OSHI v ABC Coach Works Limited

2023 IND 80

Cause Number 7/21

In the Industrial Court of Mauritius
(Criminal side)

In the matter of:

OSHI

v.

ABC Coach Works Limited

Judgment

Accused being an employer is charged under Section 5(1) and Section 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 with unlawfully failing on or about the 4th day of September 2017 to ensure so far as is reasonably practicable, the safety and health at work of one of its employees namely one Abdool Nooranee Deenmahomed as a result of which he sustained injury resulting in the amputation of his left fourth and fifth fingers when his left hand was caught in between the in running nips of the middle roller and metal bar passing through the roller of an electric bender machine of unknown model bearing no serial number while he was working on the electric bender machine at its place of work in a workshop situated at Les Guibies, Pailles.

The Accused's authorised representative (by the accused company and to the satisfaction of the Prosecution) pleaded not guilty to the information and was assisted by Counsel.

The case for the Prosecution rested on the evidence given in Court by Mrs. Tina Ramsurrun-Baznauth in her capacity as Occupational Safety and Health Officer, Mr. Nitish Rajiv Abeeluck as Registered Mechanical Engineer, Mr. Abdool Nooranee Deenmahomed as welder and who is the injured employee, Mr. Satydanand Kanaram as foreman and Mr. Jean Christophe Steward Lavigilante as Maintenance Officer. The case for the Defence rested on the evidence given by Mr. Ibrahim Sheik Moortooza in his capacity as Technical Supervisor.

An accident at work occurred on 4 September 2017 in a workshop of Accused at Les Guibies, Pailles whereby Mr. Abdool Nooranee Deenmahomed, welder grade 1 employed by Accused, sustained amputation of his fourth and fifth left hand fingers which were caught and crushed by the in running nip point formed between the middle roller of an electric bender machine and a metal bar passing through the rollers of that machine at its place of work.

An enquiry was carried out by Mrs. T. Ramsurrun-Baznauth in her capacity as Occupational Safety and Health Officer.

On 21.9.2017, she took 3 photographs at the workshop of Accused as per Docs. A1, A2 & A3 and took another photograph on 30.5.2018 as per Doc.B1. She recorded a statement from the representative of the accused company namely Mr. Vinayak Mootoosamy in his capacity as HR Coordinator duly authorized by the said company as per Doc. C under warning as per Doc. D on 23.7.2018 where he denied the charge. On 21.9.2017, she received a copy of the risk assessment emanating from Accused dated 29.8.2016 as per Doc. E. Upon completion of her enquiry, she drew up a report dated 6.2.2019 as per Doc. F.

Her observations in line with her report dated 6.2.2019 as per Doc. F are as follows:

(a) At the time of investigation on 21.9.2017, a workshop was observed in the premises of ABC Coach Works Limited at Les Guibies, Pailles.

(b) An electric bender machine was observed in the workshop and it was the only bender machine found therein. It had no model, no make and no serial number. It was meant to bend metal bars which would be used as bus frames.

(c) It consisted of three rollers/dies which moved in clockwise and anticlockwise directions. Metal bars were passed through the rollers for bending. The different switches namely 'On & Off' and the "forward and reverse" controlling movement (clockwise and anti-clockwise) of the rollers/dies were located on the right side of the machine for the operator while he faced it.

(d) A handwheel was also part of the machine which adjusted the middle roller depending on the degree of bending required.

(e) Mr. Deenmahomed was employed as welder grade 1 by Accused. It was part of his duties to operate that machine located in the workshop of Accused.

(f) At the time of accident, Mr. Deenmahomed was operating the machine to bend a metal bar of 4.2 feet long and 1.5 inches wide and he was wearing his safety gloves provided for that purpose by his accused employer.

(g) While Mr. Deenmahomed was holding the metal bar to make it pass through the rollers of the machine, his glove got entangled in the in running nip point of the middle roller, causing his left hand to get into contact with the in running nip point formed between the middle roller and the metal bar passing through.

(h) He sustained crush injury to his left 4^{th} and 5^{th} fingers, followed by amputation of the fingers.

(i) His left 4^{th} and 5^{th} fingers were crushed by the in running nip point formed between the middle roller of the machine and the metal bar passing through the rollers. The dangerous parts (the in running nip points) of the machine

being operated at the time of accident by Mr. Deenmahomed, were exposed and thus, those dangerous parts were easily accessible.

(j) In order to remove his entangled glove from the middle in running nip point, Mr. Deenmahomed had to press the reverse button found on his right side on the machine itself.

(k) As per the risk assessment submitted by the employer on 21.9.2017 following the accident, no mention was made of that machine which existed and which was frequently used in the workshop.

(l) As remedial action, management had placed a fixed metallic barrier covering the rollers of the machine.

(m) Because its rollers were exposed at time of accident and in running nip points were created when metal bars were passed through them and which were not securely fenced, that gave rise to the possibility for any person in the workshop to easily get access to the dangerous parts of the machine as per Doc. A1.

(n) Had the dangerous parts of the machine been securely fenced, the glove of Mr. Deenmahomed would not have been caught in its in running nip point and he would not have sustained injury.

Under cross-examination, she conceded that she was in charge of the enquiry and was the main investigator. She had no personal knowledge of the circumstances of the accident. She was aware of the report made by Mr. Abeeluck in his capacity as Mechanical Engineer and who had a better understanding than her as to how machines worked. The report of Mr. Abeeluck was made before her report on 15.6.2018 while hers was made on 6.2.2019. She agreed that in his report it was written that "*No handling of the middle section to be done at the middle roller during bending work*" and which was not mentioned in her report although he also worked for the Occupational, Safety and Health Inspectorate and that she was the main Investigator. She investigated into the accident and what her enquiry revealed, she put it in a report and also what she observed. She observed that the in running nip

points which were dangerous parts of the machine were not fenced and which she mentioned therein. Those dangerous parts should have been fenced and the employer failed to do so and that was why a risk assessment was not made on the safety of the machine and such fact was mentioned in her report. She only mentioned what her enquiry revealed. She further admitted that the Accused submitted to her office a document entitled 'procedure for the use of the electric bender machine' and that her office received that document during her enquiry and that she did not bother to mention that in her report nor in her testimony in Court. She admitted that it was an important document to analyse the system of work of Accused and that she did not testify to that effect nor did she mention that document in her report. She admitted that it was relevant and that she should have mentioned therein that there was a written procedure for the use of the machine and which she missed. She further admitted that there was a well-established procedure for the use of the machine among all the employees of the Accused's workshop.

The procedure was as follows:

1. The operator must first insert the metal bar on the first roller, that is, on the first dye on the right when positioned himself in front of the machine.

2. When putting the metal bar on the first roller, he should only hold the end of the metal bar from the right side of the machine.

She admitted that every operator of the machine had been expressly warned of the danger of placing his hands close to the roller. As per Doc. A1, she admitted that there was a handwheel enabling the operator to remove the pressure of the middle roller by lifting that roller so that the purpose of that handwheel as used by the operator was to adjust the pressure exerted by the middle roller namely the middle dye for bending purposes. Therefore, if the metal bar was blocked, the operator could simply release the pressure by lifting the middle roller and the metal bar could be easily inserted in the machine. She admitted that the handwheel was a very important part of the machine because it controlled the middle roller thereby controlling the pressure which was put on the metal bar during bending work. She said that it was a common practice which could be confirmed by the injured person that sometimes when the metal bar got stuck between the rollers, the employees just pushed a little bit with their hands to push it on the other rollers so that it could move instead of using the handwheel. Then, she decided that it was not that they were not

using the handwheel, she was saying that whatever procedure was set, if the rollers were not guarded and were exposed parts, a cloth or a hand could get stuck between the rollers. Even when the handwheel was used, it was still an exposed part and that was why the rollers should have been fenced and should have been mentioned in the risk assessment to know what was the exact problem. However, she accepted that the employees received clear instructions not to put their hands close to the rollers. She also accepted that by using the handwheel, one could simply remove pressure on the metal bar and as Mr. Abeeluck stated himself, there was no need for someone to put his hand on the metal section when the metal bar was already put into the machine. Her enquiry did not reveal that the injured employee received training but that he saw and learnt from other welders and that there was no formal training as such. But his foreman gave him explanations on how to use the machine and there was nothing in writing or a training record to that effect. How the injured person was using the machine, how he was practicing it was all from other welders, other operators how they had been using the machine and he had been using it in the same way. She could not say whether Mr. Deenmahomed started to work for Accused around 25 years ago from whom he received training. But he was experienced in using the machine. She admitted that her report was a central document for the Prosecution. The central reproach to the Accused was that the in running nip point when the machine was in operation was not protected by a guard or fence. A grid was put around the rollers. She could not say whether should the rollers be fenced, it would have been impossible to bend the metal bars at some bending angles. So, there were no risk assessment and no fence on the in running nips created when the machine was in operation. She took a statement from Mr. Tilloo who was doing exactly the same job as the injured person. During her enquiry, there was no record for the safe use of that electric bender machine shown to her by the Accused.

Mr. N.R. Abeeluck gave evidence in Court in his capacity as Registered Mechanical Engineer. In the year 2017, he was posted at the Ministry of Labour. He together with Mrs. Baznauth enquired into an accident at work which occurred on 4.9.2017 at Accused's workshop. After his enquiry, he drew up a report as per Doc. G. His observations when he went at Accused's workshop were to the following effect. There was an electric bender machine that did not have a serial number, nor make nor model. The machine consisted of a middle roller, the left and right rollers. There was an on and off switch and a "forward and reverse" switch on the machine. The dangerous part of every machinery should be fenced unless it was in such a

position of such construction, safe to the employee or people working on the premises, otherwise it should be fenced if it was a dangerous part as per Section 47 of the above Occupational Safety and Health Act (OSHA). The importance of fencing the rollers area was because at the middle roller, if someone put his hands near it, it could become a danger to him as it represented a hazard which was what happened when the injured person's hand got entangled in between the in running nip point.

Under cross-examination, he stated that he had experience in Health and Safety matters as he was posted at the Ministry of Labour. Point 3.3. of his report read as follows: *"No handling of the metal section was required to be done at the middle roller during bending works."* He meant that the operator did not require to put his hand at the middle roller near the part that was dangerous meaning that the operator of the electric bender machine did not need to place his hands near/on the metal bar when it was in operation in the machine. At the middle, when the metal bar was under pressure, there was a device that lay pressure on that bar. There was no need for the operator to put his hands near the middle roller. If the metal bar was blocked on the middle or third roller, the machine should be de-energised so that it did not represent a hazard to the operator. The handwheel was to control the middle roller. If the handwheel was used to lift up the middle roller, it released the pressure and by lowering the middle roller by using the handwheel, the pressure increased. There was no technical reason why the operator placed his hand in the machine while in operation. He was not present at the time of the accident. He agreed that Section 47 of OSHA had exceptions and that the Accused was not prosecuted under Section 47, but under Section 5 of the OSHA. He agreed that the nip point was only created when the machine was in operation. His recommendation was that whilst the machine was in operation, it should have been fenced. He admitted that for some angles it was not possible to fence the nip point because otherwise, the machine did not serve its purpose. He again admitted that it was not possible to fence the nip point when the machine was in operation and that was why he did not recommend to put a guard on the machine. But he did recommend to put a fence as it was possible to a certain degree to put a fence vertically on the middle roller so that any operator could not get access to the middle part.

The injured person, Mr. A. N. Deenmahomed, gave evidence in Court. On 4.9.2017 he was working for Accused as Coach Builder and had been working there for about 29 and a half years. He was working as welder doing the work for the concerned manufacturing. He already learnt the job outside work and he was also

taught and trained by his colleagues at the workplace. He was taught to work on that electric bender machine in the beginning by one colleague namely Mr. Ibrahim. He was trained on that machine. He received training from Mr. Ibrahim who was a foreman. On the day of the accident, he received instructions from another foreman, Mr. Kanaram to do the work concerned on the machine. He was asked to make the panel of a bus to be assembled. On the material day, he thought he worked until about 3.45 or 3.50 hours. He had 3 metal bars of about 4 feet long to pass through that machine. While he was pushing a metal bar in the machine with his gloves on, his glove got squeezed with a roller of the machine which was in operation. While the roller was turning, it squeezed and crushed two of his fingers and was heading towards the third one when he managed to struggle to put the machine in the reverse mode to remove his hand. He did work on that machine before. The procedure that was followed when a metal bar was blocked, there was a forward or reverse switch. The machine was the way it was for about the past 29 years.

Under cross-examination, he admitted that since the first day of his employment, he had been working on that electric bender machine. In the year 2017, before he was injured, it was more than 26 years that he had been working on that machine. He was an experienced employee as he obtained training and advice regularly and received training from several foremen. He was explained the procedure as per the one communicated to the main enquiring officer, Mrs. Baznauth, as to how to use that machine. Once the metal bar reached the third roller, he had to remove his hand. Then, he had to go and recuperate the metal bar on the other end on the other side. He was never instructed to put his hands near the roller. When he pushed the metal bar for it to get to the other side of the machine, his hand got caught in the middle roller when he pressed the metal bar for it to go on the other roller. The metal bar did the first round. It was when it returned that the accident happened. He admitted that he was given clear instructions not to put his hands near the roller. His glove got caught in the middle roller as his hand was quite near to the middle roller although he was told at what distance to keep his hand away from the roller.

Mr. S. Kanaram in his capacity as foreman gave evidence in Court. On 4.9.2017, he was working for Accused's workshop at Les Guibies, Pailles as foreman. He had 31 years of experience at accused's company. Before working as foreman, he was a welder and then assistant foreman. As foreman his job was to assist the workers in their job namely welders and turners. He was working for the

team of welders for the Accused which included Mr. Deenmahomed. He was the one who gave instructions to him. At the workshop of Accused, there was an electric bender machine which was equipped with 3 rollers and an engine. For the rollers to start turning, the switch button had to be put on. A metal bar was put in the machine and when the switch button was put on, it moved automatically. On the day of the accident while he was coming back from a meeting, Mr. Deenmahomed held his hand and told him that it was crushed by the bender machine and needful was done by the Accused to have him conveyed to hospital for treatment. He went to see the bender machine and there was blood on the first roller. That bender machine was found at the workshop for 40 years. The machine had remained the way it was. But only after the visit of the Labour Inspectors after the accident, a guard was put on the machine.

Under cross-examination, he confirmed that in the year 2017, he had about 25 years of experience at Accused's company. In the course of the 25 years, he was foreman 4 times and the bender machine was still there. He was the head of the bender team and welders. The bender machine was used by his team. Before 2017, Mr. Deenmahomed did not have any accident on that machine and he knew how to operate the machine safely. Mr. Deenmahomed received training for that job just like other welders on that machine which was for about 2 years and he worked safely until 2017. Before year 2017, Mr. Deenmahomed was trained to work on that machine and when the previous worker left, Mr. Deenmahomed was made to work on that machine. He obtained training to work on it. He was trained how to start it, where to put the metal bar, where to stop and when to switch it off. There was also an emergency switch. If ever the metal bar was going too fast, then, an emergency switch button which was the main switch was to be pressed. The metal bar was inserted at the first roller and then the machine was switched on. The metal bar went by itself and came out at the third roller. The middle roller shaped the metal bar by exerting pressure on it and then, the metal bar came out at the level of the third roller. The middle roller moved at the top and at the bottom as well. He accepted that when the handwheel was tightened, the pressure was increased at the level of the middle roller on the metal bar and it was bent. That was the way the machine functioned. A welder or an operator did not have the right to put his hand on the rollers. If a guard or fence was put on the rollers, it would have been impossible to work on the machine. There were 3 ways to bend the metal bar in the machine and the presence of a fence or guard would prevent the bending process from going on. After the accident, the Accused put a guard on the rollers. But each time the machine was in

operation, the guard had to be removed in order to bend the metal bar. There was no written record that Mr. Deenmahomed received training from the Accused to operate the machine. The emergency stop was at the place of the machine and the stopper was used when the metal bar went too quickly or turned in the wrong manner. The emergency stop button had to be switched on first.

Mr. J. C. S. Lavigilante in his capacity as Maintenance Officer gave evidence in Court. On 4.9.2017 he was working for the Accused as Maintenance Officer for all the machines including an electric bender machine. He had been doing that work for 25 years. He did the maintenance and repairs for that bender machine for about 10 years. He had a Supervisor and in 2017, he had one called Varun. The bender machine was manufactured locally by a Marine Engineer, Mr. Philippe De Maingot. It did not have any manual concerning the precautionary measures to be taken with that machine. When he started employment with the Accused, the machine already existed and was there at the workshop. There were 3 rollers involved for the bending of the metal bar. After the accident, the Accused put an emergency switch and a side guard. There was no emergency switch before the accident. When he was working for the Accused, the bender machine was there and the machine had been there for a minimum of 25 years. About every six months, a servicing was done on that machine and before the accident, a last servicing was done on 10.8.2017 and the servicing revealed that there was no problem with that machine as per Doc. H. He admitted that the handwheel controlled the pressure exerted by the middle roller on the metal bar in the machine to be bent. When the middle roller was lowered, there was more pressure on the metal bar. When the middle roller was lifted there was less pressure on that metal bar. Should the latter be blocked at the middle or third roller, the handwheel could be used to release the pressure exerted by the middle roller and the metal bar would move. He explained the procedure in line with the procedure communicated to the main enquiring officer, Mrs. Baznauth. No hands were allowed near the rollers. He added that there was a stopper switch in relation to the first roller which prevented the metal bar from slipping. He confirmed that there was no justification for an operator to put his hand near the middle or third roller. As an experienced person as regards machines in the workshop, he agreed that it was not possible to bend the metal bar at certain angles should there be a fence or guard on the rollers. The latter had to be completely free for the bender machine to operate correctly. A fence could be used after the work was completed and when the machine was in operation it had to be removed. That emergency switch which was installed after the accident was meant to stop the electricity supply

and to stop the machine. But before the accident there was an on and off push button. If the off button was pushed, the machine would have switched off. He dealt with both the repairs and servicing part of the electric bender machine.

Mr. Ibrahim Sheik Moortooza in his capacity as Technical Supervisor gave evidence in Court for the Defence.

He had been working for the Accused for 35 years. When he joined employment with the Accused, after about 2 years, the electric bender machine was constructed so that for more than 30 years it existed at the Accused's workshop. The foreman meaning his previous colleague taught Mr. Deenmahomed how to use that machine. At the beginning, there were two of them working on it, then one started having heart problems and was a regular absentee. Therefore, Mr. Deenmahomed was one of the employees who worked together with him. He had been working on that machine for 15 years. It could be that Mr. Deenmahomed worked on that machine for about 5-6 years. The handwheel controlled the amount of pressure to be exerted by the middle roller for bending purposes as regards the metal bar already put into the machine and the pressure had to be gradual and done many times until the amount of bending was achieved. The procedure for the bending process was explained. The start button had to be switched on for the electricity supply after the metal bar had already been inserted in the machine and there was a stop button. The handwheel was used to apply the right pressure on the metal bar thus inserted. If too much pressure was exerted at one go, then the metal bar refused to move towards the rollers so that the right amount of pressure was needed to be applied for the metal bar to continue to move. That exercise had to be done about 3-4 times by gradually increasing the pressure to obtain the required bending of the metal bar. He was not present at the time of the accident. When there was too much pressure exerted on the metal bar by means of the middle roller, the metal bar got blocked. In such a case, the handwheel had to be turned for the middle roller to be lifted and thus, removing the pressure exerted on the metal bar. A fence would have impeded the bending process of the metal bar in the machine at all required angles as per Doc. K. The machine could not operate in the presence of a fence on it.

Under cross-examination, he did not agree that the movement of the 3 rollers represented a danger to the operators of the machine as the fence had to be removed for the machine to operate.

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

First and foremost, there is unrebutted, undisputed and uncontested evidence emanating from those Prosecution witnesses and the Defence witness who were conversant with the operation of the electric bender machine, that no use of hands was allowed near the rollers meaning that a blocked metal bar already inserted in that machine whilst in operation, could not be dislodged by pushing it a little towards the rollers with hands, apart from the testimony of the injured person who at no time testified to the fact that it was a common practice to do so at times. There is again unrebutted evidence from those Prosecution witnesses that either the pressure should have been removed as exerted by the middle roller should the metal bar be blocked at the level of the middle or third roller or the stop button be pushed on for the metal bar to be unblocked should it be blocked at the level of the first roller. The switch off button if pressed, there would have been a cut in the supply of electricity and the machine would have stopped. Thus, it is plain enough that such a short cut of dislodging a blocked metal bar by using hands at the level of the rollers while the machine was in operation was not a short cut in accordance with the training given to the injured person. True it is that the electric bender machine did not have a brand nor a serial number and was made by a local Engineer, but it was maintained and serviced at regular intervals and training was dispensed by foremen to operators including the injured person. Therefore, it stands to reason that there was no risk assessment done as it was the only electric bender machine that had been used at the workshop of Accused for at least 25 years without any injury being caused to any trained worker. Indeed, the injured person conceded that he was a trained and experienced operator and had been working on that electric bender machine for 25 years without sustaining any injury prior to the year 2017. As explained clearly, even by the Mechanical engineer, Mr. Abeeluck who stressed that no hands were allowed at the level of the middle roller and that a guard was not appropriate and a fence could not be placed for the complete operation of the machine. Moreover, the unrebutted testimonies of those Prosecution witnesses who were conversant with the operation of the bender machine including the Defence witness, boil down to the fact that it was not possible for the machine to function correctly in the presence of a guard or fence as bending at all angles was impossible and such fact remained uncontested by the main enquiring officer viz. Mrs. Baznauth. Thus, a guard or fence could only be used when the machine was not in operation which obviously will not

serve any useful purpose as the rollers would not be in motion then to create in running nip points in the absence of the bending process of the metal bars. Furthermore, the type of job was not new to the workers for which a risk assessment was warranted as there was no added equipment on that machine so that it can be inferred that there was a departure from the set procedure in place for at least 25 years.

Secondly, it has remained unchallenged that there was a handwheel that could be used manually to remove pressure exerted by the middle roller because if the pressure exerted by that roller was removed, the pressure would be removed on the other 2 rollers as there would be no pressure on the metal bar anymore as the 2 other rollers were to be found below the metal bar as per Doc. A2. The machine had to be switched off and the metal bar could be inserted anew and then the machine would have been switched on again. Now if the metal bar was at the level of the first roller, then the stop button had to be pushed on in order to have the metal bar inserted again in the machine after it had been switched off.

Finally, on the material day, no one witnessed how the accident happened. We have only the testimony of the injured person that his glove got stuck at the level of the middle roller and thus, his 2 fingers got crushed in the in running nip point of that roller and the metal bar in the absence of a medical certificate to support same. At no time, he said that he immediately removed the pressure on the metal bar by having that middle roller lifted by turning the handwheel bearing in mind that he was bound to be constantly using it for at least 3-4 times in order to monitor the pressure exerted by the middle roller which had to be increased gradually by turning manually the handwheel to achieve the required bend of the metal bar already inserted in the machine. Nor did he say that he switched off the machine. Thus, it is clear enough that he used his left hand to dislodge a blocked metal bar at the middle roller by pressing it towards another roller instead of removing the pressure on the metal bar which is achieved by having the middle roller lifted by turning the handwheel manually so that the metal bar could move. In case the metal bar did not move, then the machine had to be switched off to have the metal bar inserted anew and then the machine had to be switched on again. The injured person clearly acted in utter disregard to the training he had been given by the Accused by choosing a totally unacceptable short cut although he had more than sufficient experience in operating that machine viz. 25 years.

At this stage, I find it apt to reproduce below both Section 5(1) of the Occupational Safety and Health Act 2005 which has been qualified by Section 96(6) of the said Act:

> *"**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.*
>
> ***96. 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)***

I take the view that the Accused has discharged the burden placed upon it on a balance of probabilities in that it was not reasonably practicable for it –

"***to do more than was in fact done to satisfy the duty or requirement***" and that "***there was no better practicable means or step than was in fact used or taken to satisfy the duty or requirement***"

because – (i) the presence of an emergency switch button installed after the accident had the same effect of the existing switch off button, (ii) although the electric bender machine was of unknown model bearing no serial number, it was serviced and maintained at regular intervals and repaired if needed, (iii) an adequate period of training was given by the Accused to the welders or turners working on it including the injured person who admitted having reckoned 25 years' experience on that machine before the accident so that before 2017 when the machine had been in use in the workshop of Accused for at least 25 years, no trained worker operating the machine was injured including Mr. Deenmahomed, and (iv) the use of fencing or guard on the roller area while the machine was in operation was clearly not feasible for the proper functioning of the machine as clearly admitted by those workers being

conversant with the operation of the machine meaning by both those Prosecution witnesses let alone the mechanical Engineer namely Mr. Abeeluck and by the only Defence witness (see - **Talbot Fishing Co Ltd v Ministry of Labour & Industrial Relations (Occupational Safety and Health Inspectorate)** [2005 SCJ 76]).

For all the reasons given above, the case for the Prosecution not having been proved beyond reasonable doubt, I dismiss the information against the Accused.

S.D. Bonomally (Mrs.) *(Vice President)*
30.11.23