OSHI v Precigraph Limited

2025 IND 59

Cause Number 143/22

In the Industrial Court of Mauritius
(Criminal side)

In the matter of:

OSHI

v.

Precigraph Limited

Judgment

Accused being an employer is charged under Sections 5(1), 85(1)(a) and 94(1) (i) (vi) of the Occupational Safety and Health Act – Act No.28 of 2005 coupled with section 44(2) of the Interpretation and General Clauses Act- Act 33 of 1974 with unlawfully:

1. failing on or about the seventh day of February 2020 to ensure so far as is reasonable practicable, the safety and health of its employees at work namely one John Laval Roddy Wong Sai Chun who sustained amputation of his right middle and ring fingers terminal phalanges when the blade of a Spine Cutter machine of make Dghongming descended on his fingers while he was removing cartons stuck under the blade of the machine at its place of work at St Vincent de Paul Avenue, Les Pailles.

2. failing to forthwith notify the Director, Occupational Safety and Health by the quickest practicable means of an accident arising out of work which occurred

at its place of work at St Vincent de Paul Avenue, Les Pailles and as a result of which accident one of its employees namely one John Laval Roddy Wong Sai Chun sustained amputation of his right middle and ring fingers terminal phalanges which necessitated his admission into hospital for more than 24 hours.

The Accused's representative, Mr. Medhi Dowlut, in his capacity as Safety and Health Officer has pleaded not guilty to both Counts and has retained the services of Counsel at his trial.

At the very outset, I find it relevant to reproduce section 5(1) of the Occupational Safety and Health Act 2005 (hereinafter referred to as "OSHA") below:

> *"**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 his employees."*

True it is that as per Count one to the information, the words "*so far as is reasonably practicable, (…)"* are not used but *"so far as is reasonable practicable, (…)"*. Given that there is no comma between the words "reasonable" and "practicable", there is nothing to impute that those words have to be construed as two separate elements of the offence (which is unknown to law). But on the contrary, the word "reasonable" necessarily qualifies the word "practicable". In the circumstances, in view of the fact that there is no evidence borne on the record to show that the Accused was in any way misled or prejudiced in the preparation of its defence, I *proprio motu* amend the information so that the word "reasonable" now reads "reasonably" pursuant to Section 73 of the District and Intermediate Courts (Criminal Jurisdiction) Act with the aim of having such a defect in the information cured solely for the purpose of enabling it to tally either with a conviction or an acquittal (*vide* – **Venkiah v R** [1984 MR 62]).

The case for the Prosecution rested on the evidence led by –

(a) Mrs. Kowlessur Jankee in her capacity as Occupational Safety and Health Officer,

(b) the injured employee (Mr. John Laval Roddy Wong Sai Chun) and
(c) Mr. Bablee Ajegen (the Supervisor of the injured employee).

1. Mrs. Kowlessur Jankee in her capacity as Occupational Safety and Health Officer gave evidence in Court.

She enquired into an accident at work which occurred on 7.2.2020 at Precigraph Limited, St Vincent de Paul Avenue, Les Pailles when John Laval Roddy Wong Sai Chun (hereinafter referred to as "Roddy") sustained amputation of his right middle and ring fingers terminal phalanges.

She went to the locus of the accident on 4.3.2020 and on 13.7.2020 and she took a set of six photographs as per Docs. A2 to A4 & A6 and Docs. A1 & A5 respectively. During her enquiry, she recorded a statement from the Accused's duly authorized representative, Mr. Vincent de Labauve D' Arifat, General Manager, under warning on 17.11.2020 (Doc. B). After her enquiry, she drew a report of the accident which she produced (Doc. C). In the course of her enquiry, she secured from the Accused a copy of the risk assessment record dated December 2019 (Doc. D). The report of the Accused's representative (namely that of Mr. Medhi Dowlut) of the accident or dangerous occurrence as per the 13th Schedule of the OSHA was submitted to the Ministry concerned on 11.2.2020 (Doc. E.). A letter from Mr. Medhi Dowlut was produced (Doc. F) wherein it was stated that modifications had been done to the machine concerned to avoid recurrence and needful was going to be done to improve the safety aspects of that machine.

When she called to the locus of the accident, her observations were as follows: -

(a) A fixed guard was installed in that machine which prevented access to the blade (Doc.A6) and also a deviator was installed near the blade (Doc. A4) to prevent accumulation of the cartons near the blade.
(b) Two buttons namely a switch on and off were provided at that machine as well as a lock handle (Doc. A5).

Her enquiry revealed: -

According to Roddy (the injured employee), the fixed guard to restrict access to the blade of the 'spine cutter' machine (Doc. A6) was only installed after the accident,

so that at the time of the accident, there was no guard that prevented access to the descending blade.

Further, when he tried to switch off the machine, it took some time for the machine to switch off completely. That was why when his hand was nearby the blade, it got cut.

To prevent that accident from happening, the descending blade should have been securely fenced to avoid any contact to the dangerous part of the machine. Moreover, the accident which occurred on 7.2.2020 was only notified to the Director, Occupational Safety and Health outside the prescribed delay of 24 hours namely on 11.2.2020.

Under cross-examination, she conceded that for a risk to be prevented, it had to be foreseeable. She could not confirm whether the switch on and off buttons as well as the lock handle were already on the machine at the time of accident.

In relation to Count two, she stated that the term amputation meant the cutting of part of the body which involved bones which had to be severed completely. She could not say whether the bones in the hand of the injured person meaning his phalanges were completely severed as she conceded that she was not qualified to say whether there is a difference between phalanges and a bone. There was no defect in the blade as per her enquiry. The lock handle provided on the machine was used to immediately stop the machine in case of emergencies. She was not informed nor was aware of the fact that one had to turn off the machine and that it was still necessary to use the lock handle to secure the blade completely. The injured person told her that normally to stop the machine, he used only the switch off button. A statement was recorded from the injured person and he was aware that the lock handle was available at the time of the accident.

As per her report (Doc. C), she stated that the injured person had said that he switched off the machine to remove the carton stuck between the blade and the descending table. However, the machine did not stop immediately and the blade descended on his fingers. As per the information, the accident occurred because the blade descended on his fingers. According to the injured person, the fixed guard was only installed after the accident. So, during the accident, there was no guard that prevented access to the descending blade and also when he tried to switch off the

machine, it took some time for the machine to switch off completely. That was why when his hand was nearby the blade, he got cut. Although she agreed that had the injured person used the lock handle provided on the machine, there would have been no accident, she also conceded that had the descending blade been securely fenced to avoid contact to the dangerous part of the machine, the accident could have been prevented. Given that the dangerous part created at the point of contact of the descending blade and the machine table of the spine cutter was accessible at the time of accident on 7.2.2020, the Accused had thus failed to ensure so far as is reasonably practicable the safety at work of its employee namely Roddy.

She agreed that the descending blade of the spine cutter was accessible and according to safe working procedures, the injured person should have locked the machine with a lock handle before accessing the dangerous part. It was after the accident that Accused had securely fenced the dangerous part of the spine cutter and a deviator had been installed near the blade to enable the finished product to slide down the collector and avoid the pieces of carton to accumulate near the blade. Normally only cartons of small size that had the tendency to accumulate near the blade but after installing the deviator, all sizes of carton slid easily. Operators had to remain at the feeding section of the machine only. She accepted that as per the risk assessment made by the Accused in December 2019 (Doc. D), the calibration before operation and the safe distance from the roller, the operator worked at the feeding section and was not exposed to the blade. The delivery section was curved and the cut paper both fell into the curved delivery board. She conceded that there would have been no contact to the blade had the employee followed the procedure. She further agreed that it was not foreseeable for the Accused that the employee would firstly not make use of safety features on the machine and secondly would leave the feeding section and put his hand near the blade.

As regards Count two, the accident occurred on a Friday afternoon. Given that the injury sustained by the injured person is listed under the Eleventh Schedule of the Occupational Safety and Health Act – Act No.28 of 2005, the accused employer should have forthwith notified the Director of Occupational Safety and Health of the accident by the quickest practicable means, that is, either by phone or by calling in person at the office or by email or by fax and also should have within 7 days sent a report of the accident set out in the Thirteenth Schedule of the OSHA to the said Director of Occupational Safety and Health.

2. <u>The injured person, Mr. John Laval Roddy Wong Sai Chun gave evidence in Court.</u>

He stated that at the time of the accident, he was working as Assistant Operator on the machine concerned for the Accused and had been doing so for about four years at that time. He was given training to work on that machine by his Operator, Mr. Bablee Ajegen who was his Supervisor at that point in time. There were 3 people needed to work on the machine namely one Operator and 2 Assistants. He was the second person working on that machine till to date. One was at the feeder, that is, where the carton was filled and one at delivery to check everything. There was paper, carton and glue. The cartons were of different sizes depending on the clients for the format to be adopted. There were 3 persons and they decided among themselves who would calibrate the machine for the different sizes and how they would organize the work. On the material day, Mr. Ajegen was instructed to do the work. He was monitoring the back of the carton folded in two. The calibrated carton was supposed to fall in a metal container. There was a switch off button and a lock handle. Both the switch on and off buttons were present. Normally the lock handle was used when there were problems with the carton. On that day, near the delivery section, there were several pieces of carton at the blade and they were going to be stuck near the blade, meaning when they were being cut, they would have remained on the blade with the blade. When the machine was stopped, the blade did not stop immediately. He did not use the lock handle with the speed of the work. He was injured as the machine did not stop completely and when he went to remove the carton, his hand got cut. He knew that he had to use the lock handle which he did not. His Supervisor was informed and he was conveyed to hospital for treatment by two drivers of Accused. They knew that he had to stay at the hospital for more than 24 hours. They inquired about his health about one and a half hours later. They came to see him on the following day at the hospital.

Under cross-examination, he stated that Mr. Ajegen was his Supervisor from whom he received training to operate the machine. He accepted that had he used the lock handle, the blade would not have moved, it would have stopped. On the day the accident happened, he did not use the lock handle. But he ought not be in a hurry and the accident would not have happened. He had to move. He could not remain at the feeding section as he had to move and feed the carton and check and then remain there to continue to feed after having got the dimensions for the quantity. The carton did not fall in the required container on the material day as it was getting

stuck to the blade. Had he used the lock handle, he would not have been cut and the accident would not have happened. The bone was not cut, but his finger tip was and there was a craft of his finger done at a private clinic. Mr. Dowlut came to see him at his place after his discharge. He accepted that had he used the lock handle the blade would have been blocked. He was aware that he did not have to put his hand in the machine while it was turning and that he used the switch off button and that normally he had to remain at the feeding section.

3. Mr. Bablee Ajegen gave evidence in Court.

On 7.2.2020, he was working as Coordinator for Accused. He was responsible for a team, like a Supervisor and there were about 5-6 persons including the injured person. There was a spine cutter machine cutting cartons of 5, 6,8-10 mm and there was a calibration to be done and it was the back of a book. There were several people working as operator on that machine. But on that day, Roddy was working as operator on that machine. The latter was operated by one person and he occupied all its compartments from start to finish. There was no one else working on it on the material day.

The blade went up and down automatically when activated meaning when started. It had to be stopped to be calibrated for the amount of mm for the carton to be cut. But at times, the carton got stuck in the machine. It had to be removed with a tool. He thought on that day, Roddy wrongly stopped the machine as how come his hand went in. He was 3 metres away from him at the time of accident. He did not see how the accident happened. But when his hand was cut, Roddy came towards him telling him that it was cut and he contacted a driver who owned a licence to convey him to the clinic for treatment. Often, carton got stuck in the machine and the machine had to be stopped to remove the stuck carton. The machine just had to be stopped and the carton removed. There was a lock handle, sometimes it was used and sometimes not. As a reflex, they pressed stop to go a bit faster. When the stop button was pressed, it did not stop at the time it needed to, he thought. The machine would have stopped. When the stuck carton was removed from the blade, the latter did not move. There had never been any accident on the machine. After the accident, there was a plastic protective guard installed to prevent the operator from putting his hand down. Now, if a carton was stuck, the machine was allowed to continue to turn and to crush the carton and remove it completely. They did not remove it by using the hands. The blade was accessible since its origin.

Under cross-examination, he stated that there were 2 safety levels to stop the machine. There was the switch off button and if the lock handle was used, it would have blocked the blade. If the Operator had used the lock handle, the blade would not have moved. Normally an Operator had to remain near the feeding section and not at two places at the same time. He provided training to Roddy.

Mr. Medhi Dowlut was the only witness who gave evidence in Court on behalf of the Defence.

He was a health and safety officer for about 10 years on a part time basis. On the material day, Roddy the employee of Accused, was working on a Spine Cutter Machine imported from China by the Accused. The machine was not modified before the accident. It was equipped with a blade, to cut cartons for the frames of books. The carton was to be fed in the feeding section and the machine would have cut it for the specific size of the frame of the book. The Accused was a printing company. The machine was equipped with switch on and off buttons meaning to switch on and off the machine. When the machine was switched off by applying that button, it would not stop immediately but would eventually stop after one or two movements. The Operator had to use the switch off button and then apply the lock handle. The latter would have stopped the blade of the machine completely once activated. As per instructions received Roddy did not use the lock handle on the day of the accident and he was aware of its presence. He was trained by Mr. Ajegen and he knew that by applying the lock handle, the blade would have stopped completely. Had there been any problem, the machine had to be stopped first, the lock handle applied and then to have approached the machine. Given that Roddy did not use the lock handle, there was a movement going on prior to it being stopped completely and Roddy put his hand on the side of the machine. Had he followed the adequate procedures, he would not have been injured. The accident happened at 13.15 hours on 7.2.2020 and he was conveyed to Welkin Clinic. He was informed through a colleague of his that he was admitted at 14.00 - 14.30 hours as he was injured as he got a cut injury and that he had to remain longer for treatment. He had no idea about the extent of the injury. Two days after, he went at Roddy's place to have the document filled by himself namely the 13th Schedule of the OSHA dated 10.2.2020 (Doc. E). On that day, he did not try to contact the Ministry concerned as per Doc. E and the document was sent to that Ministry on 11.2.2020. According to him, he took the necessary precautions to contact that Ministry of the accident and Roddy was still

employed by the Accused. After the accident, a protective guard was put on the machine which was not necessary as the Operator was not supposed to be in a position to have access to the blade. The accident was not foreseeable as the machine was as it was in its original state and the Operator was trained to stop the machine. He was supposed to apply the switch off button and then apply the lock handle. He was not supposed to be in a place where he had access to the blade. He ought to be at the delivery section to see the blade. It could not be foreseen that there was a paper stuck near the blade as normally when the paper was cut, it fell directly in the container and no one had to put his hand near the blade of the machine. The Accused was not responsible for the accident.

Under cross-examination, he stated that the machine was modified after the accident. A guard was introduced to prevent access to the blade as Roddy had put his hand and it had rendered the blade safer as per the law although he was not aware of the contents of the law.

The other Accused's representative did not admit any charge in his out of Court statement given to the enquiring officer as per Doc. B.

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

At this stage, I find it apt to deal with Count two first. As regards Count two, there is no medical certificate produced by the Prosecution to show that the injured person was admitted into hospital for more than 24 hours, because he sustained the amputation of his right middle and ring fingers terminal phalanges which meant that the said fingers were completely severed from the bone or joint. On the contrary, there is a report of the accident involving injury to the said employee (pursuant to the Thirteenth Schedule to the OSHA) emanating from the Accused to the effect that the said Mr. Roddy had no joint or bone severed following the present accident as per Doc. F.

Indeed, the Eleventh Schedule to the Occupational Safety and Health Act 2005 – Act No 28 of 2005 provides:

*"**ELEVENTH SCHEDULE***

[Section 85]

LIST OF INJURIES REQUIRING IMMEDIATE NOTIFICATION

2. Fracture of any bone-

(a) in the arm or wrist, but not a bone in the hand; or

(…)

3. Amputation of –

(b) a finger, thumb or toe, or any part thereof if the joint or bone is completely severed.

10. Any other injury which results in the person injured being admitted into hospital for more than 24 hours."

Thus, the Prosecution has failed to prove that Roddy has sustained injuries of the kind specified in the Eleventh Schedule to the OSHA. Therefore, Count two fails.

As regards Count one, the enquiring officer relied on the version of the injured person namely Roddy who deposed in Court as regards the circumstances of the accident. True it is that he supported the version of the enquiring officer and his Supervisor, that the lock handle was not used all the time and that the switch off button was used. Although the rotating blade would have taken some time to stop completely while descending, it would have stopped eventually. Then, the carton papers between the blade and the descending table could have been removed without the use of the lock handle after the blade had stopped moving completely bearing in mind that there is unrebutted evidence that the blades were in good working order at the material time. Thus, there was no need for the lock handle to be used to stop the machine immediately, as the exposed moving blades of the machine would have stopped after a short while after the switch off button had been turned on. Had his hand been stuck between the descending blade and the descending table, then it would have been an emergency and the lock handle would have been applied. But by remaining near the feeding section, the stuck carton paper would not have reached the delivery section, although it was curved and the cut paper would not have fallen into the curved delivery board had he not put his hand near the blade. That was why after the accident, a deviator was installed to prevent accumulation of the cartons near the blade. Furthermore, the Supervisor stressed that <u>after the accident, there was a plastic protective guard installed to prevent the operator from putting his hand down.</u> He went on to say then that, if a carton was stuck, <u>the workers did not have to remove it by using their hands</u> as the machine was allowed to continue to turn and to crush the carton and remove it completely.

Indeed, as per the risk assessment record dated December 2019, nowhere it is written that the switch off button had to be accompanied by the application of the lock handle. Therefore, it is abundantly clear that it was foreseeable that the lock handle would not be used and that only the switch off button would have sufficed in the present situation so that the machine would have stopped after a short while. The injured person, instead of waiting for the machine to stop completely, thought that by the time he would have put his hand on the dangerous part (meaning the point of contact between the exposed rotating descending blade and the machine table being very accessible in the absence of a fixed protective guard) to remove the stuck cartons, the machine would have stopped completely and which was not the case and was the cause of the accident. The risks of accidents in that manner being caused to like workers are highly foreseeable, as it is unlikely that the worker would have waited indefinitely at the feeding section for the stuck carton to have reached the delivery section bearing in mind that the testimony of the Supervisor remained unrebutted that Roddy was working alone on the machine on the material day and that he was working as Operator for which he received training from him. As clearly illustrated in **Babooram J. v Ministry of Labour** [2013 SCJ 6] at page 2, where emphasis was laid on the fact that *"at work"* is a concept and not a physical location so that the safety, health and welfare of the worker extends to the work and not to the place (in the present situation the place would mean the feeding section) and in that regard the Supreme Court made the following pronouncements in relation to Section 5(1) of the Occupational Safety, Health and Welfare Act (Act No. 34 of 1988)(consolidated in section 5(1) of the Occupational Safety and Health Act 2005) as follows:

"

[8] *In law, the liability of an employer to his employee is not demarcated physically by the area of the ground, floor or surface area where the employee is made to work but by the concept of "at work". The duty is not related to the work-place as such but to the work.*

(…)

[10] *The meaning of "at work" is larger than on site. It includes the provision of a working environment that is safe and without risks to health. It is no defence to state that "My working place is safe. If there are noxious fumes coming from the neighbour that is not my problem." Nor is it a defence to state that "My workplace is safe. If the*

worker falls into a ditch dug just outside my gate, that is the worker's problem." In this sense, "at work" is a concept not a physical location." ***(emphasis added)***

Now as clearly stressed in **The DPP v Flacq United Estates Ltd [2001 SCJ 301]** "(…) *it is not because no serious accident had occurred in the past that a system of work is necessarily compliant with the requirements of the Act"* so that the primary issue for the Court to decide is whether the *"particular system of work"* adopted by the Accused at the material time was safe or not and not whether the injured person was somehow imprudent.

Now given that the dangerous part of the cutting machine became accessible, the accident could have been avoided by providing a protective guard placed on that dangerous part and thus, the working environment could hardly be inferred as being safe and without risks given the unrebutted testimonies of the Supervisor that Roddy was alone working on that machine as operator at the material time and that it was not rarely that carton was stuck at the blade and that of Roddy that he could not stay immobile at the feeding section as he had to calibrate the machine for the number and size of the carton to be cut in order to be able to continue to feed the carton to the spine cutter.

Therefore, the Prosecution has successfully established beyond reasonable doubt that the accident occurred on the material day due to an unsafe system of work adopted by the Accused resulting in injuries being caused to Roddy.

Section 96(6) of the OSHA reads as follows:

> *"**Special provisions as to evidence***
> *(6) In any proceedings for an offence under any provision of this Act consisting of a failure to comply with a duty or requirement to do something so far as is practicable, or so far as is reasonably practicable, or to use practicable means or to take practicable steps to do something, it shall be for the accused to prove that it was not practicable or not reasonably practicable to do more than was in fact done to satisfy the duty or requirement, or that there was no better practicable means or step than was in fact used or taken to satisfy the duty or requirement, as the case may be."(**emphasis added)***

The term *"reasonably practicable"* has been clarified in **Halsbury's Laws of England, (5th Edition) (2020), Vol 52**: **Health and Safety at Work** at **paragraph 382** referred to in **Sinassamy M.A. & Anor v Navitas Holdings Ltd [2021 SCJ 424]** as follows -

*" "Reasonably practicable" is a narrower term than physically possible and implies that a computation be made, before the breach complained of, in which the quantum of risk is placed in one scale and the sacrifice involved in the measures for averting the risk(whether in money, time or trouble) is placed in the other and that, if it be shown that there is a gross disproportion between them, the risk being insignificant in relation to the sacrifice, the person upon whom the obligation is imposed discharges the onus which is upon him. (…) Measures may be practicable which are not reasonably practicable but, nonetheless, 'practicable' means something other than physically possible. The measures must be possible in the light of current knowledge and invention; thus it is impracticable to take precautions against a danger which cannot be known to be in existence, or to take precautions which have not yet been invented, so that the concept of practicability introduces at all events some degree of reason and involves at all events some regard for practice. If a precaution can be taken without practical difficulty, then it is a practicable precaution, notwithstanding that it may occasion some risks to those who take it and even though the risk far outweighs the benefit to be achieved." (***emphasis added***)*

Hence, I hold that the Accused has failed to discharge the burden placed upon it under section 96(6) of the OSHA on a balance of probabilities in the sense that it has failed to prove that it was not reasonably practicable for it to have taken the safety measures before the accident rather than after.

Therefore, in the light of all the reasons given above, I find the Accused guilty as charged in relation to Count one to the information only and Count two is accordingly dismissed.

S.D. Bonomally (Mrs.) *(Vice President)*
20.8.2025