Oaten v Engineering Employers Association SA Group Training Scheme Inc **[2006] SAIRC 70**

MAGISTRATES COURT OF SOUTH AUSTRALIA
(INDUSTRIAL OFFENCES JURISDICTION)

OATEN, Lynette

v

ENGINEERING EMPLOYERS ASSOCIATION SOUTH AUSTRALIA GROUP TRAINING SCHEME INCORPORATED

JURISDICTION: Prosecution

FILE NO/S: 2768 of 2006

HEARING DATES: 8 September 2006

JUDGMENT OF: Industrial Magistrate SM Lieschke

DELIVERED ON: 29 September 2006

CATCHWORDS:

Prosecution - Guilty plea - Sentence - Failure to ensure so far as reasonably practicable the safety of its employee - 18 year old first year apprentice died after becoming tangled in unguarded shaft of horizontal borer - Defendant in role of labour hirer of apprentice to host employer - Defendant a registered training provider - Failed to ensure that hazard identification and risk assessment performed on use of borer - Failed to ensure safe operating procedures existed and communicated - Failed to ensure deceased was trained by experienced tradesperson - Failed to ensure deceased had received available formal training on use of borer - Failed to ensure deceased had been properly assessed in general machining prior to use of borer - Failed to ensure deceased received reasonably necessary supervision - Contrition by defendant - Held: Conviction and fine of $60,000 - s 19 Occupational Health Safety and Welfare Act 1986 - Criminal Law (Sentencing) Act 1988.

REPRESENTATION:

Counsel:	
Complainant:	Mr K. Soetrama
Defendant:	Mr G. Dart
Solicitors:	
Complainant:	Crown Solicitor's Office
Respondent:	Engineering Employers Association of South Australia Group Training Scheme Incorporated

Introduction

1 The Engineering Employers Association SA Group Training Scheme Incorporated was the employer of Daniel Madeley, a first year apprentice. It had an obligation to take reasonable steps to ensure Daniel's health and safety in his work at Diemould Tooling Services Pty Ltd, where he regularly operated an unguarded horizontal boring machine. EEAGTS failed to take reasonably practicable steps to ensure Daniel was afforded the protection of adequate training, supervision, hazard identification and safe operating procedures. Daniel had been trained on the horizontal borer by other apprentices. He had not been given access to available formal training nor had he been properly assessed in using the borer. He did not have assistance from any written safe operating procedures. And, unknown to him, no proper hazard identification or risk assessment had been carried out on use of the borer.

2 On Saturday 5 June 2004 Daniel was pulled onto the spinning shaft of the borer by his dustcoat. Daniel was unable to stop the machine, which was not fitted with any automatic stopping mechanisms. He suffered extremely traumatic injuries and died the following day.

The offence

3 EEAGTS was charged with failing to ensure so far as was reasonably practicable that Daniel was, while at work, safe from injury and risks to health contrary to s 19 of the *Occupational Health Safety and Welfare Act 1986*. EEAGTS pleaded guilty to the charge at the earliest opportunity. It is now being sentenced.

4 Diemould has also been charged with a breach of s 19. It has not yet been dealt with by the Court. Diemould is the first defendant. EEAGTS is the second defendant. The particulars of the charge are as follows:-

> "3. **Safe systems of work:** The second defendant failed to maintain, so far as was reasonably practicable, safe systems of work for Daniel Madeley's use of the horizontal borer in that:
>
> (1) the second defendant failed to ensure that an adequate hazard identification and risk assessment had been performed in respect of Daniel Madeley's use of the horizontal borer in order to develop appropriate risk control measures, and in particular safe operating procedures;

(2) the second defendant failed to ensure that safe operating procedures had been communicated to Daniel Madeley in respect of his use of the horizontal borer.

(a) in the form of a sign displayed prominently by the machine; or

(b) in the form of documents supplied to employees using the horizontal borer.

4. **Information Instruction Training and Supervision:** The second defendant failed to provide such information, instruction, training and supervision as was reasonably necessary to ensure that Daniel Madeley was safe from injury and risks to health in that:

(1) **training:** the second defendant failed to ensure that any training given to its apprentice employee Daniel Madeley in the use of the horizontal borer was delivered by a qualified tradesperson experienced in the use of the horizontal borer;

(2) **training:** the second defendant failed to ensure that Daniel Madeley had received adequate formal off site training prior to commencing duties on the horizontal borer, and in particular failed to ensure that Daniel Madeley had received formal training in the unit of competency entitled MEM7.13A – *Perform machining operations using horizontal borer and/or vertical boring machines.*

(3) **training:** the second defendant failed to ensure that Daniel Madeley was provided with adequate assessment in respect of Daniel Madeley's use of the horizontal borer, and in particular had not ensured that a competency assessment had been carried out in respect of Madeley by a certified workplace assessor in relation to the unit of competency entitled MEM7.5 – *Perform general machining* prior to Madeley's use of the horizontal borer;

(4) **supervision:** the second defendant failed to ensure that Daniel Madeley received such supervision as was reasonably necessary to ensure his safety as an employee who was inexperienced in the

> performance of work of a hazardous nature, namely the use of the horizontal borer."

Background circumstances

5 It is necessary to describe a number of the features of the work arrangements on Diemould's premises to properly understand EEAGTS' responsibility for the risks and fatal injury to Daniel.

6 EEAGTS was the employer of Daniel under a contract of service being a mechanical engineering apprenticeship. It employs a large number of apprentices which it then hires out to various host employers. Diemould was one such host employer with whom EEAGTS has been placing apprentices for approximately 15 years. EEAGTS has various responsibilities to its apprentices as their employer at law, and as a party to contracts of training pursuant to the *Training and Skills Development Act 2003*. EEAGTS is acting as both a specialist training and skills development body and an apprentice labour hire organisation. EEAGTS is an incorporated association, said to be wholly owned by the Engineering Employers Association of South Australia.

7 While the EEAGTS did not have day-to-day control over the engineering features of the machines and work processes used by Daniel, it nonetheless had responsibility to take all reasonably practicable measures within its control to ensure Daniel's safety whilst working at Diemould.

8 Daniel commenced his apprenticeship on 14 July 2003. At the time of the fatal incident he had been working for 11 months and had been using the horizontal borer for about five months.

9 The horizontal borer's rotating shaft is completely unguarded. The machine has no interlocking devices. The machine did not have an emergency breaking device which meant that once the stop button was pressed it would take some time to slow down and stop. The control panel for the machine had two operation buttons that were located immediately next to each other. One was a continuous operation button that needed to be pressed once to bring the machine into operation on a continuous basis. This was next to a hold-to-run button, which needed to be pushed and held down for the shaft to turn. Once the button was released the machine powered down. The machine's emergency stop button was on a moveable control panel. Depending on position it could be up to 3 metres away from the operator. The machine itself did not have any proximity or probe switches, which if contacted would have caused the machine's breaking system to operate. An operator may need to stand very close to the rotating shaft of the machine, in the job set-up process.

10 The complainant submits that the physical condition of the machine and its controls is the starting or reference point for EEAGTS when determining what was going to be required by either it or Diemould to devise safe systems of work to reduce risks to operators.

11 Whilst the complainant has suggested a number of engineering improvements that could have been made to the machine, these are not within the domain or control of the employer and accordingly I will not canvas them.

12 It is obvious, as a matter of foresight, that the machine is potentially very dangerous, and so careful consideration needed to have been given to all available ways of eliminating or reducing those dangers.

The incident

13 Daniel was working unsupervised and out of sight of any other employees on the morning of Saturday 5 June 2004. He was wearing overalls and a large loose fitting dustcoat supplied by Diemould. When Daniel's clothing became tangled on the shaft of the machine, as it rotated at high speed, he was picked up by the power of the machine and repeatedly flung around the borer shaft. As this happened his body struck various parts of the machine. Two nearby workers heard loud banging sounds and quickly came to Daniel's work area. They saw Daniel entangled and rotating at high speed around the machine, which was still under full power. They immediately stopped the machine and arranged for whatever assistance could be provided.

14 Daniel suffered catastrophic injuries. He suffered what has been described as a flailed chest, involving fractures of most of his ribs, lacerations to his lungs, and severe bruising to his lungs, heart, kidneys and liver. He suffered blows to his head and swelling to the brain. His spleen was lacerated. Both legs were broken above the ankles. Both ankles had been torn from his legs. An arm was broken and a shoulder was fractured. Daniel lost consciousness at some point while enduring this horror. Remarkably he regained consciousness before an ambulance arrived. He was taken to Flinders Medical Centre but his odds of survival were extremely slim. Daniel died on Sunday 6 June.

15 The autopsy report indicates the major contributor to his death was respiratory failure secondary to the damage to his lungs. I will return to the impact of Daniel's death later in these reasons.

Inadequate Hazard Identification and Risk Assessment

16 Every employer is obliged to ensure that appropriate steps are taken to identify all reasonably foreseeable hazards arising from work which may

affect the health or safety of employees or other persons in the workplace. If a hazard is identified it must make an assessment of the risks associated with the hazard. There is no prescriptive way of carrying out a hazard identification. It is really no more than thinking in advance in a systematic way of the potential uses and misuses of a machine and the hazards that may arise.

17 Once a risk has been identified an employer must ensure that those risks are either eliminated or where that is not reasonably practicable minimised. This simple obligation is found in regulation 1.3.3(1).

18 Risk elimination or minimisation must be achieved by first ascertaining whether there are any reasonably practicable engineering controls that can be implemented, and secondly if such measures are not reasonably practicable or do not sufficiently minimise the risk, by administrative controls such as safe operating procedures.

19 Particular 3(1) is comprised of the fact that EEAGTS took no steps to enquire whether Diemould had carried out any hazard identification or risk management process or to carry one out itself. As it was, Diemould did have a two page list of individual machines including the horizontal borer with notations such as, "general machine risks", "safety to be observed at all times", and "all staff trained in these areas."

20 EEAGTS' training coordinator at the time of the incident, Robert Drysdale, had a supervisory role over Daniel's apprenticeship. Whilst Mr Drysdale had assumed that an appropriate risk assessment had been performed at some stage previously, he acknowledged that no steps had been taken to ensure this was the case.

21 EEAGTS' responsible officer Sue Frazer, admitted it had no process for ensuring that hazard identifications and risk assessments were carried out in the workplaces and on the machines that its employees were assigned to. She expected that host employers would regularly conduct their own hazard identifications, although this is little more than assumption because there was no practice of calling for such documents to ensure that they had been carried out and responded to appropriately. I add that Ms Frazer commenced employment with EEAGTS only a few months before the incident.

22 It was clearly a reasonably practicable step for EEAGTS' officers to ask for and to read Diemould's two-page document. If it had done this it would have realised that the document was hopelessly inadequate and could have either required Diemould to perform a proper hazard identification and risk assessment or conducted one itself.

Safe operating procedures

23 Particular 3(2) deals with EEAGTS failure to ensure that safe operating procedures regarding use of the borer had been communicated to Daniel. This was an administrative measure available to and within its control.

24 Safe operating procedures are a reasonably practicable measure that would have provided a daily reminder to all operators of the risk of death or injury from entanglement with the shaft of the borer. Such simple instructions should include: never wearing loose clothing near a borer; always wearing safety glasses; never leaving the borer running unnecessarily; only standing in close proximity to the turning shaft when it was in set-up mode; always looking and visually confirming that the operator is pressing the correct button; only performing continuous run drilling procedures from a specified distance away from the shaft; and always keeping all objects clear of the moving shaft. These matters could have been included on a sign permanently placed prominently on the machine and on written instructions given to all operators.

25 The machine had no written safe operating procedures displayed on it and there is no evidence of any written safe operating procedure ever being given to Daniel.

26 Mr Drysdale thought that apprentices were provided with safe operating procedures verbally but not in writing. He did not know what they were. He had never seen any written documentation and he had never had an apprentice show him anything in writing. He did indicate that apprentices were expected to complete a log book in which they were asked to record not only their work activities but also any comments that had been made to them. This is not a substitute for a carefully considered safe operating procedure.

27 EEAGTS had no agreement with Diemould that set out with any reasonable particularity the safe working arrangements for its employees at Diemould's premises.

28 At best EEAGTS had a checklist form, which was issued to host employers covering a number of issues including the observation of safety procedures. No such form existed in relation to Daniel.

29 Daniel often wore a dustcoat. It was acceptable for apprentices to wear dustcoats whilst working on the horizontal borer. I accept the complainant's submission that one of the most basic and fundamental precautions when working with machinery with exposed moving parts is not to wear loose clothing. The wearing of dustcoats clearly should have been banned. Employees should have been told of this in writing. Whilst EEAGTS was not in control of the clothing that was worn by its

employees on a daily basis it was in a position to ascertain from Diemould whether it had any relevant policy. EEAGTS did not call for or inspect Diemould's safe operating procedures. If it did it would have realised that nothing had been committed to writing, and it could then have taken immediate action in consultation with Diemould to rectify the default.

Failure to ensure appropriate training and supervision

30 Every employer also has an obligation to ensure that an employee receives suitable and adequate information, instruction and training for any task they may be required to perform. See regulation 1.3.4(1). This obligation is closely followed by an obligation to ensure that an employee must be provided with suitable and adequate supervision to ensure his or her health and safety at work and the supervision must be relevant to the employee's level of competence and experience and naturally, carried out by a competent person.

31 In addition EEAGTS had entered a mutually binding covenant of apprenticeship with Daniel to, amongst other things, teach and instruct him in the trade to which he was bound.

Training from apprentices

32 Particular 4(1) relates to EEAGTS' failure to ensure that the training given to Daniel in the use of the horizontal borer was delivered by a qualified tradesperson experienced in the use of that particular machine. The apprentice who trained Daniel was in turn trained by another apprentice before him. The person who had been nominated by Diemould to be in charge of first year apprentices admitted that he himself had not actually operated the borer, and it appears there were not many qualified tradespeople at Diemould who actually knew how to operate the machine. It is not appropriate for safety purposes, for apprentices to be responsible for the training of other apprentices on such dangerous machinery. As Mr Soetrama, counsel for the complainant, put it,

> "Apart from the fact that few apprentices have the experience and life skills that are necessary to teach, the danger is that in practice bad habits or deficient practices might inadvertently be passed from one apprentice to the next; practices which might otherwise have been detected and prevented by a qualified tradesperson experienced in the use of the borer."

33 EEAGTS' officers were not aware of who provided training to Daniel and other apprentices on the borer. It failed to make any appropriate enquiries and therefore failed to make sure that Diemould was using qualified

tradespeople to deliver such training and that those persons were in fact experienced in the use of that particular machine.

No Formal training on horizontal borer

34 Training in the safe use of the borer should have formed part of Daniel's formal off-site apprenticeship training prior to commencing duties on the borer. Mr Drysdale knew that a horizontal boring course existed and could have been provided by TAFE.

35 Daniel had only completed 24 days of off-site TAFE training in the 11 months of his apprenticeship and this all took place before he was placed at Diemould. EEAGTS had an arrangement with TAFE whereby accelerated training was provided in a ten-week intensive course at the start of an apprenticeship. About six months into the apprenticeship EEAGTS was supposed to notify TAFE of what was required for the remainder of the training plan. Whilst that arrangement is not criticised the difficulty here is that Daniel had not in fact done the full ten-week course as he had entered the apprenticeship scheme towards the end of the course. This was not followed up at the six month mark.

36 Mr Drysdale says he informed relevant officers of Diemould of Daniel's limited off-site training. However the first year apprentice coordinator of Diemould thought Daniel had completed the course. These arrangements were simply too casual for an 18-year-old first year apprentice who was expected to operate an inherently dangerous specialist machine. Given that apprentices appeared to be training other apprentices, and that the immediate supervisor didn't actually have experience using the borer, the need for formal training was of great importance.

No assessment of general machining competency

37 Daniel had commenced, but not completed, the TAFE general machining course. A practical component of this required a competency assessment of his general machining skills on the factory floor. Despite that not occurring Daniel was expected to operate the borer, relying on whatever training a fellow apprentice could provide, as the basis for ensuring his safety.

38 An assessment of Daniel's work should have been performed by a certified workplace assessor. His work on the horizontal borer was not assessed. Diemould did not have a qualified assessor at the time and EEAGTS took no steps to ensure the assessment occurred. Whilst TAFE was capable of providing the required assessment service EEAGTS had contracted TAFE to deliver the training but not to perform any competency assessments. It chose to retain that responsibility itself, as it was entitled to do, because it was a registered training organisation.

39 Whilst there was some basic performance assessment carried out by Diemould, there was no specific competency assessment of his work or of the safety of his work on the horizontal borer.

40 In discussing training deficiencies I do not suggest there is evidence to suggest Daniel was being careless in any way.

Failure to ensure necessary supervision

41 EEAGTS' duty included ensuring that Diemould was providing adequate supervision; to know what that the level of supervision was, and whether the people providing that supervision were qualified to do so.

42 On occasions Daniel would work overtime shifts, without supervision and alone in the workshop. On the day of the incident there was no-one with line of sight supervision over him. Daniel's nominal supervisor on that day was working in a completely separate part of the factory. Even then Daniel was more experienced in the use of the borer than was the supervisor. The person who was probably the most qualified to provide supervision, based on experience with the horizontal borer, was a fellow apprentice who was working nearby. Therefore any chance of the apprentice or any other person seeing Daniel doing anything dangerous, had he enough experience to know it was dangerous, would have been a matter of luck rather than design.

43 Whilst EEAGTS was reliant on Diemould's provision of supervision, it had a duty to check to ensure that Diemould was carrying out its supervisory obligations adequately. Instead EEAGTS chose to simply trust that Diemould knew what it was doing and would exercise the appropriate level of care.

44 Whilst the precise sequence of events leading to Daniel's death are unknown, it is clear that had EEAGTS not disregarded its obligations to Daniel, the chances of him not becoming entangled by the machine would have been greatly improved.

Impact of Daniel's death

45 Daniel's mother Andrea Madeley had a very close bond with her only child. She has suffered a nightmare that no parent should ever have to endure. Ms Madeley has spoken of Daniel being a wonderful son, and an amazing and clever person, with a great aptitude for his work. Ms Madeley has also described in moving terms the shattering impact of Daniel's death upon her life.

46 In addition to submitting a written victim impact statement Ms Madeley addressed in open Court the representatives of EEAGTS who attended the hearing of sentencing submissions.

47 In her comments to EEAGTS Ms Madeley again expressed her grief and great sense of loss. Her comments however were not just about grief and were not focussed on revenge. Ms Madeley acknowledged that EEAGTS had enough integrity to admit to her that its working procedures failed her son. She acknowledged that EEAGTS had accepted responsibility for its actions and while it failed in its duty of care to her son, it did not fail her in attempting to right a terrible wrong.

EEAGTS systems prior to the incident

48 Mr Dart, counsel for EEAGTS, conceded that the offence was brought about by an unacceptable level of complacency by EEAGTS in its long term dealings with Diemould. EEAGTS however did have some regard to the health and safety of its apprentices placed at Diemould. Some form of induction was carried out by Diemould although it was not documented. EEAGTS itself is said to have had a rigorous selection process. Its training coordinator had some regular follow up with its apprentices. There was supposed to have been a pre-placement safety inspection carried out by EEAGTS, but it was not done in respect to Daniel's placement at Diemould. EEAGTS also required some form of reporting by Diemould as to Daniel's progress.

Response of EEAGTS

49 The immediate response of EEAGTS was to notify Workplace Services. Officers attended at Diemould's premises and ensured that all other Scheme apprentices were notified of the incident and offered counselling, and to make sure they were in a fit state to resume work. Arrangements were made for apprentices to attend Daniel's funeral. It arranged counselling for its staff, for Daniel's mother and his girlfriend. It arranged with Diemould to ensure the funeral expenses were met. It has established an honour board in memory of Daniel at its premises. It assisted with payment for a memorial service and cooperated in its apprentices attending a dedication service in January 2005 at Ms Madeley's home. Ms Frazer has maintained supportive contact with Ms Madeley.

50 With respect to its systems of work it undertook complete internal and external review of its procedures and systems. Its systems were then completely reorganised. It started with the development of a formal written agreement between EEAGTS and host employers with the aim of ensuring that the responsibilities of both parties were clearly understood and contractually enforceable. The document covers the various defaults

that were present when Daniel died. Its training coordinators are now required to have a formal level of qualifications in occupational health and safety. A comprehensive induction process has been devised and implemented. New reporting systems have been put in place and each apprentice's training plans are regularly reviewed. EEAGTS is also now participating in a WorkCover performance assessment program. In short, it now has a clear focus on the safety of its apprentices as a paramount issue.

Additional considerations

51 I accept that EEAGTS has pleaded guilty at the first available opportunity and has expressed through its senior officers genuine remorse. It has fully cooperated with Workplace Services. I accept that it has responded appropriately with respect to the people affected by Daniel's death, and with respect to implementing appropriate and complying safe systems of work. I accept that with new systems and attitude it is unlikely to commit a further breach in the foreseeable future.

52 EEAGTS, as a hirer of about 200 apprentices to 70 businesses, is required to take positive steps to ensure that these workplaces do not present unnecessary risks to health and safety. A large specialist labour hire organisation which: only deals with apprentices; is a registered training provider; has obligations up to tradesperson level; and has readily available expertise through its controlling body; can reasonably be expected to discharge its obligations to a high standard.

Assessment of penalty

53 The maximum financial penalty is a fine of $100,000. That maximum must be reserved for the worst type of offence, being an offence short of an aggravated offence, where a person knowingly and recklessly endangers another person. The penalty must reflect the culpability of a defendant for its acts and omissions. Whilst the consequences of an offence for any victim is a relevant factor to be taken into account, the penalty is not focussed on punishment for the consequences of the offence nor is it an attempt to place a value of the victim's injury or life.

54 General deterrence is a very important consideration given the prevalence of complacency to health and safety obligations, as a common factor in many serious workplace injuries. Health and safety cannot be assured by on the job experience. A structured process of thinking about health and safety both before work commences, and whilst it continues, is essential.

55 EEAGTS' offending is very serious. It comprises of multiple failures that developed over time and which put Daniel at unnecessary risk of being

trapped in the borer. A penalty at the higher end of the scale is appropriate.

56 EEAGTS is entitled to a reduction of the fine I would otherwise have imposed by reason of the demonstrably genuine remorse and contrition of its senior officers and by full acceptance of responsibility for the consequences of its failings. Its full cooperation with the investigating authority and early guilty plea are aspects of this. I will accordingly reduce the fine by $15,000.

57 In all the circumstances a conviction will be recorded, and a fine of $60,000 will be imposed. In addition the following costs, levy and fees are to be paid.

Court costs	$104
Victims of Crime Levy	$35
Counsel fee	$750*
TOTAL	**$60,889**

*Payable to the Crown Solicitor's Office

58 The total amount of $60,889 is to be paid within 28 days.

59 The question of compensation to Daniel's mother and girlfriend are adjourned for further consideration after there has been an outcome to the charge against Diemould.