CITATION:	*John Carroll v Alcan Gove Pty Ltd* [2008] NTMC 061
PARTIES:	JOHN CARROLL v ALCAN GOVE PTY LTD (ACN 000 453 663)
TITLE OF COURT:	Court of Summary Jurisdiction
JURISDICTION:	*Mining Management Act*
FILE NO(s):	20811200
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JUDGMENT OF:	Jenny Blokland CM

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SENTENCING – MINING MANAGEMENT ACT (NT)

Sentencing Act (NT) s 5(2)(b)
R v Fosters Australia [2008] VC 902, *DPP v Amcor Packaging Pty Ltd* (2005) 11 VR 557

REPRESENTATION:

Counsel:

Prosecutor:	Mr Anderson
Defendant:	Mr Ray QC

Solicitors:

Plaintiff:	Department of Justice
Defendant:	Not filed

Judgment category classification:	C
Judgment ID number:	[2008] NTMC 061
Number of paragraphs:	30

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

No. 20811200

[2008] NTMC 061

BETWEEN:

JOHN CARROLL
Complainant

AND:

ALCAN GOVE PTY LTD
Defendant

REASONS FOR DECISION

(Delivered 16 September 2008)

JENNY BLOKLAND CM:

Introduction

1. Alcan Gove Pty Ltd ("the Defendant") entered guilty pleas to the following offences:-

Count 1

Between 18 March and 23 April 2007, at the Alcan Refinery on the Gove Peninsular in the Northern Territory of Australia ("the mining site"), being the operator of the mining site, failed to do an act, in breach of an obligation imposed by Division 1 of the *Mining Management Act*, that caused the death of a person, namely Daniel Burman, knowing, or ought reasonably to have been expected to know, that the failure to do the act might cause the death of a person, namely Daniel Burman, knowing, or ought reasonably to have been expected to know, that the failure to do the act might cause the death of or a serious injury to a person, contrary to s 23(2) of the *Mining Management Act*.

Particulars of Act:

To ensure that there was established, implemented and maintained an appropriate safety, health and environment protection management system for the mining site, involving the establishment, implementation and maintenance of a system to ensure that mobile equipment, including a JLG800AJ boom lift serial number 0300081794, was inspected, whether by Alcan Gove or others in charge of mobile equipment on the mining site, in accordance with the manufacturer's recommendations and the defendant's Mobile Equipment Safe Operation and Maintenance Procedure GPM-EHS-027-02.

Particulars of Obligation:

So far as is practicable, to operate and maintain the mining site to minimise risk to the safety and health of workers on the mining site, as required by s 16 of the *Mining Management Act*.

Count 2

Between 20 March and 23 April 2007, at the Alcan Refinery on the Gove Peninsular in the Northern Territory of Australia ("the mining site"), being the operator for the mining site, failed to do an act, in breach of an obligation imposed by Division 1 of the *Mining Management Act*, that caused the death of a person, namely Daniel Burman, knowing, or ought reasonably to have been expected to know, that the failure to do the act might cause the death of or a serious injury to a person, contrary to s 23(2) of the *Mining Management Act*.

Particulars of Act:

To establish, implement and maintain an appropriate safety, health and environment protection management system for the mining site, involving establishing, implementing and maintaining a system to ensure that mobile equipment, including a JLG800AJ boom lift, serial number 0300081794, was only operated by employees of contractors to the defendant, including Norblast Industrial Solutions Pty Ltd, who had completed the defendant's mobile equipment operating training course for the specific mobile equipment involved and had demonstrated adequate competency and skill on the specific mobile equipment, in accordance with the defendant's Mobile Equipment Safe Operation and Maintenance Procedure GMP-EHS-027-02.

Particulars of Obligation:

So far as is practicable, to operate and maintain the mining site to minimise risk to the safety and health of the workers on the mining site, as required by s 16 of the *Mining Management Act*.

2. The penalty for a breach of s 23(2) of the *Mining Management Act (NT)*, in these circumstances is not less than 500 penalty units and not more than 5,000 penalty units: (or, between $55,000.00 and $550,000.00).

Prosecution Facts

3. The agreed facts in support of the prosecution case are detailed in Exhibit P1 and other documents before the Court. I also had the benefit of further submissions and a demonstration on a model concerning the operation of the JLG800AJ boom lift. In short, in early 2007 the Defendant contracted Norblast Industrial Solutions Pty Ltd ("Norblast") to undertake maintenance work on one of its tanks on the Defendant's refinery site. Norblast had previously been engaged to perform similar work. Norblast supplied the employees, including the deceased, Daniel Burman, a painter who recommenced employment with Norblast on 20 March 2007 when he and other workers flew to Gove to commence the maintenance work. The deceased had previously worked for Norblast. The deceased completed a *working safely at heights* training course as required by the Defendant and undertook a further course on Hazard Identification, Risk Assessment and Risk Control Awareness. It was agreed this course would enable him to identify working from a height as a hazard and working from heights without a harness as a risk.

4. The relevant period also coincided with expansion of the Defendant's refinery known as the "G3" project. Additional equipment was purchased and contractors were engaged for the G3. The equipment included elevated work platforms. The Defendant hired an 80 foot articulated work platform from Top End Hire which was manufactured by JLG Industries Inc in the United States and referred to in these proceedings as an "800AJ boom lift".

The lift is hydraulically powered for diverse machine motions and functions which are controlled by electrically activated hydraulic valves using switches and control levers.

5. The Defendant had its own written procedure governing the use of equipment such as the 800AJ boom lift, the *Mobile Equipment Safe Operation and Maintenance Procedure* requiring specific staff to maintain an inspection register for mobile plant on site. The *Service and Maintenance Manual* for the 800AJ boom lift provided by the manufacturer recommended inspection of most parts of the machine by a qualified mechanic every three months or 150 hours of use, whichever came first. The Defendant engaged specialist plant inspectors through a company trading as Safe Options Solutions (SOS). Although there is evidence of inspection of the 800AJ boom lift throughout parts of 2005 and 2006, Top End Hire did not consider it necessary to perform further checks in 2007 when it performed maintenance work at various stages on the 800AJ boom lift. As a result, the 800AJ was not inspected in early 2007. A scheduled inspection with SOS on 27 February 2007 did not occur as apparently for some time the whereabouts of the machine was unknown.

6. Alcan Gove's *Mobile Equipment Safe Operation and Maintenance Procedure* requires employees of contractors who are to operate mobile equipment, to complete its mobile equipment training course and be able to demonstrate competency and skill. Two of the Norblast employees working with the deceased were not required to complete the course for the operation of the 800AJ boom lift. Alcan Gove's *Mobile Equipment Safe Operation and Maintenance Procedure* requires a pre-use inspection be performed in accordance with the manufacturer's guidelines prior to operating mobile equipment. The manual provided by the manufacturer details specific precautions, inspections and functional checks to be carried out. The manual is kept in a box on the 800AJ platform specifically designed to hold it.

7. At the relevant time, the Norblast employees were not given the training specific to the elevated work platform, nor given instruction on the daily functional checks. The *Operation and Safety Manual* was not provided to the employees and at least one employee was not aware that it was necessary to consult the manual in relation to the checks.

8. On 22 April 2007, an SOS inspector located the 800AJ boom lift and commenced the inspection that was due in February 2007. The inspection was terminated as it was considered too windy on that occasion to continue. The inspector believed the machine had not been inspected since August 2006 and left the machine in service.

9. On 23 April 2007, the three Norblast employees, including the deceased, attended at the tank site. One did a walk around inspection but did not perform the daily functional checks and did not record an operator safety check in the logbook. Two employees (the deceased and Fraser) entered the platform with full body safety harnesses and attached the lanyards to the platform. Once the boom lift was in the elevated position, Fraser noticed the deceased did not have his harness properly done up around his legs and spoke to him about it. The deceased said something like "she'll be right". The deceased proceeded to paint the hand rail while Fraser drove the boom lift. During a break, they decided to blow accumulated garnet off of the support rim. The deceased and Fraser used a blow hose while the other employee (Sayer) took the platform back down to the ground. After 15-20 minutes the boom lift was placed adjacent to the pipe work at the base of the tank, preventing it from being driven further around the base of the tank. Fraser and the deceased returned into the platform wearing their harnesses with lanyards attached, the deceased did not secure the harness around his legs. Fraser moved the platform from the roof of the tank and in doing so, extended the tower boom. The tower boom was not in the most vertical position and the base of the 800AJ boom lift was not moved as the pipe work prevented it. While Fraser left the controls momentarily, the platform

started to move, Fraser attempted to grab the controls, but the boom lifted and tipped until the knuckle between the tower boom and the main boom hit the ground. The effect of this was that Fraser and the deceased were thrown from the platform. Fraser was caught by his harness, but the deceased fell approximately 10 metres to the ground and died almost instantly from injuries sustained on impact.

10. The investigation of the accident revealed a number of faults that are detailed in Exhibit 1. Those faults include the failure of two safety interlocks which allowed the boom lift to be placed in an unstable position. The proximity switch designed to prevent the tower telescope from functioning until the tower boom was fully elevated had been disabled, probably inadvertently. Further, the valve designed to prevent the tower telescope from functioning until the tower boom was fully elevated was found to be poorly designed, was not sealed properly and allowed moisture to enter the gland nut causing corrosion that led to the valve being seized at the time of the accident.

11. The accepted causes of the accident are the disability of the proximity switch, along with the hydraulic vertical limit valve seizure that enabled the tower boom telescope to extend without it being fully elevated, placing the 800AJ lift in an unstable position. Further, the faults noted with the proximity switch and valve were likely to have been detected if the inspection the day before the accident had proceeded. Similarly if the functional checks had been completed in accordance with the *Operation and Safety Manual*, the faults most likely would have been detected. Further, if the deceased had been wearing his safety harness correctly, it is unlikely he would have died as a result of the accident.

Primary Submissions in Mitigation

12. In support of the submission that Alcan Gove respects the sentencing process and takes the matter very seriously, it was drawn to the Court's

attention that four of the Defendant's senior managerial officers were present in the Court for the proceedings. I agree the presence of those officers in the Court is most appropriate in the circumstances of such a serious and tragic matter and illustrates the Defendant Company taking responsibility and taking the matter seriously.

13. Submissions emphasised that there was an inspection regime in place through the presence on site of Top End Hire and Safe Operation Solutions. Although the submissions accept the legal obligations were non-delegable, it was emphasised on behalf of the Defendant that having contracted specialist safety inspectors such as Safe Operation Solutions, together with Top End Hire, there was an expectation on the part of the Defendant that safety issues were being dealt with appropriately. The Court was told that Top End Hire had a significant contract with Alcan Gove in the order of $20 million over four years and had a significant presence at the site. It was pointed out that it was never drawn to Alcan Gove's attention that the relevant equipment was overdue for inspection. In my view, this is a reasonable point in mitigation.

14. It was also pointed out that the standard for training set out by Alcan Gove for operating the mobile equipment at the site was higher than the generic industry requirement which does not have a certification requirement as a matter of law that requires machine specific training. It was pointed out this was a specific site standard but that the standard set was not maintained. It was also pointed out that the Work Health Authority checklist does not require an operator of elevated work platforms to check the operating manual. It was submitted the standards imposed by Alcan Gove were higher than generally accepted standards. In my view there is some, but marginal mitigation in this point, as the Defendant is obliged to maintain standards commensurate with its specific risk context, including the specific equipment and associated risks that may not be contemplated in broader generic standards.

15. Further matters in mitigation pointed out that Alcan Gove Developments *occasionally* rather than continuously made plant and equipment available for the use of Alcan Gove and hence Norblast – that this incident was not an example of what typically occurred. The Court was asked to note that although the manual was not within the 800AJ boom lift, the log book required pre-start checks in any event, Mr Fraser had completed the generic training and a Mr Mizzen who audited the maintenance contractor accepted assurances from contractors that the pre-start checks were done. As acknowledged, the checks would be by their nature superficial without reference to the manual.

16. The Court was reminded that the immobilisation of the proximity switch was something not within the Defendant's knowledge and was most likely an oversight, possibly by someone involved in maintenance of the machine. The Court was told that in July 2007, as a result of this incident, the manufacturers of the machine issued a field service bulletin effecting a software upgrade so it is no longer possible when using the analyser to turn off the proximity switch. It was submitted that as a result of the tragedy, the manufacturer has recognised the machine could be made safer. The Court was also told the poorly designed plunger leading to corrosion has been redesigned.

17. In relation to background issues relating to the Defendant, it was confirmed Alcan Gove operates a significant bauxite mine and alumina refinery on the Gove Peninsular and is a major international exporter. The mine commenced in the late 1960s with alumina production commencing in 1972. Alcan became involved in 2001. The significance of the sheer size of the operation, including the size of the mine and refinery, it was submitted, means there will be significant exposure to risk. Although not put as justification for this and other breaches, it was submitted the breaches must be seen in context of the volume of the total operation including the significant numbers of employees and contractors. All aspects of the

operation involve demanding industrial and managerial hazards. The Court was advised Alcan Gove has a hazardous energy control taskforce which meets regularly and over 160 audits have been done in 2007 with a 98% compliance rate. Similarly work in confined spaces have separate hazard assessments, hot work permits systems were reworded in 2007 and the mobile equipment committee meets fortnightly to manage traffic and pedestrian risks. Contractor management risk also receives specific attention.

18. In 2007 the Defendant Company was acquired by Rio Tinto. Following this incident, a number of improvements were implemented, including retraining and competency assessment for all operators working with elevated work platforms, assessment for competency in relation to fall protection, dissemination of information about the issue within the workplace and beyond to share learning from the experience. A significant leadership audit around all occupational health and safety issues was introduced in late 2006 to early 2007, which is being continually monitored. Further, it was submitted the Rio Tinto health and safety standards and systems are vigorously enforced. All boom lifts were grounded for a period after the incident, there were reminders to wear harnesses and notices about reinforcement of safety were widely distributed. A new position has been created that is a dedicated mobile equipment superintendent who has responsibility for administering mobile equipment systems. A further position has been created to assist with implementation and record keeping for every piece of plant and equipment. As well as the pre-start log, there is now a requirement to complete a document confirming that the pre-start check has been done, supported by random checks and audits. Signage on safety has been increased. Alcan instituted a world-wide stoppage on the purchase of JLG machines.

19. Alcan’s co-operation with authorities, especially Work Safe was emphasised. Although submissions acknowledge the tragic loss to the

deceased's family and that no support can ever be enough, the Court was advised that Norblast set up a fund and Alcan matched the fund dollar-for-dollar and contributions were also made towards travel and other associated costs for the deceased's family.

20. The contributions of Alcan to the local community were mentioned, including its partnership in the Garma Festival, Dimuru Land Corporation, night patrols, the "Alert" training scheme and significant contributions to Charles Darwin University for environment research programmes.

21. Finally, the plea of guilty and co-operation. Examples were given from *R v Fosters Australia* [2008] VCC 902 of discounts of 25%, bearing in mind the complexity of these cases.

Objective Seriousness of the Offences

22. Appreciating there were safety systems in place to prevent incidents such as this one occurring on 23 April 2007 and appreciating in particular the Defendant had an expectation its plant and machinery were being appropriately maintained, and further appreciating the multiple causes of the incident, the fact that breaches of the safety obligations by the Defendant caused the accident that resulted in the death of the deceased, objectively places these offences within a serious category. Even granted that the nature of the breaches are not at the highest level, the consequences of the breaches are such as to leave these offences in a serious category. The breaches had devastating consequences. The deceased was 33 years of age. The Court is obliged to have regard to the *"nature of the offence and how serious the offence was, including any physical psychological or emotional harm done to a victim": Sentencing Act (NT)* s 5(2)(b). The Court was advised that the deceased's parents, his partner, his sister and two brothers and other members of the family were present in Court at the sentencing hearing. Some had travelled from Perth to attend. The Court was also

advised the deceased was survived by three children, including one step-child.

23. Victim impact statements were made and tendered by consent from Sheree Leanne Russell, Anton Burman, Julie Burman, Bryant Burman, Michael Burman and Edna Burman. I have now had the opportunity to read those statements. As would be expected and underlining the seriousness of this matter are the expressions of devastation, anguish and grief in those victim impact statements. A number of family members receive counselling and continue to suffer significantly as a result of the loss of their loved one. This is acknowledged as a significant factor in the assessment of the seriousness of the offending.

24. It is accepted general deterrence is the primary sentencing consideration to ensure that entities conducting mining or similar operations that may be inherently dangerous are performed in a way to minimise the risks of serious harm and death to employees and others who may engage with such operations. Alcan Gove has relevant previous convictions that tend to lessen the strength of otherwise significant points of mitigation. On 1 February 2006, Alcan Gove was convicted and fined $315,000.00 for a breach of s 23(2) of the *Mining Management Act (NT).* The victim in that case was the employee of a contractor to Alcan Gove. The contractor was fined the same amount: (See Ex P1, para 65). On 11 September 2006, Alcan Gove was convicted and fined $175,000.00 for a breach of s 23(4) of the *Mining Management Act (NT).* For an offence of a different character and not strictly speaking a previous conviction, on 8 November 2007 the Defendant was convicted for failing to notify of a critical incident contrary to s 29 of the *Mining Management Act (NT): Sellers v Alcan Gove Pty Ltd* [2007] NTMC 076. It is true that Alcan Gove is an extensive operation with associated inherent risks that are complicated to manage – the previous matters still impact on the penalty in terms of the need for specific deterrence.

25. The prosecution has submitted that the Defendant was previously warned on 15 August 2005 when the operator of a different JLG 800AJ was injured on the site when the platform was inadvertently raised by the operator into some pipes which were protruding from a pipe rack. An investigation concluded the operator could not be considered competent to operate the JLG800AJ. The Mining Officer recommended all operators be site assessed for competency before being allowed to operate the machines and that the competency tests be specific to each type and model of machine. (P1, para 58). It was submitted on behalf of the Defendant that this previous incident is the reason Alcan Gove agreed to implement the increased standard that it departed from in this case. Although I agree the previous warning does not demonstrate the higher level of disregard to safety issues as in the more serious examples contemplated in *DPP v Amcor Packaging Pty Ltd* (2005) 11 VR 557 and *R v Fosters Australia* [2008] VCC 902, it still has a role to play in the assessment of both Counts here. Alcan Gove introduced a system as a result of the incident on 15 August 2005 involving workers who were not conversant with the operation of the same machinery. I agree with the prosecution submission that the Defendant Company was on notice. In my view, it is an aggravating feature of both offences.

26. In assessing the significance of the breaches, the moral blameworthiness of the Defendant is lessened somewhat in relation to Count 1 by its expectation that it has dealt with the risk through the inspector's staff and others it thought was providing the relevant checks. Given the antecedent history, the safety checking with contractors is an area that needs improvement. I agree with submissions of both Counsel that Count 2 should be regarded as mid-range in terms of the character of the breach itself.

27. Notwithstanding the serious consequences of the breaches, the steps the Defendant has taken since the incident, its ongoing community support for various projects and its co-operation in the investigation described above lead to significant mitigation, but I am reminded that these subjective

factors "must play a subsidiary role in the determination of penalty to the gravity of the offence itself" – *DPP v Amcor* at para 35 citing *Work Cover Authority of NSW v Profab Industries Pty Ltd*.

28. All matters considered, in relation to Count 1, I have come to the conclusion that a fine of $230,000.00 reduced to $207,000.00, taking account of the plea of guilty is appropriate. In relation to Count 2 I have come to the conclusion that a fine of $250,000.00 reduced to $225,000.00, taking account of the plea of guilty is appropriate. I have allowed significant mitigation for the Defendant Company's co-operation and participation in the investigation and evidence gathering process. To allow a reduction of more than 10% for the plea of guilty in these circumstances would detract from the overall gravity of how the offences are regarded.

29. There will be convictions on both Counts and fines totalling $432,000.00.

30. I understand the Defendant has agreed to reimburse the prosecution for disbursements totalling $12,910.37 and contribute $15,000.00 towards the prosecution's professional costs. I will ask counsel if formal orders are sought on those two matters.

Dated this 16th day of September 2008.

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Jenny Blokland
CHIEF MAGISTRATE