PARTIES:	GRIFFITHS, Alfred John
	v
	JAYROW HELICOPTERS PTY LTD
TITLE OF COURT:	SUPREME COURT OF THE NORTHERN TERRITORY
JURISDICTION:	APPEAL FROM COURT OF SUMMARY JURISDICTION EXERCISING TERRITORY JURISDICTION
FILE NO:	AS49 OF 1997
DELIVERED:	16 January 1998
HEARING DATES:	2 December 1997
JUDGMENT OF:	MARTIN CJ

CATCHWORDS:

Criminal law and procedure – Appeal and new trial and inquiry after conviction – Appeal against sentence – Breaches of *Work Health Act* – Whether penalty imposed manifestly inadequate – Application of same principles as for an appeal by the Attorney-General or Crown – Failure by respondent to ensure employee properly instructed and trained in accordance with its manuals and systems – Embarking passenger killed instantly by helicopter tail rotor –

Work Health Act 1986 (NT) ss29(1)(b) & (2)(a)(d)(e)
Sentencing Act 1995 (NT) s18

R v Anzac (1987) 50 NTR 6 at 11-12, applied.
TTS Pty Ltd v Griffiths (1991) 105 FLR 255, referred to.

Appeal and new trial and inquiry after conviction – Appeal against sentence – Respondent called upon to meet true case appellant wished to bring against it for first time on appeal – Clear case of doubt jeopardy – Appellate court to guard against injustice to respondent which could arise – Failure of respondent company related only to particular day in question

– No disturbance of penalty on basis Magistrate failed to take into account respondent's alleged criminal conduct extending beyond the day nominated in complaint –

R v Tait and Bartley (1979) 46 FLR 386, applied.
R v Nagas (1995) 5 NTLR 45, applied.

Appeal and new trial and inquiry after conviction – Appeal against sentence – Sentencing principles – Failure in employer's duty leads to a degree of risk to health and safety – More numerous the failures the higher the risk – Assessment of criminal culpability – Personal deterrence – General deterrence.

REPRESENTATION:

Counsel:

Appellant:	Mr T Riley QC with M Ridsdale
Respondent:	Mr D Farquhar

Solicitors:

Appellant:	Morgan Buckley
Respondent:	Poveys

Judgment category classification:	B
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Mar98002

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

No. AS49 of 1997

BETWEEN:

ALFRED JOHN GRIFFITHS
Appellant

AND:

JAYROW HELICOPTERS PTY LTD
Respondent

CORAM: MARTIN CJ.

REASONS FOR JUDGMENT

(Delivered 16 January 1998)

This appeal against sentence is brought by the complainant in proceedings before the Court of Summary Jurisdiction sitting at Alice Springs, in which the respondent as defendant was fined $10,000 in the aggregate (*Sentencing Act* 1995 (NT), s18) upon its pleas of guilty to the following charges arising from events on 10 August 1995 at Yulara:

"**CHARGE NO: 1**

Failed when carrying out the business of providing helicopter scenic flights at Connellan Airport, Yulara, to ensure that the health and safety

of another person was not adversely affected as a result of the work in which the company engaged or any worker was engaged contrary to Section 29(1)(b) of the Work Health Act.

CHARGE NO: 2

Failed to provide and maintain systems of work that are so far as is practicable, safe and without risk to health contrary to Section 29(2)(a) of the Work Health Act.

AND FURTHER did commit an offence in that it did:

CHARGE NO: 3

Failed to provide such information, instructions, training and supervision to a worker as is necessary to enable the worker to perform his work in a manner that is safe without risk to health contrary to Section 29(2)(d) of the Work Health Act.

AND FURTHER did commit an offence in that it did:

CHARGE NO: 4

Fail to ensure that visitors to a work place under its control and management, are aware of the safety requirements relevant to such visitors and that they abide by those requirements contrary to Section (2)(e) of the Work Health Act."

The maximum penalty in each case at the relevant time was $50,000, previously $2,000 and now $125,000. It appears that the prosecutor may have unwittingly misled his Worship as to the maximum penalty, which it was said was only $2,000 in respect of each of the second, third and fourth charges.

The sole ground of appeal is that the penalty is manifestly inadequate. It is common ground that the appeal is to be treated on the same footing as an appeal by the Attorney-General or Crown, the principles applicable being well

settled and affirmed in this jurisdiction in the Court of Criminal Appeal, in, for example, *R v Anzac* (1987) 50 NTR 6 at p11-12 as follows:

> "There is a strong presumption that the sentence imposed is correct, … . The sentence should stand unless this court is satisfied that it was clearly inadequate; the rationale for this approach is explained by Isaacs J in *Whittaker v R* (1928) 41 CLR 230 at 248-9 and in *R v Holder* [1983] 3 NSWLR 245 at 254-5. It is clear that in this appeal, where no definite or specific error on the part of the sentencing judge is alleged, the Attorney-General must show that the exercise by his Honour of his discretionary sentencing power was unsound, that unsoundness being manifest in a sentence and non-parole period which were clearly and obviously (and not just arguably) inadequate; see *Cranssen v R* (1936) 55 CLR 509 at 520. What the Attorney-General must show has been described in various ways: that the sentence was so inadequate to the occasion as to be unreasonable (adapting *Cranssen, supra,* at 520); or that the sentence was so disproportionate to the sentence which the circumstances required as to indicate an error in principle (*R v Prindable* (1979) 23 ALR 665 at 669)."

An appeal court is often assisted by reference to comparable cases, but here there are none in my opinion. Mrs Shepherdson, to whom reference will be made shortly, had been fined $2,000 after trial for a related offence under s31(1) of the *Work Health Act* 1986 (NT), but arising from the same circumstances. That fine amounted to 40% of the maximum penalty then available.

The agreed facts were contained in a précis tendered as exhibit P3. They are:

> "On 10 August 1995, Jayrow Helicopters Pty Ltd were operating a helicopter, registration VH-FHX, at Connellan Airport, Yulara. The helicopter was being used for scenic flights over Ayers Rock and the

Olgas. Jayrow had office facilities within the general aviation area of the terminal where intending passengers assembled before boarding a mini-bus that took them to the helicopter.

At about 14:15 hours the helicopter returned from its fourth trip of the day. To ensure maximum use of the helicopter and a quick turn around of passengers, the helicopter's engine was not stopped during the dis-embarkation of returning passengers and the embarkation of intending passengers.

Jayrow's procedure was for the pilot to throttle the engine back to "ground idle", lock the controls, disable the hydraulic system and then for him to get out of the helicopter to help with the passengers. This left the helicopter's main and tail rotors still spinning whilst passengers were being moved about. This is accepted industry practice provided the passengers are kept under close and constant supervision. The passenger loading doors in use were on the far side of the helicopter in relation to where the mini-bus was parked.

The intending passengers were a group of four elderly female tourists including Madge Leitch. They were brought to the landing area in a mini-bus driven by Ms Kim Shepherdson, manageress of the Company at Yulara. Whilst travelling in the mini-bus, passengers were given a briefing by her which covered the way the intercom headsets worked, how to put their seat belts on and general safety precautions. These safety precautions should have included a warning about the danger of the spinning rotors but it seems it was not given or was mis-understood on this occasion. The passengers could not recall having been so warned when they were asked after the accident.

The helicopter landed at about the same time as the bus drew up with its passengers. The pilot followed company procedure and got out of the helicopter to help with the passengers. The manageress left her intending passengers by the mini-bus and went to the helicopter to help with those passengers leaving. She directed these out-going passengers towards the mini-bus and signalled with her hands for the intending passengers to walk over to the helicopter. She then turned her back to them and went to stand on the far side of the helicopter to talk to the pilot. Neither the pilot nor the manageress could see the intending passengers as they walked from the mini-bus.

One of the passengers, Madge Leitch, left the intending passenger group at some point along this walk between the mini-bus and the helicopter. The other three ladies did not notice her leave the group. Neither the pilot nor the manageress noticed her leave the group. She made her way

to the rear of the helicopter apparently with the intention of being first to reach the loading doors. She ducked under the tail boom just forward of the vertical fin and was struck on the side of the head by the tail rotor. She suffered catastrophic head injuries and died instantly.

The pilot did not realise there was a problem until he felt an unusual vibration pass through the fuselage of the helicopter on which he was leaning. At the same time as he heard a rapid "rat a tat" noise. The manageress saw out of the corner of her eye something splatter at the rear of the helicopter and on looking directly saw one of the intending passengers lying on the ground.

The briefing given by the manageress to the passengers whilst still on the mini-bus seems to have been totally inadequate. This is not to say that they were not briefed but it does suggest that whatever briefing they were given did not achieve its primary purpose. It should be remembered that all the intending passengers had never flown in a helicopter before and perhaps had never even been close to one before. They would have been somewhat excited and anxious and perhaps not ready to listen to any briefing that might delay their fun.

Passengers are not normally left alone to find their way to a helicopter which has its rotors spinning. Those passengers leaving are physically guided to a safe area and those boarding are again physically shepherded from their waiting area to the helicopter. This allows the ground marshal to control where and when passengers move and leaves the passengers in no doubt as to where they are supposed to be. Industry best practice is for the ground marshal to place himself between the danger area and the passenger.

The manageress's training was somewhat sketchy. Although she received training in Cairns regarding escape under water, the only other training she recalled being shown in general passenger comfort type training. She said she had on-going training in Cairns with other pilots but again this seems more to do with operating the helicopter than loading and unloading passengers safely. There was no record of any training apart from the underwater escape training in Cairns.

There was no documentation within the Company Operations Manual that gave specific guidance to either the pilot or crew as to what the Company expected of them in regards to passenger control whilst loading or unloading although some general guidance was given in those sections entitled "Passenger and Crew Briefing" (Ch 310) and "Safety Briefing" (Ch 423.13).

> There was a passenger information card inside the helicopter detailing the do's and don'ts for passengers, similar to that found in commercial aircraft. This card made mention of not going near the rear of the helicopter and had a diagram of a helicopter and the surrounding areas. The areas were marked in red and green – red for no-go areas and green for safe areas. This card was not available to passengers before they boarded and indeed the diagram was of a different type of helicopter.
>
> The tail rotor of the helicopter was virtually invisible whilst it was spinning. To someone who was not aware it was there it would have been invisible. Madge Leitch was not known to have had any previous experience with helicopters and would have been unaware of the tail rotor and the danger it presented. The vertical fin positioned across the disc of the spinning rotor may have confused her into thinking the helicopter was similar to a fixed wing aircraft and that it was safe to move in the area.
>
> She also wore prescription bi-focal sun glasses which may have contributed to her not seeing the tail rotor and the warning sign on the tail boom. The position of the sun, being virtually overhead and in front of her, may also have contributed to this as the glare would have been directed over the top of her glasses."

Those facts were supplemented during the course of submissions on the hearing largely by reference on the part of the respondent to the findings of the Coroner on the inquest relating to the death of Mrs Leitch.

The respondent had failed to ensure that cards explaining the safety requirements to prospective passengers on a helicopter were available. It was normal to have that information available, but the cards upon which it was contained were not available on that particular day. Mrs Shepherdson had not been trained in the importance of the cards. She had failed, contrary to her usual practice, to allocate the front seat in the helicopter to a particular passenger so as to avoid dispute. Had that been done it was unlikely that the

deceased would have taken the course she did. Similarly, Mrs Shepherdson did not follow the company procedure whereby a member of the staff physically escorted passengers to the helicopter door. In this case, Mrs Shepherdson had gone ahead, motioned to the four women to follow her, but then turned away and did not keep them under observation or control. The respondent company had all the appropriate procedures in place, the written instructions to prospective passengers, the prior allocation of the front seat, and the method of escorting passengers to the helicopter, but, on this occasion Mrs Shepherdson did not follow them. Together, those matters made up the essence of the first charge.

The second charge arose from Mrs Shepherdson's parking the bus in which the passengers travelled to the airport in such a position in relation to the waiting helicopter that the prospective passengers had to pass to the opposite side of the helicopter to get to the doors. Had the bus been parked in the correct position, there would have been no need for any of the passengers to go around the helicopter to get to the doors. Mrs Shepherdson was the driver of the bus, and the error occurred because she had not been properly trained, and she mistook markings on the ground as indicating a bus parking area.

As to the third charge, the respondent had operations manuals and written safety instructions which, if followed, may have avoided the accident. The

offence was in the respondent's failure to ensure that Mrs Shepherdson had been properly instructed and trained with reference to the material.

As to the fourth charge, the complaint was that the respondent failed to brief this group of prospective passengers in the safety requirements, in particular, in regard to avoiding the rear of the helicopter. Mrs Shepherdson's evidence was that she had given such a briefing whilst the passengers were on the bus on their way to the airport, but that evidence was contradicted by one or more of the passengers and was not accepted by the Court. The respondent required the briefing to be given, but Mrs Shepherdson did not give it.

The respondent's culpability on all charges was regarded as laying in its reliance on an ill-trained person to implement the safety requirements on that occasion. As so often appears to be the case it was a most unfortunate combination of circumstances which led to the accident and the death of Mrs Leitch, but all to be founded in the single failure of the respondent to ensure that Mrs Shepherdson had been properly instructed and trained in accordance with its manuals and systems. In the course of the proceedings attention was drawn to part of the Coroner's report in which it was said that incidents similar to this are not common; an expert who gave evidence before the inquest stated he was unaware of similar incidents occurring in Australia. That was because the danger of a rotating tail rotor was real and recognised, as was the danger of passengers wandering near the tail rotor, the need to prevent

that happening was appreciated. It was not put as part of the prosecution case that the tail rotor of the helicopter should have been turned off whilst passengers were embarking or disembarking from it.

As to the respondent company, it was incorporated in Victoria in 1965 and commenced operating in the Territory in about 1968. It had two permanent bases in the Territory, at Jabiru and Darwin and others in Western Australia, Queensland and Victoria, its principal work being in the mining and pastoral industries. However, in the two years surrounding the date of the action, it had carried over 7,000 passengers in its operations at Yulara, but has since ceased doing that type of work. It was claimed in submissions before his Worship that the respondent had been in the business involving the use of helicopters for longer than any other company in Australia. It had no prior convictions.

Some limited material was placed before his Worship regarding penalties imposed for failure by employers to maintain a safe working environment for workers (s29(1)(a)), but it is not suggested that that information could have been of any real assistance to the Court by way of indicating an appropriate range of penalty or tariff for the offending in this case. However, it did lead his Worship to enquire of counsel for each party before him as to the range of penalty which would be appropriate. In so doing, his Worship made it clear that the discretion was his, but he sought assistance. Counsel for the

respondent, saying he was speaking as an officer of the Court, suggested $10,000 which his Worship immediately indicated was in the range he had in mind – "… there has to be a significant fine in terms of general deterrence". Counsel for the appellant drew attention to a case in which an appeal against penalty of 75% of the maximum under s29(2)(a) was dismissed as not being excessive by Asche CJ. in *TTS Pty Ltd v Griffiths* (1991) 105 FLR 255. In that case there was an important feature in that the unsafe system, which led to the worker being injured, was found to have been authorised by the defendant company. It provides no guidance for this matter.

His Worship adjourned sentencing until the following day. He briefly reviewed the facts and noted that it was conceded on behalf of the defendant before him that it was operating an:

> "… inherently dangerous and lethal piece of machinery. … I am of the opinion that employers operating such dangerous machinery in and about relaxed and joyful and perhaps not particularly alert tourists, ought to be deterred from being careless in their work practices and arrangements … . Such was not argued against by counsel for the defendant company who apparently, and I accept, are manifestly contrite for their actions which led indirectly to the catastrophic injury to the head of that tourist. They have pleaded guilty to four charges which are particularised and which I won't repeat, but they all concern the work practices and safety of workers and visitors to the workplace … . Apparently the defendant has put into place various safety measures immediately after the accident, was cooperative with the Coroner, did all things one would expect a contrite and responsible employer to do which goes to its credit, and has of course pleaded guilty to the charges."

His Worship erred in adopting what had been said by counsel for the prosecutor as to the maximum penalties for the charges other than the first. They are the same, $50,000. Each of the charges numbered 2, 3 and 4 related to particular instances of the breach alleged against s29(1)(b); that is how it was treated before his Worship and by him. That error, however, does not matter greatly given that the prosecutor before his Worship did not argue against his Worship's early indication that he considered that the principles akin to concurrency in sentencing to imprisonment would be applied to the prospective fines, and his Worship's decision to proceed to fix an aggregate penalty.

His Worship noted that it was not suggested that the respondent had been negligent in the extreme or had deliberately cut corners, but he found that it could have been and should have been more careful, in which case the death may not have occurred. He found the respondent to be a serious and responsible employer and user of helicopters, but that the circumstances giving rise to the charges were a serious breach of its responsibilities. He did not elaborate in what manner they were regarded by him as serious. Without further, his Worship proceeded to again note the seriousness with which the offending was to be regarded, bearing in mind the maximum penalty, and imposed the fine of $10,000 plus victim assistance levies, totalling $80 and ordered the respondent to pay $1,750 costs.

The appellant submits that his Worship fell into error by limiting his consideration of the respondent's culpability to the events immediately preceding the death of Mrs Leitch. It was put to this Court that although the first charge was so limited, the others go beyond that particular incident; it was submitted that the respondent did not have any system to ensure that the health and safety of persons (other than workers) was not adversely affected as a result of the work in which the employer or any worker was engaged as was demonstrated by the failures referred to in the other charges drawn from s29(2). The complainant's case was not put to his Worship in that way. The complaint itself is limited to offences committed on 10 August 1995. The précis of agreed facts was limited to the events of that day involving Mrs Shepherdson. It was not part of the case at first instance that Mrs Shepherdson had previously been responsible for carrying out the duties she undertook on that particular day. All that is shown from the agreed facts is that her training was "somewhat sketchy", but if it had not been anticipated that she would be responsible for looking to the safety of prospective passengers whilst in the vicinity of a helicopter, then there would have been no call for her to have been trained in relation to that matter. It was not suggested that all the employees of the respondent should have received training in that particular task nor that any employee, apart from Mrs Shepherdson, who had been so responsible, had not been properly trained in that task. So far as the agreed facts are concerned, the failure of the company was related only to that particular day. Mrs Shepherdson had been

permitted to undertake the task that day when she had not been trained for it. Certainly the Coroner's report was in evidence before his Worship and his attention drawn to particular parts of it, but in so far as it may have suggested that there had been criminal conduct by the respondent prior to 10 August 1995, it was not charged with any of that and it was not open to his Worship to take those matters into account. They were not relied upon by the prosecutor. The respondent had no need to consider the impact of any allegations such as that in the proceedings before his Worship. To my mind the respondent was being called upon to meet the true case which the appellant wished to bring against it for the first time on the appeal. That is a clear case of double jeopardy of which the appellate courts must be especially aware, and be jealous to guard against given the injustice to the respondent which could arise (see *R v Tait and Bartley* (1979) 46 FLR 386). This and other cases to do with Crown appeals were again recently considered and affirmed in the Court of Criminal Appeal in *R v Nagas* (1995) 5 NTLR 45. I would not disturb the penalty imposed on the basis that his Worship failed to take into account the respondent's alleged criminal conduct extending beyond the day nominated in the complaint.

The other submission by the appellant, however, is not open to the same objection. In essence, it is that his Worship failed to properly take into account the degree of risk to the persons involved and the nature of the injury likely to be sustained if the risk eventuated. The degree of risk is to be

measured by the likelihood of a person's health and safety being adversely affected if the employer fails in its statutory duty. The nature of the injury likely to be sustained is a matter for assessment taking into account the nature of the relevant work in which the employer is engaged. In this case, the degree of risk must be fairly high. All of the standard safety procedures acknowledge it, there is nothing to protect a person from coming into contact with the revolving rear rotor blades other than to ensure that the person does not go anywhere near them. That is why prospective passengers are usually instructed as to the danger and how to avoid it, such as by taking the path to be followed when approaching the doors to a helicopter, that is why the path usually leads directly to the side of the helicopter in which the doors are located, that is why those responsible for the safety of those persons are trained to watch and control them all the time until they are safely on board. People undertaking joy flights are unlikely to be experienced in such things, as his Worship acknowledged, and may well be distracted from a real appreciation of the danger by their excitement and anticipation. Once there is a failure in the employer's duty, there is a degree of risk to health and safety and the more numerous the failures, as in this case, the higher the risk. The nature of the injury likely to be sustained in a case like this needs no comment. The criminal culpability of an employer is to be assessed taking these matters into account along with others which may be relevant in the particular circumstances of the case, and those relating to the particular employer. His Worship's reference to the inherently dangerous and lethal piece of machinery

was a clear indication that he acknowledged the degree of risk and the likely outcome if the risk were not avoided, and his Worship was quite right in considering that employer's operating machinery of that sort must be deterred from being careless in their work practices. No new case is sought to be made out here on that score.

There is little need in this case for personal deterrence as the respondent has ceased operating the type of business which gave rise to the breaches. However, it can not be doubted that an element of personal deterrence is called for in that its continuing operation of helicopters in other industries in the Territory gives rise to an ongoing need for safe work practices in the interests of workers and others. General deterrence looms large. Others who operate businesses which call for the loading and unloading of passengers on and from helicopters must recognise that the risk attendant upon breach of safety procedures and the nature of the consequences likely to follow are such that any breach will in all likelihood be punished severely.

I accept that the penalty of $10,000 was manifestly inadequate. It did not sufficiently recognise the seriousness of the breaches. It is quashed and in lieu thereof a fine of $30,000 is imposed. The other orders as to victims assistance levies and costs remain undisturbed.
