to a risk to her safety and subsequently received fatal injuries.

The brief of evidence generated by WH&SQ showed that:

- Mr and Mrs Eden did not have any documents outlining any training or induction provided to staff.

- The Afron HAS-650 EWP was inspected by a technician and found to have a number of faults. This may have contributed to this incident.

- Mr and Mrs Eden allowed the EWP in crane mode.

- Mr and Mrs Eden did not ensure that workers wore appropriate personal protective equipment.

- Mr and Mrs Eden did not ensure that there were no hazards or obstructions where the mobile plant was being used.

- Mr and Mrs Eden did not maintain the EWP.

- Mr and Mrs Eden did not ensure that the operator of the plant was trained in the use of the EWP.

- Mr and Mrs Eden did not ensure that the maximum safe load of the EWP was not exceeded.

WH&SQ prosecution

The matter was subsequently referred to the Director of Legal and Prosecution Services for consideration of instigating legal proceedings for the failures of Mr and Mrs Eden under ss. 24 and 28 of the Act.

Complaints for both Mr and Mrs Eden were made on 27 August 2012 in the Beaudesert Magistrates Court.

On 20 February 2013, the complaints against Mr and Mrs Eden were finalised by a dismissal. Mr Eden died on 11 January 2013 and the prosecution against Mrs Eden (aged 76 years) was subsequently withdrawn after a submission was made by her lawyers. The submission, which was accepted by WH&SQ, asserts that Mrs Eden, for a number of years prior to the incident, had no input or control over the conduct of the business, and as such, Ms Peuckert's death was due to causes over which Mrs Eden had no control. Whilst Mrs Eden had previously completed book work for the business, this responsibility was handed over to a local bookkeeper in 2000. Since that time, Mrs Eden suffered from a number of serious medical issues and in 2007

she ceased all work on the farm. It was therefore submitted that Mrs Eden was not an 'employer' at the relevant time and had no control over the causes of Ms Peuckert's death. This submission was accepted by WH&SQ and the complaint against Mrs Eden was withdrawn.

Following the incident, WH&SQ released a number of publications in relation to EWP's regarding the appropriate maintenance, record keeping, safety and training requirements as well as the appropriate uses of the machines.

Conclusion

Ms Peuckert was 48 years of age when she died as a result of neck and chest injuries sustained whilst operating a cherry picker. It is clear that Ms Peuckert had been directed to use the machine in an inherently unsafe manner and for a purpose contrary to its design. In addition, the machine had a number of faults, which may have contributed to the incident. Contrary to the farm operator's responsibilities, Ms Peuckert and the other employees working on the farm had not been provided with any training as to the appropriate and safe use of the farming equipment prior to the incident.

The circumstances surrounding Ms Peuckert's death have been thoroughly and professionally investigated by the police and WH&SQ. I am satisfied that the conclusions reached, as identified in the Coronial Reports provided, are supported by the evidence obtained and are appropriate.

Based upon the material obtained during the coronial investigation, I am satisfied that the circumstances surrounding the incident have been sufficiently examined and there are no further matters which require investigation. Having considered all the material obtained during the course of the investigation, I am satisfied that there are no further issues, which require exploration, and as such I am of the view that it would not be in the public interest for this matter to proceed to inquest.

Mr James McDougall
Coroner
Southport