OSHI v Alteo Milling Ltd

2022 IND 38

Cause Number 7/16

In the Industrial Court of Mauritius
(Criminal side)

In the matter of:

OSHI

v.

Alteo Milling Ltd

Judgment

Accused being an employer is charged under Section 5(1) and Section 94(1) (i) (vi) of the Occupational Safety and Health Act 2005 – Act No.28 of 2005 coupled with Section 44(2) of the Interpretation and General Clauses Act with unlawfully failing on or about the 14th day of May 2015 to ensure so far as is reasonably practicable, the safety, health and welfare at work of its employees as a result of which one of its employees namely one Francoise Guy Laval sustained an amputation of his distal phalanx ,left thumb, when he slipped and his left hand got caught between the in running nips created by the chain and the tail drum of the main cane carrier while he was involved in maintenance work of the said main cane carrier at his place of work at Alteo Milling Ltd, Flacq.

The Accused represented by Mr. Richard René in his capacity as Production Manager pleaded not guilty to the information and was assisted by Counsel.

The particulars of the body of the information read as follows:

1. *The risk assessment dated 30 December 2014 was not reviewed as at 14 May 2015.*
2. *No safe work procedure was established for this work in situations where the floor became slippery.*
3. *The in running nips created by the chain and the tail drum of the main cane carrier were not securely fenced.*

The case for the Prosecution rested on the evidence given in Court by Mrs. Poomalay Poinen-Sohoraye in her capacity as Principal Occupational Health and Safety Officer, Mr. Guy Laval Francoise who is the injured employee and Mr. Keshwar Goordyal, his helper as witness.

An accident at work occurred on 14 May 2015 at the main cane carrier section of Alteo Milling Ltd whereby one employee, Mr. Guy Laval Francoise, sustained injuries namely the amputation of his left thumb.

An enquiry was carried out by the Principal Occupational Health and Safety Officer namely Mrs. Poomalay Poinen-Sohoraye. It revealed that at the time of the accident, the injured person was at the back of the main cane carrier and was checking the alignment meaning was ensuring that the extended chain just fitted to that cane carrier was not blocked when passing on the moving tail drum.

While doing so, he suddenly slipped on the floor which was slippery at that time and when he tried to get hold of a support to maintain his equilibrium, he found the tail drum and he inadvertently placed his left hand on that tail drum which kept the main cane carrier in motion and he sustained injury to his left thumb.

There were two drums on the main cane carrier. The head drum was on the front and the tail drum was at the back. She observed that the chain was moving on the outer side of the drums and when that chain came into contact with the said drums, dangerous points were created known as the nip points which were not securely fenced with a cover to prevent access to those dangerous parts. She meant that anyone who came into contact with those nip points could sustain an injury.

She also observed that the place where the extension work was carried out at the back of the main cane carrier, it was an open area with no proper lighting and with water accumulation on the floor. Thus, when it rained heavily, water accumulated on the floor making it slippery and muddy. But she could not say whether the floor was rough or not. She did not go to the place of the accident on the day it happened.

As part of his duty, Mr. Francoise, the injured person, had to ensure that the chain was not blocked while moving on the tail drum by checking the alignment of the chain. To do so, he had to go down the steps along the tail drum.

She stated the following –

1. There was no review done by management of the risk assessment after that extension work. Had management done so, it would have identified the hazards associated with the unguarded or unfenced moving dangerous part created by the in running nips of the chain on the tail drum and necessary action would have been taken to guard that part.

2. Moreover, management would have also identified the importance of providing a mechanism for evacuating the excess water accumulated at the back of the main cane carrier and water would not have accumulated at the time of the accident.

3. Management would have identified the importance of providing sufficient lighting at the back of the main cane carrier and that accident probably would not have occurred.

4. Where the injured person had slipped, there was no support at the locus. A handrail could have been provided as a support which the injured person could have placed his hand as a support to prevent him from slipping.

5. Although the risk assessment presented to her during the enquiry was reviewed, it did not specify that extension work.

The injured person, Mr. Guy Laval Francoise, gave evidence in Court. He was a fitter and had 30 years of experience in his job and had been doing that

specific job for about 10 years and was a team leader of about 7 workers at the material time.

Maintenance work was done during intercrop season each year and the links were removed and fitted again to the chain. While fitting the links on the extended chain, the cover or guard on the tail drum had to be removed. Usually a fitter like him had to walk with his hammer and chisel. The place was safe and secure to work at the material time although the floor was not completely dry as in the morning, another team evacuated all accumulated water by means of an evacuation water pump provided by the Accused for that purpose and he had the power to order the evacuation of water again if necessary. Had the place been guarded or fenced, he would not have been able to do that maintenance work. The place was partly open without a roof so that light came in and he was behind two metal structures supporting the tail drum in the middle. He was wearing special shoes at that time but could not say whether the floor was rough. He said that when he slipped his feet went forward and when he gripped the tail drum with his left hand while the chain was passing on it, his left thumb got caught between the tail drum and the chain meaning between chain links and was amputated. But he was not injured anywhere else not even a scratch. The junior worker closer to him at that time was Mr. Keshwar Goordyal who was on his opposite side.

Mr. Keshwar Goordyal, a helper from his team, deposed to say that he was working on the opposite side of Mr. Francois on the material day. The chain work was completed and it was being tested. The machine, that is, the main cane carrier started running. The chain was moving when Mr. Francoise was trying to disengage a slat linked to the moving chain and then he said he forgot whether it was moving. Subsequently, he heard Mr. Francoise shouting that he slipped and got injured at his left thumb.

The case for the Defence rested on the evidence given by Mr. Yashvin Mungur in his capacity as Safety and Health Officer which is to the following effect.

The risk assessment was being renewed every two years and was not due yet given that there were no significant changes in terms of additional machines or equipment as all remained the same. After the harvest, the chain was dismantled and reassembled as part of the maintenance work being done every year. The extension work was not a major change in the machine meaning the main cane

carrier, as it had to do with yearly common maintenance work and refurbishment. The chain which was, say, originally 5 metres long was already extended by about 4 metres so that it was 9 metres long, but the metal chain links had to be reassembled individually. The tail drum which caused the cane carrier to return was fixed to metal supports called I-beams meaning metal beams which formed a frame for it. An I-beam was a horizontal iron bar of about 1.5 metres high to support the tail drum. Part of the place was in the open so that when it was sunny the place was dry and when it rained, water could get in and it could be accumulated and get muddy. There was a water evacuation pump that was used to remove accumulated water so that there was no risk at that place as the floor was rough and the workers including the injured person were provided with anti-slip shoes.

Furthermore, there was a procedure known as lock out and tag out so that the machine was switched on and off by the electrician and it could not be switched on accidentally by itself. When there was a problem, for example, the chain getting blocked or not properly aligned on the moving tail drum, the machine should be switched off and then the chain being put rightly as part of the lock out and tag out procedure.

There was a guard on the main cane carrier which was removed while the metal links were being fitted to the chain and then being checked when they were moving on the drums as to whether they were blocked or not or aligned or not. It would not have been practicable in order to be able to do that work should the place be fenced or guarded. After that exercise the guard was put back. According to the worker, working opposite Mr. Francoise, Mr. K. Goordyal, he got injured while he was trying to disengage a chain link on the main cane carrier instead of having that cane carrier stopped. Mr. Francoise said that he slipped and when he gripped something viz. the tail drum, his thumb was amputated. According to him, it was not too plausible that he could slip as there was a metal structure surrounding that tail drum and to grip the moving tail drum by his thumb instead of the metal beams. There was at least about 30 centimetres from the tail drum to one metal beam. All the employees wore anti-slip shoes. The version that he found more plausible was that he was trying to disengage a metal link while the cane carrier was moving and that he ought to have asked the electrician to switch off the machine before doing that exercise but he chose a short cut.

I have given due consideration to all the evidence put forward before me and the submissions of learned Counsel for the Accused.

First and foremost, there is no evidence emanating from the Prosecution to justify that an extension of, for example, 4 metres to the chain's original length of 5 metres as part of Accused's maintenance work including refurbishment necessitated a risk assessment exercise. The type of job was not new to the workers for which further training was required as each year the chain was dismantled and then reassembled. The alignment of the chain on the drums was then checked by their experienced team leader when the drums were in motion causing the chain to move on the main cane carrier. There were no added machines or equipment so that it can be inferred that there was a departure from the common practice. Thus, I fail to see how a risk assessment exercise entailing further training to be provided to the workers was called for.

Secondly, it has remained unrebutted that there was a water evacuation pump to remove water accumulation from the floor which could get muddy as the place was partly without a roof. On the material day, the floor where the main cane carrier was found specifically at the tail drum, a team evacuated the water in the morning so that the floor was not completely dry. The injured person who was the team leader with about 10 years of experience in that specific maintenance work, had the power to ask for accumulated water if any to be evacuated from the floor prior to the maintenance work being done by him and his helpers. In fact, Mr. Francoise admitted that he was satisfied with the safety in place at the material time and that he was wearing his special shoes which the Defence called anti-slip shoes provided to the workers and his helmet at that time. It remained unrebutted that there was a guard on the main cane carrier meaning on the head and tail drums but which had to be removed each time for maintenance purposes so that the workers could see clearly where there was any problem which would not have been possible with a guard or fence or hand rail. So, the risks associated with that type of work with or without a fence or handrail or guard had already been assessed.

Finally, neither the enquiring officer who did not go to the place of the accident on the same day, nor the injured person could say whether the floor was rough or not. It has remained unchallenged that the tail drum was supported by a metal frame and that the floor was rough. I find it hard to believe that Mr. Francoise being someone having about 10 years of experience in that specific job as arrogated

by himself, while slipping so that his feet were moving forward and that he could grip with his left hand only, the most dangerous part of that cane carrier namely a moving tail drum to support his full body weight to restore his equilibrium on which the chain was passing so that continuous nip points were created, thus being continuously highly dangerous to him and that he did not sustain any injury to his left hand or to his other left hand fingers at all but only to his left thumb. Furthermore, being a team leader, he would choose not to grip the metal frame for the tail drum at all when he was fully conversant with the place and that he would not have sustained any scratch on his body bearing in mind that the floor was rough. I find it more plausible as Mr. Francoise conceded himself that it was usual for a fitter like him to walk with his hammer and chisel and that as per the version of Mr. K. Goordyal when the facts were fresh in his mind that according to him, he inadvertently tried to disengage a chain link when the chain was in motion and as a result, his left thumb got amputated which is in line with the unsworn version of the Accused and to some extent with the testimony of Mr. K. Goordyal that he had to correct something on the moving chain on the material day after which he heard him shouting in pain. Thus, the testimony of Mr. Francoise is open to doubt.

It is apposite to reproduce Section 5(1) of the Occupational Safety and Health Act 2005 which reads as follows:

> *"**5. General duties of employers***
> *(1) Every employer shall, so far as is reasonably practicable, ensure the safety, health and welfare at work of all its employees."*

For all the reasons given above, I am unable to find that the case for the Prosecution has been proved beyond reasonable doubt in that the Accused had failed so far as was reasonably practicable to ensure the safety, health and welfare at work of all its employees as a result of which Mr. Guy Laval Francoise was injured at his left thumb while he was involved in maintenance work of the said main cane carrier at his place of work. I accordingly dismiss the information against the Accused.

S.D. Bonomally (Mrs.) *(Vice President)*

25.7.22