

## Company and director convicted after workplace explosion

**July 2010**

A manufacturer and its chief operating officer have failed to defend claims that their OHS failings were responsible for the 2006 Gladstone factory explosion which killed three people and seriously injured two more.

### What happened?

On May 9th 2006, five Quin Investments Pty Ltd (**Quin**) employees were preparing a premix for cartridge explosives in a second hand ribbon-blending machine, which had been purchased by Quin. A displaced shaft and worn components in the ribbon blender created friction which created a self-supporting "hot spot" and triggered a chemical reaction, causing the blast.

### Who was charged?

Quin was subsequently charged with failing to maintain a safe working environment under the Occupational Health Safety & Welfare Act 1986 (**SA OHS Act**), while its director was charged as an individual under the responsible officer provisions for failing to take reasonable steps to ensure Quin complied with its OHS obligations.

### What went wrong?

The Court heard that when the ribbon-blender was purchased second-hand in 1984 the manufacturer's operating manual, service guide or maintenance schedule were provided. The court heard that the ribbon-blender had worn components, including a shaft that had never been inspected, and had inadequate maintenance records.

The Court also heard that on the day of the incident, approximately 4500 kilograms of cast TNT, 20,000 litres of methanol and 20,000 litres of caustic methanol were stored in close proximity to the factory. It was this "state of affairs" which the Court said showed a "complete absence" of steps to reduce risk, and constituted a serious breach of OHS regulations.

### Arguments by the defendant

Quin accepted that the storage of the hazardous substances was unsafe, but argued that the regulator's investigation was focused solely on the disrepair of the blender, and failed to conclusively determine the cause of the explosion "beyond reasonable doubt." This argument was rebutted by the Court, who accepted the "hot spot" theory, and attributed the explosion to the defective blender.

The defendant director sought to rely on the fact that he had formulated a document relating to safety management systems, however the Court found there was no evidence to indicate it had been practically applied.

### Decision of the Court

The Court found that "the defendants did not take any positive steps to make risks as low as reasonably practicable" and ultimately "failed to provide and maintain so far as was reasonably practicable plant in a

safe condition." Both defendants were found guilty. Sentencing has been set down for a later date.

### **Implications of this decision**

The decision serves as an important reminder of the need to implement and enforce sound safe work procedures and take an active approach in maintaining plant and equipment.

The conviction against Quin's director should impress upon employers the significance of management's role in not only establishing a safe system of work, but ensuring the system is put into practice and stringently adhered to.

The Court's message is patent; in the performance of workplace safety there are no stagehands - everyone has a role to play.

For further information, please contact [Paul Cutrone](#) on +61 2 9373 1434.

---

Adelaide | Brisbane | Canberra | Melbourne | Newcastle | Perth | Sydney | Upper Hunter

#### **Contact Sparke Helmore**

Phone: (02) 9373 3555 | Fax: (02) 9373 3599 | Email: [webinfo@sparke.com.au](mailto:webinfo@sparke.com.au)