CITATION:	*THE WORK HEALTH AUTHORITY v OM (MANGANESE) LTD (ACN 097 091 506)* [2023] NTLC 18
PARTIES:	*THE WORK HEALTH AUTHORITY* V *OM (MANGANESE) LTD (ACN 097 091 506)*
TITLE OF COURT:	LOCAL COURT
JURISDICTION:	CRIMINAL
FILE NO(s):	22126067
DELIVERED ON:	11 October 2023
DELIVERED AT:	Darwin
HEARING DATE(s):	18 September 2023
DECISION OF:	Judge Opie

CATCHWORDS:

*Work Health and Safety (National Uniform Legislation) Act 2011 (*NT*)*

Duty of employers – risk of death or serious injury – objective seriousness – impact on victims - deterrence – mitigating factors – assistance to law enforcement authorities – remorse

REPRESENTATION:

Counsel:

Work Health Authority: Duncan McConnel SC

Defendant: Mary Chalmers SC

Solicitors:

Work Health Authority

Defendant: Ward Keller

Decision category classification:	B
Decision ID number:	2023 NTLC 18
Number of paragraphs:	51

IN THE LOCAL COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. 22126067

BETWEEN:

THE WORK HEALTH AUTHORITY

Complainant

AND:

OM (MANGANESE) LTD (ACN 097 091 506)

Defendant

REASONS FOR DECISION

(Delivered 11 October 2023)

JUDGE OPIE

Charge

1. Om Manganese Ltd **("OMM")** has pleaded guilty to a single charge that contrary to section 32 of the *Work Health and Safety (National Uniform Legislation) Act 2011(*NT*)* **("WHS Act")** the company failed to ensure so far as reasonably practicable the health and safety of workers engaged by OMM and that failure exposed individuals to whom it owed a duty to the risk of death or serious injury.

The incident

2. On 24 August 2019 Mr Craig Butler was working as a mining superintendent at the Bootu Creek mine, 110 km North of Tennant Creek. He was overseeing a team of workers mining manganese ore in an open cut pit called the Tourag pit.

3. During the morning shift, workers in the pit observed rilling at the southern end of the hanging wall. Rocks fell from the wall, were partially captured within the catchment bund and spilled over part of the pit access ramp.

4. Mining superintendent Butler entered the pit to conduct an assessment of the hanging wall. While conducting the assessment, the wall above him failed. He was unable to escape and was engulfed by a 48,000 cubic metre section of the wall. Tragically, he died at the scene. The debris extended across the pit floor to a width of 80m. Two other workers were located in dangerously close proximity to the fall but were not physically harmed.

5. By its plea of guilty OMM has accepted that it had a duty to eliminate or minimise the risk to workers in the Tourag pit during a pit slope failure so far as was reasonably practicable. OMM failed to take reasonably practicable measures. Workers were exposed to an unacceptable risk of serious injury or death and in Mr Butler's case that risk materialised.

Relevant matters for determining what was reasonably practicable

6. OMM used aggressive (steep) pit slope geometries in the Tourag pit, which increased the probability of pit slope failure.

7. OMM had a risk assessment matrix which was used to manage the safety of activities at the mine **("Risk Matrix").**

8. OMM possessed geotechnical information including:

   (a) A geotechnical report from Absolute Geotechnics Pty Ltd dated 26 July 2019;

   (b) A geotechnical report from Absolute Geotechnics Pty Ltd detailing a footwall failure in the Yaka Pit at the mine on 13 June 2019; and

   (c) Prism monitoring data from 23 July 2019 to 23 August 2019 (collectively **"Geotechnical Information"**).

9. The Geotechnical Information showed that the hanging wall of the Tourag pit was subject to slope movement which placed it in the highest range of active instability.

10. As at 24 August 2019 the following reports and observations had been made of visible pit slope instability in the Tourag pit:

    (a) On 19 August 2019 one of the shift supervisors observed that two catch berms were starting to lose their structure, crack and give way. The area was marked with cones and the observations were reported to the next shift supervisor; and

    (b) In the days leading up to 24 August 2019 a machine operator had observed some rocks falling from the pit slope about halfway up the wall and heard it being reported to the shift supervisor (collectively **"Reports of Visible Pit Slope Instability"**).

11. Based on the Geotechnical Information and Reports of Visible Pit Slope Instability available on 24 August 2019, OMM's Risk Matrix would have classified the risk as "extreme risk" and "unacceptable risk" requiring work to stop or not start until controls were established to reduce the risk to an acceptable level.

12. The extreme risk of failure of the Tourag pit slope was foreseeable. OMM knew or ought reasonably to have known:

    (a) The "extreme risk" of failure of the Tourag warranted:

        i. Stopping operations;

        ii. Implementing OMM's risk management process; and

        iii. Installing and routinely monitoring additional slope stability monitoring using LiDAR, Slope Stability Radars and automated total stations (prism monitoring) across the Tourag pit slope **("Recommended Measures").**

    (b) Stopping operations in the Tourag pit would eliminate the risk to the health and safety of workers at the work by pit slope failure in the Tourag pit; and

    (c) Installing the Recommended Measures in the Tourag pit would:

        i. Identify precursor information necessary to enable the implementation of risk management processes proportionate to the risk; and

        ii. Provide early warning of a pit slope failure and enable OMM to take steps to minimise the risk to workers.

13. The loss of production and costs associated with implementing OMM's risk management processes and installing the Recommended Measures were not disproportionate to the risk to which the workers were exposed.

Sentencing

14. Sentencing for offences under the WHS Act is governed by the *Sentencing Act 1995*. The maximum penalty is a fine of $1,500,000. While there is a discretion for the Court to sentence a defendant without recording a conviction I find that this is not a case where the discretion should be exercised. The regulatory nature of the legislation and the public interest of its safety objectives weighs against such a course for such serious offending.

Objective seriousness of the offence

15. It is acknowledged that the defendant falls to be sentenced only in respect of its failure to comply with its health and safety duty to the extent that the failure exposed workers to the risk of death or serious injury. The category 2 offence is constituted by a failure to comply with a duty rather than the recklessness required for the more serious category 1 offence.

16. The death of Mr Butler was devastating for his family, colleagues and the community. It is relevant as a circumstance in the sentencing and as evidence of the manifestation of the risk that was to be guarded against. It is not an element of the charge.

17. The defendant is a mining company operating in an industry that is expected to maintain the highest levels of workplace health and safety regulations.

18. The defendant operated a sophisticated system of work which included regularly obtaining expert advice regarding the geotechnical aspects of conducting mining operations. It obtained geotechnical reports to provide advice on pit slope stability and the necessary pit slope design parameters to minimise the risk of pit slope failure.

19. The defendant had a Ground Control Management Plan which identified the risks of pit slope failure and contained recommendations for pit slope designs.

20. By reason of those matters the risk of injury or death to workers working in pits on the mine was foreseeable and foreseen by the defendant.

21. The defendant chose to develop the Tourag Pit with an aggressive pit slope design meaning it was steeper and carried a higher risk of pit slope failure.

22. By virtue of the defendant opting for an aggressive design it had to be more vigilant about managing the risk of pit slope failure by firstly, adhering to design parameters and secondly monitoring pit slopes for any indication of instability and responding to such indications.

23. In 2013 the defendant obtained a Ground Control Management Plan ("**GCMP**") which identified minimum standards of design and excavation control, including advice on pit wall monitoring by survey prisms with suitable spacing and interval on high walls and critical areas. The GCMP recommended the defendant implement a Trigger Action Response Plan ("**TARP**") for each pit at Bootu creek as part of the slope monitoring program to create a scale of alert conditions for potential slope failure. The TARP was not implemented.

24. The most recent geotechnical advice regarding pit design (October 2015) had recommended that the batter height be decreased from 20m to 10m on the lower parts of the pit wall; that berms be 3m wide and the batter angle be maintained at 55 degrees. A further recommendation was made for the installation of a 6m wide berm halfway down the lower part of the wall once the height exceeded 75m.

25. The defendant did not follow the geotechnical advice regarding the pit design.

26. In subsequent proposed designs, put to new geotechnical engineers in 2016, earlier design parameters from 2014 (before the recommendation for reduced batter heights in 2015) were used resulting in more aggressive batter angles and heights – which designs in fact exceeded some of the 2014 pit design recommendations too.

27. Despite the change in geotechnical advisors, the defendant was still variously advised, even as late as July 2019 that because of the elevated risk of hanging wall slope failure, prisms should be installed and routinely monitored.

28. Prism monitoring included measurement of prism movement. Where movement was recorded, depending on the amount of movement, the defendant was required to take action to shut down work in the pits until further monitoring confirmed the slope had stabilised and it was safe to resume working.

29. There was pit slope failure in a nearby pit in June 2019. Following the failure, the defendant obtained a report which recommended that it implement a TARP for work being

undertaken in the vicinity of the failure. The defendant did not implement a TARP for that failure and as a result it did not have any active TARP on the mine site, even in the three months leading up to 24 August 2019, when it should have been implemented from at least 2013.

30. There had been an earlier pit slope failure in Tourag Pit in January 2019 and workers continued to work in the vicinity of that previous failure. They did so without a TARP in place and with limited prism monitoring.

31. The defendant had installed prism monitoring but not for the full length of the Tourag pit.

32. Notwithstanding that the prism monitoring was limited, even the limited monitoring showed sufficient movement that the risk level for pit slope instability was extreme on its own risk matrix. The defendant did not respond to that risk weighting by stopping work in the Tourag pit or at all.

33. There was some additional visible signs of pit slope instability in the days leading up to 24 August 2019.

34. Although the prism monitoring data and the visible signs of instability were not necessarily signs of the slip that occurred on 24 August, they were sufficient signs of instability in general to warrant the pit being closed to all workers and further monitoring until the signs of instability passed and the pit was deemed safe to re-enter.

35. In that sense the risk was obvious and was known (having come to pass at Bootu Creek in January and again in June) the only proper response was to close the pit. The defendant continued operations.

36. The defendant did undertake some monitoring of the pit for instability including daily inspections. It also monitored reports of instability on 24 August 2019 by its supervisors undertaking inspections of reported rilling or movement on the pit slip. While it did so, it cleared most workers from the pit but allowed some to remain. It was during such an inspection that Mr Butler was killed and a number of others narrowly missed being seriously injured or killed.

37. The defendant did undertake some risk management for pit slope failure across Bootu Creek including visual inspections which were logged by shift supervisors. The defendant had a Highwall inspection and management procedure as part of its safety systems. The defendant had a Highwall Machines and Personnel Procedure. The defendant had a Mining near slips and unstable ground procedure.

38. The defendant had implemented a workplace health and safety system to address the identified risk and some of the aspects of that system were actively carried out such as pre-start meetings, toolbox meetings, Staff Take 5s and pre-shift hazard identification procedures.

39. Counsel for the Authority submitted that the offending fell within the upper end of the mid-range of seriousness or the lower end of the high-range of seriousness. Counsel for defence submitted that the offending fell within the mid-range of seriousness.

40. Having regard to the combination of factors listed above I find that the circumstances place it in the *lower end of high range of seriousness*.

Impact on victims

41. The death of Mr Butler was a tragedy and his loss has had a profound effect on his friends, family and colleagues. I have had specific regard to victim impact statements from two of Mr Butler's colleagues, working at the Tourag Pit in close proximity to the hanging wall, at the time of the fall. They write of the shock and devastation of seeing the wall collapsing, knowing that Mr Butler could not survive. They write that the event has affected them deeply. They have been unable to work for the company, or even in the industry again, affecting their capacity to earn and their quality of life. These are significant impacts that must be acknowledged and considered in the course of sentencing.

General deterrence

42. The mining industry is one that involves a considerable amount of high risk work such that general deterrence is an important sentencing consideration. The community is entitled to expect that employers will comply with safety requirements and take obligations imposed by the WHS Act very seriously.

Specific deterrence

43. OMM continues to operate and conduct activities of the same nature as the subject incident. While OMM has taken comprehensive steps to minimise similar risk to workers in the future, the penalty imposed must reinforce the importance of constant vigilance by the company and its supervisory staff.

Matters in mitigation

44. The defendant has no prior history of offending.

45. The defendant facilitated the course of justice from the earliest time cooperating fully with a complex investigation.

46. The defendant has entered a guilty plea at an early opportunity and is entitled to a full discount on sentence of 25%.

47. The defendant has expressed remorse.

48. The defendant has made substantial and comprehensive efforts to review and improve its operations in response to the incident.

49. The defendant has agreed to pay the Authority's costs of and incidental to the proceedings in the amount of $193,000.00 demonstrating remorse, acceptance of responsibility and contrition.

Penalty

50. The defendant, OM (Manganese) Ltd, is convicted.

51. The defendant is fined $487, 500.00.