DISTRICT COURT OF QUEENSLAND

CITATION:	*Connors v Wilmar Sugar Pty Ltd* [2019] QDC 73
PARTIES:	**WAYNE STEVEN CONNORS (Workplace Health and Safety Queensland)** (Appellant) v **WILMAR SUGAR PTY LTD (ACN 081 051 792)** (Respondent)
FILE NO/S:	D87/18
DIVISION:	Criminal
PROCEEDING:	Appeal pursuant to section 222 of the Justices Act 1886 (Qld)
ORIGINATING COURT:	Magistrates Court at Proserpine
DELIVERED ON:	10 May 2019
DELIVERED AT:	Mackay
HEARING DATE:	29 April 2019
JUDGE:	Smith DCJA
ORDER:	**1. The appeal is dismissed.** **2. The order made below is confirmed.** **3. I will hear the parties on the question of costs.**
CATCHWORDS:	INDUSTRIAL LAW - INDUSTRIAL SAFETY, HEALTH AND WELFARE - Occupational Health and Safety - Duties of Employer - Whether breach of duty of care - whether reasonably practicable means of avoiding risk of death - whether causation proved *Justices Act 1886 (Qld)* ss 222, 223 *Work Health and Safety Act 2011 (Qld)* ss 17, 18, 19, 32, 275 *Work Health and Safety Regulation (Qld)* rr 35, 36 *Allesch v Maunz* (2000) 203 CLR 172; [2000] HCA 40 *Baiada Poultry Pty Ltd v R* (2012) 246 CLR 92; [2012] HCA 14 *Bulga Underground Operations v Nash* (2016) 93 NSWLR 338; [2016] NSWCCA 37

Charters Towers Regional Council v Coggins Unreported Queensland District Court DC5/17 and DC28/17 Lynham DCJ 24 October 2018.

R v Dookheea (2017) 262 CLR 402; [2017] HCA 36

Forrest v Commissioner of Police [2017] QCA 132

John L Pty Ltd v Attorney-General (1987) 163 CLR 508; [1987] HCA 42

Johnson v Miller (1937) 59 CLR 467; [1937] HCA 77

Kirk v Industrial Court (NSW) (2010) 239 CLR 531; [2010] HCA 1

Parsons v Raby [2007] QCA 98

Robinson Helicopter Co. Inc. v McDermott (2016) 90 ALJR 679; [2016] HCA 22

Safework (NSW) v Tamex Transport Pty Ltd T/A Tamex [2016] NSWDC 295

Safework (NSW) v Wollongong Glass Pty Ltd [2016] NSWDC 58

Slivak v Lurgi Australia Pty Ltd (2001) 205 CLR 304; [2001] HCA 6

Teelow v Commissioner of Police [2009] 2 Qd R 489; [2009] QCA 84

COUNSEL:	Mr M Copley QC & Ms C Hartigan for the appellant
	Mr R Perry QC for the respondent
SOLICITORS:	Prosecution Services Workplace Health & Safety Queensland Office of Industrial Relations for the appellant
	Herbert Smith Freehills for the respondent

Introduction

[1] This is an appeal by Workplace Health and Safety Queensland against the dismissal of a complaint by a magistrate in the Magistrates Court at Proserpine on 16 November 2018 after a three day trial.

[2] The appeal is pursuant to s 222 of the *Justices Act* 1886 (Qld). Section 223 of the *Justices Act* provides that the appeal is to be by way of rehearing. In *Forrest v Commissioner of Police*[1] it was said that an appeal by way of rehearing requires the appellate court to decide the case for itself. It must conduct a real review of the

1 [2017] QCA 132.

evidence and make up its own mind about the case giving due weight to the magistrate's view.[2]

[3] It was said in *Robinson Helicopter Co. Inc. v McDermott*[3] that an appellate court should not interfere with a judge's findings of fact unless they are demonstrated to be wrong by incontrovertible facts or uncontested testimony or are glaringly improbable or contrary to compelling inferences. Respect and weight should be given to the trial judge's analysis.[4]

[4] In *Teelow v Commissioner of Police*[5] it was held that ordinarily to succeed in such an appeal it is necessary for the appellant to demonstrate that having regard to all of the evidence before the appellate court, the order is the result of some legal, factual or discretionary error.

Charge

[5] The respondent was charged with one charge of failing to comply with a health and safety duty under s 19(1) of the *Work Health and Safety Act* 2011 (Qld) ("WHSA") contrary to s 32 of the WHSA and the failure exposed an individual to a risk of death or serious injury.

[6] The complaint[6] alleged that the respondent failed to comply with its duty contrary to s 32 of the *WHSA*.

[7] The complaint alleged in paragraph 5 that the hazard giving rise to the risk was:

(a) At approximately 10 am on 11 November 2012 John Martin Erikson walked from the crib room (smoko room) door exit to the tippler area towards the coupling/uncoupling shed.
(b) An empty cane bin exited the tippler and was moving down a ramp towards the coupling/uncoupling shed.
(c) John Martin Erikson continued to walk down the "corridor" on the outside of the yellow line and then proceeded to cross the yellow line in front of the braking system.
(d) Immediately upon crossing the yellow line, John Martin Erikson was struck by the moving cane rail bin.
(e) John Martin Erikson was forced by the cane rail bin into the braking system and crushed.
(f) John Martin Erikson sustained injuries from which he died.

[8] The risk was particularised in paragraph 6 as follows:

(a) The risk arising out of the hazard of which Wilmar Sugar Pty Ltd (ACN 081 051 792) ought to have known is of death or serious injury to workers and the risk of entrapment and crushing injuries to John Martin Erikson.
(b) There was a risk that workers walking in the "corridor" while cane rail bins were moving would be seriously injured or killed if they came into contact with moving cane rail bins.

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2 *Parsons v Raby* [2007] QCA 98 at [23].
3 (2016) 90 ALJR 679 at [43]; [2016] HCA 22.
4 (2016) 90 ALJR 679 at [56]; [2016] HCA 22.
5 [2009] 2 Qd R 489 at [4]. Applying *Allesch v Maunz* (2000) 203 CLR 172 at [33].
6 Exhibit 7.

(c) There was an increased risk of being hit, entrapped or crushed by moving cane rail bins in proximity to the braking system.

(d) The risk of death materialised when John Martin Erikson was hit by moving plant in proximity to the braking system along the walkway and received fatal injuries particularised in paragraph 6(a).

[9] And the failures alleged in paragraph 7 were as follows:

(a) Wilmar Sugar Pty Ltd (ACN 081 051 792) did not ensure, so far as reasonably practicable, the health and safety of John Martin Erikson while he was at work in that it failed to:

(i) adequately identify and assess the hazard of allowing workers to access the walkway from the tippler room exit door to the coupling/uncoupling shed while cane bins were moving on the cane rail track;

(ii) adequately identify and assess the risk of workers accessing the walkway from the tippler room exit door to the coupling/uncoupling shed while cane bins were moving on the cane rail track;

(iii) eliminate the risks to health and safety of workers by preventing access to the hazard by implementing a system of work to prohibit walking alongside moving cane bins;

(iv) provide and maintain safe systems of work.

(v) …

(vi) …

(vii) ensure that workers used one of the available alternative means of accessing the coupling/uncoupling shed;

(viii) adequately monitor and review controls.

(b) Wilmar Sugar Pty Ltd (ACN 081 051 792) failed to provide a standard of work health and safety equivalent to or higher than the standard required in the:

(i) *Sugar Industry Code of Practice 2005* and *Sugar Mill Safety – A Supplement to the Sugar Industry Code of Practice 2005* at Part 4.4; or

(ii) *How to Manage Work Health and Safety Risks Code of Practice 2011*.

[10] The control measures which the appellant alleges could have been implemented were particularised in paragraph 8 to be:

(a) eliminating the hazard by preventing access by workers to the "corridor" while cane bins are moving along the cane rail track and by providing access to work areas without the need to walk alongside or near moving cane rail bins;

(b) systems to prevent access by all workers to the hazard area through separation such as:

(i) ensuring that gates along the fence line or entry/exit to the hazard area are locked;

(ii) ensuring there is barricading to separate workers from moving cane bins;

(iii) ensuring there is no access from the crib room (smoko room) exit to the "corridor";

(iv) requiring all workers to utilise the existing overpass or underpass provided within this area to access the coupling/uncoupling shed;

(v) ensuring workers traverse on the outside of the permanent fence and only enter through the gate closest to the coupling/uncoupling shed;

(c) conducting an adequate risk assessment in accordance with the *Sugar Industry Code of Practice 2005* and *Sugar Mill Safety – A Supplement to the Sugar Industry Code of Practice 2005* or the *How to Manage Work Health and Safety Risks Code of Practice 2011*.

The evidence

Background

[11] On 11 November 2012 Mr John Erikson at about 10.00 am was killed at a sugar mill operated by the respondent at Mills Street in Proserpine. A cane rail track ran through the relevant work area. Located on either side of the cane rail track were yellow painted lines which delineated the area between a pedestrian corridor and the cane rail track. At about 10.00 am Mr Erikson exited the smoko room and commenced walking down the corridor towards a recoupling shed. At one point he crossed the painted yellow line and was struck from behind by a moving cane bin. He sustained significant crush injuries and died. The incident involving Mr Erikson can be seen on CCTV footage.[7] The footage shows Mr Erikson exiting the crib room door adjacent to the tippler and walking towards the recoupling shed on the outside of the painted yellow line. When he approached the braking system and was about 0.5 – 1 metre away from it he crossed the yellow line continuing on a trajectory inside the yellow line before he was struck by a moving cane bin which had exited the tippler and was moving down the ramp towards the recoupling shed. The evidence was that Mr Erikson was walking from one area of the mill to another in order to relieve another worker.

Exhibits and testimony

[12] Exhibit 1 was tendered by the appellant. This contained a number of documents including:

(a) A series of 11 photographs taken from the scene (tab 3)
(b) A diagram of the scene (tab 4)
(c) A drawing of the shift office and cane receiver tippler (tab 5)
(d) A drawing of the cane receiver tippler (tab 6)
(e) A drawing of the brake foundation positions (tab 7)
(f) A drawing of the rolling stock cane bins ten tonne external dimensions (tab 8)
(g) Email correspondence with screenshots showing bin weight data dated 14 November 2012 (tab 9)
(h) Pre-incident procedure recoupling cane bins (tab 10)
(i) Pre-incident procedure clean area between tippler/weighbridge and recoupling shed (tab 11)
(j) Pre-incident procedure cleaning around road bridge/tippler (tab 12)
(k) Form 12 prohibition notice dated 12 November 2012 (tab 13)

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7 Exhibit 1 tab 16.

(l) Training record and heavy vehicle licence of John Erikson (tab 14)
(m) Overall assessment summary for John Erikson (tab 15)
(n) CCTV footage taken at time of incident (tab 16)
(o) 7 image frames extracted from CCTV footage (tab 17)
(p) Sugar Industry code of practice 2005 (tab 18)
(q) Sugar Mill Safety – A Supplement to the Sugar Industry Code of Practice 2005 (tab 19)
(r) How to Manage Work Health and Safety Risks Code of Practice 2011 (tab 20)
(s) Australian Standard AS 1657-1992 (tab 21)
(t) WHSQ investigation report by Gavin Wesche dated 16 April 2013 (tab 22)
(u) Record of interview of Thomas Badger dated 12 November 2012 (tab 23)
(v) Record of interview of Nicholas Cronan dated 12 November 2012 (tab 24)
(w) Record of interview of Anne Gardner dated 12 November 2012 (tab 25)
(x) Record of interview of David Frazer dated 5 December 2012 (tab 26)
(y) Record of interview of Rodney Victor Camm dated 5 December 2012 (tab 27)

Evidence of Inspector Gavin Wesche

Report

[13] The report of Inspector Wesche noted that the deceased was called in early to his shift to relieve in the recoupling section of the cane receivals area of the mill. He had been trained and worked in the area prior to that day. The work area had several specific work activities (namely uncoupling, coupling and tippler) and there was a practice to rotate the workers around on the differing work activities. The workers on this rotation would access a work area that extended from the tippler crib room down to the coupling shed/work area. This access had a yellow demarcation line running the length of the work area that would identify a line of separation between the pedestrian and moving plant namely empty moving bins. It was a known practice that those persons authorised to be in this work area would use this path to undertake the rotation handover process.

[14] As to the event, at about 9.59 am on Sunday 11 November 2012, Mr Erikson for some unknown reason walked across the demarcation line into the path of an empty bin travelling from behind him striking him resulting in fatal injuries. Site investigations were undertaken on 12 November 2012, statements were taken from six workers and various documents obtained.

[15] Mr Erikson exited a door from the smoko room located outside of the tippler. He proceeded down the designated corridor of the work area to relieve a worker when for some unknown reason he walked across and inside of the clearly marked yellow demarcation line into the path of the empty cane rail bin travelling from behind him striking him and causing the fatal injuries.[8] The report noted there was a clean clear access and clear yellow demarcation line for pedestrian traffic. It noted that workers

[8] Report p 7.3.

had been provided with training and information on how to move around safely in this work area in the broader milling area induction, the job areas specific procedure training and follow up seasonal training.[9] There was training for specific tasks and safe work procedures for the work area including safety signage.[10] There was a lockout isolation system in place for any work that had to be undertaken in a specific area that is, if one had to cross the yellow demarcation line to undertake work, one had to undertake the notification/lockout/isolation process.[11] The employer had accessed the work area and had identified the risks associated with uncoupling and recoupling, an inherited hazard when they purchased this milling factory prior to the crushing season and had risk control investigated actions in the removal of workers and replacing them with automatic mechanical systems.[12]

[16] As to immediate post-incident actions the PCBU[13] had isolated the work area. Also, a physical barrier had been placed in the weighbridge/tippler region that lets area 1 and 2 of the Restricted Access Permit to be physically demarcated.[14] It was a temporary measure. Gates had been locked which could only be opened by a supervisor and barricading had been erected along the western side of the empty bin tram line that runs from the tippler to the fence at the wheel brakes.[15] Barricading had been erected on the eastern side of the tram line adjacent to the wheel brakes to cover a gap in the fence and additional barricading erected on the eastern side of the recoupling shed from the overpass to a distance of about 10 metres past the edge of the shed.[16]

[17] The report noted that Mr Erikson was provided with and undertook a number of training sessions both in theory and on the job that went through a number of operating procedures for this work area.[17] The training covered off on the safety points of being aware of moving bins and staying outside of the yellow demarcation lines. "Such information and on the job training would have given John Erikson enough information to allow him to work safely in the work environment he was directed to work in this day".[18] In this regard exhibit 5.1 contains relevant procedures/documents.[19] A summary of the statements noted that the corridor used by Mr Erikson was one of some varying common access paths used by authorised workers in this area.[20] The path was only accessible by authorised persons – uncoupling, recoupling employees, shift supervisors, fitters and electricians and day cleaners.[21]

[18] There was an area specific induction/training/information provided to the authorised persons including John Erikson and they were all made well aware and were continually advised to be aware of moving plant and bins throughout the mill and in

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9 Report p 8.3.
10 Report p 8.5.
11 Report p 8.6.
12 Report p 8.9.
13 Particulars of the person conducting a business or undertaking.
14 Report p 9.3.
15 Report p 9.7.
16 Report p 10.1.
17 Report p 11.5.
18 Report p 11.5.
19 Tabs 10, 11 and 12 of Exhibit 1.
20 Report p 12.3.
21 Report p 12.5.

this specific work area.[22] They were also made well aware of the yellow line demarcation requirements for the workplace and in particular this specific work area.[23] The statements confirmed that an administrative notification/lockout/isolation system was in place prior to the incident for any work that had to be undertaken in the specific incident area.[24]

[19] The report from pp 13 to 36 summarised the statements taken from the various witnesses. The report then dealt with the current position of the PCBU with respect to changing from manual coupling to automatic systems. It was noted this project was currently in the feasibility and concept design phase but because of the complexity of the potential outcome changes would not be possible before the 2013 season.[25] A project team had been established with a project manager being appointed. In conjunction with improvements to be implemented for the 2013 crushing period, a study was being undertaken (namely a HAZOP) on the tippler exit and recoupling operations to determine the feasibility of an intermediate manual coupling zone similar to the tippler uncoupling arrangement.[26]

[20] The following improvements were to be implemented for the 2013 crushing period relating to safe operations of bin movement of the tippler exit:

(a) A full and extensive review and an assessment process was undertaken of the entire work area which resulted in significant changes to the work environment and work practices.[27]
(b) The area at exit of tip categorised as restricted area with access via restricted area permit and subject to stopping tippler operations.[28]
(c) Additional permanent fencing/handrail installed at common room area and tippler drive to prevent access to restricted area.[29]
(d) Exit from smoko room to tippler area will be limited to fenced enclosure for the purpose of instrument inspection and cleaning.[30]
(e) Permanent remote brake adjustment installed for bin brake units.[31]
(f) Gates locked and subject to restricted access permit only.[32]
(g) New gate installed at recoupling area to restrict pedestrian movement.[33]
(h) New procedure developed for cleaning activity in restricted area requires isolation of tippler before cleaning.[34]

[21] An analysis was conducted of other mills in the area.[35]

[22] The report concluded that the PCBU had ensured so far as reasonably practicable the provision and maintenance of a work environment without risk to health and safety.[36]

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22 Report p 12.6.
23 Report p 12.7.
24 Report p 12.9.
25 Report p 37.2.
26 Report p 38.3.
27 Report p 38.7.
28 Report p 38.8.
29 Report p 38.9.
30 Report p 38.9.
31 Report p 38.9.
32 Report p 38.1.
33 Report p 39.2.
34 Report p 39.3.
35 Report pp 40-41.
36 Report p 44.1.

[23] It was noted:

> "The PCBU provided a clear clean and clearly defined demarcation (distinct clear yellow line) between pedestrian and moving Plant in this work area for workers authorised to be in this area and had provided and maintained safety systems of work with respect to pedestrian access in this area the PCBU had specific and global work place safe systems (documented policies and procedures) that required workers not only in this area but throughout the entire mill to stay on the outside of the yellow demarcation line. The PCBU also had alternative access paths available for the workers to take that provided safe access between the two stations."[37]

[24] It was also noted:

> "The PCBU has provided information training instructions and the supervision to John Erikson to allow him and other workers to undertake work safely in this work area. John Erikson was provided with and undertook a number of training sessions both in theory and on the job that went through a number of operating procedures for this work area. The training covered off on the safety points of being aware of moving bins and staying outside of the yellow demarcation line. Such information and on the job training would have given John Erikson enough information to allow him to transfer safely in the work environment he was directed to work in this day."[38]

Further "[t]he PCBU has a strong supervision/monitoring process in this area and has had a global auditing process undertaken on the workplace."[39]

Trial

[25] Mr Wesche gave evidence that for 18 years he was the principal inspector of workplace health and safety investigations.[40] He gave evidence as to the layout of the scene of the incident. He gave evidence that tab 3 in exhibit 1 depicted a temporary fence which had been put in place after the incident.[41] Photo 5 of tab 3 of exhibit 1 was the recoupling shed down past the brake systems.[42] The witness identified the other photographs in tab 3. The recording of the incident was played. This was provided to him at some later point.[43] The witness said the cane bin in the footage was coming from the exit tippler and moving beyond the gravity fed ramp towards the braking system then on to the recoupling shed.[44] Tab 17 of exhibit 1 contained still images from the footage.[45] He agreed that the floor plan and plans of the cane bins and designs of the cane bins were provided voluntarily to him by the respondent.[46] Exhibit A for identification were documents headed "Sucrogen Proserpine tippler exit regarding improvements".[47]

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37 Report p 44.3-7.
38 Report p 45.1-4.
39 Report p 46.1.
40 Transcript day 1, p 13.11.
41 Transcript day 1, p 17.22.
42 Transcript day 1, p 18.1
43 Transcript day 1, p 21.40.
44 Transcript day 1, p 23.42.
45 Transcript day 1, p 24.
46 Transcript day 1, p 24.45.
47 Transcript day 1, p 31.

[26] In cross-examination the witness said that he expressed his conclusions and opinions in his report based on his 18 years of experience as a principal investigator.[48] He agreed that from the evidence he had obtained Mr Erikson had been trained and had experience in working in the area prior to the day of his death.[49] He agreed that the area in which Mr Erikson walked and where the incident took place was an authorised only work area and those not authorised were completely precluded entry from that area.[50] The authorisation extended to a small finite group of people including shift fitters, shift electricians, a cleaner etc.[51] He agreed that only those persons who were sufficiently trained and experienced were allowed in the area.[52]

[27] The documentation allowed him to conclude that on the job training and information given to Mr Erikson provided enough information to allow him to work safely in the work environment he was directed to work in that day.[53] He agreed that the course of the cane bin was entirely predictable because it was running down a fixed track,[54] unless of course, it derailed. The bin came out of the tippler after the tippler emptied its contents.[55] One bin smashing into the other had sufficient force to eject the empty bin from the tippler and they make an "echoey" rattly sound and frequently squeal as they go down around the bend.[56] It was his conclusion that the respondent had in fact complied with the relevant aspects of the Act.[57] It was his conclusion that the PCBU had provided a clean, clear and clearly defined demarcation – a distinct clear yellow line between pedestrian and moving plant.[58] He agreed that people could either go down through the demarcated corridor or on the outside of the other side of the fence line, but workers who were not specifically trained to work in the relevant area were precluded entirely from entry into it.[59] The purpose of the yellow line was so that people would not come into collision with the bins.[60] He concluded that the PCBU had provided information and training, instructions and supervision to Mr Erikson to allow he and other workers to undertake work safely in the work area.[61]

[28] He agreed that as to cleaning, where that involved crossing the yellow line onto the rail track, there was a system in place which included a lockout so the bins could not come out of the tippler.[62] There was a second type of cleaning involving the use of the air-lance where cleaning staff would not cross the yellow line.[63]

[29] He agreed that as Mr Erikson walked down to the right of the piece of machinery in the video, he was complying with the requirements placed upon him by staying on the outside of the yellow line.[64] His examination revealed the bins came out of the

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48 Transcript day 1, p 38.40.
49 Transcript day 1, p 39.17.
50 Transcript day 1, p 39.25.
51 Transcript day 1, p 39.30.
52 Transcript day 1, p 39.35.
53 Transcript day 1, p 40.1.
54 Transcript day 1, p 41.12.
55 Transcript day 1, p 41.20.
56 Transcript day 1, p 41.36.
57 Transcript day 1, p 43.17.
58 Transcript day 1, p 43.27.
59 Transcript day 1, p 44.5.
60 Transcript day 1, p 44.17.
61 Transcript day 1, p 44.24.
62 Transcript day 1, p 46.5.
63 Transcript day 1, p 46.15.
64 Transcript day 1, p 46.30.

tippler every 50 to 55 seconds,[65] some said 60. His investigations revealed the ramming of the tippler to the next bin was with sufficient force to punch it out of the tippler that produced a fairly significant crash and noise.[66] Mr Erikson had a view directly towards the tippler through the left window as he was coming to the door.[67] When a bin is in the tippler you can readily see the bin.[68] It could well have been that the view of Mr Erikson coming out of the crib room door was that of a bin in the tippler with the tippler going through its sequence.[69] He agreed that when one passed the narrow point near the braking system there was sufficient open space to the right to allow one to remain outside the yellow line and go around the braking system.[70] If Mr Erikson followed in conformity with his instruction, he could not have been struck by the bin.[71] He got hit metres down the track when he decided to go left, instead of into the open area to his right.[72] From his investigations Mr Erikson unexpectedly and without explanation suddenly crossed the yellow demarcation line directly into the oncoming cane bin which was about half a metre to a metre in front of the braking system.[73]

[30] There was a safe system of work of precisely avoiding that which happened to Mr Erikson if he had acted in conformity with his training by going right.[74] This was in the administrative documentation (reinforced in training) stating the primary obligation was not ever to cross the yellow line[75] and should it be necessary to cross the yellow line, to do cleaning for example, the system was that a lock out of the tippler system would take place.[76] There was available to Mr Erikson a path which was an area of complete safety.[77] He agreed that from the training modules and assessment, Mr Erikson was a particularly experienced worker.[78] People in that area did not only include those working in the recoupling yard, but included people who were using, for example, the air-lance.[79] Mr Erikson, of course, was authorised to be in that area.[80] The air-lance was used to clean away cane billets and also for persons to pick up loose pins if they saw them.[81] Cane billets can cause a derailment but also people might slip on them.[82] After every three or four bins an ad hoc clean was undertaken using the air-lance.[83] He agreed that the PCBU employed appropriate people as authorised people which included Mr Erikson.[84] The PCBU provided a clear clean access and a clear yellow demarcation line for pedestrian traffic.[85] The PCBU provided workers with training and information on how to move around safely

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65 Transcript day 1, p 48.25.
66 Transcript day 1, p 48.35.
67 Transcript day 1, p 48.47.
68 Transcript day 1, p 49.1.
69 Transcript day 1, p 49.10.
70 Transcript day 1, p 49.35.
71 Transcript day 1, p 49.40.
72 Transcript day 1, p 51.23.
73 Transcript day 1, p 51.30-35.
74 Transcript day 1, p 52.5.
75 Transcript day 1, p 52.10.
76 Transcript day 1, p 52.14.
77 Transcript day 1, p 52.25.
78 Transcript day 1, p 55.22.
79 Transcript day 1, p 56.15.
80 Transcript day 1, p 56.22.
81 Transcript day 1, p 56.42.
82 Transcript day 1, p 57.5.
83 Transcript day 1, p 57.7.
84 Transcript day 1 p 57.17.
85 Transcript day 1 p 57.32.

in the work area.[86] This was predominantly provided verbally on an ongoing basis and in written material.[87] The evidence was that if you had to cross the yellow demarcation line there needed to be a lockout process.[88] The evidence was the company had identified the risks associated with uncoupling and recoupling, an inherited hazard when they purchased the mill prior to the crushing season.[89] The witness said when considering tab 3 of exhibit 1, there was a build-up of cane billet rubbish around the gravity fed area.[90] The video revealed a significantly lesser degree of cane billet rubbish than that shown in the photos taken the afternoon of the succeeding day.[91] He was made aware that there was regular cleaning by the recoupling crew using air-lances and if there was to be a crossing of the yellow line there would be an isolation of lockout procedure.[92] The bins remained about 200 millimetres inside the yellow line as they proceeded down the track.[93]

[31] With respect to the improvements to be implemented the witness agreed that it was already the situation that only authorised personnel were permitted to be in that area.[94] The persons who were authorised were small in number and were trained.[95] He did not recall whether the gates were actually locked prior to the incident but there was signage on the gates pointing out restricted access.[96] Ultimately, even if the gates were locked or the smoko room door was locked, only authorised people were permitted to be there in any event to do work.[97] The bins weighed about three tonnes each.[98]

[32] In re-examination he agreed that there were no engineering or physical controls with respect to controlling the risk or hazard.[99] With respect to the improvements implemented for the 2013 crushing period, the locking of the door meant that no one was allowed in there unless they went through administrative control to get through the door.[100] With respect to the fence which was erected for the 2013 crushing period, that eliminates any person from going down the path and eliminated any risk of coming into contact with a moving bin or moving plant.[101] With respect to the locking of the gate as he understood it there was an interlocking system which would shut down the plant if people inadvertently went through the particular gate.[102]

Evidence of Nicholas Cronan

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86 Transcript day 1 p 57.35.
87 Transcript day 1 p 57.37.
88 Transcript day 1 p 58.32.
89 Transcript day 1 p 58.35.
90 Transcript day 2 p 3.7.
91 Transcript day 2 p 3.17.
92 Transcript day 2 p 3.20-35.
93 Transcript day 2 p 5.5.
94 Transcript day 2 p 6.27.
95 Transcript day 2 p 6.31.
96 Transcript day 2 p 7.1.
97 Transcript day 2 p 7.45.
98 Transcript day 2 p 9.1.
99 Transcript day 2 p 9.45.
100 Transcript day 2 p 12.17.
101 Transcript day 2 p 15.22.
102 Transcript day 2 p 15.32.

Interview

[33] Nicholas Cronan provided an interview dated 12 November 2012.[103] He was a trainee assessor and plant operator. He had started at the mill in May 2005. The deceased was a plant operator on another shift and was in his second year. Mr Cronan had picked up his assessor's ticket in June 2012. He had been training in on-site assessing for two and a half to three years. On the day of the incident just before 9.00 am the shift supervisor called him up and asked him to do an assessment on a coupler. He went down to the coupling yard to do the assessment. At about 9.30 am he asked for Tom Badger to come down while he did a "crane job" on the number 2 pinion.[104] He didn't feel Ms Gardner was confident and they decided to ask Mr Erikson to come and do 4 or 5 hours with her so she could build her confidence up. Mr Erikson came out of the crib room and everything seemed to be okay but for some unknown reason instead of staying outside of the line he stepped left in front of the bin.[105] At the relevant time Mr Cronan was assessing Anne Gardner.[106] A safety brief is undertaken to start and familiarisation of the stations and then they go and do coupling units for 8 hours and uncoupling units for 4 hours.[107] They are doubled up with another operator and once their time is up they are assessed on operating the system.[108] A practical assessment and written assessment is done.[109] On any particular day a number of people would access where Mr Erikson came down namely a coupler, uncoupler, plant operator, shift electrician, shift fitter and shift supervisor. Cleaners go into that area as well.[110] Instructions are given to the workers that they are not allowed to cross the yellow line unless they have permission from the supervisor.[111] They are told this at the training program and a demonstration is done as well and it is addressed a number of times with the workers.[112] The signage in the area had the words "authorised personnel only".[113] Every year the workers are assessed.[114] If there is a safety breach a re-assessment is done.[115] There are cameras in place all of the time.[116] The induction involves 2 to 2 ½ hours in a classroom.[117]

[34] He agreed there were other access areas aside from going along the path where Mr Erikson went.[118] The other members of the mill were not allowed in the area.[119] In training Mr Cronan tells them that they should make sure to look for the tippler when they come out of the smoko room[120] and that moving bins are a hazard.[121] As to Mr Erikson immediately prior to the incident, he wasn't attentive and he was looking at

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103 Exhibit 1 tab 24.
104 Interview 5.35.
105 Interview p 6.10.
106 Interview p 9.5.
107 Interview p 9.25.
108 Interview p 9.35.
109 Interview p 10.5.
110 Interview p 10.
111 Interview p 11.37.
112 Interview p 12.
113 Interview p 12.30.
114 Interview p 13.20.
115 Interview p 13.30.
116 Interview p 14.12.
117 Interview p 14.32.
118 Interview p 15.37.
119 Interview p 16.12.
120 Interview p 18.20.
121 Interview p 18.27.

the ground. The three of them were yelling at him but he did not look up.[122] He was on the outside of the yellow lines and all of a sudden he took one step to the left.[123] Since the incident they barricaded around the door and you can only go out of the door and clean it if there's a spotter. The gates had been locked and there was temporary barricading put up.[124]

Trial

[35] Mr Cronan gave evidence that he commenced working for the mill in May 2005 and was still employed there. As at 2012 he held the position of plant operator, trainer and assessor.[125] His role in 2012 was to train and assess the workers in whatever skills they required.[126]

[36] Mr Erikson was training to be a plant operator but he did not hold all of the relevant tickets and they were training him up to hold those.[127] The witness held a Trainers Assessors Competency as a trainer which he did in Mackay in 2010 and 2011.[128] The general training for staff included inductions, confined space, working at heights, safety, lockout procedures, work permit procedures, mobile reassessments and authority to operate machinery.[129] There would also be a specific site induction.[130] He agreed that he had performed work in the area inside the fence, namely uncoupling, coupling, push throughs, bin recovery, tippling yard cleans and rectifying any rail damage.[131] One had to have an authority to be in that area and secondly one had to be assessed to operate as a coupler/uncoupler.[132] Also, to operate as a coupler or uncoupler there would have had to have been a presentation given to them, they would have physically walked around the area and been shown it and there was a practical period under the eye of a supervisor and when they were ready for assessment they would do a written and practical assessment.[133]

[37] Other people required to work in that area would include the shift fitter and shift electrician and they would have a set of procedures to follow.[134] Other persons authorised to be in there including the cleaning gang.[135] The couplers/uncouplers also did cleaning as part of their training and work.[136] In addition to the cleaning gang, the shift supervisor was also authorised to be in the relevant area.[137] Plant operators were also authorised to be there because part of their role was to relieve the couplers and uncouplers from meal breaks, toilet breaks and so on.[138]

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122 Interview p 19.10-15.
123 Interview p 21.15.
124 Interview p 23.10.
125 Transcript day 2 p 39.26.
126 Transcript day 2 p 39.46.
127 Transcript day 2 p 40.20-30.
128 Transcript day 2 p 41.12.
129 Transcript day 2 p 41.30.
130 Transcript day 2 p 41.45.
131 Transcript day 2 p 43.22.
132 Transcript day 2 p 43.27.
133 Transcript day 2 p 43.30-37.
134 Transcript day 2 p 44.5.
135 Transcript day 2 p 45.22.
136 Transcript day 2 p 45.35
137 Transcript day 2 p 46.1.
138 Transcript day 2 p 46.5.

[38] He agreed that document 10 in exhibit 1 namely the respondent's policy on "recoupling cane bins" noted "a clear focus of this procedure is to supply lines of correctly coupled bins to the locomotive crews while keeping empty bins clear of tippler/ weighbridge".[139] The matters mentioned on p 33 of document 10 exhibit 1 (including never entering between bins whilst they were moving; never attempting to couple bins while moving; and staying clear of bins until they stop moving) was contained in a presentation in training and they would physically walk the area and the equipment would be pointed out.[140] Document 10 p 33 exhibit 1 noted at section 4 potential hazards including moving bins and moving machinery. There was also a list of equipment/PPE.[141] There was practical demonstration of the information contained in the document.[142]

[39] Document 11 of exhibit 1, "Cleaning area between Tippler/Weighbridge & Recoupling Shed" was issued in July 2012 and related to the cleaning and removing of cane billets on the ground.[143] At p 46 of the document it was noted "be vigilant at all times and aware of moving bins" and this was something the witness provided instruction on as well.[144] Section 4 of the document set out the potential hazards including moving machinery and moving cane bins.[145] There was also a note during the cleaning procedure "do not cross the yellow lines painted on the steel floor".[146] This was repeated on p 48 of the document.

[40] Document 12 of exhibit 1 was a policy called "Cleaning around Weighbridge/Tippler". Potential hazards were identified on p 56 of the document. If workers were not authorised to be in the area they could not go in there. This was brought up at the site induction and during training and familiarisation.[147] The witness agreed that he asked for Mr Erikson to come down to the coupling yard on the day of the incident.[148] He saw Mr Erikson from when he opened the door from the crib room right until he got hit. Mr Erikson was looking at the ground from the moment he left the smoko room.[149] He followed the outside of the yellow line but for some unexplained reason he just stepped to the left.[150] After the incident the gates were locked out. The couplers and uncouplers, the electrician and the shift engineer were allowed to go there if accompanied by a supervisor.[151] They were only able to go through gate 1. Additionally, the door in the crib room is locked and a big sign was put on there.[152] Basically the area where the incident took place was a "no go zone" other than when they were required to clean and there was a better lockout procedure.[153] Barricading was also erected.[154]

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139 Transcript day 2 p 46.20.
140 Transcript day 2 p 48.1.
141 Document 10 p 33 exhibit 1.
142 Transcript day 2 p 49.37.
143 Transcript day 2 p 52.7.
144 Transcript day 2 p 52.42.
145 Exhibit 1 document 11 p 47.
146 Exhibit 1 document 11 p 47 and transcript day 2 p 54.3.
147 Transcript day 2 p 60.35.
148 Transcript day 2 p 62.1.
149 Transcript day 2 p 62.15.
150 Transcript day 2 p 63.1.
151 Transcript day 2 p 64.11.
152 Transcript day 2 p 64.25.
153 Transcript day 2 p 64.47.
154 Transcript day 2 p 65.20.

[41] Document 15 of exhibit 1 was an Overall Assessment Summary Unit of Competency Uncoupler under the name of Mr Erikson.[155] He had done a similar assessment on an annual basis.[156] Mr Cronan conducted the safety assessment of Mr Erikson.[157] There was a unit of competence with regard to the position of coupler which was performed on 12 October 2012.[158] There was also an oral assessment as regards to safety.[159]

[42] The witness agreed that he was involved with the review of hazards in 2013,[160] he said the position of the brakes were altered, there was permanent fencing and gates erected and the rail was lifted.[161]

[43] In cross-examination the witness agreed there was now an automated recoupling system.[162] The effect of this was that, other than in an emergency situations, no recouplers are required in the area because their job is done by machinery.[163] He agreed that the couplers were required to clean on a frequent basis using the air lance.[164] If a coupler or a relieving person like Mr Erikson came out of the crib room door and used the path he was expected to undertake cleaning if required or report the presence of billets to the supervisor.[165] He agreed that document 11 p 46 exhibit 1, noted "be vigilant at all times and aware of moving bins and be aware of cane billets, do not clean across the lines, do not cross the yellow line when bins are moving".[166] These points were made clear in the training undertaken by Mr Cronan and he actually took the inductees through a walk-through and one of the things highlighted was the yellow line.[167] The absolute prohibition upon crossing the yellow line was stressed and people were only allowed to cross the line if there was a lockout.[168] The dot points at p 46 of tab 11 exhibit 1 were highlighted to the workers.[169] If a worker stuck by the safety points and a bin was on the train line they would never come sufficiently near the bin to be struck by it.[170] These documents were given to the workers and a presentation was given to them as well. There were oral instructions, a walk-through and a written and practical assessment.[171] He considered Mr Erikson was sufficiently knowledgeable of the restrictions.[172] From his observation of Mr Erikson, he gave satisfactory answers during the assessment.[173]

[44] With respect to the fencing installed after the incident, the fence was extended from the brake area and past the coupling shed on the western side.[174] The purpose of this is not to restrict the access of authorised people but to restrict the access of

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155 Transcript day 2 p 66.27.
156 Transcript day 2 p 67.10.
157 Transcript day 2 p 67.24.
158 Transcript day 2 p 67.42.
159 Transcript day 2 p 68.5.
160 Transcript day 2 p 69.1.
161 Transcript day 2 p 70.5.
162 Transcript day 2 p 73.30.
163 Transcript day 2 p 73.36.
164 Transcript day 2 p 74.5.
165 Transcript day 2 p 74.40.
166 Transcript day 2 p 75.20-25.
167 Transcript day 2 p 75.40.
168 Transcript day 2 p 76.4.
169 Transcript day 2 p 77.10.
170 Transcript day 2 p 77.12.
171 Transcript day 2 p 77.15-20.
172 Transcript day 2 p 77.47.
173 Transcript day 2 p 78.1.
174 Transcript day 2 p 78.25.

unauthorised people.[175] This was the same purpose as the fencing on the eastern side.[176] Mr Cronan agreed that staff were instructed when exiting the crib room door to always look to the tippler to see whether a bin was in it and to assess the stage of the cycle.[177] Anyone coming out of the crib room door can look at the tippler and become aware of when it is likely the next bin would be ejected.[178] He agreed that a bin was effectively shunted by a full bin behind it and this makes a lot of noise.[179] Even with hearing protection one can readily hear the noise of a bin being ejected.[180] He also agreed that as the bin went around the corner it squealed with a high pitch sound.[181] One could readily come out of the crib room to blow away the cane billets with an air lance without crossing the yellow line.[182] One of the points of cleaning is to make it safe for transit.[183] The couplers would use the air lance every three or four bins to keep it clean.[184] There was very little billet activity at the point of the accident.[185]

[45] It was completely banned to use an iPhone or mp3 player.[186] When he reached Mr Erikson he noted that he had a hearing bud in one ear and the other was on his chest.[187] The ear pieces were associated with music which was strictly prohibited and Mr Erikson was aware of that.[188] During the training regime Mr Cronan drummed into the workers the prohibition of using mobile phones and mp3 players, never to cross the yellow line and never to be complacent.[189] The couplers were expected to keep the area clean of billets because of potential derailments, slips, trips and falls. Additionally, they were to look out for pins when they came out of the crib room, collect them and put them into a box.[190] The inductees were told never to cross the yellow line and never to walk between the braking system pylons.[191] There was plenty of room to walk around the braking system on the outside of the yellow line.[192] The gating or fencing which was put in after the incident was not to prevent authorised coupling staff from going there but to prevent unauthorised people coming in.[193] It was quite a common thing to use an air lance with the bin coming past the worker,[194] the air lance was about 2 to 3 metres long.[195]

[46] In re-examination the witness agreed there was now an automated system plus a full-blown lock out system for cleaning.[196] With respect to the buds in Mr Erikson's ears

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175 Transcript day 2 p 78.27.
176 Transcript day 2 p 78.30.
177 Transcript day 2 p 79.5.
178 Transcript day 2 p 79.20.
179 Transcript day 2 p 79.30.
180 Transcript day 2 p 79.42.
181 Transcript day 2 p 80.32.
182 Transcript day 2 p 81.22.
183 Transcript day 2 p 81.46.
184 Transcript day 2 p 82.5.
185 Transcript day 2 p 82.7.
186 Transcript day 2 p 82.10.
187 Transcript day 2 p 82.17.
188 Transcript day 2 p 82.32. Also see exhibit 1 tab 10 p 32.
189 Transcript day 2 p 82.46-83.3.
190 Transcript day 2 p 83.5-12.
191 Transcript day 2 p 83.27.
192 Transcript day 2 p 83.40.
193 Transcript day 2 p 84.20.
194 Transcript day 2 p 86.30-45.
195 Transcript day 2 p 87.5.
196 Transcript day 2 p 87.30.

when he was walking down, there was one in each ear but when he got hit there was one in one ear and one across his chest.[197]

Evidence of Anne Gardner

Interview

[47] Anne Therese Gardner provided an interview dated 12 November 2012.[198] Ms Gardner was employed by the respondent as a weighbridge clerk and was training for filling in coupling and uncoupling stations.[199] This was her second crush season at the mill. She started her shift at 2.00 am. Her normal shift starts 6.00 am but because there was four hours overtime she started to fill in at coupling. They needed someone down there.[200] She was being observed and trained by Mr Cronan.

[48] The incident occurred close to 10.00 am. Mr Cronan had been there long enough and it was time for him to go off site and someone who knew how to couple the bins had to come and assist her because she was not ready to be left there on her own.[201] Mr Erikson came down to assist her and he was on his way when the incident occurred. She noticed that Mr Erikson's head was down.[202] After Mr Erikson was struck emergency procedures "kicked in".[203]

[49] As to her training, the first part was with Mr Cronan. It involved both the theory side and the safety side in the crib room. Safety procedures were done first and then there was brief talk about the operating procedure.[204] She did this session about six weeks prior. After this she did practical experience, perhaps five hours and a couple of different shifts.[205] Information was given to her about where she should walk after going from the smoko room to the recoupling area. There were instructions given about not crossing the yellow line and always looking sideways at the bins coming out of the tippler.[206] Information about being aware of the bins was in the training manual/the training sheets.[207] There were also instructions not to step between moving bins, it was drummed in as a safety message to not go near the line when there were moving bins.[208] This was drummed in from the first orientation day.[209]

Trial

[50] Ms Gardner gave evidence that she was no longer employed by the respondent. Her usual position as at November 2012 was as a weighbridge clerk.[210] She was in the process of being trained to fill in at the coupling station and the uncoupling station.[211] She commenced working on the day at 2.00 am. There was four hours overtime

197 Transcript day 2 p 88.22.
198 Exhibit 1 tab 25.
199 Interview p 3.37.
200 Interview p 5.10.
201 Interview p 6.12.
202 Interview p 8.27.
203 Interview p 9.21.
204 Interview p 9.35.
205 Interview p 10.25.
206 Interview p 11.25.
207 Interview p 11.37.
208 Interview p 15.25-35.
209 Interview p 16.3.
210 Transcript day 2 p 95.22.
211 Transcript day 2 p 95.27.

because she was originally going to commence at 6.00 am.[212] She worked in the uncoupling shed for four hours and then went to the weighbridge and carried out her normal duties.[213] She commenced her training at about 7.00 am and went up to the coupling station. She was trained by Mr Cronan first and then Mr Badger. She had received her competency for uncoupling but not coupling at the time.[214] She saw Mr Erikson come out of the crib room at about 10.00 am. She was about 70 metres away. She observed that he was not walking in a straight line.[215] He then started following the pathway; was looking down and did not look up. He was deviating.[216]

[51] In terms of persons authorised to be in the area, there was the coupler, an uncoupler; a messenger; the shift engineer; the shift supervisor; the electrician and the crew on cleaning duties.[217] The witness said she was told by her employer to stay outside of the yellow line. They were told that at the initial induction and in the training for the coupling/uncoupling position. They were told this verbally and it was also in the printed training manuals.[218] She agreed that the area was very noisy, the main noise was when the bins crashed together.[219] The following morning after the incident there were more heavier and temporary barricades set up along the pathway.[220] She also couldn't recall when the gates started being locked.[221] Access became restricted.[222] They were still able to access the sensors.[223]

[52] In cross-examination she agreed that the main noise that she heard was the bins crashing together.[224] She agreed that she was trained when she came out of the crib room they should look into the tippler to see whether a bin was there and what the cycle of the bin was.[225] She agreed that persons who took the pathway were the uncouplers and recouplers as they switched shifts, a fitter and an electrician and a cleaning gang.[226] She agreed that when she was at the recoupling shed she was being constantly assessed and supervised by Mr Cronan and Mr Badger.[227] She agreed that persons used an air lance hose and she would use it whilst on cleaning duties.[228] This was to keep the billets off the rail line and there was constant cleaning required.[229]

Evidence of David Frazer

Interview

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212 Transcript day 2 p 95.40.
213 Transcript day 2 p 96.7.
214 Transcript day 2 p 97.1.
215 Transcript day 2 p 97.
216 Transcript day 2 p 98.5-20.
217 Transcript day 2 p 98.25-45.
218 Transcript day 2 p 99.30-42.
219 Transcript day 2 p 100.32.
220 Transcript day 2 p 101.25.
221 Transcript day 2 p 102.12.
222 Transcript day 2 p 102.22.
223 Transcript day 2 p 102.32.
224 Transcript day 2 p 103.24.
225 Transcript day 2 p 103.45.
226 Transcript day 2 p 104.25-30.
227 Transcript day 2 p 104.37.
228 Transcript day 2 p 105.5.
229 Transcript day 2 p 105.17.

[53] Mr Frazer provided an interview on 5 December 2012.[230] Mr Frazer started work at the Proserpine Mill in 2012. He was initially employed as a mill attendant and was then transferred to the uncoupling/coupling position which he held for the rest of the crushing season.[231] With respect to coupling/uncoupling he would work with a partner and they would change positions every two hours.[232] On the day of the incident he was in the process of finishing up when the incident happened.[233] He was in the uncoupling shed and had just handed over to Adam Day and was getting ready to leave. He was not an eye witness to the actual incident.[234] When he started at the mill his first introduction to the uncoupling area was by Mr Feedler. He was instructed to ensure the gates were closed and always walk on the outside of the yellow line. He was later given training by Mr Cronan who also stressed he should walk on the outside of the yellow line.[235] This was drummed into them.[236] Cleaning around the weighbridge and tippler involved a full lockout.[237] There was a sign which said "authorised entry only".[238] Other mill workers were not supposed to go into that area, they were supposed to go over the overpass.[239] He was shown a photograph of a fence and sign which was put up post-incident.[240] The bins were about 100 – 200 millimetres inside the yellow line.[241] It was about 55 to 60 seconds for each bin.[242] They were advised to be aware of moving bins.[243] Brad Birkwhistler, the supervisor, would drop in two or three times during a shift to supervise them.[244] Mr Cronan impressed on him not to get complacent.[245]

Trial

[54] Mr Frazer gave oral evidence that he was employed as at November 2012 with the respondent and finished working there in 2015. He was briefly a mill attendant and was then transferred to be an uncoupler/coupler. With respect to the role of coupler/uncoupler, you generally work with a partner and you take turns in two hours, uncoupling cane bins and then two hours recoupling them at the other end.[246] If you're an uncoupler you're in the uncoupler shed which is situated about 50 metres down the line.[247] With respect to the changeover every two hours, one would call up the other on the radio, arrange the changeover and then the recoupler would walk up to the uncoupling shed and the uncoupler would walk down to the other shed.[248] There was at least one occasion per shift where they would walk from the smoko room to the recoupling shed.[249] Generally, when he finished his lunch break he would

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230 Exhibit 1 tab 26.
231 Interview p 5.25.
232 Interview p 5.37.
233 Interview p 7.15.
234 Interview p 8.1.
235 Interview p 8.35.
236 Interview p 9.1.
237 Interview p 10.1.
238 Interview p 12.35.
239 Interview p 13.7.
240 Interview p 20.7.
241 Interview p 26.11.
242 Interview p 26.30.
243 Interview p 26.37.
244 Interview p 31.20.
245 Interview p 34.25.
246 Transcript day 2 p 19.14.
247 Transcript day 2 p 19.25.
248 Transcript day 2 p 20.22.
249 Transcript day 2 p 21.17.

walk down to the recoupling shed inside the fence but there was no hard and fast rule.[250] With some clean-up work there was a lockout.[251] The only people authorised to be in the relevant area within the fence line were the authorised couplers and uncouplers and there was a sign on the gate stating "authorised persons only".[252] Shift supervisors and the shift electrician were also permitted there.[253] He became authorised through training which involved a classroom session and written examination.[254] With respect to his training that included dealing with coupling and uncoupling of bins, safety procedures etc.[255] He recalled very clearly they were instructed to always walk outside the yellow line.[256] They were also told always to be aware of moving cane bins.[257] There was a two day induction including a video presentation.[258] The witness said he did not generally work with Mr Erikson.[259] He was in the brick uncoupling shed at the time of the incident.[260] After Mr Erikson's death some changes had occurred, such as the smoko room door being kept locked. This happened on the next shift.[261] He thought that since the incident, bearing in mind his memory was not that good, that fencing was erected which prohibited them going past the tippler brakes.[262]

[55] In cross-examination the witness agreed that during his training it was drummed into them they were always to be aware of the moving bins.[263] They were also told never to cross the yellow lines unless lockout was in practice.[264] This was done in both his training and repeatedly thereafter.[265] He said that the bins came out of the tippler every 45 to 50 seconds and the way they came out was that the next bin behind it (which was full) smacked into the back of the empty bin and ejected it out of the tippler which made a very loud noise.[266] He agreed that as one comes out of the smoko door the tippler was to the left front, there was a clear view of whether there was a bin on the tippler and one could tell what part of the cycle the tippler was going through.[267] They were trained to look in the tippler to see what the state of the cycle was.[268] He agreed that as the bins came around the left curve they tended to squeal and there was the noise of the rattling empty cages.[269] If there was any occasion on which people had to cross the yellow line there would be a full lockout.[270] He agreed it was made fundamentally clear to him that he should never cross the yellow line.[271]

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250 Transcript day 2 p 24.20.
251 Transcript day 2 p 24.32.
252 Transcript day 2 p 25.30.
253 Transcript day 2 p 25.37.
254 Transcript day 2 p 25.45.
255 Transcript day 2 p 26.37.
256 Transcript day 2 p 27.5.
257 Transcript day 2 p 27.22.
258 Transcript day 2 p 27.45.
259 Transcript day 2 p 32.5.
260 Transcript day 2 p 32.32.
261 Transcript day 2 p 33.1.
262 Transcript day 2 p 34.45.
263 Transcript day 2 p 36.15.
264 Transcript day 2 p 36.17.
265 Transcript day 2 p 36.20.
266 Transcript day 2 p 36.27.
267 Transcript day 2 p 36.35.
268 Transcript day 2 p 36.42.
269 Transcript day 2 p 37.25.
270 Transcript day 2 p 37.40.
271 Transcript day 2 p 37.45.

It was drummed into him also they should always be looking for bins and they should never be complacent.[272]

Evidence of Rodney Camm

Interview

[56] Mr Camm provided an interview dated 5 December 2012[273]

[57] Mr Camm said that he started at the mill in 2007 and had been a full-time employee since 2008.[274] At the time of the incident he was the shift supervisor on the 'C Crew'. His task was to maintain the operation of the mill. He commenced the afternoon shift at 2.00pm after the incident happened.[275] All of the workers in the relevant area were trained by Mr Cronan. Mr Cronan took them through standard work procedures and signed them off after a number of hours of training.[276] There was a yearly induction process at the mill.[277] The induction is pretty much a full day which includes the onsite safety officer.[278] With respect to how the hazard in the relevant area was controlled, only people who should be working in the area were permitted. All of the cane rail and transport guards have an overpass ladder over the top of the recoupling station.[279] If it's a major problem and the tippler needs to be isolated, there is a shutdown so there is no chance of any rolling stock coming through the area.[280] There were exclusion zones from moving plant and there were policies of where persons entered the mill.[281] Instructions concerning the yellow line should all be part of the training package.[282] The area where the incident occurred was not a high traffic area, but recouplers tended to walk down there.[283] Recouplers work in that area because they clean the area, tag out, isolate and lock out.[284] A number of changes were made post incident.[285] There have never been any near misses in that area before and he had never heard of people being hit by bins.[286] There were no problems with Mr Erikson.[287]

Trial

[58] Mr Camm gave evidence that as at 11 November 2012 he was an employee of the respondent at the mill.[288] He had started there as a contractor in December 2007 and started working for the mill itself from June 2008.[289] As at November 2012 he was a

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272 Transcript day 2 p 38.5.
273 Exhibit 1 tab 27.
274 Interview, p 5.7.
275 Interview, p 6.24.
276 Interview, p 7.20.
277 Interview, p 9.1.
278 Interview, p 9.17.
279 Interview, p 10.17.
280 Interview, p 10.32.
281 Interview, p 11.20.
282 Interview, p 13.7.
283 Interview, p 16.1-7.
284 Interview, p 16.30.
285 Interview, p 18-19.
286 Interview, p 23.
287 Interview, p 24.10.
288 Transcript day 2, p 124.45.
289 Transcript day 2, p 125.1.

shift supervisor.[290] There were 19 people working across the entire mill.[291] He also supervised people performing work in the area of the incident.[292] Shift electricians, shift fitters, and the recoupling uncoupling crews worked in the area.[293] Sometimes the cleaning gang worked there as well.[294] He was not there when the incident happened. He started his shift at 2.00 pm.[295] With respect to the yellow line adjacent to the cane rail track there were written procedures in place with respect to that and they had to be mindful there were bins coming through there and they were taught to stand on one side.[296] There were about 50 seconds to a minute intervals between the cane bins.[297] Whilst it was noisy it was not as noisy as other parts of the mill. There was a loud banging noise when the bins came into contact with each other.[298] Derailments had occurred in that area before but they were not a regular occurrence.[299] After the incident with Mr Erikson they "stayed clear of that area so to speak".[300] Also after the incident there was a definite permitted entry and increased vigilance and an exclusion zone.[301] There were padlocked gates[302] and a barrier.[303] The shift electrician could still access the area but "if it was any sort of major thing it was a complete lockout".[304] With cleaning after the incident it was a lockout procedure.[305] They also extended the barrier fencing so that there was no chance of other people walking into the area.[306] When they went to auto coupling it was a 100 per cent lock out.[307]

[59] In cross-examination the witness agreed that the principal causes of derailments were either cane billets or pins on the rail track and the purpose of the cleaning was to reduce the risk of derailment.[308] There were instructions that people walking down the alleyway would look for billets and pins and if they were there they could be hosed away with the air lance.[309] A person could use the air lance without impinging upon the yellow line.[310] The most efficient way to reduce the risk of derailment was to have very frequent cleanings.[311] In his time this was undertaken safely and there were no incidents of any risk to individuals in the vicinity of the rail line and walkway.[312]

Evidence of Thomas Badger

290 Transcript day 2, p 125.6.
291 Transcript day 2, p 125.41.
292 Transcript day 2, p 127.13.
293 Transcript day 2, p 127.20-26.
294 Transcript day 2, p 127.31.
295 Transcript day 2, p 129.12.
296 Transcript day 2, p 129.30.
297 Transcript day 2, p 131.41.
298 Transcript day 2, p 132.7.
299 Transcript day 2, p 133.15.
300 Transcript day 2, p 134.37.
301 Transcript day 2, p 135.25.
302 Transcript day 2, p 136.1.
303 Transcript day 2, p 136.22.
304 Transcript day 2, p 137.41.
305 Transcript day 2, p 138.20.
306 Transcript day 2, p 140.1.
307 Transcript day 2, p 140.12.
308 Transcript day 2, p 140.35-40.
309 Transcript day 2, p 141.6.
310 Transcript day 2, p 141.9.
311 Transcript day 2, p 141.35.
312 Transcript day 2, p 142.5.

Interview

[60] Mr Badger provided an interview dated 12 November 2012.[313] He was employed by the respondent as an acting assistant production manager. He started at the mill in 2003 and was a shift supervisor until the respondent took over in December 2011 and he had continued in supervisory roles after then.[314] As to the incident, he worked from 10.00 pm until 6.00 am. He was about to go home at 6.30 am but he was working on some other issues. At about 9.00 am he was told there was an inexperienced person in the recoupling shed and was asked to give them a hand and keep an eye on them.[315] He made his way out there and assisted and they ran the station for about an hour. At about 10.00 am he was told he was going to be replaced by Mr Erikson. He saw him coming down from near the tippler area but as he approached the wheel brake area he seemed to be zigzagging around the wheel brakes. Mr Erikson didn't realise the bin was coming. He yelled out loudly but for some inexplicable reason Mr Erikson veered across the yellow line and was struck.[316] With respect to the station, they employed two people on each shift.[317] There were a number of written procedures prior to such employment and employees are assessed to ensure they are competent to run solo.[318] The trainers drum into people to stay outside the yellow line and never turn their back on the moving bins.[319] There are written procedures which say that one has to stay outside the yellow line.[320] Only authorised people are allowed to access that area[321] anybody else is supposed to go up and over the walkways.[322] The area is not a general access way for the general mill population.[323] The shift supervisor monitors the "guys" every 20 minutes or so.[324] Mr Erikson, when he was walking towards them had his head down as though he was preoccupied but was walking casually.[325] He did not recall if he had ear plugs in.[326] He said that when the bins get shunted into the tippler they make a distinctive sound and the bins generally squeal on the curve.[327] Mr Erikson was certainly experienced in the area.[328] With respect to the area, two gates had now been locked to stop casual access to the area and barricading had been put up at the tip. There had been extra barricading put closer to the recoupling station to close off a gap in the fence so persons can't walk casually in there.[329]

Trial

[61] Mr Badger gave evidence that as at 11 November 2012 he was acting as assistant manager with the respondent.[330] He had worked at the mill since 2003. He was due

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313 Exhibit 1 tab 23.
314 Interview p 3.27.
315 Interview p 4.17.
316 Interview p 4.25-35.
317 Interview p 5.27.
318 Interview p 5.35.
319 Interview p 6.12.
320 Interview p 6.32.
321 Interview p 7.17.
322 Interview p 7.25.
323 Interview p 8.25.
324 Interview p 11.12.
325 Interview p 14.11.
326 Interview p 14.17.
327 Interview p 15.
328 Interview p 16.7.
329 Interview p 17.5.
330 Transcript day 2 p 106.20.

to finish at 6.00 am but remained because he was training Ms Gardner.[331] He was familiar with the area between the tippler and the coupling shed and agreed that only authorised employees were permitted inside that area.[332] A number of persons were authorised including the uncoupler; the recoupler, the shift supervisor, the shift electrician, the shift fitter and the cleaning gang.[333] There were 15 to 16 employers on shift at the relevant time.[334] Seven or eight of those would have been authorised to go into the relevant area.[335] Mr Erikson was authorised to go into that area.[336] He said that oral directions were given to people to stay outside the painted line (yellow) whilst the bins were in motion.[337] He agreed that cane bins came out of the tippler about every 45 to 50 seconds while they were crushing.[338] He did not consider the area where the incident took place as the noisiest area in the factory.[339] Turning back to the incident, he had been told a little earlier that Mr Erikson was coming in to take over in the recoupling role.[340] He saw Mr Erikson open the door of the weighbridge crib room and saw his entire walk to the wheel brakes. He was looking down at the track with his back to the exiting bins. He was walking pretty normally.[341] He did not observe anything in his ears.[342] He then saw Mr Erikson step over the line which he thought was an unusual thing to do.[343] After the incident there were some changes to the procedures.[344] There were new exclusion zones in place. The recouplers could only go as close to the tip as the outlet side of the wheel brakes and the gates with the exception of one were secured and there were limitations of where people could travel in that area.[345] There was also some barricading put up which ran from the exit side of the tip out towards the recoupling station.[346] If they needed to access the now barricaded area for maintenance, an isolation would need to be performed.[347] He agreed that the couplers were involved with the cleaning because there'd be a certain amount of build-up of cane billets and trash on the weighbridge structure which needed to be cleaned off. His recollection is that procedure changed too after the event.[348]

[62] In cross-examination the witness agreed that prior to the death, workers were required to clean the billets away using the air lance.[349] They could do this by staying outside of the line because the air lance was quite long. The purpose of the cleaning was to keep the walkway safe and to reduce the risk of derailment.[350] He agreed that in terms of instructions he gave, the biggest matters were to keep aware of the moving bins and to keep the area clean. He agreed that keeping outside the yellow line was a

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331 Transcript day 2 p 107.7.
332 Transcript day 2 p 108.5.
333 Transcript day 2 p 108.15-25.
334 Transcript day 2 p 109.12.
335 Transcript day 2 p 109.24.
336 Transcript day 2 p 110.5.
337 Transcript day 2 p 110.25.
338 Transcript day 2 p 111.40.
339 Transcript day 2 p 112.5.
340 Transcript day 2 p 113.22.
341 Transcript day 2 p 113.47.
342 Transcript day 2 p 114.10.
343 Transcript day 2 p 114.32.
344 Transcript day 2 p 114.47.
345 Transcript day 2 p 115.4.
346 Transcript day 2 p 115.42.
347 Transcript day 2 p 117.1.
348 Transcript day 2 p 117.25.
349 Transcript day 2 p 118.7.
350 Transcript day 2 p 118.20.

prohibition drummed into all inductees.[351] If one kept outside the yellow line, absent a derailment one could not be struck by a bin. The yellow line was of a sufficient distance from the rail line to prevent this.[352] He agreed that about seven or eight people in a shift would have authority to be in the area.[353] The principal safety controls were drummed into those persons in their training. That is, to keep aware of the bins, stay outside the yellow lines and not to be complacent.[354] He agreed that the bins were ejected every 45 to 50 seconds and this made a loud noise.[355]

[63] After the incident the couplers would access the coupling yard by walking down the outside route but there was nothing preventing them going up to the wheel brakes.[356] The purpose of the fencing was to prevent unauthorised and untrained people accessing the yard.[357] The unauthorised untrained people used the overhead catwalk to get across the rail line.[358] With respect to the locked doors, the recouplers were not prevented from accessing the recoupling yard.[359] One of the prohibitions in place prior to the event was not crossing the yellow line and it was effective as far as he saw it and the invariable practice of people working in the area until the incident was to conform with the direction.[360] Mr Erikson did not conform to the direction.[361]

Evidence of Benjamin John Edmunds

Trial

[64] Mr Edmunds, an engineer, was engaged by Workplace Health and Safety to consider the incident involving Mr Erikson.[362] He gave evidence that the bin speed was 2.2 metres per second or 7.92 kilometres per hour.[363]

[65] In cross-examination the witness agreed he did not do any calculations of Mr Erikson's walking speed.[364] He agreed that a 1996 study showed that 2.2 metres per second is faster than what people might normally walk at.[365]

Prosecution submissions

[66] The prosecution submitted that the codes of practice were admissible under s 275(2) of the WHSA and the code at s 4.4 of the supplement[366] identified that hitting and being hit by moving objects was a major hazard at a sugar mill.[367] The code of practice as to how to manage work, health and safety risks[368] identified the step by step process of dealing with such hazards.

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351 Transcript day 2 p 118.30.
352 Transcript day 2 p 118.40.
353 Transcript day 2 p 119.1.
354 Transcript day 2 p 119.35-45.
355 Transcript day 2 p 120.12.
356 Transcript day 2, p 122.5-10.
357 Transcript day 2, p 123.6.
358 Transcript day 2, p 123.11.
359 Transcript day 2, p 123.31.
360 Transcript day 2, p 123.1\40-45.
361 Transcript day 2, p 124.1.
362 Transcript day 3, p 3.7.
363 Transcript day 3, p 5 and Exhibit 2.
364 Transcript day 3, p 9.37.
365 Transcript day 3, p 10.7.
366 Exhibit 1, tab 19.
367 Transcript day 3, p 17.12.
368 Exhibit 1, tab 20, p 170.

[67] The prosecution accepted there had been an oral direction not to cross over the line.[369] It was also accepted the written procedures contained a similar statement.[370] It was submitted that the respondent should have implemented higher order controls.[371]

[68] With respect to Inspector Wesche the prosecution pointed out that he did not refer to any of the codes or the hierarchy of controls in his report.[372] The prosecution submitted as to the alleged failures by the respondent. It was submitted it was a failure to allow workers to access the walkway from the tippler room.[373] It was submitted that there was an alternative path available and if workers had been directed to use that alternative path the risk would have been eliminated.[374] This had been done by closure of access gates to the area and the erection of barricading and fencing.[375] The prosecution relied particularly on p 129 of the supplementary code[376] which provided that the risk of injury from persons for a rolling stock is eliminated if access is provided to work areas without the need to walk through the bins and mill yards.[377] It was submitted that the employer must have a proactive approach to safety issues.[378] Part 8 of the complaint and summons set out the measures which could have been implemented by the respondent.[379]

Defence submissions

[69] The defence relied on written submissions. It was accepted that the respondent owed a health and safety duty to Mr Erikson under s 19(1) of the WHSA.

[70] It was submitted that the prosecution case could not be sustained because:

(a) only authorised persons were allowed in the walkway from the crib room and were undertaking functions related to work;
(b) authorised persons were trained and required to undertake cleaning operations in the area;
(c) the purpose of such a task was to maintain a clean and safe work place;
(d) the frequency of the use of the walkway was minimal and confined to authorised persons only;
(e) a person only became authorised after they had completed training and passed competency assessment;
(f) the assessment and training procedure by Mr Cronan was comprehensive;
(g) the witnesses gave evidence that training instructions particularly with regard to crossing the yellow line were universally adhered to, save for the incident;
(h) there was no evidence of any previous incident where a person was injured or there was a near miss;
(i) the content and nature of the training emphasised not crossing the yellow line, being aware of moving bins, being mindful and guarding

369 Transcript day 3, p 18.37.
370 Transcript day 3, p 19.15.
371 Transcript day 3, p 20.20.
372 Transcript day 3, p 20.27.
373 Transcript day 3, p 29.5.
374 Transcript day 3, p 29.25.
375 Transcript day 3, p 29.37.
376 Exhibit 1, tab 19, p 129.
377 Transcript day 3, p 32.1.
378 Transcript day 3, p 34.12.
379 Transcript day 3, p 35.5.

against complacency and taking particular note of the tippler on exiting the crib room;

(j) Mr Erikson departed the crib room a few seconds prior to the cane bin being ejected;

(k) the sound of the cane bin was obvious;

(l) Mr Erikson ought to have been aware that the bin was ejected shortly after he left the crib room;

(m) once Mr Erikson passed the "pinch point"` there was ample room for him to move to the right;

(n) that he did not do so was irrational and completely contrary to clear, explicit and express instructions;

(o) the act could not have been in the reasonable contemplation of the respondent;

(p) Mr Wesche's evidence should be accepted;

(q) the evidence of what occurred after the incident could not be relied on as they were taken in compliance with a prohibition notice; and

(r) steps taken after the automated recoupling were irrelevant.

[71] It was submitted that the failures particularised in paragraph 7 of the complaint could not be established beyond reasonable doubt and as to paragraph 8 of the complaint, that the steps would not prevent access by authorised persons to the area in any event.

[72] In those circumstances the complaint ought to be dismissed.

[73] In oral submissions the respondent stressed there was no evidence of any other similar incident.[380] There were instructions about keeping outside of the line.[381] The instructions were drummed into the workers.[382] Mr Erikson had been sufficiently trained and had sufficient information to enable him to work safely.[383] There was adequate space to walk around the braking system.[384] It was submitted that the requirements of the code, paragraph 4.4, were general rather than specific and they had been complied with.[385] With respect to the barricading after the incident, that was to keep unauthorised people out and had nothing to do with the authorised people.[386]

[74] The measures put in place after the incident were irrelevant because it just simply meant that the authorised persons effected entry by other means.[387] It was submitted that Mr Wesche's opinion should be given due weight bearing in mind his experience and his investigation.[388]

Decision

[75] The magistrate in his decision noted that the prosecution bore the onus of proof and proof was beyond reasonable doubt.[389] He held that the fact of death was not

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380 Transcript day 3, p 42.12.
381 Transcript day 3, p 45.17.
382 Transcript day 3, p 47.12.
383 Transcript day 3, p 48.27.
384 Transcript day 3, p 50.25.
385 Transcript day 3, p 55.37.
386 Transcript day 3, p 56.20.
387 Transcript day 3, p 57.1.
388 Transcript day 3, p 58.5.
389 Reasons p 2.7.

determinative of the matter nor were subsequent changes to the workplace (although they may be relevant).[390] The magistrate had regard to the exhibits, the relevant authorities and the evidence called.[391] The magistrate found that Mr Erikson had been called to the recoupling shed to undertake duties there. He stayed on the outside of the painted yellow line until he was less than a metre from the braking system. He then stepped or veered over the yellow line and was struck sustaining fatal injuries.[392]

[76] The magistrate, with reference to the particulars, noted that the prosecution case was that the respondent failed to adequately identify the risk and failed to adequately respond to the risk by failing to protect persons from the hazards and risks by failing to eliminate or adequately control them.[393] He noted the prosecution case was that the workers should not have been there and they should have been excluded from the corridor area by directing them to use a different path.[394] There was an alternative path available. The defence contended this was not reasonably practicable. The magistrate noted that Mr Erikson had been trained and certified as being competent to work in that area.[395] Most of the time the coupling teams traversed this area. Other workers would also access the corridor.[396] Part of the duties involved to keep watch for the build-up of cane trash (billets). This was to avoid slipping and possible derailment.[397]

[77] The magistrate found that policies required a watch to be kept for safety reasons. The magistrate accepted it was "hammered" into the workers never to cross the yellow line.[398] This was reinforced at least annually.[399] The magistrate accepted the evidence of Mr Wesche who determined there was no breach.[400] He accepted Mr Erikson was well trained and experienced.[401] His actions were completely unexpected.[402] The magistrate accepted no previous similar incidents had occurred.[403] The magistrate was not satisfied beyond reasonable doubt that the locking of the smoko room and access gates were required in the discharge of the respondent's duties under the WHSA. It was not reasonably practicable to eliminate the risk of workers traversing the corridor.[404] The respondent had turned its mind comprehensibly to the risks associated with moving cane bins.[405] The magistrate was not satisfied beyond reasonable doubt that the respondent breached its WHSA obligation.[406] He was not satisfied beyond reasonable doubt that there were other reasonable and practical measures to ameliorate the risks faced.[407]

Relevant law

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390 Reasons p 2.12.
391 Reasons p 2.22.
392 Reasons p 3.14-47.
393 Reasons p 4.1-5.
394 Reasons p 4.18-22.
395 Reasons p 5.3.
396 Reasons p 5.7-15.
397 Reasons p 5.17.
398 Reasons p 5.25-35.
399 Reasons p 5.37.
400 Reasons p 5.40-6.11.
401 Reasons p 6.25.
402 Reasons p 6.30.
403 Reasons p 6.27.
404 Reasons p 6.40-45.
405 Reasons p 7.1.
406 Reasons p 7.20.
407 Reasons p 7.21.

[78] Section 32 of the WHSA provides:

"A person commits a category 2 offence if—

(a) the person has a health and safety duty; and

(b) the person fails to comply with that duty; and

(c) the failure exposes an individual to a risk of death or serious injury or illness.

Maximum penalty—

(a) for an offence committed by an individual, other than as a person conducting a business or undertaking or as an officer of a person conducting a business or undertaking—1,500 penalty units; or

(b) for an offence committed by an individual as a person conducting a business or undertaking or as an officer of a person conducting a business or undertaking—3,000 penalty units; or

(c) for an offence committed by a body corporate—15,000 penalty units."

[79] Section 19 of the WHSA provides:

"(1) A person conducting a business or undertaking must ensure, so far as is reasonably practicable, the health and safety of—

(a) workers engaged, or caused to be engaged by the person; and

(b) workers whose activities in carrying out work are influenced or directed by the person;

while the workers are at work in the business or undertaking.

(2) A person conducting a business or undertaking must ensure, so far as is reasonably practicable, that the health and safety of other persons is not put at risk from work carried out as part of the conduct of the business or undertaking.

(3) Without limiting subsections (1) and (2), a person conducting a business or undertaking must ensure, so far as is reasonably practicable—

(a) the provision and maintenance of a work environment without risks to health and safety; and

(b) the provision and maintenance of safe plant and structures; and

(c) the provision and maintenance of safe systems of work; and

(d) the safe use, handling and storage of plant, structures and substances; and

(e) the provision of adequate facilities for the welfare at work of workers in carrying out work for the business or undertaking, including ensuring access to those facilities; and

(f) the provision of any information, training, instruction or supervision that is necessary to protect all persons from risks to their health and safety arising from work carried out as part of the conduct of the business or undertaking; and

(g) that the health of workers and the conditions at the workplace are monitored for the purpose of preventing illness or injury of workers arising from the conduct of the business or undertaking.

(4) If—

(a) a worker occupies accommodation that is owned by or under the management or control of the person conducting the business or undertaking; and

(b) the occupancy is necessary for the purposes of the worker's engagement because other accommodation is not reasonably available;

the person conducting the business or undertaking must, so far as is reasonably practicable, maintain the premises so that the worker occupying the premises is not exposed to risks to health and safety.

(5) A self-employed person must ensure, so far as is reasonably practicable, his or her own health and safety while at work."

[80] Section 18 of the WHSA provides:

"In this Act, ***reasonably practicable***, in relation to a duty to ensure health and safety, means that which is, or was at a particular time, reasonably able to be done in relation to ensuring health and safety, taking into account and weighing up all relevant matters including—

(a) the likelihood of the hazard or the risk concerned occurring; and

(b) the degree of harm that might result from the hazard or the risk; and

(c) what the person concerned knows, or ought reasonably to know, about—

(i) the hazard or the risk; and

(ii) ways of eliminating or minimising the risk; and

(d) the availability and suitability of ways to eliminate or minimise the risk; and

(e) after assessing the extent of the risk and the available ways of eliminating or minimising the risk, the cost associated with available ways of eliminating or minimising the risk, including whether the cost is grossly disproportionate to the risk."

[81] Section 17 of the WHSA provides:

"A duty imposed on a person to ensure health and safety requires the person—

(a) to eliminate risks to health and safety, so far as is reasonably practicable; and

(b) if it is not reasonably practicable to eliminate risks to health and safety, to minimise those risks so far as is reasonably practicable."

[82] Section 17 is expressed in identical terms to s 35 of the *Work Health and Safety Regulation* 2011 (Qld) (WHSR). Relevantly, s 36 of the WHSR sets out what it describes as a hierarchy of control measures where, pursuant to s 17(b) of the *Act*, it is not reasonably practicable for a person on whom the health and safety duty is imposed to eliminate risks to health and safety. The hierarchy of control measures are incorporated into the *Sugar Industry Code of Practice 2005* and *Sugar Mill Safety*

– a supplement to the Sugar Industry Code of Practice 2005 and the *How to Manage Safety Risks Code of Practice 2011*.

[83] Section 275 of the WHSA identifies what evidentiary use may be made of the relevant codes of practice. Section 275 of the WHSA provides:

> "(1) This section applies in a proceeding for an offence against this Act.
> (2) An approved code of practice is admissible in the proceeding as evidence of whether or not a duty or obligation under this Act has been complied with.
> (3) The court may—
> (a) have regard to the code as evidence of what is known about a hazard or risk, risk assessment or risk control to which the code relates; and
> (b) rely on the code in determining what is reasonably practicable in the circumstances to which the code relates.
> (4) Nothing in this section prevents a person from introducing evidence of compliance with this Act in a way that is different from the code but provides a standard of work health and safety that is equivalent to or higher than the standard required in the code."

[84] The codes were tendered as part of exhibit 1. Particulars 7(b) and 8(c) referred to the standards contained in the *Sugar Industry Code of Practice 2015* (the Sugar Industry Code) the *Sugar Mill Safety – a supplement to the Sugar Industry Code of Practice 2005* (the Supplementary Code) of part 4.4 and *How to Manage Work Health and Safety Risks Code of Practice 2011* (the Management of Risk Code).

[85] The *Sugar Industry Code of Practice 2005* describes methods for controlling major hazards associated with sugar mill operations and cane rail operations of the machinery equipment substances and work practices and what should be considered to safeguard the health and safety of workers, the public and others.

[86] Relevantly with respect to managing health and safety, clause 3 of the Sugar Industry Code provides that the purpose of the code is to "… identify industry specific hazards, suggest possible controls and provide examples on the risk management process". It would be expected that metal and rail operators would develop a risk register as outlined in the Management of Risk Code, assess the risks in their operation, implement controls and monitor and review the systems implemented to control these risks. The Supplementary Code is described in clause 1.1 as being a "… supplement to the *Sugar Industry Code of Practice 2005* and forms part of that code". The Supplementary Code identifies how health and safety is to be managed by a duty holder and further at clause 4 identifies general workplace hazards. Relevantly clause 4.4 deals with hitting and being hit by a moving object. Clause 4.4 states:

> "Hitting and being hit by moving objects is a major hazard at sugar mills. This can be caused by:
>
> - Cluttered workplaces
> - Workers colliding with moving plant or equipment (e.g. rolling stock in a mill yard)
> - Lack of warning signs fitted at intersections

- Doors opening into walkways
- Plant not maintained in safe condition (e.g. unguarded or inadequately guarded machinery which generates flying objects such as splinters, metal fragments and dust)
- Lack of appropriate personal protective equipment such as safety glasses to protect eyes from slivers of wood, metal, concrete or sparks
- Lack of warning devices on moving plant and vehicles such as forklifts."

Grounds of appeal

[87] The appellant relies on the following amended grounds of appeal[408]:

1. The learned magistrate erred in law by failing to consider and/or by misdirecting himself as to the proper application of s 17 of the *WHSA*.
2. The learned magistrate erred in law by failing to consider and/or by misdirecting himself as to what properly constitutes evidence of what is "reasonably practicable" within the meaning of s 18 of the WHSA.
3. The learned magistrate erred in law by failing to have regard to and rely on the relevant codes of practice pursuant to s 275(3) of the WHSA.

Ground one

Appellant's submissions

[88] The appellant argues[409] that in discharging its primary duty of care the respondent was required to manage risk pursuant to s 17 of the WHSA. If it was determined it was not reasonably practicable to eliminate the risk then the risk should be minimised so far as is reasonably practicable and by reference to the hierarchy of controls referred to in s 36 of the regulation and the codes.

[89] It is submitted the magistrate fell into error because he concluded the control measures would not eliminate the risks so far as reasonably practicable and then fell into error by failing to consider whether the risk was minimised so far as is reasonably practicable. It is submitted that the measures implemented by the respondent were the painting of the yellow lines adjacent to the cane rail track and a direction issued to workers whilst they were being trained with respect to specific tasks, not to cross the yellow line. The magistrate, it is submitted, fell into error in failing to have regard to and apply the hierarchy of control measures. It is further submitted the magistrate erred in concluding that Mr Erikson disregarded the training with respect to his safety. It is submitted that there is no evidence as to Mr Erikson disregarding the training he had received. It is submitted that the approach the magistrate should have taken was not to concentrate on Mr Erikson disregarding his training but more rather to see whether the respondent had taken a more proactive approach to safety and guarded against foreseeable acts of inadvertence. In this regard the appellant relies on *Charters*

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408 Exhibit 4.

409 Exhibit 5.

Towers Regional Council v Coggins.[410] It was known Mr Erikson was a competent and trained employee but the control measures were not adequate to manage the risk in accordance with s 17 of the WHSA and the respondent failed to discharge its duty pursuant to s 19 of the WHSA.

[90] In oral submissions counsel for the appellant submitted the magistrate failed to consider the evidence which was to the effect that after the event there was a "lock out" in place.[411] He submitted the magistrate failed to consider the minimisation of risk in connection with steps taken after the event.[412]

[91] As to the suggestion that a "minimisation" case was not pleaded, counsel relied on the final address by prosecuting counsel below where this was not abandoned.[413]

Respondent's submissions

[92] The respondent on the other hand submits[414] contrary to the appellant's submission that s 36 of the Regulation does not have application with respect to s 17 of the WHSA. It accepts that the court may have regard to the codes of practice in determining what is reasonably practicable in the circumstances. The respondent submits that no evidence was led from any witness as to how the proposed measures could be achieved. The respondent submits that a reading of the magistrate's reasons show he properly apprehended the matter. The *Charters Towers* decision is distinguished. It is submitted in the present case there was an effective exclusion zone and known safety procedures and practices. There was no evidence the respondent failed to discharge due diligence to ensure these practices and procedures were adhered to. It is submitted it was established by the evidence it was not reasonably practicable to exclude workers from the workplace while cane bins were moving on the track. It was always the case that cane workers were required in the area. The onus was on the prosecution to establish the respondent failed to minimise the risks so far as was reasonably practicable. The magistrate addressed this issue.

[93] In oral submissions counsel for the respondent submitted that the evidence was entirely uncertain as to whether a lockout procedure was implemented after the event but before automation.[415]

[94] It was submitted that the locking of doors and fencing was in effect irrelevant as this did not exclude authorised persons from entering the corridor.[416]

[95] It was submitted no witness was called to say that steps proposed were reasonably practicable.[417]

[96] It was submitted there was no error as the magistrate did consider "minimisation" when he considered "amelioration."[418]

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410 Unreported DC5/17 and DC28/17 Lynham DCJ 24 October 2018.
411 Appeal transcript day 1 page 20.10.
412 Appeal transcript day 1 pages 18-19.
413 Appeal transcript day 1 page 45.45.
414 Exhibit 6.
415 Appeal transcript day page 27.35.
416 Appeal transcript day 1 page 34.
417 Appeal transcript day 1 page 34.35.
418 Appeal transcript day 1 page 37.45.

[97] In any event it was submitted that the case was solely one of elimination of risk and not minimisation if one refers to paragraph 8 of the complaint.[419]

[98] In any event, if one referred to the codes of practice[420] the only relevant step was an exclusion zone and in fact there was an exclusion zone by reason of the painted yellow line. Compliance with this exclusion zone prevented any risk.

Disposition of ground one

[99] I accept the respondent's submissions.

[100] The prosecution bore the onus of establishing beyond reasonable doubt the following:
1. The respondent had a health and safety duty;
2. The respondent failed to comply with this duty;
3. The failure exposed an individual to a risk of death or serious injury.

[101] The respondent had the duty under s 19 of the WHSA of ensuring so far as was reasonably practicable the health and safety of its workers. Section 17 of the WHSA required the respondent to eliminate risks to health and safety so far as is reasonably practicable and if it was not reasonably practicable to eliminate risks to health and safety, to minimise those risks so far as is reasonably practicable.

[102] There was no doubt in this case that the duty was owed and there was a risk of death or serious injury. The issue was whether the prosecution had proved beyond reasonable doubt the respondent failed to comply with his duty as defined in s 17 of the WHSA.

[103] It is my view an entire reading of the reasons for decision disclosed the magistrate appropriately directed himself in this case. The magistrate referred to the appropriate sections of the WHSA. He referred to the prosecution particulars.[421] He found that on the evidence it was not reasonably practicable to eliminate the risk by the measures alleged by the prosecution.[422] He also found that it was not reasonably practicable to ameliorate the risk by the measures alleged by the prosecution.[423] In this way he did deal with the other measures proposed by the prosecution.

[104] It is my view he considered both limbs of section 17 contrary to the appellant's submissions.

[105] But in any event, I accept the respondent's submissions as to the way in which the complaint was framed. The measures referred to in paragraph 8 all referred to the elimination of the risk. There was no reference to minimisation. Particulars are crucial in a case such as this.[424]

[106] I will deal with the specific measures relied upon by the appellant when I come to consider grounds 2 and 3.

[107] It is my view the ground of appeal is not made out. I reject the ground.

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419 Appeal transcript day 1 page 39.35.
420 Exhibit 1 tab 19 pages 129 and 130. Appeal transcript day 1 pages 40-41.
421 Reasons p 4.5.
422 Reasons p 6.42.
423 Reasons p 7.20.
424 *Johnson v Miller* (1937) 59 CLR 467 at pp 489-490; *John L Pty Ltd v Attorney-General* (1987) 163 CLR 508 at pp 520-521; *Kirk v Industrial Court (NSW)* (2010) 239 CLR 531 at [14] and [26].

Appeal grounds 2 and 3

Appellant's submissions

[108] The appellant submits that grounds 2 and 3 can conveniently be dealt with together. The appellant submits that the magistrate failed to direct himself as to the applicable codes and failed to undertake any evidentiary examination of what the respondent knew or ought to have known for the purpose of determining what was reasonably practicable. It is submitted that s 275 of the WHSA renders reference to the codes relevant. Clause 4.4 of the supplementary code identified that hitting and being hit by a moving object is a major hazard at sugar mills which can be caused by workers colliding with moving plant or equipment. Clause 4.41 states that "preventing or minimising exposure to the risk of being hit by moving objects can be achieved through separation…". It is submitted the magistrate failed to have regard to this. It is further submitted the magistrate misdirected himself as to what was "reasonably practicable" in that he failed to have regard to the particularised failures. He did not consider what should have comprised a safe system of work and whether it was reasonably practicable to implement the alleged control measures.[425] The magistrate failed to have regard to the control measures implemented after the incident, namely locking the door in the smoko room and the gates to the corridor, installing barricading and fencing, lockout procedures and enforcing no go zones. These were clearly reasonably practicable.

[109] In oral submissions the appellant submits the magistrate failed to consider specifically the issue of lockout. There was no consideration of higher forms of control.[426]

[110] It is submitted that the prohibition notice argument is not supported by authority and in any event specific measures were not mentioned in the notice.[427]

[111] It is submitted that the magistrate took into account an irrelevant consideration namely that the magistrate did not "… think it is fair or reasonable for the employer to expect someone who has fairly specific training allowing them to be in the area to then disregard that training with respect to their safety after they have been taught about how they are to stay outside the yellow line and conduct their duties accordingly."[428]

[112] Counsel for the appellant repeated his submissions that the magistrate failed to have regard to the separation mentioned in Exhibit 1 tab 19 page 129. Total exclusion was not reasonably impracticable.

Respondent's submissions

[113] The respondent on the other hand submits that the magistrate was not required to have regard to the code's practice. It is submitted the magistrate in any event did give sufficient reasons. It is also submitted the control measures in the codes of practice were not proven to be reasonably practicable to implement.

[114] As to the control measures implemented after the incident, it is wrong at law to rely on these as:

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425 Particulars 7(a) (iii), (iv) and (vii).
426 Appeal transcript day 1 pages 25-26.
427 Appeal transcript day 1 page 21.42.
428 Reasons page 7.7. Appeal transcript day 1 pages 22-23

(a) The control measures were implemented by the respondent in response to a prohibition notice.[429]
(b) The steps taken under compulsion cannot be used as evidence but even if they can be, the conclusions of Inspector Wesche support the respondent's case.
(c) The lockout procedure does not apply to the work area workers use to transverse between the tippler and the recoupling shed.
(d) The fencing is in an area opposite to where the incident occurred.
(e) The evidence of what steps were taken after the event is not determinative of the issue. One should not approach the matter with the benefit of hindsight.
(f) Finally, it is submitted the magistrate gave sufficient reasons in this case.

[115] In oral submissions the respondent submitted that the evidence was unclear as to whether there was total lockout after the event.[430]

[116] It was submitted that, in any event, there was access to the area near the moving bins after the event near the shed to the brake system.[431] The locking of the gates and erection of the fences was irrelevant as this just prevented unauthorised persons from accessing the area.[432]

[117] Again, because of the risk of derailment it could not be proved that lockout or any other alternative was reasonably practicable. No witness gave evidence that this was so.[433] This could not be inferred.[434]

[118] It was not an irrelevant consideration to see whether Mr Erikson acted fairly and reasonably in light of the training given.[435]

Disposition

[119] In this case the magistrate said he had regard to exhibit 1 (including the codes).[436] He also specifically took into account the particulars.[437] The magistrate then specifically had regard to the alternatives put forward by the prosecution including the exclusion from the area and an alternative path outside the fence line.[438] He also considered the alternative of the locking of the smoko room door together with the locking of the gates.[439] He was not satisfied beyond reasonable doubt that the locking of the smoko room and the access gates was required as it was not reasonably practicable.[440] He was not satisfied the respondent breached its work health and safety obligations and was not satisfied beyond reasonable doubt there were other reasonable and practicable means to ameliorate the risk.[441]

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429 Exhibit 1.
430 Appeal transcript day page 27.35.
431 Appeal transcript day 1 page 31.25.
432 Appeal transcript day 1 page 34.
433 Appeal transcript day 1 page 34.35.
434 Appeal transcript day 1 36.5-20.
435 Appeal transcript day 1 page 36.35.
436 Reasons p 2.20.
437 Reasons p 2.22 and p 4.1-30.
438 Reasons p 4.27.
439 Reasons p 4.25-30.
440 Reasons p 6.40-42.
441 Reasons p 7.25.

[120] As to the later measures imposed, the magistrate also did refer to these in a general way noting they were not determinative but they were relevant.[442] He also mentioned the prosecution particulars in his reasons. Also, one has to approach later implementations cautiously. As was noted in *Safework (NSW) v Tamex Transport Pty Ltd T/A Tamex*[443] the court must be satisfied beyond reasonable doubt that the steps were reasonably practicable to achieve the provision of a safe working environment at the time leading up to the incident and not with the benefit of hindsight.

[121] Also with respect to the closing of the crib room door, the signs, the locked gates, the additional fencing and the use of the alternate path, the evidence revealed that this did not necessarily prevent authorised persons from accessing the area prior to automation after the incident.[444]

[122] I now deal with the evidence of lockout as this appears not specifically dealt with by the magistrate in his reasons.

[123] Even if this was an error, for the reasons which follow I do not think it material as in my view the outcome is not affected by this.

[124] On my assessment of the evidence there was good reason why he did not, as the evidence on this point was unclear. This much was conceded by the appellant's counsel.[445]

[125] First, although Mr Cronan initially said that the whole area was a "no go zone",[446] he later said that this was presently the situation.[447] It is not entirely clear to me whether the total lock down situation is with the new automated system or whether it was in place after the incident but before the automation.[448] He also later conceded that authorised and trained people had access up until the automated system was put in place.[449] In re-examination this was entirely clarified as he said that there was now an automated system with a full blown lock out system.[450] He said that this improved as time went along and they had added extra lock out systems.[451]

[126] Second, Mr Camm gave evidence that after the incident they "… stayed clear of the area so to speak. We pretty much stayed where the actual recoupling station was."[452] He then said it was an exclusion zone but then said that they could still operate in the recoupling area but the top end was an exclusion zone referring to the gates.[453] In my view this would not remove the risk of exposure entirely. He then said that after the incident there was total lockout[454] but he added "they can still access the area below

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442 Reasons p 2.15.
443 [2016] NSWDC 295 at [76].
444 Wesche transcript day 2 p 6.27, 7.45; Cronan transcript day 2 p 78.27, 84.20; Gardner transcript day 2 p 102.35; Badger interview exhibit 1 tab 23 p 6-7; Badger transcript day 2 pp 116.12, 123.6-11; Camm transcript day 2 p 137.37.
445 Appeal transcript day 1 page 9.35.
446 Cronan transcript day 2 p 64.43.
447 Cronan transcript day 2 p 71.22-72.18.
448 See also Cronan transcript day 2 p 73.45.
449 Cronan transcript day 2 p 84.25.
450 Cronan transcript day 2 p 87.30.
451 Cronan transcript day 2 p 88.5.
452 Camm transcript day 2 p 134.35.
453 Camm transcript day 2 p 135.20.
454 Camm transcript day 2 p 137.27.

the creepers."[455] He then added that there was a complete lockout "if it was any sort of major thing."[456] What he meant by "major thing" was not explored in his evidence. This leaves open the possibility of access being given where it was not "major."

[127] He then said there was a lock down for cleaning but clarified this as being in force today.[457] He then said he was not able to give a date as to when the full lock out started[458] but then said it was in place by the 2013 crushing season.[459] He then added there were uncouplers still there but it was more controlled.[460] He later added that it was in place when it was automated and it might have been the 2014 crushing season.[461]

[128] Third, Mr Badger said that after the incident he observed new exclusion zones in place. This included that recouplers could go only so close to the tippler and there were limitations as to where one could travel in the area.[462] He also said that the gate was opened to allow the recouplers access to their console.[463] He later said recouplers were not prevented from accessing the recoupling yard.[464]

[129] Finally, Inspector Wesche in his evidence said that after the event only authorised personnel were permitted into the area to undertake work.[465]

[130] It is my assessment of the evidence that it was not established that there was a full lockout procedure implemented whenever a person accessed the area soon after the event. This may well have been quite some time later.

[131] On my view of the evidence it was likely that authorised persons were still accessing the area and therefore exposed to risk for a time after the incident. Or, at the least this could not be disproved.

[132] Also, no witness gave evidence that these further measures were reasonably practicable in terms of the operation of the mill bearing in mind the dangers of derailment in particular. It is my view it was not proved the measures were reasonably practicable.

[133] It is my view it was not proved the additional measures most likely would not have prevented the death as the death resulted from Mr Erikson's inattention and failure to comply with his training.

[134] In any event, in my view the yellow line was an exclusion zone for the purpose of the code.[466] Also in my view the respondent complied with some of the measures

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455 Camm transcript day 2 p 137.37.
456 Camm transcript day 2 p 137.40.
457 Camm transcript day 2 p 139.12.
458 Camm transcript day 2 p 139.27.
459 Camm transcript day 2 p 139.35.
460 Camm transcript day 2 p 139.40.
461 Camm transcript day 2 p 140.10-17.
462 Badger transcript day 2 p 115.3.
463 Badger transcript day 2 p 116.12.
464 Badger transcript day 2 p 123.31.
465 Wesche transcript day 2 p 6.25.
466 Exhibit 1 tab 19 page 129.9.

mentioned at page 130.2 of exhibit 1 tab 19 i.e. providing training, ensuring site rules were prepared and followed and providing separation.[467]

[135] In my view it is highly doubtful whether the prosecution proved causation beyond reasonable doubt (i.e. that the risk of death would have been prevented if the alternative measures had been implemented).

[136] As to causation, the prosecution must prove beyond reasonable doubt that the act or omission of the defendant was a significant or substantial cause of the deceased being exposed to the risk of injury.[468]

[137] In this case, in my judgment, the substantial cause of the death was Mr Erikson's own negligence.

[138] I do not consider the magistrate took into account an irrelevant consideration as contended by the appellant.

[139] I consider the grounds have not been established and I reject them.

Rehearing

[140] Even if I am wrong in my conclusions on the grounds of appeal, on my review of the evidence I would come to the same conclusion as the magistrate.

[141] In reaching this view I take into account the relevant provisions of the WHSA, the Regulation, the relevant codes, the evidence and the submissions of counsel.

[142] I also note the decision of *Safework NSW v Wollongong Glass Pty Ltd*[469]. In that decision Scotting DCJ noted that an employer should take a proactive approach to safety issues[470] but his Honour also noted at [29]-[32]:

> "A defendant must have regard not only for the ideal worker but for one who is careless, inattentive or inadvertent: *Dunlop Rubber Australia Ltd v Buckley* [1952] HCA 72; (1952) 87 CLR 313 at 320 per Dixon CJ. If there is a foreseeable risk of injury arising from the employee's negligence in carrying out his or her duties then this is a factor which the employer must take into account: *Smith v Broken Hill Pty Ltd* [1957] HCA 34; (1957) 97 CLR 337 at 343. It may not always be possible to foresee various acts of inadvertence by workers but defendants must conduct operations on the basis that such acts will occur and they must be guarded against to the fullest extent practicable.
>
> The unforeseeable behaviour of a disobedient employee may well lead to the happening of an event that could not be reasonably foreseen and therefore was not reasonably practical to guard against*: WorkCover*

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467 Exhibit 1 Tab 19 page 129- the appellant's proposed control measure was separation by total exclusion (appeal transcript day 1 page 25.36-26). The respondent says that this was not proved to be reasonably practicable and there was separation by the yellow line exclusion zone (appeal transcript day 1 page 40.30-41.7). I accept the respondent's contentions.

468 *Safework (NSW) v Wollongong Glass Pty Ltd* [2016] NSWDC at [33] applying *Bulga Underground Operations v Nash* (2016) 93 NSWLR 338; [2016] NSWCCA 37 at [127].

469 [2016] NSWDC 58.

470 [2016] NSWDC 58 at [28].

> *Authority of New South Wales v Kirk Group Holdings Pty Ltd* [2004] NSWIR Comm 207; (2004) 135 IR 166 at [129].
>
> In some cases, it will not be practicable to guard against a detriment to safety occasioned by an appropriately trained and instructed employee departing from a known safe procedure. There are limits to the degree of instruction which can be expected to be provided to an experienced employee*: Genner Constructions* at [68].
>
> Where an employer is found to have laid down a safe and proper practice and there is no evidence that the employer failed to use due diligence to see that the practice is observed, then a casual failure by inferior employees, even if of supervisory rank, to observe that practice on a particular occasion will not render the employer criminally liable for a failure to ensure safety: *Collins v State Rail Authority of New South Wales* (1986) 5 NSWLR 209 at 215E."

[143] As to the meaning of "reasonably practicable" his Honour noted at [27]:

> "The words reasonably practicable indicate that the duty does not require a defendant to take every possible step that could be taken. The steps to be taken in performance of the duty are those that are reasonably practicable for the employer to achieve the provision of and maintenance of a safe working environment. Bare demonstration that a step might have had some effect on the safety of a working environment, does not without more demonstrate a breach of the duty: *Baiada Poultry Pty Ltd v R* [2012] HCA 14; (2012) 246 CLR 92 at [15] and [38] per French CJ, Gummow, Hayne and Crennan JJ"

[144] Gaudron J in *Slivak v Lurgi Australia Pty Ltd*[471] stated:

> "The words "reasonably practicable" have, somewhat surprisingly, been the subject of much judicial consideration[26]. It is surprising because the words "reasonably practicable" are ordinary words bearing their ordinary meaning. And the question whether a measure is or is not reasonably practicable is one which requires no more than the making of a value judgment in the light of all the facts. Nevertheless, three general propositions are to be discerned from the decided cases:
>
> . the phrase "reasonably practicable" means something narrower than "physically possible" or "feasible"[27];
>
> . what is "reasonably practicable" is to be judged on the basis of what was known at the relevant time[28];
>
> . to determine what is "reasonably practicable" it is necessary to balance the likelihood of the risk occurring against the cost, time and trouble necessary to avert that risk[29]."

[145] Of course, one must also consider in this regard the provisions of section 18 of the WHSA.

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471 (2001) 205 CLR 304 at [53]. It is to be noted Gaudron J dissented but the statement of principle is correct.

[146] It is my view the incident occurred because Mr Erikson (despite intensive and ongoing training) failed to comply with a clearly marked exclusion zone.

[147] The CCTV footage shows Mr Erikson inexplicably crossing the yellow line.

[148] It is my view the uncontradicted evidence was that:

(a) the exclusion zone as at 11 November 2012 would by reason of its dimensions and the dimensions of a bin on the rail track and absent a derailment have ensured that no worker in the area could possibly come into contact with a moving bin;

(b) whilst episodic major cleaning would occur with a lockout in place, the risk of derailment due to cane billets on the track required constant inspection and cleaning including whilst bins were moving;

(c) the sequence of crushing meant that a bin would come onto the track in a consistent predictable pattern about every 50 seconds; and

(d) only a small number of highly trained, authorised, staff were permitted in the corridor and there was no evidence of any other workers accessing or utilising the corridor as a walkway.

[149] According to Inspector Wesche, the respondent upon purchasing the mill "had identified the risks associated with uncoupling and recoupling, an inherited hazard when they purchased this milling factory prior to the crushing season and had risk control being investigated/actioned and the removal of workers and replacing with automatic mechanical systems (this process required time and refinement that could not be achieved prior to this instant)."[472] The respondent had a number of controls in place to minimise risks to health and safety of workers whilst in the work area.

[150] First, the work area was limited to authorised personnel only. Mr Erikson was one of a very small number of authorised workers. All other personnel were precluded from the work area.[473] Workers became authorised after they completed training and passed competency assessments that included both a written exam and on the job assessment.[474] The training and assessment conducted by experienced trainer and assessor and plant operator Mr Cronan was detailed, comprehensive and effective to ensure authorised persons were competent.

[151] This training emphasised:

(a) that no one was to cross the yellow line unless lock out and isolation procedures were in place;[475]

(b) that all workers should take steps to be aware of moving cane bins;[476]

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472 Wesche report exhibit 1 tab 22 p 8; Wesche transcript day 1 p 58.35.

473 Wesche transcript day 1 p 39.30; Cronan transcript day 2 p 43.27; Frazer transcript day 2 p 25.30; Gardner transcript day 2 p 98.25-45; Badger transcript day 2 p 109.24, 119.1.

474 Wesche report exhibit 1 Tab 22 p 8; Wesche transcript day 1 p 46.5; Cronan transcript day 2 p 43.30-42, 60.35, 77.25-46; Frazer transcript day 2 p 25.45.

475 Exhibit 1 Tab 10 p 35.5; Exhibit 1 Tab 11 p 46.7, 47.7; exhibit 1 tab 22 p 11.5; Wesche transcript day 1 p 52.10; Cronan interview exhibit 1 tab 24 p 11.37; Cronan transcript day 2 p 75.35, 76.4, 82-83; Gardner interview exhibit 1 tab 25 p 11.25; Frazer interview exhibit 1 tab 26 p 8.35; Frazer transcript day 2 p 27.5, 37.45; Camm interview exhibit 1 tab 27 p 13.7; Camm transcript day 2 p 129.30.

476 Exhibit 1 tab 10 p 33.3; Exhibit 1 tab 11 p 46.6, 47.2; exhibit 1 tab 12 p 56.2; Wesche report exhibit 1 tab 22 p 11.5, 45.1-4; Cronan interview exhibit 1 tab 24 p 18.27; Cronan transcript day 2 p 75.20, 76.5; Gardner interview exhibit 1 tab 25 p 14.17; Frazer interview exhibit 1 tab 26 p 26.37; Frazer transcript day 2 p 27.22.

(c) that all workers should be mindful of and guard against complacency;[477]

(d) that all workers who exited the crib room should take particular note of the tippler so as to ascertain the presence of a cane bin and the stage of the tippler cycle in order to be informed as to when it was likely that a cane bin would be ejected from the tippler.[478]

[152] The evidence was that the authorised workers traversed the corridor between the tippler and the recoupling shed to rotate between coupling and recoupling tasks every two hours during their shift.[479] The authorised workers were trained and required to undertake cleaning of the work area using an air-lance to clear cane billets from the rail line and to retrieve and collect cane pins which had fallen.[480] The purpose of such task was to maintain a clean and thereby safe work area to avoid slip, trip and falling risk to workers and most significantly potential derailment of cane bins.[481] Training for the tasks carried out in the work area was achieved through oral instruction, practical demonstration and written procedures.[482]

[153] The workers gave evidence that the training strictures particularly with respect to the yellow line were "drummed into the workers". They were universally adhered to except for Mr Erikson on the day of the incident.[483] There was no evidence of any previous instance where a person was injured or where there was a near miss such that the respondent had been put on notice that the subject event was likely.[484]

[154] Inspector Wesche accepted Mr Erikson would have had a clear view of any cane bin in the tippler as he exited the crib room. Those bins were ejected from the tippler at approximately 50 second intervals and the process of ejecting bins produced a very loud noise.[485] Mr Erikson was a competent and trained worker and recently had been assessed as competent to work in the area in the months before the incident. The content and extent of his training provided a sufficient basis for the conclusion of the inspector that the information and training provided to Mr Erikson was sufficient to enable him to work safely in the work area.[486] The number of workers authorised to enter the corridor whilst the tippler was operating was very small, indeed no more than three or four every shift, apart from specialist crews who entered only when there was a lockout. Mr Erikson was one of that very small number of workers who were authorised to be in the corridor.

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477 Frazer interview exhibit 1 tab 26 p 34.25; Frazer transcript day 2 p 38.5; Cronan transcript day 2 p 82.46-83.3; Badger transcript day 2 p 119.44.

478 Cronan interview exhibit 1 tab 24 p 18.20; Cronan transcript day 2 p 79.13-36; Frazer transcript day 2 p 36.42.

479 Badger transcript day 2 p 119.14-25; Frazer transcript day 2 p 19.14.

480 Wesche transcript day 1 p 46.15, 56.42, day 2 p 3.20-35; Cronan transcript day 2 p 74.1, 75.22-42, 83.

481 Cronan transcript day 2 p 77.5-14.

482 Exhibit 1 tabs 10-12; Wesche report exhibit 1 tab 22 p 11.5, 45.1-4; Wesche transcript day 1 p 40.1, 52.10; Cronan interview exhibit 1 tab 24 p 12.7-15; Cronan transcript day 2 p 43.30-37, 49.37, 60.35, 75.40, 77.15-40; Camm interview exhibit 1 tab 27 p 9.1; Badger interview exhibit 1 tab 23 p 11.

483 Gardner interview exhibit 1 tab 25 p 16.3; Frazer interview exhibit 1 tab 26 p 9.1; Frazer transcript day 2 p 38.5; Cronan transcript day 2 83.3-13 Badger transcript day 2 p 118.32-35, 119.38-40.

484 Camm interview exhibit 1 tab 27 p 23; Camm transcript day 2 p 142.32-37.

485 Wesche transcript day 1 p 41.36, 48.20; Frazer transcript day 2 p 36.27; Cronan transcript day 2 p 79.32; Badger interview tab 23 p 15; Badger transcript day 2 p 112.5; Gardner transcript day 2 p 103.24.

486 Wesche report exhibit 1 tab 22 p 11, 45.1-4; Wesche transcript day 1 p 40.1, 44.24; Cronan transcript day 2 p 77-78.

[155] There were alternative means of accessing the corridor but the evidence led by the prosecution established that workers in the recoupling shed were expected to and did traverse the corridor up to the entrance in the crib room even if they were to access the coupling shed in the way put forward by the prosecution. They did this in order to clean billets off the line. Thus the risk would not have been obviated even if the steps alleged by the prosecution were implemented.

[156] It is my opinion that the safety distance delineated by the yellow line ran the length of the corridor. The yellow line was sufficiently far from the cane rail line such that a worker could not be struck if he or she stayed outside the line as instructed.[487] There was effectively an exclusion zone and compliance with this absolutely prevented a worker coming into contact with a moving cane bin. The "safe access way" was an area to the right of the braking system as one approaches it from the direction Mr Erikson was coming from. There was ample space for him to move to the right of the braking system.[488]

[157] A significant part of the training given to the workers authorised to be in the corridor concerned the need to be vigilant, aware of the cane bins and never to cross the yellow line. The uncontradicted evidence was that workers undertaking recoupling tasks may have been required to proceed from the recoupling shed up past the braking system nearer to the tippler to recouple cane bins.[489]

[158] Also the report of Inspector Wesche contained an express conclusion by him that the training received by Mr Erikson was adequate to enable him to work safely. Clearly enough, the inspector's views and opinions concerning the WHSA are of no weight in terms of conclusions as to the law but what was of some weight were the conclusions concerning safety.

[159] Ultimately, the prosecution case was left to establish it was reasonably practicable for the operation of the recoupling process to exclude workers from the work area while cane bins were moving by preventing access to the work area through the means outlined in paragraph 8 of the complaint.

[160] It is my view that this particular:

(a) Is contrary to the evidence concerning the operation of the recoupling process, that is, cane bins need to keep moving through the area at approximately 50 second intervals while workers are recoupling and the area needs to be observed and kept clean in order to avoid other safety implications.

(b) Fails to appreciate other implications which would result from preventing access to the area including a significant build-up of cane billets and the potential derailment of cane bins, alternatively a severe dislocation of the milling process in order to clean the lines by way of a lockout being imposed.

(c) Fails to take into account that the overpass in the work area existed for the purpose of crossing the cane rail track not accessing the recoupling shed from the crib room.

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487 Wesche transcript day 2 p 5.5; Cronan transcript day 2 p 77.12; Badger transcript day 2 p 118.37-46.

488 Wesche transcript day 1 p 51.23, 52.5, 52.25.

489 Camm transcript day 2 p 141.38; p 142.4.

[161] I am satisfied that the prosecution did not prove beyond reasonable doubt it was either reasonably practical to implement the control measures asserted in the complaint, or that the control measures asserted would in fact prevent workers from walking alongside moving cane bins as alleged.

[162] I am satisfied on the evidence that the substantial cause of this incident was Mr Erikson crossing over the yellow line without warning contrary to his training. If he had complied with his training he would not have been hit.[490]

[163] It may be he did not hear the bin because he had earpieces in his ears contrary to instructions given.[491]

[164] On the evidence the later measures did not entirely restrict access anyhow.

[165] In light of the findings I have made above, my specific findings concerning the particulars noting the standard of proof is beyond reasonable doubt[492] are:

(a) I am not satisfied that the respondent failed to comply with its health and safety duty as particularised. In other words I am not satisfied the respondent failed to adequately identify and assess the hazard.[493]

(b) I am not satisfied the respondent failed to adequately identify and assess the risk of workers accessing the walkway at the times alleged.[494]

(c) I am not satisfied the respondent failed to eliminate the risks as alleged.[495] I do not consider this was proved to be reasonably practicable.[496]

(d) I am not satisfied the respondent failed to eliminate the risks as alleged.[497] I do not consider this was proved to be reasonably practicable.

(e) I am not satisfied the respondent failed to provide and maintain a safe system of work.[498] In fact I find to the contrary that it did.

(f) I am not satisfied the respondent failed to ensure the workers used one of the alternative means of accessing the coupling/uncoupling shed. I do not consider this was proved to be reasonably practicable.

(g) I am not satisfied the respondent failed to adequately monitor and review controls. I consider in fact it did.[499]

(h) I am not satisfied the respondent breached its duty by providing a standard as required by Part 4.4 of the supplement or the *How to Manage Work Health and Safety Risks Code of Practice 2011*.[500] I do not consider the measures relied on by the appellant were proved to be reasonably practicable. In any event I am satisfied there was separation provided by the exclusion zone.

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490 Wesche transcript day 1 p 49.40, 52.5; Cronan interview exhibit 1 tab 24 p 6.10, 21.12; Badger transcript day 2 p 124.1.

491 Exhibit 1 Tab 10 p 32; Cronan transcript day 2 p 82.46-83.3.

492 This is much higher than the civil standard- see *Dookheea v R* (2017) 262 CLR 402 at [41].

493 Particular 7 (a) (i).

494 Particular 7 (a) (ii).

495 Particular 7 (a) (iii).

496 Sections 17, 18 and 19 WHSA.

497 Particular 7 (a) (iii).

498 Particular 7 (a) (iv).

499 Particular 7 (viii).

500 Particular 7 (b).

(i) I am not satisfied that the matters alleged in paragraph 8 (a) were proved to be reasonably practicable in light of the operations at the mill and the nature of the hazard and risk.

(j) I am not satisfied the matters alleged in paragraph 8 (b) were proved to be reasonably practicable in light of the operations at the mill and the nature of the hazard and risk.

(k) I consider that adequate risk assessments were conducted contrary to that alleged in paragraph 8 (c).

[166] It is my opinion that the best and most effective way to address the risks here was the exclusion zone and rigorous training. This is what Inspector Wesche concluded and what the magistrate concluded. This is what was done.

[167] It may have been a different result if the respondent did not have in place an exclusion zone and/or did not provide rigorous training.

[168] I am not satisfied beyond reasonable doubt that the prosecution had proved its case.

[169] My formal orders are:

1. The appeal is dismissed.

2. The order made in the Magistrates Court is confirmed.

3. I will hear the parties on the question of costs.