

DISTRICT COURT OF QUEENSLAND

CITATION: *Peapell v The Smith's Snackfood Company Limited* [2016] QDC 265

PARTIES: **ROSSLYN PATRICIA PEAPELL**

(plaintiff)

v

**THE SMITH'S SNACKFOOD COMPANY LIMITED
(ACN 057 976 940)**

(defendant)

FILE NO/S: 4363/13

DIVISION: Civil

PROCEEDING: Trial

ORIGINATING COURT: District Court, Brisbane

DELIVERED ON: 28th October 2016

DELIVERED AT: Brisbane

HEARING DATE: 17-21 October 2016 (inclusive)

JUDGE: Ryrie DCJ

ORDERS: **Judgment for the plaintiff**

CATCHWORDS: TORTS – NEGLIGENCE – EMPLOYER AND EMPLOYEE – LIABILITY - where the plaintiff was injured at work when she was crushed by a machine's robotic arm while she was clearing jammed cardboard from a machine – whether the defendant breached its duty of care to take reasonable care not to expose the plaintiff to any risk of injury or damage in the course of her employment, to implement and maintain a safe system of work and to provide a safe place of work, plant and equipment.

TORTS – CONTRIBUTORY NEGLIGENCE – whether the plaintiff is contributory negligent

Evidence Act 1977 (Qld) s 92 – applied.

Bankstown Foundry Pty Ltd v Braistina (1986) 160 CLR 301 – applied.

Briginshaw v Briginshaw (1938) 60 CLR 336 – applied.

Bus v Sydney County Council (1989) 167 CLR 78 – applied.
Davie v New Merton Board Mills Ltd [1959] AC 604 – distinguished.
Joslyn v Berryman [2003] 214 CLR 552 – applied.
Kennedy v Queensland Alumina Limited [2015] QSC 317 – applied.
Kondis v State Transport Authority (1984) 154 CLR 672 – applied.
McLean v Tedman (1984) 155 CLR 306 – applied.
Nelson v John Lysaght (Aust) Ltd (1975) 132 CLR 201 – applied.
Podrebersek v Australian Iron & Steel Pty Ltd [1985] 59 ALR 529 – applied.
Reck v Queensland Rail [2005] QCA 228 – applied.
S J Sanders Pty Ltd v Schmidt [2012] QCA 358 – applied.

COUNSEL: T Matthews QC, with M Horvath, for the plaintiff
C Heyworth-Smith QC, with D Cormack, for the defendant

SOLICITORS: Hall Payne Lawyers for the plaintiff
B.T. Lawyers for the defendant

Introduction

- [1] On the 29th of July 2009, Mrs Peapell (the plaintiff) suffered personal injuries while she was carrying out her duties at the defendant's factory as a Packing Machine Operator. The plaintiff was at the time operating the Schubert Multi Pack Machine. During the course of that operation, she was crushed by a robotic arm of that machine while she was clearing jammed cardboard from that machine's 'former', which is situated within the actual confines of the machine.
- [2] The plaintiff instituted proceedings in the District Court claiming that her personal injuries were caused by the negligence and/or breach of contract of the defendant, its' servants or agents. Relevantly, the plaintiff claimed that the defendant owed her a duty to take reasonable care not to expose the plaintiff to any risk of injury or damage in the course of her employment generally, but also that of which the defendant knew or ought to have known. That duty also including implementing and maintaining a safe system of work, providing a safe place of work, plant and equipment and to adequately train, instruct and supervise the plaintiff whilst undertaking her duties. Quantum was subsequently agreed between the parties but liability remained a live issue at trial.

Background

- [3] The plaintiff had been employed as a Packing Machine Operator at the defendant's factory, Smith's Snackfoods at Tingalpa, for about 13 years prior to the accident. She had regularly worked in the multi pack section and also on the Schubert machine since

its installation. On the morning in question, she was working her shift on the erector area of the relevant machine. Her colleague Mr Lowe was working on the 'lidder' area of the machine.

- [4] The machine being operated by the plaintiff had been manufactured and supplied by a reputable German company. It had been commissioned by the defendant company for its' operations at the Tingalpa factory. How that machine actually worked during operation in production mode was helpfully set out in the report of Mr Dargusch, Mechanical Engineer, dated 7th August 2009, commencing at page 6 at 4.1 (exhibit 3, Vol 1). At 4.2 in that report, Mr Dargusch also explained how each cell (there are two in total contained within the confines of the machine) is surrounded by a series of clear perspex/polycarbonate doors. The door of interest (that is, where the plaintiff actually entered) was a side door shown in Figures 9 and 20 at pages 11 and 20 of that report. Mr Dargusch also helpfully explained how those perspex doors were meant to operate while the machine was in a particular operating mode. At 4.3, he explained that the machine has a number of modes including basic, production, automatic stop (referred to as 'stop'), fault and emergency stop.
- [5] While the precise mechanism that led to the plaintiff suffering her injury was in issue at trial, it was not disputed that the plaintiff had in effect been injured while she was within the confines of the machine after she had opened a side door in order that she could carry out a routine duty required of her as part of her normal role.

What happened?

- [6] The defendant submits that the plaintiff's evidence of the events immediately preceding the accident is inconsistent with any mechanism by which the incident could have, in fact, occurred. In short, the defendant submits that it was simply not possible for the plaintiff to have opened the closed side door with just 'a little tug' while the machine was operating in production mode. In support of that submission, the defendant refers to Mr Dargusch's test results commencing at 5.4 of his report, dated 7th August 2009, which he conducted while the machine was in production mode.
- [7] For the purpose of his first report, it is apparent that Mr Dargusch particularly concentrated his testing while the machine was in production mode. He specifically had regard to the door which the plaintiff had entered. He was aware that it had been found during an earlier investigation (by whom it is not clear) that when the machine was in stop mode, the door could easily be opened using sufficient door opening force of 2 to 2.5 kg as the doors are not actually locked in that situation (page 19). Put another way, the door safety switch is meant to be activated while it is in that mode. He further discovered however, through his own testing, that the side door in question could be 'defeated' even when the machine was in production mode. That is to say, the doors could be opened, whether from a partially open or fully closed position without the door safety switch being subsequently activated, as long as sufficient force was being applied by the person who was opening the door. Mr Dargusch found during his testing that a side door cam, which he had been provided (he couldn't remember when he had received it) was worn (approximately 1mm) and that this had played a contributing role in allowing the door to be opened from a partially open door position even while the machine was still in production mode. The sufficient door opening force required in that circumstance was described as being measured at 5–7 kgs (see 5.4 of his report dated 7 August 2009). He also found that the worn cam had played a contributing role in

allowing the side door to be opened even when the door was in a fully closed position while the machine was still in production mode (5.5 of his report dated 7 August 2009). The sufficient door opening force required in that circumstance was described as being measured at 17kg for the door of interest.

- [8] The defendant submits, having regard to the results of those tests, that the door therefore could not have been opened by the plaintiff with 'just a little tug' (as she had described when giving her evidence) while it was operating in production mode. The defendant submits that in those circumstances the Court is without any evidence of how it is that the door happened to fail on this occasion. It is further submitted that in those circumstances the plaintiff has failed to discharge the burden of proof upon her to demonstrate that her injury occurred in such a manner that it could have been avoided by the exercise of reasonable care by the defendant and that therefore her claim must fail. I cannot accept the submissions made on behalf of the defendant on this issue. I shall now explain why with reference to the relevant evidence which I have taken into account.
- [9] Both the plaintiff and her colleague Mr Lowe were working together prior to the plaintiff suffering her injury. Mr Lowe described how he was working in the lidder area during the same shift as the plaintiff. He noticed some Twisties product from the previous run and needed to remove it. He asked the plaintiff to release the rear door adjacent to that area, which she did. He was effectively across from her when he saw her do this. He then entered and removed the product. He then heard the production mode start up after the plaintiff had pressed it to commence and in fact saw that it had commenced running himself (T1-69). He also heard however what he described as cardboard crunching just at the start of that production run. He then saw the plaintiff enter the side door in order to remove the cardboard in question. He saw her reach across to the relevant former where the 'jam up' was. He saw her remove the tray and as she removed it, the tooling unit which was situated at that point above where the presentation units were at that stage, then commenced picking up the next lot of trays from there and travelled across and collected the plaintiff (T1-74).
- [10] Having regard to that evidence, I find that Mr Lowe's description of the subject accident supports a conclusion being made that the plaintiff had only entered within the confines of the machine to clear out a cardboard jam at a time when the subject machine was not fully operational (as demonstrated in the video which was played to him (exhibit 2)). Put another way, the tooling unit (or robotic arm) which subsequently came into contact with her was not actually operating and performing its usual function when she first entered into the confines of the machine through the door or even as she was leaning over the subject former. I find that it only started operating after the plaintiff was already within the confines performing that task and had in effect, cleared the cause of the jam.
- [11] That version of events is also consistent with that of the plaintiff. The plaintiff gave evidence that she had initially released the rear door adjacent to where Mr Lowe was working after she had been asked by Mr Lowe to do so. They both then entered into the confines of the machine in order to carry out routine tasks. He then cleared out the old product left from the previous run and she cleaned the scanner eyes. She then finished her task in that regard then came out and she headed towards the erector, when she saw 'some tray' from a previous run in the back of the erector (T2-8). She remembers going in the (side) door which she believed was closed before she entered into that area. She described giving it just 'a little tug', pulled the door open and then stepped in. It was at

that point that while she was reaching over the former area in order to grab the tray at the back, she felt something touch her back and subsequently realised what it was (the robot). That account is also not inconsistent with the statement which she had provided to Mr Innes (A Workplace Health and Safety Inspector), an extract of which has been included in Mr Dargusch's 2nd report (Exhibit 3, Vol 1; dated 26th November 2015) where she indicated that the erector was in the 'off' position at the point she opened the door to clear the old trays.

- [12] The defendant submits that I should reject the account given by the plaintiff regarding the force which she says she used to open the subject door in light of the evidence given by Mr Dargusch during his testing regarding what force would actually be required to open a closed door while the machine is in production mode (at least 17 kgs or 5 to 7 kgs for a partially open door). I cannot accept that submission.
- [13] While I accept that the plaintiff, as a result of a hypoxic brain injury suffered as a result of the accident, is unable to now recall all the exact details of the accident, she nevertheless impressed me as a credible witness insofar as that she was able to recall some details of what had happened prior to entering the door. At no time did she attempt to embellish her evidence by attempting to suggest that she actually recalled pressing a stop button or otherwise, before entering the machine to clear the tray. Her account in my mind, was sufficiently consistent with the account given by Mr Lowe who was actually present when the subject accident happened. I had no reason to reject his evidence. Even with the passage of time, and the obvious distress it caused Mr Lowe to recall the events of that day, I found him to be a credible witness.
- [14] The submission made also overlooks the following matters.
- [15] Mr Dargusch's test results were premised upon the machine actually being in production mode and not some other mode at the time the plaintiff entered through the door, such as fault mode. In this regard, I make the following observations, which I have taken into account in reaching my conclusion. In Mr Dargusch's second report dated 26th November 2005, he had for the first time been provided with Mr Lowe and Ms Peapell's written statements made during the initial workplace health and safety investigation. In addition, he was provided with the machine's technical and operator's manuals. The extract of the plaintiff's statement, which is set out in his report at page 7, indicates that after the plaintiff had helped Mr Lowe in the area where he was working (number 10 robots) she had walked towards the erector and noticed trays left over from the previous run. Significantly, she stated 'The erector was in the off position so I opened the door to clear the old trays'. She also stated that it is only when she needs to enter the machine when it is in *running mode* (emphasis added) that she would press the stop button for that particular erector machine before entering. Significantly, she also stated in that statement that if the machine detects a fault or jam it will stop itself and the doors can be opened (which I take to mean as safely).
- [16] The evidence which the plaintiff gave regarding a fault or a jam was confirmed by Mr Lowe in his statement also outlined in Mr Dargusch's report, and again confirmed by both Mr Lowe and the plaintiff when they both gave their evidence before me (T1-57; T2-10).
- [17] As I understood it, Mr Dargusch had primarily formed his opinion that the machine was in production mode at the point that the plaintiff entered through the door and was not in

some other mode because of two things; Point (1) the extract from the Operator's Manual set out by him at page 4 which confirms that in production mode the TLM line may be in the 'wait' position with automatic restarting (for example, in the case of interrupted product feed); and Point (2) on his reading of the printout of the log of the actual machine's operation sequence on that day that had been provided to him (page 5).

- [18] The point which I consider may be made in respect of Point (1) is that Mr Dargusch did not appear to consider whether or not the machine may have in fact been in another mode other than production mode at the point that the plaintiff actually entered the door. The Operators Manual to which he referred also included fault mode which is described (see Exhibit 1 Volume 1 page 202 and 203) of which he made no mention. Secondly, that extract out of the Operators Manual indicates the following: for fault mode, the TLM line was automatically set to the 'fault' operating mode from the production mode as a result of a fault which occurred. In those circumstances, it describes that pneumatic circuits 1 and 2 are pressurized; the units are in the rest position; and the safety doors can be opened (that is, with very little force).
- [19] The evidence from Mr Lowe, and indeed the plaintiff herself, to which Mr Dargusch had regard confirms that a fault may well have arisen during production mode as a result of the cardboard crunching, that the erector had gone into an 'off' position (from the plaintiff's point of view) as a consequence and that it was only then that she opened the door to correct that jam up. Mr Dargusch confirmed in his evidence before the court that if the machine goes into fault mode from production mode as a consequence of a fault, then the result is that the machine will automatically stop itself and the safety doors can be opened (T4-95) with very little force required. He had also confirmed this position in his first report at page 11.
- [20] Mr Dargusch also confirmed during his evidence that in all other modes (other than production mode) the safety doors can be opened from a closed position with very little force needed, which was 2 to 2.5 kgs (page 22 of his first report) because the pneumatic air cylinder is not engaged onto the relevant lever in any of those modes which then allows that lever to make contact with the safety switch device and depress it, allowing the door to be safely opened. Mr Dargusch however also confirmed in his 1st report at page 18 at 5.2.2 that even where the relevant door was left in a partially open position, the lever which is meant to activate the safety switch had pivoted upwards but had not actuated the safety switch. He then noted during his testing at 5.4.1 of the report that where the partially open position is set into that position, that when the machine is then put into production mode, with sufficient door force of 5–7 kgs the door can still be defeated because a worn cam is a contributing factor. Dr Gilmore (Mechanical Engineer) called on behalf of the plaintiff, did not consider that the force required to pull a door outwards even in that scenario would be of any real difference. That is to say between 2-2.5 kgs to 5-7 kgs (T2-42) as the door would come open pretty easily or would not be noticeably different (T2-43).
- [21] Turning then to Point (2), the point which I consider that can be made here is that Mr Dargusch says that he believes the machine was in fact operating in production mode at the time the plaintiff entered the door because of the machine's printout log. Several things may be said about it. Firstly, Mr Dargusch conceded during cross examination that the log to which he referred in his second report was not determinative as it contained insufficient information to be interpreted properly (T4-107; T4-108). Secondly, if one has regard to the log itself, Mr Dargusch has presumed that the Event No 489

corresponded with the robot interaction with the plaintiff. The log itself appears to show however that whenever the machine transitions from one mode to another, it records it. It is apparent from that log that it transitioned from production (Event 488) to fault mode (Event 489) and then to basic mode (Event 490) and subsequently to fault when the emergency stop was pressed (Event 492). There was no evidence given regarding what 'Excessive Control Deviation' or (F2028) actually meant as it is recorded at Event 489.

- [22] As such, I am satisfied on the balance of probabilities that the plaintiff has demonstrated that the mechanism of her injury resulted in the manner which she described. I find that the said machine had jammed during the course of its operations as described by Mr Lowe as a result of the cardboard tray crunching. As a consequence, I find the machine had stopped as a consequence of that problem being detected by the machine. I find to the requisite standard required, that the description which the plaintiff gave regarding the force she had then used to open the door ('just a little tug') is consistent with exactly what she can do if the machine transitions itself into fault mode as a consequence of it detecting a jam. The weight of the evidence available in my mind supports such a conclusion being made.
- [23] I also find that even if the door was already partially ajar and was then opened by the plaintiff, as suggested as being the likely scenario proposed by Mr Dargusch while the machine was still in production mode, then the force used even in that circumstance would not have been particularly noticeably different to the plaintiff and therefore would not have been inconsistent with her description of 'just a little tug'. However, as I have already stated, I have nevertheless found, on the balance of probabilities, having regard to the available evidence for consideration, that it was more probable than not,¹ that the machine was in another mode, namely fault mode (rather than in production and in 'wait' or 'pause' as Mr Dargusch opined) at the point the plaintiff entered through the door and she was entitled to believe, especially where the machine had stopped, that if the door opened with just a little tug, then it was safe for her to enter in order to clear out the cardboard jam.
- [24] Just for completion, there was cross examination of the plaintiff which suggested that her failure to tell Inspector Innes exactly what force she says she used when opening the said door, cast doubt on her veracity for truth. I cannot accept that submission. The explanation which the plaintiff gave was completely plausible given the circumstances she was in when she gave that statement (T2-13). Similarly, it was submitted that because the plaintiff did not remember telling her solicitor when preparing her statement on 24th February 2010 as to the particular force required to open the door, her evidence ought to be rejected. I cannot accept that submission. There was no reason for her to tell her solicitor what force she used on the door to open it in circumstances where once the machine had already 'stopped' due to a jam, she merely had to go and open it in order to enter within the confines of the machine, which is exactly what she did.

In light of what happened, was it in any event detectable?

Plant and Equipment

- [25] It is trite to say that an employer owes a concurrent duty of care in contract and tort to provide safe and proper plant and equipment and to devise a safe system of work for its

¹ *Briginshaw v Briginshaw* (1938) 60 CLR 336.

use by way of training and instruction.² However, that obligation is discharged where the employer purchases appropriate equipment from a reputable manufacturer or supplier and makes any inspection which a reasonable employer would make.³ The principle in ‘Davies case’ has been reaffirmed as being applicable law in Queensland by Gotterson JA in *S J Sanders Pty Ltd v Schmidt* at [37].⁴

- [26] At paragraph 10 of the plaintiff’s written submissions (Exhibit 7), a single formulation of the case before me for consideration is stated as being ‘that as early as March 2008 the defendant knew or ought to have known that the door had failed twice and that the plaintiff’s accident occurred as a result of the lack of and/or inadequate maintenance’. As such, much of the trial was occupied by both parties with addressing this particular issue.
- [27] As I understand the defendant’s oral and written submissions, reliance is placed on the principle in Davie’s case in the following way. The principle provides a defence to well settled law that an employer has a non-delegable duty to take reasonable care to provide a safe place of work and equipment and to devise a safe system of work for its use by way of training and instruction.⁵ The defence arises however in circumstances if a reputable manufacturer supplies equipment with a latent defect (emphasis added), and injury results.
- [28] It is accepted by the defendant that the non-delegable duty placed upon an employer also extends to inspecting the machine supplied for fitness and to service it and maintain it, together with ensuring that proper training, instruction or warnings for risks that are reasonably foreseeable is given in respect of it.⁶

Was this as a consequence of a ‘latent defect’?

- [29] The defendant submitted that in the event that it is found that the plaintiff had in fact opened the door in production mode, whether it be from a partially ajar or a fully closed position, by means of having used the necessary force prescribed by Mr Dargusch to do so, then her injury was a direct consequence of a latent design defect which would not have been readily discoverable by any measures that the defendant had taken or ought to have reasonably adopted before the subject accident.
- [30] In support of that submission, the defendant made the following points. The defendant had purchased the machine from a reputable manufacturer (which was not disputed), and had relied on that manufacturer for their testing, the initial set up of the machine, adjustments to the relevant side door (after the ‘near miss’ incident in March 2008), its’ 24-hour support, local technician, together with their Manual for risk assessments, maintenance and training (exhibit 6, page 5). The defendant says that it had specifically relied on the manufacturer’s design of the machine including its’ built in safety features, namely the doors which were designed to be locked at all times during production mode which could not be opened unless switched to stop mode. The defendant says it also

² *S J Sanders Pty Ltd v Schmidt* [2012] QCA 358 [29].

³ *Davie v New Merton Board Mills Ltd* [1959] AC 604, 646 (‘Davies Case’).

⁴ [2012] QCA 358.

⁵ *S J Sanders Pty Ltd v Schmidt* [2012] QCA 358 [29].

⁶ Exhibit 6, paragraph 193.

relied on the fact that the doors were designed to only ever open in ‘basic’, ‘fault’, ‘stop’ and ‘emergency stop’ modes, but not in ‘production’ mode.

- [31] Further, the defendant submitted that the hypothesis that a worn cam of 1mm would also operate to contribute to the door being able to be opened during production mode from a partially ajar or a fully closed position if the necessary force to which Mr Dargusch referred was applied when opening the door in either of those circumstances, could not have been known or ought to have been known by the defendant either by inspection or by any continued maintenance of the relevant plant and equipment.
- [32] The defendant’s primary submission was that in either of those door scenarios, the failure of the safety feature was not because of any breach of duty owed by the defendant but as a consequence of a latent design defect which could not have been prevented by anything which the defendant did, regardless of what steps the defendant ought to have reasonably adopted before the accident. Put another way, the defendant said that there were no steps which it could have taken or ought to have reasonably taken that would have prevented the accident happening, as the subject accident had arisen as a direct result of a latent design defect. I have presumed the submissions are made by the defendant in the event that I find that the mechanism of injury was as the plaintiff had so described which, on the balance of probabilities, I have in fact determined.

‘The near miss’ in March 2008; was it a predictor for the subject accident?

- [33] In addressing the ‘latent design defect’ point, the defendant referred to the ‘near miss’ in March 2008 (the subject of which are found in a variety of e-mails commencing at Ex 1 Vol 1 page 21–40) which had involved the exact same side door. On that occasion, as the e-mail chain reveals, the machine had apparently started into production mode notwithstanding that the same side door was already open. The defendant submitted that there had only been one near miss rather than two. The plaintiff on the other hand says there has been two near misses related to the exact same door, as demonstrated by the Maximo spreadsheet (last entry on page 10 of 69 of that document; Ex 3 Vol 3 page 166). I have carefully considered this entry and the submissions made. I find that the relevant entry does suggest and allows for a reasonable inference to be made that the similar problem that had arisen in early March 2008 in respect of the door had arisen again. The entry says as much. It also refers to Corrective Maintenance. Accordingly, I find that the entry does support a conclusion being made that there had been two near misses relating to the same door; which is the exact same side door involved in the subject accident. Regardless of whether there are one or two near misses, the defendant submits the fact remains the same. That is, that the incident or incidents in March 2008 described as a ‘near miss’ was not a predictor for the subject accident as the incident in March 2008 was not of the same ‘type’ as the subject accident in July 2009.
- [34] In this regard, the defendant referred and relied upon Mr Dargusch’s evidence which he gave during his evidence on this point. He considered the near miss incident was not a predictor to the subject accident because they were different (T4-79). He said that was because the subject accident had arisen because a door was opened after the production had already started, whereas the ‘near miss’ incident was described as production mode only being commenced after a door was already opened. Mr Dargusch explained that the significance which he saw in that difference was that if the door was already open as it was found to be in the near miss incident, then the machine’s lever which makes contact with the safety switch had not been correctly adjusted to make the necessary contact, in

order that the machine should know that the door was open already and therefore should not, in those circumstances, go into production mode like it did. He continued to explain that because that adjustment had not been done correctly on the lever when the machine had initially been installed by the manufacturer, then that had caused the lever to not come up far enough to push the safety switch in. As such, the machine had started in production mode because it had not, in effect, recognised that a side door was already open.

- [35] In effect, the general tenor of Mr Dargusch's evidence on this issue as I understood it was that the level of adjustment of the lever had very little to do with the subject accident occurring (unlike the near miss incident) because there is a pneumatic cylinder which holds down that lever in place while the machine is in production mode. This prevents the lever from then being able to rise upwards in order to make contact with the safety switch. He stated that it is only at the point that the machine is stopped that the pneumatic cylinder will retract, allowing the lever to rise upwards when the door is rotated open which then allows contact to be made with the safety switch. As such, he didn't consider that the lever and its adjustment height had much to do with the subject accident as the machine on that occasion was already in production mode when the plaintiff had entered through the side door.
- [36] Mr Dargusch accepted however that the wear of the cam which he observed from the subject door had still nevertheless contributed to the subject accident and its' occurrence even in the scenario as he had found it to be. That was because, as he explained with reference to the testing he had undertaken while the machine was in production mode, that the worn cam had directly affected the amount of force that would then have been required to be applied by the plaintiff in order to open the door while it was still in production mode (which was what he had opined to be as the most likely hypothesis that gave rise to the subject accident, that is, that the plaintiff could not have simply given the door 'just a little tug' in order to get into the confines of that machine as she had so described). Mr Dargusch however nevertheless accepted that 5 to 7 kgs (even though it was put to him as 5–7 kgs and a half (T4-85)) was the force to be applied when the door is partially ajar and the worn cam was a consideration.
- [37] Dr Gilmore also gave evidence on this issue. He had provided two reports dated 3rd March and 30th September 2016 respectively. His first report concentrated on a number of factors. The first being the tests which Mr Dargusch had conducted which had revealed that the side door could be 'defeated' even when in production mode in the way which Mr Dargusch described. The second was what Dr Gilmore described as the obvious presence of a worn cam as an exposed component related to the subject side door which was readily visible from the external location of the machine and readily able to be inspected. In short, Dr Gilmore opined that such a worn component would have been readily detected had the maintenance of 500 operating hour been carried out in the factory as specified in the Operator's Manual. Dr Gilmore specifically referred to certain sections of the Operator's Manual, in particular the pages which provided information on the maintenance work which must be carried out on the line every 500 operating hours. As the cam had not been changed since the implementation of the machine 18 months before, Dr Gilmore considered that based on an average 40 hour working week, 500 hours would expire approximately every 3 months. Dr Gilmore opined that over time, the cam had worn each time the side door was opened and closed as it was a component which directly bore the weight of the door as it slid on a bearing plate. He agreed with Mr Dargusch that this had allowed the door to be opened at a reasonable

applied force if the machine was in production mode but also said that it had also allowed the sensor detecting the open door to fail to activate.

- [38] In his second report, Dr Gilmore noted that the wear to the cam had in his view prevented the lever from depressing a push button style position switch wired into the safety circuit (i.e. the machine control system). He considered it to be a major cause as to why the door was able to be opened by the plaintiff if she had in fact done so when the machine was in production mode. As Dr Gilmore stated in his report, the safety doors were only able to be opened in basic, auto stop, fault and emergency stop modes as they are intended to be locked in production mode (page 4).
- [39] Dr Gilmore, like Mr Dargusch, was first asked to comment about the near miss incident in March 2008 at trial and whether it acted as a predictor for the subject accident in July 2009 (because neither had included a consideration of it in their respective reports, presumably because they had not been asked to do so).
- [40] Dr Gilmore considered that the near miss incidents were directly relevant to the foreseeability of the subject accident occurring. That was because the wear of the cam in the subject accident of 1mm also had a direct correlation as to how far the relevant lever would rise upwards in height when the door was opened, which in turn directly impacted upon whether that lever then made contact and depressed the safety switch button. That is, at the point that the cam left its base plate slot upon the door being rotated in order to open it. As Dr Gilmore explained, the door components are all mechanically connected and have an effect upon one another as they are connected rigid parts. Dr Gilmore noted that in the near miss incident, that because the lever was not correctly adjusted it had not in turn made contact with the safety switch when the door was open. Dr Gilmore therefore considered that the 1mm wear of the cam which had occurred before the subject accident which he believed would have been self-evident upon proper inspection and/or maintenance, was directly relevant to the height which the lever would then rise (and whether it would make contact with the safety switch or not) whenever the door was opened; whether that be in basic or even in production mode in the scenario that Mr Dargusch had described as the likely cause giving rise to the subject accident. In this regard, Dr Gilmore noted that Mr Dargusch's tests had demonstrated that the door could be 'defeated' by applying sufficient force when opening the door even when the machine was in Production Mode.
- [41] Mr Dargusch, on the other hand, did not agree with Dr Gilmore regarding the role which Dr Gilmore had considered the worn cam had played if the door was in fact opened with the necessary applied force while the machine was in production mode during the subject accident. Dr Gilmore considered that the worn cam was a major contributing factor, whereas Mr Dargusch was only willing to concede it had been a contributing factor not an essential one (his words) (T4-90), which I understood to mean it was not a major contributing factor. Indeed, Mr Dargusch only considered that the necessary adjustment of the lever as a result of a worn cam over time would only be a relevant consideration that needed regular inspection in basic or in any other of the modes other than in production mode (T4-86, T4-93). That is because in essence Mr Dargusch considered that the main thing locking the lever into place in a downwards direction during production mode was the pneumatic cylinder holding the lever in it's place. Dr Gilmore on the other hand considered that once the pneumatic cylinder was defeated with enough force being applied by a person opening the door, the wear of the cam became relevant

insofar as the height of the lever and its' subsequent ability to depress the safety switch (page 3 of Dr Gilmore's report dated 30th September 2016 - last two paragraphs).

- [42] Notwithstanding the variance of opinion on this issue between the respective experts, Mr Dargusch nevertheless agreed during cross examination (T4-95 L10) that the only way he found that the pneumatic cylinder retracted when it was in production mode was either when the stop button was pressed *or by the machine going into stop by itself* (emphasis added). Mr Dargusch stated that as soon as that cylinder retracted the machine was no longer in production mode, and 'that you are in a *fault mode* (emphasis added) or you're in a stop mode or some other mode such as basic mode' (T4-95 L15–20). The evidence already referred to, confirms that in those circumstances the door can be easily opened.
- [43] Having regard to the concession which Mr Dargusch made regarding the ongoing need for regular inspection and any necessary adjustment of the lever as a result of the wearing of a cam overtime that would be required in all modes (but not needed in production mode according to him if the pneumatic cylinder is doing its' job) (T4-86), and the opinion which Dr Gilmore gave on this issue, I find on balance, after having careful regard to what both experts said, that the weight of the expert evidence which I have already referred nevertheless supports a conclusion being made that there was a continuing obligation placed upon the defendant to ensure that any necessary adjustment of the lever as a result of a worn cam over time be undertaken. That is particularly so where Dr Gilmore said that this would have been easily discernible upon proper inspection and during maintenance, which including cleaning and the like of those components. I find that that inspection and that maintenance would have been reasonably required to be undertaken on the part of the defendants' ongoing obligation to inspect and continually maintain the subject plant and equipment especially where moving mechanical parts are involved.
- [44] I also find that the near misses which had occurred in March 2008 which related specifically to the exact same door, whereby a problem was arising in that it had remained open even when the machine apparently was started in production mode, ought to have put the defendant on notice that further careful monitoring and attention was required in respect of it. This is so regardless of the submission made that because the manufacturer had advised that they had 'fixed it' (after the 1st near miss) then the defendant was entitled to rely solely on that advice. The impact which both experts agreed that a worn cam over time could have upon a lever's height and its' ability to depress the safety switch as intended is relevant. They both concurred that this was an important aspect of ensuring that the lever (by measurement testing) and the safety switch remained in contact especially where wear to a cam has occurred due to the passage of time. The only difference between the experts on this particular point was of its' relevance if the machine was operating in production mode. In this regard, I have preferred Dr Gilmore's opinion regarding the significance and the role that the worn cam played as it related to the subject accident, namely that it was a major contributing factor and not just a contributing factor as Mr Dargusch opined. I also accept Dr Gilmore's opinion that such wear would have been self-evident upon any proper inspection and/or maintenance being carried out between the near miss incidents and the subject accident, particularly having regard to the fact that maintenance was said to have been performed only 3 days before the subject accident (Ex 1 page 45). I find in those circumstances that the near misses should have operated as a predictor for the subject accident notwithstanding the nature that gave rise to them. The fact that the door was already opened before production mode subsequently commenced (near miss) or the door being

opened after production mode had already commenced (as hypothesized by Mr Dargusch as being the likely cause of the subject accident) should nevertheless have put the defendant on sufficient notice that there was still a problem with the machine's safety side door particularly having regard to the 2nd near miss incident.

- [45] In this regard, I also refer to the e-mail chain relating to the 1st near miss incident which I understand was also given to Mr Dargusch for comment. Mr Reilly, the National Project Manager for the defendant was one of the witnesses called to discuss the relevant e-mail chain. As he explained, he had understood the 1st near miss incident related to the door being already open but the machine commenced into production mode nevertheless. A careful perusal of that e-mail chain however does not clearly show whether the machine had already been in production mode just prior to the door being opened on that occasion before the machine started into production mode (again) or not. Both Mr Reilly and Mr Dargusch (who was provided presumably with the same e-mail chain) believed that the machine had only been started into production mode while the door, which had already been opened beforehand, remained open. Neither witness however specifically gave evidence regarding what mode the machine was actually in at the point that door was opened prior to the machine going into production mode on that occasion. The words in the e-mails do little to assist on an absolute resolution of this point. One e-mail refers to a side door being wide open and the machine started and began operations (7th March 2008 e-mail, Ex 3 Vol 2 page 266) yet another e-mail of the 14th March 2008, which Mr Reilly stated was compiled by him as a result of what he had understood had in fact happened, was that the machine was (only) started in operation (i.e. put into production mode) whilst the door was still open (14th March 2008 Ex 3 Vol 2 page 294). While the e-mails reveal that adjustments were then made to ensure that the lever subsequently depressed the safety switch as it was required to do, I find that the fact that the measurement level of the lever which had to be adjusted after the 1st near miss incident still remained nevertheless an important aspect in the continuing overall reasonable inspection and/or maintenance that an employer is required to undertake in respect of its' plant and equipment supplied for its' use by its workers. Mr Reilly certainly thought it was (T4-21). He said as much in his evidence and in the relevant e-mail chain. That inspection is particularly relevant when one has regard to the 2nd near miss which has again involved the same door. As such, I find that the near miss incidents were a predictor or ought to have been a sufficient enough predictor to the subject accident which occurred in July 2009 as the exact same door was involved.
- [46] In respect of the competing expert opinion provided for assistance to the court regarding how the subject accident probably occurred, the defendant has submitted that all of Dr Gilmore's opinions ought to be completely disregarded; firstly because he did not appear to understand how the machine even worked (such as its' locking mechanism) and secondly, that any maintenance testing as prescribed by the manufacturer of the doors (to be done while in basic mode) post the near miss incidents in March 2008, would not have predicted the incident of July 2009 as Mr Dargusch himself had conducted that very same test and the safety switch which had in fact worked as it was required to do even with the worn cam.
- [47] I cannot accept the submissions made. I shall now explain why. Firstly, a review of the transcript of evidence in my mind shows that Dr Gilmore had a good understanding regarding how the machine worked and with respect to its' safety mechanism (see T2-79; T2-81; T2-83 and T3-27 by way of example). Secondly, Dr Gilmore also understood the tests which Mr Dargusch had undertaken in respect of the subject door while it was

in production mode, and how it could be defeated. That was evident from his reports and the evidence which he gave. In this regard, I have also noted that the subject tests carried out by Mr Dargusch (set out in detail in his 1st report at point 5 page 17) referred to the ‘machine testing’ conducted by him when in production mode. Mr Dargusch gave evidence at trial however that he also did ‘machine testing’ in basic mode in order to understand how the machine operated and when doing so observed a message on the monitor that said ‘doors are opened’, ‘safety doors are open’ (T4-78) which in effect meant that the worn cam therefore had no significant impact because the safety doors were working as they should even at that point (that is to say, some days after the subject accident) just as they were intended to. Notwithstanding the submission made, I note however there was no reference whatsoever to any monitor message which Mr Dargusch says he observed during his machine ‘testing’ when it was in basic mode. A careful perusal of his 1st report does not reveal that observation recorded at all in relation to any testing which he said that he had undertaken as it relates to basic mode. There is also evidence that the base plate had at the very least, been cleaned and the shroud covering the relevant lever had been removed prior to Mr Dargusch’s testing on site. He agreed that the photographs taken of the relevant base plate and the lever depicted in the photographs taken by Inspector Innes on the day or the day after the subject accident (Ex 1 Vol 1 pages 97 to 99) shown to him did not reflect what he saw the condition of the parts to be when he inspected them for the purpose of his testing. As such, I cannot place the weight that the defendant submits I should give to the fact that Mr Dargusch performed testing himself in basic mode and found that the lever (even with a worn cam that was given to him, but by whom and at what point is unknown) and the safety switch was working properly.

Was there lack of and/or inadequate maintenance in the intervening period as alleged which could have prevented the subject accident happening?

- [48] A large part of the trial was occupied by the maintenance work, procedures adopted and the work performed during the intervening period between the near miss incidents in March 2008 and the subject accident in July 2009. The defendant in effect submits that the defendant had performed all adequate inspection and/or maintenance during the intervening period up until the subject accident and as such, has not breached any duty of care owed in that regard. As I have already indicated I am not so persuaded. I shall also refer to the other evidence which I have had further regard to as it relates to this issue.
- [49] There was evidence of Mr Reilly who conceded that there were very fine tolerances involved in the safety switch working in relation to the lever and that adjustment using a feeler gauge would be appropriate to safeguard against subsequent failure in that respect. Mr Reilly’s own concession that he had signed off the doors as ‘failsafe’ as at May 2008 without being advised by anyone that they were in fact so demonstrates Mr Reilly’s lack of knowledge regarding the 2nd near miss that occurred later in March 2008 involving the exact same door.
- [50] There was no evidence that lever/switch clearance was checked at any time between May 2008 and the subject accident using the plan which Mr Reilly had proposed as vital or that it was even adopted as an ongoing inspection and/or maintenance practice after the near miss incidents. It is evident that it was only adopted after the subject accident.

- [51] The work orders given to the preventative maintenance staff allowed them to ‘self-regulate’ what work they said they actually performed. Mr Donaldson stated that he would probably tick off the tasks as the tasks were performed (T3-42) and if time ran out or he didn’t have a tool he would tick as much as he could and just write a note (T3-44). Mr Cantarella said that he would sign off on the work order once he completed it (T4-113). Mr Zuidema said that the boxes provided on the work order form were optional generally speaking, insofar as being ticked or not (T5-20), but sometimes he did and sometimes he didn’t (T5-22). He also confirmed that major faults would be recorded into the Maximo system but ‘minor’ faults ‘sometimes recorded sometimes not’ (T5-21). None of the maintenance workers who gave evidence could remember when they had actually performed the work (not surprisingly due to the passage of time) but there was no issue taken that Mr Cantarella had only performed preventative maintenance once; Mr Zuidema twice and no specific date was discussed during evidence as it related to Mr Donaldson.
- [52] Mr Newman provided a statement (marked Ex 5) which was accepted under section 92 of the *Evidence Act 1977* (Qld). Mr Newman’s statement provides that he did most of the maintenance work on the machine, he sometimes ticked the boxes, and he had completed the work the subject of the work order dated 26th July 2009 (Ex 1 Vol 1 page 45). In that statement Mr Newman says at paragraphs 21 and 22 that he believed that one work item required him to use a feeler gauge (that is, relating to the lever/safety switch). I find that this work could not have been performed by Mr Newman during the course of his preventative work on the 26th July 2009 because that requirement only came into effect as part of a work order after the 24th August 2009 (Ex 3 Vol 2 page 430) (emphasis added). As such, it is difficult to accept that Mr Newman did in fact perform this work as submitted by the defendant three days prior to the subject accident occurring.
- [53] Regarding whether ‘metal filings’ were seen or not near the subject door components during the course of the performance of the maintenance carried out by any of the maintenance staff referred to, only one of the witnesses called, namely Mr Zuidema, stated that he had not found any when doing his maintenance (T5-21). None of the other maintenance staff called ever suggested that they had in fact also checked for metal filings, and had not found any. It must also be remembered that Mr Zuidema had only performed maintenance on the 25th of May 2008 and the 8th November 2008 in respect of the subject machine, some approximately 8.5 months prior to the subject accident. The photos taken by Inspector Innes on the day of and the day after the subject accident clearly showed debris (Ex 1 vol 1 pages 97 to 99) and the base plate in its state at the time of the subject accident. As it already has been outlined, Mr Dargusch also confirmed that when he inspected the site some days later, that debris simply was not there and that the base plate had been cleaned in comparison to what the photo showed. He confirmed that what he saw on site didn’t look anything like what was shown in the photographs but expected that the debris seen there in the photos might be cardboard dust or something (T4-97). He accepted however that a shroud surrounding the lever had already been removed before he attended site.
- [54] Further, the work orders said to be performed were not in any event audited to ensure the work stated as completed actually was. Mr Bruce confirmed as much in his evidence. Neither were those work orders kept as a record prior to the subject accident. The work orders required staff to only perform the lever/switch levels after the subject accident notwithstanding that the near miss had involved that exact same problem with the exact same side door as that related to the subject accident (emphasis added).

- [55] I therefore find that had the inspection of the 26th July 2009 been conducted adequately in accordance with work order (Ex 1 page 45), then it was more probable than not that the wear pattern on the baseplate (where the cam was sliding across every time the subject door was been opened and closed) would have been **self-evident** visually and observable to anyone carrying out a proper inspection on the door and/or even a proper cleaning and maintaining of the said base plate. The photos taken by Inspector Innes as contained in Ex 1, pages 97 to 99, were taken on the day of or the day after the subject accident. Those photos show the relevant base plate in situ and the state of it. The photo contained in Mr Dargusch's 1st report of the worn cam which was handed to him at some point was also reported as having 1mm wear. Dr Gilmore stated that some of that wear would have been discernible from a side view of it upon proper inspection of it and the base plate. That observable wear ought to have caused a further inspection of it, the base plate and the cam by its removal in order to discern how much wear had in fact resulted between the two moving parts in order to determine if it was significant wear or not, which then it could have been replaced or necessitated a requirement that the level/switch measurements be taken in order to determine whether they were operating still as intended. I find that any wear to the cam found could not have occurred over a short period of time but rather occurred over a longer period, especially where the cam had never been replaced since the initial handover of the machine.
- [56] There was also no evidence to support a conclusion being made that the machine, at the point Mr Dargusch even inspected it, was in fact in the same state as it was at the time of the accident. There was no chain of custody proven in respect of the subject cam or the base plate. Mr Dargusch's picture of the worn cam in his 1st report merely shows what cam he had presumably been given. The photos which had been taken by Inspector Innes (already referred to) when shown to Mr Dargusch did not appear to reflect what he recalled the base plate to even look like when he saw it some days later during his inspection. He noted that the base plate had been cleaned and the shroud on the lever had been removed. That evidence supports a conclusion being made that what Mr Dargusch actually was shown or saw during his inspection on site may not have in fact been of the same condition or state as when the subject door was inspected and photographed by Inspector Innes.
- [57] In support of its' submission that the defendant had carried out all the necessary inspection and reasonable maintenance required of it subsequent to the near miss incident in March 2008, the defendant also referred to the Operator's Manual provided to it from the manufacturer upon hand over of the machine in May 2008. In this regard, the defendant pointed out that there was no recommendation made by the manufacturer in that manual requiring any need for ongoing lever adjustments; it was silent in respect of inspecting for the possibility of a worn cam or base plate, and only required the greasing and lubrication of moving parts. The defendant also pointed out the manual only required a safety door test to be run when the machine was in basic mode to check to make sure it came up on the screen. The defendant's submission on this point was that even though it was accepted that there is an obligation placed upon the defendant to take reasonable care in inspecting and maintaining its plant and equipment provided for its use by its' workers in order to prevent them from risk of harm, that obligation cannot be extended beyond what is required of it as recommended in the manual which had been provided to it by the manufacturer. In this regard, the defendant referred to the test to be performed only in basic mode and that there was no specific reference to the lever measurements

being specifically required, nor any requirement to look for worn components such as 1 mm of wear to a cam or checking the base plate per se.

- [58] I cannot accept the submission made as it overlooks the following matters.
- [59] The two near misses that had already occurred on site and the recommendations made in respect of it by Mr Reilly as it related to the 1st near miss incident which involved the exact same door.
- [60] The fact that a further test had been included to be performed in production mode by the maintenance staff to ensure the doors were safe (implemented subsequent to the near miss incident) which was in addition to the only test required to be performed in basic mode set out in the relevant manual.
- [61] That there is a continuing obligation in any event which is placed upon every employer to ensure that it performs and make any inspection and performs any maintenance which a reasonable employer would make. I find that the wearing of metal components (such as a worn cam and/or base plate which are intrinsically connected with each other and the lever/safety switch) would be part of that inspection and a requirement for further maintenance or replacement reasonably expected to be undertaken by an employer regardless of whether the Operator's Manual was silent on the point.
- [62] Accordingly, I find that the defendant has breached the duty of care imposed upon it to ensure that proper inspection and/or maintenance was carried out on its plant and equipment so as to ensure that its' workers were not exposed to any foreseeable risk of harm or injury. It follows that I am not satisfied that the principle in Davie's case applies. Put another way, I do not consider that this accident occurred as a result of a latent design defect as submitted by the defendant.

Was there an unsafe system of work in any event?

- [63] Having regard to the pleadings, and the finding which I have made regarding the mechanism of how the injury has occurred having regard to the acceptance by me of the plaintiff's account, I also find that the defendant has breached its duty of care in failing to provide a safe system of work in any event. I shall now explain.
- [64] In *S J Sanders Pty Ltd v Schmidt*, Boddice J outlined the law in this area as follows:⁷

“An employer’s duty of care requires that it establish, maintain and enforce a safe system of work.⁸ That obligation requires the undertaking of appropriate risk assessments, the devising of a proper method, training in its use, instruction to use that method, and the taking of reasonable steps to ensure its implementation.⁹ It includes the giving of such instructions, and the supervision of their enforcement, to experienced workers, having regard to the fact that an experienced worker may inadvertently or negligently injure themselves.”¹⁰

⁷ [2012] QCA 358 [29].

⁸ *McLean v Tedman* (1984) 155 CLR 306, 313.

⁹ *Reck v Queensland Rail* [2005] QCA 228 [16].

¹⁰ *Bus v Sydney County Council* (1989) 167 CLR 78, 90.

- [65] Such a duty of care also requires an employer to ensure that its workers are not exposed to any foreseeable risk of harm or injury.¹¹
- [66] Further, in *Kondis v State Transport Authority* it was emphasised that the degree of the standard of care required by an employer varies according to the risk involved in the nature of the work, as such that ‘those who engage in inherently dangerous operations must take precautions not required of persons engaged in routine activities...’.¹² There is no dispute on the pleadings that the relevant machine was inherently dangerous as part of its operation because as part of its operation it involved using hazardous voltage, temperatures, lasers, pneumatic pressures and moving mechanical parts (see exhibit 2).
- [67] The evidence from Mr Lowe and the plaintiff which I had no reason to reject was that they understood that when the machine jammed or had a fault, it was safe for them to open the door and enter the confines of the machine in order to rectify the problem because the machine had stopped (T1-57; T1-75).
- [68] Mr Lowe also confirmed that the instructions which he had received prior to the subject accident was that if a carton was jammed or there was a blockage somewhere, which was indicated on the control screen, that he could just open the door, clear that fault, close the door and press the start button to commence production again (T1-58). There was also evidence that the particular side door was the door entered the most often during any one shift to clear a jam, which was dependent upon how often that happened during the shift (T1-79, 78). Mr Lowe also gave evidence that the stop button would only be needed to be pressed in order to enter the confines of the machine if there was no jam up (T1-80).
- [69] The plaintiff also confirmed in her evidence that she would never attempt to enter the confines of the machine while it was running in full production mode and making trays (T2-9). She also confirmed that if the machine jams or tears (such as a cupboard box doesn’t form properly), she understood the doors could automatically be opened without the necessity of pressing the stop button in order to get those doors to open (T2-10). She stated that was because it had gone into a fault mode (T2-10). During cross examination the plaintiff also confirmed that it was only *when it was necessary to unlock the door* (emphasis added) that she would press the stop button before she entered the confines of the machine; something which she also said she had told other workers to do (T2-11, 12).
- [70] The evidence to which I have just outlined with respect to both witnesses is also not in my mind significantly inconsistent with the evidence provided to Mr Innes (extracts of those statements set out in Mr Dargusch’s 2nd report dated 26th November 2015, page 6 and 7). Further, there was no other evidence given at trial regarding the actual procedures to be adopted by the workers in the event of a jam or fault arising during production mode. Mr Dargusch, by reference to the Operator’s Manual, noted that the machine could well be in the ‘wait’ position with automatic restarting (for example, in the case of interrupted product feed) while nevertheless remaining in production mode (see page 4 of his 2nd report). Mr Dargusch also confirmed in his evidence when questioned by me that if a fault is detected by the machine during production mode, then the machine itself will initiate its own stop without the necessity of anyone having to press the stop button,

¹¹ *McLean v Tedman* (1984) 155 CLR 306, 311-313.

¹² *Kondis v State Transport Authority* (1984) 154 CLR 672, 679-680.

and that the door could then be opened (T4-110). He confirmed that the door could be opened in those circumstances with very little force being required (T4-111). That is also consistent with the Operator's Manual itself regarding the fault mode.

- [71] Accordingly, I find that no proper instructions, or sufficient training was provided to the plaintiff either in her initial training or otherwise that advised her how to identify, let alone know, when the machine may have been either in a 'wait' position with automatic restarting (as noted in the manual under production mode to which Mr Dargusch referred to support his hypothesis regarding how the subject accident may have occurred) or when the machine had simply transitioned to fault mode by itself.
- [72] I find that the plaintiff was left to her own devices to determine whether it was safe to enter the confines of the machine after the machine had stopped running as a result of a jam occurring where a cardboard tray had crunched up during production mode. Mr Lowe himself stated that he heard that happening during production mode at the start of it, which was just prior to him seeing the plaintiff then enter through the side door in order to clear it.
- [73] I also find that the plaintiff was left to her own devices to determine when she should press the stop button in the circumstances just described. As Mr Lowe stated, it depended on what the fault was: "like, we didn't really have to press that stop button all the time" (T1-80). That was because, as I understand it, Mr Lowe, like the plaintiff, thought that once the machine had stopped during production, then the door could be opened safely in order to rectify it, particularly if there was a cardboard jam. The weight of the evidence supports such a conclusion being made.
- [74] I find that the plaintiff was also required as part of her ordinary normal work duties to attend to such jams in order that production could keep progressing as quickly as possible.
- [75] I find that the fact that the machine could enter into 'wait' (or 'pause') position during production mode with automatic restarting (for example, in the case of interrupted product feed) to which Mr Dargusch referred, would have been or ought to have been a fact well known to the defendant. It was after all, contained in the Operator's Manual which it had received from the manufacturer upon hand over of the machine.
- [76] I find that the plaintiff was entitled to think that she could in fact enter into the confines of the machine after the machine had stopped during its' production mode because she understood that it was safe to do so. There was no evidence before me that suggested that she was not entitled to think just that. In this regard I find that there was no necessity for her to think that she needed to press the stop button before doing so in those circumstances because as she stated, it was not necessary for her to unlock the door in order to enter into the confines of the machine because it had already stopped itself during production as a result of the jam arising. I therefore find that there was no proper warning given to the plaintiff by the defendant to ensure that she understood that she should not enter the confines of the machine in circumstances where the machine had stopped during production mode and that before entering it was incumbent upon her to press the stop button.
- [77] I also find that there was no proper instruction, training or advice given to the plaintiff to advise her that the machine may be in 'wait' or in 'pause' before it automatically

restarts itself while in production mode (as Mr Dargusch noted when extracting the relevant description from the Operators Manual for the purpose of his 2nd report) and how she should distinguish that fact.

- [78] I also find that there was no clear direction, training or advice given to the plaintiff regarding the necessity of ensuring that all doors were in fact properly closed prior to production even commencing. Mr Lowe thought he had received such instruction (T1-86) and in fact did that himself (T1-87) whereas the plaintiff stated she had not ever received such instruction (T2-15). However, even in this regard Mr Lowe stated that he even though he checked that the doors were all closed, he understood that if the door wasn't, the machine would not start anyway (T1-88). I also note that his concession regarding whether he was told to ensure the doors were closed before production was started was with specific reference to when he was being asked about when he was changing one lot of boxes for another into the magazines before the commencement of any run.
- [79] Accordingly, having regard to the findings I have just made, I find the defendant breached its duty of care by its failure to implement a safe system of work which exposed the plaintiff to a foreseeable risk of harm or injury.
- [80] I have also taken into account the steps which have since been implemented by the defendant following the subject accident. Extra safety switches were installed on the doors and the programming changed so that the stop button had to be pressed before the doors will open. Mr Lowe also confirmed a safety check of the doors is now carried out at the commencement of each shift while the machine is running, and if a door can be opened then the instructions are that the workers are not to enter and are to press the stop button immediately. Mr Lowe also referred to an emergency chord running the length of the machine (T1-76, 77). Mr Lowe also confirmed that illuminated lights were fitted inside the robots so when the lights are on they indicate it is safe to enter (T1-76). Mr Cantarella also confirmed that extra safety measures were implemented to the machine (T4-114). Mr Dargusch also considered that the proposals put forward for consideration by the defendant after the subject accident to address the relevant side door issues were appropriate (T4-94).
- [81] It is trite to say that if a defendant introduces precautions after an accident, evidence of that introduction is admissible and often leads to a conclusion that such precautions were practicable prior to the accident,¹³ however this is not conclusive as to a finding of a breach of duty of care.

Contributory Negligence

- [82] The defendant's claim of contributory negligence is brought at common law. In *Bankstown Foundry Pty Ltd v Braistina* it was held that:

“A worker will be guilty of contributory negligence if he ought reasonably to have foreseen that, if he did not act as a reasonable and prudent man, he would expose himself to risk of injury. But his conduct must be judged in the context of a finding that the employer had failed to use reasonable care to provide a safe system of work, thereby exposing him to unnecessary risks. The question will be whether, in the

¹³ *Nelson v John Lysaght (Aust) Ltd* (1975) 132 CLR 201.

circumstances and under the conditions in which he was required to work, the conduct of the worker amounted to mere inadvertence, inattention or misjudgement, or to negligence rendering him responsible in part for the damage.”¹⁴

- [83] It is also recognised that there is a heavy obligation imposed on an employer to provide a safe system of work and that where an employer requires an ‘employee to work according to an unsafe system [of work] they should bear the consequences’.¹⁵
- [84] Having regard to the findings which I have made, I do not find any contributory negligence has been established.
- [85] The defendant submitted at paragraph 222 of her written submissions that the plaintiff well knew she had to press the stop button before entering the erector cell (the subject machine), that she trained other workers to do so, and that Mr Lowe had seen her do so and that she accepted that she did so. With respect to the latter point made, on careful reading of Mr Lowe’s evidence, at no point did he actually say that he had seen the plaintiff train other workers to press the button before entering. His evidence in fact was that he was not sure whether the plaintiff had done that or not (T1-80). The submission made on this issue therefore must fail.
- [86] I shall now return to the balance of the submission made. The evidence which I have already outlined demonstrates that the plaintiff stated that she would only press the stop button when it was necessary for her to unlock the door, a fact which she said she had also told other workers to do and had done so herself (emphasis added). She also stated that this was not necessary to do if the machine had stopped itself as a result of a cardboard jam which was what had happened here (T2-11, 12). There was evidence from the extract of the statement which the plaintiff provided to Inspector Innes, as set out in Mr Dargusch’s 2nd report at page 7, where the plaintiff has stated ‘that if a machine or robot detects a fault or jam it will stop itself and the doors can be opened. I never do this. I always hit the stop button before I enter. I cannot remember it (sic) I did it this time’. The defendant submits that the plaintiff has contributed to her own demise by her failure to press the stop button prior to entering the machine on this occasion and therefore that there ought to be a substantial reduction in damages of no less than 50%. She relies on certain authorities in support of that reduction.
- [87] I cannot accept the submission made on this issue. The need to press a stop button was not the standard procedure which had been imposed upon the plaintiff by any instruction, training or otherwise, that was to be adopted by her before she entered the confines of the machine if a fault or a jam caused the machine to stop itself during production mode. Therefore, even if there was a failure on her part to do so on this occasion as submitted, I am not satisfied that her conduct went ‘beyond mere inadvertence, inattention or misjudgement’ having regard to all of the circumstances of this case¹⁶ and also having regard to the evidence to which I have already referred throughout the text of this decision.

¹⁴ *Bankstown Foundry Pty Ltd v Braistina* (1986) 160 CLR 301, 310-311.

¹⁵ *Kondis v State Transport Authority* (1984) 154 CLR 672, 687-688; *Kennedy v Queensland Alumina Limited* [2015] QSC 317, 19-20.

¹⁶ *Bankstown Foundry Pty Ltd v Braistina* (1986) 160 CLR 301, 310-311.

- [88] Nor do I find that there has been any contributory negligence established on her part even in the event that had I found that the door was partially ajar before she had opened it (as hypothesised as the likely scenario by Mr Dargusch). That is because the door could nevertheless still be opened easily, the machine had already stopped in operation itself as a result of a jam and the plaintiff herself was entitled to believe that she could enter into the confines of the machine safely even in those circumstances.
- [89] Accordingly, I find the plaintiff has proved her case against the defendant to the requisite standard required.

Conclusion

- [90] I find that the defendant has breached its' duty of care which it owed to the plaintiff, that that breach was causative of the plaintiff's damage and that no contributory negligence on the part of the plaintiff has been established.

Order

Judgment for the plaintiff.