_____

NORTHERN TERRITORY OF AUSTRALIA

LOCAL COURT

No: 22126067

WORK HEALTH AUTHORITY

and

OM (MANGANESE) PTY LTD

JUDGE OPIE

TRANSCRIPT OF PROCEEDINGS

AT DARWIN ON 11 OCTOBER 2023

Transcribed by:
Epiq:

MS CHALMERS: Yes, we're here for sentencing in the matter of OM. I appear for the defendant with Mr Stuchbery.

HER HONOUR: Thank you.

Thanks, Mr Stuchbery.

MR INGRAMS: I appear for the Work Health Authority, Ingrams.

HER HONOUR: Sorry?

MR INGRAMS: Ingrams appearing for the Work Health Authority.

HER HONOUR: Ingrams. Thank you, sir.

What I've done is I've actually, I'm going to publish the sentence but I'll read it out this morning.

MS CHALMERS: Your Honour, can we confirm that you did receive the joint submissions late yesterday?

HER HONOUR: I did. I did. Thank you for that and I thank both parties for their detailed submissions that were filed previously and also that were filed yesterday. It's been of great assistance.

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

The incident: on 24 August 2019 Mr Craig Butler was working as a mining superintendent at the Bootu Creek Mine 110 kilometres north of Tennant Creek. He was overseeing a team of workers mining Manganese ore in an open cut pit or the Tourag pit.

During the morning shift workers in the pit observed drilling 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.

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 48,000 cubic, 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 80 metres. Two other workers were located in dangerously close proximity to the fall but were not physically harm.

By its plea of guilty OM 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. OM failed to take reasonably practical measures. Workers were exposed to an unacceptable risk of serious injury or death, and Mr Butler's case that risk materialised.

OM used aggressive steep pit slope geometries in the Tourag pit which increased the probability of pit slope failure. OM had a risk assessment matrix which was used to manage the safety of activities at the mine.

OM possessed geotechnical information including a geotechnical report from Absolute Geotechnics dated 26 July 2019. A report detailing a foot wall failure in the Yaka pit at the mine on 13 June 2019 and prism monitoring data from 23 July and 23 August known as the geotechnical information.

This showed that the hanging wall of the Tourag pit was subject to slope movement which placed it in the highest range of active instability. As at 24 August 2019 the following reports and observations had been made of the visible pit slope instability in the Tourag pit:

(a) on 19 August one of the shift supervisors observed that two catch bones 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 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 the reports of visible pit slope instability.

Based on the geotechnical information and reports of visible pit slope instability available on the 24 August 2019 OM's risk matrix would have classified the risk as extreme and unacceptable requiring work to stop or not start until controls were established to reduce the risk to acceptable level.

The extreme risk of failure of the Tourag pit slope was foreseeable or knew or reasonably to have known the extreme risk of failure of the Tourag pit warranted; (1) stopping operations; (2) implementing OM's risk management proceed and; (3) installing and routinely monitoring additional slope stability monitoring using LiDAR slope stability radars and automated total stations prism monitoring across the Tourag slope. That is the recommended measures.

And; (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; (1) identify precursor information necessary to enable the implantation of risk management processes proportionate to the risk and; (2) provide early warning of a pit slop failure and enable OM to take steps to minimise the risk to workers.

The loss of production and costs associated with implementing OM's risk management processes and installing the recommended measures were not disproportionate to the risk to which the workers were exposed.

Sentencing for offences under the *Work Health and Safety Act* is governed by the *Sentencing Act*. The maximum penalty is a fine of 1,500,000. While there is a discretion for the court to sentence the 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 interests of its safety objectives weighs against such a course for such serious offending. 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. 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.

The defendant is a mining company operating in an industry that is expected to maintain the highest levels of workplace health and safety regulations. 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 pt slope stability and the necessary pit slope design parameters to minimise the risk of pit slope failure. The defendant had a ground control management plan which identified the risks of pit slope failure and contained recommendations for pit slope designs.

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. 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.

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.

In 2013 the defendant obtained a ground control management plan 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 in critical areas.

The ground control management plan recommended the defendant implemented a trigger action response plan for each pit at Bootu Creek as part of the slope monitoring program to create a scale of alert conditions for potential failure. This was not implemented.

The most recent geotechnical advice regarding pit design from October 2015 had recommended that the batter height be decreased from 20 metres to 10 metres on the lower parts of the pit wall. That berms be 3 metres wide and the batter angle be maintained at 55 degrees.

A further recommendation was made for the installation of a 6 metre-wide berm halfway down the lower part of the wall once the height exceeded 75 metres. The defendant did not follow the geotechnical advice regarding the pit design.

In subsequent proposed designs put to new geotechnical engineers in 2016, earlier designed 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 recommendations.

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.

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

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.

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

The defendant had installed prism monitoring but not for the full length of the Tourag pit. 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, waiting and stopping work in the Tourag pit at all or at all. There was additional visible signs of pit sloping instability in the days leading up to 24 August 2019.

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 works and further monitoring until the signs of instability passed and the pit was deemed safe to re-enter.

In that sense the risk was obvious and was known. The only proper response was to close the pit. The defendant continued operations. 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 supervisors undertaking inspections of reported drilling or movement on the pit slip.

While it did so it cleared most of the 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.

The defendant did undertake some risk management for pit slop failure across Bootu Creek including visual inspections which were logged by shift supervisors. The defendant had a high wall inspection and management procedure as part of its safety symptoms.

The defendant had a high wall machines and personnel procedure. The defendant had a mining near slips and unstable ground procedure. 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 prestart meetings, toolbox meetings, staff take 5s and pre-shift hazard procedures.

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

The death of Mr Butler was a tragedy and his loss has had a profound effect on his friends, family and colleagues. I've 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.

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 Work Health and Safety Act very seriously.

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

The defendant has no prior history of offending. The defendant facilitated the course of justice from the earliest time cooperating fully with a complex investigation. The defendant has entered a plea of guilty at an early opportunity and is entitled to a full discount on sentence of 25 per cent.

The defendant has expressed remorse. The defendant has made substantial and comprehensive efforts to review and improve its operations in response to the incident. The defendant has agreed to pay the authority's costs of, and incidental, to the proceedings in the amount of $193,000 demonstrating remorse, acceptance of responsibility and contrition.

The penalty; OM (Manganese) Limited is convicted and is fined $487,000 - $487,500. I hand down that decision.

Anything arising, parties.

MR INGRAMS: Your Honour, a victim's levy ought to be imposed. I think it's $1000 for a corporation.

HER HONOUR: Thank you.

Now, do I need to make an order with respect to costs or has that been agreed by the parties and no court is required?

MS CHALMERS: Your Honour, I think the submissions the did, at some stage, formulate the order for your Honour.

HER HONOUR: Thank you.

MS CHALMERS: We don't resist an order being made but you're right, there is agreement. The proposed order is set out in par 2 of the submissions from last night.

HER HONOUR: Thank you. Thank you, Ms Chalmers.

Thank you.

MR INGRAMS: Your Honour, just for the avoidance of doubt, also that fine is already taking into account the discount?

HER HONOUR: Yes. It's taken into account the discount.

Thank you, parties

ADJOURNED