IN THE COUNTY COURT OF VICTORIA
AT MELBOURNE
CRIMINAL DIVISION

Revised
Not Restricted
Suitable for Publication

Case No. CR-21-01338
Indictment No. L12409540

DIRECTOR OF PUBLIC PROSECUTIONS

v

MARSHALL LETHLEAN INDUSTRIES PTY LTD
(A.C.N. 124 965 582)

JUDGE:	HIS HONOUR JUDGE TRAPNELL
WHERE HELD:	Melbourne
DATE OF HEARING:	1 March 2022
DATE OF SENTENCE:	24 June 2022
CASE MAY BE CITED AS:	DPP v Marshall Lethlean Industries Pty Ltd
MEDIUM NEUTRAL CITATION:	[2022] VCC 945

REASONS FOR SENTENCE

Subject:	CRIMINAL LAW - Sentencing
Catchwords:	Failure of a person who has management or control to ensure that the workplace is safe and without risks to health – Serious and multiple failures to observe safety procedures – Risk of catastrophic injury or death high and readily foreseeable – Asphyxiation caused by argon gas leak from welder left in confined space overnight – Serious example of offending – General deterrence, denunciation and just punishment given substantial weight – Early plea of guilty – Remorse – Cooperation with WorkSafe investigation – Significant effort put into remedial procedures
Legislation Cited:	*Occupational Health and Safety Act 2004* ss 2(1)(a), 2(1)(b), 4(2), 20(2)(a), 26(1),
Cases Cited:	*DPP v Amcor Packaging Pty Ltd* (‘*Amcor Packaging*’) (2005) 11 VR 557 - *DPP v Frewstal Pty Ltd* (‘*Frewstal*’) (2015) 47 VR 660 - *DPP v Vibro-Pile (Aust) Pty Ltd* (2016) 49 VR 676
Sentence:	Marshall Lethlean Industries Pty Ltd convicted and fined $600,000

APPEARANCES:	Counsel	Solicitors
For the DPP	Ms S J Keating	Ms A Hogan, Solicitor for Public Prosecutions
For the Accused	Mr S T Russell	Holding Redlich

HIS HONOUR:

1 Marshall Lethlean Industries Pty Ltd (A.C.N. 124 965 582) ('the Company'), by its authorised representative, Mr Guopeng (Sven) Liao, has pleaded guilty to an indictment alleging one charge of failure of a person who has management or control to ensure that the workplace is safe and without risks to health.[1]

2 The maximum penalty for this offence is 9000 penalty units where the accused is a corporation. This equates to a maximum penalty of $1,450,710.[2]

The Facts

3 The prosecution filed a summary of prosecution opening dated 7 February 2022,[3] which the Company's counsel told me I can treat as a statement of agreed facts. I have supplemented this by adding non-controversial facts provided by the Company's counsel during the plea hearing.

Overview

4 The Company manufactures and supplies liquid and dry bulk road tankers and employs approximately 40 to 50 workers on the factory floor.

5 Labour hire company, Australian Industry Group Training Services Pty Ltd ('AIGTS') employed Xi Lei Wu, the deceased, as an engineering fabrication apprentice and trainee welder. He commenced a placement at the Company on 24 September 2018.

6 At the time of his death, Mr Wu was 20 years of age. He was a trainee welder and did not have a trade qualification. As part of his employment with AIGTS, he was enrolled in an apprenticeship with Chisholm Institute to complete a Certificate III in Engineering Fabrication. He was completing the practical components of this apprenticeship at the Company

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1 Contrary to s 26(1) of the *Occupational Health and Safety Act 2004*.
2 At the time of the commission of the offence in October 2018 a penalty unit was fixed at $161.19 (see *Victoria Government Gazette*, No S 145, 29 March 2018, 1).
3 Exhibit ('Ex') P1.

7 On 4 October 2018, Mr Wu was asked to clean out the inside of a tanker. The tanker had an opening to atmosphere of approximately 2.2 metres in length and 935 millimetres wide making a total opening of 2.06 square metres. The previous day, an employee of the Company had left a Cigweld 400SP welder ('the welder') and a Cigweld SP400G wire feeder ('the wire feeder') inside the tanker. They remained there overnight.

8 The wire feeder had fallen into a state of disrepair. The solenoid valve in it would intermittently become stuck in the 'on' position, allowing argon gas to leak freely through the welder's MIG torch nozzle when it was not in use. As a result of that defect, over which the Company had management and control, argon gas was able to flow into the tanker overnight, reducing the level of oxygen in it.

9 Mr Wu died from asphyxiation after entering the tanker to perform cleaning out work ('the incident'). These circumstances give rise to the breach of s 26(1) of the *Occupational Health and Safety Act 2004* ('*OHSA*') alleged in Charge 1 on the Indictment.

Previous Safety Audit

10 Prior to this incident, on 6 July 2018, Adrian Eagles of Solve Safety Pty Ltd attended the workplace to conduct a safety audit on behalf of Australia Wide Personnel Pty Ltd ('AWP'). AWP is a labour hire company that was engaged by the Company at the time. The Company was in the process of moving from a factory premises in Dandenong to one in Cranbourne West and authorised AWP to conduct a safety audit at the new site. The Company requested Mr Eagles return to conduct another audit in August 2018. Production had recently commenced at the new site but the setup of the new factory was not complete.

11 On 9 August 2018, Mr Eagles returned to the workplace and conducted a further audit. In his further report dated 9 August 2018, Mr Eagles observed the Company had not implemented any of the systems he had proposed and there were no safety or emergency systems in place to protect workers at the site.

12 Following receipt of this further report, the Company approached AI Group Ltd ('AIG') to conduct a more detailed risk assessment at the workplace and provide an action plan designed to address any issues identified. On 29 August 2018, AIG provided the Company with a staged proposal for its consideration.

13 On 24 September 2018, Mr Wu attended the workplace for work. AIGTS provided his labour to the Company as part of a labour hire agreement.

14 Christopher Horsey had been employed by the Company for approximately one year at the time of the incident. On 4 October 2018, he commenced a morning shift at the workplace. He told investigators Mr Wu was allocated the job of cleaning out the tanker, which is typically a first-year apprentice's job. It involves cutting off some brackets and sanding down edges. It does not typically involve welding, unless one cuts into the bulk-head whilst grinding or cutting and has to do what is termed 'a pad weld'. Mr Horsey taught Mr Wu how to do a pad weld inside the tanker, how to clean it out without cutting into the sides and to 'patch up' if needed.

15 According to Mr Horsey, Mr Wu told him he was already competent at welding owing to his previous job. According to Mr Horsey, the cleaning out is a task that is done without supervision and gas detectors. There is generally someone around to help when needed. Mr Horsey uses a respirator when welding.

16 The system for the cleaning task and patching has always been the same in that one works alone without a spotter. He was not aware of any written procedures for any of the tasks at this workplace. Mr Horsey was aware that the tanker Mr Wu was working in had a 'feeder' section in one of the compartments because he could see the cables from the main welding unit leading into the tanker.

17 The welders were connected to argon gas mains systems, located on a main pillar near the area they were working in. Mr Horsey was not aware of any instructions regarding the use of the argon gas supply system, including whether the gas should be closed off at the main supply point at the end of the job.

18 Jordan Field, an apprentice boiler maker, had been working at the Company for approximately one year at the time of the incident. On 3 October 2018, he was inside the tanker using the welder. He left the welder inside the tank so that he could continue using it the following day if required. He did not turn the gas off at the main supply point overnight and he believed it would have been on from the night before.

19 On 4 October 2018, Mr Field arrived at work just before 7am and spoke with Kim Walton, a team leader, and Mr Horsey. He was briefed by both of them on the jobs to be done. He was asked to clean out the tank. Mr Field said he 'hand balled' this job to Mr Wu. He wasn't sure whether Mr Wu had done a job like this before.

20 To perform the cleaning work, workers would descend into an internal compartment of the tank from a ladder attached to the combing rail or bulkhead. The number of compartments in each tanker varied between four and ten and the gap between the compartments' bulkheads varied between 1 and 2.5 metres.

21 The cleaning out task requires workers to take off the hinges that are used to pull the cylinder together, making up the tank, with an air grinder from inside of the tank. Each piece that is ground off is on the bulkheads. Workers would use the circular air grinder and cut off the brackets then use the grinder to smooth the tank and then 'go over it' with an orbital air sander, then do the same in the next compartment.

22 A welder is used inside the tank in the event the tank wall is nicked in the grinding off process. There is then a need to weld the inside of the tank to cover the nick. As far as Mr Field was aware, the only other time Mr Wu had been inside a tank was with him two days before the incident. Mr Wu was not welding on that occasion.

23 According to Mr Field, the welder had been left inside the tank from when he had previously been welding there. He believed the gas supply would have been left

on from the night before the incident. He did not think welders are routinely checked, 'if they work then they are used if they stop working then we check them,' he said. The Company practice was to send welders needing repair to a welder supply and repair store. The Company had not engaged a qualified welding inspector to routinely inspect and maintain its welding equipment.

The Incident

24 On the morning of 4 October 2018 at around 8.55am, the 'smoko' bell sounded. Mr Field walked over to the tanker where Mr Wu had been working. He kicked it to let Mr Wu know that it was time for smoko. He then sat down and looked at his phone. At around 9.10am the smoko bell went off again to let workers know smoko was over. Mr Field had not seen Mr Wu but observed that as he was a 'quiet kid' he did not think anything of it. Mr Field went back to the work he was doing.

25 According to Matthew Ryan, a boilermaker welder, the incident must have occurred at about 9.30am just after smoko finished. He was working on his tanker when Jack Beard, another boilermaker welder, was alerted to Mr Walton yelling. Mr Ryan went over to Mr Walton who told him that Mr Wu had 'gone down' in the tank, meaning he had fainted or was concussed.

26 Mr Walton got in to see if Mr Wu was alright. Mr Ryan went to get a harness and when he returned, he saw Mr Beard and Mr Walton inside the tank attempting to lift out Mr Wu. Christian Cortina, the Company's production manager, was present by this stage. Mr Walton and Mr Beard were struggling to lift Mr Wu out and appeared exhausted.

27 Mr Ryan then also went down into the tank and checked Mr Wu's pulse and noted that he looked blue in the lips and pale in the face. Mr Ryan began to feel dizzy, light-headed and started shaking. Mr Beard and Mr Ryan got the gas detector from about five metres away from where he had been working. They tested the atmosphere in the tanker. The meter returned a reading for very low levels of oxygen in the tank.

28 Mr Walton and Mr Cortina were still inside the tank trying to extract Mr Wu at this point. Mr Ryan later told investigators that at this stage, ‘our procedure kicked into my mind’ which is to cut a side panel out of the tank to remove Mr Wu and to allow airflow. According to Mr Ryan, it had been ‘a good five to ten minutes’ since Mr Walton had raised the alarm. Mr Walton and Mr Cortina were still inside the tank.

29 Mr Ryan went with Mr Beard to obtain an extraction fan from the same place the gas detectors were located, about 10 to 15 metres away. Other workers assisted to get the fan to the top of the tank to force air into it.

30 Mr Walton and Mr Cortina placed Mr Wu in the harness whilst a crane was brought over to hoist him out. Mr Wu was lowered to the ground outside the tank. Mr Walton and Nigel Dryden performed CPR on Mr Wu. Mr Dryden went to find the defibrillator. Emergency Services arrived within about five minutes after Mr Wu was extracted from the tank. Mr Wu died at the scene.

31 In relation to the cause of the incident, Mr Ryan told investigators:

> The wire feeder that is inside the compartment would have the wire spool, as well as power and argon gas line connected to it. If connections are loose or there is a crack in the hose there is potential for the argon gas to leak out. When we were located at the Dandenong facility around two months ago, the wrapping area which is where the incident happened, they had a swing arm that would go over the tank. The wire feeder was attached to the swing arm and was above the tank being worked on. I would say this is a safer way of doing this task, because all your gas connections are outside the tank. If there was any chance of gases leaking, they wouldn’t go inside in the tank. Argon depletes the oxygen, this is used to get rid of the oxygen to create a good weld. At Dandenong where applicable we had the extraction fan to put in fresh air or take out the fumes.
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> We have all sort of moved in to Cranbourne West facility during the last six months. Things are sort of put everywhere and not fully functional because we are still in the process of setting up this workshop, while trying to do production. The extractor and the swing arm in [Mr Wu’s] area were not in place.

WorkSafe Investigation

32 On 4 October 2018 at 10.15am, WorkSafe Inspector Michael Devlin received a call from WorkSafe to attend the workplace in relation to the incident.

33 As part of the investigation, Delta V was requested to attend as was Melbourne Testing Services Pty Ltd ('MTS'). Mr Carey Arthurson of MTS attended the Company's premises, inspected the tanker and transported the welder to his workshop for testing.

34 On 3 September 2019, the Informant invited the Company to participate in a record of interview. On 19 September 2019, the Company declining the invitation.

Expert Evidence

35 In the course of the investigation, the Informant obtained an expert opinion from MTS on the condition of the welder and wire feeder and the service history of the welder and wire feeder.

36 The MTS Report notes that in typical welding operations, pressing the MIG torch trigger acts as a switch to allow gas to flow from the gas supply through the torch nozzle, shielding the molten weld from oxygen. Pressing the trigger also energises the welding wire facilitating the electrical arc, allowing the welder to commence welding. In the event the MIG torch trigger was stuck in the depressed position, inert gas flow would be expected.

37 The trigger on the MIG torch in this case was tested. It was manipulated numerous times by pushing in, pulling out and moving it laterally in an attempt to stop the flow of gas. However, despite this manipulation, gas continued to flow from the MIG torch nozzle whilst the gas bottle's valve was open. Moreover, despite actuating the MIG torch trigger on numerous occasions, no clicking sounds typically produced by an operative gas solenoid valve were observed.

38 A gas solenoid valve is an electromechanical device that controls the flow of a gas or fluid. In the case of the wire feeder under examination, the gas solenoid valve is electronically operated when the welding unit is powered and the MIG torch trigger is pressed. The trigger actuates the solenoid allowing gas to flow through the valve. During typical welding operations, the trigger switch must remain

depressed to allow gas to flow. As soon as the trigger is released, the solenoid valve is closed, stopping the flow of gas. The wire feeder examined had the gas solenoid valve positioned inside the right-hand side removable panel.

39 In summary, the MTS Report concluded that the gas solenoid valve fitted to the wire feeder had become stuck or jammed in the open position. Argon welding gas was able to flow from the open gas valve, discharging into the atmosphere through the MIG Torch.

Guidance Material at the Time of the Incident

40 Safe Work Australia's Welding Processes: Code of Practice (May 2018) at part 4.3, titled 'Maintenance of Equipment', states the following which was or ought to have been known by the Company:

(a) You must ensure any equipment used in welding is adequately maintained.

(b) Electrical equipment such as power sources, generators and welding machines and devices like ventilation systems and equipment must be properly installed, maintained, repaired, and tested.

(c) Equipment used with compressed gases, including regulators, must be properly maintained to prevent hazards such as gas leaks.

Victim Impact

41 Mr Wu's family did not attend the plea hearing, however a victim impact statement written by Mr Wu's father, Xiancong Wu, was tendered and read aloud by the prosecutor.[4]

42 Xiancong Wu wrote that his son's death has had a huge impact on their family. His son's image often appears in his head, which leads him to make mistakes at work. His wife stopped working because of their son's death. Their son's girlfriend was pregnant at the time of his death and has since had an abortion.

[4] Ex P2.

Offence Seriousness

43 The seriousness with which the legislature, on behalf of the Victorian community, views this offence is reflected in the maximum penalty of 9000 penalty units equivalent to a maximum fine exceeding $1.45 million.[5]

44 General deterrence is of considerable significance in offences of this kind.[6] Securing health and safety and eliminating or reducing risks so far as is reasonably practicable must be a paramount concern of all entities which have the management and control of workplaces. This is particularly the case where the potential risks to health and safety include the risk of death or serious injury, as was the case here.

45 In my opinion, a strong message needs to be sent to companies which place employees and others in highly dangerous situations, such as was the case here, that they must do their utmost to ensure the safety of those persons. If they do not meet their obligations in this regard, then they should know that they will be met with strong punishment.

46 The *OHSA* imposes a number of duties on people involved in work and workplaces. Those duties are to be interpreted in the light of the objects of the *OHSA* set out in s 2(1) of the Act and the 'principles of health and safety protection' set out in s 4 of the Act. Of particular relevance in the present case is the principle that '[p]ersons who control or manage matters that give rise or may give rise to risks to health and safety are responsible for eliminating or reducing those risks so far as reasonably practicable'.[7]

47 In *DPP v Frewstal Pty Ltd* ('*Frewstal*') the Court of Appeal laid down a number of principles as a source of guidance for sentencing judges regarding the relevant

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5 See *DPP v Vibro-Pile (Aust) Pty Ltd* (2016) 49 VR 676, 730 [233] (Maxwell P, Redlich and Whelan JJA) ('*Vibro-Pile*').
6 Ibid; *DPP v Amcor Packaging Australia Pty Ltd* (2015) 11 VR 557, 565 [36] (Vincent, Eames and Nettle JJA) ('*Amcor Packaging*').
7 *OHSA* s 4(2).

sentencing principles to be applied in prosecutions brought under the *OHSA*.[8]

48 The Company is to be punished according to the gravity of the breach of duty owed under the *OHSA*. The gravity of the breach is measured by two factors — the seriousness of the breach itself (that is, the extent to which the Company departed from its statutory duties); and the extent of the risk of death or serious injury which might result from the breach.

49 The assessment of the extent of the risk itself involves consideration of two factors — the likelihood of the occurrence of an event as a result of the breach (such as the event that occurred here) endangering the safety of employees or others; and the potential gravity of the consequence of such an event (in particular, whether there is a risk of death or serious injury).[9] The fact the present incident resulted in the death of Mr Wu is relevant in the sense that it manifests or demonstrates the degree of seriousness of the relevant threat to health or safety resulting from the breach.

50 In *Frewstal*, Maxwell P succinctly summarised the position when he said, 'the touchstone for sentencing is the gravity of the breach of the *OHSA*, not the gravity of the consequence.'[10]

51 In circumstances, as was the case here, where the risk of catastrophic injury or death is high, constant, and readily foreseeable, the term 'so far as is reasonably practicable' must involve the creation of strict, rigorous and comprehensive standards which are then rigorously maintained.

52 In *DPP v Amcor Packaging Pty Ltd*[11] ('*Amcor Packaging*') the Court of Appeal said:

> When determining the appropriate penalty in a case of the breach of a statutory duty imposed for the purpose of protecting the lives and well being of those who may be affected by the breach, the foreseeable potential consequences must be taken into account as it is the avoidance of those consequences which, when

8 (2015) 47 VR 660, 686–87 [127] (Priest and Kaye JJA).
9 See *OHSA* s 20; *Dotmar Epp Pty Ltd v The Queen* [2015] VSCA 241 [22]–[23] (Priest JA, Maxwell P and Kaye JA agreeing).
10 Ibid 671 [48].
11 (2005) 11 VR 557.

> considering the objective seriousness of the offence, constitutes the raison d'être for the establishment of the legislated regime in the first place. To a substantial extent the seriousness of a breach must be assessed by reference to those potential consequences and the measure of evidenced disregard concerning the safety of employees in the circumstances.[12]

53 The primary sentencing consideration is the objective seriousness of the offence. In cases involving a serious breach of the *OHSA*, such as this case, subjective mitigation, such as an early plea of guilty, cooperation with the investigation and subsequent measures taken to improve safety, plays a subsidiary role in determining the appropriate penalty.[13]

54 The Company is charged on the basis that it failed to provide and maintain a safe system of work, that would have reduced or eliminated the risk of asphyxiation by argon gas leak, by failing to:

a. Require a qualified welding inspector to routinely inspect and maintain welding equipment, including power supply units, wire feeder units and all associated hoses and cables to ensure that the plant remained in safe operating condition; and/or

b. Require workers to store the welder and wire feeder outside the tanker when not in use; and/or

c. Require employees and workers to turn off the argon gas main at the end of use.

55 In assessing the objective seriousness of the instant offence it is necessary to determine the extent of the Company's departure from its duty to take reasonable steps to ensure the reduction of risk. That is, what the Company did (the extent to which the duty was satisfied) and did not do (the extent of the Company's departure), to meet the risk of injury or death associated with a gas leak from welding equipment. In this case the Company:

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12 Ibid 565 [35] (Vincent, Eames and Nettle JJA).

13 Ibid quoting *WorkCover Authority of New South Wales (inspector Hopkins) v Profab Industries Pty Ltd* (2000) 49 NSWLR 700, 714 [31] (Wright P, Walton VP and Hungerford J).

a. Routinely used welding equipment in tasks at the workplace, including in relation to the work being performed by the deceased, but had no system in place for routine inspection and maintenance of such equipment.

b. Did not require workers to store the welder and wire feeder outside of the tanker when not in use.

c. Did not require employees and workers to turn off the argon gas main at the end of use, a simple step that would have reduced the risk of an argon gas leak.

56 Where a wire feeder falls into disrepair, and is used in a partially enclosed space, the risk of a gas leak and consequent asphyxiation is obvious and foreseeable.

57 Safe Work Australia's *Welding processes: Code of Practice* (May 2018), which applied at the relevant time, provided that such equipment must be adequately maintained, repaired, and tested, including to prevent hazards such as gas leaks. Accordingly, a reasonable person with management or control of a workplace, ought to have been aware of the risk and ways to eliminate it.[14]

58 It is not contended by the Company it subjected this equipment to routine maintenance and testing and there is no evidence it did.

59 I find, the company took no steps to ensure against the risk of injury or death associated with a gas leak from defective welding equipment. The available steps were accessible, relatively low cost and in the case of turning off the gas main, no cost at all. In my opinion that conduct amounts to evident disregard by the Company for the safety of Mr Wu and others at its workplace.

60 I accept the prosecutor's submission that the Company's departure from its statutory duty is 'comprehensive in this case and complete'. Moreover, the risk of death from the breach was foreseeable and materialised.

[14] See *OHSA* s 20(2)(a).

61 The prosecution submits, and I accept, this is a serious example of this offence having regard to:

(a) The accessible and reasonably practicable means of eliminating or reducing the risk.

(b) The total failure of the Company to take any such steps.

(c) The inherent seriousness of the risk, evidenced by the fatality in this case.

62 I do not accept the Company's characterisation of its offence as being 'mid-range'. That the incident did not occur as a result of a deliberate or intentional act is not at all unusual in cases of this kind. Indeed, had this been the case, it would have been a seriously aggravating feature.

63 Moreover, the Company's accepted 'failure to comply with the SOP and site rules that required the removal of equipment from the tanker and the requirement to turn off the gas' at the end of the shift were, in my opinion, both serious failures to take reasonably practicable steps to secure the health and safety of employees and other persons at work[15] and to eliminate, at the source, risks to health, safety and welfare of employees and other persons at work.[16] Additionally, there was the failure to have an adequate equipment inspection and service procedure in place, otherwise, the welder would not have leaked argon gas in the first place.

64 In my opinion, the fact 'changes' have been made 'to ensure that such an event would not occur again' is not relevant to my assessment of the objective gravity of the offending conduct that did occur.

65 In my opinion, the breach is properly to be categorised as serious and the Company's moral culpability is high. There was a total failure by the Company to establish and maintain a system of work to eliminate or reduce the risk that eventuated. The extent of the risk to health and safety was manifest. Here there were three separate failures which all contributed to the risk which eventuated. If

[15] *OHSA* s 2(1)(a).
[16] *OHSA* s 2(1)(b).

any one of three safety procedures — namely, inspection and servicing of the welder,[17] removal of the welder from the tank overnight[18] or turning off the argon gas flow at the end of the shift[19] — had been observed, the incident would not have happened. Moreover, I accept employees at the workplace were not aware of any safe work procedure for the performance of the task being undertaken by Mr Wu at the time of the incident.[20]

66 Clearly, general deterrence, denunciation and just punishment must be given substantial weight in my instinctive synthesis. I consider specific deterrence and protection of the community need be given very little, if any, weight in this case.

Company Background

67 The Company was founded in 1973 as a family business and was taken over by the CIMC Vehicle Group in 2008. CIMC is a large international group of companies employing 60,000 staff across over 300 companies in several countries.

68 The Company designs and supplies a full range of liquid and dry bulk road tankers and equipment to carry petrol, diesel, chemicals and milk products. It provides tankers to leading logistics companies including the Toll Group and Linfox.

69 The Company employs on average nine full-time factory employees who are assisted by seven full-time casual employees and four office staff.

70 The incident occurred a short time after the Company moved to new, specially designed premises in Cranbourne West. It upgraded plant and equipment at the new premises at a cost in excess of $2.8 million.

71 The incident occurred during a time of transition between the old system and the new system, where the new system had not yet been fully implemented at the new site. Rather than the welding equipment being supported overhead outside the

[17] See in effect Charge 1 particulars 5 and 7(a).
[18] See in effect Charge 1 particulars 6(b) and 7(b)
[19] See in effect Charge 1 particular 7(c).
[20] See Prosecution Opening, dated 7 February 2022 (Ex P1) [8].

tanker, it was placed inside the tanker and left there at the end of the shift. The tanker where the incident occurred had an opening to atmosphere and I was told, and I accept, there had never been a previous incident in connection with the work being carried out within the tanker.

72 The Company apparently had an isolation and tagging policy for faulty or service-due plant and equipment which had been in place since 2013. There was a safe operating procedure in place that required all gas cylinders to be disconnected when not in use. Moreover, Site Rule No. 9 required all welders and mobile equipment to be stored at the end of every shift. There were a number of written safety procedures in place and Mr Wu had been inducted prior to the incident.

73 As a general comment and not meant to be technically relevant to this particular charge, it was indeed unfortunate these procedures were not observed on this occasion and there was inadequate supervision of employees to ensure they were observed.

Mitigating Circumstances

74 The Company pleaded guilty at the earliest opportunity. The plea has significant utilitarian benefit, particularly in the COVID-19 environment.[21] The plea also indicates the Company's acceptance of responsibility for the offending conduct and a willingness to facilitate the course of justice.

75 Moreover, I accept the Company, through its authorised representative, deeply regrets the loss of Mr Wu's life and is remorseful. And the Company has cooperated fully with the WorkCover investigation into the incident.

76 I also accept the Company had no foreknowledge of the welder or the wire feeder being faulty and was not seeking to avoid expenditure by not having a preventative

[21] *Worboyes v The Queen* (2021) 96 MVR 344, 356–7 [22], [34]–[39], [2021] VSCA 169 (Priest, Kaye and T Forrest JJA); *Chenhall v The Queen* [2021] VSCA 175 [29]–[30], [33]–[35] (Priest, Kaye and T Forrest JJA); *Tran v The Queen* [2021] VSCA 278 [59] (Kaye and T Forrest JJA); *Rossi v The Queen* [2021] VSCA 296 [13]–[16], [19] (Priest and T Forrest JJA).

maintenance program.

77 I also accept the Company has made significant changes to its procedures and processes since the incident to ensure a similar tragedy does not happen again. Its employees have been required to undergo training programs and supervision has been increased. Regular safety briefings are conducted with employees. Moreover, the Company has engaged a number of external safety consultants to conduct fortnightly site safety walks to monitor compliance with new and updated safety procedures and to conduct ongoing safety checks and risk management assessments. All welders and ancillary equipment are now independently inspected and serviced at regular intervals.

Application of Sentencing Principles

78 I have had regard to current sentencing practice in relation to the present charge as informed by the decisions of the High Court of Australia in *R v Kilic*[22] and *DPP (Vic) v Dalgliesh (a Pseudonym)*[23] and the Victorian Court of Appeal decision in *DPP v Zhuang*.[24] I have had particular regard to the very helpful written analyses of comparable cases provided by the prosecutor[25] and the Company's counsel.[26]

79 Whilst current sentencing practice is relevant to the sentence I impose on the Company, it is only one of a number of sentencing considerations I must take into account in formulating an appropriate sentence in this case.[27]

80 Moreover, it is always difficult to gauge more than a general yardstick from so-called 'comparable cases', given the wide range of offending conduct that can constitute this offence and the myriad of general circumstances pertaining to individual offenders. Nonetheless, to the extent I have been able to gain any

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22 (2016) 259 CLR 256, 266–8 [21]–[25] (Bell, Gageler, Keane, Nettle and Gordon JJ).
23 (2017) 262 CLR 428 (Kiefel CJ, Bell, Gageler, Keane and Gordon JJ).
24 (2015) 250 A Crim R 282, 292 [30]–[31] (Redlich, Priest and Beach JJA). See also *Williams (a pseudonym) v The Queen* [2021] VSCA 35 [21]–[[25] (Priest and Kyrou JJA) ('*Williams*').
25 *DPP v Fergusson* [2017] VCC 1276 (Judge Cannon) and *DPP v S J & T A Structural Pty Ltd* [2019] VCC 2016 (Judge C Ryan).
26 Accused's Comparable Cases, Exhibit D2.
27 See *DPP (Vic) v Dalgliesh (a Pseudonym)* (2017) 262 CLR 428.

assistance from comparable cases, I have sought to do so in this case.

81 The basic purposes for which a court may impose a sentence are just punishment, deterrence, both specific and general, rehabilitation, denunciation and protection of the community. In sentencing the Company, I must have regard to a range of factors, such as the seriousness of the offence, its culpability for it and its general circumstances.

82 Denunciation, general deterrence and just punishment must be given substantial weight in sentencing the Company for this offence. However, because of the Company's lack of prior convictions, its previous good safety record and the remedial steps it has taken since this tragic incident occurred, I consider very little, if any, weight need be given to specific deterrence or protection of the community.

Mr Liao

On the charge of failure of a person who has management or control to ensure that the workplace is safe and without risks to health, Marshall Lethlean Industries Pty Ltd (ACN 124 965 582) is convicted and fined $600,000. That fine is referred to the Director, Fines Victoria for management and collection.

In accordance with s 6AAA of the *Sentencing Act 1991*, I declare that but for the Company's plea of guilty, I would have sentenced it to be convicted and fined $800,000.

To Mr Wu's family and partner, I want to say on behalf of the Victorian community how tragic the loss of your son and partner is in these circumstances, or any circumstances for that matter. The fine I have imposed on the Company is that which the law properly, in my assessment, lays down for me to impose and obviously it cannot do anything to ameliorate your loss, but I do hope that as a result of this proceeding and the sentencing hearing today there may be some closure for you all.