SUPREME COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**R v Watts**
Citation:	**[2020] ACTSC 91**
Hearing Date:	16 April 2020
Decision Date:	20 April 2020
Before:	Murrell CJ
Decision:	The offender is sentenced to 12 months' imprisonment, wholly suspended upon the offender entering into a good behaviour order for 12 months.
Catchwords:	**CRIMINAL LAW** – JURISDICTION, PRACTICE AND PROCEDURE – Judgment and Punishment – Sentence – Industrial law – Workplace incident resulting in death – Breach of s 31(1) of *Work Health and Safety Act 2011* (ACT) – Duty of worker under s 28 of *Work Health and Safety Act 2011* (ACT) – Reckless conduct exposing individual to risk of death or serious injury – Unsafe operation of a crane in construction site – Imprisonment
Legislation Cited:	*Crimes (Sentencing) Act 2005* (ACT) ss 7, 12, 33, 35, 36 *Occupational Health and Safety Act 2004* (Vic) ss 24, 32, 144(1) *Work Health and Safety Act 2011* (ACT) ss 19, 28, 31 *Work Health and Safety Act 2011* (NSW) ss 31, 32 *Work Health and Safety Act 2011* (QLD) s 31(1) *Work Health and Safety Act 2012* (SA) s 31 *Work Safety Act 2008* (ACT) s 31(1) (repealed)
Cases Cited:	*Campbell v Rowe* [2019] SAET 104 *Orbit Drilling Pty Ltd v The Queen* [2012] VSCA 82 *Orr v Cudal Lime Products* [2018] NSWDC 27 *R v Canberra Contractors Pty Ltd* [2016] ACTSC 13 *R v De Simoni* (1981) 147 CLR 383 *R v Lavin* [2019] QCA 109 *WorkSafe Victoria v Jackson* (Latrobe Valley Magistrates Court, 19 December 2018)
Parties:	The Queen (Crown) Michael Watts (Offender)
Representation:	**Counsel** K Weston-Scheuber with S Janackovic (Crown) J Agius SC with P Boncardo (Offender) **Solicitors** ACT Director of Public Prosecutions (Crown) Hall Payne Lawyers (Offender)

File Number(s): SCC 44 of 2019

MURRELL CJ

Introduction

1. On 12 February 2020, the offender pleaded guilty to the offence that he was a person with a work health and safety duty under s 28 of the *Work Health and Safety Act 2011* (ACT) (*WHS Act*) who, without reasonable excuse, engaged in reckless conduct that exposed an individual to whom that duty was owed to a risk of death or serious injury, and was reckless as to that risk, contrary to s 31(1) of the *WHS Act*.

2. When such an offence is committed by an individual, the maximum penalty is $300,000, five years' imprisonment, or both.

3. On 4 August 2016, the offender was instructed to use a crane at the University of Canberra Hospital construction site (the construction site) to transport a large generator. In performing the lift, the offender operated the crane in excess of its rated capacity, with insufficient planning, at night with reduced visibility, and on uneven terrain. While transporting the generator, the crane overturned. As it overturned, the boom of the crane impacted a worker, Herman Holtz, crushing him between the boom of the crane and the ground, and killing him.

4. At the outset, the Court acknowledges the profound loss suffered by Mrs Holtz, the deceased's children and grandchildren, and his wider family.

5. Initially, the offender was prosecuted for manslaughter and the s 31 offence was charged in the alternative. At criminal case conferencing in May 2019, the offender indicated that he was willing to plead guilty to the alternative offence. The matter was not set down for trial until 31 August 2019. By that stage, the prosecution had indicated that it would accept the offered plea in full satisfaction of the indictment, subject to the parties agreeing on a statement of facts. There was a delay in finalising an agreed statement of facts, and the plea was not entered until 30 January 2020, 11 days prior to the date on which the trial was to commence.

6. The timing of the offender's relatively early offer to plead guilty to the relevant offence is significant. Further, the plea had a high utilitarian value as the trial would have occupied seven weeks, involved 63 prosecution witnesses, and raised technically complex issues. The Crown case was of only moderate strength, there being no eyewitnesses to the offence other than persons who have been charged as alleged co-offenders. Currently, there are proceedings before the ACT Industrial Court involving eight related parties (including Multiplex Constructions Pty Ltd, RAR Cranes Pty Ltd and several individuals), none of whom have been sentenced.

7. In these circumstances, it would be appropriate for the offender to receive a discount of 20 per cent for the plea of guilty under s 35 of the *Crimes (Sentencing) Act 2005* (ACT) (*Sentencing Act*).

8. The offender has spent no time in custody.

Facts

Offender's training and experience with cranes

9. The offender held a full unrestricted Heavy Rigid Class motor vehicle driving licence issued in Queensland, a general safety induction (Construction Industry) card, and was licensed to perform high risk work. He had undertaken training to perform rigging at basic and intermediate levels. The offender's licences authorised him in the classes of DG-Dogging, RI-Intermediate Rigging, WP-Boom Elevated Work Platform, and C1-Slewing Mobile Crane up to 100 tonnes.

10. From June 2014, the offender worked in Queensland as a rigger, while being trained in the operation of cranes. The training reinforced the safety limitations of cranes. Under the supervision of a licensed crane operator, he performed over 120 hours of crane operation.

11. On 1 July 2016, the offender relocated from Queensland to Canberra. On 13 July 2016, he commenced working for RAR Cranes Pty Ltd (RAR) on a casual basis as a dogman/crane driver. As a casual worker, he had limited job security. He undertook a pre-employment safety induction but was not instructed in the operation of particular cranes.

Construction of the University of Canberra Hospital

12. In 2016, the University of Canberra Hospital was in the early stages of construction. Multiplex Constructions Pty Ltd (Multiplex) was the principal contractor for the construction. For work health and safety purposes, it conducted the business or undertaking at the construction site and had primary responsibility under the *WHS Act*.

13. Multiplex contracted with RAR for the provision of mobile crane services at the construction site. RAR was also an entity conducting a business or undertaking with primary responsibility under the *WHS Act*.

The crane

14. The crane that was involved in the offence was a 2016 Terex MAC-25 non-slewing "pick and carry" crane. It was the only such crane owned by RAR. It operated differently from other similar types of cranes.

15. The lifting capacity of the crane was determined by the operator, who had to consider the boom length, radius and articulation required for a lift. Usually, the operator's decision would be guided by the load mover indicator (LMI) system on the crane.

16. The LMI system on the crane was important because it calculated the crane's carrying capacity from moment to moment, taking account of the many variables that influenced carrying capacity. The LMI system provided the crane operator with real-time dashboard information, including load/overload, percentage of rated capacity, load radius, boom angle, boom length, and additional lifting capacity. The display showed the crane's "rated capacity", i.e. the maximum load that the crane could safely carry based on its current configurations. The LMI system also showed the terrain and the forward and side tilt of the crane. However, the display only showed the percentage of rated capacity up to 110 per cent. If the load exceeded 110 per cent of rated capacity, the display continued to show 110 per cent.

17. Once the LMI system showed that the crane was overloaded for its configurations, a cut out was immediately activated, as were visual and audible alarms, operating internally and externally. To increase the overloaded state of the crane, the operator had to manually override the safety function.

18. The crane could operate in a "superlift mode" or "301 mode". This mode increased the crane's lifting capacity from 10 tonnes to as much as 25 tonnes, depending on the crane's configurations at the relevant time.

19. For the crane to operate in "superlift mode", the operator had to install a second counterweight at the rear of the crane. The counterweight needed to face a particular direction so that the crane's sensors would register that the counterweight had been fitted, and the LMI system would assess the crane's load capacity by reference to the "superlift mode".

20. Within the crane's cabin, there was an operator manual and lifting chart showing the crane's lifting capacity in various modes, including the "superlift mode". The operator manual clearly stated that the operator should not operate the crane until they had read and understood the manual. The manual explained the safety system, stating that all safety messages should be obeyed "to avoid possible injury or death".

21. At the construction site, there was a generator with a marked gross weight of 10.3 tonnes. It was to be used by Multiplex to provide temporary power. It was fitted with lifting points and pull plates.

Events prior to 4 August 2016

22. Mathew Holt, an RAR employee, operated the crane to perform lifts at the construction site on two occasions. Before operating the crane on the construction site, Mr Holt received the mandatory site induction. On 7 June 2016, he used the crane to move the generator from the front gate of the site. On 18 July 2016, he used the crane to move the generator to a new position.

23. Mr Holt told RAR that he did not believe that it was safe to use the crane to move the generator. This information was not conveyed to the offender. Had the offender been provided with this information, he would have refused to use the crane to undertake the lift. The agreed statement of facts indicates that RAR should have conveyed Mr Holt's opinion to the offender.

24. On 2 and 4 August 2016, Mr Holt was on holiday.

25. On 2 August 2016, the offender was directed to work as the driver/operator of the crane. Mr Paul Kelly was assigned as his dogman. The offender performed one job with the crane but did not use the "superlift" mode.

26. Mr Holt had been given training in how to use the crane, including how to operate the crane in "superlift" mode. However, RAR did not provide the offender with information, training or instruction about how to safely operate the crane, how to use the "superlift" mode, or how to fit the associated counterweight. He was provided with general induction information.

27. Several weeks before 4 August 2016, Multiplex decided that the generator should be moved to a new position about 50 metres away, from where it could provide temporary power to the tower crane.

4 August 2016

28. On 4 August 2016, Multiplex decided that the generator should be moved to its new position as the tower crane was to be used the following day. There was some urgency about repositioning the generator.

29. Between 2:00 and 2:30 PM, Multiplex directed RAR to move the generator that day. Multiplex managers and a RAR representative inspected the site to determine how it would be moved. RAR proposed using a 200-tonne slewing crane or a tilt tray truck. Multiplex rejected the proposal as the cost and logistics of using that equipment were not something that Multiplex was "eager to be part of". The offender did not participate in the discussion and was not told about it.

30. RAR and Multiplex walked the travel route and concluded that the crane would be suitable for the job. Neither Multiplex nor RAR undertook the requisite risk assessment concerning the means and route by which the generator would be moved.

31. That day, commencing at 6:35 AM, the offender and Mr Kelly completed four jobs using the crane, all of which were conducted within the safety limits of the crane. None involved using the "superlift mode".

32. Mr Kelly and the offender were then told by Mr Newton of RAR that there was a further job to be done.

33. At about 4 PM, they returned to the RAR yard and were told by Mr Newton that they were to use the crane to move a generator for Multiplex, and that the job had to be completed that day so that the tower crane could be used the following morning. Mr Newton conveyed the impression that the job was important to RAR.

34. RAR directed the offender and Mr Kelly to take the "superlift" counterweight and "D shackles".

35. At about 4:52 PM, the offender and Mr Kelly arrived at the construction site. The offender drove the crane; Mr Kelly drove a small truck containing the "superlift" counterweight.

36. When they arrived, they were met by four Multiplex employees: Andrew Drummond (senior site supervisor), Munro Jones (health and safety representative for the site work group), Herman Holtz (tower crane operator), and Timothy Brown (tower crane dogman).

37. Mr Drummond was advised that, as the offender had not previously attended the construction site, he required the mandatory safety induction. The offender himself requested a site induction. However, none was undertaken.

38. All present agreed that the "D shackles" were inappropriate as they were too heavy and did not fit the lifting points.

39. The offender told Mr Drummond that RAR had a 200-tonne slewing crane which would be more appropriate for the job (the same suggestion that had been made earlier in the day by another RAR employee), but was told that it was "not an option" and the crane had to be used for the job and was suitable, having previously been used to move the generator.

40. As stated above, at no stage was the offender told that Mr Holt had expressed a different view regarding the suitability of the crane; had he known of Mr Holt's view, it would have been decisive in persuading him that he should not proceed with the lift.

41. As the offender was concerned about doing the job and felt that Multiplex was pressuring him to proceed, he called Mr Newton for the purpose of seeking guidance, but Mr Newton did not answer the telephone.

42. The offender felt compelled to proceed because both RAR and Multiplex wanted the job done and he was worried about his job security.

43. However, after discussing the matter with Mr Kelly and Multiplex workers, the offender felt more comfortable with the job. Those present agreed that the lift would be a difficult one, but it could be done.

44. The offender knew that the generator weighed about 10 tonnes (it was 10.3 tonnes) and that the crane had a lifting capacity of 10 tonnes. In addition to the weight of the generator, the weight of the lifting equipment was about 1.2 tonnes, bringing the total weight to 11.5 tonnes. The offender knew that the crane's lifting capacity would be increased if the "superlift" counterweight was fitted; if so, it would operate in the "301 mode" rather than the basic "201 mode".

45. The offender was told that he could not move the generator by the shortest route (a straight-line distance of about 50 metres) because of in-ground plumbing. The travel distance would be about 600 metres.

46. The offender considered that the only way in which the generator could be moved was by picking it up with the boom extended and then bringing it close to the crane. All present agreed with this course. Due to the associated configuration of the crane, the load at the commencement of the lift would exceed the safe lifting capacity of the crane as described in the lifting chart for the "301 mode".

47. Had the offender checked the lifting chart for the "301 mode", he would have realised that the load exceeded the available lifting capacity, given the necessary configuration of the crane at the commencement of the lift.

48. Prior to commencing the lift, the offender should have undertaken a risk assessment of the lift, but he did not do so because the light was fading, and the generator needed to be moved that day. A risk assessment would have involved driving the unladen crane along the travel path to assess the terrain and any risks along the path, including the slope of the path which, at one point, involved an unavoidable side slope of 6.59° and other terrain angles of up to 10.27°. The manufacturer warning stated that the crane must not operate on a slope greater than 5°.

49. The offender and Mr Kelly connected the counterweights to the crane. However, the "superlift" counterweight was fitted in the incorrect direction vis-à-vis the crane. This meant that its sensor could not be detected by the crane's computer, and the computer would make calculations as though the counterweight was not fitted; it would not recognise that the crane could operate in "301 mode", and the figures shown on the LMI display for overload and rated capacity of the crane would be inaccurate.

50. Neither the offender nor Mr Kelly knew that these problems would flow if the counterweight was fitted incorrectly, although the process for fitting the counterweight

was described in the operator's manual. The offender looked at the manual but did not locate the relevant section.

51. Once the offender realised that the crane's computer was not recognising the "superlift" counterweight and the "301 mode", he tried to call Mr Newton at RAR but again his call went unanswered.

52. The offender then rechecked the load charts in the crane's cabin and decided that the crane could readily perform the lift.

53. The offender believed that the computer was not recognising the "superlift mode" because of a computer malfunction. He informed several people, including Mr Kelly and the deceased, that the crane thought it was in "201 mode" but that it was, in fact, in "301 mode".

54. The offender, Mr Kelly, Mr Holtz and Mr Brown rigged the generator using the dragging lugs of the generator rather than the lifting points. This meant that the load was not rigged in a way that minimised the load height; the height and length of the boom were greater than was required to lift the load. Further, the chains were longer than necessary because they were attached to the dragging lugs rather than the lifting points of the generator, changing the generator's centre of gravity and inducing a tilt of 6.61°. The safer lifting configuration would have reduced the swing of the load and the total slung load height.

Moving the generator

55. At about 5:53 PM, the lifting operation commenced.

56. Initially, the offender had to extend the boom of the crane to pick up the generator. He knew that the crane may be overloaded but that the overloading would cease once the boom was brought in. This was the first occasion that the crane operated in excess of its rated capacity.

57. The crane alarm sounded several times and the computer indicated that the crane was overloaded. However, the offender surmised correctly that the computer system was displaying incorrect information as it had not registered the "superlift" counterweight. Consequently, he overrode the safety mechanism when the alarm sounded.

58. For approximately five minutes after commencing the lift, the offender operated the crane with the safety alarms operating because the LMI system did not register that the "superlift" counterweight was fitted. In fact, the crane was not overloaded.

59. At one stage in the first five minutes, the offender reversed the crane up a slope that, at its steepest, was 9.22°.

60. The offender carried the load as low as he thought that the conditions allowed. However, between 5:59 and 6:01 PM, the load was carried at an excessive height. Contrary to the safety recommendations of the manufacturer and the Crane Industry Council of Australia, the offender operated the crane while the base of the generator was more than two metres above ground.

61. By about 6 PM, it was dark. According to Mr Brown, it was so dark that "he could not see where he was walking". Ordinarily, a series of lighting towers would be used to illuminate such an area, but no such lighting was provided. To provide additional

lighting, Mr Drummond improvised by reversing his vehicle in front of the crane with the spotlights and headlights illuminating the ground in front of the crane.

62. Despite the poor visibility, the offender continued with the lift.

63. The route south sloped downwards from right to left. At the base of the slope, there was a body of standing water. The left wheels of the crane were on the edge of the water, on soft ground of uncertain surface stability. The internal and external visual and audible alarms were activated because of the side slope. Between 6:10 PM and 6:11 PM, the offender drove the crane at a side tilt of more than 5° for one minute and 29 seconds, with a tilt of 10° at 6:10:50 PM.

64. The offender made a right turn and continued forward in a westerly direction to an area where the track narrowed and there were dirt piles on either side. Mr Brown was walking in front of the crane, steadying the load by hand as the load swung. He heard the offender comment that the back wheels were coming off the ground and saw for himself that the back wheels were indeed coming off the ground.

65. The offender continued to drive the crane before stopping and then reversing up an incline on a track that ran north/south.

66. As the offender reversed the crane, Mr Kelly, Mr Jones, Mr Brown and Mr Holtz were positioned at each corner of the generator to assist by manually stabilising it. A “controlled lift” such as this is a recognised practice in the construction industry. At this point, the higher end of the generator was almost 1.8 metres above the ground.

67. At about 6:21 PM, the crane approached a narrow section of the path. The offender stopped and reconfigured the crane so that it would fit. He lowered and telescoped out the boom, then rotated the generator to carry it lengthways, parallel with the crane. The lowering of the boom increased the radius from 2.87 metres to 4.44 metres, overloading the crane so that it was operating at 102.2 per cent of its rated capacity. The alarms were operating but the offender repeatedly overrode the safety system. This was the second occasion on which the crane operated in excess of its rated capacity.

68. The offender drove up the slight incline of the rough and uneven path.

69. At approximately 6:24 PM, the offender repositioned the load so that the generator was across the front of the crane. He continued to reverse up a slight incline and commenced a U-turn. As he was turning, the right wheels of the crane hit a dirt mount on the edge of the travel path, causing the crane to tilt to its left at 10.10° for about one minute. Again, the alarms were activated.

70. From this tilt, the offender drove the crane forward, towards its destination.

71. At about 6:38 PM, the offender manoeuvred the crane by lowering and extending the boom. He used the override function for 13 seconds while the boom was extended to the point where the crane was overloaded to 104.6 per cent of its rated capacity.

72. The offender again extended the boom to rotate the generator. The boom was extended from 8.55 metres to 9.81 metres, and articulation was increased from 11.3° to 30.5°. Because the heavier end of the generator was further from the crane, the crane and load were destabilised. At this stage, the higher end of the generator base was over 2 metres from the ground.

73. At 6:41 PM, the offender operated the crane at 130.5 per cent of its rated capacity. The crane tipped to its right while carrying the generator. As it tipped, the gravitational force of the generator pulled the crane from the tip of the boom, accelerating the boom as it fell to the ground, where four persons were in the immediate vicinity.

74. The tip of the boom impacted Mr Holtz, crushing him between the boom and the ground, and killing him instantly.

Victim impact

75. The deceased's wife, four children, one of his 12 grandchildren, a sister, and a niece provided victim impact statements.

76. Naturally, the shocking loss of their beloved husband, father and family member at only 62 years of age has devastated the family.

77. When family members were told of the victim's death, they were horrified and disbelieving. The family was thrown into chaos. Some family members were inconsolable.

78. The deceased and his wife of 32 years enjoyed a wonderful relationship. She continues to experience profound grief and loss. At the time of the offence, the couple was planning to move to Canberra, where the deceased would work for a period and would then retire. On 4 August 2016, the deceased's wife was in Sydney and was to join the deceased in Canberra in a couple of days. The couple's plans for a happy retirement were ruined. In 2017, the deceased's wife suffered a serious illness and her life partner was not available to support her through that crisis.

79. One of the matters that caused deep upset to the family was that the deceased's wife and other family members were unable to see the deceased and farewell him after his death. The family is of New Zealand Maori background and adhered to a tradition of burying a deceased person three days after their passing, allowing adequate time for family members to farewell the deceased, usually at a marae (Maori meeting hall).

80. The deceased was very much a family man. He is sorely missed by his children. He was a caring father who had great integrity and was always available to provide support and advice to his children. They continue to harbour strong feelings of grief, depression, irrational guilt, and anger at the loss. Family occasions are no longer a cause for celebration. Despite the passage of three and a half years, the children are by no means reconciled to their loss.

81. His grandchildren loved their "papa" and were adored in return. They cherished long holidays with their grandparents and other family occasions when they saw the deceased. They remain deeply saddened and continue to grieve over his loss.

82. Other family members said that the deceased provided a strong foundation for his immediate and broader family. He had a strong work ethic and loved his work, where he was a team player who was highly respected.

Objective seriousness

83. Under the *WHS Act*, there are three categories of offences, which accord with Australian work health and safety laws as harmonized in 2011. Category 1 offences are the most serious offences and the only category to carry a sentence of imprisonment.

84. The offence to which the offender pleaded guilty is a category 1 offence. It involved having a health and safety duty; without reasonable excuse, engaging in conduct that exposed an individual to whom the duty was owed to a risk of death or serious injury or illness; and being reckless as to that risk. In contrast, a category 2 offence comprises having a health and safety duty, failing to comply with that duty, and thereby exposing an individual to a risk of death or serious injury or illness; category 2 offences do not involve the element of "recklessness".

85. For a category 1 offence committed by an individual, the maximum penalty is $300,000, imprisonment for five years, or both. If committed by an individual conducting a business or undertaking, the maximum penalty is $600,000, imprisonment for five years or both. If committed by a body corporate, the maximum penalty is $3,000,000. In relation to a category 2 offence, the maximum penalties are $150,000 for an individual (there is no penalty of imprisonment), $300,000 if the individual is conducting a business or undertaking (again, there is no penalty of imprisonment), and $1,500,000 for a body corporate.

86. Section 28 of the *WHS Act* deals with duties of workers. It provides:

> **28 Duties of workers**
>
> While at work, a worker must—
>
> (a) take reasonable care for his or her own health and safety; and
>
> (b) take reasonable care that his or her acts or omissions do not adversely affect their health and safety of other persons; and
>
> (c) comply, so far as the worker is reasonably able, with any reasonable instruction that is given by the person conducting the business or undertaking to allow the person to comply with this Act; and
>
> (d) cooperate with any reasonable policy or procedure of the person conducting the business or undertaking relating to health or safety at the workplace that has been notified to workers.
>
> (Notes omitted)

87. Section 31 deals with category 1 offences. It provides:

> **31 Reckless conduct—category 1**
>
> (1) A person commits a ***category 1 offence*** if—
>
> (a) the person has a health and safety duty; and
>
> (b) the person, without reasonable excuse, engages in conduct that exposes an individual to whom that duty is owed to a risk of death or serious injury or illness; and
>
> (c) the person is reckless as to the risk to an individual of death or serious injury or illness.

88. The prosecution relied on *Orbit Drilling Pty Ltd v The Queen* [2012] VSCA 82 (*Orbit Drilling*) as establishing principles for the assessment of the moral culpability for an offender. That case concerned a breach of a not dissimilar provision to s 31 of the *WHS Act* by an employer that had required an employee to drive an unroadworthy truck. The Court observed that the offender's degree of culpability was to be determined by the degree of probability that a person would be placed in danger of serious injury and the nature of the probable danger.

89. That analysis may have been apposite to the circumstances in *Orbit Drilling*. However, the terms of s 31 direct attention to four matters: health and safety duty,

conduct, risk and recklessness. This suggests that objective seriousness is to be decided by reference to the nature of the health and safety *duty* and the circumstances in which it arises; the nature and duration of the *conduct* exposing another to risk; the nature and extent of the *risk* of serious injury or death (including the number of persons exposed to the risk, the likelihood of the risk materialising and whether it was a risk of death or serious injury), and the degree of *recklessness* (the degree to which a substantial risk was appreciated but was unjustifiably taken).

90. I accept the offender's submission that the offence crystallised in a relatively short period, 6:38 PM to 6:41 PM, when the overloaded crane was at risk of tipping onto the deceased.

91. However, the following features put the offender's conduct into a proper context, demonstrate that there was a relatively high degree of recklessness, and mean that the offence was of substantial objective seriousness:

    (a) The offence occurred in the context that the offender engaged in a variety of risky behaviours over a significant period, albeit that they may not have carried an immediate risk of serious injury or death. He failed to adequately plan or undertake a risk assessment. On a total of three occasions during the lift (including the offence occasion), he operated the crane in excess of its rated capacity. The route that was taken was unsafe because of the slope and the soft and uneven terrain. The counterweight was fitted incorrectly, which meant that the usual warning processes were ineffectual. The rigging was suboptimal. There was inadequate lighting.

    (b) The offender knew that several people were in the vicinity. The evidence does not permit findings as to whether and over what period persons other than Mr Holtz were exposed to a risk of serious injury or death. Nevertheless, the fact that others were in the vicinity of an inherently dangerous operation where the crane's safety mechanisms were ineffective must have alerted the offender to the substantial possibility that the operation was putting persons at risk of injury.

    (c) From the outset, the offender questioned the capacity of the crane to perform the lift and felt disquiet about the operation. However, he permitted others to pressure him into performing the lift.

    (d) From the outset, the offender knew that the LMI safety system was not operating properly, so it could not provide a reliable warning about when or by how much load capacity was exceeded. He repeatedly overrode the safety system, knowing that there was no alternative means of objectively assessing the safety of the operation. The operator of a crane can, and should, terminate a lifting operation if they believe that it is not safe to proceed. The danger of the lift was repeatedly reinforced by the alarms and flashing lights that were triggered.

    (e) Contextually, as the offender had no reliable means of assessing overload, the duration of his recklessness about general risks was not limited to three minutes. He continued with the task for a significant period. Having failed to undertake a risk assessment at 5 PM or shortly thereafter, the task was undertaken between 5:53 PM and about 6:38 PM (for about 45 minutes). At any point, he could have terminated the lift.

(f) The risk in question was a risk of death. The proximity of others to the heavy generator and crane made that an obvious risk. The death of the deceased evidenced the reality of the risk.

92. On the other hand:

(a) Pursuant to s 19 of the *WHS Act*, the primary responsibility for risk assessment and worker safety lay with Multiplex (as occupier and controller of the construction site) and RAR (as employer). However, this does not absolve workers of responsibility. The greater responsibility of a party that conducts a business or undertaking coexists with that of a worker; the difference in responsibility is recognised by much higher penalties for parties with greater responsibilities.

(b) RAR had inspected the site of the lift and were fully informed; they had doubted the proposed method but deferred to Multiplex. Senior Multiplex representatives were present throughout the operation. Rather than discouraging the operation, they required and encouraged it. Multiplex rejected an alternative proposal made by RAR and the offender for reasons of cost and logistics. The offender asked about a different means of performing the task but was told that there was no other option.

(c) The offender had received no training or instruction from RAR in relation to the correct operation of the crane in the "superlift mode". When he tried to contact RAR for advice, his calls went unanswered.

(d) The offender sought an induction to the site but was not inducted because there was pressure to get the job done.

(e) There was pressure from RAR and Multiplex for the offender to carry out the lift that day. The offender understood that the job was important to RAR and he reasonably believed that, if he did not carry out the lift, his regular but casual employment may be threatened. In a practical sense, he was in a relatively powerless position (albeit a position in which many workers find themselves).

(f) The offender deferred to RAR and Multiplex in relation to the suitability of the crane to carry out the work.

(g) The offender was unaware that another crane operator, Mr Holt, had told RAR that he did not believe that it was safe to use the crane to move the generator. Had he factored in Mr Holt's opinion, he would have refused to undertake the task.

(h) The offender took some steps to ensure that the lift was performed safely by consulting lifting charts and assessing the load capacity of the crane.

(i) Although the operation of the crane was somewhat risky and unsafe throughout the lift, the evidence does not establish that anyone was exposed to risk of serious injury or death by the crane tipping or collapsing, other than in the final moments.

(j) At all times, the offender was working in accordance with instructions from RAR and Multiplex; he was not a frolic of his own.

93. I accept the offender's submission that the offence in question concerns the taking of a risk. It is not an element of the offence that the risk materialised; that serious injury or death ensued. The offender is not being sentenced for manslaughter by criminal negligence. The principles in *R v De Simoni* (1981) 147 CLR 383 per Gibbs CJ at 389 apply. However, the fact that the risk of death manifested is a very relevant matter under s 33(1)(e) of the *Sentencing Act*.

Subjective features

94. The offender was 44 years old at the time of the offence. He is now 48 years old.

95. The offender and his wife have been together for 26 years. They have two children, aged 9 and 12 years. At present, because of his employment and the needs of his parents, he resides with his parents. However, he sees his family daily. The offender and his family live in northern Queensland.

96. The offender is a person of prior good character. He has a short and very minor criminal history which, because of the age and/or nature of the convictions, does not detract from his otherwise good character. He has not previously been convicted of an offence against the *WHS Act* or its equivalents in other jurisdictions.

97. The offender enjoyed a normal upbringing in Townsville, Queensland with his parents and older brother; they are a close-knit family.

98. After leaving school in Year 11, he trained as a boilermaker before working in the construction industry, ultimately becoming a licensed crane driver. He worked as a crane driver for several years before the incident.

99. According to the agreed statement of facts, prior to the incident, the offender was considered to be a safe crane operator. Referees described him as a "very safe operator". Mr Richard Garrety, the Safety Officer for RAR Cranes, recalled that, on one occasion, the offender had refused to undertake a crane task as a rigger (not a crane driver) because of safety concerns, although the refusal had caused the client to engage another company to carry out the lift.

100. The offender had no history of mental impairment prior to the incident.

101. The offender's initial reaction to the incident was one of horror and shock. He felt responsible for causing the deceased's death. The offender reported to Dr Nielssen the experience of seeing "the man's legs sticking out from under the generator … every night before I go to bed". He felt unable to sleep or leave the house.

102. Dr Nielssen opined that, following the incident and because of it, the offender developed major depression, post-traumatic stress disorder, and alcohol use disorder (as a form of self-medication).

103. After the incident, the offender attended several counselling sessions that were organised by his trade union but discontinued the counselling because he had difficulty discussing the incident. He was diagnosed with depression six months after the incident and was advised to take antidepressant medication. However, he did not do so until late last year. He now takes the medication and finds it helpful. Over the past eight months, he has returned to counselling and is seeing a psychologist. He now realises the importance of psychological assistance.

104. Prior to the incident, the offender was an outgoing and sociable individual. However, he is now irritable, anxious and socially withdrawn. He suffers from poor concentration. The offender's poor mood, irritability and increased alcohol intake have strained his marriage. At one stage, there was a brief separation. However, the offender's wife has remained loyal and supportive and the marriage survives. The offender does engage in some social interaction, associating with a small group of close friends and work colleagues.

105. Dr Nielssen reported that the offender's mental difficulties are wholly due to the psychological impact of the incident. He anticipated that, with appropriate treatment, the conclusion of legal proceedings and the passage of time, the offender's post-traumatic stress disorder symptoms would lessen but would be triggered periodically.

106. The offender is the main breadwinner for the family. After the incident, he returned to work for RAR but, after a few days, he felt unable to continue. He and his wife decided to move away from Canberra to distance themselves from memories of the incident. The offender has not returned to the construction industry and has not driven a crane since the incident. He has been unable to sustain employment for an extended period because of his irritability and tendency to panic at job sites, perceiving there to be safety issues. As a result, he has walked out of several jobs.

107. The offender and his wife entered bankruptcy in 2018. Currently, he is employed on a casual basis by a trucking company. His wife has part-time employment in the retail industry but is not in a position to independently support the family. The couple has no savings and owns no real property. Their financial position is insecure.

108. The offender is extremely remorseful. He is deeply ashamed and has often remarked to his wife that it is he who should have died. He has insight into his offending conduct and the distress caused to Mr Holtz's family. I accept that he is genuinely and profoundly contrite and fully accepting of responsibility for the death of the deceased and the tragic consequences for his family.

109. The authors of the pre-sentence report assessed the offender as being at low risk of general reoffending because of factors such as family support, stable accommodation, and employment. The only risk factor that they identified was excessive alcohol consumption.

Discount for assistance

110. On 11 March 2020, the offender provided the prosecution with a statement. On 18 March 2020, he participated in a recorded interview with WorkSafe ACT and the AFP. The offender has undertaken to give evidence in the prosecution proceedings against Multiplex, RAR, and the individuals who have been charged.

111. He is entitled to a discount under s 36 of the *Sentencing Act*. In determining the extent of the discount, I must have regard to the factors set out in s 36(3). Some of those factors repeat factors that are otherwise to be taken into consideration.

112. Although the offer of assistance came some years after the incident, it is valuable, substantial, and considered to be reliable. The offender will provide a direct account concerning most of the significant matters surrounding the incident, as well as information in relation to the operations of RAR. As nearly everyone who was present at the time of the incident has been charged, his account of events is important.

113. Unfortunately, the prospect of having to give future evidence will probably impact on the offender's capacity to recover from the psychological effects of the incident. The offender will need to return to Canberra and relive the events of 4 August 2016.

114. I will allow a combined discount under ss 35 and 36 of 40 per cent, noting that a combined discount is not necessarily the sum of its parts.

Comparable cases

115. There have been few cases concerning category 1 offences and most have involved corporations with duties under the *WHS Act* (i.e. with a primary duty of care as the person conducting the business or undertaking). The sentences imposed for category 2 offences are of relatively little assistance as such offences do not carry a sentence of imprisonment.

116. In *R v Lavin* [2019] QCA 109, a jury convicted the offender under s 31(1) of the *Work Health and Safety Act 2011* (QLD), which mirrors s 31 of the *WHS Act*. The charge referred to the failure to exercise due diligence to ensure that the company complied with its duty under s 19 of the Act. The offender was the sole director of a roofing company that had been contracted to perform roofing work. The company had been required to install a safety rail. Instead, the offender had adopted a different plan whereby workers near to the edge of the roof used harnesses, and scissor lifts were to be positioned as barriers at the edge of the roof. The deceased worked away from the edge of the roof and had not been directed to wear a harness. However, he approached the edge, tripped in a gutter and fell from the roof, sustaining fatal injuries. The offender was sentenced to 12 months' imprisonment, suspended after 4 months. An appeal against conviction resulted in an order for retrial.

117. In an unreported decision of the Latrobe Valley Magistrates Court in Victoria, *WorkSafe Victoria v Jackson* (19 December 2018), the offender had pleaded guilty to offences under ss 24 and 32 of the *Occupational Health and Safety Act 2004* (Vic). Section 32 is similar to the subject provision and also carries a maximum penalty of five years' imprisonment. The offender was the owner and operator of a scrap metal business. She transferred scrap metal from inside a 1.8 metre metal bin into a larger 6 metre metal bin by operating a forklift that she was not licensed to operate. The deceased was inside the smaller bin, which was raised approximately 3 metres from the ground by the forklift. The forklift tines were not sufficiently wide, and the task was carried out on uneven ground with a slight incline. The deceased and the bin fell from the forklift. Part of the bin landed on the deceased's head, killing him. For the breach of s 32, the offender was convicted and sentenced to six months' imprisonment. She was also fined $10,000 for breach of s 24.

118. Both *Lavin* and *Jackson* involved the prosecution of persons with overall responsibility for a dangerous operation; they were not merely workers.

119. In *Orr v Cudal Lime Products* [2018] NSWDC 27, both the company operating a mine and a worker employed by that company were prosecuted under the *Work Health and Safety Act 2011* (NSW) (mirror legislation). The company was fined $900,000 under s 31 (category 1 offence); the maximum penalty was $3,000,000. The worker was fined $48,000 under s 32 (category 2 offence); the maximum penalty was $150,000. The deceased was a de facto partner of one of the workers who had resided in a cottage near the mine belonging to the mine's owner. The mine and the cottage were powered by a substation located at the mine. Over several years, there had been

many electrical issues with the substation. The worker had been directed by the company to conduct electrical work in the absence of a qualified electrician. The deceased was electrocuted because of an electrical fault in the mine.

120. In *Campbell v Rowe* [2019] SAET 104, an experienced site supervisor and an offending worker were prosecuted under s 31 of the *Work Health and Safety Act 2012* (SA) (the equivalent South Australian provision), which also carries a maximum penalty of five years' imprisonment. During an incident of "horseplay that got out of hand", the supervisor had failed to stop the offending worker from squirting flammable liquid onto the clothing of another worker and igniting it. Despite the risk of serious harm, only minimal injury was sustained. The supervisor had entered an early plea, expressed remorse, and suffered a loss of employment. He received a discount of 40 per cent for the early plea and was fined $12,000. The offending worker benefited from a 40 per cent discount for an early plea and was fined $21,000.

121. It is also worth noting two decisions that concerned different provisions.

122. In *R v Canberra Contractors Pty Ltd* [2016] ACTSC 13, the offender pleaded guilty to one offence of failure to comply with a safety duty that negligently exposed a person to a substantial risk of serious harm, contrary to s 31(1) the *Work Safety Act 2008* (ACT) (now repealed). The offence carried a maximum penalty of 1,000 penalty units ($750,000 for a body corporate), two years' imprisonment, or both. The offender was a company that had employed the victim who was fatally injured when he was hit by a reversing road grader. It was fined $82,500.

123. In *Orbit Drilling* (see [88] above), a worker died when he lost control of an unroadworthy truck on a steep slope and the truck overturned. The worker was untrained and was driving under the instructions of the company's site manager. The employer company pleaded guilty to an offence under s 32 of the *Occupational Health and Safety Act 2004* (Vic) and its managing director pleaded guilty to an offence under s 144(1) of the Act. The company was fined $750,000. The director was fined $120,000. The Victorian Court of Appeal dismissed the appeals against sentence.

Other sentencing considerations

124. In sentencing the offender, the Court must have regard to the considerations in s 33 of the *Sentencing Act*, insofar as they are known and relevant. I have referred to the relevant considerations above.

125. As to the sentencing purposes that are important under s 7 of the *Sentencing Act*, for breaches of work health and safety laws, general deterrence is almost always the dominant sentencing purpose. See also the object of the legislation, as expressed in s 3 of the *WHS Act*.

126. I accept the offender's submission that, having regard to his ongoing serious psychological difficulties he may be a somewhat less appropriate vehicle for general deterrence. Nevertheless, I consider that general deterrence remains the dominant sentencing purpose.

127. I do not accept the defence submission that a good behaviour order would be an adequate penalty. I consider that, given the objective seriousness of the offending conduct, the only appropriate sentence is a sentence of imprisonment. No lesser sentence would convey an adequate message of general deterrence. However, I

accept that it would be appropriate for the sentence to be wholly suspended, an inherently more lenient way of serving a sentence of imprisonment.

Sentence

128. The starting point for the sentence is 20 months' imprisonment. I discount the sentence by 40 per cent, arriving at a sentence of 12 months' imprisonment.

129. The offender is convicted and sentenced to 12 months' imprisonment. Pursuant to s 12 of the *Sentencing Act*, the sentence is wholly suspended upon the offender entering into a good behaviour order for 12 months.

I certify that the preceding one hundred and twenty-nine [129] numbered paragraphs are a true copy of the Reasons for Sentence of her Honour Chief Justice Murrell.

Associate:

Date: