QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Jennifer Kohl**
TITLE OF COURT:	Coroners Court
JURISDICTION:	SOUTHPORT
FILE NO:	2017/5470
DELIVERED ON:	01 December 2023
DELIVERED AT:	Southport
HEARING DATES:	10-11 May 2023
FINDINGS OF:	Carol Lee, Coroner
CATCHWORDS:	CORONERS – INQUEST – International Backpackers – Farm Equipment – Ride on Mower Roll Over – Whether Engaged in Work – Workplace Health & Safety Duties and Obligations

REPRESENTATION:

Counsel Assisting:	Ms Melinda Zerner
Ms Cornelia Kohl (Next of kin):	Ms Peta Willoughby, instructed by Caxton Legal Centre Inc.
Ms Kathryn Singleton & Mr Kenneth Jacobi:	Mr Jonathan Ivanisevic, HopgoodGanim Lawyers
Office of Industrial Relations (OIR):	Ms Jesika Franco, instructed by OIR
Queensland Ambulance Service (QAS):	Ms Sally Robb, instructed by QAS Legal Unit
Queensland Fire & Emergency Service (QFES):	Ms Antonietta Kersten, QFES Legal Unit

Contents

Introduction

1. Ms Jennifer Kohl was a 27-year-old woman[1]. She was a German national who was travelling in Australia on a working holiday with her 27-year-old boyfriend of 7 years, Mr Paul Tunik[2]. They arrived in Australia in February 2017 and began working on an avocado farm at 200 Macdonnell Road, Tamborine Mountain ('the farm') for two to three weeks prior to the accident. They received room and board in exchange for picking avocados.

2. On 8 December 2017 at around 11:00 hours, Ms Kohl was involved in a fatal accident at the farm. The accident concerned Ms Kohl being trapped under an overturned John Deer X 595 4x4 ride on mower ('the mower').

3. After regaining consciousness, Mr Tunik unsuccessfully tried to move the mower off Ms Kohl. He called 000 at 11:20 hours but there was a delay in first responders attending the scene, in part due to Mr Tunik's limited English. He tried to flag down some cars on the road above and eventually two persons stopped and rendered assistance. Despite valiant attempts, the three of them were unable to lift the mower off Ms Kohl.

4. Queensland Ambulance Service ('QAS') arrived at 11:52 hours. On their arrival Ms Kohl was unresponsive and not breathing. The mower was lifted off Ms Kohl with the assistance of Queensland Fire and Emergency Service (QFES), and despite resuscitation attempts she could not be revived. The Queensland Police Service ('QPS') attended the scene and commenced an investigation[3], as did Workplace Health and Safety (WHS) inspectors and investigators, resulting in the delivery of subsequent investigation reports[4].

5. The former Deputy State Coroner Jane Bentley finalised chamber findings on 3 December 2021, when the Office of Industrial Relations (OIR) advised that the criminal prosecution into Ms Kohl's death was not proceeding.

6. The coronial investigation was re-opened following receipt of an application by Caxton Legal Centre on behalf of by Ms Kohl's mother, that an inquest be held.[5]

7. By Notice of Inquest dated 15 February 2022, former Deputy State Coroner Bentley confirmed an inquest would be held as part of her investigation.

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[1] Having been born on 4 December 1990.
[2] Also a German national, who was born on 10 April 1990.
[3] Including officers from the Forensic Crash Unit (FCU).
[4] FCU and WHS.
[5] Received on 17 December 2021.

8. Following former Deputy State Coroner Bentley's departure as Southeastern Coroner, I took over the carriage of these proceedings in May 2022 and progressed the matter to Pre-Inquest Conference (PIC) on 17 November 2022 and subsequently to Inquest, which took place in Southport over two days commencing 10 May 2023.

9. Ms Kohl's mother travelled from Germany with a support person to attend the hearing. As they missed their flight and with the indulgence of the Court and the parties, the hearing was delayed by one day to accommodate them. At the hearing, arrangements were made for an interpreter to simultaneously interpret oral evidence through a German interpreter based in Perth. Ms Kohl's mother was provided the opportunity after each witness to ask questions through her legal representatives.

10. I acknowledge the comprehensive submissions given by Counsel Assisting and representatives of the parties following the Inquest; the last of which was received on 31 August 2023.[6]

The Coronial Jurisdiction

11. Under the *Coroners Act* 2003 (CA), a Coroner has jurisdiction to investigate a '*reportable death*'.[7] A violent or otherwise unnatural death that happened in Queensland is a reportable death.[8] An inquest may be held into a reportable death (including multiple deaths) if the Coroner investigating the death considers it desirable to hold an inquest.[9]

12. On 15 February 2022, the former Deputy State Coroner Bentley gave the parties a notice that an inquest would be held.

The Scope of the Coroner's Inquiry and Findings

13. A Coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible, the Coroner is required to find: -

[6] Received on 24 July 2023 (Counsel Assisting), 9 August 2023 (Cornelia Kohl), 21 August 2023 (QAS), 21 August 2023 (OIR) and 31 August 2023 (Mr Jacobi and Ms Singleton) respectively. The QFES made no submissions.
[7] CA, s 11.
[8] ibid, s 8.
[9] ibid, ss 28, 33.

- who the deceased person is;
- how the person died;
- when the person died;
- where the person died; and
- what caused the person to die.[10]

14. The scope of a Coroner's jurisdiction to inquire into the circumstances of a death and make statutory findings goes beyond merely establishing the medical cause of death.[11]

15. A Coroner may, whenever appropriate, comment on matters connected with a death investigated at an inquest and make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.[12] A Coroner must not include in the findings or comments made any statement that a person is, or may be, guilty of an offence or civilly liable for something.[13]

16. As a former State Coroner of Queensland has observed: '*an inquest is not a trial between opposing parties but an inquiry into the death…..The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths*'.[14]

17. Fundamentally, an inquest is '*investigative, inquisitorial and does not result in findings which bind participants inter partes. The standard of proof which applies is not the criminal standard*.'[15]

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[10] Ibid, s 45(2).
[11] However, it has been held that the '*findings*' referred to in s 45 of the CA are '*to the matters required to be 'found' in s45(2) of the Act*'. It is said to be '*clear*' from the text of the CA that these '*findings*' are '*the ultimate findings which a coroner is required to make by s 45(2)*': *Hurley v Clements & Ors* [2009] QCA 167 at [20] per McMurdo P, Keane JA and Fraser JA.
[12] ibid, s 46(1).
[13] ibid, s 45(5), s 46(3).
[14] Findings of State Coroner Michael Barnes in the Hamilton Island air crash *Inquest into the deaths of Joanne Bowles, Michael Bowles, Sophie Bowles, Kevin Bowles, Andrew Morris & Christopher Andre le Gallo*, Brisbane, p 2.
[15] See *Domaszewicz v The State Coroner* (2004) 11 VR 237 at par [81]; cf *Musumeci v Attorney-General (NSW)* (2003) 57 NSWLR 193 at 199 where the juristic nature of an inquest was described as a '*hybrid process*' containing both adversarial and inquisitorial elements.

The Admissibility of Evidence and the Standard of Proof

18. The Coroner's Court is not bound by rules of evidence but may inform itself in any way it considers appropriate. The inquiry undertaken by a Coroner '*must be sufficient for the purpose of investigating the death and making, if possible, the findings required by the Act*'. The Coroner *'cannot be limited to investigating the material placed before (the Coroner) by other persons*'.[16] That doesn't mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a Coroner greater scope to receive information that may not be admissible in litigated proceedings and to have regard to its provenance when determining what weight should be given to the information.

19. This flexibility has been explained by reference to the nature of an inquest as a fact-finding exercise rather than a means of attributing blame: an inquiry rather than a trial.[17]

20. In *Doomadgee v Clements*[18], Justice Muir stated the test as follows:

> *'It is significant also that the rules of evidence do not bind a coroner's court and that it may inform itself in any way it considers appropriate. That does not mean that there are no constraints at all on coroners in relation to the gathering of evidence. The evidence relied on by the coroner must be relevant to the matters within the scope of the coronial inquiry. The coroner may act "on any material which is logically probative"; that is, "the decision must be based upon material which tends logically to show the existence or non-existence of facts relevant to the issue to be determined, or to show the likelihood or unlikelihood of the occurrence of some future event the occurrence of which would be relevant.'*

21. It is generally accepted that the civil standard of proof applies in coronial investigations in relation to factual findings that are to be made. However, the '*clarity*' of the proof required (or the degree of satisfaction called for by application of the civil standard) may vary according to the '*gravity*' of the factual matter to be determined.[19] A Coroner must apply the civil standard in a way that is '*appropriate to the gravity of the allegations*' made against a person; if a finding may have an '*extremely deleterious effect*' upon a person's character,

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[16] *Plover v McIndoe* (2000) 2 VR 385 at [19] per Balmford, J.
[17] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625.
[18] *Doomadgee v Clements* [2005] QSC 357 at [35].
[19] See *Briginshaw v. Briginshaw* (1938) 60 CLR 336 at p 362 per Dixon J, as qualified by *Rejfek v. McElroy* (1965) 112 CLR 517.

reputation or employment prospects, that circumstance will generally demand '*a weight of evidence that is commensurate with the gravity of the allegations*'.[20]

22. A Coroner is not required to exclude every possibility, but rather to establish, if possible, what is more likely to have occurred upon findings '*reasonably supported by the evidence*'.[21]

23. It is also clear that a Coroner is obliged to comply with common law rules of natural justice and act judicially.[22] Coroners must accord procedural fairness to parties that appear at an Inquest.[23]

The Issues

24. The following list of issues were proposed at the PIC undertaken on 17 November 2022:

    1. The findings required by s 45(2) of the *Coroners Act* 2003; namely the identity of the deceased, when where and how she died and what caused her death.
    2. What caused the mower to roll and land on Ms Kohl.
    3. Whether Mr Jacobi and Ms Singleton had implemented appropriate workplace health and safety measures in relation to the use of the mower on the property.
    4. Whether the Queensland Ambulance Service appropriately dispatched the paramedics and Queensland Fire and Emergency Services to the accident scene.
    5. Whether there was a delay in the dispatch of emergency services, and if so, could this have been avoided, and would it have made any difference to the outcome.
    6. What measures are in place to safeguard international backpackers, such as Ms Kohl and Mr Tunik, undertaking farm work, and are these measures adequate.

[20] *Anderson v Blashki* [1993] 2 V.R. 89 at 96-97 per Gobbo J.
[21] *Hurley v Clements & Ors* [2009] QCA 167 at [16].
[22] *Harmsworth v State Coroner* [1989] VR 989 at 994.
[23] *Annetts v McCann* (1990) 170 CLR 596, 600; *Danne v Coroner* [2012] VSC 454, [21]; *Victoria Police Special Operations Group Operators 16, 34, 41 and 64 v Coroners Court of Victoria* (2013) 42 VR 1, [36]; [2013] VSC 246.

25. The parties were provided the opportunity to make submissions on the proposed issues. None were received.

The Evidence

26. A large bundle of exhibits were tendered into evidence, comprising documents[24] numbered A1-A4, B1-B5.7, C1-C4.2, D1-D7, E1-E11.5, F1- F5, G1 and H1-H2.2.

27. The following persons were called as witnesses to give oral evidence at the Inquest:

- Mr Kenneth Jacobi (co-owner of the avocado business);
- Ms Kathryn Singleton (co-owner of the avocado business);
- Mr Patrick Amadeu (QAS);
- Ms Michelle Kerwin (friend of Mr Jacobi and Ms Singleton);
- Mr Rodney Bray (bystander)[25];
- Mr Michael Beak (QAS); and
- Dr Stephen Rashford (QAS Medical Director).

28. No submissions were received by any party as to the witnesses to be called at inquest.

29. Three witnesses require specific mention:

<u>Mr Tunik</u>

a. Despite attempts to encourage Mr Tunik to provide evidence at the Inquest, he failed to do so. He was referred for separate representation and participated in preliminary conferences with his legal advisor. However, in the lead up to the Inquest, Mr Tunik failed to engage and/or confirm his attendance or non-attendance at the Inquest, with the consequence that his legal advisor withdrew as solicitor acting for him[26].

b. Mr Tunik resides outside of the jurisdiction and hence, he could not be

[24] Including audio and photographs.
[25] Not an advanced care paramedic as inadvertently noted in Annexure A the submissions of Counsel Assisting.
[26] By email dated 17 April 2023.

compelled to attend the Inquest (either in person or remotely) to give oral evidence.

c. Mr Tunik has given a number of conflicting versions of events. Some of these are detailed below.

d. The only available evidence from Mr Tunik given under oath or affirmation is from the transcript of the WHS prosecution, which was eventually discontinued.[27].

e. Given the passage of time since Ms Kohl's death and the prosecution in April 2021, Mr Tunik's memory was not good, and at one point he said, '*I can barely remember anything*'.[28] A number of responses to several questions asked during the prosecution was that he could not remember.

f. An independent expert was engaged to assess Mr Tunik's concerns about the accuracy of the interpretation of the WHS prosecution. That opinion was to the effect that the interpretation was '*fair and accurate*'[29]; which undermines Mr Tunik's concerns somewhat.

g. In addition, Mr Tunik gave various accounts to different persons in the aftermath of the accident, including first responders and others[30]. There are also audio recordings including the 000 call. In particular, two of those persons, Mr Amadeu and Ms Kerwin, gave oral evidence under oath at the Inquest. Their versions are largely consistent and speak of the remorse Mr Tunik expressed as a result of convincing Ms Kohl to ride on the mower, amongst other things. They have no interest in the coronial issues and no reason to give self-serving evidence. To the extent that Mr Jacobi and Ms Singleton's evidence is probative on this issue, given that they do have a vested interest in the outcome, I note that their versions are also consistent.

h. As a result of the above factors, I approach the evidence of Mr Tunik with some caution and where his versions are in conflict with the evidence of others, his versions (except those given under oath or affirmation at the

[27] Ex B2.9.1; Ex B2.10; Ex B2.11.1; Ex B5.1; Ex B5.2 and Ex B5.3 [The prosecution hearing was adjourned due to Mr Tunik raising issues with the accuracy of the interpretation – this led to an expert report being obtained (Ex B5.3) – at the relisting of the prosecution the matter did not proceed as the prosecution was unable to offer any evidence due to the primary material witness (Mr Tunik) not attending the scheduled court hearing)].
[28] Ex B5.2, 2-7, line 31.
[29] Ex B5.3, 1.
[30] Including Mr Patrick Amadeu, Ms Shelly Kerwin, Mr Jacobi and Ms Singleton.

WHS trial) are not accepted.

Mr Jacobi and Ms Singleton

i. Ms Singleton and Mr Jacobi reside interstate. Being outside of the jurisdiction, they also could not be compelled to attend at the Inquest and give oral evidence. Nevertheless, subpoenas were sent to them through their legal representatives, and submissions about their participation were advanced on their behalf.

j. Having had no objection by any other party, they were granted an immunity to give their oral evidence on the grounds of public interest pursuant to section 39 of the CA. This was on the background of a previous WHS prosecution where proceedings against them were dismissed at the hearing[31]. Relevantly though, that dismissal did not extend to the provision of certificates under Section 149 of the *Justices Act* 1886 (Queensland), thereby exposing them to a fresh prosecution by reason of this Inquest. Their evidence, and any derivative evidence arising therefrom, is not admissible in any other proceeding, other than a proceeding for perjury.

Summary of Evidence

Circumstances Leading up to the Death

Background

30. Except where otherwise indicated, I have adopted the summary of evidence as set out comprehensively by Counsel Assisting. For clarity of these findings, I repeat a summary below.

31. The farm was a 10-acre property, located on the western side of Macdonnell Road, Tamborine Mountain and facing northwest. For ease of reference, a photographic representation of the property is displayed at paragraph 51 below. The gradient of the property was not consistent across the entire 10 acres.

32. Relevantly:

a. the orchard immediately below the homestead where Ms Kohl and Mr

[31] On 27 and 28 April 2021.

Tunik picked avocados was referred to by Mr Jacobi as '*flat*' until about the fifth row of trees, where it increased to a '*very gentle slope'*.[32]

b. The QPS FCU investigators assessed the accident site, not the entire property. The evidence at the Inquest was that the accident site was not in the orchard referred to in the preceding paragraph, but in an unused area of the property. The FCU investigators determined the gradient of the grassed slope where the accident occurred was greater than 20 degrees.[33]

33. At the relevant time, the farm was owned by Mr Kenneth Jacobi.[34] Mr Jacobi jointly operated a business, farming avocados, under the name 'Mount Tamborine Avocados'. His partner in the business, which was operating as a family partnership, was Ms Kathryn Singleton.[35] The farm was also the location of Mr Jacobi and Ms Singleton's residential address.[36] They had a child who was aged about 13 years at the time of the accident.[37]

34. Mr Jacobi and Ms Singleton purchased the adjoining farm at 210 Macdonnell Road at Tamborine Mountain in or around 2005 and the mower which was involved in the fatal accident came with the purchase of that property.[38]

35. At the time of the accident, Mr Jacobi was employed on a full-time basis as a Court bailiff in the Magistrate and District Courts.[39] Mr Jacobi's involvement on the farm was generally limited to discussing what needed to be done on the farm. Ms Singleton would usually look after the day-to-day activities.[40]

36. During his interview with the QPS on 23 January 2018, Mr Tunik said it may have rained one day before or two days before the accident. He also said there were a few drops of rain shortly before they started.[41] He later said there was a drizzle but then said the grass was dry.[42] During the WHS prosecution he

[32] T1 50, 40.
[33] Ex C1, p2
[34] Mr Jacobi was around the age of 53 at the time of the accident (See Ex D1, p1); There is some inconsistency in the material, as in Ex B2.4, para 14, it says the farm is owned by Mr Jacobi and Ms Singleton and was purchased approximately 14 years prior to the accident. This was not clarified at inquest.
[35] Ms Singleton was about the age of 55 at the time of the accident (See Ex D1, p1).
[36] Ex B1, p3.
[37] Ex D1, p1 (Liam Robert Jacobi).
[38] T1.22, 47.
[39] Ex B1, p2 and 3.
[40] T1.17, 20.
[41] Ex B2.11.1, p8, para 136-142.
[42] Ex B2.11.1, p17, para 328.

recalled the weather on the day of the accident was sunny.[43] The QPS FCU investigators reported at the time of the accident it was dry but very overcast with rain clouds coming in. There was good daylight and no atmospheric conditions that contributed to the accident.[44] Mr Jacobi and Ms Singleton were not at the farm at the time of the accident.[45]

37. Whilst there may have been a few drops of rain that morning, there was no substantive rain. I accept the evidence of the QPS investigators concerning the conditions prior to the accident.

38. Mr Jacobi and Ms Singleton had previously had backpackers working on the farm through the WWOOF (World Wild Opportunities on Organic Farms) Association. They stopped using WWOOF when the visa changes were made in or around 2010 that volunteer work was no longer required towards a second new visa.[46] From 2014 through to the accident they had had 11 backpackers stay and work on the farm in exchange for food and accommodation.[47] Mr Jacobi thought it was about a year prior to the accident since they had any backpackers stay with them on the farm.[48]

39. Of the backpackers they had had on the farm, English was a second language for about 50 percent of them.[49] Mr Jacobi explained a practical demonstration of the work they were to do would be provided and stated, "…*the vast majority would have been simply weeding or picking avocados – the vast majority of people wouldn't have used any machinery apart from a Whipper Snipper*".[50]

40. Mr Jacobi says they did not see the backpackers as workers, but they would treat them probably more like family than a worker. He says they were very conscious of keeping them safe but acknowledged he did not consider them as workers in the same way as someone employed to work on the farm.[51] Ms Singleton similarly saw the workers as being like family.[52]

41. Mr Jacobi and Ms Singleton were not aware of the various codes of practice prior to the accident which included, 'How to Manage Work Health and Safety

[43] Ex B5.1, T1-66, line 34.
[44] Ex C1, p2.
[45] Ex B2.4, para 13.
[46] T1.30, 44.
[47] T1.30, line 34.
[48] T1.31,7.
[49] T1.40, 36.
[50] T1.40, 40.
[51] T1.31,36.
[52] T1.98, 28.

Risks for Practice 2011'; 'Managing Risks for Plant in the Workplace Code of Practice 2013'; 'Rural Plant Code of Practice 2004'; and 'Safe Design Operations Practice, Code of Practice 2005'.[53] Mr Jacobi had reviewed them following the accident and stated,

> *'I feel that without actually having read the documents we were doing that in our way. I wish I did know about them so that we documented but I feel we were – safety was a very big concern of ours and we took it very seriously*'.[54]

42. Counsel Assisting submitted that a risk assessment regarding the task of picking avocados had not been undertaken. Mr Jacobi said,

> '*…it would have been our experience from the time we purchased the property that those risks became apparent to us because – by just doing the job. So, no, I don't – it wouldn't have been a, like, one time we sat down and – under a tree and did it, no…*'.[55]

43. Mr Jacobi explained from their experience on the farm they would share the risks they had identified with the people coming to work on the farm.[56] There was no written document.[57] He stated,

> *'As I said, simple things like sunscreen, gloves, hat. We – we removed the need for machinery, we'd keep the trees down low so that we didn't have to use cherry pickers and things like that. The mower was the easiest piece of equipment to transport up to the shed for the backpackers, there were no gears involved. There were – it was rather than have anyone drive a ute or things like that, so, yeah, I believe we did*'.[58]

44. On behalf of Mr Jacobi and Ms Singleton, it was submitted that it was an incorrect view of the evidence to advance the proposition that no risk assessment was undertaken. Rather, the effect of the evidence given by Mr Jacobi and Ms Singleton under examination by Counsel Assisting and in cross examination was that a risk assessment was in fact undertaken, just that it was not documented. The exchange referred to in these submissions bears this out.[59]

45. Although it should have been documented, I find that a risk assessment had

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[53] T1.32, 18; T1.98, 31.
[54] T1.32, 18.
[55] T1.39, 40.
[56] T1.39, 44.
[57] T1.40, 10.
[58] T1.40, 2.
[59] Submissions of Mr Jacobi and Ms Singleton, paragraphs [27], [30] and [31]. T1. 38, 35-40, T1. 42, 0 and T1. 54,25.

been undertaken by Mr Jacobi and Ms Singleton regarding the task of picking avocados.

46. On 20 November 2017, Mr Jacobi and Ms Singleton advertised on Gumtree for farm workers. The ad read,

> 'Stunning sunset views on top of Tamborine Mountain in the Gold Coast Hinterland on an Avocado Farm. Picking weeding whipper snipping painting and more. This job is in exchange for food and accommodation. Working hours negotiable'.[60]

47. Mr Jacobi explained the reason for advertising was that while they employed a worker, Mr Bill Shelton, one day a week, Ms Singleton was requiring more assistance on the farm as she was burning out.[61]

48. In addition to Mr Shelton working one day a week, a friend of Ms Singleton and Mr Jacobi, Ms Kerwin volunteered on the farm. She started doing that about eight or nine months before the accident. She did it just for fun. She says it was just a few times that she picked avocados with Ms Singleton.[62] She did not pick avocados with Ms Kohl and Mr Tunik.[63] She does not recall using the mower and trailer on the occasions she picked avocados.[64] She only picked from the trees in front of the packing shed at 210 Macdonnell Road and from the orchard directly below the homestead at 200 Macdonnell Road.

49. Ms Kohl responded to the Gumtree add by text message and Ms Singleton responded back by text confirming the offer. She could not recall having a conversation with either Ms Kohl or Mr Tunik before they arrived.[65] Ms Kohl and Mr Tunik travelled from Brisbane on a train and were picked up. They were shown around the farm and told what jobs they would be required to do in lieu of food and accommodation. [66] Mr Jacobi thought they started working on the farm from 23 November 2017[67] (15 days before the fatal accident).

50. Ms Singleton says working hours were negotiated at four hours Monday to Friday prior to their arrival and this would have been at the same time she instructed what they needed to have (water bottle, hat, sunscreen, long pants

[60] Ex B2.10, p24.
[61] T1.31,19.
[62] T2.4, 14-42.
[63] T2.4, 44.
[64] T2.5, 41.
[65] T1.70, 5-21.
[66] Ex B2.7, p7.
[67] T1.20, 24.

and boots).[68] The four hours were not rigid, they would usually start in the morning when it was not hot and if the work was finished earlier than the four hours they would finish for the day.[69]

The Accident Site

51. At the commencement of Mr Jacobi's evidence, with reference to a colour Google map and several photographs, some time was taken in orientating the Court to the accident site. The Google map can be found at Exhibit B5.6 and has handwritten annotations by Mr Jacobi in red pen. It is displayed as follows:

52. It was established the packing shed where avocados were transported after having been picked was on the adjoining farm at the top of the hill close to Macdonnell Road. It is marked as '**A**'. The row of trees directly below (left of) the homestead occupied by Mr Jacobi and Ms Singleton was an avocado orchard on a gentle slope. To the right of the avocado orchard is a track which led down to two sheds which are not visible due to tree foliage. The sheds are marked as '**B**'. Directly below (left of) the avocado orchard is a clearing which was described as a track which emanates from the sheds. Below (left of) the track emanating from the sheds is an old block of avocado trees that were not

[68] T1.71, 21.
[69] T1.113, 4.

used ('the unused area'). This was described as a steep area and an area that was only mowed and slashed. The accident occurred on the steep slope in the unused area.[70] The accident site is marked as '**C**'.

53. Mr Jacobi described the slope going from 12 degrees to 23 degrees where the accident occurred. In regard to comparing the slopes where the avocado orchard directly below the homestead was and the unused area, he stated,

> *'Chalk and cheese. Where they would have been picking is virtually flat, it's – it's mowed, it's – the trees are pretty clear. Like, we don't use any poison so there would be grass at the bottom…*
>
> *Yeah, and the sloping one it would have – yeah, like I said, I would mow it going up and down but I would never – and I would never go on there with the trailer on the back*'.[71]

54. Ms Singleton agreed there was a marked difference in the slope between the avocado orchard and the unused area.[72] There was an exchange in evidence about Ms Kohl and Mr Tunik being in the unused area:

> CA: …*Now, at any time was there any expectation that Mr Tunik and Ms Kohl would be on that lower section of the track where the accident occurred?*
>
> Ms S: *No.*
>
> CA: *And why is that?*
>
> Ms S: *They were never – they were never told to go into that area. There was no avocados there. It was overgrown, yeah*.[73]

55. Mr Kerwin described the orchard as a '*very gradual slope'* and agreed where the accident occurred it was '*quite a more substantial slope'*.[74] Mr Bray, a bystander to the accident described the slope with the orchard is undulating, then flattening out a little before dropping off. This '*dropping off*' area is the area he described as being on the side of a steep slope in his statement and is where the accident occurred.[75] Mr Beak, one of the attending QAS paramedics, described the slope were the accident occurred as being '*significant*'.[76] He said

[70] T1.9, 16.
[71] T1.46, 16.
[72] T1.97, 21.
[73] T1.97, 30.
[74] T1.7, 43.
[75] T2.19, 19-45.
[76] T2.29, 48.

it was steep enough that he was conscious of his footing.[77]

56. There is no discrepancy as to where the accident occurred. I find on the evidence that the slope where the accident occurred was of a significantly greater gradient than the slope where the avocado orchard was directly below the homestead.

The Mower and Trailer

57. The mower was a large John Deere X595, 4 x 4 ride on mower. At the time of the accident a homemade trailer was attached to the mower.

58. The cutting deck of the mower had been removed about a year or so prior to the accident because it was developing some fractures in the metal. Mr Jacobi intended on getting it repaired but before that occurred, they purchased another mower for cutting the grass. The old John Deere mower was then used for transporting avocados or at times, equipment like a whipper snipper.[78]

59. Mr Jacobi maintained the equipment on the farm, including the John Deere mower. He had a copy of the manual and would consult that as necessary when he undertook maintenance work.[79] He said the mower was not used often probably once or twice a month and he would check it over when it was used.[80] He says this would have included checking the tyre pressure on both the mower and trailer.[81]

60. Mr Jacobi was taken to page 24 of the Instruction Manual in evidence which stated, '*Without a mower deck installed on the machine it is recommenced you install rear wheel weights to increase stability'*. He confirmed he was not aware of that requirement.[82] He acknowledged this was an important requirement but says because there was a trailer attached on the back it would also create down pressure.[83]

61. On behalf of Mr Jacobi and Ms Singleton, it was submitted that the recommendation referred to in the preceding paragraph was not one that applied at all times and in all circumstances. It was to be viewed in the context

[77] T2.34, 20.
[78] T1.23, 9-46.
[79] T1.24, 20.
[80] T1.45, 3.
[81] T1.44, 42.
[82] T1.24.
[83] T1.25, 34.

of what is stated in the Instruction Manual in full and bearing in mind the different functional tasks which the mower may be engaged in (i.e., those involving front mounted, mid-mounted or rear mounted attachments) and the locations where that may occur.

62. Relevantly, the recommendation was *only* for when the mower was being operated in 4WD when more traction is needed; the circumstances of which are detailed at page 19 of the Instruction Manual. Consequently, the use of '*ballast*' or '*wheel weights'* is recommended for the tasks which the mower was to perform on the terrain it was to perform it. Such is only recommended, according to the manufacturer, when the mower is operating on '*difficult ground conditions'*, such as steeply sloping terrain or icy, wet or gravelled surfaces. The evidence before me is that that was not the case for the mower, in the circumstances in which it was to be operated.

63. Mr Jacobi did not see any issue with the type of tyres on the mower because from his experience he had never had any issue with them.[84] He says this is in the context he only used a mower on a slope to go up and down the hill and would not go sideways.[85] He stated, "…*in every instruction on every machine I've got it talks about – you always mow up and down, you never traverse the slope sideways*".[86] Ms Singleton thought the tyres on the mower were appropriate for the grass area they were using it on.[87]

64. Like the mower, the home made trailer had come with the purchase of the adjoining farm in 2005.[88] Mr Jacobi would not concede the tyres on the trailer were balding but says he would not have used the trailer on a road.[89] Ms Singleton agreed the tyres did not have a tread you would use to drive on a road.[90] She agreed this was because of the speed required to travel on the road.[91] She considered the tyres were sufficient to transport the avocados on the relevant terrain in dry weather conditions.[92]

65. Counsel Assisting submits that the absence of a weighting mechanism without the cutting deck, the use of the home-made trailer and the state of the tyres

[84] T1.29, 29.
[85] T1.29, 44-49.
[86] T1.30, 23.
[87] T1.92, 46.
[88] T1.28, 4.
[89] T1.29, 9.
[90] T1.92, 41.
[91] T1.111, 10.
[92] T1.111, 19.

were '*potentially problematic'*. Having considered the evidence on this issue and noting the absence of expert evidence, I am not persuaded this is the case. The mower was to be used in specific areas and for specific tasks shown to Mr Tunik and Ms Kohl, not in an unused and overgrown area where they had no cause to be. I find that in the circumstances in which it was to be operated, the mower was suitable.

66. Mr Tunik estimates he had driven the mower about 50 times prior to the accident.[93] He said the same during his interview with QPS investigators on 23 January 2018.[94] Mr Tunik said the mower had not previously slipped when he was driving across the hill.[95] However, in the transcript of the interview of 18 December 2017, Mr Tunik says he used the mower '*two or three times a week*'.[96] He would always use the mower with the trailer.[97]

67. Mr Jacobi and Ms Singleton vehemently denied Mr Tunik had used the mower on multiple occasions prior to the accident.[98] They say the first time Mr Tunik had been instructed on the use of the mower and had used the mower was the day prior to the accident.[99]

68. Ms Singleton explained they would usually only pick avocados on a Wednesday, Thursday, and Friday so they would be ready for the honesty stand they had up on the road outside of the farm. This would occur on weekends. She says it was near the end of the season when Ms Kohl and Mr Tunik arrived at the farm.[100] They would only pick four crates of avocados each day because otherwise there would be a surplus of avocados which would go off.[101]

69. I agree with the submission made by Counsel Assisting that it is difficult to accept Mr Tunik had ridden the mower '*about 50 times'* before the accident. It does not make sense regarding the relatively short time they had been working on the farm (11 working days), the relatively short hours they were required to work and the days of the working week picking avocados towards the end of the season. Further, there is no evidence the avocado harvesting was of

[93] Ex B1 p17.
[94] Ex B2.11.1, p11, para 202.
[95] Ex B1, p17.
[96] Ex B2.10, p8, line 14.
[97] Ex B2.7, p9.
[98] T1.21, 28.
[99] T1.20, 40; T1.79, 36.
[100] T1.74, 0.
[101] T1.77, 38; T1.78, 5.

significance, as the avocados were sold on the side of the road through an honour system (the method of selling the avocados was confirmed by Mr Tunik[102]).

70. I accept the submissions of Counsel Assisting that while there was some discrepancy in Mr Jacobi and Ms Singleton's evidence on certain points, they were generally credible witnesses and they both specifically recall it was the day prior to the accident that Mr Tunik was instructed on the use of the mower. While Mr Tunik may have previously used the mower without their knowledge, there is no evidence of this, and if it did occur, they were not aware.[103]

71. Acknowledging there was no opportunity to cross examine Mr Tunik, I accept the submissions of Counsel Assisting that on the balance of the material, Mr Tunik was instructed on the use of the mower on the day prior to the accident and had not to the knowledge of Mr Jacobi or Ms Singleton, driven it before that day.

Mr Tunik's English

72. Mr Jacobi thought Mr Tunik's English was quite good. He says Mr Tunik had more to do with Ms Singleton as they would often stay up at night chatting. He says apart from the accent it was not difficult to understand Mr Tunik. If there were words he could not understand Ms Kohl, whose English was more proficient, would interpret for him, or he would use Google translator, '*Paul used it a lot*'.[104]

73. Ms Singleton confirmed Ms Kohl's English was better than Mr Tunik. She said if she and Mr Tunik could not understand a word he would ask Ms Kohl the English equivalent, or they would use the German speaking translation on the phone. She said it was just the odd word he could not find the English word for.[105] If he did not understand something he would ask Ms Singleton to clarify or find the word out.[106] She was not sure if Mr Tunik was able to read English.[107] Ms Singleton would often spend a few hours talking with Mr Tunik after dinner

[102] Ex B2.10, p9, line 30.
[103] T1.108, 3150; T1.109, 0-7.
[104] T1.19, 16-44.
[105] T1.72, 18.
[106] T1.72, 42.
[107] T1.72, 5.

as Ms Kohl would go into her room to look at her iPad.[108]

74. Mr Amadeu a QAS paramedic who attended the scene to assist in the resuscitation of Ms Kohl, is German. After all attempts had been exhausted to treat Ms Kohl, Mr Amadeu had a conversation with Mr Tunik. He described him as being '*absolutely distraught'* and that he could barely speak a single word, be that English or German.[109] He formed the view his difficulty in talking was due to a mix of emotion and trauma.[110] Mr Amadeu could not recall interpreting for Mr Tunik for officials at the scene (there is evidence he did).[111]

75. Ms Kerwin had dinner with Mr Jacobi, Ms Singleton, Ms Kohl and Mr Tunik one night prior to the accident, she cannot recall when. She also spent a little bit of time with them when she drove them to Curtis Falls to drop them off for a walk.[112] She also saw them working with Ms Singleton on one occasion which she described as a casual meet.[113] She did not use a translator device with them.[114] Regarding Mr Tunik's English she stated,

> *'His English was actually pretty good. You know, but I mean obviously the German bit but I didn't have any trouble understanding Paul or Paul understanding me'*.[115]

76. Ms Kerwin was asked to urgently attend the accident scene by Ms Singleton as she could not attend immediately.[116] Like Mr Amadeu, Ms Kerwin observed Mr Tunik to be very distraught. She arranged for a local General Practitioner who was of German heritage that she worked with to come to the house. There was an exchange about this in evidence:

> CA: *Was it because of Mr Tunik's English and difficulty understanding his English that Dr Steinfort was going to translate for him?*
>
> Ms K: *Well, no, not necessarily, but if – I would – if someone's really nervous and they're in a really scary situation like that, if he is concerned about how he's talking or if he's worried about people understanding, I just thought that would be someone that might be helpful.*[117]

[108] T1.73, 11.
[109] T1.59, 8.
[110] T1.61, 14.
[111] T1.61, 30.
[112] T2.8, 33.
[113] T2.9, 10.
[114] T2.9, 31.
[115] T2.9, 27.
[116] T2.9. 43.
[117] T2.10, 48.

77. Mr Bray, one of the passersby who attended the accident scene, recalls being flagged down by an extremely distressed Mr Tunik running out on to the road. While he described Mr Tunik as having a heavy accent he was able to discern the words '*mower*' and '*girlfriend under'* and says given his experience, knew what had happened.[118] When he was speaking with Mr Tunik at the accident scene he described Mr Tunik's English as understandable and said he could comprehend him.[119]

78. In addition to the evidence of the witnesses' accounts of Mr Tunik's level of English, I have had the benefit of the audio recordings, some taken immediately after the accident and others sometime after the accident, and the triple 0 recording.[120]

79. While there was difficulty in the QAS call taker and supervisor understanding Mr Tunik (which is discussed further below), the high emotion and trauma he was facing at the time needs to be taken into account. I accept the submissions of Counsel Assisting and find Mr Tunik could understand basic English and would seek out assistance as necessary either through Ms Kohl or be assisted through a translation tool on a phone.

Instructions provided to Mr Tunik regarding Avocado Picking

80. Ms Kohl and Mr Tunik undertook various work on the farm including weeding and painting. Prior to the day of the accident, Mr Jacobi says they had only picked avocados on one occasion. That was with Mr Shelton. On that occasion Mr Shelton used a ute to transport the avocados.[121]. Mr Jacobi says it was felt the mower was a lot easier for back packers because it was hydrostatic, had no gears, no clutch, and a lower centre of gravity.[122]

81. Ms Singleton cannot recall when was the first time Ms Kohl and Mr Tunik picked avocados, as they were also doing other jobs. She says it would have either been in their first week on the Friday or on the Wednesday in their second week on the farm.[123] They would have picked with Ms Singleton and their worker Mr

[118] T2.18, 26.
[119] T2.21, 21.
[120] Ex B2.9.1; Ex B10.1; Ex B2.11; Ex E3.1 (000 call).
[121] T1.34, 24-38.
[122] T1.46, 6.
[123] T1.74, 36.

Shelton.[124] Ms Singleton says while on most occasions Mr Shelton would use his ute she recalls when she picked avocados with Ms Kohl and Ms Tunik, she used the mower to transport the avocados.[125] She is pretty sure the area they picked was in the orchard located on 210 Macdonnell Road (i.e. different to where they had been directed to pick on the day of the accident).[126]

82. As Ms Singleton's evidence proceeded she did not think they picked avocados in their first week but was quite confident it would have been in their second week on the farm. She did not recall what they did each day leading up to the accident, including how many times they had picked avocados but does recall the first time she provided instruction to Mr Tunik regarding the use of the mower prior to the accident was on the day before the accident.[127]

83. Ms Singleton commonly used the mower and trailer for transporting avocados to the shed and agreed it was her main vehicle or mode of transport for transporting avocados on the farms. She said, '*I use that a lot'*.[128]

84. There is a discrepancy between Mr Jacobi and Ms Singleton on the frequency of use of the mower prior to the accident. I accept Ms Singleton's evidence over that of Mr Jacobi given she was the one who was working with and providing instruction to Ms Kohl and Mr Tunik. Mr Jacobi was not involved in the day-to-day operations on the farm.

85. On the day prior to the accident Mr Jacobi had to get his car serviced but before leaving was present while Ms Singleton advised Mr Tunik on the use of the mower. Prior to her providing those instructions he and Ms Singleton had walked with Ms Kohl and Mr Tunik down to the avocado orchard directly below the homestead. He says as it was the end of the season there were not a lot of avocados to pick so they showed them the trees which needed to be picked.[129] The avocado trees in the unused area where the accident occurred were not identified as avocado trees to be picked by Ms Kohl and Mr Tunik.[130]

86. Ms Singleton recalled walking down to the orchard they were to pick avocados from with Mr Jacobi, Ms Kohl and Mr Tunik. They were not told how many trees

[124] T1.74, 24.
[125] T1.75, 31.
[126] T1.75, 48.
[127] T1.9-36.
[128] T1.90, 15.
[129] T1.35, 31.
[130] T1.37, 44.

to pick from but to pick four crates.[131] Mr Tunik was shown where to drive down into the rows of trees and to park the mower near the trees.[132]

87. Immediately following the accident, Mr Tunik told investigators he was instructed where he could drive the mower, he stated, '*This area looking for avocados. And you see a good tree and you are picking, finish the tree, looking for next tree and picking again*'.[133] When asked about the slope they were standing on, through Mr Amadeu it was conveyed, '*So she said he can actually pretty much go anywhere slowly, yeah carefully but yeah just anywhere'*.[134] Mr Tunik said he had driven the mower in the area on the hill before and had had no problems.[135] During the WHS prosecution, Mr Tunik was asked '*had you driven in the area that the accident happened before*?', he responded, '*I think it was the first time I was there, but I'm not sure anymore. It's too long ago*'.[136]

88. At a formal interview with the WHS investigators on 18 December 2017, Mr Tunik said there were no forbidden areas they could not go.[137] With regard to the hill, he was asked if he was ever told to drive up or down, not across. He stated, '*She said you have to go on a curve, sort of a smooth curve rather than abruptly across*'.[138] He said he had driven across the slope, '*very often'*, he estimated 50 times.[139] In his interview with the QPS investigators on 23 January 2018, Mr Tunik said he had gone across the slope where the accident occurred before with no problem.[140] He said this was every Monday as that was food picking.[141]

89. During the WHS prosecution, Mr Tunik was asked what he did after they unloaded the avocados in the shed. He said they drove down the hill to the next avocado tree.[142]

90. Mr Jacobi did not disagree Mr Tunik was instructed to look for a good tree and pick the tree until it was finished and then move on to the next. He stated,

> '*In those three rows potentially but not in the property. Between the two*

[131] T1.81, 17.
[132] T1.81, 40.
[133] Ex B2.9.1, para 133.
[134] Ex B2.9.1, para 136.
[135] Ex B2.9.1, para 143-146.
[136] Ex B5.1, 1.66, line 20.
[137] Ex B2.10 p15, line 21.
[138] Ex B2.10, p16, line 20.
[139] Ex B2.10, line 34.
[140] Ex B2.11.1, p14, para 265.
[141] Ex B2.11.1, p14, para 272.
[142] Ex B5.1, 1-65, line 17.

properties there's around 500 trees and there would be at least three areas that they're on slopes that we don't work. They're too difficult to work. They're overgrown. They – some of the slopes are up near the packing shed. The trees there could have avocado tree – have avocados on them but we simply just didn't pick them…'.[143]

91. Regarding the task of picking avocados, they were told to pick four crates each day. Mr Jacobi estimates this would take a backpacker a maximum of two hours. He agreed to pick four crates, that would require one trip from the house to the orchard and then from the orchard back up to the packing shed.[144]

92. Mr Tunik says he was not told there were any areas on the farm where he could not use the mower.[145] Mr Jacobi conceded he was not there when Ms Singleton was orientating Mr Tunik and Ms Kohl as to where they were to take the avocados and the route they were to take.[146] Mr Jacobi did not provide any instructions to Ms Kohl and Mr Tunik on the day of the accident.[147] There was the following exchange with Ms Singleton in evidence:

CA: *…That Mr Tunik was not told that there was any forbidden areas using the mower, but to go carefully and slowly?*

Ms S: *Walking pace, I always said.*

CA: *Walking pace, all right. What about the no forbidden areas, is that something you told him?*

Ms S: *I don't recall. I just know I showed him exactly where to go.*

CA: *That Mr Tunik understood that he could pretty much go anywhere but to go slowly?*

Ms S: *No, that's not correct.*

CA: *Going back to what you just said before, you showed him where he could go?*

Ms S: *Yes.*

CA: *Was there any specific instruction on where he couldn't go?*

Ms S: *No*.[148]

93. Despite not providing any specific instruction on where he could not go, Ms

[143] T1.36, 21.
[144] T1.49, 39.
[145] Ex B2.7, p14.
[146] T1.36, 34; T1.37, 7-16.
[147] T1.48, 36.
[148] T1.84, 18-29.

Singleton had an expectation Mr Tunik would be using the mower for the task of picking avocados she had given them, and that the mower was to be used in the area they had been told to pick avocados from.[149] While it was expected, there was no specific instruction he could only use the mower to transport avocados. I discuss this further below.

94. Mr Jacobi agreed the track between the avocado orchard and the unused area was the dividing line regarding where Ms Kohl and Mr Tunik were to pick.[150] The following exchange occurred in evidence:

> CA: *And in relation to that pathway, I guess, of ensuring and understanding as to the area they were picking at, how can you be confident, or did you ascertain their understanding as to the area to be picked?*
>
> Mr J: *I suppose just because we walked there with them and we pointed out the trees.*[151]

95. Ms Singleton said while there were avocado trees in the '*unused area*' they were not picked and were overgrown. This was because they were quite sick and did not have any fruit on them.[152] Ms Kerwin had never picked avocados from the '*unused area'* when she had volunteered on the farm.[153]

96. During the WHS prosecution Mr Tunik was asked whether he was ever prohibited from driving the mower on any parts of the property. He responded, '*I don't think so, I'm not sure, but I don't think she said anything about that*'.[154]

97. Ms Kohl and Mr Tunik were not provided a map or any guide to where they were to pick avocados.[155] Mr Jacobi expected Mr Tunik would only drive the mower in the orchard where they were to pick the avocados, and that there would have been enough avocados to fill four crates.[156]

98. Mr Jacobi says he cannot recall exactly what was said about the operation of the mower but says Ms Singleton is pedantic. He says she would explain the parts of the mower, how it was controlled, how it should be driven, the speed it should be driven, always in four-wheel drive. He says if Ms Singleton missed anything he would '*chirp up with instruction'*. Mr Tunik had advised Ms

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[149] T1.84, 37.
[150] T1.38, 9.
[151] T1.38, line 14.
[152] T1.68, 40.
[153] T1.8, 10.
[154] Ex B5.1, 1-56, line 37.
[155] T1.38, 19.
[156] T1,56, 33.

Singleton he had used a similar machine quite a few times in Germany.[157] This is not disputed by Mr Tunik. In relation to the instructions she provided, Ms Singleton stated,

> *'I demonstrated to him how to start it, the forward and reverse pedal, the brake, the handbrake, the diff, diff lock, second and fourth four-wheel drive and so I explained how it all worked. I showed him. He watched me drive it and then he got on and then I – I rode next to him on the other one and I watched him and we travelled up to the packing shed, I showed him where to turn around to put it into two-wheel drive. So I – I rode next to him*'.[158]

99. After the explanation, Ms Singleton got on the mower and Mr Tunik followed her up to the packing shed where Mr Jacobi understands she was going to show them where the crates were and all things like that.[159] Ms Singleton picked avocados with Ms Kohl and Mr Tunik that day from the orchard they had all walked down to.[160]

100. Mr Jacobi thought there was no great difficulty in Mr Tunik understanding and that if there was anything not understood Ms Kohl would usually explain it a bit more. Mr Jacobi does not recall this being a problem.[161]

101. Mr Tunik says Ms Singleton told him Ms Kohl could ride on the mower with him, but she did not see Ms Kohl on the mower.[162] Ms Singleton denies this and did so in the written response to WHS investigators.[163] She recalls after she had shown Mr Tunik how to use the mower he turned around to Ms Kohl, tapped the side and said, '*Hop on'*. This is when Ms Singleton told him he was to have no passengers on the mower.[164] She says Ms Kohl was not interested in any event.[165]

102. Mr Tunik said the only day Ms Kohl rode on the wheel arch beside him was on the day of the accident.[166] He thought it was no problem for her to sit on the wheel arch and stated, '*First time down, finish picking. She sit with me up again. (ui) and chat, avocados finish sitting again. It was, was accident*'.[167] Mr Tunik

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[157] T1.80, 41.
[158] T1.80, 3.
[159] T1,32, 41.
[160] T1.82, 37.
[161] T1.33, 25.
[162] Ex B2.7, p11.
[163] Ex B2.34, para 38.
[164] T1.83, 4-38.
[165] T1.83, 2.
[166] Ex B2.11.1, p19, para 371.
[167] Ex B2.11.1, p20, para 392.

agreed after they had unloaded avocados, they headed back down to pick more avocado. He was asked about distraction and while he responded, he was cut off during his response. He said, '*We talking about nice place here and Katherine say she would like to sell this property, I say*…'.[168]

103. I accept the evidence of Ms Singleton over the evidence of Mr Tunik on this issue. In her evidence, Ms Singleton was adamant about not permitting Ms Kohl as a passenger on the mower and I accept her account as credible.

104. Regarding the mower, Mr Tunik says he was shown how it went into reverse, the break and accelerator. He was not provided the operator's manual. Mr Jacobi and Ms Singleton say the operator's manual was kept in the machinery shed and was available to all operators.[169]

105. During the WHS prosecution Mr Tunik agreed Ms Kohl was beside him when Ms Singleton explained to him how to use the mower.[170] He stated, '*And she tried to explain it to me – her English is much better than mine*'. He recalled Ms Singleton told him how to use the drive gear and the reverse gear. In relation to his understanding of what Ms Singleton told him, he said he understood 10 or 20 percent. By way of example, he said '*I would understand two or three words of the sentence*'.[171] Later in evidence he said in 2019, he probably understood 40 percent when someone was speaking to him in English.[172]

106. Mr Tunik says Ms Singleton told Mr Tunik he was to take extra care on slopes and was told to leave it in gear 4, and something about pressing the forward gear and then reverse gear to maybe slow it down. He was told not to go too fast and to always go slow.[173] Ms Singleton agrees she would have told Mr Tunik to take extra care on the slopes and to use reverse to slow down.[174]

107. Ms Singleton says Mr Tunik was provided with hands on training on site. She worked alongside him every day except for the day of the accident. She says he claimed he was familiar with the mower having used a similar one in Germany. Ms Singleton is of the view Mr Tunik appeared to understand the use of the mower and appeared to be competent and cautious in his use of it. He

[168] Ex B2.11.1, p21, para 412.
[169] Ex B2.46, para 37.
[170] Ex B5.1, 1-53, line 43.
[171] Ex B5.1, 1-54, line 17.
[172] Ex B5.2, 2-18, line 43.
[173] Ex B2.7, p11.
[174] T1.84, 2.

was asked to repeat instructions to ensure he understood.[175]

108. Mr Tunik says he was advised by Ms Singleton that he had to drive the mower on a curve, sort of a smooth curve rather than abruptly crossing it.[176] Ms Singleton denies this because there were no slopes which she orientated him to that he would have had to do a smooth curve on.[177] She conceded though she does not recall if this was a general instruction she provided at the time of instructing him on the use of the mower.[178] She is adamant she would have told him to always drive up and down a hill not across it.[179]

109. Ms Singleton and Mr Jacobi say they had both read the user manual for the mower to ensure their use was within its capability. They say it could be used for towing and the weight being towed never exceeded the amount provided in the manual.[180]

110. I accept the submissions of Counsel Assisting and find Mr Tunik was provided with instruction on the operation of the mower and that with the likely assistance of Ms Kohl, Mr Tunik was able to understand the instructions provided. He also had had experience with driving a similar mower in Germany.

111. I am not persuaded however, that there was an issue with providing instruction on where the mower could be driven, and the level of supervision provided to Ms Kohl and Mr Tunik.

112. Based on the available evidence, I accept the submissions made on behalf of Mr Jacobi and Ms Singleton that:

    a. Mr Tunik and Ms Kohl were shown the areas within the orchard immediately below the homestead where they were to pick avocados from the day before the accident.

    b. They had been shown how to perform that task, which was not complex, and demonstrated competency in the same.

    c. They were also shown the route from the orchard to the packing house and back again, which Ms Singleton drove with them. Again, Mr Tunik (in the presence of Ms Kohl) was provided with instruction and training

[175] Ex B2.46, para 41.
[176] Ex B2.7, p16.
[177] T1.85, 40.
[178] T1.85, 4.
[179] T1.97, 3.
[180] Ex B2.46, para 30.

on the operation of the mower and demonstrated his competence in doing so.

d. It was made clear to Mr Tunik and Ms Kohl that the mower and trailer were only to be used to carry avocados '*from the tree to the packing shed*' and that passengers were not permitted on the mower.

113. I accept that the above was sufficient instruction and supervision of two adults for the tasks which they were to perform. No evidence was led to show a different level was practicable or ought to have been provided.

The Fatal Accident

114. Mr Jacobi estimates he and Ms Singleton left the farm at around 08:00 hours on the day of the accident.[181] Ms Singleton agreed.[182] Ms Kohl and Mr Tunik were at the mower ready to start work as they were leaving.[183] This is consistent with Ms Singleton's recollection of Mr Jacobi checking the connection between the trailer and mower that morning just before they drove out.[184]

115. Ms Singleton says she had told Ms Kohl and Mr Tunik they were to pick four crates of avocados and that they would then be finished for the day.[185] She expected that would take them a couple of hours.[186] This would involve Mr Tunik driving the mower and trailer from the house down into the orchard and parking it, packing the four crates and then driving the mower and trailer with the avocados up to the packing shed and then returning the mower and trailer to the homestead.[187]

116. Ms Kohl was sitting on the wheel arch of the mower when it rolled over. Mr Tunik says the trailer swung and the mower went with it. He does not know what happened after it tipped over.[188] Mr Tunik was driving the mower in the '*unused*' area that did not have viable avocado trees when the accident occurred.

[181] T1.49, 42.
[182] T1.93, 36.
[183] T1.94, 35.
[184] T1.115, 21.
[185] T1.93, 41.
[186] T1.93, 0.
[187] T1.94, 3-22.
[188] Ex B2.7, p18.

The Emergency Response

117. Mr Tunik called '000'. The call and various radio transmission recordings have been provided by the QAS. The 000 call is harrowing and goes for 30 minutes.[189]

118. It was very difficult to understand Mr Tunik. Understandably, he was desperate to obtain help but had difficulty communicating the correct address and what had occurred. Ms Kohl is heard screaming in the background.

119. Originally Mr Tunik said he was at 210 McDonald Road, Mount Cootha. At two minutes into the call, Mr Tunik says he is on an Avocado Farm. At 3.36 minutes into the call, it was confirmed he was at 210 Macdonell Road, Tamborine Mountain.

120. The spelling of the road was not confirmed, and it would have been difficult to do so given Mr Tunik's limited English. The Emergency Medical Dispatcher ('EMD') then asked if the cross street is Beaudesert Beenleigh Road which Mr Tunik said yes to, but he does not seem to understand the question. As a result, the QAS were dispatched to McDonald Road, Jimboomba instead of Macdonell Road, Tamborine Mountain.

121. While on the 000 call after numerous attempts at trying to communicate with the QAS EMDs, and while still on the phone, Mr Tunik went up to the main road to try and get help.

122. It is unfortunate the paramedics were dispatched to McDonald Road, Jimboomba when it was established with Mr Tunik that the address was at Tamborine Mountain. Jimboomba was not suggested back to Mr Tunik. It seems it was assumed the address was Jimboomba because of Mr Tunik's reference to McDonald Road and the call taker confirming with him that Beaudesert Beenleigh Road was nearby.

123. The responding QAS unit was dispatched by the Operations Centre at 11:29 hours (nine minutes after the call was picked up by the EMD).[190] They had been at the station and there was no delay in getting underway.[191] They were originally dispatched to McDonald Road at Jimboomba which was in the opposite direction to the accident scene.[192] Things were not lining up with the

[189] Ex E3.1.
[190] T2.25, 4.
[191] T2.25, 40.
[192] T2.26, 11.

cross streets when the correct address came in as Macdonnell Road, Tamborine Mountain.[193]

124. When it was eventually confirmed the accident was at Tamborine Mountain, the QAS units were re-directed. There is reference in the radio transmissions to the ambulances doing a U-turn. Mr Beak described them as doing a '*screaming uey'* and that they started to head back towards the accident scene.[194] Adding to the confusion, one of the passersby referred to the road as Tamborine-Oxenford Road and when questioned said it was also called Macdonnell Road.

125. From the radio transmissions, due to the confusion over the address, the Tamborine Mountain fire service which was originally dispatched was stood down but were then re-engaged. Auxiliary fire fighter, Mr Sullivan says he was originally dispatched at 11.32.09 hours with four other officers. The original dispatch address was 2017-2205 Beaudesert Beenleigh Road, Tamborine Mountain.[195] They were in the fire truck and making their way out of the fire station at 11.38.08 hours when they were stood down.[196]

126. Two passersby spoke with the QAS EMD and confirmed the address. QFES were re-dispatched to 200 Macdonnell Road, Tamborine Mountain at 11:48 hours.[197]

127. Mr Bray with the other bystander and Mr Tunik ran down the drive to the accident scene.[198] They immediately tried to lift the mower, but they could not budge it.[199] Mr Bray spoke to the QAS operations centre on Mr Tunik's phone.[200] He advised all that could be seen of Ms Kohl was her legs and by that time there was no movement or sound from her. He told the EMD he suspected Ms Kohl had died.

128. Mr Bray described Mr Tunik as being extremely distressed, '*probably more than I've ever seen anyone in my life distressed, just screaming'*. He was asking '*why they couldn't get a helicopter*', '*where are they'* and '*what's happening'*.[201]

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[193] T2.26, 22.
[194] T2.26, 48.
[195] Ex F5, p1.
[196] Ex F5, p2.
[197] Ex F5, p2.
[198] T2.18, 40.
[199] T2.20, 0.
[200] T2.20, 9.
[201] T2.20, 38.

129. The Tamborine Mountain QAS and QFES stations are located next to each other.[202]

130. The QFES officers drove out of the station at 11.49.47 hours and were at the address by 11.55.26 hours. Mr Sullivan estimates it would then have taken about three minutes to enter the property and drive through the terrain with the appliance to reach the mower.[203]

131. Mr Beak and his partner arrived at the address at around 11:52 hours (this being the time the button was hit on the Mobile Data Terminal in the vehicle). The extrication of Ms Kohl is recorded as taking place at around 11:58 hours (the time is a manual time taken as a '*guestimate*' from the on scene time to turning on the defibrillator).[204] Mr Beak recalls the QFES officers arrived a short time after the QAS, they lifted the mower while the QAS officers slid Ms Kohl out from under the mower.[205] Mr Sullivan cannot recall the specifics but believes they lifted the mower using manpower and then chocked the mower with step chocks to stabilise the mower.[206]

132. Mr Beak the responding paramedic accepted it was about 27 minutes between leaving the station and arriving to the accident scene, and that had they been dispatched to the accident scene directly from the station it would have taken five to eight minutes, depending on traffic.[207]

133. Mr Amadeu the Critical Care Paramedic arrived and assisted with resuscitation attempts. Mr Beak advised if Mr Amadeu had not arrived at the scene, and it was just him and his partner they still would have been able to decompress Ms Kohl's chest and provide sufficient airway management. He said intubation was not required per se to protect her airway in this case.[208]

After the Accident

134. Senior Constable Hutchinson observed directly uphill from the mower several small furrows in the turn and some plastic debris consistent with components from the mower. He says this was consistent with the mower moving across

[202] T2.24, 37.
[203] Ex F5, p2 and 3.
[204] T2.25, 13-30.
[205] T2,30, line 14-27.
[206] Ex F5, p3.
[207] T2.27, 41.
[208] T2, 31, 31.

the slope from right to left then rolling over.[209]

135. On his arrival to the scene, Senior Constable Vickers was advised Ms Kohl had been removed from under the mower. He observed the mower had come to rest against a tree on its left side. He states, '*this indicates that the mower had rolled three quarters of a full rotation stopping on its left side*'. [210] He also noticed the cutting deck had been removed and that there was a home-made trailer that was upside down just directly behind the mower that was being towed at the time of the accident.[211]

136. Mr Amadeu ascertained information from Mr Tunik in German immediately following the resuscitation. He states:

> *'He had very poor English and I spoke to him in German. When speaking German, he made more sense. He stated that they were going to pick some avocados and he got the mower ready and attached the trailer for the avocados. He said he encouraged her to ride on the mower with him despite her telling him she didn't want to. She told him it was dangerous. He stated that she eventually agreed and she was riding with him on the mower. He stated he was going downhill and the mower was gathering speed and wouldn't slow down despite him hitting the brakes, so he turned to the left to take the speed out of it and the whole thing rolled and she got trapped underneath the mower next to the tree'*.[212]

137. Ms Singleton recalls Mr Tunik kept repeating the same thing again and again after the accident. She stated,

> *'He – he said that he told Jen, 'Hop on. Let's pretend this is our farm'. And she said, 'No'. And he said three times, 'Hop on. Let's pretend this is our farm', and she said 'No.' And he said, 'Come on, let's pretend this is our farm. Hop on'. So when he told me that, I said he shouldn't have done that and he said he knows, and I know he felt quite guilty about that, but he just keep repeating that he said that to her*'.[213]

138. Ms Kerwin spent some time with Mr Tunik after the accident. She described it as a very emotional time. It included trying to arrange a service for Ms Kohl and a walk on the beach. She says, '*we spent some good time together'*.[214] She

[209] Ex B2.6, p3.
[210] Ex C1, p3.
[211] Ex C1, p3.
[212] Ex C2.1, para 5.
[213] T1.99, 14.
[214] T2.11, 35.

remembers Mr Tunik had told her that he had asked Ms Kohl to get on the mower but that she didn't really like the mower. Mr Tunik had said to Ms Kohl '*let's pretend like this is our farm'*. She says he said these things more than once to her. She sensed some remorsefulness on the part of Mr Tunik.[215]

139. During the WHS prosecution Mr Tunik described Ms Kohl firstly walking down to where they were to pick avocados and he drove the mower down. They then were intimate, '*quickly fucked'*.[216] After they picked avocados, he asked Ms Kohl if she would like to sit beside him on the mower. He said they had done that a few times but then said it was the first or second time she had sat on the mower.[217] They unloaded the avocados in the packing house and when they drove down for a second time to the next avocado tree, Ms Kohl was sitting beside him on the mower.[218] The accident occurred when they went back down the hill.

140. Even allowing for some difficulties with his English, there is inconsistency in Mr Tunik's various accounts of the events. I find that Mr Tunik encouraged Ms Kohl to ride with him on the mower despite her hesitations, that it was the first day she had ridden on the mower with Mr Tunik and that this was the first time he had driven the mower to the significantly sloped unused area where the accident occurred.

Autopsy

141. An autopsy was carried out by the late Associate Professor ('A/Prof') Olumbe on 15 January 2018. The post-mortem examination showed Ms Kohl had sustained collapsed lungs. A/Prof Olumbe states,

> '*Given both the circumstances surrounding the death and the postmortem findings, the cause of death is considered to be traumatic asphyxia due to being 'pinned under the upturned mower and a tree'. Traumatic asphyxia is mechanical compression of the chest that causes impaired respiratory action and subsequent asphyxia'*.[219]

[215] T2.12, 5.
[216] Ex B5.2, p1.
[217] Ex B5.1, 1-59, line 27.
[218] Ex B5.1, 1-63, line 24.
[219] Ex A3, p8.

142. The toxicology results were unremarkable.[220]

143. The 'Cause of Death' is recorded as "*1(a) Traumatic asphyxia*".[221]

Investigation by QPS

144. On 16 January 2018, Senior Constable Vickers of the Coomera FCU provided a detailed (8 page) Supplementary Form 1 to the Coroner ('the QPS report').[222] He was briefed on his arrival to the scene by the first officers on the scene, Senior Constable Guerin and Senior Constable Ellis.[223]

145. The QPS conducted a formal record of interview with Mr Tunik, the only witness to the accident.[224] The QPS concluded there were no suspicious circumstances surrounding the accident.[225]

146. Police Vehicle Inspection Officer, Mervyn Ritchie performed a mechanical inspection of the mower. The inspection found the mower to be in an unsatisfactory mechanical condition due to free play in the steering joint. This though was not thought to have contributed to the accident. The right-hand rear tyre was found to have a minor air leak, but the cause of the leak was inclusive (that is, it is unclear whether it occurred prior to or during the accident). If it was low prior to the accident, it may have altered the operating angle of the mower.[226]

147. Consideration was given by QPS as to whether to charge Mr Tunik. Advice was sought from Senior Police Prosecutor Senior Sergeant Halfpenny. It was determined that the facts did not support the sufficiency of evidence test under the Department of Public Prosecutions Guidelines.[227]

148. On behalf of Mr Jacobi and Ms Singleton, it was submitted that the mechanical inspection was undertaken after the accident occurred and after the mower had been lifted, righted and stabilized and removed from the scene. The evidence is that the mower had rolled over, performing (at least) one three-quarter roll down a hill, before coming to rest against a tree. No evidence is before this

[220] Ex A4.
[221] Ex A3, p8.
[222] Ex C1.
[223] Ex C1, p3.
[224] Ex C1, p7.
[225] Ex C1, p1.
[226] Ex C1, p7.
[227] Ex C1, p7.

Court about how the mower was then lifted, other than that it was thought to be using '*manpower*', what points of contact were used to lift (and attempt to lift) the mower and how it was then righted and removed from the scene. Ms Singleton's evidence is that she drove the mower '*all the time'* including the day before the accident, and that she never had any issues with its functionality.

149. On that basis, it was submitted that the mechanical inspection comment about '*free play in the steering joint'* cannot be assumed to reflect the state of the mower before the accident. That inference is against the evidence of Ms Singleton, who was familiar with the mower and regularly operated it. She reported no such issue and there is no evidence before me about the cause of the '*free play'* or the length of time it may have existed. In any event the '*free play in the steering joint'* was thought as not contributing to the accident.

150. Finally, it was submitted that it is unclear what material was provided to the Police Prosecutor which formed the basis of his opinion about sufficiency of evidence, but that it did not include all the material which is before this Court in these proceedings.

Investigation by WHS

151. A WHS Queensland investigation was authorised under Part 9 of the *Workplace Health and Safety Act 2011* ('the WHS Act').[228]

152. Principal Inspector (Investigations) Anthony Sheean conducted the investigation with the assistance of Principal Inspector Luke Massey and Senior Inspectors John Huang and Brendan Warrell.[229]

153. Inspectors attended the accident scene on Friday 8 December 2017.[230]

154. As part of the investigation, statements were obtained from:

    a. Paddy Couper – John Deere supplier with 20 years' experience;

    b. Matthew Tomney – New Zealand resident who resided and worked on the farm from March to May 2015;

[228] Ex B1, p2.
[229] Ex B1, p2.
[230] Ex B1, p2.

c. Alicea Young – Canadian resident who resided and worked at the property from 6 March to April 23, 2017.[231]

155. Investigators spoke with Mr Couper, the John Deere supplier as an expert on two occasions.[232] The second occasion was to seek clarification as the original discussion concerned the wrong model of mower. Mr Couper advised there was no real difference between the X595 (model involved in the accident) and the X575.[233]

156. Mr Couper opined:

a. The mower, while 4WD was not suitable for the farm as the maximum slope as recommended in the operator's manual is slopes not greater than 13 degrees[234];

b. The tyres were normal residential use and it would have been prudent to have used a more chunky tyre for the farm[235];

c. There should only be one operator per machine as per the operator's manual which says '*keep riders off*'[236];

d. The trailer had bald tyres and it would be the first thing to let go, it would also make the rest of the mower unstable[237]; and

e. The mower deck had been removed and that would contribute to the instability of the mower[238].

157. Mr Tomney, a previous backpacker[239], who worked on the farm in 2015 used the mower to mow grass and it seems for other purposes. He says he used it at least once or twice a day, but it varied. He stated,

> *'I operated their mower similar to the one in the photos emailed to me by inspector Sheean around the property. Before I operated the mower I was shown how to start the mower and the basic functions of it and Ken and Kathryn just told me to be careful around the sloped areas of the property but the speed to travel up or down or across the slopes was never mentioned*'.[240]

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[231] Ex B1, p2.
[232] Ex B2.9 and Ex B2.42.
[233] Ex B2.42, p4.
[234] Ex B2.9, p6.
[235] Ex B2.9, p7.
[236] Ex B2.9, p6.
[237] Ex B2.9, p7.
[238] Ex B2.9, p9.
[239] It seems he was from New Zealand but that is not confirmed in his statement.
[240] Ex B2.31.

158. Ms Young, a previous backpacker, did not use the mower while staying at the farm.[241]

159. An electronically recorded interview was conducted with Mr Tunik.[242] Ms Singleton and Mr Jacobi declined to be interviewed but provided written responses to questions posed pursuant to a WHS Act s155 Notice.[243]

160. The investigators obtained other information as outlined in their report, including various documentation from the QPS, manufacturers operating manual for the mower, and records from WWOOF Australia.[244] In addition, the investigators reviewed various legislation and Codes of Practice relevant to the accident.[245]

161. The following combination of factors were identified by the investigators as contributing to the cause of the accident:

    a. *Although the mower was a single seat vehicle Ms Kohl was riding as a passenger on the left hand side wheel arch / mud guard in contravention of the safety instructions contained within the Manufacturer's manual and the Safe design and operation of mowers COP 2005.*

    b. *A low set trailer was attached to the rear of the mower which is likely to have affected the stability of the mower as indicated in the Manufacturer's manual and the Safe design and operation of mowers COP 2005.*

    c. *The mower was engaged in 4WD and did not have a mower deck attached, however no wheel weights or counterweights were fixed to the mower for added stability as recommended in the Manufacturer's manual.*

    d. *Tunik drove the mower across a slope (rather than up and down) in contravention of the safety instructions contained within the Manufacturer's manual.*

[241] Ex B2.9, p2.
[242] Ex B1, p2.
[243] EX B1, p15 and p20.
[244] Ex B1, p3.
[245] Ex B1, p3.

e. *Whilst driving the mower across the slope Tunik made a sudden change in direction in contravention of the safety instructions contained within the Manufacturer's manual.*[246]

162. On behalf of Mr Jacobi and Ms Singleton it was submitted as follows:

a. Despite the investigation by Inspectors from WHS, no Improvement Notices[247] or Prohibition Notices[248] were issued to Mr Jacobi or Ms Singleton after the accident. If any of the Inspectors involved in the investigation reasonably believed that an activity was occurring or may occur that would involve a serious risk to health and safety to a person, then they were empowered to do so. They did not.

b. The Brief prepared by the Inspectors contained the incorrect Product Manual for the mower at Exhibits B2.15 and B2.16. Those documents have no bearing on the mower and should be disregarded in their entirety. The correct version of the Manual appears as an annexure to the response to the s.155 Notice which Mr Jacobi and Ms Singleton provided: see Exhibit B2.34. However, that document attracts the protections afforded by s.172 of the *Work Health & Safety Act* 2011.

c. With the greatest respect to Mr Couper, he has not been established as an expert and his qualifications and experience do not qualify him as an expert for the purposes of the opinions sought to be expressed. Further, the factual matters necessary to found the opinions stated by Mr Couper are not in evidence. For example, Mr Couper did not attend at the property to inspect it, nor did he inspect the mower. He was not advised of the intended use(s) to which the mower would be put or the terrain upon which that was to occur. He was simply shown some photographs and asked to express some opinions. Counsel Assisting did not call Mr Couper to give oral evidence at the Inquest and there was no indication given by Counsel Assisting or any party of an intention to rely on his recorded statement. His evidence is therefore untested. No weight should be attached to them.

d. The statements of Mathew Tomney and Alicea Young are irrelevant, and no weight should be attached to them. They relate to different

[246] Ex B1, p10.
[247] Section 191 *Workplace Health & Safety Act* 2011.
[248] Section 195 *Workplace Health & Safety Act* 2011.

people, at different times and in the case of Mr Tomney, different plant. They are not logically probative and are untested, as those witnesses were not called.

e. The OIR Investigation Report is hearsay and unqualified opinion. No weight should be given to it. The Report also incorrectly describes the relevant test under the *Work Health & Safety Act* 2011 (Qld) [see p14 paragraph (j)], which is to ensure, so far as reasonably practicable, the health and safety of workers engaged, or caused to be engaged, by the person while the workers are at work in the business or undertaking. Those two aspects, namely what is '*reasonably practicable'* and while the workers are at work in the business or undertaking, are live issues before the Court, as discussed below.

f. The WWOOF material is entirely irrelevant, as Mr Tunik and Ms Kohl were not engaged that way, and Mr Jacobi and Ms Singleton have not been members of that organisation for a considerable period of time. Those documents, or at least some of them, bear the date 3 January 2017, which is well after Mr Jacobi and Ms Singleton ceased their association with that organisation.

Information sought from OIR and Department of Home Affairs

163. The Department of Home Affairs ('DHA') confirmed Ms Kohl had been granted a Working Holiday (subclass 417) visa on 15 December 2016.[249] Her visa was valid until 15 February 2018 and was part of the Working Holiday Makers Program (WHMs). DHA advised those who choose to work are entitled to the same rights and protections at work (including pay and work conditions) as Australian residents and citizens. The author states,

> *'Therefore, there are a number of obligations that employers must meet including paying appropriate salary, deducting taxation payments and making superannuation contributions. Workplace conditions, and any breaches of these conditions, are a matter for the Fair Work Ombudsman*'.

164. At my request, the OIR helpfully provided an overview of the regulatory environment related to workplaces. Similarly, they were asked a series of questions about measures put in place for the safety of young people

[249] Ex H1, para 4.

participating in the Working Holiday Maker Program or other such schemes.[250] A very comprehensive 14-page response was provided, including a number of suggested recommendations.

165. One of the recommendations was for information and links about workplace health and safety (amongst other statutory rights and regulations) to be included on the Home Affairs website or on a specific central '*one stop shop'* webpage, so that from early in the process visa applicants may become more aware of the laws and protections in workplaces in Australia. They also suggested it may be useful for the federal Government to undertake a coordinated national study to build an evidence base for WHS risks specific to migrant workers, to inform future policy development.

166. DHA was asked to respond to the suggested recommendations by OIR, the author states,

> *'In light of the OIR's response, the Department will consider whether to include specific information relating to Work Health and Safety (WHS) on its website. The relevant areas of the Department are not opposed to providing other relevant WHS information for visa holders. However, I note that workplace conditions, and any breaches of these conditions, are a matter for the Fair Work Ombudsman'*.[251]

Review by QAS

167. On 11 December 2017, Mr Stephen Moore, Acting Assistant Commissioner State Operations Centres requested a Call taking Special Review be undertaken as part of QAS's Quality Assurance processes.[252]

168. The 000 call was reviewed by CSO Robert Hartley and moderated by A/CSO Natasha Allen. It was approved by SQAO Trevor Tighe.[253] The EMD was found to be compliant. Several comments were made regarding the difficulties the call taker faced due to the language barrier. The reviewer states,

> *Address was unable to be obtained via CLI data.*
>
> *The callers first language was one other than English and the caller advised he was a German Backpacker. The EMD was having significant difficulty*

[250] Ex B41.1.1.
[251] Ex H2. p2.
[252] Ex E5.
[253] Ex E5.

understanding the caller. There also appeared to be some connectivity issues with the phone line. The EMD utilised some reassurance and calming techniques and the caller became more understandable.

The reviewers also had difficulty understanding the caller.

Initially, the EMD thought the caller was calling from Mount Coot-tha and the caller confirmed Mount Coot-tha. It was later in the call, where it appeared the PUSH MoLi data was used, that the Tamborine area became a possibility. This was quickly confirmed by the caller.

It is clear the EMD had sought assistance with the verification process as a second person (OSC WINLAW) was heard in the background of the call assisting.

The language differences presented difficulties for the EMD, particularly in Key Questions. The incident, when it was understood clearly the patient was entrapped, has been sent to the Waiting Incident Queue (WIQ).

After the incident had entered the WIQ, there is clear conversation happening in the background of the EMDs side of the call, where attempts are being made to confirm the actual location of the incident.

After the incident entered the WIQ, The OCS essentially took over the call. It was when a third party was hailed down by the caller and that person eventually got on the phone, the location was verified to the correct location.

The OCS was then able to focus on finding out exactly what was happening with the patient.

Once contact was made on scene with a fluent English speaker, further details and confirmation was noted in the incident and the original EMD on the call resumed the call.[254]

Evidence of Dr Rashford

169. Dr Stephen Rashford is the Medical Director of the QAS. He provided a written response to me[255] and was called as a witness to give oral evidence at the inquest.

170. An EMD both receives and categorises triple 0 calls and dispatches ambulances. They are civilian call takers who have undergone a custom designed QAS training program. On completing the training which includes 12

[254] Ex E5.
[255] Ex E6.

months practical experience under supervision, they receive a Certificate IV qualification.[256]

171. Dispatch is through a computerised program. In creating a case it is first necessary to establish where the incident is so an ambulance can be sent to a person in a timely manner. Then there are a series of scripted questions asked via a system called Medical Priority Dispatch System, which is a simple algorithmic system with a series of questions which establish the nature of the complaint and the acuity of the complaint.[257] As occurred in this case, the whole dispatch process is recorded (is time stamped and cannot be altered) in the Incident Detail Report.[258] The case was dispatched as a 1A which is lights and sirens and the highest response available to QAS.[259]

172. All operation centres are supervised by a very senior/experienced EMD. There is also a level of clinical supervision with clinical deployment supervisors available in the operation centres. They provide oversight on resource allocation and can provide advice to crews and to the EMDs if required.[260] A supervisor can stand behind the EMD or plug in live to a call. Dr Rashford confirmed this is what occurred in this case, the supervisor was involved in the background of the call and then came on the line to try and establish the correct details from Mr Tunik.[261]

173. According to the Incident Detail Report the triple 0 call was answered at 11:20:26 hours.[262] Mr Beak and his partner were dispatched at 11:29:39 hours. Dr Rashford explained until they know exactly where to dispatch the ambulance it cannot be put in the queue. He stated, '*once we actually have an address, we have a case created and we can update all the other details beyond that*'.[263] If the caller can provide the address immediately, the average time between call pick up and dispatch is between 120 and 180 seconds but if it is someone in for example cardiac arrest they aim to get that done under 60 seconds.[264]

174. Due to Mr Tunik's difficulties in expressing himself various attempts were made to confirm his location. A Command Line Interface ('CLI') was run on the

[256] T2.38, 34.
[257] T2.40, 25.
[258] Ex E2.
[259] T.41, 20.
[260] T2.39, 15.
[261] T2.40, 11.
[262] T2.41, 26.
[263] T2.42, 45.
[264] T2.42, 21.

number Mr Tunik was calling from but that was registered to a Sydney backpackers (the billing address).[265] Attempts were then made using Push MoLi data. It goes off mobile towers that can be accessed and creates an area on a map where the mobile phone may be located. It was the best technology available at the time (there have been advancements since which are addressed further below).[266]

175. The actual address of the incident was outside the polygon created on the map from the MoLi data[267], and both Macdonnell Road, Tamborine Mountain and the McDonald Road Jimboomba were in the vicinity of the polygon. Dr Rashford said the map really demonstrated the difficulty with the technology at the time to establish exactly where Mr Tunik was.[268]

176. Dr Rashford confirmed it was not until three minutes into the call that Mr Tunik agreed he was at Tamborine Mountain rather than at Mount Cootha. By using the Push Mo Lo, the EMD was trying to establish where at Tamborine Mountain he was.[269] Dr Rashford is of the opinion it was unfortunate but not unreasonable in the circumstances that the QAS paramedics were dispatched to the address at Jimboomba, he stated,

> '*I think despite the caller doing their absolute best with, you know, trying to describe exactly where they were in the context of a life-threatening event having occurred to them, there were just numerous bits of information being thrown at the EMD. Now, we listened to the call retrospectively and I've listened to the call numerous times. To have a call like this in live mode when you can't go back and listen – well, they do have the ability in comms to go back, but you can't do it when you're on the phone to someone, listening to the pieces of information being thrown at them live and basically using the resources available to them at the time, following the wild card function, coming up with 210 Macdonnell Road, Jimboomba as a potential address and it being roughly in the area of the polygon, and given the context of the way the call had progressed and the circumstances, I thought it was – it's, you know, I thought it was not unreasonable for the EMD to have chosen that – that address, and on that basis – and that's the basis I made that statement*'.[270]

177. Dr Rashford said Mr Tunik confirmed the cross street for the Jimboomba

[265] T2.43, 21.
[266] T2.42, 44; T2.43, 0-10.
[267] Ex10.1.
[268] T2.44, 15.
[269] T2.44, 47.
[270] T2.45, 39.

address put to him by the ED. He says he does not know if he cognitively knew what was being asked of him and that you can hear the desperation in his voice. He notes sometimes in those circumstances people can mishear information or say 'yes' or 'no' with the best of intentions but says this led to the initial address at Jimboomba being chosen.[271]

178. Dr Rashford is unsure why the interpreter service available to QAS was not contacted.[272] They have access and in general are able to get the major languages relatively quickly.[273] He says in retrospect it might have assisted but he says if Mr Tunik did not know the address it would not have assisted.[274] It is the case, on the audio, Mr Tunik was able to relay three minutes into the call he was calling from Macdonnell Road at Tamborine Mountain.

179. There was no delay after the original dispatch, in the high acuity and the critical care paramedic Mr Amadeu arriving to the scene, as they were headed in the general direction when the address was updated.[275] Dr Rashford acknowledged Mr Beak and his partner could have compressed Ms Kohl's chest and managed her airway sufficiently until the more higher acuity clinicians arrived at the scene.[276]

180. Dr Rashford did not have the autopsy report when he provided his written response, he had assumed there would have been traumatic injury to the lungs, there was not. As to mechanism of death he states,

> '…*I think most likely is that she suffered profound respiratory fatigue which consequently resulted in low oxygen and probably significantly low oxygen along the way which had caused her heart to stop, and effectively then she stopped breathing. So, the only true treatment that I know would – ability to stop her from dying initially was to be able to remove the weight*'.[277]

181. In evidence a timeline was suggested to Dr Rashford. That is, if the call taker had identified the 210 Macdonnell Road Tamborine Mountain address instead of the 210 McDonald Road Jimboomba address at or around three or so minutes into the call, allowing for two minutes for dispatch, and allowing for five to eight minutes to the address plus six minutes to the accident site and one

[271] T2.46, 6-16.
[272] T2.54, 19.
[273] T2.57, 36.
[274] T2.54, 19.
[275] T2.47, 14
[276] T2.47, 28
[277] T2.48, 38

minute to extricate what the outcome would have been. In evidence Counsel Assisting suggested this would take around 23 to 26 minutes (this included the six minutes it would have taken QFES before they could have been underway on road).[278]

182. Dr Rashford said at 27 minutes into the call it was confirmed by a bystander that they thought Ms Kohl was deceased.[279] Noting Mr Tunik was away from the accident scene for a number of minutes flagging down the passersby before returning back to the accident scene, this meant there was no sounds able to be heard from Ms Kohl during this period.

183. Dr Rashford says it is likely Ms Kohl was in an agonal state for probably at least three to four minutes before dying.[280] He says so if the address had been clearly established earlier, the paramedics may have just arrived in the last few minutes of her being able to breathe and suggests it is unlikely they would have been able to stop her having a cardiac arrest.

184. Dr Rashford puts the cardiac arrest at around 22 to 27 minutes and qualifies this by saying it was difficult to tell if it was Ms Kohl or Mr Tunik making noises in the last five-minute period. In hindsight he thinks it was Mr Tunik but states,

> '…*the quality of the noises up until 22 minutes were rapidly deteriorating and I felt that – at some point, I thought they were probably more agonal sort of or very impaired vocalisations and – and ability to breathe during that period, and the person says quite clearly, 'We think she's – she's deceased" at 27 minutes into it*'.[281]
>
> …
>
> "*It's a really difficult one, and I – you know, the times are so – one minute here, two minutes there, but it's just, I think, this is, yeah, it's a terrible tragedy and I think it's – for us to be able to resuscitate her, both cognitively intact, and, you know, doing well, we had to get her out before the 22 minute mark, from my perspective'*.[282]

185. Dr Rashford informed the court of the changes in technology that have occurred since Ms Kohl's death. This includes an advanced mobile location system which has been available since 2020 and was rolled out across the country in

[278] T2.47, 38; T2.47, 0-5
[279] T2.49, 5
[280] T2.49, 6
[281] T2.50, 9.
[282] T2.50, 35.

2021. With a modern mobile phone (which up to 70% of people have) QAS is now able to pinpoint a call to within a five-metre radius outdoors and 25 metre radius if they are indoors.[283] The fire service has also now been included into the interagency Computer Aided electronic messaging system – ICEMS. It is 'live' and stops phone calls and is far more efficient.[284]

186. At the close of the inquest, Dr Rashford was requested to provide additional material about the training provided to EMDs.[285] He has confirmed the training of call takers includes education on the management of Triple 0 calls from non-English speaking callers.

187. When it is identified a caller is from a non-English speaking background, and no critical information is able to be obtained from the caller, the EMD is trained to select 'Language not understood (no interpreter in centre)'. The EMD is to engage the Translating and Interpretation Service ('TIS'). Once the EMD has engaged the TIS and established effective communication with the caller, they recommence the QAS process for dispatch. The phone numbers for the TIS are all immediately available to the EMD via a speed dial function. EMDs have ongoing professional development which includes exposure to calls from persons of non-English speaking backgrounds and are required to review changes to Standard Operating Procedures when that occurs (the relevant SOP has been amended three times since its inception in 2016).

188. There is no criteria to mandate the use of the TIS. If the EMD is able to establish critical information which allows an appropriate response to be formulated, there is the option to enter other non-critical details as unknown. The intent of this is to expedite the dispatch of appropriate resources and then, if necessary, engage TIS to obtain additional information later in the call cycle. There has been a significant increase in calls being referred to TIS since the accident.

[283] T2.50, 44; T2.51, 0.
[284] T2.51, 32.
[285] Ex E 11.

Coronial Issues

189. The scope of the inquest was confined to the Coronial Issues. Each is addressed below.

Coronial Issue 1:

The findings required by s45(2) of the Coroners Act 2003, namely the identity of the deceased, when, where and how, and what caused her death.

190. On the evidence and considering the analysis of the coronial issues below, I make the following findings:

a. The identity of the deceased person is Jennifer Kohl.

b. On 8 December 2017, Ms Kohl was sitting on the wheel arch of a four-wheel drive mower. The driver of the mower drove the mower down a steep hill, and to slow the mower turned sharply causing the mower to roll and entrap Ms Kohl under the mower.

c. Date of the death of the deceased person was 8 December 2017.

d. The place of death of the deceased person was at 200 Macdonnell Road, Tamborine Mountain.

e. The cause of the death of the deceased person was traumatic asphyxia.

Coronial Issue 2:

What caused the mower to roll and land on Ms Kohl.

191. The mower was being driven by Mr Tunik down the steep hill in an unused area of the property. Oral evidence given at the Inquest was that the trees in that area were overgrown and non-fruit bearing.[286] As the mower gathered speed, he could not slow it down. To try and slow the mower, Mr Tunik turned sharply to the side and in doing so, the mower rolled. As it did, Ms Kohl's upper body became entrapped under the upturned mower.

192. Even with the assistance of two bystanders, Mr Tunik was not able to lift the mower to free Ms Kohl from the weight of the mower on her chest.

193. Counsel Assisting submits as follows:

[286] T 1. 68,40.

a. That on balance, it is open for me to find it is likely the weight of the trailer and the tyres on the home-made trailer (which did not have any brakes) contributed to the difficulties Mr Tunik had in slowing the mower as he drove it down the hill. While Mr Tunik had not been specifically instructed not to drive in the unused area, it was not an area where he had been shown he was to harvest avocados from. It was not an area Mr Jacobi and Ms Singleton foresaw Mr Tunik would use the mower on and therefore the set-up of the mower with the trailer and balding tyres on the trailer, had not been identified as a potential risk.

b. While there is reference to the right-hand tyre of the mower having an air leak, there is inconclusive evidence this leak was present prior to the accident.

c. While there was free play in the steering joint of the mower, there is no evidence it contributed to the accident.

d. There was a failure to install rear wheel weights due to the removal of the cutting deck from the mower. It is possible this contributed to the balance issues of the mower but there is no expert evidence as to whether the failure to install these weights contributed to the mower rolling over. As such, it's not open for me to make a finding one way or the other concerning the effects of the removal of the undercarriage on the mower rolling over.

194. On behalf of Ms Cornelia Kohl, it was submitted that the following factors should be regarded as contributing to the rollover of the mower:

a. The mower was unsuited to the terrain and the task, particularly when paired with the trailer;
b. The mower and the trailer were inadequately maintained; and
c. The mower was operated unsafely.

195. The submissions of Counsel Assisting were accepted on behalf of Mr Jacobi and Ms Singleton, except as follows:

a. The impact, if any, which the trailer and tyres had on the braking capacity of the mower is a matter of expert evidence. There is no expert evidence of that kind before the Court.
b. There is no evidence before the Court about:
    i. the weight of the trailer and the tyres;

ii. the weight of Mr Tunik or Ms Kohl (noting that Ms Kohl was seated on one of the wheel arches of the mower);
iii. the speed of the mower at the time of the accident;
iv. the braking capacity of the mower; and
v. the coefficient of friction of the surface where the accident occurred at the time of the accident.

c. Evidence of these matters, and others, are necessary for me (with the assistance of an expert) to make a determination of the impact, if any, which the trailer and tyres may have had on the braking capacity of the mower.
d. Consequently, it is not open for me to make a finding that it is likely that the weight of the trailer and the tyres on the home-made trailer (which did not have any brakes) contributed to the difficulties Mr Tunik had in slowing the mower down as he drove it down the hill.
e. For the reasons detailed above, the installation of wheel weights was not mandatory for the functional tasks which were to be performed by the mower, following the removal of the cutting deck. The use of '*ballas*t' or '*wheel weights*' is only recommended, according to the manufacturer, when the mower is operating on '*difficult ground conditions*,' such as steeply sloping terrain or icy, wet or gravelled surfaces. That is addressed above and was not case for the mower.
f. In any event, Counsel Assisting has correctly submitted that there is no expert evidence addressing these issues which would permit an open finding to be made on the available evidence. That is particularly so, as Ms Kohl was seated on the left-hand rear wheel arch of the mower at the time it overturned, which may have impacted upon the stability of the mower.
g. The mower was not used, nor was it intended to be used, on a '*slope of the terrain exceeding the limits of the operating capacity of the mower'* as submitted by counsel for Ms Cornelia Kohl. It was to be used in the orchard and on the identified pathways, neither of which exceed the limits of the operating capacity of the mower.
h. Mr Tunik and Ms Kohl's operation of the mower in the disused area of the property was unauthorised, contrary to instruction and not anticipated. The fact that it was not anticipated is accepted by counsel for Ms Cornelia Kohl. That use by Mr Tunik and Ms Kohl changed the functional deployment of the mower and is a matter which, as is

accepted by counsel for Ms Cornelia Kohl, could not have been foreseen or expected by Mr Jacobi or Ms Singleton.

i. The submissions by counsel for Ms Cornelia Kohl in relation to Mr Couper and his opinions are addressed above. In essence, Mr Couper has not been established as an expert in the areas upon which he has sought to opine and the factual basis for those opinions has not been established. Mr Couper's opinions are unqualified and unsound. No weight should be given to Mr Couper's recorded interviews.

196. After carefully considering the available evidence, I accept the submissions made on behalf of Mr Jacobi and Ms Singleton on Coronial Issue 2 and find accordingly. In particular, I find that:

a. The mower was to be used in specific areas and for specific tasks shown to Mr Tunik and Ms Kohl, not in an unused and overgrown area where they had no cause to be.

b. In the circumstances in which it was to be operated, the mower was suitable, and it was not necessary for '*ballast*' or '*wheel weights*' to be installed.

c. In any event, and in the absence of expert evidence, I am unable to make a positive finding that the absence of weighting and braking mechanisms contributed to the accident.

d. Even making allowances for some difficulties with his English, there is inconsistency in Mr Tunik's various accounts of the events. Mr Tunik repeatedly encouraged Ms Kohl to ride with him on the mower despite her hesitations, that it was the first day she had ridden on the mower with Mr Tunik and that this was the first time he had driven the mower to the significantly sloped unused area where the accident occurred.

Coronial Issue 3:

Whether Mr Jacobi and Ms Singleton had implemented appropriate workplace health and safety measures in relation to the use of the mower on the property

197. Submissions made on behalf of Ms Cornelia Kohl and OIR (and to a lesser extent, Counsel Assisting) were to the effect that it was open for me to find that Mr Jacobi and Ms Singleton failed to comply with their WHS duties and obligations, involving the provision and maintenance of safe plant, the provision

of training instruction and supervision necessary to protect Mr Tunik and Ms Kohl from risks to health and safety arising from their work and compliance with approved codes of practice.

198. Coronial Issue 3 is predicated on the basis that Mr Tunik and Ms Kohl were engaged in work at the time of the accident. For the reasons that appear below, I do not accept that they were engaged in work at the time of the accident, such as to engage WHS obligations; the duties of which would have otherwise attached to Mr Jacobi and Ms Singleton. Just because Mr Tunik and Ms Kohl lived at the property where they undertook some work in return for board and food, does not mean that they were engaged in work at all times.

199. The steps required to comply with the duties imposed by the *Work Health & Safety Act* 2011 are limited to those that are '*reasonably practicable'* and are limited to workers while they are *at work in the business or undertaking*[287] or to risks arising *from the workplace*.[288]

200. After careful consideration of the evidence, I find that Mr Tunik and Ms Kohl were not engaged in work at the time of the accident, particularly having regard to the following factors:

    a. The timing of the accident was such that the 'work' had been completed. Mr Jacobi and Ms Singleton left the property at about 08:00 hours at which time Mr Tunik and Ms Kohl were at the mower ready to start work. The pattern of work was that they started in the morning to avoid the heat of the day and picked until they were finished for the day. At this time of year, it was the end of the season hence the number of avocados available to be picked were diminished. Consequently, all that was required to be picked were 4 crates of avocados, taking no more than 2 hours and requiring only one trip to the packing shed to unload. This takes the timing to approximately 10:00 hours. The 000 call was made at 11:20 hours, some 3 hours and 20 minutes after Mr Jacobi and Ms Singleton left the property.

    b. The work was to be undertaken in the orchard immediately below the homestead, in an area where Mr Tunik and Ms Kohl had been shown the day before and in which they were familiar. It was not steeply sloping, and it was in view of the homestead where Mr Jacobi and Ms

[287] Section 19(1) *Workplace Health & Safety Act* 2011.
[288] Section 20 *Workplace Health & Safety Act* 2011

Singleton's son remained whilst his parents went out.

c. The accident occurred in a disused area of the property, where there were no fruit bearing trees and it was overgrown. There was no reason for Mr Tunik and Ms Kohl to be in that area.

d. There were no fruit picking implements found at the accident site. Had they gone there to pick avocados, the picking poles would have been nearby as they were a necessary part of picking. There was no freshly picked fruit observable in the area. Instead, they were near a big tree in a secluded part of the disused area of the property.

e. The direction of travel as identified by the FCU was in the opposite direction to that which would have been used to travel from the house to the orchard or from the orchard to the packing shed.

f. The evidence of Ms Kerwin in the aftermath of the accident was to the effect that Mr Tunik asked Ms Kohl to get on the mower because he wanted to pretend the property was theirs and go on a ride together as a romantic gesture. In her post accident discussions with him, she formed the view Mr Tunik was remorseful for encouraging Ms Kohl to ride on the mower when she did not want to. Her evidence was consistent under cross examination. I formed the view that her evidence was credible and accept it over the suggestion that they were picking avocados (working) at the time, as per the evidence of Mr Tunik.

g. Paramedic Amadeu's evidence was consistent with Ms Kerwin's on the issue of Mr Tunik informing him immediately after the accident that he had repeatedly requested Ms Kohl to get on the mower, and that he was remorseful for doing so in the circumstances. Equally, his evidence was consistent under cross examination. I accept his evidence.

h. Both Mr Jacobi and Ms Singleton gave evidence that in discussions in the aftermath of the accident, Mr Tunik disclosed to them that he had coaxed Ms Kohl to ride on the mower with him as a romantic gesture. I have accepted them to be credible witnesses and, to the extent their evidence is consistent with Ms Kerwin and Mr Amadeu, I accept their evidence on the nature of the mower ride by Mr Tunik and Ms Kohl.

i. In fortification of the above accounts, the most telling in my view is the evidence from Mr Tunik himself on the romantic nature of the outing,

from the aborted WHS hearing. He said, '*She walked down and I took the tractor and we met at the tree where we quickly fucked*'. That statement has been confirmed as accurate by an independent expert. It is difficult to accept that Mr Tunik would make that up.

201. Consequently, I find that Mr Tunik and Ms Kohl had completed the work that had been assigned to them on the day of the accident and had engaged in sexual intercourse in a disused and out of sight part of the property, on a joyride pretending the property was theirs. Such activity on the mower was unauthorised and in departure from the instructions given to them. It was not foreseeable behaviour by Ms Jacobi and Ms Singleton.

202. To the extent it is relevant in view of the above, I find that:

    a. The mower was fit for the tasks which it was to perform. It became unsuitable when Mr Tunik chose to operate it in the disused area of the property and in the manner which he did.

    b. It was in working order and functional. Ms Singleton had identified no functional issue with it for those tasks, in circumstances where she used it '*all the time'*.[289] For the reasons discussed above, weighting mechanisms were not necessary.

    c. A risk assessment had been undertaken by Mr Jacobi and Ms Singleton regarding the task of picking avocados, albeit not in documented form. Hazards identified were in relation to the operation of the mower and trailer for the purpose of picking avocados and transporting them to the packing shed. There were not any steep inclines/declines in those areas.

    d. The instruction and supervision given to Mr Tunik and Ms Kohl was sufficient instruction and supervision of two adults for the tasks which they were to perform. Despite Mr Tunik's professed familiarity with like machinery, Ms Singleton was '*pedantic*'[290] in her practical demonstration of the operation of the mower, and she was satisfied Mr Tunik was competent when he demonstrated his understanding of that instruction. Ms Kohl was present for this and in particular, for the instruction that passengers on the mower were prohibited. That training

[289] T1.110, 40.
[290] T1.32,45.

took place on the very path where they were to traverse for the allocated work of the day. No evidence was led to show a different level was practicable or ought to have been provided. I accept the submission that demonstrated competency by performing the required task under direct supervision is a widely accepted method of confirmation of instruction and training, particularly in circumstances where language may be a barrier. I accept that the work process that was developed and implemented for Mr Tunik and Ms Kohl was adequate and reasonably practicable in the circumstances.

e. I am not persuaded that insufficient guidance was given to persons of a non-English speaking background like Mr Tunik on where the mower could be operated on the farm. Mr Tunik had operated like machinery before. He understood English sufficiently. It does not necessarily follow that when a person lives at a place of work, that they can use plant and equipment, particularly heavy machinery like the mower, for non-work-related or recreational activities. It also does not follow, in my view, that Mr Tunik and Ms Kohl had to be specifically informed where on the property they must not go. I am satisfied they were given sufficient instruction on where they were to pick avocados from for work allocated to them. The area of the accident was not one of those areas. The overgrown state and topography of that area was such that common sense ought to have prevailed, as was the inappropriate use of farm equipment in circumstances where they knew the owners were absent from the property.

Coronial Issue 4:

Whether the Queensland Ambulance Service appropriately dispatched the paramedics and Queensland Fire and Emergency Services to the accident scene.

203. I accept the submissions of Counsel Assisting as they relate to this issue and for clarity of these findings, I repeat them.

204. The EMD was faced with a very challenging call. It is not clear why she did not access the TIS. It may be that she felt she was able to distill the necessary information and had confirmed the address in a relatively timely manner (albeit

wrongly).

205. Mr Tunik confirmed the cross street with the EMD. It is likely the EMD had entered the most common spelling for Macdonnell Road as McDonald Road, resulting in the Jimboomba address being populated. Once the error had been identified, the first QAS response team were quickly re-directed to the correct address. The incorrect address did not delay the response of the higher acuity QAS resources to the accident scene.

206. It is difficult to be critical of the EMD in the circumstances of the case. It is only after analysing the call in some detail and listening to it several times, that it can be identified that there was an issue in the EMD confirming the address with Mr Tunik. While he said yes to the proposed cross street, the suburb of Jimboomba was not confirmed with him in circumstances he had told the EMD he was in Tamborine Mountain (after initially saying he was in Mount Cootha). In hindsight the use of TIS would likely have been helpful.

207. On behalf of the parties, it was submitted:

<u>Ms Cornelia Kohl</u>

a. The family adopts the submissions of Counsel Assisting on this issue.

b. Whilst TIS should have been engaged, and also that the Jimboomba location should have been put to Mr Tunik, it is difficult to distill any specific criticism which should be applied to the management of Mr Tunik's call by the operators in the circumstances of:

    i. A very difficult and emotive telephone call;

    ii. The conflicting information being provided by both Mr Tunik and the bystander, Mr Bray; and

    iii. The inconclusive Push MoLi information, which suggested that the Jimboomba address was as likely as the Mt Tamborine address.

c. It was also acknowledged on behalf of Ms Kohl that changes have been made to procedure and technology since the accident.

<u>OIR</u>

d. The OIR adopts the submissions of Counsel Assisting on this issue.

<u>QAS</u>

e. QAS adopts the submissions of Counsel Assisting on this issue, and says:

i. The professional conduct of the paramedics who attended Ms Kohl, and who gave evidence in statements and at the Inquest, were not called into question by the Inquest issues or challenged by Counsel Assisting or the family.

ii. The relevant circumstances include the receipt of conflicting information from multiple sources and that the EMD made the best use of the QAS systems that were available at the time; the functionality of which has since been surpassed.

iii. The EMD was not called by any party to give evidence at the Inquest.

iv. There is no submission before the Court that the QAS did not act appropriately in the dispatch of emergency services in the circumstances as they stood on 8 December 2017.

v. QAS appropriately dispatched the paramedics and QFES to the accident scene.

208. Mr Jacobi and Ms Singleton made no submissions in relation to this issue.

209. I find that QAS appropriately dispatched the paramedics and QFES to the accident scene in the circumstances.

Coronial Issue 5:

Whether there was a delay in the dispatch of emergency services, and if so, could this have been avoided, and would it have made any difference to the outcome.

210. I accept the submissions of Counsel Assisting as they relate to this issue and for clarity of these findings, I repeat them.

211. There was a delay in the original dispatch due to difficulties in confirming the address, albeit wrongly. By dispatching the first QAS response team to the wrong address, this added to the delay. The timeline was discussed in evidence and has been outlined above.

212. It is difficult to make a finding that the delay could have been avoided, given

the challenges faced by the EMD in taking the call. However, as canvassed above, even if the first QAS response team could have been dispatched three minutes into the call, the arrival to the scene would on balance have made no difference to the outcome. In the alternative, there was a high possibility Ms Kohl would have suffered a hypoxic brain injury due to the prolonged asphyxia she sustained before going into cardiac arrest.

213. On behalf of the parties, it was submitted:

Cornelia Kohl

a. The family adopts the submissions of Counsel Assisting on this issue, for the reasons set out in Coronial Issue 4.

OIR

b. The OIR adopts the submissions of Counsel Assisting on this issue.

QAS

c. QAS adopts the submissions of Counsel Assisting on this issue, and says:
    i. It is uncontroversial that there was a delay in dispatching emergency services to the correct address during the 000 call. Counsel Assisting fairly and comprehensively details the unenviable circumstances in which the EMD was attempting to confirm the correct address to dispatch emergency services to.
    ii. Counsel Assisting effectively submits that the evidence does not support a positive finding that the delay in dispatching emergency services by the QAS could have been avoided n the circumstances.
    iii. Counsel Assisting also acknowledges, consistent with the evidence of Dr Stephen Rashford, that a possible earlier arrival on scene by QAS would likely have made no difference to the outcome.
    iv. There was a delay in the dispatch of emergency services to the correct address which could not have been avoided in the circumstances. The evidence before the Court is to the effect that had it been possible to avoid the delay, the outcome was unlikely to have been different and if different unlikely to have been materially so, because of hypoxic brain injury.

214. Mr Jacobi and Ms Singleton made no submissions in relation to this issue.

215. I find that the delay in the dispatch of emergency services to the correct address could not have been avoided in the circumstances. If it had been possible to avoid the delay, the tragic outcome was unlikely to have been different or materially so because of the lack of oxygen Ms Kohl received at relevant times.

Coronial Issue 6:

What measures are in place to safeguard international backpackers, such as Ms Kohl and Mr Tunik, undertaking farm work, and are these measures adequate.

216. This issue has been comprehensively addressed by the information provided by the OIR and DHA, which is in evidence in these proceedings. There is information provided through various mechanisms about the rights a young person on a Working Holiday visa has regarding workplace health and safety.

217. It was not able to be canvassed at inquest as to whether Ms Kohl and Mr Tunik had been aware of these rights prior to accepting the offer to work on the farm by Mr Jacobi and Ms Singleton.

218. On behalf of Ms Cornelia Kohl, it was submitted that:

    a. DHA:

        i. introduce information about work health and safety on the website;

        ii. link workers to appropriate regulators in each state to obtain more information about their safety at work; and

        iii. provide options to obtain communications and information in languages other than English.

    b. WorkSafe Australia and WHS introduce:

        i. simple resources for working holiday makers, explaining their rights to a safe workplace and how concerns can be raised, and for those resources to be made available in languages other than English;

        ii. resources, potentially up to a code of practice addressing persons conducting a business or undertaking engaging working holiday makers and providing:

1. minimum requirements to adapt training and instruction for workers from non-English speaking backgrounds; and

2. requirements for simple signage in the workplace about responding to an emergency, including the Australian emergency telephone number (000) and the address of the workplace.

iii. Increased resources for regulators to undertake safety audits on farms, with specific emphasis on safety of workers vulnerable to exploitation in the agricultural sector.

219. On behalf of the OIR, it was submitted as follows:

a. WHS has made available a Young Worker Safety Toolkit, designed to assist those who engage with young people aged 15 to 24 years of age about work health and safety. Checklists are provided to assist employers in meeting their obligations and to identify any gaps;

b. Other resources include an eNews subscription service for employers and published general information regarding work health and safety awareness;

c. WHS has a dedicated agricultural unit which proactively offers advice to businesses, monitors compliance with WHS legislation and enforces as required;

d. Farm Audits can be undertaken although there are no specific auditing or reviews of farms employing young people participating in the Working Holiday Maker Program or other schemes. There are, however specific auditing of agricultural and horticultural sectors (cattle feedlot, livestock industry and macadamia nut growing industry) three times annually which, relevantly, ascertains information relating to how the employer accesses their workers and is designed to identify workers such as backpackers. One section captures training for working holiday makers who operate mobile plant that is at risk of plant rollover. Inspectors seek out and speak to these workers to elicit certain information;

e. The implementation of various campaigns to highlight common hazards on rural properties and to advocate for safe working practices on farms; and

f. The appreciation that WHS does not have jurisdiction over working holiday maker and visa worker programs, which fall within the scope of the Commonwealth.

220. In response to the submissions made on behalf of Ms Cornelia Kohl, the OIR submitted:

a. Information for workers from overseas, including working holiday makers, has recently been published in 22 languages on the Safe Work Australia (SWA) website. The information includes an explanation of the obligations of the employer and worker as well as a checklist to complete before starting work. The contact details of the relevant work health and safety regulators are also included in case further information is required.

b. Work health and safety codes of practice are typically targeted at an industry or type of work, for example, the *Excavation Work Code of Practice 2021* or the *Scaffolding Code of Practice 2021*. This means workers and employers in industries covered by a code of practice can largely refer to a single code to understand how to meet their work health and safety obligations. As individuals from non-English speaking backgrounds work across a range of industries, it is not in the interests of practicality or accessibility for a specific code for this cohort. However, in industries where non-English speaking workers are commonly found, such as in agriculture, content has been included in the relevant codes of practice to make sure that employers deliver on-site training and display safety signage that can be understood by those with a low comprehension of English. In this regard, the *Rural Plant Code of Practice 2004*, the key code of practice for the rural and agricultural industries, and the *Sugar Industry Code of Practice 2005* are currently under review, with the updated versions to make these obligations clear. In addition, all Work Health and Safety Queensland (WHSQ) codes of practice have a strong focus on employers consulting with their workers. A consultation process will allow the employer to identify whether their employees are young, inexperienced or lack a strong understanding of English. The employer can then manage these risks appropriately.

c. In addition, employers must manage the additional risks which arise if they employ workers who undertake remote or isolated work. Remote

or isolated work is work that separates someone from other people and can make it harder to get help such as rescue, medical assistance, and emergency services. This can be due to location, time, or the nature of the work being done. Under the *Managing the Work Environment and Facilities Code of Practice 2021,* effective communication systems, such as radios or mobile phones (if there is sufficient network coverage), should be implemented so workers can call for help in case of an emergency. Depending on the communication system used, workers should know how to call for help; whether that is to Triple Zero or otherwise.

d. With respect to the resourcing of farm audits, the OIR overview of the regulatory environment relevant to this matter outlined that auditing is just one approach among numerous regulatory interventions used by OIR to raise maturity across the agricultural industry. Other ways of engaging with industry to improve compliance include publication of incident alerts, communication and education campaigns, and direct contact with agricultural stakeholders on codes of practice and safe methods of work.

221. In submissions made on behalf of Mr Jacobi and Ms Singleton, I was helpfully referred to a report to the Western Australian WorkSafe Commissioner and the latter's response in March 2023, following an inquiry into the agricultural industry on 22 June 2022 after 12 work related deaths were reported in a 12-month period. Various recommendations were made and adopted which focussed attention on the farming sector and the prevention of fatalities and serious injuries, including the following:

a. That in the allocation of resources, the agricultural industry be prioritised, with the establishment of a dedicated specialist agricultural team including inspectors with a proactive focus on the development of education and information activities including the following activities:

i. proactive and reactive inspections;

ii. attendance at industry events;

iii. developing and updating a comprehensive industry webpage;

iv. translation into languages relevant to the workforce;

v. development of a newsletter directed to framers and their

workers; and

vi. engagement with industry media to publish and promote farm safety).

b. The development of a free advisory service;

c. To raise the industry's awareness of safety;

d. The development of a suite of codes of practice and guidance notes directed to the agricultural industry;

e. Engagement with machinery and equipment manufacturers and dealers to draw attention to the need for machinery and equipment to be fit for purpose, to remove the need for farmers to modify them. A targeted campaign is to be employed, to include things like lone worker emergency contact systems; and

f. Consideration of timely provision of information to the agricultural industry about the causes of fatalities and serious injuries, as well as preventative actions available to the industry.

Recommendations in accordance with S 46

222. Section 46 of the CA provides that a Coroner may comment on anything connected with a death that relates to:

a. Public health and safety,

b. The administration of justice, or

c. Ways to prevent deaths from happening in similar circumstances in the future.

Backpacker safety

223. To the extent that this issue remains relevant given the above findings, I make the following comments.

224. I accept it would be difficult to provide further specific guidelines to employers due to the very broad range of work that young people undertake while on a working holiday.

225. I also accept there may be some merit in the suggested recommendations by

the OIR in improving the information on worker rights and access to the information available to young people coming to Australia. The DHA is open to considering the suggested recommendation made by the OIR.[291]

226. Having considered the evidence available to me, I make the following recommendations:

a. That the DHA consider including information and links about workplace health and safety (amongst other statutory rights and obligations) on its website or on a specific central 'one stop shop' webpage, so that from early on in the process visa applicants may become aware of the laws and protections in workplaces in Australia. This could include some information on the overarching principles of a safe workplace and links to the websites of the workplace health and safety regulator in each jurisdiction.

b. As there are a number of Commonwealth agencies that communicate with workers undertaking working holiday programs, initiatives could include a 'one stop shop' communications campaign and website that provides an initial point of contact for queries including workplace health and safety queries (and also, for example queries about workplace rights and pay, or other issues such as health, tax, anti-discrimination laws etc) and issues for working holiday makers and other temporary migrant workers.

c. For the Federal Government to undertake a coordinated national study to build an evidence base for WHS risks specific to migrant workers, to inform future policy development.

d. That WHS consider the recommendations arising out of the Western Australia WorkSafe Commissioner's report, to identity if any of the recommendations are applicable for improvements to the framework in Queensland.

QAS

227. On behalf of Ms Cornelia Kohl, it was submitted that QAS give consideration to whether additional training could have improved the skill of call takers in:

[291] Ex H 2,2.

a. Identifying that the caller was of a non-English background and assessing TIS promptly;

b. Managing the communication difficulties associated with trauma; and

c. Appropriately verifying the address when uncertain of the location.

228. In making the submission in the preceding paragraph, it is not assumed by the family that the additional training would necessarily have altered the outcome of this accident, but rather only that it would be appropriate for QAS to give consideration to whether there are any improvements to be made beyond those already adopted (and which are acknowledged).

229. Counsel Assisting submits that the QAS has adopted more advanced technology since the accident which would have resulted in Mr Tunik's whereabouts being located within five metres of where he was standing with his mobile phone. Further, there is evidence of adequate training to EMDs on TIS, already in place.

230. On behalf of QAS, it was submitted that it is not the case that the difficulties in verifying the correct address in this instance were attributable to the skill of the EMD. Counsel Assisting made the sage observation to the effect that at least until it was known the address was wrong, the EMD did not realise that the QAS had been dispatched to the wrong address, which likely informed her judgement. The evidence does not support a conclusion that the EMD did not realise the caller was from a non-English speaking background or that the caller's trauma was mismanaged by the EMD. The introduction of Advanced Mobile Location technology in 2020 assists EMD's to ascertain the whereabouts of callers, providing further redundancy where there is confusion as to the location of a caller.

231. Given the extensive training EMD's receive and received, as detailed in Dr Rashford's evidence[292], and my finding in relation to Coronial Issue 4, it is difficult to see the utility in making the recommendation sought by Ms Cornelia Kohl and I decline to do so.

[292] Exhibit 11.

Referral in accordance with S 48

232. Section 48 of the CA states:

> **Reporting offences, corrupt conduct or police misconduct**
>
> (1) A reference in this section to information does not include information obtained under section 39(2).
>
> (2) If, from information obtained while investigating a death, a coroner reasonably suspects a person has committed an offence, the coroner must give the information to –
>
> (a) for an indictable offence – the director of public prosecutions; or
>
> (b) for any other offence – the chief executive of the department in which the legislation creating the offence is administered.
>
> ….
>
> (emphasis added)

233. At Chapter 9.13 (Management of s48 referrals) of the State Coroner's Guidelines 2013 ('the Guidelines'), the Guidelines stipulate it is necessary should I make a referral under s48 of the CA that it be set out clearly at the conclusion of my findings. The Guidelines state:

> *Being informed that the coroner intends referring the material to prosecutorial or disciplinary bodies for further consideration, and if not why not, is an essential part of a coroner's function. Bereaved family members and members of the public expect at the end of the inquest to know what happens next. If the answer is "nothing", they will want to know why.*
>
> *Although this approach involves a risk to reputation, that can be ameliorated by the coroner making clear the low threshold on which the obligation to refer arises and referring to the role of the DPP in determining whether charges should be brought.*
>
> *It follows that the right to make submissions should be confined to Counsel Assisting and counsel for the person or organization subject to possible referral.*

234. Pursuant to s14(5) of the CA when investigating a death, a Coroner must comply with the Guidelines and any directions issued to the Coroner to the greatest practicable extent.

235. Given my findings in relation to Coronial Issue 3 above and noting that the oral evidence of Mr Jacobi and Ms Singleton given at Inquest and any derivative evidence arising from it is not admissible for this purpose[293], no WHS offence can arise and accordingly a referral is not appropriate.

236. To the extent that any residual concerns exist about the general condition of Mr Jacobi and Ms Singleton's farm plant and equipment, I acknowledge that in circumstances where this has been sharply brought into focus in these proceedings and the WHS prosecution, I am satisfied that Mr Jacobi and Ms Singleton have taken this issue seriously such as to have a wider appreciation of risks that may present in circumstances like this and to act accordingly.

Mr Tunik

237. Pursuant to Section 48(2)(a), I have formed a reasonable suspicion that an indictable offence has been committed by Mr Tunik.

238. Not having received a submission from Mr Tunik after affording him an opportunity to make a submission, I make a referral to the Office of the Director of Public Prosecutions.

Conclusion

239. This was a tragic accident which resulted in the death of a young woman who was on a back packing adventure, exploring Australia. Her death has had an impact on many people, in particular her mother who travelled from Germany for the inquest.

240. At the conclusion of the evidence at the Inquest, I invited Ms Kohl's mother to provide a statement. A statement was read out in full by Ms Kohl's legal advisors. Suffice to say that that statement was heartfelt and sincere.

241. I express my sincere condolences for the loss suffered by Ms Kohl's family. It is hoped that the coronial process and these findings will assist those people affected by Ms Kohl's death to make some sense of the tragic accident.

[293] S 48 (1) CA.

Findings required by S 45

Identity of the deceased – Jennifer Kohl (DOB 04 December 1990)

How she died – On 8 December 2017, Ms Kohl was sitting on the wheel arch of a four-wheel drive mower. The driver of the mower drove the mower down a steep hill, and to slow the mower turned sharply causing the mower to roll and entrap Ms Kohl under the mower.

Place of death – 200 Macdonnell Road
TAMBORINE MOUNTAIN
QLD 4272 AUSTRALIA

Date of death– 08 December 2017

Cause of death – 1(a) Traumatic asphyxia

I close the inquest.

Carol Lee
Coroner
SOUTHPORT