S. Kidman & Co v Lowndes CM and the Director of Public Prosecutions [2016] NTSC 3

PARTIES:	S. KIDMAN & CO v LOWNDES CM And: THE DIRECTOR OF PUBLIC PROSECUTIONS
TITLE OF COURT:	SUPREME COURT OF THE NORTHERN TERRITORY
JURISDICTION:	SUPREME COURT OF THE NORTHERN TERRITORY EXERCISING APPELLATE JURISDICTION
FILE NO:	84 of 2015 (21545396)
DELIVERED:	11 January 2016
HEARING DATE:	3 December 2015
JUDGMENT OF:	SOUTHWOOD J

CATCHWORDS:

JUDICIAL REVIEW – Jurisdictional error – limitation period – workplace safety prosecutions – where Chief Magistrate held that a complaint was laid within the limitation period prescribed by the *Work Health and Safety (National Uniform Legislation) Act* – whether the complaint was laid within one year of a coronial report being made or coronial inquiry or inquest ending – meaning of 'coronial inquiry or inquest' – whether a decision not to hold an inquiry evidences a coronial investigation – *Work Health and Safety (National Uniform Legislation) Act*, s 18, s 19, s 20, s 26, s 27, s 29, s 32, s 230(4), s 232 (1)(b); *Coroners Act*, s 16, s 26, s 35, s 44, s 49

JUDICIAL REVIEW – Jurisdictional error – complaints – workplace safety prosecutions – duplicity or insufficiency of complaints – where Chief Magistrate held that a complaint was defective but could be amended out of time – where the complaint cites provisions containing multiple duties of care – where the complaint does not set out all the legal elements of an offence – whether insufficiency or duplicity of complaint is ameliorated by provisions of the *Justices Act* (NT) – *Justices Act* (NT), s 22A, s 55, s 181, s 183

Work Health and Safety (National Uniform Legislation) Act (NT) s 18, s 19, s 20, s 26, s 27, s 29, s 32, s 230(4), s 232 (1)(b)
Justices Act (NT) s 22A, s 55, s 181, s 183
Coroners Act (NT) s 16, s 35, s 26, s 44, s 49

Page v Walco Hoist Rentals Pty Ltd [1999] 87 IR 286, cited.
Kirk v Industrial Court of New South Wales (2010) 239 CLR 531, distinguished.

REPRESENTATION:

Counsel:

Appellant:	M Crawley
First Respondent:	No appearance
Second Respondent:	D Morters and M Chalmers

Solicitors:

Appellant:	Sparke Helmore
First Respondent:	Solicitor for the Northern Territory
Second Respondent:	Office of the Director of Public Prosecutions

Judgment category classification:	B
Judgment ID Number:	Sou1601
Number of pages:	23

IN THE SUPREME COURT
OF THE NORTHERN TERRITORY
OF AUSTRALIA
AT DARWIN

S. Kidman & Co v Dr Lowndes CM and the Director of Public Prosecutions
[2016] NTSC 3
No. 84 of 2015 (21545396)

BETWEEN:

S. KIDMAN & CO
Applicant

AND:

LOWNDES CM
First Respondent

AND:

THE DIRECTOR OF PUBLIC PROSECUTIONS
Second Respondent

CORAM: SOUTHWOOD J

REASONS FOR JUDGMENT

(Delivered 11 January 2016)

[1] This is an application for judicial review under Order 56 of the Supreme Court Rules. The applicant seeks the following orders.

1. An order in the nature of certiorari quashing the decision of the first respondent, his Honour Lowndes CM, delivered on 14 August 2015 whereby his Honour determined that (a) the complaint made in the prosecution below was made within the limitation period fixed by s 232 (1)(b) of the *Work Health and Safety (National Uniform Legislation) Act*; and (b) notwithstanding the complaint was defective, it was capable of being amended under s 183 of the *Justices Act* (NT) and that such amendment should be allowed.

2. An order that the complaint be dismissed.

[2] As is appropriate, the first respondent did not participate in these proceedings. His Honour the Chief Magistrate has correctly chosen to abide the outcome.

The background to the application

[3] The corporate applicant is the owner of Helen Springs Station which is a pastoral lease that operates as a cattle station. In 2011 Mr Matthew Arena, who was a diesel mechanic, was employed on the station as head of maintenance.

[4] On 8 February 2012 a large metal pole fell from the tine of a New Holland LS 190 skid steer loader and landed on Mr Arena's abdomen, killing him. The incident occurred while Mr Arena was working on the cattle station in the process of moving and shortening metal poles which were to be erected as light poles for a horse yard. The poles were nine metres long and weighed 354 kilograms. The pole which landed on Mr Arena was being moved inside a work shed so that it could be shortened using an oxy-acetylene torch.

[5] The applicant reported Mr Arena's death to the regulator, NT WorkSafe. The regulator issued a prohibition notice preventing the applicant from using the loader; and an improvement notice requiring the applicant to review its procedures for hazard identification, risk assessment and control measures for safe systems of work. Mr Arena's death was also reported to the Office of the Coroner.

[6] On 14 February 2012, Mr Gannon from Fluid Power NT Pty Ltd, inspected the loader at the instruction of NT WorkSafe and advised that it (a) crept to the left on low revolutions; and (b) had a major creep in the lifting rams.

[7] NT WorkSafe also obtained an opinion about the loader from Mr Stuart Davis, Principal Advisor (Construction Engineering), Work Health and Safety Queensland. Mr Davis performed an examination of the loader, including a function test, visual inspection and hydraulic creep test on the raising and lowering of the arms. He reported that:

> The function test of the unit included the operation of all controls at varying engine speeds. All control functions operated correctly with the exception that when the operator's hands were removed from the hand lever the unit did not remain stationary as it is designed to do. Instead the loader turned to the left in a forward motion at approximately 0.5 metres/second (when the engine speed was at a fast idle). Mr Gannon indicated that this fault occurred because the hydraulic control valves connected to the control levers needed to be adjusted.
>
> The general visual condition of the skid steer loader was satisfactory and no obvious visual defects were noted on the unit.
>
> For the hydraulic creep test of the main lifting arms the forklift carriage were raised to the maximum height and then the unit's engine was turned off. Over a period of 10 minutes the hydraulic ram on the cylinder crept only 5 mm – in the author's opinion this amount of creep is within acceptable limits.

[8] On 31 January 2014 NT WorkSafe advised the Office of the Coroner that it had finalised its investigation into the death with no further action to be taken.

[9] The Deputy Coroner, who investigated Mr Arena's death, decided not to hold an inquest. On 6 February 2014, under s 16 and s 34 of the *Coroners Act*, she recorded her decision and specified her reasons for not holding an inquest in a document titled 'Coroner's Reasons for Decision not to Hold Inquest'. In her reasons for decision the Deputy Coroner stated:

> Following a coronial investigation, in conjunction with an investigation by NT WorkSafe, it was established that [the operator of the loader] had commenced work at the station the day prior, however, was not familiar with the loader and had not operated a foot pedal loader prior.
>
> ....
>
> Management of the station were aware the "hydraulics move to the left a little".
>
> ....
>
> I accept the evidence of the coronial investigation and find that the loader defect of turning to the left in a forward motion when the operator's hands are taken off the lever and operator inexperience contributed to the pole falling on the deceased's abdomen.

[10] On 6 February 2014 the Deputy Coroner sent a letter to Ms Kayla Dobson. The letter stated:

> I am writing to you as the potential senior next of kin of Matthew Arena. Please find enclosed a copy of the coronial findings into his death.
>
> My findings were drafted after a thorough coronial investigation was undertaken by Police and I am satisfied the investigation is sufficient for coronial purposes.

> I refer you to s 16 of the *Coroners Act* (attached) which sets out my obligations to advise you of my decision not to hold an inquest.
>
> You may now apply for a death certificate which is available on application to Birth, Deaths and marriages for a fee. ….
>
> ….

[11] Following their receipt of the Reasons for Decision Not to Hold an Inquest, the deceased's next of kin wrote to the second respondent requesting that the applicant be prosecuted.

[12] On 30 January 2015, which was nearly three years after the death of Mr Arena but within one year of the delivery of the Deputy Coroner's Reasons for Decision Not to Hold an Inquest, the second respondent filed a complaint in the Court of Summary Jurisdiction. The complaint pleaded the following.

> S. Kidman and Co Ltd of 183 Archer Street North Adelaide, S.A. 5006 committed the following offence(s):
>
> On 8th day of February 2012
>
> at Helen Springs in the Northern Territory of Australia
>
> 1. Being a person conducting a business or undertaking and having a health and safety duty, failed to comply with that duty which failure exposed an individual namely, Matthew Arena, to a risk of death or serious injury.
>
> Contrary to Section 32 of the *Work Health and Safety (National Uniform Legislation) Act* read with Section 19 of the *Work Health and Safety (National Uniform Legislation) Act*

[13] After the complaint was filed in the Court of Summary Jurisdiction, there was a preliminary hearing of the following issues:

a. Was the complaint issued within time? If not, there was no power to extend time and the complaint would need to be dismissed.

b. Was the complaint so defective as to be rendered invalid and incapable of cure by amendment such that it would need to be dismissed?

[14] At the preliminary hearing, the applicant contended that s 232(1)(b) of the *Work Health and Safety (National Uniform Legislation) Act* did not apply in this case for a number of reasons including, there had been no coronial inquiry or inquest, the Deputy Coroner had not made a report, and it did not appear from the Deputy Coroner's Reasons for Decision not to hold an Inquest that an offence had been committed against the *Work Health and Safety (National Uniform Legislation) Act*. The applicant also argued that the complaint was defective because it did not specify the act/s of omission/s constituting the contravention of s 32 of the Act; nor did the complaint state what the applicant should have done to ensure, so far as is reasonably practicable, the health and safety of the deceased. It was submitted that the complaint failed to set out all of the essential legal elements of the offence and the particular facts and circumstances alleged in this case.

[15] On 14 August 2015 his Honour Lowndes CM delivered his reasons for decision which are the subject of this application. His Honour determined

that the complaint was laid within the limitation period fixed by s 232(1)(b) of the *Work Health and Safety (National Uniform Legislation) Act*; and notwithstanding the complaint was defective it was capable of being amended under s 183 of the *Justices Act* (NT). His Honour made an order allowing the complaint to be amended to include either an allegation or particularisation of the act or omission, or act or omissions, constituting the contravention of s 32 of *Work Health and Safety (National Uniform Legislation) Act*.

The issues

[16] The main issues are as follows.

(1) Was the Chief Magistrate correct in deciding that s 232(1)(b) of the *Work Health and Safety (National Uniform Legislation) Act* applied to fix the limitation period for prosecuting the applicant for an offence contrary to s 32 of the Act?

(2) Is the complaint filed in the Court of Summary Jurisdiction defective?

(3) If the complaint is defective, could it be amended after the limitation period fixed by s 232(1)(b) of the *Work Health and Safety (National Uniform Legislation) Act* had expired?

[17] The respondent did not argue that if his Honour the Chief Magistrate erred in determining any of these issues, the errors did not amount to a jurisdictional issue and were not amenable to judicial review in any event.

[18] In my opinion, the answer to question (1) is yes. The answer to question (2) is no. As to question (3), the applicant is entitled to particulars of the specific grounds on which it is alleged to have failed to ensure, so far as was reasonably practicable, the health and safety of Mr Arena and such particulars may be provided after the expire of the limitation period. The application should be dismissed.

***Work Health and Safety (National Uniform Legislation) Act* (NT)**

[19] The *Work Health and Safety (National Uniform Legislation) Act* commenced on 1 January 2012. The main object of the Act is to provide for a balanced and nationally consistent framework to secure the health and safety of workers and work places. This is principally achieved under the Act by imposing health and safety duties on persons conducting businesses and undertakings, making it a strict liability offence for a person to fail to comply with a health and safety duty, providing mechanisms for securing compliance with health and safety duties, establishing a regulator and empowering the regulator and the Director of Public Prosecutions to prosecute persons for breaches of health and safety duties.

[20] A 'health and safety duty' means a duty imposed under divisions 2, 3 and 4 of Part 2 of the *Work Health and Safety (National Uniform Legislation) Act*

which contain sections 19 to 29 of the Act. Section 19 of the Act imposes two primary duties of care on a person conducting a business or undertaking. Sections 20 to 26 of the Act impose further and more specific health and safety duties on a person conducting a business or undertaking and sections 27 to 29 of the Act impose health and safety duties on other persons.

[21] Each duty imposed on a person conducting a business or undertaking requires the person to ensure, so far as is reasonably practical, the health and safety of workers or other persons in various situations. What is *reasonably practicable* in ensuring health and safety is specified in s 18 of the *Work Health and Safety (National Uniform Legislation) Act*.

[22] Section 18 states:

> In this Act:
>
> ***reasonably practicable***, in relation to a duty to ensure health and safety, means 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.

[23] For the purposes of this proceeding the relevant duty imposed on the applicant is one of the two duties imposed on a person conducting a business or undertaking by s 19 of the *Work Health and Safety (National Uniform Legislation) Act*, which is in Division 2 of Part 2. The two duties imposed by s 19 are: (1) a duty owed to two classes of workers while the workers are at work in the business or undertaking; and (2) a duty to other persons. It is the duty imposed by s 19(1)(a) in conjunction with s 19(3)(b)(c) and (f) of the Act on the applicant that is the relevant duty.

[24] Section 19 states:

(1) A person conducting a business or undertaking must ensure, so far as is reasonably practicable, the health and safety of:

(a) workers engaged, or caused to be engaged, by the person; and

(b) 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.

(2) A person conducting a business or undertaking must ensure, so far as is reasonably practicable, that the health and safety of other persons is not put at risk from work carried out as part of the conduct of the business or undertaking.

(3) Without limiting subsections (1) and (2), a person conducting a business or undertaking must ensure, so far as is reasonably practicable:

(a) the provision and maintenance of a work environment without risks to health and safety; and

(b) the provision and maintenance of safe plant and structures; and

(c) the provision and maintenance of safe systems of work; and

(d) the safe use, handling and storage of plant, structures and substances; and

(e) the provision of adequate facilities for the welfare at work of workers in carrying out work for the business or undertaking, including ensuring access to those facilities; and

(f) the provision of any information, training, instruction or supervision that is necessary to protect all persons from risks to their health and safety arising from work carried out as part of the conduct of the business or undertaking; and

(g) that the health of workers and the conditions at the workplace are monitored for the purpose of preventing illness or injury of workers arising from the conduct of the business or undertaking.

(4) If:

(a) a worker occupies accommodation that is owned by, or under the management or control of, the person conducting the business or undertaking; and

(b) the occupancy is necessary for the purposes of the worker's engagement because other accommodation is not reasonably available;

the person conducting the business or undertaking must, so far as is reasonably practicable, maintain the premises so that the worker occupying the premises is not exposed to risks to health and safety.

(5) A self-employed person must ensure, so far as is reasonably practicable, his or her own health and safety while at work.

[25] The health and safety duty imposed by s 19(1)(a) is imposed on a person conducting a business or undertaking. The duty is owed by the person to workers engaged or caused to be engaged by the person. The duty applies while the worker is at work in the business or undertaking. So far as is reasonably practicable, the person is required to ensure the provision and maintenance of safe plant to such workers while they are at work in the business or undertaking, provide safe systems of work and provide information, training, instruction or supervision that is necessary to protect all persons from risks to their health and safety arising from work carried out as part of the business or undertaking.

[26] Division 5 of Part 2 of the *Work Health and Safety (National Uniform Legislation) Act* creates three categories of offences, category 1 being the most serious offences and category 3 being the least serious offences. Category 1 offences involve recklessness and a risk of death or serious

injury or illness. Category 2 offences involve a risk of death or serious injury or illness and category 3 offences simply involve a failure to comply with a health and safety duty.

[27] The relevant section for this proceeding is s 32 of the *Work Health and Safety (National Uniform Legislation) Act.* Section 32 states:

> A person commits a ***Category 2 offence*** if:
>
> (a) the person has a health and safety duty; and
>
> (b) the person fails to comply with that duty; and
>
> (c) the failure exposes an individual to a risk of death or serious injury or illness.
>
> Maximum penalty:
>
> (a) in the case of an offence committed by an individual (other than as a person conducting a business or undertaking or as an officer of a person conducting a business or undertaking) – $150,000; or
>
> (b) in the case of an offence committed by an individual as a person conducting a business or undertaking or as an officer of a person conducting a business or undertaking – $300,000; or
>
> (c) in the case of an offence committed by a body corporate – $1,500,000.

[28] Subsection 230(4) of the *Work Health and Safety (National Uniform Legislation) Act* recognises the capacity of the second respondent to bring a prosecution for an offence against the Act.

The limitation period – Subsection 232(1)(b) of the *Work Health and Safety (National Uniform Legislation) Act*

[29] Section 232 of the *Work Health and Safety (National Uniform Legislation) Act* fixes certain limitation periods for commencing a prosecution for an offence against the Act. Section 232(1)(b) of *Work Health and Safety (National Uniform Legislation) Act* states:

> (1) Proceedings for an offence against this Act may be brought within the latest of the following periods to occur:
>
> (a) ….
>
> (b) within 1 year after a coronial report was made or a coronial inquiry or inquest ended, if it appeared from the report or the proceedings at the inquiry or inquest that an offence had been committed against this Act;
>
> (c) ….

[30] The *Work Health and Safety (National Uniform Legislation) Act* does not contain a definition of a 'coronial report' or 'coronial inquiry or inquest'. Nor does the *Coroners Act*. There are only two sections in the *Coroners Act* which contain the word 'inquiry', s 44 and s 49. Section 44 deals with the Supreme Court's powers to make an order to reopen a coronial inquest and to order a new coronial inquest. Section 49 is a transitional provision. However, the *Coroners Act* makes a distinction between an investigation and an inquest and contains detailed provisions dealing with the coroner's powers of investigation and powers at an inquest. A coroner has jurisdiction to investigate a death if it appears to the coroner that the death is or may be

a reportable death;[1] and a coroner who has jurisdiction to investigate a death, other than a death in custody, may hold an inquest as the coroner thinks fit.[2] A coroner must hold an inquest where there has been a death in custody. Under s 26 of the *Coroners Act* a coroner must investigate and report on the care, supervision and treatment of a person while being held in custody where there has been a death in custody and may investigate and report on a matter connected with public health or safety or the administration of justice that is relevant to a death in custody. Under s 35 of the *Coroners Act* a coroner may report to the Attorney-General on a death or disaster investigated by the coroner. Under s 16 of the *Coroners Act*, if a coroner who has jurisdiction to hold an inquest into a death makes a decision not to hold an inquest, the coroner must record the decision in writing and specify the reasons for the decision.

Pleading in the Court of Summary Jurisdiction

[31] The pleading of the charge on the complaint in this case is subject to s 22A, s 55 and s 181 of the *Justices Act* (NT).

[32] Section 22A of the *Justices Act* (NT) states:

> (1) Any information, complaint, summons, warrant or other document under this Act in which it is necessary to state the matter charged against any person shall be sufficient if it contains a statement of the specific offence with which the accused person is charged, together with such particulars as are necessary for giving reasonable information as to the nature of the charge.

[1] s 14.
[2] s 15.

(2) The statement of the offence shall describe the offence shortly in ordinary language, avoiding as far as possible the use of technical terms, and without necessarily stating all the essential elements of the offence, and, if the offence charged is one created by any law of the Territory, shall contain a reference to the section of the law of the Territory creating the offence.

(3) After the statement of the offence, necessary particulars of the offence shall be set out in ordinary language, in which the use of technical terms shall not be required.

(4) Any information, complaint, summons, warrant or other document to which this section applies, which is in such form as would have been sufficient in law if this section had not come into force, shall, notwithstanding anything contained in this section, continue to be sufficient in law.

[33] Section 55 of the *Justices Act* states:

> In any complaint and in any proceedings thereon the description of any offence in the words of the Special Act or other document creating the offence, or in similar words, shall be sufficient in law.

[34] Section 181 of the *Justices Act* states:

> It shall be sufficient in any information or complaint, if the information or complaint gives the defendant a reasonably clear and intelligible statement of the offence or matter with which he is charged.

The submissions of the applicant

[35] As to whether the limitation period specified s 232(1)(b) of the *Work Health and Safety (National Uniform Legislation) Act* applied in this case, the applicant submitted the following. The trial magistrate misconstrued s 232(1)(b) and the relevant provisions of the *Coroners Act* by finding that the process involved in the Deputy Coroner determining not to hold an

inquest was a coronial inquiry, a process which ended on 6 February 2014 when the Deputy Coroner recorded her decision not to hold an inquest in writing. There was no coronial inquiry or inquest. The words 'coronial inquiry or inquest' appearing in s 232(1)(b) of the *Work Health and Safety (National Uniform Legislation) Act* require some form of hearing rather than a purely administrative process undertaken on the papers. There was no hearing by the coroner in this case and the decision not to hold an inquest or conduct a hearing of any kind is the antithesis of an inquiry. Further, it does not appear from the proceedings conducted by the Deputy Coroner that an offence was committed. There is no finding of any fault by the applicant in the Reasons for Decision Not to Hold an Inquest. Nor do the reasons suggest that incident resulting in the death of Mr Arena was caused by an offence against the Act.

[36] As to whether the complaint was defective in form, the applicant submitted the following. The Chief Magistrate made a jurisdictional error by finding that "the complaint as laid (with or without reference to s 19 of the Act) addressed all of the essential legal elements of the alleged offence and disclosed the nature of the offence with which the defendant was charged". Further, the applicant submitted that the complaint was duplicitous as it did not differentiate between the duties created by s 19 of the *Work Health and Safety (National Uniform Legislation) Act*. Further still, the complaint did not set out all of the essential legal elements of any such duty as was imposed on the applicant under s 19 of the Act. The complaint did not set

out the particular act, matter or thing that forms the basis of the charge against the applicant and it did not disclose any offence known to the law. Any attempt to now make specific reference to s 19(1)(a) of the Act by particulars or otherwise is impermissible. There can be no amendment of any kind resulting in a fresh charge after the limitation period has expired. Any amendment would now have the effect of commencing a fresh charge.

Consideration

[37] In my opinion, his Honour the Chief Magistrate was correct in finding that the complaint was filed within the limitation period fixed by s 232(1)(b) of the *Work Health and Safety (National Uniform Legislation) Act*. I do not accept the applicant's submissions to the contrary.

[38] Both the Macquarie Dictionary and the Australian Oxford Dictionary state that 'inquiry' means 'an investigation, as into a matter'. The word 'inquiry' covers a wide field. An inquest is a specific kind of formal inquiry. As stated at [30], a coroner in the Northern Territory may conduct either an investigation or an inquest or both into a reportable death of a person. It follows that an investigation conducted with the authority of the coroner in accordance with the *Coroners Act* would be a form of coronial inquiry. A coronial inquest is an inquest conducted with the authority of the coroner in accordance with the *Coroners Act*. For the purposes of s 232(1)(b) of the *Work Health and Safety (National Uniform Legislation) Act* a coronial investigation conducted by the coroner in accordance with the *Coroners Act* would fall within the terms 'coronial inquiry or inquest'.

[39] It is also apparent from comments made by the Deputy Coroner in her Reasons for Decision Not to Hold an Inquest that there was a coronial investigation in this case. Among other things, the Deputy Coroner states, "Following a coronial investigation, in conjunction with an investigation by NT WorkSafe …", and "I accept the evidence of the coronial investigation and find that…". It is also apparent from the affidavit of Mr Luke Holland and the annexures to his affidavit and the letter to Mr Kayla Dobson dated 6 February 2014 that the coronial investigation in this case came to an end on 6 February 2014, when the Deputy Coroner recorded her decision and specified her reasons for not holding an inquest in writing, and that the complaint was filed within 12 months from 6 February 2014.

[40] While the Deputy Coroner's Reasons for Decision Not to Hold an Inquest are not a report but reasons for decision made under a specific provision of the *Coroners Act*, the document still forms part of the proceeding that comprised the coronial inquiry in this case. I accept the respondent's submission that it appears from the Reasons for Decision Not to Hold an Inquest that an offence has been committed. The appearance comes from the specific findings of defective plant, knowledge of the defect and operator inexperience, each of which is capable of forming the basis of an offence under s 32 of the *Work Health and Safety (National Uniform Legislation) Act* in the circumstances of this case. A relevant health and safety duty under the Act and a failure to comply with the relevant duty are readily discernible. The word 'appeared' in s 232(1)(b) of the Act has its ordinary

meaning which is 'to be made clear by evidence'.[3] Further, something may appear at a coronial inquiry even though the same thing may have earlier appeared from other sources that were available to the prosecutor.[4]

[41] Likewise, I do not accept the applicant's submission that the pleading of the charge on the complaint was defective because it is insufficient and duplicitous. The charge is saved by the ameliorating provisions of the *Justices Act*. In accordance with the provisions of the *Justices Act* set out at [31] to [34], the charge contains a sufficient pleading of the essential legal elements of the offence. Further, while s 19 of the *Work Health and Safety (National Uniform Legislation) Act* creates two health and safety duty provisions and a contravention of two or more health and safety duties cannot be charged as a single offence,[5] the pleading of the charge contains such particulars as are necessary to give the applicant reasonable information as to the relevant duty which is the duty created by s 19(1)(a) of the Act.

[42] The effect of sections 22A, 55 and 181 of the *Justices Act* is that a charge on a complaint will be sufficiently pleaded if:

1. The description of the offence pleaded is in the words of the Special Act creating the offence, or similar words;

[3] Macquarie Dictionary 5th ed.
[4] *Page v Walco Hoist Rentals Pty Ltd* [1999] 87 IR 286 at 292.
[5] This is made clear by the provisions of s 233(2) of the *Work Health and Safety (National Uniform Legislation) Act.*

2. The pleading of the charge gives the defendant a reasonably clear and intelligible statement of the offence with which the defendant is charged; and

3. The pleading contains a statement of the specific offence with which the defendant is charged, including by reference to the section of the Act creating the offence, together with such particulars as are necessary for giving reasonable information as to the nature of the charge without necessarily stating all the essential elements of the offence.

[43] The offence with which the applicant is charged is an offence contrary to s 32 of the *Work Health and Safety (National Uniform Legislation) Act*. The essential legal elements of such an offence are:

1. The defendant has a health and safety duty;

2. The specific health and safety duty of the defendant;

3. The defendant has failed to comply with the specific health and safety duty; and

4. The defendant's failure to comply with the specific health and safety duty exposed an individual to whom the duty was owed to a risk of death or serious injury or illness.

[44] In the factual matrix of this case, I find that the charge on the complaint gives the applicant a reasonably clear and intelligible description of all of the legally essential elements of the offence in similar words to the words of the section of the Act creating the offence together with such particulars are necessary for giving reasonable information as to the nature of the charge being a failure contrary to s 32 of the *Work Health and Safety (National Uniform Legislation) Act* to comply with the health and safety duty created

by s 19(1)(a) of the Act. There is no dispute between the parties that (1) the applicant was carrying out a business or undertaking, (2) Mr Arena was employed by the applicant, and (3) on 8 February 2012 Mr Arena was killed while at work in the applicant's business or undertaking. So much is made clear from paragraphs 1 to 4 of the applicant's outline of written submissions. The particulars of the date on which the incident occurred, the place where the incident occurred, the name of the person who was exposed to risk, the pleading that the applicant was conducting a business or undertaking and had a health and safety duty, and the reference to sections 32 and 19 of the *Work Health and Safety (National Uniform Legislation) Act* amounts to compliance with the pleading provisions of the *Justices Act*.

[45] While the applicant is entitled to particulars of the specific grounds on which it allegedly failed to ensure, so far as was reasonably practicable, the health and safety of Mr Arena, the failure to plead those particulars in the complaint does not mean that the complaint is invalid or that it fails to plead the essential legal elements of the relevant offence. Those particulars have now been provided to the applicant.

[46] The decision of *Kirk v Industrial Court of New South Wales*[6] is distinguishable from this case. That was a case in which the particulars of the specific grounds on which it was alleged the defendant failed to ensure compliance with the relevant duty were never provided.

[6] (2010) 239 CLR 531.

Conclusion

[47] In the circumstances, the application for judicial review is dismissed. I will hear the parties further as to costs.
