Prosecution Summary of Conviction

Airdrill Pty Ltd (Administrators Appointed) (ACN:109 184 447)

LEGISLATION:		*Work Health and Safety Act 2020*				
Charge	**Charge Number**	**Sentenced Date**	**Regulation**	**Section**	**Penalty**	**Offence Date**
1	**PE9215/2025**	**22/10/2025**		**19(1) 31(1)**	**$897,500**	**13/03/2023**

BREACH(ES)

Being a person conducting a business or undertaking did not ensure, so far as was reasonably practicable, the health and safety of a worker engaged, or caused to be engaged, by the person; and workers whose activities in carrying out work were influenced or directed by the person, while the worker was at work in the business or undertaking, and by that failure caused the death of a worker, contrary to sections 19(1) and 31(1) of the *Work Heath and Safety Act 2020.*

DETAILS

SUMMARY
On 13 February 2023, a worker (**the victim**) was killed in the course of his employment with Airdrill Pty Ltd (**Airdrill**) whilst attempting to use an overhead crane to move a skid mounted mud pump (Skid Assembly) that had been placed on trestles at a workshop operated by Airdrill in Welshpool (**Workshop**).

The victim was standing on the Skid Assembly and operating the overhead crane using a handheld pendant when it unexpectedly tipped, trapping him between the chain from the overhead crane and a handrail on the Skid Assembly.

BACKGROUND
Airdrill operated the Workshop in Welshpool, which was primarily used for the design, manufacture and commissioning of new drill rigs. The Workshop was also used for servicing and repairs on other drilling equipment. Maintenance, servicing and refurbishments were carried out in an area of the workshop designated as the Service Area. The other main area of the Workshop where equipment was manufactured was designated as the Fabrication Area.

The usual process for work in the Service Area was for the service manager to secure the work and verify job requirements and quotes by email. The service manager would then allocate the job to workers that he considered suitably qualified. Any fabrication or welding work would be allocated to boilermakers.

Generally, trust was placed in the workers to ensure that work was carried out to an acceptable standard. The tradespeople would often complete a drawing for the task and then have the drawing reviewed by onsite engineers to ensure compliance with relevant standards.

The use of overhead cranes at the Workshop was a common part of the operation. However, Airdrill did not have any documented risk assessment or safe systems of work procedure for the use of overhead cranes at the time of the incident.

THE INCIDENT

On 13 February 2023, the victim was at work in the Service Area of the Workshop under the direction of the service manager. The victim was asked to assist another worker with a job that involved designing, fabricating and fitting handrails to the Skid Assembly.

The Skid Assembly had arrived at the Workshop in early January 2023. It was to be deployed to a mine site and needed to be refurbished to satisfy requirements of the mine. The work to be completed included replacement of handrails, replacement of the wheels and axles, and relocation of entry and exit points.

Because the work required the axle group to be replaced, the trailer was placed on steel trestles using a 12.5 tonne overhead crane with a “basket slinging” technique. Four 6000kg rated synthetic slings were used to lift the complete pump assembly onto steel trestles. The weight of the Skid Assembly was not known and was not measured or known at any point prior to the incident.

The Skid Assembly was placed on the trestles in a configuration which meant that the front of the Skid Assembly was supported by the draw beam of the trailer (used to hitch the trailer to tow a vehicle). This meant the front of the Skid Assembly was supported only by a single 200mm centralised square beam. The rear trestle was placed on the two chassis rails of the trailer. To overcome a height difference between the chassis rails and the draw beam, a square tube of metal was placed on the trestle supporting the rear of the trailer. The weight distribution of the Skid Assembly meant it was not stable when it was supported in this manner.

Work was then commenced on the assembly. The original railing was removed along with other material to make room for a walkway. The other worker was the person responsible for most of the fabrication work.

On 10 February 2023, the leading hand in the Fabrication Area and supervisor, advised the other worker that the victim, who usually worked in the Fabrication Area, was available if he wanted help with the task. The other worker accepted the offer, and that day the victim assisted with welding handrails to the Skid Assembly.

On 13 February 2023, the victim and the other worker discussed the day’s work. The other worker asked the victim to clean up welds while the other worker completed a separate task unrelated to the assembly. The other worker returned, and the victim explained that he was unable to access some parts of the Skid Assembly. They decided to remove the skid from the trailer and place it on a separate set of trestles.

The victim drove a 12.5 tonne overhead crane to the bay where they were working. The other worker went outside the Workshop and used a forklift to retrieve a trestle. While the other worker retrieved a trestle, the victim connected a single chain to the skid base in a reeved configuration. The chain had a working load limit of 2.4 tonnes. The total mass of the skid was approximately 6.3 tonnes. The mass of the skid had not been calculated at the time of the incident.

The victim was a licenced dogger and would have had some knowledge as to how to connect loads to cranes. However, there was no verification of competency or training provided by Airdrill and there was not requirement for the victim to complete a risk assessment before using the overhead crane.

As the other worker was driving the forklift back to the bay where the skid Assembly was located, he saw the victim standing on top of the Skid Assembly with the chain hooked up. He saw the trailer tip rapidly and uncontrollably to its left hand side.

The victim was standing on top of the trailer using the overhead crane control pendant. As the assembly tipped, the chain from the crane caught the victim's head and neck and pinned him against the newly installed handrailing causing catastrophic head injuries. The victim died as a result of his injuries.

CHANGES MADE AS A RESULT OF THE INCIDENT

Following the incident, Airdrill implemented a new training and induction procedure. It developed a standard operating procedures for all operations including the use of overhead cranes and the use of trestles. A process for verifying competency in the use of overhead cranes was also introduced with requirements for supervision to ensure adherence to the lift plan.

OUTCOME	Pleaded guilty – convicted and fined
FINE	$897,500
COSTS	$6478.00
COURT	Magistrates Court of Western Australia – Perth