STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of **Blaine Rozs**
Hearing dates:	**25-27 July 2016** **5 October 2016**
Date of findings:	**13th December 2016**
Place of findings:	State Coroners Court NSW
Findings of:	Magistrate M.Jerram
Catchwords:	CORONIAL LAW
File number:	2014/353755
Representation:	Counsel Assisting the Coroner, Sgt Stephen Kelly
Non publication order:	**1/ Transcript and recordings of 000 call** **2/ Minutes of Turfco Aust P/L Board meeting at Tab 6.3 pp 45-58** **3/ Two videos-tab 34 and 35 of Volume 5. Volume 5 tab 36- 3rd video to be allowed with removal of identifying pictures or voices of civilians.**
Findings:	**Blaine Rozs died on December 1, 2014, at the Turfco site at 270 Princes Highway, Jaspers Brush, New South Wales, of traumatic asphyxiation suffered as the result of an accidental fall from a harvester.**

Recommendations:	**1. To the Minister for Health** That the NSW Ambulance Service conduct a review of the evidence and findings in relation to the death of Blaine Rozs for the purpose of determining whether any changes are necessary to its protocols and procedures for persons trapped under heavy equipment , with a view to improving patient outcomes prior to the arrival of emergency service personnel. **2. To the Minister for Innovation and Better Regulation and the Chief Executive Officer for Safework** 1) Prior to sale, suppliers of sod (turf) harvesters should consider the provision of mirrors/devices that allow the operator a larger field of vision to the rear of the plant and a reversing obstruction alarm to be installed. 2) Currently owned /operated sod (turf) harvesters, PCBU's should consider retro fitting mirrors/devices that allow the operator a larger field of vision to the rear of the plant and a reversing obstruction alarm where there is a risk of a person being struck. 3) Turf harvesting businesses are to implement a system of work where: a) the operator is to remain in control of the harvester at all times whilst the plant is in operation/use. b) whilst in operation the harvester is only to be driven in reverse when absolutely necessary c) stackers leave the harvester and move into a safe position where they can be seen by the operator d) the operator does not reverse until identifying that the stackers are in the safe location e) whilst reversing the operator monitors the path of travel and that stackers remain in sight out of the travel path, and f) the operator stops when the obstruction alarm sounds until they check the path is clear, g) workers are trained in the system of work 4) Turf harvesting businesses are to regularly monitor the work through supervision and consultation to ensure the system is being used and is effective.

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The Coroners Act in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of Blaine Rozs.

Introduction

Blaine Rozs was a fit, happy young man of 19, with a loving family and a job which he had had for two years, since he left school, for Turfco, a company growing and supplying turf commercially, where he was liked and thought highly of by his colleagues. He played rugby league at a high grade.

On December 1, 2014, Blaine arrived at work at approximately 5 am with his work colleague, Deejay Seymour. Prior to commencing work, DJ (as Mr Seymour will now be called) changed the blade and refuelled the Harvester on which they worked together.

Normal practice was for both of them to work on that harvester, DJ driving and Blaine stacking the cut turf onto a pallet. The driver would line the harvester up with the row of turf to be cut. The harvester would then be set to slowly and automatically move forward (at approximately a slow walking pace), cutting the turf into strips and delivering them via a conveyer belt to the rear of the harvester.

Blaine, the stacker, would stand on the side platform next to the turf pallet which was located on the rear, and stack the turf. The driver would leave his seat to assist with the stacking until the pallet was full, then return to the drivers seat, and either reverse or drive forward to the loading area where the turf would be loaded onto a truck.

On this day, 20 rows of turf had been cut. DJ placed the tractor in reverse back along the previously cut row to the unloading area, with Blaine standing on the tractor's platform behind him, on the driver's side. After a few checks, he realised that Blaine was no longer there, and stopped, got off, and saw Blaine trapped underneath the tractor.

Other colleagues, including Steve Franks and Scott Parker came immediately, as they saw DJ calling and running towards them. Steve Franks and DJ both observed that the step, or folding platform, of the cutter was folded up , which is not supposed to be done until reaching the truck. Blaine was unresponsive. Although thought by some to be conscious, this now seems unlikely. Steve Franks rang 000 at 7:01. He stayed on the line with the operator until the ambulances and paramedics arrived at 7:15

While waiting, an attempt was made to partially lift the tractor off Blaine with a forklift. By the time the Paramedics attended to Blaine, he showed no vital signs. He was pronounced deceased. A Limited Autopsy two days later found that he had died of Traumatic Asphyxia.

The Issues

1. What caused Blaine to fall from the tractor?

2. Did Turfco have appropriate safety and training practices in relation to the operation and use of the tractor?

3. Should attempts have been made to remove the tractor off Blaine sooner than advised by the 000 operator?

4. Are there recommendations which could improve workplace safety and patient outcomes arising from this tragedy?

The Evidence

A. Those from Turfco, including eyewitnesses:

DJ Seymour was the first witness. He was clearly still very distressed by the accident and the loss of a friend. Understandably, he had problems remembering every detail, and at times contradicted what he had said in his original statements and interview. It should be said that there was absolutely no evidence to suggest that any fault lay with DJ, or that he was not being truthful to the court. My impression was that he was open and honest, despite some hiccups of memory, doubtless due to the trauma of the incident.

For several years, he had operated the tractor as originally (albeit briefly) trained, without mishap. The Operator's manual which comes with the harvester states: "Never try to get on or off a moving harvester before leaving position. Place in park, lower implement to the ground, stop the engine and remove the keys," but he and the other employees had never had any refresher training or read the Operations manual . DJ did say that he had seen Blaine several times lift the rear platform of the tractor while the tractor was still moving, and told him not to do so as it was dangerous, but that Blaine had 'stopped for a while then started back up again'. He confirmed that the rear platform was up when he stopped and found Blaine trapped and that they had all been previously instructed by Scott Parker not to lift it while the harvester was in motion. He raised the possibility that Blaine bent down, picked it up, and slipped, although he did not see that happen.

Scott Parker is the Logistics Manager for Turfco.
He admitted that some of what he had said in his Safework interview was not wholly truthful, but he rectified that in his open evidence to the court. He was immediately on the scene of the accident, heard Blaine give a couple of deep gut-wrenching breaths ' which sounded like the last bit of air leaving his lungs. He was purple in colour. He did not look at the platform. He described lifting the tractor 2 inches with the forklift after about 8-10 minutes

while waiting for the ambulance, and when Steve Franks, who was on the line, was told to try by the 000 operator.

It was Scott's own view that Blaine was dead after the two breaths which he had heard. He also confirmed that the practice of the off-sider, or stacker, riding on the back had been the practice at Turfco ever since he had been employed there. A few months before the accident, he, Scott, had seen Blaine lifting a platform while the harvester was mobile and had spoken to him about it as it was dangerous, but like the others, he himself had never read the manual, and was not aware of the prohibitions or recommended systems for leaving aside the stray turf. There are now new procedures in place, but there was nothing, in retrospect, in Scott's view, that he would have done differently at the time.

Steve Franks has been a driver at Turfco for 11 years. He was using the forklift when he saw DJ waving frantically, and drove straight there, noticing that the rear platform was up when he arrived. He immediately dialled 000, calling out to Blaine but receiving no response, as he did so. He described noises from the body as if exhalations, not inhalations. The scene was pandemonium. He spoke to the Operator and then to a Paramedic on line, and was initially told not to lift anything because of the danger of that causing a bleed-out. When asked if Blaine was awake, he said he did not use the word 'semi-conscious,' though after about 9 minutes he advised the Operator that there was no longer any breathing. In oral evidence Steve said that he felt no pulse, and felt from the start that Blaine was gone, but really couldn't remember the details very much at all.

The Farm Manager for Turfco is Dave Smith. He agreed that the 'Safe System' used at the time was contrary to the Operations Manual, but insisted that regular 'toolbox' talks were held on site, with an emphasis on the importance of the tractor and its workers staying in the designated 'safety zone' and the stacker being in greater danger walking by the tractor than riding on it. He used the Manual for maintenance rather than safety. He said that he did realise that the Manual stipulated only one method of cutting, that it had been considered and rejected for the firm's normal practice, with no need to change it. Since the accident, there have been many changes and improvements, and all recommendations of the Manufacturer are now met. The harvester now used is automatic, and the old ones no longer used. Reverse mirrors and an alarm are installed. New signage is prominent on the machine. Drivers are instructed not to alight, and to reverse as little as possible. Safety Consultants have been engaged who visit quarterly and review and advise on all safety and training issues.

The brothers Marcus and Joseph Rogers gave brief evidence, Marcus being questioned about his having fallen off the back of a moving harvester about 3 years before but dismissing it as a trivial incident without injury, and in quite different circumstances. Joseph reiterated that Parker had regularly instructed everyone not to lift the rear platform while the harvester was moving. Both men mentioned the exhalation or expelling of air which they heard come from Blaine, as not sounding like breathing.

Their father, Gavin Rogers, who founded Turfco, is now an Adviser and part-time Farm Manager. He was defensive about the company's work practices, noting that the modifications now made both to the harvester and the practices have been done by no other company in Australia, and that the firm never received a visit from Workcover (as it was previously named) to advise or recommend any alternate methods. He said that there had been no difficulty after the accident in changing systems.

Mr Rogers had obviously taken very very seriously the ramifications of Blaine's accident which seems to have been the first in 30 years of Turfco's operation. Seminars are held, and a magazine sent out regularly, as well as safety notices regularly being sent to employees by text. Presentations have been made to the peak body, TurfAustralia, by Turfco to warn about the accident and its problems, and to emphasise Safety and Health. There are ongoing consultations with Safework. As he said, any Recommendations should be industry-wide.

B. Ambulance personnel:

Mr GRAHAM MCCARTHY, Director of Patient Safety and Clinical Quality for the Ambulance Service, was asked to explain the protocols for Emergency calls and policies, in particular why it is common practice to tell a caller not to move a patient or any weight unless there is immediate further danger.

It is a very difficult question. As Mr McCarthy agreed, it is not possible to assess the knowledge of a caller, particularly in a crisis, so that, Safety remaining the key consideration, it is generally considered better to say 'Don't move unless absolutely necessary". A civilian caller is not always able to tell consciousness from lack of consciousness (the levels of which are not defined in any case), breathing or movement. Operators no longer query whether there is a pulse for that reason. Breathing, he noted, is far more important for the Operator to know in order properly to advise, but not always clear to the observer/caller, as in this case.

Mr McCarthy asserted that he would not have advised the personnel on the ground, as the Supervisor Russell ultimately did, to partially lift the weight, (the tractor was over 4000kgs, so taking 'a little weight' would never have assisted much,). He believes it would have achieved nothing but more danger.

On the other hand, he agreed that while not unique, this was a very difficult case, that more questions may have been asked usefully and that the Supervisor might have stayed on the call till ambulances arrived but for his other duties. It was impossible to say whether Blaine's outcome may have been better if the colleagues had used a forklift at the beginning to remove the tractor, but the risks involved were huge.

Asked to comment on a different view from the Australian Resuscitation Council, Mr McCarthy agreed that there needed to be more overall discussion to ascertain whether it was possible to formulate a common protocol for crush accidents.

As for the Operator, having listened to the call, while he agreed that maybe more questions could have been asked, he described the prime of an Operator was to direct an ambulance to the scene as quickly as possible, which occurred this day. In this matter, he stated that he did not believe that there was anything done or not done which might have saved Blaine.

STEPHEN HAZELTON was the first paramedic on the scene to assess Blaine. Until then, he had not been aware that Blaine had stopped breathing, for as he said 'we don't take a lot of notice of bystanders'. He also explained that not much information is passed to them as they travel, other than the first brief description and location details. 'When a 1A is called (a cardiac arrest), 2 vehicles are taken. Although he did not put on a helmet, because of wanting to get to Blaine quickly, he crawled under the tractor, because he is small, using a defibrillator with pads and found no response, no movement ,no radial or carotid pulse, fixed, dilated pupils, no electric activity, and declared the patient systole'. There was a pool of blood near Blaine's head from his nose and mouth.
The other highly experienced paramedic from whom the court heard was SCOTT STYLES.

He found Mr Hazelton under the tractor with Blaine, whom he observed to be lying directly across the rear axle with his feet trapped underneath the rear right wheel. He was informed by Paramedic Hazelton that the patient was deceased. Once the Forensic Services Police Officer had completed his investigation, the paramedics began to extricate the patient. They did not use the forklifts. They dug underneath and forward of the deceased's feet and inflated a low pressure airbag, placing cribbing under the chassis of the tractor as it rose. Once the weight of the chassis had also been lifted off the torso, they were able to slide the body from underneath the tractor. This process took 20 minutes. Scott Styles stated that they would have done nothing differently if the patient had been alive, (apart from being more expeditious) and that this process was according to their training. He would never have used the forklifts which were there, as there was no control over their action and the first priority was the safety of bystanders and emergency personnel as well as the patient. Had the forklift been used and slipped, it could have been worse for the patient, although as he said,' every situation is different, needs to be taken case by case, and always depends on the particular circumstances.'

The Medical Experts

The inquest had the benefit of both written opinions and oral evidence from two independent experts, Dr Toby Fogg and Professor J. Duflou, each of whom agreed that the cause of Blaine's death was the rare condition of Traumatic Asphyxia.

DR FOGG is an Emergency Physician and Pre-Hospital and Retrieval Specialist and the Medical Director of Careflight. Although he had some criticisms of questions asked, or not, by the 000 operator, and decisions made, or not, as to lifting the harvester from Blaine earlier, he did state that he had never seen machinery removed, prior to his own arrival at an accident scene as the Emergency Physician. In highly unusual situations such as this must have been, he agreed it was very hard to enunciate a specific guideline, and that it was impossible to say what would have been the best way to proceed. In particular, more information was needed as to the risk at the scene, and the answers to questions about breathing, levels of consciousness, pulse etc were not to be relied on as necessarily accurate from civilian, traumatised callers. Nevertheless, he stated that it was vital for any history to be taken, even if unreliable. That taken on this day was insufficient, and the questions in regard to breathing should have been clearer and more frequent.

He advised that such force as would have come from the harvester would take very little time to cause death, and that traumatic asphyxia can cause death in less than minutes. It was Dr Fogg's view that the gagging noise combined with blood from the nose and mouth, even six minutes in to the call, might well have been an aspiration of blood displaced by pressure, and did not mean that Blaine was necessarily still alive.

Dr Fogg gave the supposition that the ONLY chance Blaine may have had was for the weight to have been lifted SAFELY by the forklifts immediately and totally . Without being there, and knowing whether that could have been possible , (which other evidence suggests it was not), he reiterated that that would have taken minutes , if practical at all, and that death may in any case have resulted very rapidly indeed.

PROFESSOR DUFLOU is a forensic pathologist, formerly Director of the Glebe Department of Forensic Medicine, and now an independent expert. He too had no doubt that the death was due to Traumatic Asphyxia rather than a Crush Syndrome. He agreed with Dr Fogg that Traumatic Asphyxia is most unusual and usually very rapid. A patient tends to become unconscious in less than 10 seconds. He totally accepted the difficulty of bystanders being able to assess whether an injured person is dead or not in such circumstances. He agreed that the gagging noise heard from Blaine did not necessarily mean there was any cardiac function remaining by that time.

In the given view of Professor Duflou, lifting "a little" would not have made any difference. Like Dr Fogg, he said that the whole weight would have had to be removed, in a vertical lift, to be of any use.

Police

DETECTIVE SENIOR CONSTABLE KLEIN, the Officer in charge of the Investigation , showed the court some demonstration DVDs of the harvester. Detective Klein confirmed his written statement that he had inspected the harvesting tractor involved with Work Cover investigators, 3 weeks after the accident. He was concerned that once lifted, there was no locking system to hold the rear platform, as there was on the second harvester owned by the company. A photo produced showed no lock. (Deejay had also said that there was no lock/catch). When the step is raised from it lowest position and lifted upwards, it passes the point of 90 degrees , over-balancing, and resting against a metal frame, with nothing to hold the ramp upright. He had drawn the hypothesis that it was possible that Blaine was in the process of lifting this step, and fell from the rear as a result.

Two days later, Detective Klein again attended the holding yard where the tractor was secured, and made a video recording of Gavin Rogers operating the tractor, demonstrating its operating speed in forward and reverse, in low and high range second gears, as well as one of the inspectors raising and lowering the rear step whilst standing on the machine. He inspected the machine's operating Manual. He concluded that the then current operations of the tractor were not compliant with the instructions in the Manuals with the driver regularly leaving his seat while the vehicle is in forward motion. There is a risk that with no driver on the machine in case of a need to halt immediately, danger occurs. However, he noted that this inherently unsafe practice had not played a part in Blaine's death. He remains of the belief that the cause of Blaine's fall was that Blaine was lifting the rear step while the tractor was reversing , which caused him to over balance and fall.

Conclusions:

1. The Cause of the Fall

While Detective Klein's supposition (and that of others) is highly plausible , it is not conclusive. No one saw Blaine fall. The evidence as to whether the step was up or down immediately after the accident is conflicting. As Counsel for Turfco has pointed out, it may have been lifted subsequently by those colleagues who rushed to help, so that the full load of turf could be removed from the pallets. There is no doubt that Blaine was hardworking, intelligent and a good employee, but he was 19, loved a bit of fun, and on the evidence not always compliant with every direction given. There seems to have been no fault or deviation from the common, if improper, practice, by the driver, DJ who had been working with Blaine as a two man team for well over two years, without incident. We cannot be certain how Blaine came to fall.

2. Did Turfco have appropriate safety and training practices in relation to the operation and use of the harvester?

Turfco has operated successfully since 1987, when it was founded by Mr Gavin Rogers. Mr Rogers told the court that there had been not one incident involving the harvesters in all that time, during which the same practices were in place. I accept that, and I do not suggest that it was a company which had no care for its employees, or put profit above safety relentlessly , or deliberately failed to provide a safe system of work. It was clear from the witnesses that they felt generally happy and secure in their jobs, and were well thought of.

However, Blaine's fall tells its own story. Despite the lack of accident before that day, he did fall, he did die, and it was because he was riding on the side platform in a practice, not only accepted but taught, which should never be approved in general agriculture or horticulture. A side platform is not, as Worksafe says, a 'safety zone'. The Manual, although I concur that it is inconsistent with the design of the tractor for two persons, prohibits riding on the tractor by a second person, and in particular whilst reversing. It may be luck that such an accident had not previously occurred.

There were inadequacies in the system, highlighted by the fact that only mild warnings seem to have been given, more than once, about lifting the platform during motion. There was little, if any, ongoing training or education in regards to protocols and safety after initial 'on the job' training. Perhaps employees and supervisors had become complacent , but it cannot be said that there was a rigorous attention to ensuring that all workers were aware of safety precautions, and occupational health and safety regulations, as should have occurred in an otherwise decent, pleasant workplace.

It is understandable, as Mr Rogers told the court,that the Manual was written for operating the harvester in conditions very different from ours in the southern hemisphere. North American soils and weather differ from those in Australia significantly; for example, Canadian turf springs back after pressure, whereas Australian soils would be adversely affected and rendered unusable by heavy wheel marks. Perhaps the manufacturer could have been asked for advice on modifications required in different countries. Perhaps, as is now the case, consideration should have been given by the company earlier to the purchase of fully automated machines.

The changes introduced by the company immediately after the tragedy, including the sale of the tractor involved and it's replacement by the automatic Robomax, operated by only one person, demonstrates that at least the company is on its way to ensuring that protocols and training, are now taken seriously and machinery has been modified to avoid future incidents. Safework is advising and assisting on a regular basis.

The accident has been discussed and analysed at major conferences in the nation -wide industry, and seminars held. Safety messages are sent by texts and mobiles, and a magazine now being published regularly concentrating on safety issues. It is necessary to find that on December 1, 2014, the work and safety practices of Turfco were not sufficient.

However, in view of the evidence that major changes have already been put in place, I intend only to make those recommendations under s 82 submitted by Safework. Furthermore, whatever the shortcomings in training by some senior employees, the actions of all those immediately involved in Blaine's accident should not be criticised. Each of them appears to have acted swiftly and sensibly as far as possible. There is absolutely no evidence that any blame can fall on Deejay. Steve Franks and Scott Parker , though both very distressed, did every thing possible in the circumstances, contrary to the assertions of Counsel for the family, and Franks talked the emergency operator through that call to the best of his ability.

THE ISSUE OF WHETHER THE TRACTOR SHOULD OR COULD HAVE BEEN MOVED, and the advice of the emergency operators.

This is the question which has agonised Blaine's grieving family. Mr Franks telephoned emergency services at approximately 7:01, and the first ambulance arrived at 7:15. During that 14 minutes, Mr Franks stayed on the phone with the operator, who was unable to determine accurately Blaine's clinical status, partly because she may not have asked sufficient information as to his clinical status, and partly because there was confusion amongst those at the scene as to whether Blaine was conscious or breathing, moving or deceased. (in the somewhat calmer conditions of the court room, the majority of those recalled believing that he was dead when they first arrived. His eyes were closed, he was unresponsive, showed no sign of a pulse, was purple in colour and, apart from one exhalation, showed no sign of breathing.).

The Operator did tell Mr Franks initially not to attempt to rescue him, or lift the machine, which was totally according to protocol. She was not told the size of the tractor, what equipment was available, or the competency of the forklift operators on scene. The Operator passed the call to her supervisor, who, in contrast asked Franks if it was possible to lift the harvester using two forklifts, one on either side, to take the weight off Blaine by safely lifting the harvester 'a little bit'. The attempt was made before the ambulances arrived, but although a very slight lift was achieved, the harvester was too heavy for the forklifts , which on taking the weight, sank into the soft ground.

Mr McCarthy, the director of Patient Safety and Clinical Quality, for NSW Ambulance, outlined the prime concern in such situations to be to ensure the safety of persons at the scene as well as the victim. Using the forklifts was dangerous as the load, once raised, could have fallen and injured the rescuers or worsened Blaine's injuries. He asserted that

the Protocol 22 followed by the initial Operator was appropriate and followed the internationally accepted Medical Priority Dispatch System. It specifically provides for the call taker to instruct persons not to rescue the victim of ‘an inaccessible incident/other entrapments” . Apart from the issue of overall safety, the concern in crush accidents is that lifting the crushing cause may precipitate torrential haemorrhage or crush syndrome. However, Mr McCarthy did acknowledge that this protocol is inconsistent with current advice in the first aid environment.

As submitted by the family, the fact that the operators ultimately deviated from the protocol, and advised that some lift was warranted, is telling , in that it demonstrates either a lack of confidence in the protocol, or perhaps just how complicated and uncertain that protocol is. Dr Fogg stated that if it was ‘safe’ to do so, earlier attempts to have lifted the machine prior to the arrival of the paramedics, would have been sensible. The issue is what is ‘safe’ and the difficulty for the Operator to assess that safety . Dr Fogg acknowledged that he would have wanted more information before giving any advice to lift the weight. He had attended many such crush accidents, and never seen the weights removed from a patient before he attended.

Dr Duflou said that the removal of the machinery could have provided relief from the compressive pressure and allowed greater access to the patient for the purposes of emergency treatment, but that the removal of the heavy weight may have caused further injury and uncontrolled bleeding.

Dr Duflou and Dr Fogg both believed that Blaine would have died very rapidly , and that the release of the weight in the time available would most likely have had no positive effect on his survival. However they also both agreed that it may have been the only, if unlikely, hope for Blaine. They were also in agreement that the cause of death, as given by the pathologist who performed the autopsy, was TRAUMATIC ASPHYXIATION.

Blaine was declared deceased upon the arrival of the paramedics. Ultimately, they needed 20 minutes to extricate Blaine’s body from under the tractor by the use of low pressure airbags. Thus, it seems unlikely he would have survived prior to their arrival, even if attempts to extricate him had occurred immediately. We are unable with certainty to determine whether that the weight should or should not have been moved earlier, or whether doing either would have affected Blaine’s state.

I must say however, that having heard all the evidence, from both the medical experts and the colleagues on the scene, on the balance of probabilities, it seems unlikely it would have made a difference. The paramedics should be praised for their actions and professionalism.

The issues are complicated, and in reality there is no simplistic or unequivocal resolution to the initial question of when or whether the tractor should have been removed. There is also some conflict between the Ambulance protocols and their adherence to the MDPS on the one hand, and Australian Resuscitation Council Guidelines (which empowers bystanders to intervene after making their own safety assessment) on the other.

I accept those submissions as to a recommendation to the Minister for Health made by my Counsel Assisting, Mr Kelly, agreeing with him that any amendment to NSW Ambulance Protocols on this issue would require specialist input which is outside my expertise, and cannot occur from a single recommendation.

It was painfully obvious that Blaine's family have been deeply affected by his death. Everyone who heard the evidence was moved by his tragedy and their sorrow. I only hope that this inquest has shown them, whether or not they agree with the findings, that many others, from Blaine's friends and colleagues, through Detective Klein, and the coronial staff, continue to care about the loss of such a fine young man.

We all extend you our deepest sympathies.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence given at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

The person who died was Blaine Rozs

Date of death

Blaine Rozs died on 1/12/2014

Place of death

Blaine Rozs died in, Jaspers Brush NSW.

Cause of death

The cause of death is Traumatic Asphyxia

Manner of death

The manner of death is accidental fall from a harvester.

Recommendations

Pursuant to s 82 of the *Coroners Act 2009*, Coroners may make recommendations connected with a death.

1. To the Minister for Health

That the NSW Ambulance Service conduct a review of the evidence and findings in relation to the death of Blaine Rozs for the purpose of determining whether any changes are necessary to its protocols and procedures for persons trapped under heavy equipment , with a view to improving patient outcomes prior to the arrival of emergency service personnel.

2. To the Minister for Innovation and Better Regulation and CEO of Safework NSW

1) Prior to sale, suppliers of sod (turf) harvesters should consider the provision of mirrors/devices that allow the operator a larger field of vision to the rear of the plant and a reversing obstruction alarm to be installed.

2) Currently owned /operated sod (turf) harvesters, PCBU's should consider retro fitting mirrors/devices that allow the operator a larger field of vision to the rear of the plant and a reversing obstruction alarm where there is a risk of a person being struck.

3) Turf harvesting businesses are to implement a system of work where:

a) the operator is to remain in control of the harvester at all times whilst the plant is in operation/use.
b) whilst in operation the harvester is only to be driven in reverse when absolutely necessary
c) stackers leave the harvester and move into a safe position where they can be seen by the operator
d) the operator does not reverse until identifying that the stackers are in the safe location
e) whilst reversing the operator monitors the path of travel and that stackers remain in sight out of the travel path, and
f) the operator stops when the obstruction alarm sounds until they check the path is clear,
g) workers are trained in the system of work.

4) Turf harvesting businesses are to regularly monitor the work through supervision and consultation to ensure the system is being used and is effective.

I close this inquest.

Magistrate M Jerram

NSW State Coroner Court
44-46 Parramatta Road
Glebe NSW 2039

Date 13th December 2016