CITATION: *Clary v Coogee Resources (Ashmore Cartier) Pty Ltd* [2007] NTMC 085

PARTIES: KEVIN SEAN CLARY

v

COOGEE RESOURCES (ASHMORE CARTIER) PTY LTD

TITLE OF COURT: Court of Summary Jurisdiction

JURISDICTION: Justices Act (NT); Petroleum (Submerged Lands) Act (Cth)

FILE NO(s): 20718909

DELIVERED ON: 5 December 2007

DELIVERED AT: Darwin

HEARING DATE(s): 22 November 2007

JUDGMENT OF: Jenny Blokland CM

CATCHWORDS:

CRIMINAL LAW – SENTENCING CORPORATIONS – HEALTH AND SAFETY OFFENCES – MAXIMUM PENALTY APPLICABLE

Petroleum (Submerged Lands) Act (Cth)
Crimes Act (Cth)
Petroleum (Submerged Lands) (Management of Safety on Offshore Facilities) Regulations 1996 (Cth)

Collins v State Rail Authority of New South Wales (1986) 5 NSWLR 209
Italo Australia Construction Pty Ltd v Parkes [1988] 24 IR 421
Palynolab Resounces Pty Ltd v Morrison, 22 August 1996 SC (WA), unreported;
Haysdale v Shepherd (1998) WA SCA 89
Inspector Schultz v Leonard J Williams (Timber) Pty Ltd [2001] NSWIRComm 286
Chugg v Pacific Dunlop (1990) 170 CLR 249
Workcover Authority of NSW v TRW [2001] NSWIRComm 52
Holmes v R E Spence & Co Pty Ltd (1992) 5 VIR 119

REPRESENTATION:

Counsel:

Complainant:	Ms Dixon
Defendant:	Ms Harrison

Solicitors:

Complainant:	Commonwealth DPP
Defendant:	Mallesons Stephen Jaques

Judgment category classification:	B
Judgment ID number:	[2007] NTMC 085
Number of paragraphs:	24

IN THE COURT OF SUMMARY JURISDICTION
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. 20718909

BETWEEN:

KEVIN SEAN CLARY
Complainant

AND:

COOGEE RESOURCES (ASHMORE CARTIER) PTY LTD
Defendant

REASONS FOR DECISION

(Delivered 5 December 2007)

Jenny Blokland CM:

Introduction

1. On 22 November 2007 a plea of guilty was entered on behalf of Coogee Resources (Ashmore Cartier) Pty Ltd, ("the Defendant") to a charge contrary to subclause 3(1) of Schedule 7 to the *Petroleum (Submerged Lands) Act* (Cth). The charge is as follows:

   (1) Between about 2 May 2006 and 11 May 2006 in Commonwealth water in the Timor Sea, being the operator of a facility, namely the Jabiru Venture, the defendant failed to take all reasonably practicable steps to ensure that the facility was safe and without risk to the health of any person at or near the facility and that all work or other activities carried out on the facility were carried out in a manner that was safe and without risk to the health of any person at or near the facility.

Particulars:

The defendant did not take all reasonable steps as:

1. The defendant failed to erect temporary barriers or fall prevention equipment inside four-starboard cargo tank when maintenance work was occurring;

2. The defendant failed to ensure that the workers inside four-starboard cargo tank used safety harnesses attached to a static line or other restraints when working from height;

3. The defendant failed to fill four-starboard cargo tank with water to the level of the stringer when workers were operating from the stringer;

4. The defendant failed to ensure that the work area was adequately illuminated;

5. The defendant failed to prepare an adequate Temporary Work Instruction for the work to be performed in four-starboard cargo tank;

6. The defendant failed to prepare an adequate Job Safety Analysis for the work to be performed in four-starboard cargo tank;

7. The defendant did not implement the Permit to Work System by signing off the Permits even though the Temporary Work Instruction was not attached;

8. The defendant failed on the day of the incident to ensure that its system for ensuring there was adequate risk assessment was properly implemented;

9. The defendant failed to adopt steps/code of practice in its Safety Case and Safety Management System to prevent falls from height such as a specifically required to ensure appropriate mitigators had been specified as being required where work had to be conducted at heights;

10. The defendant failed provide specific working at heights training to all employees who may have had to work at heights;

11. The defendant failed to properly evaluate the method of performing the work so as to identify specific factors which might give rise to hazards.

Facts Accepted In Support of the Charge

2. A detailed summary of the facts is contained in Exhibit P1. In short the Defendant is the registered operator of "Jabiru Venture", a Floating Production, Storage and Offloading facility (FPSO) located in the Timor Sea. Crude oil produced and stored in the FPSO is removed by tankers mooring astern of the Jabiru Venture. On 2 May 2006 Gerard Weldon commenced working for the first time as a Relief Integrated Operator on the Jabiru Venture. As part of his induction he watched the DVD "Safety for Visitors aboard the Jabiru Venture" and was given the Jabiru Venture "Offshore Safety Handbook". Both items include brief statements instructing that a safety harness shall be worn while working aloft outside of properly scaffolded areas or areas protected by guardrails. Some training had been arranged by the Defendant on *working at heights* for some employees. Mr Weldon had not received the training.

3. On or about 5 May 2006 the Defendant's facility management and crew decided to replace anodes in four-starboard cargo tank. The anodes are about 1.5 metres long and weigh 40 – 50 kg. The job included transferring new anodes into the tank and clamping the new anodes on the tank bottom and vertically on the walls of the tank.

4. The Defendant's safety system at that time included a requirement that before any job was undertaken a Job Safety Analysis be completed that involved each component task being analysed for hazards and that measures be identified and put in place to mitigate risks. On 6 May 2006 the workers and supervisors involved in the anode replacement job, (including Gerard Weldon), met and completed the Job Safety Analysis. The Job Safety Analysis was based on a previous job completed several years earlier – the previous job related to attaching anodes to the bottom of the tank. In

addition to attaching anodes, the job in question involved installing the anodes on the sides of the tank. The Job Safety Analysis ("JSA") was not modified to have regard to that difference. It did not have regard to the fact that the anodes would be installed vertically from height on level 1 and level 2 of the tank. It did not identify *working at heights* as a potential hazard, but rather identified "slips, trips and falls' that failed to recognise the potential hazard of falling from one level to another. The JSA identified poor lighting as a potential hazard and required a minimum of 2 lights be used at each work site.

5. The Temporary Work Instruction (TWI) was prepared by the Marine Specialist (MS) using the Temporary Work Instruction from the job undertaken several years previously which did not involve *working at height*. In the circumstances the Temporary Work Instruction was not proper for this job. The Marine Supervisor and off shore installation Manager still authorised the Confined Space Entry Permit and the Hot Work Permit without the proper Temporary Work Instructions.

Incident of 11 May 2006

6. By 11 May 2006 the anodes had been attached to the lower level of the tank and the workers were ready to move up to the first and second stringer levels. On the morning of 11 May 2006 facility management raised confined space entry permit No. 7060 to cover entry of personnel into the four-starboard cargo tank and Hot Work Permit No. 27626 was raised to cover the work of installing the anodes and testing their conductivity. These permits were signed by all of the facility management team. These two permits were approved and signed by the heads of department in circumstances where the Temporary Work Instruction and Job Safety Analysis were not attached to the unsigned permits. They should have been attached. The Chief Integrated Operator conducted a "*tool box*" meeting on the morning of 11 May 2006. The integrated operators on the work crew

were present and the Marine Supervisor counter signed the *tool box* minutes. At this point, *working at height* was identified as a hazard. The Chief Integrated Operator cautioned the workers to take great care when working on the landings (or stringers) of the aft bulkhead outside of the walkway handrail due to the possibility of falling from height. This is noted in the *tool box* minutes. The Chief Integrated Operator asked if all of the integrated operators were comfortable doing the job. He told them if they were not comfortable they did not have to do it. No member of the crew was given fall protection equipment and no area inside the tank had been fitted with any equipment designed to prevent a fall, other than the existing handrails that protect the area around the walkway but not the part of the stringer where they would be working. It was decided that the alertness of personnel in the tank would be sufficient and no hazard controls were implemented.

7. On the same day, Mr Weldon was asked to install the anodes inside the confined space of four-starboard cargo tank with other workers. The team started working on level one but split into two groups because it was too crowded to have five people working on level one. Two workers moved to level two and Mr Weldon and two others remained on level one. Although the Job Safety Analysis required two lights at each level, only one was provided to give light to all levels inside the tank. The area of the stringers to starboard of the walkway which runs the length of the tank is outside of the protected handrail area. Anodes were to be attached to the aft bulk head in that area that did not have the protection of the guard rail. At approximately 11.00am two workers were installing an anode on the starboard side of the level one stringer which was a part of the landing not protected by a handrail. Mr Weldon was on the walkway, but stooped under the handrail to join the other workers. He stepped forward with his right foot to pick up one of the anodes but when he stepped forward with his left foot he stepped off the edge of the stringer deck, falling sideways 4.7 metres

to the tank floor. As he was falling, he put his hands to his right side to brace for the fall. His hands hit a steel beam on the bottom of the tank. His right hand hit the beam and bent back and his left wrist and leg also hit the beams. He fell parallel in between two main structural beams in the sludge at the bottom of the tank. Facility management and crew initiated first aid and emergency response. He was evacuated from the bottom of the tank and a medical evacuation was arranged to Truscott Airbase and then to Royal Darwin Hospital. Mr Weldon sustained the following injuries: his left wrist was broken; his right wrist had a compound fracture and required pins to hold the bones in place; his left knee had deep bone bruising and required a partial knee construction; he developed and ear infection as a result of the sludge entering his ear when he fell.

Events Since the 11th May 2006

8. On 12 May 2006 a new Job Safety Analysis was completed that identified the potential hazard of falling from heights and inadequate lighting. The hazard management steps identified included the following:

- Erecting barriers to prevent access to the edge of the stringer plate.
- Having a safety harness attached to a static line.
- Filling of tank to under stringer deck with sea water.
- Additional lights to be provided sufficient to illuminate the work site adequately.

9. Mr Andrew Jacob, the Defendant's Chief Operating Officer participated in a record of conversation with investigators. He admitted that the temporary work construction did not identify the hazard of working at height. He stated that personnel at the time decided that awareness of the hazard was sufficient protection.

10. The Court was informed and it is accepted that the defendant has no previous convictions. The Court was also informed and it is accepted that Mr Weldon's injuries, (Exhibit P3 documents the injuries in the radiology department reports) injuries have resolved and he has now returned to work at full capacity.

Maximum Penalty

11. On behalf of the Defendant it was submitted the maximum penalty applicable was 1000 penalty units, (or $110,000). The Defendant submitted Section 4B *Crimes Act* did not apply. I disagree. Section 4B(3) *Crimes Act* (Cth) provides:

> "Where a body corporate is convicted of an offence against a law of the Commonwealth, the court may, *if the contrary intention does not appear* (emphasis added) and the court thinks fit, impose a pecuniary penalty not exceeding an amount equal to 5 times the amount of the maximum pecuniary penalty that could be imposed by the court on a natural person convicted of the same offence". (In effect a maximum fine of $550,000 when applied to this offence).

12. For the Defendant's argument to succeed, there needs to be an indication, either express or clearly revealed by necessary implication to indicate the penalty set down in s 4B(3) *Crimes Act* does not apply to corporations convicted of committing this offence. The Defendant submits there has never been an individual "*operator"* as contemplated by s 3, Schedule 7, *Petroleum (Submerged Lands) Act* (Cth); it submits that all "*operators*" are corporations. The complainant raised an example of an *operator* in the past who was an individual, rather than a corporation. Although on balance it seems unlikely there would be many or any "*operators*" that were not corporations, (given the sheer size, cost and scope of duties of "*operators*" of offshore and associated facilities within the reach of the *Petroleum (Submerged Lands) Act)*, the contextual approach asserted cannot displace the plain intent of s 4B(3) *Crimes Act* that the general penalty for corporations is governed by s 4B(3) unless a contrary intent is manifest.

13. The Defendant argued that if parliament had intended a different fine to be imposed on corporate operators it would have made this clear, especially, (as the Defendant argued), given clause 9 of schedule 7 of *Petroleum (Submerged Lands) Act* clearly applies to individuals as opposed to corporations and that clause (it was argued) imposes a less significant maximum penalty of 50 penalty units. Clause 9 sets out the duties of "persons" in relation to occupational health and safely. Clause 9 therefore sets out duties imposed on "persons" other than "*operators*". Other clauses regulate other categories and imposes obligations on them commensurate with their role. Clause 9 envisages duties on "persons" who are not *operators* and may not be caught by other categories. "*Operators*" clearly are regulated and governed by Part 2 *Petroleum (Submerged Lands) (Management of Safety on Offshore Facilities) Regulations 1996.* Clearly it is envisaged that *operators* could be natural persons as well as corporations: (see Regulation 6, entry of ACN "if applicable"). Whatever the case, *operators* have duties over and above those categories of other persons. I conclude the maximum penalty is governed by s 4B(3) *Crimes Act*, in this instance the maximum penalty is $550,000 and I will sentence on that basis.

Discussion of Matters Submitted in Mitigation

14. In terms of the assessment of the gravity of the offending, the Defendant points out that the risk of a fall had been identified at the *tool box* meeting; the induction DVD and safety hand book instructed on wearing harnesses and the appropriate harnesses were available on the day of the incident. It is pointed out that neither Mr Weldon nor other workers with him were wearing height protection, nor had they taken steps to address the hazard other than they should "stay close to the bulkhead". (Para 6, Defendant's submissions). This provides little comfort to the Defendant who should have enforced its own safety standards as it was legally required to do. There is some, albeit little mitigation available by pointing to what Mr Weldon should have done when there was no effort made on behalf of the

Defendant to recommend harnesses on the day nor to properly light the area in accordance with its own procedures.

15. The Defendant accepts that there should have been a requirement of a "sign off" to ensure all appropriate risk mitigators had been specified; that all members of the work force should have been trained in *working at heights* training and that employees should have prepared appropriate Job Safety Analysis and Temporary Work Instructions. (Para 10, Defendant's submission). I take it the Defendant accepts that its own procedures were not complied with – on this occasion persons at supervisor level re-used a previous Job Safety Analysis that was not appropriate to the job in question.

16. Related to this, it is submitted on behalf of the Defendant that the breaches must be seen in light of the other reasonably practicable measures taken by the Defendant to comply with its obligations to ensure the safety of the facility. These include:

- the Defendant had a Safety Management System that if followed should have resulted in the hazard being identified during the JSA/"toolbox" meeting
- the Temporary Work Instruction should have specified the individual steps of the work including any risks/hazards and putting in place measures – if those involved had followed the Management Standards, the incident may have been prevented
- the JSA Management Standard specifically requires the JSA to consider "fall from heights" and that 5 of the 10 people (including the work crew) had specific *working at heights* training
- the JSA identified the hazard but was conducted contrary to the Management Standard
- the JSA had identified "slips, trips and falls" and required "correct PPE (Personal Protective Equipment) be worn and alertness moving around the tank"

- the two Marine Supervisors who inspected the work site, participated in the JSA and had working at heights training decided to use the old TWI and JSA

- the work crew were required to continually monitor the safely of their work and take all appropriate steps to ensure the hazards are reduced – they took no action other than to identify the risk and agree to stay close to the bulkhead while conducting work

- as well as the JSA Management Standard, the TWI Management Standard; the Permit to Work Management Standard; the tool box meeting, the Defendant had a system of use of hazid cards for use to continually monitor safely and "times outs" – where employees are encouraged to take time (5 minutes) to consider the safely of their tasks

- training had been provided in "safe working at heights" in February 2005 and had been given to marine, maintenance and production personnel

- the safety case in place designed to reduce the safety risks

- 2 dedicated health and safety officers based in the Defendant's head office who worked regularly at the Defendant's facilities

- ongoing process by safety personnel of examining safety standards against corporate bench marks

- training to all workers in relation to hazard identifications

- reporting procedures for high risk events and responding to reports

- availability of safety information to workers and seeing their input in reviewing work risks

- emergency Response Team on board at all times

- hazid card system

- formal weekly workplace inspections

- daily workplace inspection sheets.

17. I accept that measures taken and safety systems in place prior to the incident are relevant. The Defendant submits that *Collins v State Rail Authority of New South Wales* (1986) 5 NSWLR 209 stands for the proposition that in general where the employer has laid down a safe and proper practice, a casual failure by inferior employees, event those of a supervisory rank, to observe that practice on a particular occasion, will not render the employer liable for an offence against occupational health and safety duties. *Collins* may be distinguished. It concerns a more fundamental question of guilt in circumstances of a long standing and proven effective procedure concerning isolation and tagging electrical circuits. The long standing practice was not followed on a particular occasion. The Defendant in that case was acquitted as there was no evidence of failure by it to use due diligence to ensure the practice was observed. Here the Defendant accepts its guilt – the question of due diligence as a defence has not arisen. The Defendant accepts that despite it had certain systems in place at the time, the system was not complete in terms of ensuring compliance. In my view, with respect, the authority of *Collins* is in any event somewhat dated when seen in the light of modern occupational health and safety statutes. It is the compliance and assurance of maintenance of the safety system that is important (*Italo Australia Construction Pty Ltd v Parkes* [1988] 24 IR 421 distinguishing *Collins*).

18. It is self evident on the facts of this matter that senior persons subject to the Defendant's safety systems thought it was appropriate to use a dated and inappropriate JSA and that error infected a number of other component steps that the Defendant's system required. Even the recommendation on lighting was not enforced. In assessing the degree of negligence involved in order to assess the gravity of the offending, (*Palynolab Resounces Pty Ltd v Morrison*, 22 August 1996 SC (WA), unreported; *Haysdale v Shepherd* (1998) WASCA 89), although not at the highest level of negligence imaginable, and I do not consider it to be a case of "blatant disregard" for

safety, it was still a significant falling short of the standard expected and cannot be dealt with as a technical or minor lapse. I adopt what was said in *Inspector Schultz v Leonard J Williams (Timber) Pty Ltd* [2001] NSWIRComm 286 at para 29 "[it] is simply insufficient to give general directions and to, effectively, hope for the best". That reasoning is of significant relevance here.

19. I agree with the prosecution submission (para 16) that *Chugg v Pacific Dunlop* (1990) 170 CLR 249 at 260 is relevant to this matter:

> "In some cases the mere identification of the cause of a perceptible risk may, as a matter of common sense, also constitute identification of a means of removing that risk, thereby giving rise to a strong inference that an employer failed to provide "so far as practicable" a safe workplace."

Further, as pointed out by the prosecutor (at para 17), the obligation of an employer under the Act to an employee extends not only to the ideal worker but to the careless, inattentive and inadvertent worker as well. In *Workcover Authority of NSW v TRW* [2001] NSWIRComm 52 Boland J said [at 13]:

> "…However, the duty to provide a risk free work environment is a duty owed not only to the careful and observant employee but also to the hasty, careless, inadvertent, inattentive, unreasonable or disobedient employee in respect of conduct that is reasonably foressable."

Further, with respect I have been influenced by *Holmes v R E Spence & Co Pty Ltd* (1992) 5 VIR 119 at 123-124 where Harper J stated:

> "The Act does not require employers to ensure that accidents never happen. It requires them to take such steps as are practicable to provide and maintain a safe working environment….One must then weigh the chances of spontaneous stupidity, or a fall, or the like, against the practicability of guarding the machine so as to maintain its function while preventing the human factor from resulting in injury. If the danger is slight and the installation of a guard would be impossibly expensive, or render the machine unduly difficult to

> operate, then it may be that the installation of that guard is properly to be regarded as impracticable. Each case must be decided on its own facts."

20. Of significance and to the credit of the Defendant are the steps taken since the incident to improve safety including:

    - memorandum from senior management to all personnel reinforcing mandatory compliance with the prescribed safety systems,
    - review of the SMS and Management Standards
    - reviewed the working at heights training and engaged Accrete to conduct training
    - reviewed confined space entry training
    - begun developing a training needs analysis for safety training
    - engaged Wild Geese International to conduct an independent review of the SMS
    - completed external audit of the SMS and made plans for similar audits to review annually its processes
    - conducted post incident investigation
    - issued an alert notice to APPEA so that learnings from the incident may be shared (I agree with the submission that this justifies some easing of the impact of general deterrence)
    - review of the air quality testing procedures
    - engaged a second health safety environment coordinator.

21. Although an enhanced regard to safety after the incident provides some mitigation, particular in terms of the impact of general deterrence, specific deterrence and rehabilitation of the Defendant, the fact of these improvements highlight what could have been done to prevent the incident. Clearly the training on *working at height* was inadequate and the Safety handbook did not refer to working at height in tanks or confined spaces.

Further, as pointed out by the prosecutor, two other workers were working at a higher level than Mr Weldon. The Defendant could have conducted regular audits of its safety procedures and could or would have been alerted to supervisors signing off on permits without adhering to safety systems. The implementation of the Defendant's safety system appears to have largely failed at least in relation to *working at height in tanks*.

22. Of significant credit to the Defendant is its lack of previous convictions; its past good safety record and that for the past 11 months, the Defendant has not had any employees sustain injuries nor lost any time due to injury. The Defendant submits and I accept it is a good corporate citizen contributing to community activities in Western Australia and the Northern Territory. It has teams in various fundraising events to raise money for genuinely charitable causes and has donated money to sponsor the Royal Darwin Hospital's Anne Arthur Award (celebrating International Nurses Day); has donated to N.T. Rugby, Leukaemia Foundation, Down's Syndrome Association of W.A. and to the Special Children's Christmas Party in W.A.

23. The Defendant has provided material to the Court demonstrating its commitment to safety including the fact that is spends approximately 3% of its turnover on safety measures and commitment (after expenses approximately 4.6%). It would be expected that the Defendant dedicate significant expenditure to safety given the high level of risk to be managed in its activity. It has introduced the measures as detailed above and has had safety programmes such as "Target Zero Injuries" and "Hazid Cards". A number of more particular enhancements have also been introduced (para 82 Defendant's submissions).

24. The Defendant accepts that the injuries suffered by Mr Weldon were serious and accepts full responsibility for that consequence and the fact that its systemic efforts were not sufficient to discharge its statutory safety obligations. The consequences of the offence were indeed serious. I was

impressed that a representative of the Defendant was present in Court and accept the Defendant takes this matter very seriously. I note this is an early plea and there has been an indication of a plea for some time. I note the Defendant has cooperated in the investigation. All matters considered, a fine of $200,000 is appropriate. Given the timely plea and the early indication of a plea a conviction and fine of $180,000 will be imposed. I will order accordingly.

Dated this 5th day of December 2007.

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Jenny Blokland
CHIEF MAGISTRATE