_____

NORTHERN TERRITORY OF AUSTRALIA

WORK HEALTH COURT

E X T R A C T

No 21806758

WORK HEALTH AUTHORITY

and

NICHOLAS MITCHELL, BARGE EXPRESS

(Sentencing Remarks)

JUDGE ARMITAGE

TRANSCRIPT OF PROCEEDINGS

AT DARWIN ON 8 APRIL 2019

Transcribed by:
EPIQ

HER HONOUR: Yes. Mr Mitchell has pleaded guilty to failing to comply with his duty pursuant to s 32 of the *Work Health and Safety (National Uniform Legislation) Act*. The maximum penalty for that offence is a fine of $150,000. Mr Mitchell was a worker as defined in s 7 of the Act and had a health and safety duty pursuant to s 28 of the Act. Colin Murphy Proprietary Limited was the person conducting the business or undertaking.

The particulars of the charge are that Mr Mitchell failed to ensure safe access to the vessel, the Sammy Express. Specifically that he did not ensure that a gangway was rigged when the vessel was safely alongside the wharf and he did not restrict access on or off the vessel. Mr Mitchell's failure to comply with his duty was one of the matters that contributed to and resulted in the death of Mr Daniel Bradshaw.

The facts of the matter are that Mr Mitchell as the worker, or was a worker for the person conducting the business, that had a health and safety duty. Sorry, I withdraw that. The facts of the matter are the Sammy Express was a barge owned and operated by Colin Murphy Proprietary Limited. Mr Mitchell was the master of the Sammy Express on the 7 and 8 January 2017.

On 7 January 2017 the Sammy Express was returning from its weekly scheduled service between Darwin and Port Keats. On board the Sammy Express were its regular crew of Mr Mitchell, who was the master, a Mr Kroemer, who was the engineer, Mr Ashley Irvine, a deckhand, and Mr Bradshaw who was also a deckhand.

Mr Mitchell was advised that the Sammy Express could not come alongside its usual wharf due to mechanical issues with another vessel and he was told to either anchor or go to the west wall. Mr Mitchell advised that the Sammy Express was at anchor at Catalina Island at 3:53 and would go alongside the western wall at 10:30. The Sammy Express was berthed at the western wall at 10:58. At the time of berthing the tide was rising with a high tide at 5:44 metres at 12:47. Work ceased on the Sammy Express at around 15:30 hours. At this time Mr Kroemer(?), Mr Irvine and Mr Bradshaw disembarked and went ashore to do various things. Mr Mitchell remained onboard as the vessel is required to be manned even whilst berthed.

Mr Mitchell, Mr Cromer and Mr Bradshaw were using accommodation in cabins onboard the vessel on the night of the 7 January. That means that they were expected to return to the vessel. Mr Irvine had gone home but returned about 7:15 on the 8 January to commence work. Mr Kroemer and Mr Bradshaw returned to the wharf at 18:30 hours. Mr Kroemer went back on board the Sammy Express at about 18:45 hours and remained onboard until the following morning. Mr Bradshaw remained in a shed in the yard where he was consuming alcohol. The consumption of alcohol was not permitted on board the Sammy Express.

Mr Bradshaw was seen at 20:00 hours and 22:00 hours and records show that he last used his phone at approximately 5:45 hours. There is evidence that Mr Bradshaw did embark the Sammy Express on one or more occasions during the night as pizza left out for him had been removed and his phone charger had been

plugged in. His phone and hat were found on the wharf the next morning. It is unknown how many times he went between the vessel and the wharf.

Mr Bradshaw was found by Mr Irvine floating face down in the water between the vessel and the wharf at around 7:16 hours. At this time the tide was falling with a low tide of 2.41 metres at 8:03 in the morning. Mr Bradshaw was deceased at this time. He died as a result of drowning associated with blunt force trauma to the chest. The time of death is estimated to have been between 5:45 am and 7:15 am. The toxicology report stated that Mr Bradshaw had a blood alcohol content of 0.28 per cent.

Mr Bradshaw fell either from the wharf or from the Sammy Express. There was no gangway or other means of safe access on or off the vessel. He was heavily intoxicated and the available evidence suggests he had little or no sleep during the night of the 7th to the 8 January, both of which would have rendered him significantly impaired.

The defendant's shipboard safety management manual stated that is the responsibility of the master to ensure the safe handling of the vessel and checks of equipment are carried out in a safe and well-organised manner. The manual further stated that when the ship is safely alongside a gangway must be rigged in order to secure safe access to the ship. Mr Mitchell being the master retained responsibility for the safety of the vessel. Mr Mitchell did not arrange for a gangway to be rigged once the vessel was berthed. A 6-metre gangway with safety rail was available for use in the yard and Mr Mitchell was aware of its existence.

In the absence of a gangway access on or off the boat was achieved by jumping across a gap onto a tyre which was tied to the wharf as a fender and then by climbing up ropes or chains onto the wharf. The ropes or chains constituted trip hazards. The degree of difficulty in jumping across the gap varied depending on the tides which determined whether the boat sat high up near the wharf level or was sitting on the bottom well below the wharf. Access to and from the vessel using this method was unsafe and gave rise to a risk of a fall from height off either the vessel or the wharf itself. There was no action taken by Mr Mitchell to restrict access on or off the Sammy Express whilst it was berthed at the western wharf.

When the first responders, namely the police, attended at the scene on the morning of 8 January 2017 there was still no gangway rigged and the crime scene photographer had to utilise a fireman's ladder that had been provided and used a plank which he scrambled across.

Northern Territory WorkSafe issued an improvement notice on the owner-operator of the vessel which has now been complied with. It is now a requirement that gangways be rigged whenever a vessel is berthed. The responsibility for this rests with the master and if a gangway exceeds 12 degrees access or egress from a vessel is no longer permitted.

In determining the appropriate penalty in this matter there are a number of factors which I must take into account. Firstly, the penalty that is imposed must compel attention to the occupational health and safety of workers to ensure that workers are not exposed to risks. I note that Mr Mitchell is a worker. He is not the business owner and I take into account his annual income. However, the risk in this case, was obvious and there have been two serious similar workplaces incidents in the NT since this incident.

I have considered the findings of the coronial inquest and the photos in that inquest and provided to me in this sentencing exercise. In my view, the risk of injury was entirely foreseeable. Access on and off the vessel without a gangway posed an obvious risk of injury or death. In my view, this risk was known and the large tidal movement in Darwin Harbour increased the risk associated with access and egress to this vessel.

It is, in my view, quite clear that the risks associated with this method of access and egress were actually foreseen. The shipboard safety manual required the rigging of a gangway when in port. And further when one looks at the photographs it was simply obvious to any observer that this was not a safe method of accessing or leaving the vessel.

The offending in this case resulted in the death of Mr Bradshaw and the circumstances of this case and this death does manifest the degree of seriousness of the risk. Put simply the risk was high and the level of injury that could result from not addressing the risk was high.

I accept that this was an unusual situation. That normally when the vessel came into harbour in Darwin there were berths that were used that had proper gangways or utilised another safe method of accessing and leaving the vessel. However, in my view, it is this very situation that calls for the master to exercise appropriate judgement and decision-making and ensure that workplace safety is maintained. In my view, that did not occur in this case. Reasonable decisions were not made by the master and he allowed the risk to continue throughout that night.

While this offending did not reflect a systemic failure to address known risks, namely because the Sammy Express did not normally moor at this wharf, it did in my view reflect a failure by the master and by the owner of the vessel to properly consider all sorts of situations that can arise and have in place appropriate responses.

In my view I am persuaded that the court ought to give considerable weight to general deterrence in light of the fact that falls are a common cause of workplace death in Australia and falls from vessels, and this is not the only fall from a vessel in recent history. I consider that boats are inherently dangerous workplaces and the master of any vessel is required to exercise vigilance and must make considered and responsible decisions for workplace safety even if confronted with situations that are out of the ordinary. I consider that Mr Mitchell's breach in this case was

significant and should be characterised at the mid to upper level for this type of offending.

The provision of a mode of safe access to a vessel is a well-known precaution to deal with the risk of falling from a vessel or the wharf. If a safe gangway could not be rigged then restricted access to and from the boat could and ought to have been enforced by the master of the vessel. In my view the objective seriousness of the offence calls for a significant penalty to enforce the industrial intentions of the legislation, sorry, to enforce the policies of the legislation which are industrial workplace health and safety.

I am satisfied that the offending in this case was significant, the harm was at a high level, namely the death of a worker. Mr Mitchell's failure to ensure a safe means of access and egress was a significant contributor to the death although I acknowledge and I accept that there were contributing failures by the owner to ensure that its mooring policy was adhered to. The owner also failed to hold regular safety meetings and failed to monitor and enforce its alcohol and fatigue policy. All of these failures contributed to the death as did Mr Bradshaw's own decision to not sleep and to drink excessively over the course of that night.

I have received two victim impact statements. The first from Ms Patricia Baird, Mr Bradshaw's mother. I will not read it in full. I have considered it and I will refer to parts of it now. Ms Baird said:

> "My son Daniel was killed at work in the prime of his life due to culpable workplace negligence. The purpose of this statement is to outline the devastating effect Daniel's death has had on my husband and me, on our only other son, James, on Daniel's beloved partner, Tania, and their two small children, on his extended family and seafaring and school friends throughout his short 37 years of life. Daniel was the most loving, caring and compassionate son and friend to all. We as parents were so proud of him and his achievements and often told him so. I thank God we have a lot of beautiful and funny memories of Daniel that help to sustain us as we grieve our loss of our beautiful son.
>
> Daniel's death devastated our eldest son, James, who has served nine deployments in the SAS in Afghanistan and was awarded the Distinguished Service Medal for courage and bravery. He was with us the morning when the policeman came to tell us of Daniel's death. Daniel's partner of 16 years, Tania, and their two small children have been left bereft by the loss of her soulmate and little Kimberley(?) and Hemmy(?)'s much loved father. While they have had support from the school and friends nothing can replace the loss of the warm, loving father who made them laugh.
>
> I am horrified by the conditions at Daniel's workplace where he was expected to get on and off the barge up to a much higher wharf without a gangplank, ladder or other safe means. I cannot understand how such dangerous workplace practices have been allowed to go on given all the legislative requirements of occupational health and safety that should be in place."

Ms Louth also provided a victim impact statement. Again I will only refer to a small part of the contents of that statement. Ms Louth said: "Daniel Bradshaw, my loving partner of 16 years and father to our two young children, was killed at work. He did not come home."

As the master you hold responsibility for the safety of your crew at all times. Ensuring safe access and egress to the vessel for crew members and visitors is one of those responsibilities. There were so many other safety measures that could have been exercised by the master to ensure the safety of his crew apart from simply putting in place an available gangway. Going to anchor, prohibiting disembarkation, creating a ship curfew, prohibiting the consumption of alcohol. Yet not one of these measures were taken. A clear message needs to be sent to workplaces in the Northern Territory and around Australia that unsafe practices will not be tolerated and will carry serious consequences.

I accept that Mr Mitchell has never been found guilty or convicted of any other offence. He comes before the court as a man of prior good character. I accept that Mr Mitchell has demonstrated some remorse and has suffered personally as a result of this death as the deceased was also his friend. I have been provided information that as a result of this incident he now suffers from anxiety and depression. He is on worker's compensation and he no longer works in the industry. I accept that his plea of guilt is demonstrative of remorse. Whilst the plea was not indicated at the earliest opportunity I understand that the facts in this case have never been disputed and so I accept it as a plea to which significant utilitarian value should attach.

There is no tariff for this type of offending and there are no sentencing decisions in the Northern Territory for the prosecution of a worker in breach of s 32. I have been referred to some decisions in other jurisdictions but as I said there is no tariff and each case is to be decided on its own facts. As indicated in my view this was a serious example of this kind of offending. The risks were obvious and Mr Mitchell failed to put in place safe workplace practices that may have mitigated the risks. This death might have been avoided had those decisions and better decisions been made.

I must also take into account Mr Mitchell's capacity to pay a fine. Given that this was a serious matter, in my view, and taking into account Mr Mitchell's capacity to pay a fine, in my view, but for the plea of guilty the appropriate fine would have been $25,000. Taking into account the plea of guilty and giving a 25 per cent discount for the plea and the other matters on behalf of Mr Mitchell the fine that I impose is $20,000.

Anything further?

MS BLUNDELL: Your Honour, two matters. Your Honour hasn't indicated whether a conviction is recorded.

HER HONOUR: In my view, given the seriousness of the matter and the foreseeability of risk and in order to get a message out to the community that workplace health and safety practices are matters to be taken most seriously, it is appropriate to record a conviction.

MS BLUNDELL: Thank you. Your Honour, ordinarily these matters also attract victim's levies so if your Honour was minded to impose - - -

HER HONOUR: The victim's levy of $150 is imposed.

MS BLUNDELL: Thank you. And finally, your Honour, I am seeking one day's costs in this matter in the *Local Court (Criminal Procedure) Act* scale of $1500.

HER HONOUR: Mr Bellach, you don't wish to be heard in relation to that?

MR BELLACH: Look, I would just ask your Honour to be – before you went to the position of awarding costs. There has been a plea of guilty and I realise that it wasn't at the first reasonable opportunity as that phrase is understood but what can be promptly taken into account, in my submission, is that Mr Mitchell was willing and did participate for a long period of time in a process which was, he had hoped, would lead to an out-of-court undertaking and that did not arise. But he was a willing participant in that. The decision against that was ultimately made by the Work Health Authority. The matter has then come back to court.

HER HONOUR: Where are the cost provisions?

MS BLUNDELL: Sorry, your Honour, I didn't bring my copy of the Act with me. It's the *Criminal Procedure Act* and then the rates are set out in the Criminal Procedure Regulations.

Your Honour, in all of the matters that I have prosecuted on behalf of the Work Health Authority which have resulted in findings of guilt after plea the courts have awarded costs so the determination of the hearing isn't the only thing.

HER HONOUR: No, no, but this is a little different because it involves an individual.

MS BLUNDELL: That's correct, your Honour, but I do note that on the 14 December last year this matter was set for hearing. It was in the directions hearing list as well for some time until it was set for hearing.

HER HONOUR: Sure, I just want to go to this section, sorry. What legislation am I looking for?

MS BLUNDELL: It's the *Local Court (Criminal Procedure) Act*.

HER HONOUR: Okay.

MS BLUNDELL: And I apologise for not having the section off the top of my head.

HER HONOUR: No, no. Do you know the section, Mr Bellach?

MS BLUNDELL: It's towards the end if that helps.

HER HONOUR: Okay, let me have a look. Costs, so we're round about 77 but I'm not sure if that's - - -

MR BELLACH: I think that's right, I think it is around s 77.

MS BLUNDELL: I think that's right.

MR BELLACH: And then I think it refers to a scale that's in the - - -

MS BLUNDELL: The regulations which, the scale being $1500 - - -

HER HONOUR: It's not so much the scale that I'm interested in.

MS BLUNDELL: Yes.

HER HONOUR: It's the exercise of the discretion. It just says that where the court finds a defendant guilty it may order costs as it thinks fit.

MR BELLACH: Yes. Look, the matters that I have just asked your Honour to consider in the exercise of that discretion are in all the other WorkSafe or Work Health Authority prosecutions they have been against companies as opposed to an individual.

Mr Mitchell has already just received a very substantial fine which is obviously going to take him a significant amount of time to pay off. He does have the usual living expenses that a man of his age with two kids and a wife has. He has already incurred costs in attempting to resolve this matter over a period of time - - -

HER HONOUR: I'm persuaded in relation to the length of time that this matter has taken to conclude and the efforts taken by Mr Mitchell and on his behalf in order to resolve the matter, that it is not appropriate to award costs in this case.

MR BELLACH: Thank you.

MS BLUNDELL: May it please the court.

HER HONOUR: Now, in relation to the fine do I need to include a time within which that should be paid?

MS BLUNDELL: Your Honour, my understanding is that it then falls under the standard fines provisions here. Your Honour can make an order that there's 28 days to pay. Then it goes through the Fines Recovery Unit here is my understanding.

HER HONOUR: You don't wish to be heard on that? Obviously that means setting up a repayment schedule within that period of time, Mr Bellach.

MR BELLACH: Yes. I think the way the legislation operates, whether or not you make that order that is what will follow. But that - - -

HER HONOUR: I will make the order 28 days to pay.

MR BELLACH: Sure.

HER HONOUR: So, Mr Mitchell, you have heard of that conviction and fine. Your lawyer will speak to you further about setting up a repayment schedule with the Fines Recovery Unit.

Anything else?

MS BLUNDELL: Nothing arising.

MR BELLACH: No, nothing.

HER HONOUR: I will now break those telephone links.

MS LOUTH: Thank you, your Honour.

MS BAIRD: Thank you.

HER HONOUR: That completes the matter.
