Prosecution Summary of Conviction

RPC Surface Treatment Pty Ltd (ACN: 131 159 405)

LEGISLATION:		*Work Health and Safety Act 2020*				
Charge	**Charge Number**	**Sentenced Date**	**Regulation**	**Section**	**Penalty**	**Offence Date**
1	**PE33451/2025**	**23/10/2025**		**19(1) 31(1)**	**$975,000**	**15/06/2023**
2	**PE33452/2025**	**23/10/2025**		**19(1) 32(1)**	**(Global Fine for 1 and 2)**	**12-15/06/2023**

BREACH(ES)

Offence 1: Being a person who had a health and safety duty as a person conducting a business or undertaking, namely a duty to ensure so far as reasonably practicable the health and safety of workers engaged or caused to be engaged by the person and workers whose activities in carrying out work were influenced or directed by the person, failed to comply with that duty while workers were at work in the business or undertaking and the failure caused death to an individual contrary to sections 19(1) and 31(1) of the *Work Health and Safety Act 2020.*

Offence 2: Being a person who had a health and safety duty as a person conducting a business or undertaking, namely a duty to ensure so far as reasonably practicable the health and safety of workers engaged or caused to be engaged by the person and workers whose activities in carrying out work were influenced or directed by the person, failed to comply with that duty while workers were at work in the business or undertaking and the failure exposed an individual to a risk of death or of injury or harm to the individual's health, contrary to sections 19(1) and 32(1) of the *Work Health and Safety Act 2020.*

DETAILS

Introduction
On 15 June 2023, a 16-year-old worker was killed when a steel beam suspended via an Overhead Monorail System (**Monorail**) fell and crushed his chest. He was employed by RPC Surface Treatment Pty Ltd (**RPC**) as a labourer who assisted with spray-painting and sandblasting. His full-time employment at RPC exempted him from attending school.

Work Activities at RPC
RPC specialised in the provision of industrial spray-painting and sandblasting services (**Services**) to client specification. The Services required RPC's workers to surface treat a diverse range of items that varied greatly in terms of weight and dimensions.

Depending on the item's weight and dimensions, workers used a variety of mechanisms to suspend the items requiring surface treatment. These included a gantry crane, trestle tables and the Monorail. New workers at RPC were verbally instructed by more experienced workers on how to use the Monorail and how to suspend items. There was no formalised procedure or training process.

The Monorail
RPC's Monorail was custom built and was connected to a large painting booth in the Workshop. Items were attached to the Monorail's overhead trolleys via lifting devices and suspended for spray-painting or sandblasting.

Items that could be picked up by workers were lifted by hand and attached to the Monorail via a lifting device. Heavier items were moved to the Monorail via forklift and suspended by the tines prior to attachment.

There was a single pulling tool or 'shepherds crook' available at the Workshop that allowed workers to move items on the Monorail without entering the fall zone. There was no formal instruction requiring the use of this tool and workers would often move suspended items by hand.

Lifting Devices at the Workshop
The relevant lifting devices in use at the Workshop were 'S-Hooks' and chain slings.

The S-Hooks were fabricated steel hooks in an 'S' shape. If the item requiring lifting had a bolt hole (or similar orifice), the end of the S-Hook was threaded through. The other end of the S-Hook was connected to a chain sling, which was in turn connected to the Monorail trolley. The S-Hooks did not have any mechanism that locked them to the item being suspended to prevent detachment through inadvertent movement and did not have a known WLL or rated capacity.

With respect to the S-Hooks, RPC had no records of:
1. how long they had been used at the Workshop for;
2. where they were sourced from;
3. who manufactured them;
4. if they were ever inspected or tested;
5. what their respective rated capacities were in particular configurations and in particular conditions of use; and
6. what their respective WLLs were.

The Process for Selecting a Lifting Device at the Workshop
Workers at RPC were routinely selecting lifting devices through a process of trial and error.

Workers were not required to determine the weight of an item prior to suspending it via the Monorail. The weight of an item may have been provided to RPC in design drawings, but it was not a requirement for this information to be passed onto the workers completing the task.

The weight of an item was estimated via visual inspection of its dimensions and whether it was unloaded via hand or forklift. There was no equipment present in the Workshop that could have been utilised to determine the weight of an item. Even if the weight was known, the S-Hooks did not have a WLL marked, so workers were unaware what item weight would exceed the lifting device's capacity.

Workers connected the S-Hooks to the items requiring suspension and conducted a visual inspection to determine if the S-Hook was 'straightening' or deforming under load. If the S-Hook underwent visual deformation, it was determined that its weight capacity was exceeded, and alternative lifting equipment would be utilised.

The Rollover Assembly
Prior to the incident, RPC was engaged by The Lifting Company Pty Ltd (**TLC**) to surface treat parts of a Cummins Engine Rollover Assembly, including two steel beams that weighed approximately 425kg each (**Beams**). RPC had completed the identical task for TLC between 4-12 times prior to the incident.

Incident
On 9 June 2023, the Beams were delivered to RPC by TLC. At about 2.00pm on 12 June 2023, the Beams were lifted via forklift and attached to the Monorail trolley via two S-Hooks connected to two chain slings. The workers involved in the task, were not advised of the weight of the Beams. On the same day, the Beams were moved into the main spray booth where they were primed.

On 13 June 2023, the Beams were top-coated. The Beams were left suspended in that configuration on the Monorail to dry until the morning of 15 June 2023. Early in the morning of 15 June 2023, one of the workers instructed the victim and other workers to move the Beams to a central area of the Monorail line. The Beams were to be unloaded from the Monorail via forklift for later collection by TLC.

At approximately 7.45am, the Deceased entered the main spray booth and started to push one of the Beams by hand in a southerly direction towards the central area of the Monorail line. A worker was nearby, pushing the other Beam in the same direction by hand. Two workers were situated in close proximity to another two workers.

Suddenly, the S-Hooks suspending the Beam being pushed by the victim deformed and 'straightened out' under load. The Beam fell uncontrollably onto the victim causing fatal crush injuries to his chest. Emergency services attended the scene shortly afterwards and conveyed the victim to hospital, where he was later declared deceased.

Between 12 June 2023 and the time of the incident on 15 June 2023, three other workers were involved in moving, sandblasting or painting the Beams while they were suspended in that same lifting configuration. This exposed them to the same risk of being crushed by falling objects.

Knowledge of the Hazard/Risk
It is common industry knowledge that:
1. lifting devices need to be rated to lift the relevant load;
2. lifting devices need to be clearly marked with their WLL so it is not exceeded;
3. the weight and centre of gravity of the load needs to be determined prior to lifting it;
4. the plant and lifting method selected must be suitable for the load to ensure it remains stable throughout the activity;
5. damaged or worn lifting equipment should never be used and lifting equipment should be inspected prior to use;
6. loads should not be moved or suspended over a person; and
7. the failure of lifting devices exposes those in the fall zone to the risk of being crushed by falling objects.

On 19 March 2021, WorkSafe Inspectors conducted a proactive inspection of the RPC's Workshop. A prohibition notice was issued to RPC prohibiting the activity of working underneath suspended loads. While the prohibition notice didn't relate to the Monorail or the S-Hooks specifically, it directed RPC to the same risk that eventuated in this incident, namely being crushed by falling objects due to the hazard of working under suspended loads.

Practicable Measures
Prior to and as at 15 June 2023, it was reasonably practicable and of low cost for RPC to have implemented the practicable measures set out in the prosecution notice.

RPC's directors were also directors of another company that specialises in lifting devices and customised lifting solutions, TLC. One of the director's confirmed that prior to the incident, TLC were able to fabricate and supply lifting devices to RPC that complied with the Lifting Standard. These devices could have been provided by the lifting company at no cost to RPC.

Subsequent Changes
Since the incident, RPC ceased trading. Workers were offered redundancies and offered a transfer.

OUTCOME	Plead guilty - convicted and fined
FINE	$975,000 (Global fine)
COSTS	$3348.00
COURT	Magistrates Court of Western Australia – Perth