



## Why the Judge Convicted the Officer

In a Sydney District Court judgement on the 2nd of November 2017 an Officer was convicted of failing to comply with his duty to exercise due diligence under section 27 of the WHS Act, to ensure that his PCBU complied with its Primary Duty of Care under section 19(1) of the WHS Act. A number of the PCBU's workers were exposed to a risk of death or serious injury and one was killed in a tragic workplace accident.

This article covers the circumstances of the death of the worker and why the Judge determined that the Officer failed to comply with his duty of due diligence. This incident and the Judge's ruling may be of particular interest to Officers and Senior Managers.

### The Fatal Incident

The PCBU is a company in the business of processing domestic and commercial waste. On the day of the fatality the Site Supervisor was operating an excavator with a sieve bucket fitted. He would scoop up a bucket load of material that had to be sorted and 3 workers sorted the contents. The excavator was stationary until the sorting was completed. Thinking that all 3 workers were still in front of him the Site Supervisor reversed the excavator. One worker was actually behind the excavator. He was struck and was caught up in the excavator track and the continued rotation of the track caused his lower limbs to rotate and his pelvis was severely injured. The worker had a cardiac arrest and died.

### The Officer

At the time of the incident the Officer was the sole director of the PCBU that had 23 employees and he was not onsite at the time. He was involved in overseeing the management and business operations of the company. Also he was responsible for all of the company's training and the development of systems associated with the site operations.

### Why the Officer was Guilty

Under section 27 of the WHS Act an Officer must exercise due diligence to ensure that their PCBU complies with any duty or obligation the PCBU has under the WHS Act. In this case the PCBU did not comply with its Primary Duty of Care as set out in section 19(1) of the WHS Act.

The Judge noted that:

- The Officer was aware of the requirement and need for work health and safety procedures as a Transport Operations Manual had been developed. However he did not ensure that any formal procedures were developed or put in place at the site. For example there was no procedure in place requiring the excavator operator to indicate to or communicate with the sorters on the occasions the excavator was to move.
- The four workers at the site doing sorting were unaware or unclear as to what a risk assessment, safe work statement or toolbox talk were.
- The PCBU did not provide instruction, information and training to all workers about the need for, and the operation of, an exclusion zone around the excavator.

- There was no traffic management plan for the site and no exclusion zones for pedestrian workers, and no fences, barricades, bollards, bunting, or witches hats in use.
- There were no documented systems of work and no system of work that required the sorters to communicate with the excavator driver when there was any change in their location.
- The onsite verbal training that was provided was insufficient, unclear and undocumented.
- A mechanical inspection of the excavator after the incident revealed that it had 93 defects including a number of defects that reduced and restricted the visibility of the operator including his ability to see behind him and no working horn or side or rear vision mirrors.

A number of changes were made to the systems of work after the incident and they shed more light on what was not in place at the time of the incident. See pages 9 to 11 of the Judgement for details at <https://www.caselaw.nsw.gov.au/decision/59faa496e4b058596cbabaae>.

### **The Officer's Penalty**

In deciding on the appropriate penalty the Judge took into account that the Officer pleaded guilty at an early stage in the prosecution. The Judge also considered other factors: the "objective seriousness of the crime", "the need for specific deterrence", "aggravating and mitigating factors", and "capacity to pay". The Officer's penalty was thus reduced to \$60,000. The PCBU was fined \$300,000.

**COURTENELL Pty Ltd**

*as Trustee for the Vowles Family Trust*

ABN 42164393628 ACN 050109281

PO Box 622, Broadway NSW 2037

147 St Johns Road, Glebe NSW 2050 [train@courtenell.com.au](mailto:train@courtenell.com.au)

~ [www.courtenell.com.au](http://www.courtenell.com.au)

Phone 02 9552 2066