EXPERTS ALONE CANNOT SAVE YOU

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Labour, Employment Workplace Safety Alert

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A recent decision by the NSW Industrial Court (Court) is a further reminder that businesses can't hide behind appointed experts or delegate their safety obligations and responsibilities to others. It is also a reminder that safety obligations extend to the use of plant and equipment at another business' premises.

Businesses must actively review and analyse advice given to them to ensure that it provides practicable management of all hazards and risks arising from work and the workplace.

In a case involving Daracon Mining Pty Ltd (Daracon), Daracon was held to have breached its work health and safety obligation despite being given clear assurances from an expert engineer that a computer controlled gate ensured that curtained hazards were eliminated. As a result, Daracon was fine AUD80,000 for a worker fatality.

BACKGROUND

Daracon was engaged to remove rock and aggregate left over after coal processing on a mine site and undertook this work using employed drivers and independent transport companies.

The rock and aggregate was released from overhead storage bins and loaded into trucks before being hauled from the mine. To load the rock and aggregate, a truck was positioned in the loading bay beneath the storage bin. Upon entering the loading bay, a programmable electronic control was primed through sensor cells. Once primed, the driver used a remote control to open the bin gates, releasing the reject material through the bin gates via a chute into the truck.

Priming the computer control required the truck to pass three sets of sensor cells positioned on either side of the loading bay driveway. When the three sensors' signals were interrupted at the same time (signaling that the truck was in the correct position) a signal was sent, priming the computer control program. Only when primed by the electronic software logic system were the bin gates able to be opened.

This system was originally designed for use by mine haulage trucks which were equipped with overhead fall protection. Around the time Daracon commenced the work, mine haulage trucks were banned from the haulage road to the bin loading bay. Truck and dog combination vehicles replaced the mine haulage trucks however the combination vehicles did not have overhead fall protection.

The computerised sensor system required amendment so it could detect the new combination vehicles. However, during the amendment a flaw was created in the system and the sensors no longer had to be 'interrupted' at the same time before the gates could open. All that was required was for each sensor to have been interrupted.

In addition, Daracon's drivers adopted a practice (without Daracon's knowledge) of driving trucks past the correct position in the loading bay and reversing back into the correct position.

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When a driver drove forward through the loading bay, all sensors were interrupted. This was sufficient to prime the remote control to allow the bin's gates to open. The sensor system could no longer detect if the truck was reversed too far. The three sensors had been interrupted, and the electronic control program was primed.

THE INCIDENT

In February 2009, a driver, who had reversed back beyond the correct position, was fatally injured when several tonnes of rock and aggregate fell through the cabin roof of the truck he was driving. The sensors had been interrupted so despite the truck being in an incorrect position under the bin gates, the gates could be opened. When the driver opened the gates, the material was released through the chute onto the cabin of the truck.

THE CHARGE

The incident occurred in 2009 and Daracon was charged under the now repealed Occupation Health and Safety Act 2000 (NSW). The alleged breaches were:

- failure to ensure it was not possible to open the bin's gates while the cabin of a truck was beneath them
- failure to require the mine operator to undertake a functional safety hazard and operability analysis of the recent modifications to the software.

Daracon had been told by the mine operator's engineers that the bin couldn't open unless trucks were correctly positioned.

The Court held that the use of a new vehicle type, the absence of overhead fall protection for those vehicles and the fact that software (which was a primary safety control) was amended *"ought to have acted as a catalyst for [Daracon] to be proactive in ensuring that the bin could not discharge its load on top of the cabin of a truck in any circumstance"*.

STEPS WHICH THE DEFENDANT SHOULD HAVE TAKEN

The prosecution claimed that Daracon could have:

1. analysed the modifications to the program software and logic, since the truck and dog combinations were to be used with the bin
2. analysed the modifications to the physical layout of the bin and the location of the sensors required with the truck and dog combination
3. implemented an equipment inspection and maintenance program in relation to the sensors, in order to ensure that the sensors functioned so that the programmable electronic control program could not open unless three sensors were interrupted simultaneously
4. analysed the operating procedures for a truck and dog combination to ensure the procedures were safe
5. ensured that the work method for loading the truck and dog combinations prevented the cabin from being located underneath the bin gates when the programmable electronic control system allowed the gates to open.

Daracon pleaded guilty, agreeing that it shouldn't have relied on the engineers' oral assurances.

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THE DECISION

The Court recognised that Daracon:

6. had an elaborate safety management system
7. did not ignore a known risk
8. had been told by engineers that the bin systems was failsafe
9. did not have complete control over the bin.

The Court held that while these were mitigating factors they did not:

10. constitute compliance
11. act as exculpatory factors
12. reduce the objective seriousness of the offence.

Daracon was undertaking work in 'a perilous workplace' and this imposed an uncompromising responsibility to take every possible precaution that was reasonably practicable. Daracon could not rely on assurance from the mine operator's engineers in order to meet its health and safety obligations. It had to take its own practicable steps to test and verify the change of vehicle type (without overhead vehicle protection), the software amendment and the work methods being used by drivers which resulted in a situation where the bin gates could never open when the truck cabin was under the gates. The verbal assurances from an expert engineer did not remove the need for further enquiry, testing and verification.

WHAT DOES THIS MEAN FOR BUSINESSES?

Businesses must review and consider their 'must never happen' scenarios. For example, a 'must never happen' scenario may be:

13. a truck cabin positioned under bin gates
14. hands coming into contact with a cutting blade
15. a person coming into contact with live electrical components
16. pedestrians working in the path of a moving forklift.

Once the business has its 'must never happen' list, they must be sure that they take active, practical steps to review and test the combination of safety systems such as engineering controls, expert designed failsafe controls (such as electronic shutdown sensors) and the worker practice to ensure, so far as is reasonably practicable, the business' 'must never happen' does not ever happen.

You cannot rely on expert assurances alone as sufficient reasonably practicable steps to comply with the safety obligation.

Daracon's case is a further reminder that in all scenarios, even when experts are involved, when there is a change to systems, circumstances or equipment, the business must default to the position that controls are no longer adequate. Businesses must then default back to risk management basics and apply active steps to identify hazards that may arise in the changed circumstance.

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