QUEENSLAND COURTS

MAGISTRATES COURT OF QUEENSLAND

PARTIES:	
Complainant:	**David Ian Fletcher**
	AND
Defendant:	**Sunshine Food Network Pty Ltd (A.C.N. 116 759 874)**
FILE NO:	**MAG-00140884/13(8)**
PROCEEDING:	**Complaint Work Health and Safety Act 2011**
ORIGINATING COURT:	**Maroochydore**
DELIVERED ON:	**19 March 2014**
HEARING DATE:	**5 March 2014**
DELIVERED AT:	**Maroochydore Magistrates Court**
MAGISTRATE:	**J A HODGINS**
REPRESENTATION:	
Complainant:	**Mr R Watson**
Defendant:	**Mr A J Glynn QC and Mr van de Beld, Counsel instructed by Ferguson Cannon**

[1] Sunshine Food Network Pty Ltd is charged that on 15 November 2012 it failed to comply with its workplace health and safety duty.

Legislation

[2] The *Work Health and Safety Act 2011* is a legislative framework to secure the health and safety of workers and workplaces[1].

[3] A person conducting a business or undertaking is required to eliminate risks to health and safety, so far as is reasonably practicable, and if it is not reasonably practicable to eliminate risks to health and safety, to minimise those risks so far as is reasonably practicable[2].

[4] Further, that a person conducting a business or undertaking must ensure, so far as is reasonably practicable , the health and safety of workers engaged and workers whose activities in carrying out work are influenced or directed by the person; while the workers are at work in the business or undertaking[3].

[5] The Code of Practice 2011 *How to Manage Work Health and Safety Risks* applies to the company. It requires thought about what could go wrong at the workplace and what the consequences could be. Steps are required then to be taken to do whatever is reasonably practicable to eliminate or minimise health and safety risks arising from the business or undertaking. Four steps in risk management are to be taken:-

- identify hazards – find out what could cause harm
- assess risks if necessary – understand the nature of the harm that could be caused by the hazard, how serious the harm could be and the likelihood of it happening
- control risks – implement the most effective control measure that is reasonably practicable in the circumstances
- review control measures to ensure they are working as planned.

Facts

[6] Sunshine Food Network Pty Ltd (referred to as "the company") operates a commercial kitchen at Warana where food is prepared for its mobile vans. There is a deep fry area in the kitchen, with three deep fryers being used.

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[1] *Refer s 3(1) (a), (e), (g) and (h) Object*
[2] *S 17 Work Health and safety Act 2011*
[3] *Refer s 19(1) Work Health and Safety Act 2011and s(19)(3 also)*

[7] A fire occurred in the workplace leading to the purchase of three Woodson WFRT80 deep fryers in February 2012[4]. The particular fryers were the same type as used prior to the fire. Food was heated in the fryers at a temperature of 170 degrees Celsius. At the completion of cooking, oil was decanted from the deep fryer by lifting back the heating element, lifting the vat containing the oil and pouring the oil through a filter cone decanter into a bucket which separated the foreign matter from the oil. The clean oil is then returned to the fryers. Rags were used to hold the vat as the decanting process occurred when the oil was hot. Mr James, a director of the company says that he gave an oral instruction to to the injured worker Ms Goodall and another employee on how to decant the oil from the deep fryer using rags[5]. It was Ms Goodall's evidence that the oral instruction was given by a person known as Ray, who was Mr James's former partner.

[8] Ms Goodall has worked for the company for nine years, as a kitchen hand preparing hot and cold food. She was one of a number of employees who continued to work for the company, when it was acquired by Mr James and his then partner on 31 December 2005.

[9] On 15 November 2012, Ms Goodall was on a 5.00 am to 9.00 am shift preparing cold food such as sandwiches and loading them on to the trays. Mr James was doing a delivery when the incident occurred. Another woman named Katie was doing the frying of food. Her shift finished at 7.45am and as the frying work was not complete, Ms Goodall took over from her. Upon completion of the frying, she commenced the cleaning up of the fryers. She was under time pressure as her shift was to finish at 9.00am.

[10] Ms Goodall turned off the fryer. She then moved the vat forward as there was not enough room to enable the heating element to be rotated out of the vat. As she was lifting the heating element out of the oil, she was not able to clip it off to pull it out cleanly. The deep fryer overbalanced splashing hot oil on her leg. She fell grabbing at the frame of the fryer, pulling the fryer over onto her with the hot oil spilling onto her legs. In falling, she knocked over the bucket containing oil, spilling further oil onto her.

[11] Ms Goodall was hosed down on site and showered at an adjacent premise to cool the burning. She recalls Mrs Ferguson being present when showering; but does not remember any of the conversation. Subsequently, she was taken to the Nambour General Hospital, where she was hospitalised for a week and then transferred to the Royal Brisbane Hospital, where she remained for three weeks. She sustained severe burns to her left leg and right foot.

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[4] Invoice Hiller & Associates 17 February 2012 Exhibit 6

[5] Decanting of oil process demonstrated in photographs – Exhibit 2

[12] Mrs Ferguson, a fellow worker gave evidence. She did not see the incident. She stated that she had a conversation with Ms Goodall when she was showering and that Ms Goodall said to her:-

"I think something slipped. I went instantly to grab it. It fell and I fell".

[13] Mr Kyling, a Work Place Health and Safety Inspector attended the work site and took photographs, including the frying area and how the oil was decanted[6]. A prohibition notice was issued regarding the decanting of the oil. This notice was lifted when the company issued a Safe Work Procedure for cleaning of fryers[7]. The procedure stipulates inter alia that the cleaning of fryers procedure is not to be attempted if the oil is still not cold. Mr Huey, another Work Place Health and Safety Inspector conducted a record of interview with Mr James, Director of the company on 1 May 2013[8].

[14] The defendant elected not to call evidence.

Issues

Code of Practice

[15] The applicable code of practice is *How to Manage Work Health and Safety Risks Code of Practice 2011.* This code of practice commenced on 1 January 2012. The company did not apply the code of practice to the workplace.

[16] Mr James and his partner purchased the business in late 2005. Ms Goodall says that the partner gave her instruction on cleaning the deep fryers and the decanting of oil. Mr James took over completely the business in late 2011, which is time-lined to be just prior to the fire that led to the replacement of the deep fryers (invoiced February 2012). Ms Goodall did not receive instruction from Mr James on the cleaning of the new deep fryers. This was probably due to Ms Goodall being a competent, long term worker in the business.

[17] No instruction was given on protective clothing or footwear. Mr James said in his interview that employees were meant to have enclosed, non-slip footwear. Ms Goodall's evidence is accepted that she was never instructed to use covered footwear. Further, that she was not told not to wear croc shoes. She said that she had never been pulled up for having inappropriate footwear. The issue of appropriateness of footwear has no bearing on the event that occurred. There is nothing to suggest that wearing different footwear would have led to a different result.

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[6] Exhibit 2
[7] Exhibit 3
[8] Exhibit 7

[18] The complaint particularises that the workplace is a commercial kitchen, in particular the deep fry area of the kitchen. Persons at risk were workers, in particular Ms Goodall.

[19] The hazard particularised in the complaint is the requirement of workers to decant hot oil at regular intervals from deep fryers in the deep fry area of the kitchen. The hot oil had the potential to harm workers in the kitchen. The company required workers to clean the vats when the oil was hot. It supplied rags for the workers to use.

[20] The identified hazard was the requirement to handle hot oil. Ms Goodall expressed that she did not clip the heating element correctly and as a result it overbalanced, starting the chain of events that occurred. However, if the direction was in place at the time that no cleaning of the fryers was to occur if the oil was not cold, then the injuries sustained would not have resulted. The risk from the hazard of decanting hot oil was that burn injuries would occur.

[21] Paragraph 6 in the particulars sets out the risk thus:-

> *"(a) The risk arising out of the hazard of which **SUNSHINE FOOD NETWORK PTY LTD (A.C.N. 116 759 874)** ought to have known is the risk of death or injury to persons, including the risk of burn injuries (second degree) to the left leg and right foot of Karen Lee GOODALL;*
>
> *(b) In the course of her duties as a kitchen hand, there was a risk that hot oil would spill on to the body of Karen Lee GOODALL when lifting a pan of hot oil from a deep fryer for the purpose of decanting through filtration paper into a bucket;*
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> *© The risk of injury as described materialized when Karen Lee GOODALL sustained the burn injuries described in paragraph 6(a) hereof."*

[22] The failures of the company to Ms Goodall identified in the particulars are the failure to:-

- provide a safe system of work when workers are required to decant hot oil from deep fryers, in particular having regard to the provisions of *How to Manage Work Health and Safety Risks Code of Practice 2011;*
- provide a standard of workplace health and safety equivalent to, or higher than that standard required in the code of practice;

- provide adequate plant, instruction and supervision, and personal protective equipment to ensure workers are not exposed to the risk of burn injury when undertaking the task of decanting oil.

[23] The prosecution did not proceed at hearing with the alternative plant control measure. It relied on these control measures:-

- A system of instruction and supervision to ensure workers are not at risk of burn injury when decanting oil from deep fryers by ensuring sufficient time has elapsed for the oil to cool before decanting;

- Provision of personal protective equipment (for example, gloves, apron and footwear) to ensure that workers are not exposed to the risk of burn injury from uncontrolled spillage of hot cooking oil.

Act or Omission

[24] Proper particularisation is necessary to enable a defendant to understand the essential factual ingredients of an alleged offence. A person charged with a workplace health and safety duty should know the particular act or omission identified as constituting the offence.

[25] Boddice J has aptly summarised the position thus[9];-

> "A defendant to any prosecution is entitled to be apprised, not only of the legal nature of the offence charged, but also of the particular act, matter or thing alleged as the foundation of the charge. Essential particulars include "the time, place and manner of the defendant"s acts or omissions. This requirement is consistent with the definition of "offence" in the Criminal Code (Qld) as it is the "act or omission which renders the person doing the act or omission liable to punishment" which is "an offence".

[26] The High Court in *Kirk v Industrial Court (NSW[10])* dismissed a complaint brought under the New South Wales Occupational Health and Safety Act 1983 which was insufficiently particularised. The defendant was entitled to know the case required to be answered so as to raise any effective defence to any charge.

[27] The Court of Appeal has now held[11] that the principles of particularisation as pronounced in *Kirk* do apply to complaints under the repealed legislation[12]. In

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[9] *N K Collins Industries Pty Ltd v President of the Industrial Court of Queensland [2010] QSC 373 at [17]*

[10] *(2010) 239 CLR 531*

[11] *NK Collins Industries Pty Ltd v President of the Industrial Court of Queensland [2013] QCA 179*

this decision, NK Collins Pty Ltd was charged with breaching its workplace health and safety obligations. The company had sought from the outset further particulars of the offence. The code of practice had not been particularised in the complaint. More than one code of practice applied and there were more than one measure for dealing with risk. The only suggestion of what measures might have been taken came after the defence case was closed and the company's submissions were made. It was described as a miscellany of steps under two different codes, at varying levels of generality, with no attempt made to isolate any particular measure as of relevance to the risk in question. Particularisation of the relevant breach is to be specified. The relevant breach is the measure not taken, the act or omission of the employer.

[28] Holmes J contextualised the particular facts thus[13]:-

> "*....it was incumbent on the prosecution to identify the measure or measures which should have been taken to ensure workers' safety from the risk; which would, presumably, have been a means stated in the Forest Harvesting Code of Practice. That would in turn clarify what the risk was, and whether it was alleged to emanate from the existence of dead trees which might fall or whether it was posed by some feature of the system of work. It would then fall to the applicant to make out its defence under s 37(1)(b)(i) or (ii)*".

[29] The effect of the Court of Appeal decision is that the *Kirk* principles will apply to the current legislation. This is particularly so, due to greater similarity of the current legislation to the New South Wales scheme considered in *Kirk.* The New South Wales legislation contained provisions permitting a defence to be raised where discharge of the occupational health and safety obligation was not reasonably practicable. The thrust in *Kirk* was that there was a requirement that the particulars of the offence be provided so that a defence might be able to be raised.

[30] In this case, no submission has been made that the particulars are insufficient; but rather the content of the particulars are at variance with the evidence at the hearing.

Essential Facts

[31] The prosecution has the burden of proof beyond a reasonable doubt to establish the elements of the offence:-

1. a person is required to comply with a health and safety duty;

2. the person commits an offence if it fails to comply with the health and safety duty; and

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[12] *Workplace Health and Safety Act 1995*

[13] *NK Collins Industries Pty Ltd v President of the Industrial Court of Queensland [2013] QCA 179 at [59]*

3. a person would only commit an offence if the failure to comply with the work health and safety duty exposed an individual to a risk of death or serious injury or serious illness.

[32] The prosecution has also to establish whether the defendant failed to do what was reasonably practicable to protect the health and safety of the persons to whom the duty was owed. Reasonably practicable means[14] "*that which is, or was at a particular time, reasonably able to be done in relation to ensuring health and safety, taking into account and weighing up all relevant matters including-*

> *(a) the likelihood of the hazard or the risk concerned occurring; and*
> *(b) the degree of harm that might result from the hazard or the risk; and*
> *(c) what the person concerned knows, or ought reasonably to know, about—*
> *(i) the hazard or the risk; and*
> *(ii) ways of eliminating or minimising the risk; and*
> *(d) the availability and suitability of ways to eliminate or minimise the risk; and*
> *(e) after assessing the extent of the risk and the available ways of eliminating or minimising the risk, the cost associated with available ways of eliminating or minimising the risk, including whether the cost is grossly disproportionate to the risk".*

[33] Essential to the consideration of what is reasonably practicable in ensuring health and safety is the identified hazard; the risk occurring and ways of eliminating or minimising the risk, that is control measures.

[34] Two control measures are particularised in the complaint and relied on at hearing. The first is a system of instruction and supervision to ensure sufficient time has elapsed for the oil to cool before decanting. The second is provision of personal protection equipment.

[35] From the hazard, risk and control measures emerge that the company failed in its health and safety duty by its requirement for workers when cleaning the deep fryers to decant hot oil. The system of instruction and supervision was very limited. Personal protection equipment was non-existent. Workers were permitted to wear runners, including crocs. A cloth apron was worn.

[36] The omission of the company was the requirement of workers to decant hot oil when cleaning deep fryers. That omission is detailed in the hazard, risk, failures

[14] *s 18 Work Health and Safety Act 2011*

and control measures paragraphs of the particulars. It emerges clearly from reading together each of the paragraphs.

[37] The defence of reasonably practicable could not overcome the hurdle that was no reason advanced as to why an instruction could not be given to decant the oil when it was cool. The oil did not solidify when cooled. It still could have been filtered. The same process of filtering could have been used. After the incident, the Safe Work Procedure issued stated that cleaning of fryers was not to be attempted if the oil was not cold.

[38] On behalf of the defendant, it is contended that paragraph 6(b) sets out that the risk of hot oil would spill on to the body of Ms Goodall when lifting a pan of hot oil from a deep fryer for the purposes of decanting through filtration paper into a bucket. The burn injuries did not occur due to the lifting of the pan of hot oil; but rather due to the way Ms Goodall clipped the heating element which resulted in the fryer overbalancing spilling oil onto Ms Goodall. It is contended that there is a difference in the risk particulars to what actually occurred and on that basis the complaint is sought to be dismissed.

[39] The submission misconceives the essential factual ingredients to constitute the offence. The Safe Work Procedure for cleaning of fryers sets out the steps in the process. However, none of the steps in the process can be taken if the oil is still not cool. The non-cooling of the oil is an essential factual ingredient. Ms Goodall received burns due to hot oil in the cleaning of fryers. In the process step 4 is "Remove Fryer Element Pivot from oil", step 5 is "Remove Pan" and step 6 is "Strain Oil into bucket and clean debris from bottom of pan".

[40] The interpretation of the defence to paragraph 6 and in particular 6© is open to challenge. The defence interpretation is that the risk of injury through spilling of hot oil occurred when lifting a pan of hot oil from a deep fryer and that risk of injury materialized when Ms Goodall sustained the burn injuries. The preferred interpretation is that paragraph 6(b) sets out an example of a risk in the process. The risk of injury namely burn injuries materialized when Ms Goodall sustained burn injuries.

Conclusion

[41] The facts of the case are not complex. Ms Goodall sustained severe burn injuries in the process of cleaning deep fryers. The hazard that gave rise to the risk was the requirement of worker when cleaning the deep fryers to decan hot oil. The company failed in its health and safety duty in the requirement its worker to undertake the process when the oil was hot. There was a risk of burn injury in the process and that risk materialized. The *How to Manage Work Place Health and Safety Risks Code of Practice* was not applied. The worker should not have been exposed to this risk of injury. Reasonably practicable control measures

could have been introduced. The workers could have been instructed not to decant hot oil.

[42] The company is found guilty of the charge beyond a reasonable doubt.

J A Hodgins

Magistrate