Public Administration Committee

From: Michael Buchan
Sent: Monday, 10 September 2018 4:45 PM
To: Public Administration Committee
Subject: FW: senate inquiry into industrial deaths
Attachments: FINAL CFMEU Submission to senate inquiry (AMENDED).pdf; D141 - Submission to Senate Inquiry - Industrial Deaths - 2 July 2018.pdf

Hi Deana,

below are the contact details of the family's that gave evidence at Perth hearings. Happy to assist in any way

Mark & Janice Murrie [redacted]

Trish Kelsh [redacted]

https://www.youtube.com/watch?v=IgmG27vAQB0

Regan Ballantine [redacted]

Jon-Paul Bradley [redacted]

Ashlea Curico [redacted]

Regards,

Michael (Mick) Buchan

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Change the RULES

CFMEU CONSTRUCTION UNION

CFMEU WA acknowledge the traditional custodians of the land where our office is located, the people of the Whadjuk, Noongar Nation. We look forward to walking alongside current and future leaders, our brothers and sisters, in creating a more just Australian society.

Construction, Forestry, Maritime, Mining and Energy Union submission to the Senate Education and Employment Committees' inquiry into:

The framework surrounding the prevention, investigation and prosecution of industrial deaths in Australia

July 2018

Construction, Forestry, Maritime, Mining and Energy Union National Office
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Contents

1. Introduction

On March 2018, the Senate referred the inquiry into the framework surrounding the prevention, investigation and prosecution of industrial deaths in Australia to the Education and Employment References Committee for inquiry.

The Construction, Forestry, Maritime, Mining and Energy Union (**the Union**) is Australia's main trade union in construction, manufacturing, maritime, mining and energy production. We welcome the opportunity to submit comment to this inquiry.

Our union has been at the forefront of battles to improve health and safety for workers in our industries and sectors for over 150 years. And for good reason; our members work in some of the most dangerous industries. The history of mining, forestry, manufacturing, construction and maritime in Australia is littered with incidences of industrial death and disease. The challenges in these industries are not historical, but contemporary. A worker is seriously injured or killed every 6 minutes in these industries. Wharfies remain 14 times more likely to die on-the-job than the average Australian worker. As many as 1 in 15 coal workers in Queensland may have contracted Black Lung Disease. Deaths on construction sites are a fortnightly occurrence.

When employers cut corners on health and safety, workers - especially apprentices, casuals and older people - often feel unable to speak up. That's why the union's role is vital.

In a globalised world it is all too easy to see what will happen if our union's role is diminished; one just needs to see what happens overseas. 1200 workers have already died in construction on World Cup stadiums and related infrastructure in Qatar between 2010 and 2017. In Bangladesh, a five-story textile and clothing factory named Rana Plaza collapsed. The search for the dead ended on 13 May 2013 with a death toll of 1,134.

Our campaigning has built today's workplace health and safety system. As the evidence shows, our work saves lives. But our work in under attack by hostile Governments (particularly a hostile Commonwealth Government), anti-union regulators, inept WHS regulators and employers who care more about the bottom line than work health and safety.

At our union's inaugural National Conference held in June 2018, a number of resolutions were passed which will inform our approach to health and safety into the future. Copies of these resolutions are found in Appendix 1.

We welcome the opportunity to participate in this inquiry, and would appreciate further opportunities to outline our special expertise and knowledge in this field.

2. Unionised workplaces are safer workplaces

Research shows that unionised workplaces are safer workplaces. Unions play a key role in educating workers about safety hazards, ensuring employers reduce hazardous tasks or workplaces, and provide well-trained OHS reps who are able to identify and fix potential safety problems in the workplace.

Employers can face conflicts of interest in relation to health and safety in a number of respects. This may include the need to increase workloads and pressure workers to work faster or longer hours in order to increase output; a temptation to have employees ignore safety protocols that slow production; the trade-off between the bottom line and costly safety related expenditure or training; or managers overlooking safety related spending such as maintenance. For example, a 2017 study examining the relationship between workplace safety and managers attempts to meet earnings expectations found significantly higher rates of injuries in firms that are under pressure to meet earnings targets. The study also found that the relationship is not as strong in industries where there is high union membership and that this is likely due to unions' aim to ensure reasonable workloads, work speed and safety.[1]

Empirical evidence has demonstrated that unionised workers suffer less injuries than non-unionised workers. Workers in a unionised workplace are 70 percent more likely to be aware of OHS hazards and issues than in a non-unionised workplace.[2] In the United Kingdom, research has found that employers that had trade union health and safety committees had half the injury rate of employers who managed safety without unions. Workers in unionised workplaces were less likely to have a fatal injury.[3] Unions have also been found to improve safety outcomes in studies across Ireland, Canada, France and the United States. In Australia, unionised workplaces have been found to be three times more likely to have a Safety Committee and twice as likely to have undergone a management safety audit that non-unionised workplaces. In addition to improved injury and fatality rates, a 2013 study of 31 industrialised countries found that union density is the '*most important external determinant of workplace psychosocial safety climate, health*' and that '*eroding unionism may not be good for worker health or the economy*'.[4] Research also finds that unionised workers are more likely to receive safety instructions; have regular safety meetings; be made aware of dangerous work practices; and be less likely to perceive that taking safety risks is part of their job[5].

In the Australian context, an interim report completed in the Deakin University, Department of Management Faculty of Business and Law on the Victorian construction industry made findings which suggest that Union OHS representatives play a valuable role in improving health and safety on Victorian construction sites and that:

- High hazard risks were less prevalent on sites with Union OHS representatives than those with management nominated OHS representatives, and those with no OHS representation at all;

[1] Caskey, J., Ozel, N. (2017), 'Earnings expectations and employee safety', *Journal of Accounting and Economics,* 63, pp. 121-141.
[2] ACTU (na), 'What has the Union movement done for OHS?', accessible at: https://www.actu.org.au/ohs/about-us/union-movement
[3] TUC (2015), 'How unions make a difference on health and safety: The Union Effect', accessible at: https://www.tuc.org.uk/sites/default/files/Union%20effect%202015%20%28pdf%29_0.pdf
[4] ibid
[5] Gillen, M., et al. (2002), 'Perceived safety climate, job demands, and coworker support among union and nonunion injured construction workers', *Journal of Safety Research,* 33(1), pp. 33-51.

- Injuries occurring on sites with Union OHS representatives were less severe than those on sites with management nominated OHS representatives, and those with no worker representation at all. They were less likely to involve hospitalisation, or require transportation to hospital by ambulance;

- Sites with Union OHS representatives were more likely to have undertaken appropriate risk assessments, contributing to a lower level of high hazard tasks. They were also less likely to have a mismatch between documented safe work method statements and work practices;

- Sites with Union OHS representatives were more likely to demonstrate a learning approach to hazards; this contrasts with a 'repeat offender' approach identified on non-union sites;

- Sites with Union OHS representatives were better informed on industry standards, demonstrated by the lesser need for OHS inspectors to provide advice on these standards;

- Improvement notices were less likely to be issued on sites without a Union OHS representative, compared to sites with no OHS representative; and

- Sites with no OHS representation appear to be under-reporting injuries to WorkSafe Victoria.[6]

Trade unions also play an important role in enforcing health and safety standards where individual workers do not feel they have the ability or power to stand up for themselves. This is particularly relevant where workers are in insecure work and feel they have to avoid upsetting their employers in order to receive ongoing work. The relationship between insecure work and safety is discussed later in this submission.

In addition, unionised and non-unionised workplaces often have a different way of investigating incidences. There is evidence that investigations in unionised workplaces result in greater learnings and preventative strategies which can be applied across a sector to improve WHS and prevent future incidences of industrial death (see **Case Study 1** below).

There is significant Australian and international evidence that a union presence in a workplace is positively associated with improved work health and safety.[7] As unionised workplaces have been

[6] Dr. Elsa Underhill, Deakin University, "Evaluating the role of CFMEU OHS representatives in improving occupational health and safety outcomes in the Victorian construction industry: Interim Report" May 2016

[7] See, eg, Maureen F Dollard*, Daniel Y Neser, 'Worker Health is Good for the Economy: Union Density and Psychosocial Safety Climate as Determinants of Country Differences in Worker Health and Productivity In 31 European Countries' (2013) 92 *Social Science & Medicine*; Andrew Robinson and Clive Smallman, 'Workplace Injury and Voice: A Comparison of Management and Union Perceptions' (2013) 27 *Work, Employment & Society* 4; Theo Nichols, David Walters, Ali C. Tasiran, 'Trade Unions, Institutional Mediation and Industrial Safety: Evidence from the UK' (2007) 49 *Journal of Industrial Relations* 2; S Grazier *Compensating Wage Differentials for Risk of Death in Great Britain: An Examination of the Trade Union and Health and Safety Committee Impact* (2007) Working Paper 2007/02, Welsh Economy Labour Market Evaluation and Research Centre, Swansea University; Department of Trade and Industry, *Workplace Representatives: A Review of Their Facilities and Facility Time*, Consultation Document, January 2007; Theo Nichols, David Walters, Ali C Tasiran, *The Relationship between Arrangements for Health and Safety and Injury Rates – The Evidence-Based Case Revisited*, (2004) Working Paper Series Paper 48, School of Social Sciences, Cardiff University; Kwan Hyung Yi, Hm Hak Cho, Jiyun Kim, 'An Empirical Analysis on Labor Unions and Occupational Safety and Health Committees' Activity, Their Relation to the Changes on Occupational Injury and Illness Rate' (2001) 2 *Safety and Health at Work* 4; Andrew Robinson and Clive Smallman, *The Healthy Workplace?* (2000) Working paper

empirically shown to increase safety and reduce the rates of injury and fatality on worksites, it would be logical for the Government to encourage and support unionised workplaces. Unfortunately, the Government's anti-union agenda is achieving the opposite, making workplaces less safe.

Case Study 1: The difference a union makes – Responding to fatalities in the pulp and paper industry

In 2010, two fatalities occurred in the pulp and paper industry: one at a unionised workplace, the other at a non-unionised site. The difference in the responses is striking.

How a unionised site deals with a fatality

At a paper mill in NSW, a pedestrian was fatally injured after colliding with a forklift carrying pulp bales.

As this was a unionised site, the union was notified of the incident within 20 minutes of it occurring.

The company and union immediately established a joint investigation team. With the union involved, the investigation was transparent, accountable and focussed on the root cause of the tragedy.

Following a five week investigation, 12 key recommendations were presented back to company and union, all of which were accepted. The recommendations were quickly implemented and actively involved senior union delegates at the site.

A pulp & paper industry Safety Alert, issued by the Pulp & Paper Industry Health, Safety & Environment Unit, was prepared and distributed across all businesses in the pulp and paper sector, aiming to improve knowledge and safety practice.

Since this incident and the subsequent implementation of the 12 key recommendations, the workers and management at the site have worked hard, collectively, to improve their safety performance, significantly reducing their first aid & medical incidents. 2013 was a Lost Time Injury free year for the mill.

How a non-unionised site deals with a fatality

At a paper finishing and converting plant in NSW an observer was fatally injured when a 400kg reel fell on him as a truck was being unloaded.

As this was a non-unionised site, it was difficult to ascertain and confirm any facts about the incident. WorkCover NSW were reluctant to share details of the incident, citing the privacy of the company and individual.

It was impossible to be confident that appropriate preventative actions had been taken. What is known is that no pulp & paper industry Safety Alert was produced – a key way of lifting safety standards in the industry, especially following such a serious incident.

Eight weeks after the incident, the Union's Pulp & Paper Workers District Federal Secretary wrote to the Head of WorkCover NSW requesting a comprehensive review of traffic management practices in the sector following this and a number of incidents in a short space of time. No response was ever received.

2000/05, Judge Institute of Management; Barry Reilly, Pierella Paci and Peter Holl, 'Unions, Safety Committees and Workplace Injuries' (1995) 33 *British Journal of Industrial Relations* 2.

3. Insecure work and exploitation of temporary overseas workers is making workplaces less safe

> "*Trade unions can play an important role in enforcing health and safety standards. Individual workers may find it too costly to obtain information on health and safety risks on their own, and they usually want to avoid antagonizing their employers by insisting that standards be respected."*
>
> – The World Bank

Temporary overseas workers are less likely to speak up about OHS issues

For many temporary overseas workers, their ability to stay in the country is linked to their employment contract. This makes this workers particularly vulnerable, particularly where they feel that speaking up about an OHS issue may result in them being sent home by an employer. As a result, temporary overseas workers may be less likely to speak up about OHS issues or to exercise their rights in the workplace with respect to health and safety. Vulnerable workers are also more likely to be willing to agree to longer work hours (contributing to fatigue), or be convinced to cut corners increasing the likelihood of injury.

Overseas workers are also likely less well informed of their rights and the obligations of their employers with respect to OHS issues. Many workers, particularly lower educated and lower skilled workers, are less likely to have received formal OHS training than domestic workers. There is also an issue in relation to culture and language. When workers are from countries where their native language is not English, their ability to read and understand instructions, safety signs etc. may be diminished. Cultural factors may also influence how overseas workers see and understand risks, particularly those from countries with poor OHS records and substantially lower OHS standards than Australia.

These problems mean many overseas workers are not prepared for working in dangerous work environments, such as construction and mining. For example, at the end of 2016 a German national hired on a work site in Perth fell 35 metres to her death down a ventilation shaft.

Case Study 2: The needless death of a German backpacker on a Perth construction site in 2016

At approximately 2.50PM on Monday 10th October 2016 a 27 year old German backpacker, Marianka Heumann, fell 35 metres to her death on construction project in the Perth CBD. It was yet another black day for Western Australian construction workers.

When Union officers entered the site about 40 minutes after Ms Heumann's death, they saw that the builder – Hanssen Pty Ltd - had failed to close off the second level of the job where the worker had landed. Blood and strewn work clothing were clearly visible and accessible, and no effort had been made to ensure the scene of the fatality wasn't contaminated. The job was still going full steam ahead with a major concrete pour taking place. The police had not been contacted.

The OHS regulator, Worksafe didn't arrive at the job until over an hour after the Union.

The deceased worker wasn't wearing a fall prevention harness when she fell from the 15th floor of the service shaft. An investigation by the Union found that there were no suitable harness points. The closest harness point was a few metres from where she was working, located on the floor. At best, the harness point was unsafe, even if it had been used to secure a harness. To make matters worse, the worker was balanced on a plastic bucket with a 35 metre fall beneath her when she slipped and fell whilst placing silica on the shaft panels.

The site was under the control of builder Hanssen, who have an exclusive building arrangement with the develop Finbar. Ms Heumann's death was not the first death of a worker at a Finbar / Hanssen site. In 2011, a worker was killed when a concrete well lid crushed his skull as the load was being lifted by a crane.

The site where Ms Heumann died was also less than 1km from the site where 2 young Irish construction workers were crushed and killed by a concrete panel less than 12 months before (see Case Study 6 below).

In 2008, Hanssen was fined $173,250 by the Federal Magistrates Court in Perth for exploiting foreign workers. In that case, the court found that the company was guilty of 21 breaches of the Workplace Relations Act in relation to Australian Workplace Agreements. At the time, then-Commonwealth Workplace Ombudsman Nicholas Wilson said: *"As highlighted in court, Mr Hanssen, the director and secretary of the company, gloated that the employees would sign anything because they were frightened of being sent back overseas. This was a deliberate case of exploitation and something that the community, quite rightfully, will not tolerate"* ("*Building Firm Hanssen fined for exploiting workers*", Perth Now, March 11 2008). Magistrate Tony Lucev said the breaches were *"deliberate and exploited vulnerable workers"* (*Jones v Hanssen Pty ltd* [2008] FMCA 291 (11 March 2008).

Since that decision, the Union has continued to raise repeated concerns in relation to the use of foreign and temporary workers on Hanssen constructions sites. The union remains concerned that Finbar / Hanssen sites are characterised by young, inexperienced construction workers – many of whom are unsupervised apprentices, or inexperienced and unqualified backpackers on working holiday visas.

Insecure work leads to poorer OHS outcomes

> *"You have got a high turnover of workers. You have got many casual workers on these jobs that work from one day to the next. They are not going to put up their hand and say, 'I've got a concern about the contamination or what I'm doing here.' They are just going to do it because they want to get paid for the work that they can do so that they can pay their bills. That is the reality"*
>
> – Mick Buchan, Branch Secretary, Western Australian branch of the Construction and General Division of the Union[8]

Non-standard work has also been associated with poorer OHS outcomes. Casual, labour hire workers and independent contractors often face greater risks because 1) the temporary nature of their work/triangular working relationship means they are often not properly trained; 2) they may have less experience in the workplace; 3) their rights under regulation may be less clear/not so well understood; and 4) their vulnerability means they may find it much harder to speak out about OHS issues in fear of not receiving future work.

Anecdotal evidence by workers in our industries demonstrates that workers in insecure work will often be less likely to speak out about OHS issues, and therefore more likely to be injured, that those in permanent work. This anecdotal evidence is consistent with international research.

For example, a report by the International Labour Organisation found that the growth of non-standard work has been associated with adverse OHS outcomes (e.g. injury rates) as well as weakening the regulatory regimes that protect workers. It finds that global evidence points to large adverse health effects from insecurity and that research directly links low pay (as associated with temporary and part-time jobs) and poor OHS outcomes. The use of subcontracting and multilevel subcontracting is associated with fractured OHS management, poor OHS outcomes and "*corner cutting on safety".*[9]

In 2006, The University of New South Wales Industrial Relations Research Centre conducted a study into the health and safety costs of casual employment. The study found that "*casual working arrangements and job insecurity are associated with adverse OHS outcomes such as increased fatalities, illnesses, occupational violence and psychological distress, deceased reporting propensity, fewer training and career opportunities, as well as inferior knowledge, compliance with OHS entitlements, standards and regulations".* The study found that characteristics of precarious work, including greater insecurity; economic and reward pressures; low levels of social support; imbalance of demands and control; disorganised work processes or settings and lack of induction and training; and regulatory failure contribute to adverse OHS outcomes. *"Job insecurity and especially the fear that absence from work or even refusal to do overtime might increase the likelihood of redundancy, means that some workers may avoid taking time off even when ill… Casual workers receive no paid sick leave, annual leave, carers*

[8] Official Committee Hansard SENATE ECONOMICS REFERENCES COMMITTEE, Non-conforming building products THURSDAY, 9 MARCH 2017 PERTH p 9.

[9] Quinlan (2015), 'The effects of non-standard forms of employment on worker health and safety', Conditions of work and employment series, No. 67, International Labour Office, accessible at: http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---travail/documents/publication/wcms_443266.pdf

leave or public holidays. Thus being sick is a real problem or hazard for the majority of casual workers."[10]

A University of Sydney study in 2004 also found that if the growth of casual jobs continues, we are likely to *'witness the further erosion of safety and training standards'.* Specifically, analysing worker entitlements the study found that while less than three percent of permanent workers are not covered by workers' compensation arrangements, over one in five casuals (21.7%) were found not to be covered.[11]

Labour hire has also found to result in poor OHS outcomes. The dissenting report of the House of Representatives Standing Committee on Employment, Workplace Relations and Workforce Participation's inquiry into Labour Hire Arrangements and Independent Contracting (2005) found credible evidence of difficulties in identifying the responsibilities of parties under labour hire agreements: "*the triangular relationship, involving the labour hire agency, the host firm and the labour hire worker has led to a blurring of legal obligations and entitlements in a number of areas, such as occupational health and safety and return to work policies."*[12]

A 2002 Worksafe Victoria study examining OHS data for labour hire employees found that they were more likely to be injured than direct hire employees, and that their injuries are more severe.[13] Brennan et al. found that approximately 40% to 50% of labour hire agencies do not consistently provide safety inductions for their employees and 34% to 39% of labour hire agencies do not even assess the host organisation's OHS systems and workplaces prior to assigning employees. Almost 50% of hosts state that labour hire agencies never conduct OHS assessments of their workplace, a further 19% say it occurs only sometimes.[14] A 2011 study examined Victorian OHS data and found that temporary agency workers (labour hire) experience different and more acute risks than direct hire employees.[15]

[10] McNamara, M. (2006), 'The hidden health and safety costs of casual employment', Industrial Relations Research Centre, Research supported by Bartier Perry, accessible at: http://wwwdocs.fce.unsw.edu.au/orgmanagement/IRRC/CasualEmploy.pdf

[11] Buchanan J (2004) Paradoxes of Significance: Australian Casualisation and Labour Productivity. Paper prepared for ACTU, RMIT and The Age Conference 'Work Interrupted: casual and insecure employment in Australia', Hotel Sofitel, Melbourne, 2 August 2004. Accessible at: www.actu.org.au/media/230391/buchanan_productivity.doc

[12] Standing Committee on Employment, Workplace Relations, and Workforce Participation (2005), Inquiry into Labour Hire Arrangements and Independent Contracting. Accessible at: https://www.aph.gov.au/Parliamentary_Business/Committees/House_of_Representatives_Committees?url=ewrwp/independentcontracting/dissent.htm

[13] Underhill, E. (2002), 'Extending Knowledge on Occupational Health & Safety and Labour Hire Employment: A Literature Review and Analysis of Victorian Workers' Compensation Claims', a report prepared for WorkSafe Victoria, accessible at: https://www.worksafe.vic.gov.au/__data/assets/pdf_file/0010/10081/LHReport_October2002.pdf

[14] Brennan, L. Valos, M. and Hindle, K. (2003), 'On-hired workers in Australia: Motivations and Outcomes', School of Applied Communication, RMIT University, Occasional Research Report, Melbourne.

[15] Underhill, E. and Quinlan, M. (2011), 'How precarious employment affects health and safety at work: the case of temporary agency workers', Industrial Relations, vol. 66, no. 3, pp. 397-421. Accessible at: https://www.erudit.org/revue/ri/2011/v66/n3/1006345ar.pdf

Case Study 3: Insecure work and adverse OHS outcomes

The following examples of workers in insecure work feeling unable to raise OHS issues come from the Union's 2015 Submission to the Victorian Inquiry into the Labour Hire Industry and Insecure Work.

PATRICK, a casual rigger/dogman hired through a labour hire firm in the construction industry in Melbourne says that his workplace is not always safe, he was not told about WorkCover and what to do if he was injured and does not feel he can discuss health and safety without risking his job.

"I work in the construction industry as a rigger/dogman, which is very dangerous at the best of times. As a casual, you have absolutely no secure ground to stand on, and if you even question health and safety, the builder you are on-site for will call you a trouble maker, phone your employer, and demand not to send you back to that job. So your employer gets angry and blames you, and before you know it you don't get any more phone calls for work and are hung out to dry. So you are constantly putting your safety at risk due to intimidation and fear of losing your livelihood."

RICHARD, a casual Crane Driver in Melbourne said his workplace was not always safe but felt he could not discuss health and safety without risking his job. '*Cranes had no load charts!!! Riggers were too inexperienced. We were expected to lift dangerous deliveries (reo in bags). Rubble and rubbish in bags instead of rated bins. No street protection for the public and dogmen. Reo bars not capped. Balconies overloaded.'* He stated that he '*carried an injury because I was afraid to report it. [he was] always stressed because safety was ignored and men with my experience are told to shut up or get sacked. NO DECENT OH AND S REPS ON MOST SITES.'*

ALISTAIR, hired through a labour hire agency in the mining industry stated *'I'm a Boilermaker by trade, and because of my height (195cm) they put in a position where I was forced to weld in overhead position for 7-8 hours with my neck in hypertension. After about 5 hours of welding in that ridiculous position, the cervical disc prolapsed in the blink of an eye.*

"It was a grindy kind of clicking sensation in my neck that lasted under a second, followed by a nervous tingle down my right arm that went for about 15-20 seconds. That was the annulus of the cervical disc failing and the jelly inside the disc squeezing out. The headshield had overloaded the cervical disc. Anyway I was stuck in the mine site like that for nearly a week, and had to wait another 2 weeks for spinal surgery in Perth. They didn't send me to hospital, they bailed me up in a hotel instead. And on the day of surgery, while on the table with a hole in my throat the size of a lemon, [the company] terminated me. Yep. Fired on the table. Now I have 25.4% of permanent overall body impairment, and 62.5% of permanent calculated injury to my cervical spine. For life. Show me an employer who will employ a Boilermaker with a prosthesis in their spine. You're joking. They won't go anywhere near me. That mining company destroyed my life and career. Personally I think that I'm better off as ash. I wasn't even compensated adequately…. I was on permanent labour hire. Meaning I could go any day. Even if I did nothing wrong or out of line. Even if injured. Working under labour hire is inappropriate for tradies when you consider what can happen to us. Labour hire is casual essentially....and in our line of work this can mean being casually injured or casually killed. Those T&Cs are inadequate and totally inappropriate".

SARAH, a contractor in the construction industry in Geelong states that her workplace was not always safe and she did not feel she could discuss health and safety without losing her job. She said *'I was contracting with an ABN but to one employer only. I know this is illegal and I know myself and other workers are being paid incorrectly through ABNs but to speak up is to lose your job. If WorkCover is mentioned it's a big issue. Employers cringe at the words so to keep your job you don't mention it.'*

4. The Government's attacks on unions is making workplaces less safe

Workplace health and safety for workers is core business for our Union. The more that the Government attacks and undermines unions' legitimate roles and positions in society, the more that they hinder and restrict unions, then the more that they undermine our capacity to implement our core business and contribute to better WHS outcomes for workers.

Attacks on our Union and our core business - which includes preventing industrial deaths in Australia - is a feature of this Commonwealth Government.

The reinstatement of the ABCC

The Commonwealth Government's attacks on unions has made workplaces less safe. There is no greater example of this than the reinstatement of the Australian Building and Construction Commission (**ABCC**).

The ABCC works to undermine the role of unions, which has had an adverse impact on work health and safety outcomes. This undermining happens in a range of ways, including application of the Building Code restricting the inclusion of clauses in enterprise agreements that facilitate union and worker participation in work health and safety matters.

By way of background, in the year in which the ABCC was introduced – 2005 - the number of workplace fatalities in construction was 30. It then exceeded that number (and the number in 2004 (35)), every year between then and 2012.[16]

Laws which cause workers to fear raising safety issues or which compromise their ability to voice safety concerns – including via their union representatives – have a negative effect on work health and safety outcomes. The fact is that when workers are faced with huge fines and a politically motivated 'watchdog' that prosecutes workers and unions, but not employers, they will think twice about taking action to fix safety problems.

The ABCC was re-established in 2016. Fines increased and compulsory interrogation powers were reinstated.

[16] Whilst there was a reduction in the frequency rate of serious injuries over that period consistent with a reduction in the all-industries rate, a number of factors need to be kept in mind. Firstly, the number of serious claims actually grew by 13% in the same period and secondly, the rate of decline in the incidence rate has decreased since 2005 by comparison with the 2002-03 to 2004-5 period.

Case Study 4: the ABCC's political priorities

The capacity of union officials to enter workplaces to assist in protecting members from unsafe work practices is critical, but the union is consistently obstructed from performing its safety role.

In 2017 a federal court judge blasted the Australian Building and Construction Commission for wasting time and taxpayers' money on taking two officials to court for "having a cup of tea with a mate" which Justice North described as a "miniscule, insignificant affair". Justice North said: "*This is all external forces that are beating up what's just a really ordinary situation that amounts to virtually nothing*"; "*for goodness sake, I don't know what this inspectorate is doing*"; and *"[when the ABCC] use[s] public resources to bring the bar down to this level, it really calls into question the exercise of the discretion to proceed*" ("Judge turns on ABCC for wasting time over 'cup to tea' CFMEU incident", *The Australian Financial Review*, 13 March 2017).

An appeal brought by the ABCC was subsequently unsuccessful.

The Code for the Tendering and the Performance of Building Work

Of further concern is the *Code for the Tendering and Performance of Building Work* (the **Code**) which was implemented at the time of the reintroduction of the ABCC in 2016. The requirements of the Code are currently applied to 310 Head Contractors in the industry, and 1,121 subcontractors that are also code-covered entities.[17]

Clauses 11(1) and 11(3) of the Code have the effect of prohibiting code-covered entities from being parties to an enterprise agreement that include an array of clauses that would otherwise be permitted under the Fair Work Act. These include clauses that provide for union participation in decision making about matters that affect workers in the workplace, such as work health and safety and excessive hours of work from a fatigue management perspective. It also prohibits clauses which provide for the rights of an official of a building association to enter premises other than in strict compliance with Part 3-4 of the FW Act.

Laws which foster joint management of work health and safety matters have a positive effect on work health and safety outcomes. Including joint management in enforceable industrial agreements should therefore be encouraged. Prohibiting joint management in industrial agreements, which is the effect of the Code, is completely counter-productive to what should be a universal goal of safer workplaces.

To compensate for restrictions on these proactive measures which unions utilise to manage fatigue and prevent occupational hazards, the Code includes a requirement for Code covered entities to abide by work health and safety laws. The Commissioner of the ABCC is empowered to refer any code-covered entity that has failed to comply with the Building Code, including because of a failure to comply with work health and safety laws, to the Minister with recommendations that a sanction be imposed.

However, rather than actively monitor compliance with work health and safety laws, which unions do in the event they are provided access to a workplace, the ABCC's approach is completely re-active. Specifically, rather than actively monitoring compliance with clause 9(3) as part of the inspection and audit regime, the ABCC will only act if there has been a court decision that a code-covered entity has

[17] Proof Committee Hansard SENATE EDUCATION AND EMPLOYMENT LEGISLATION COMMITTEE Estimates (Public) WEDNESDAY, 30 MAY 2018 CANBERRA, p 31

contravened a work, health and safety law. This approach contrasts to the ABCC's approach in other areas where it will actively investigate and refer matters for enforcement.

Their approach significantly diminishes the potential for the Building Code to effect real change in improving work health and safety in the industry, as was recently explained by Ms Cato in a Senate Estimates hearing:

> *'…As you can imagine, it takes some time for these matters to go through the courts, so, by the time there's a court outcome, it's usually two or three years after the event, so it will take a little while for the power of the code and the sanction that can also apply to the company to be able to be put in place for those OHS breaches.'*

The Federal Safety Commissioner is ineffective

It is entirely appropriate that a company's work health and safety record, and record of compliance with work health and safety laws, are taken into account when awarding public contracts. However, for several reasons the Federal Safety Commissioner (**FSC**) has proved a complete and utter failure in improving work, health and safety performance in the industry.

By way of background, the FSC was established in 2005 following the Cole Royal Commission recommending that the Australian Government use its influence as a client and provider of capital to foster improved work health and safety performance by developing, implementing and administering a work health and safety accreditation scheme for Australian Government building and construction work.

There are currently about 420 accredited companies to FSC requirements representing 30 to 50 percent of industry turnover.[18] Without FSC accreditation, companies are not allowed to be the head contractors in Government building projects.

The fact of the matter is that the presence of the FSC (and Federal Safety Officers) is invisible in the industry. Direct requests for assistance or intervention in particular safety issues of relevance to the Federal Safety Commissioner's remit have not been met. Problems would appear to include the below:

- the FSC is not valued or resourced appropriately in order to be effective. The office of the Federal Safety Commissioner has only 28 staff, along with 27 consultants engaged as Federal Safety Officers;

- An unaccredited company is only prevented from acting as a head contractor undertaking Commonwealth-funded projects, not as subcontractor (in contrast to an exclusion sanction under the Building Code); and

- the Federal Safety Commissioner will not publish the name of a company that loses accreditation (again, in contrast to an exclusion sanction under the Building Code). This protection reduces the incentive to maintain accreditation.

From 2005 up to 14 July 2017, only two companies lost accreditation for not complying with the FSC's "best practice work health and safety standards". One of these companies is apparently not John

[18] Official Committee Hansard SENATE ECONOMICS REFERENCES COMMITTEE Non-conforming building products FRIDAY, 14 JULY 2017 MELBOURNE, p 10

Holland, which retains the right to tender for and perform Commonwealth funded building work. This is despite their appalling record, which includes the deaths of multiple workers over recent years. Some - but not all – of the examples of workers being killed by John Holland's failures are set out in **Appendix 2** to this submission. And the tragedy continues – on 24 June 2018 another worker, an engineer working on Melbourne's West Gate Tunnel project, died when he was hit on the head with piling rig cable. An investigation into this needless death is ongoing.

All of these deaths and injuries that are set out in Appendix 2 have been found by courts to be directly attributable to John Holland's failure to discharge their duty of care to their employees. In this same period, the Union has faced fines for conduct ultimately designed to try improve safety to prevent these unnecessary deaths.

The Federal Safety Commissioner has not acted by removing John Holland's accreditation. The FSC stated that the reason that there were not more companies losing accreditation is because it would be the end of the company (due to not being able to tender for Commonwealth Building work), and that subsequently: "*When a CEO or a board find that their accreditation through me is at risk, they will pull out all stops to avoid the loss of accreditation*."[19]

Small fines, and a lack of willingness for the FSC to remove accreditation, would appear to result in a lack of any genuine deterrent effect. It results in a death or serious injury being treated simply as the cost of doing business for some unscrupulous companies.

The governments' actions which adversely impact health and safety are not always as blatant as the reinstatement of the ABCC. Other recent actions have included:

- The abolition of the requirement that Commonwealth Department's source textile, clothing and footwear only from Australian companies accredited to Ethical Clothing Australia (**ECA**). Accreditation to ECA requires company members to undergo a comprehensive occupational health and safety audit of their business and supply chain - to protect some of the most vulnerable workers in the country;

- Regulatory and legislative moves which have caused the decline of Australian shipping and facilitated the increasing use of Flag of Convenience (**FOC**) shipping in Australia. FOC has lax workplace and health and safety standards, with crew members being often reluctant to provide evidence to the Australian Maritime Safety Authority (**AMSA**) investigations or safety inspections;

- Refusing to act on the plague of non-conforming building products flooding the country, and widespread employer non-compliance with the National Construction Code; and

- Not implementing industrial manslaughter laws or - in the case of the Queensland Government- exempting dangerous industries from the law such as mining.

[19] Ibid, p 16

5. Improving the legislative and regulatory framework

There is inadequate enforcement action being taken by regulators

Workplace safety laws should be enforced when they are significantly breached, whether by criminal prosecution or civil penalty proceeding, even if no injury or death results. The Union has longstanding and grave concerns that that state and territory regulators are not effectively or efficiently enforcing work health and safety laws. This has led to widespread disregard of workplace safety obligation by some employers, leading to more injuries and deaths. There is a desperate need for more, and stronger, enforcement.

Indeed, the failure of state and territory regulators to act has also recently attracted criticism in multiple jurisdictions. For example:

- An inquest was recently heard in the Magistrates Court in Burnie into the 2014 death of Tasmanian roofing contractor Kurt Gorrie. Mr Gorrie fell 6 metres to his death from an unfinished roof of the King Island Airport extension onto a concrete slab; he was working on a part of the roof which had no safety mesh on it, and he was not wearing a safety harness. Evidence was led that Mr Gorrie's employer, De Jong & Sons Construction Ltd, had refused to source a crane to move a pack of roofing iron on the grounds of cost. Counsel assisting the Coroner, Sandra Taglieri, told Coroner Simon Cooper that no prosecution had been brought, and that the purpose of the *Work, Health and Safety Act 2012* was not fulfilled if prosecutions were not made[20];

- In South Australia, the Independent Commissioner Against Corruption recently commenced an evaluation of the practices, policies and procedures of the regulatory arm of SafeWork SA. This followed from the Office of Public Integrity receiving a number of complaints and reports about SafeWork SA, including relating to the death of a construction worker, Jorge Castillo-Riffo, at the Royal Adelaide Hospital site in 2014 and the death of 8 year-old Adelene Leong who was thrown from a ride at the Royal Adelaide Show in September 2014. In both cases, SafeWork SA dropped prosecutions after announcing it had withdrawn charges. In Mr Castillo-Riffo's case, this decision was made merely days before the hearing was to commence[21];

- The ACT's Chief Magistrate, Lorraine Walker, heavily criticised the Office of the Director of Public Prosecution's workplace health and safety cases as being "abysmally run" and plagued by a "lack of diligence" after prosecutors abandoned a case in May 2018. That case involved a worker being injured when he fell backwards from a service door as he mopped the cabin of a Q400 turboprop aircraft parked in the airport's QantasLink hangar on 30 January 2014. The worker's employer, Star Aviation, pleaded not guilty and was found to be at a "significant disadvantage" after it took more than two years for the matter to come to trial, and when it emerged that defence lawyers and prosecutors still had not agreed on details on the allegations and the particulars of the charges the company faced, more than four years after the incident[22].

[20] '*Critical of no prosecutions*', Leah McBey, The Advocate, 21 June 2018

[21] https://icac.sa.gov.au/sites/default/files/Public%20Statement%20Evaluation%20of%20SafeWork%20SA.pdf#overlay-context=content/public-statements.

[22] *"Star Aviation fall: ACT's chief magistrate Lorraine Waler criticises DPP's 'abysmal' Industrial Court case*, Megan Gorrey, Canberra Times, 14 May 2018

The Australian Maritime Safety Authority (**AMSA**) and the National Offshore Petroleum Safety and Environmental Management Authority (**NOPSEMA**) are other regulators who, in the Union's view and experience, seem unwilling or unable to effectively prosecute employers who breach safety laws and endanger workers. These regulators often have cross-jurisdictional coverage and, all too often, shift the burden of responsibility from one regulator to another effectively skirting their responsibilities. They are also plagued by lack of capacity, politicisation and inadequate funding which breeds a lack of confidence in workers in dealing with safety issues on the job.

The Maritime Union of Australia Division (**MUA**) of the Union has repeatedly raised concerns with the AMSA and NOPSEMA that the approach to enforcement and penalty action by these maritime regulators is grossly inadequate. The responses of these regulators to serious injury and death in the maritime sector, namely the offshore oil and gas industry, do not function as a deterrent to prevent unsafe practices by employers, nor do they allow for adequate compensation when a life is lost at sea due to employer negligence. The absence of a fully functioning regulator in the offshore oil and gas industry is particularly concerning to the MUA as the work performed in the sector is high-risk, but not duly recognised as so under the relevant legislation, the Offshore Petroleum and Greenhouse Gas Storage Act 2006 (**OPGGS Act**). We discuss the need for legislative consistency in the offshore oil and gas industry further below.

Indeed, in our experience - across all jurisdictions - there is a general reluctance for inspectors to take enforcement action (such as the issuing of formal notices) in relation to incidents which amount to breaches of work health and safety law, but where a serious injury or death has not occurred. For example, in the NSW construction industry SafeWork has begun promoting the issuing of on-the-spot fines relating to fall from heights hazards as an alternative to prosecution. Anecdotally, we are concerned that this approach is informed by a reluctance on the part of regulators which relates to their oversensitivity to complaints being made by industry employers and their representatives, leading to inspectors being criticised by the Regulator's management structure where enforcement action is taken, or despite low-level enforcement action being taken. In the construction industry in particular, the remuneration levels of inspectors are inadequate which compromises the ability of the regulators to attract and retain appropriately qualified inspectors. Regulation is also being outpaced by technology, leading some Inspectors to put an inappropriate focus on fine technical details rather than broad safety principles.

The health and safety of workers cannot be ensured unless regulators take a serious approach to all risks, big and small. It is not enough for regulators to park an ambulance at the bottom of a cliff, and wait for a worker to fall.

The failure of the regulators to take enforcement action (including through prosecution) – and the increasing phenomena of prosecutions discontinued at a late stage – is also influenced by the inadequacy of the investigatory processes undertaken by the regulators. It is overwhelmingly important that any investigation address not just the immediate cause of an incident, but also the root causes where there are systemic failures or corporate attitudes which fostered the environment necessary for the incident to occur.

Case Study 5: Inadequate investigations lead to discontinued prosecutions

In 2014, construction worker Jorge Castillo-Riffo was tragically crushed in a scissor lift during the construction of the new Royal Adelaide Hospital. A prosecution brought against Mr Castillo-Riffo's employer was dropped just three days before it was due to go to court, and an enforceable undertaking was entered into by Mr Castillo-Riffo's employer.

Due to the persistent lobbying of Jorge's partner, Pam Gurner-Hall, a coronial inquest finally commenced in 2018. The inquest is part-heard, and will resume in August 2018. At the time of this submission, however, the evidence given by one SafeWork SA Senior Work Health and Safety Inspector involved in the matter indicates:

- the Inspector's understanding was that neither they, nor the other SafeWork SA Officers in attendance on the day of the accident (several hours after Mr Castillo-Riffo's death), spoke to any eyewitnesses;

- no one from the SafeWork SA Investigation Unit attended the site of the accident on the morning it occurred, despite being a 10 minute drive from SafeWork SA's office. Neither the Inspector, nor – to her knowledge – any other SafeWork SA officials on site exercised their statutory powers to investigate at the site on the morning of the accident;

- a significant issue in the investigation was whether the control mechanism for the scissor lift which crushed Mr Castillo-Riffo's head into the underside of the concrete slab above worked properly. The inspector agreed that she did nothing to investigate whether the control mechanism had been touched, altered or moved;

- the Inspector was present when the scissor lift concerned was removed from the site of the accident. When that occurred, it was apparent that there was a problem with the controller. The inspector's evidence was that, to her knowledge, no one from SafeWork SA did anything to investigate how that problem may have related to the accident;

- the Inspector made no attempt to establish which individual was responsible for safety management of the particular area concerned, or who Mr Castillo-Riffo reported to in his employment;

- the measuring aspects of the work environment in which the accident occurred was extremely important. Notwithstanding this, the Inspector did not take any measurements of critical aspects of the work environment. Further, potentially important evidence was left on the ground at the accident site when the SafeWork SA official left, and the machine in question – once SafeWork SA took possession of it – was stored for a substantial time outside in the elements which resulted in noticeable deterioration;

- the investigation practices at the time, and those of others, were contrary to SafeWork SA's own requirements;

- the Inspector could not provide any information about the monitoring or auditing of compliance with that undertaking, other than her belief that it is monitored.

A wide-ranging approach needs to be taken to improve the practical enforcement of work health and safety laws. Such an approach should include:

- **Review of the National Compliance and Enforcement Plan** (**NCEP**). The NCEP sets out the approach regulators are supposed to take to WHS compliance and enforcement, including the criteria used to guide enforcement decisions. The Union shares the ACTU's serious concerns about the adequacy and effectiveness of the NCEP as currently drafted. The NCEP should be reviewed and improved, and should reflect a move towards 'hard' compliance rather than

emphasising ‘positive motivators’. Where duty-holders repeatedly breach WHS laws, or a worker is killed, prosecutions should follow;

- **Directors of Public Prosecution should be required to give clear reasons when it decides not to pursue prosecutions**, including its reasons for doing so where a workplace accident results in serious injury or death. For deaths in industries such as construction where there are multiple contractors and sub-contractors in a supply chain, and multiple PBCUs, an explanation should also be provided where a prosecution is taken against an employer but not the head contractor who has overall responsibility for the site.

Case Study 6: Head Contractors are not being held accountable

Irish backpackers Gerry Bradley (27) and Joe McDermott (24) were killed in November 2015 on an apartment construction site in Perth. They were in an area designated for making phone calls and having meal breaks when precast concrete tile panels – each weighing more than three tonnes – fell on them from overhead. The panels had not been individually restrained.

In the months leading up to the deaths, the Union had raised repeated concerns about safety on site, including the lack of supervision and spotting, and the failure to observe exclusion zones. Indeed, the Fair Work Building Commission (the predecessor to the ABCC) had visited the site three times, however their preoccupation with preventing the union from visiting the site to inspect safety issues prevented them from taking action on the clear safety issues which plagued the site.

Despite the deaths being entirely preventable by what Deputy Chief Magistrate Elizabeth Woods described as “simple and practical steps”, the trucking company responsible – Axedale Holdings Pty Ltd trading as Shaws Cartage Contractors – was fined only $160,000.

The Head Contractor, Jaxon Construction, was responsible for the site. It chose the subcontractors. Further, it had responsibility for ensuring a safety management system was in place that all contractors complied with; it had a responsibility to plan and coordinate works; and it had a responsibility to ensure that all parties on the site adhered to all applicable legislative requirements. Despite these obligations, WorkSafe did not see fit to prosecute Jaxon Construction effectively stating that they had done nothing wrong.

The lack of effort by the regulator to enforce builder compliance enables self-regulation at the expense of enforcement. The result was the death of Joseph McDermott and Gerard Bradley. Corporations should not be able to handball their responsibilities through the exploitation of corporate and employment structures.

- **Mandatory Coroner’s Inquiries should be held when a worker is killed at work.** It is increasingly common for coroners not to conduct open court hearings into workplace deaths. Rather, reliance is placed on the outcomes of investigations conducted by the regulator. This approach means that investigations which may not have been conducted forensically are not able to be tested by the calling of witnesses. When matters came before the coroner's court by way of a hearing, this serves as an important process for family members and engages the public interest in an important way. It also means the matters tend to be in the news and public interest attaches to the safety and other concerns that arise. It can also focus the mind of the prosecutors on their responsibilities. Moreover, coroner’s findings can be an important tool in driving reform in relation to how accidents are investigated with a view to preventing

further industrial accidents. The following observation was made by the Coroner dealing with the death of Mr Castillo-Riffo:

> *"This wouldn't be the first time I've run an inquest into an industrial death and then felt impelled to criticise the lugubrious process of criminal prosecution that ensured after that particular death…. I made certain comments about the processes involved in policing industrial deaths and that was almost 10 years ago and it's a topic that I'm not going to shy away from this time"*[23].

- **A common, publicly available database of completed prosecutions should be maintained by Regulators**. We support the ACTU's submission that such a database should be created and maintained to include information about the date of the prosecution, the nature of the entity prosecuted, the type of issue giving rise to the prosecution, the provision of the Model Act under which the prosecution was taken, the court in which the prosecution took place, the plea entered by the defendant, and the sentence imposed by the court. The database should also include links to all written court decisions;

- **Specialist Industrial Courts should be allocated, and resourced**. Prosecutions should be heard by specialist courts by judges with industrial and safety expertise and experience. Currently, there are significant differences between the jurisdictions in relation to the type of court in which the prosecution is conducted. In NSW, the Union is particularly concerned that the jurisdiction for work health and safety prosecutions has been removed from a specialist Industrial Court, to the District Court of New South Wales. The District Court does not have specialist knowledge of industrial safety matters. Criminal courts are traditionally concerned with the particular act or omission of an individual; the criminal law is not developed with corporate offenders in mind. The concepts of "*mens rea"* and "*actus reus"*, that is, guilty mind and guilty act, while making perfectly good sense when directly applied to individuals, do not easily translate to corporate offenders. In the case of industrial death, it is important that an adjudicator address offences involving systemic failings and the liability of corporate employers;

- **Independence must be secured.** As a matter of general principle, prosecuting authorities should be truly independent of, and not under the control or directions of, the relevant Minister. Enforcement should be functionally separate from 'education'; and

- **A specialist Safety Inspectorate should be established** to consider, review and correct the failures in the performance and behaviour of the current regulators.

In addition, the consistent experience of our officials is that the Regulators are reluctant to inform and consult with unions whose members are involved in a serious incident or fatality. Often, the union is the most consistent point of institutional support available to the families. The failure of the regulators to engage in a co-operative process with the union and its surviving members is not only a major disservice to those workers and their families, but also undermines the ability of the union to educate its members.

[23] See Transcript, page 1626, Lines 4 -25

Legislative inconsistency in the offshore oil and gas industry

The OPGGS Act should be amended so that it is legislatively consistent with the model *Work Health and Safety Act 2011* (Cth) (**WHS Act**) and *Work Health and Safety Regulations 2011* (Cth) (**WHS Regulations**), with appropriate consideration given to the specifics of the industry, for example remote location. This would remedy many of the threats to worker health and safety in this high-risk industry. Achieving practicable legislative consistency in the offshore oil and gas industry would also provide an appropriate regulatory framework, and impetus, for the NOPSEMA (and AMSA) to operate as fully-functioning regulators empowered and guided by the involvement of their subject workforces.

Major issues include:

- **High-risk licensing -** The offshore oil and gas industry does not have in place a high-risk licensing system. Implementation of a high-risk licensing system, which encompasses relevant training and qualifications 'designed to minimise the risk of adverse consequences associated with lack of competency' in work of such a nature, has been proven to be effective[24]. The effectiveness of such a system has been communicated and recommended to the NOPSEMA on multiple occasions however gaps in the OPGGS have provided reason for the regulator to avoid implementation. A high-risk licensing system in the OPGGS Act would harmonise it with Part 4 of the WHS Act and Part 4.5 of the WHS Regulations.

- **Safety case, stakeholders and consultation -** The NOPSEMA purports that its application of, and strong focus on operator and worker compliance with, a safety case[25] approach accounts for the high-risk nature of the industry and sufficiently mitigates risks. Given the importance of worker involvement in work health and safety management, it is critical that workers and their representatives are involved in the development and review of safety cases. In the experiences of the MUA and its members, the NOPSEMA does not appear to consider its workforce or workforce representatives as genuine stakeholders and as such, does not provide any mechanisms for meaningful consultation with its workforce or their industrial representatives regarding safety cases.

- **Health and Safety Representatives -** Where work health and safety legislation were to be harmonised in the offshore oil and gas industry, offshore Health and Safety Representatives (**HSRs**) would be afforded the same rights as HSRs in onshore industries. Critically, this would enable HSRs, under the WHS Regulations[26], to have the capacity to trigger a review of various safety management documents, including safety case documentation. Increased involvement of the workforce, in particular in the NOPSEMAs safety case model, would greatly improve health and safety outcomes for offshore oil and gas workers.

In general terms, legislative consistency would:

- Address issues of high-risk licensing;
- Amend deficiencies in the safety case model;
- Provide employees and their industrial representatives greater legislative recognition, thereby facilitating genuine and comprehensive consultation between the NOPSEMA and its workforce;

[24] *National Review into Model Occupational Health and Safety Laws*, Second Report, January 2009, paragraph 34.8, p 291.
[25] An offshore facility cannot be constructed, installed, operated, modified or decommissioned without a safety case in force for that stage in the life of the facility, NOPSEMA, Commonwealth of Australia 2018.
[26] Regulations 38(2)(e) and (f), 401(1)(g) and (3), 430(1)(d) and (2), 559(2)(e) and (4) and 569(2)(e) and (5)

- Improve the recognition and role of HSRs in the high-risk; and
- Provide a comprehensive regulatory framework for the national regulators to enforce, thereby providing a deterrent and preventative effect.

Workers, their families and their unions should be able to prosecute WHS breaches

To make the cultural change necessary to attack the scourge of workplace death, compliance should not be only reactive, but also proactive and preventative. In our experience, it is extremely rare for a regulator to commence a prosecution or civil penalty proceeding for breaches of work health and safety laws where there has not been an injury (e.g. cases of "near misses" or identified failures to provide a safe system of work).

This is a significant problem, because under the Model WHS law, only the regulator is able to bring proceedings. A request can be made to the regulator, and later the DPP, if a prosecution is not brought for any offences other than Category 1 offences. However injured workers, the families of deceased workers, and unions are unable to bring prosecution proceedings directly.

New South Wales is the only jurisdiction to retain access to union prosecutions. However these provisions are restricted to situations where the DPP has declined to bring proceedings. The application of the provision is problematic, not least of all because of the reluctance of the DPP to involve themselves in OHS matters (which means that the requisite referral cannot be made) and because, where penalties are ordered, they are unable to be retained by the prosecuting union (which exacerbates internal resourcing limitations within the unions who may seek to prosecute). Previously, between 1983 and 2011, union secretaries had standing to bring a prosecution under NSW laws and there is no evidence whatsoever that indicates that this ability was abused. To the contrary, all such proceedings were successful.

We strongly argue that the Model Act be amended so that unions have standing to bring proceeding for offences under WHS legislation. Indeed, the enforcement of work health and safety laws for contraventions of work health and safety laws would be considerably strengthened by allowing injured workers, the families of deceased injured workers and their unions to commence proceedings for the imposition of civil penalties where work health and safety laws are contravened. This would share the burden of regulatory enforcement in circumstances where persons more directly concerned in the events are motivated to take action, or where the regulator fails to take action.

Further, any requirement for review by regulator or the DPP should be removed. If a union runs a successful prosecution, it should also be entitled to the benefit of any pecuniary penalty.

The adoption of the regime similar to the civil remedy enforcement regime presently found in the *Fair Work Act 2009* (Cth) (**FW Act**) would greatly enhance the enforcement of workplace safety laws. Under that regime workers concerned, and their unions, are able to commence proceedings for the imposition of civil penalties where employment laws are contravened[27].

To be clear, such an approach should not be at the expense of criminal prosecution proceedings which the Union considers to be an essential aspect of enforcement (we discuss this further below). However, enhanced enforcement is likely to lead to enhanced compliance.

[27] The table in s539 of the FW Act sets out standing, jurisdiction and maximum penalties payable for civil remedy provisions

We further submit that the Model Act should be amended to place the onus of demonstrating that it was not reasonably practicable to reduce or eliminate a risk giving rise to a WHS duty of care offence on a defendant (a partial reverse of onus of proof).

Where penalties are ordered, they are inadequate

> *"There needs to be harsher penalties for those who are prepared to "run the risks" and play a game of "workplace probability", in order to complete their particular sphere or scope of works; no worker in the world should ever have to play a game of probability and hope that they came home safely at the end of their work "shift". And in many cases, those who decide upon the "risks" are never the ones who are exposed to the risks."*
>
> - Dr Gerard Ayers, PhD, MAppSci, GradDipOHM, OHS&E Manager, Construction and General Division, Victoria / Tasmania Branch

The penalties which are being applied in response to industrial deaths are woefully inadequate.

Because there is no current common, publicly available database of completed prosecutions maintained by Regulators, it is difficult to obtain reliable data in this regard. However, we do note that a 2012 paper examining judgements issued by the NSW WorkCover Authority under the *Occupational Health and Safety Acts 1983* and *2000,* for offences relating to workplace fatalities heard by the Industrial Court of NSW from 1988 – 2008, demonstrated that penalties were low, representing approximately only 18% of the maximum penalty allowable[28].

In order to be an effective deterrent, penalties must be significant. It is wholly unacceptable, for example, that repeat offenders like John Holland – which is worth hundreds of millions of dollars in Commonwealth Government contracts – continue to accrue penalties in the order of $170,000 - $180,000 per fatality (see Appendix 2). These outcomes allow large companies to treat the lives of their workers as a minor cost of doing business. Moreover – and despite this – John Holland is one of the very few private sector businesses who have been granted a Comcare licence, allowing it to maintain a self-insurance scheme and manage all of its own workers' compensation payments in cases of work-related injury or death. This is wholly unacceptable.

The inadequacy of pecuniary penalties is also exacerbated where small employers are able to evade the enforcement of penalties ordered by ceasing trading, stripping the business of assets and entering into insolvency.

Case Study 7: Non-compliance of sub-contractors with already inadequate penalties

On 1 February 2000, Dean McGoldrick fell 12 metres to his death on a Sydney construction site. He was employed by Metal Gutter Fascia Services Pty Ltd, a small company run by sole director John Peter Poleviak. Disappointingly, WorkCover brought a prosecution in the then-Chief Industrial Magistrates Court which had a penalty cap of $20,000. An extract of a letter written by Mr McGoldrick's mother, Robyn McGoldrick, to the then-Premier of NSW Morris Iemma reads:

[28] *'Another Brick in the Wall': Responses of the State to Workplace fatalities in the New South Wales construction industry*, Peggy Trompf, A thesis submitted in fulfilment of the requirements of the degree of Doctor of Philsophy. School of Business, Department of Work and Organisational Studies, University of Sydney, August 2012

"On the 5th of December 2003 I was presented with a Safety Award from Unions NSW. I greatly value the Award but it is a poor substitute for the loss of my son, 17 year old Dean, in a workplace accident. Dean had only worked for a few days on a Sydney building site at Broadway when he tragically fell to his death on 1st February 2000.

On the site where my son worked there was no OH&S induction provided, no scaffolding, inadequate supervision and no requirement to wear a harness. My son fell 12 metres to his death. Unfortunately WorkCover NSW initiated the prosecution of the employer in the wrong jurisdiction with the end result the employer was fined only $20,000. It caused me and my family considerable distress when I found out years later from the CFMEU that the employer only paid $1,800 of this fine. This is unacceptable. It was subsequently established that other employers had also not paid fines arising from fatalities.

When I received my Award in December 2003 I was given a commitment from the former Premier of NSW Bob Carr that I would be advised when the fine payable following the death of my son is paid. This commitment has not been honoured. I have been advised that the privacy of a rogue contractor is more important than the rights of families and friends of workers killed. I do not accept this nor does the community; I request that there be an amendment to the relevant legislation as proposed by Unions NSW and the CFMEU and that it be done as a matter of urgency. Finally I request you honour the commitment of the former Premier of NSW and advise me when the fine arising from the death of my son is paid.

Payment of the fines even when inadequate represents a form of closure for many families".

The Union is also concerned about the proliferation of enforceable undertakings. Enforceable undertakings should not be accepted in cases where workers are seriously injured or killed, and the Model legislation should be amended to expressly prohibit enforceable undertakings in these circumstances. Additionally, where the contravening employer has a history of prior convictions arising from separate investigations, they should not be entitled to the benefit of enforceable undertakings as a means of avoiding prosecution. Our experience with Comcare, in particular, is that it has a habit of accepting enforceable undertakings regarding serious work health and safety breaches and deaths which significantly undermines the effectiveness of sanctions.

Employers should also be prohibited from insuring against safety penalties and fines. The Model Act should be amended to expressly prohibit insurance contracts being entered into which cover the cost of work health and safety penalties and fines. Contravening such a prohibition should be an offence. It is unacceptable that employers should seek to reduce the life of workers to a cost that can be insured against.

The need for industrial manslaughter laws

Over many years, we have been at the forefront of the campaign to make industrial manslaughter a specific criminal offence under workplace health and safety legislation. Financial penalties, on their own, are not an effective strategy or deterrent in ensuring better health and safety at work. Specifically, financial penalties:

- do not ensure that the offenders restructure their workplace to comply with OHS standards;
- only have an impact upon the financial returns of the corporation, and not on the motivation and/or behaviour of the responsible managers;

- do not ensure any disciplinary action is ever taken against those who should be held responsible and accountable (especially if the hazards and risks were previously known to them);

- do not require management to review their systems of operation so that the offence will not reoccur; and

- can be easily avoided by restructuring the corporate structure or identities or by moving the organisation's assets to other corporate entities[29].

Effective deterrence needs to pierce the corporate veil. Corporate business must be held accountable and responsible, both morally and legally.

The proposition that the threat of personal prosecution is a substantial motivator to ensure compliance with work health and safety obligations is well-established[30]. Moreover, if law is a reflection of society's values, then criminal sanctions have both a moral and symbolic role to play. As renowned WHS academics Neil Gunningham and Richard Johnstone have stated:

> *"…symbolic or moral aims of criminal sanctions seek to apportion moral blame for criminal acts, and officially demonstrate society's intolerance of harmful behavior…we use the criminal law when our sensibilities are assaulted – when, in addition to redressing the particular problem, we want both to condemn the wrongdoers' conduct, and to stigmatize them. The criminal law both reflects existing public sentiments about the heinousness of certain activities, but can also be used to shape such perceptions, particularly if used in conjunction with media campaigns showing the reprehensible aspects of the behavior, while simultaneously emphasizing society's condemnation of that behavior…"*[31].

Gunningham has also identified that regulation and personal liability, reinforced by credible enforcement, is the single most important motivator for a CEO, in relation to their responsibility in ensuring high-level OHS standards are both implemented and maintained at their organisations' workplace[32].

The introduction of a uniform industrial manslaughter offences would demonstrate the significance of workplace health and safety as a matter of public policy, and to help bring about cultural change in workplace health and safety practices.

Currently, the only jurisdictions which contain industrial manslaughter provisions are the ACT and Queensland, although we note the Victorian Andrews government's recent commitment to legislating an industrial manslaughter offence should it win another term of government, and commend it for

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[29] Ayers, Gerard 2013, *Corporate Manslaughter legislation (A Brief summary of Australia's* experience. Report prepared on behalf of the Australian Council of Trade Unions; Gunningham, N., & Johnstone, R. 1999, *Regulating Workplace Safety: systems and sanctions*. Oxford University Press, Oxford

[30] Bailey, T, J Woolley and S Raftery (2015) "Compliance and enforcement in Road Safety and Work Health and Safety: A Comparison of Approaches *Journal of Health, Safety and Environment*, 2015; 31(2); Clough, J (2007) "A Glaring Omission? Corporate Liability for Negligent Manslaughter" 20 *Australian Journal of Labour Law* 29; Purse, K and J Dorrian (2011) "Deterrenace and Enforcement of Occupational Health and Safety Law", *The International Journal of Comparative Labour Law and Industrial Relations* 27(1)

[31] Ibid, at pp.193-194

[32] Gunningham, N. 1999, *CEO and Supervisor Drivers: Review of literature and current practice,* Report commissioned by the National Occupational Health and Safety Commission.

doing so. We also note that the Queensland legislation excludes the mining industry. This is absurd and unjustified, and we call upon the Queensland government to remove this exclusion.

The Union strongly supports the inclusion of an industrial manslaughter offence in the Model WHS laws, and within the legislative framework for work health and safety. In particular, the offence:

- should include both acts and omissions which substantially contributes to death;
- should apply to corporate duty-holders and officers who have the capacity to significantly affect health and safety outcomes. The cause of action should go not just to the immediate cause of a death, but also to the root cause of it;
- should carry significant penalties, including substantial periods of imprisonment; and
- should encompass circumstances where *any* person is killed. This would protect members of the public (such as the three pedestrians who were killed when a wall on the edge of a Grocon site collapsed in Melbourne in 2014), as well as ensure justice in industries such as construction where there are multiple contractors and sub-contractors engaged on a site / where multiple Person Conducting a Business or Undertaking (PCBU) exist under the WHS Act.

Other improvements to the Model WHS Framework which would improve safety

The Construction and General Division of the Union recently made a submission into Safe Work Australia's review of the model OHS laws which made a number of recommendations. That submission is available on Safe Work Australia's website[33]. The Union's recommendations work to improve the legislative framework in a way that will positively address the underlying causes of workplace fatalities. The recommendations included (but were not limited to):

- **Improving work health and safety "right of entry" provisions**. The capacity of union officials to enter workplaces to assist in protecting members from unsafe work practices is critical. The Model Act should be amended to remove the requirement for written notice in relation to suspected work health and safety contraventions. However if a notice requirement is retained, it should be given as soon as is reasonably practicable *after* entering a workplace, except where giving the notice would defeat the purpose of the entry to the workplace or unreasonably delay the permit holder in an urgent case. Further, notices in relation to suspected contraventions should be limited to identifying the nature of the suspected contravention, and permit holders should be specifically able to investigate suspected contraventions after entering a workplace based on matters observed whilst on site after lawful entry (irrespective of whether or not they were known at the time of the initial entry;

Case Study 8: the Union is being consistently obstructed from performing work health and safety inspections

The capacity of union officials to enter workplaces to assist in protecting members from unsafe work practices is critical, but the union is consistently obstructed from performing its safety role by aggressive and uncooperative employers, and the obstructionist ABCC.

[33] https:/zengage.swa.gov.au/32134/documents/79615

The capacity of union officials to enter workplaces to assist in protecting members from unsafe work practices is critical, but the union is consistently obstructed from performing its safety role by aggressive and uncooperative employers, and the obstructionist ABCC.

Employers consistently obstruct our officials where they are seeking to investigate suspected contraventions including by refusing to acknowledge reasonable suspicions, by calling police without any reasonable basis for doing so and by taking advantage of technical minutia in entry notices.

At the Perth Children's Hospital site – a site plagued with significant safety issues – the union was repeatedly obstructed by John Holland when trying to deal with concerns from workers over asbestos on site (just one of the serious safety issues identified at the site):

In 2012:

- Deadly asbestos was unearthed during civil works. Union officials were obstructed for hours, and denied the right to represent workers in an investigation. John Holland refused union requests for documentation relating to the discovery;
- Comcare launched an investigation into the continued obstruction of union officials who were trying to represent workers in regard to safety; a warning was issued, but a copy of the warning was not released to the union;

- Comcare held two mediation meetings between John Holland and the Union in order to make clear to John Holland that the union had a right to be a party to safety investigation, and to be on site to speak to workers. John Holland responded that this was a "grey area" in their view.

In 2016:

- Asbestos is again discovered on site. Workers contact the union and express concern about the discovery, and John Holland's handling of the discovery;

- Workers from a painting subcontractor contact the union to complain that they were being made to remove asbestos containing material but were not qualified to do so;

- The union requests legal access to the site four times, and was denied four times;

- Comcare attends site and attempts to take the unions' concerns about asbestos and untrained workers being exposed to the deadly fibres to John Holland, who respond that there were no OHS issues on site and that there was no reason for alarm;

- The union requests that Comcare meet with representatives from the site without management present. Comcare declines;

- Eventually the state government organized a meeting of all parties. As a result of the meeting, and tour of the worksite, union representatives were of the opinion that the site should be shut down while proper asbestos removal took place. This did not occur;

- Workers expressed concern that products had arrived on site from a supplier who had recently been found to be using asbestos in their products. The union was again refused entry. John Holland insisted that there was no issue but, in any event, they would investigate the issue themselves. Workers were rightly upset. The products were being cut up on site, and workers were covered in dust as a result.

- **Appropriate amendments to ensure that designated workgroups are fairly chosen and properly representative, and that Health and Safety Representatives (HSRs) are fairly elected and supported**. The designation of workgroups is an essential pre-requisite to the election of HSRs under the Model Act. It is imperative that the task of assigning workgroups is not discharged in a cursory manner, and that employees have proper access to representation without the need to make specific requests for that representation to the employer (which may expose their union membership status in an undesirable manner). In the construction industry, which is characterised by increasingly complex contracting and sub-contracting arrangements, there should be a requirement for an overall HSR to be elected by workers who is able to work across designated work groups;

- **Ensuring that HSRs and Health and Safety Committee's (HSCs) are properly trained.** Mandatory prescribed training for HSRs and HSC members should be conducted and not unduly delayed by obstructive employers, and workers must be entitled to a choice of provider approved by the regulator. Further, the restrictions around training for the exercise of HSR functions, particularly in relation to the issuing of Provisional Improvement Notices, should be removed;

- **Issue Resolution procedures are deficient and need to be strengthened**. The current Model Act fails to appropriately recognise the role of unions in the resolution of safety disputes, provides no straightforward mechanism for unions to assist workers and HSRs who are being undermined by difficult PCBUs or to otherwise resolve disputes, and unfairly excludes unions from participating in dispute resolution as initiating parties. Unions should have the right to notify safety issue/disputes on behalf of their members, including where matters affect multiple workgroups and where HSRs have been elected. Further, any worker should be able to request the assistance of their union to assist HSRs, regardless of whether or not the union officer involved is a permit-holder. The ability for HSRs to be assisted by union representatives, with respect to both on-site and representative activities, needs to be understood as an ordinary and expected practical application of the model WHS legislation;

- **Internal and External Review provisions are deficient and need to be strengthened**. Where an inspector acts inappropriately, or refuses to act at all, the issue resolution procedures come to a halt. The legislation does not include an effective mechanism through which a party, whether an HSR, a worker, or a union can satisfactorily access an appeal body. Unions are excluded from acting as initiating parties in applications for internal and external review. Despite the functions and powers provided to HSRs in the legislation, the relative power imbalance between such individuals and their employer often makes it impractical for an HSR to act as an initiating party in the commencement and resolution of a safety issue. These provisions must be reformed.

Appendix 1: Resolutions passed at the Union's National Conference, June 2018

Health and safety

Conference recognises the paramount importance and responsibility of the Union towards all issues around workplace safety. We must always ensure that our members are not exposed to unsafe work conditions and are educated in all spheres of safety rights and laws. We must organise non-members into our Union and fight insecure work to improve Workplace Health and Safety across our Union's industries and sectors.

The level of fatalities and injuries remains unacceptably high across our industries and each workplace fatality and serious injury is a travesty that could have been avoided. Families and workmates affected should have been spared the trauma of unsafe workplaces and the fact that too many employers' place productivity and profitability before safety is a disgrace.

Workers, Health and Safety Representatives (HSRs), organisers and officials should have an unfettered legal right to stop work to diminish the risk of injuries, fatalities and industrial disease, especially after a workplace incident or close miss and in order to show respect to fallen or injured comrades.

The achievement of these legal rights, especially for organisers and officials are vital in the context of increased insecurity of work in many sectors our Union has coverage for through casualisation and increased use of labour hire where workers legitimately worry about their future employment prospects if they speak out about safety.

Conference notes the absurd approach of the Queensland government in excluding the mining industry from the recently legislated industrial manslaughter laws.

Conference supports the Union's continued fight to; improve and enforce safety laws, organise to advance health and safety in the workplace, facilitate the election in the workplace of HSRs, support, educate, resource, coordinate and assist HSRs and delegates and ensure negligent employers are jailed and corporations are severely penalised where death or serious injury is caused, or serious wilful negligence is proven.

Conference calls on the Union to coordinate and link the safety struggles of all divisions with a view to a single national campaign with sector and industry specific elements and consider the merits of holding a cross divisional Health and Safety Conference.

Conference calls on the Union to continue to fight for significant improvements to workers' compensation schemes and other insurances.

Conference remains committed to ensuring that workers in all our industries return home in one piece every night and day. Safety before Profit.

Safety regulators

Conference recognises that safety is a critical issue for all workers. Conference calls on the Union to pay constant campaigning attention to positively reforming the various safety regulators and their current lack of capacity to effectively deal with issues affecting workers on the job.

AMSA, NOPSEMA, and all regulators are currently unable to deliver outcomes for workers on the job or effectively deal with employers and corporate power in resolving safety issues in the interest of workers. Conference calls for the establishment of a safety inspectorate to address these failures.

These regulators often have cross-jurisdictional coverage and all too often shift the burden of responsibility from one regulator to another effectively skirting their responsibilities.

This lack of capacity, politicisation and funding of safety regulators breeds a lack of confidence in workers in dealing with safety issues on the job.

Currently regulators seem unwilling or unable to effectively prosecute employers who breach safety laws and endanger workers.

The Union will work across all divisions with shared regulatory coverage to mount campaigns that effectively reform the regulatory regimes in the interest of working people's safety.

Conference condemns those regulators who collude with employers to breach safety laws.

Appendix 2: John Holland's abysmal safety record

CASE 1: *Comcare v John Holland Pty Ltd (No 2)* [2009] FCA 1515

Mark McCallum was working at the Dalrymple Bay Coal Terminal in Queensland on 6 March 2008. The work involved the transportation of precast concrete decks by a platform supported by two jinkers propelled by a front end loader. Mr McCallum's leg became caught amongst wooden scaffolding planks as the wheels of the front jinker began to press down and run over the planks. Another employee working alongside him believed that he could not safely assist Mr McCallum to free himself so he ran to the right side of the jetty so that he could see a third employee to signal for the transportation unit to stop. The unit stopped a few seconds later but by this time the front wheels of the front jinker had passed over Mr McCallum's trapped body. Emergency assistance was requested and a paramedic arrived at the scene, but nothing could be done to assist Mr McCallum who had suffered fatal injuries. The company admitted that its conduct had caused Mark McCallum's tragic death.

It did not carry out a plant hazard assessment for the piece of plant that killed Mr McCallum. An assessment would likely have identified a need for a remote braking system and radio protocol that would have prevented this tragedy.

The Court said:

"The dangers were obvious from the start, relatively simple to avoid, but unrecognised and unaddressed in a manner which raises the objective gravity of the offence …towards the higher end of the scale"

And:

"The size of the plant involved, the vulnerability of workers in front of it, and the very real risk of serious injury or death in the absence of a fail-safe means of immediate emergency communication does suggest a systemic failure by the respondent rather than "a risk to which an employee was exposed because of a combination of inadvertence on the part of an employee and a momentary lapse of supervision" as contended by the respondent".

John Holland was fined $180,000.00.

CASE 2: *Comcare v John Holland Pty Ltd* [2009] FCA 771

This case concerned a contravention at a worksite at Koolyanobbing railway siding in Western Australia, where the repair of rail tracks was being undertaken in November 2007. Welding activities were being undertaken, at the company's behest and direction, unsafely, near a fuel source. A fire broke out and an employee suffered second degree burns to 20% of his body.

The Court said that the company's conduct was objectively serious and that the consequences could have been far more serious but for immediate action taken by another employee. It found that the injured employee had never seen the company's documentary procedures relating to refuelling in proximity to a heat source. A fine of $124,960 was imposed.

CASE 3: *Comcare v John Holland Pty Ltd* [2012] FCA 449

The incident that caused Wayne Moore's death occurred on 19 March 2009 at the Mount Whaleback mine in WA. Unsecured grid mesh Mr Moore was standing on and which had not been secured in accordance with Australian standards when it was laid, gave way, causing him to fall 10 metres and sustain fatal injuries.

Two previous incidents involving grid mesh falling to the ground, labelled by the Court as 'near misses', had occurred just days before. Significantly, John Holland Pty Ltd had failed to report these incidents (of which its management had actual notice) to the SRCC. No action was taken after these earlier incidents to rectify a serious occupational health and safety issue.

The Court said there were measures open to John Holland Pty Ltd that were reasonably practicable and would have prevented Mr Moore's tragic death. Specifically, it found that there were no adequate reporting procedures in place in regards to the incidents. The Court was minded to impose the maximum penalty of $242,000 available under the Act. The incident was the result not of inadvertence by an employee, but a fundamental systematic failure by John Holland Pty Ltd.

The Court lamented that the maximum penalty imposed was insignificant compared with the loss of human life and that large corporations like John Holland Pty Ltd might be expected by the community to pay substantially more than the prescribed maximum penalty in the circumstances.

John Holland gave an undertaking to ensure that they would "use their best endeavours to observe and implement industry best practice in relation to work health and safety".

CASE 4: *Comcare v John Holland Pty Ltd* [2014] FCA 1191

On 30 December 2011 Anthony Phelan was working on sinking of the railway tracks to and from Perth Central railway station. He was operating a high pressure water and air mist hose cleaning debris from the rail tracks. He was wearing earplugs. At the same time, about 160 metres further up the rail tracks was a hi-rail vehicle. The hi-rail vehicle was located on a decline. During the offtracking process, the hi-rail vehicle lost its braking capability. It started descending the decline gathering momentum as it went.

The employee operating the vehicle lost control of it. He sounded the vehicle's warning horn. Mr Phelan was directly in the path of the runaway vehicle. There were warning shouts from other workers. Mr Phelan apparently did not hear the warning horn or shouts because of the earplugs he was wearing and the noise from the hose he was using. The hirail vehicle struck him and he was fatally injured.

The accident that killed Anthony Phelan was determined by the Court to have been foreseeable. The Court said neither John Holland Group company had taken steps identified by both of them to be necessary to discharge their obligations in relation to their employee's safety. This was made worse by the fact that the companies had been sent a safety notice by the Office of Rail Safety Western Australia following a similar incident involving a runaway vehicle before the death of Mr Phelan and had failed to take remedial action. That notice advised the companies of the need to restrain vehicles to prevent the potential for 'runaway'. The Court noted that the death of Mr Phelan was the third fatal accident in 5 years that had occurred at sites JH Pty Ltd controlled.

It concluded: The need to remind the (companies) of the importance of constant vigilance in relation to workplace safety, is particularly important because (they) operate in an industry which on a daily basis requires their employees to carry out inherently dangerous activities or to operate, and work in the vicinity of, vehicles which have the propensity to put their lives at risk. Constant vigilance was not present in the circumstances of this tragic case. The result was that a man lost his life… The two JHG companies were fined $180,000 each.

CASE 5: *Comcare v John Holland Pty Ltd* [2015] FCA 388

John Holland Pty Ltd failed to take all reasonably practicable steps to protect the health and safety of its employees in relation to an incident that occurred on 1 December 2011 on the Airport Link Tunnel project in Brisbane. The incident involved a metal bridge being dislodged and falling to the ground, striking an employee of John Holland in the head. The employee, Alexander Hogg, suffered serious lacerations and other injuries. Other employees were also exposed to risk or injury from the dislodgement of the metal bridge. The Court found that the company had: - failed to conduct a formal risk assessment; - failed to provide the work crew with any information or training; - failed to take steps reasonably practicably open to it which would have enabled maintenance of a safe working environment. The event that led to Mr Hogg being injured was foreseeable. The Federal Court imposed a $110,000 fine on John Holland Pty Ltd.

CASE 6: *Comcare v John Holland Pty Ltd* [2015] FCA 388

In June 2016, John Holland pleaded guilty in the Adelaide Magistrate's Court to two charges of failing in its work health and safety duty during construction of the city's South Road Superway, in an incident that endangered the lives of two Adelaide motorists. A 40 kilogram section of concrete pipe broke off and fell around 15 metres into evening peak hour traffic. The pipe snapped because it was not properly supported. The company was convicted and fined $130,000 in what was the first criminal prosecution brought by federal regulator Comcare under the Commonwealth Work Health and Safety Act. The Court found John Holland did not carry out a risk assessment for the job or ensure the work was done safely, exposing the drivers to the risk of serious injury or death.

This was the first criminal OHS prosecution against John Holland.

CASE 7: *Comcare v John Holland Pty Ltd* [2016] FCA 501

On 29 September 2011, Sam Beveridge, a 40 year old diesel fitter employed by John Holland Pty Ltd on the Brisbane Airport Link project died after being struck by a falling beam whilst performing work on the formwork that was used to pour suspended concrete slabs which formed the roof of the tunnel. Mr. Beveridge suffered severe crush injuries to his head, neck and chest. He died in hospital two days later.

John Holland admitted it failed to provide Mr Beveridge with training on risk or control measures for the work, or a safe system of work for the cutting of the formwork. "In this case there was a clear failure to take all reasonably practicable steps to ensure this work was carried out safely," the CEO of Comcare said after the decision. "Detailed risk assessments are fundamental requirements in identifying hazards and ensuring the health and safety of workers, and that did not happen here." The company was fined $170,000.

Inquiry into the framework surrounding the prevention, investigation and prosecution of industrial deaths

Submission by the Australian Council of Trade Unions to the *Senate Education and Employment References Committee*

ACTU Submission, 2 July 2018
ACTU D. No 141/2018

Contents

Introduction

The ACTU is the only peak body representing working Australians through over 40 affiliated unions and trades and labour councils.

The ACTU welcomes this important Senate Inquiry and the opportunity to make a submission.

A number of the ACTU's affiliated unions have made separate submissions to this Inquiry, and the ACTU endorses the content of those submissions. In addition, the ACTU recently made a submission to the 2018 Review of Model Workplace Health and Safety (**WHS**) laws, making 44 recommendations aimed at strengthening the capacity of the Model WHS laws to respond to changing work arrangements and better prevent injury and death at work. The submission is directly relevant to the current Inquiry and is **attached** for the Committee's reference.

Workplace health and safety is a fundamental human right. Every worker should be able to go to work and return home safely to their loved ones. From 2003 to 2016, at least 3,414 workers lost their lives in work-related incidents in Australia. In 2017, there were 187 Australian workers killed at work, compared with 182 workers in 2016. As at 28 June, there have been 70 Australian workers killed at work already this year.[1] While the number of fatal work injuries has declined over time in most developed countries, limitations in data collection continue to result in an underestimation of the true extent of work-related deaths, including those arising from work-related diseases such as cancer and cardio-vascular disease. Any death at work is unacceptable, and there is no evidence to suggest that industrial deaths can or will be eliminated without additional or new regulatory measures.

Work-related injury, illness and disease continue to impose a significant cost on the community. It is estimated that there are 2.2 million work-related deaths world-wide and that workplace injury, illness and death cost the global economy some $US1,250,000 million or 4% of world GDP.[2] The total cost of work-related injury and disease in Australia was $AU61.8 billion in 2012-13, including the cost of productivity loss, additional hours of work, insurance, loss of earnings and funeral, carer, compensation, medical, litigation and prosecution costs.[3] Employers bear 5% of these costs, workers bear 77% and the community 18%. These figures do not include the suffering, social dislocation and economic hardship endured by the families of those affected by work-related deaths.[4]

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[1] Safe Work Australia, Fatality Statistics, accessed 2 July 2018
[2] International Labour Organization (ILO), *Safety in numbers: Pointers for a global safety culture at work*, 2003
[3] SafeWork Australia, *The cost of work-related injury and illness for Australian employers, workers and the community: 2012-13*, 2015.
[4] Quinlan, M., Matthews, L, Bohle, P, *Employer and Union Responses to Traumatic Death at Work: Evidence from Australia New Zealand Journal of Employment Relations, 40(3): 1-23*

Competitive pressures and work intensification have led to the proliferation of non-standard and precarious forms of employment, particularly in the transport, construction and agriculture industries. These pressures often result in 'corner-cutting' on WHS in order to meet deadlines, which can have fatal consequences for workers and others. Changing work relationships and complex industry structures such as supply chains have made locating WHS duty-holders, and holding them accountable, much more difficult.[5]

In this environment, the current legislative framework is insufficient to effectively prevent or prosecute occupational fatalities and a number of reforms are required.

Terms of Reference

On 26 March 2018, the Senate referred the inquiry into the framework surrounding the prevention, investigation and prosecution of industrial deaths in Australia to the Education and Employment References Committee for inquiry and report by 20 September 2018, with particular reference to:

i) *the effectiveness and extent of the harmonisation of workplace safety legislation between the states, territories and Commonwealth;*

ii) *jurisdictional issues surrounding workplace investigations which cross state and territory boundaries;*

iii) *issues relating to reporting, monitoring and chains of responsibility between states, territories and the Commonwealth;*

iv) *safety implications relating to the increased use of temporary and labour hire workers;*

v) *the role of employers and unions in creating a safe-work culture;*

vi) *the effectiveness of penalties in situations where an employer has been convicted of an offence relating to a serious accident or death; and*

vii) *any other related matters.*

This submission addresses these matters.

[5] Johnstone, R and Tooma, M, *Submissions in relation to draft Model Work Health and Safety Regulations and Codes of Practice*, 18 March 2011

Executive Summary

There is no quick fix or single solution to the problem of work-related deaths. A package of reforms is needed, including amendments to WHS laws, improvements to regulator practices, reforms to tackle corporate phoenixing and a review of government licensing and procurement rules.

The ACTU's key concerns with the current WHS framework are as follows:

- Inadequate penalty regime:
    - The maximum penalties in WHS Model Laws are too low, for example when compared with those applicable for corporate crime;
    - Courts frequently award penalties lower than the available maximum, even for the most serious breaches causing death;
    - The ability of companies to insure against WHS penalties and 'phoenix' to avoid fines further undermines the effectiveness of penalties.
- Inadequate national enforcement, monitoring and compliance strategy by regulators – particularly in relation to non-standard workplaces and cross-border incidents. The balance between education/encouragement and hard enforcement activity is not appropriate to prevent workplace injury and death. An urgent review is needed.
- Inadequate consultation and participation mechanisms for workers and unions, particularly in insecure and precarious work environments.
- Under-reporting and inadequate data collection, which impedes effective early intervention and prevention measures by regulators and social partners.
- Inadequate legal mechanisms:
    - Unions should be authorised to commence both civil and criminal prosecutions for WHS breaches;
    - A partial reverse onus of proof should be introduced, by removing the 'so far as reasonably practicable' qualifier from the primary duty of care and relocating it as a defence, with the onus on the defendant to prove that reasonably practicable steps have been taken;
    - A new offence of corporate manslaughter should be introduced;
    - Amendments should be made to strengthen officers' duties, including changing the definition of 'officer' to ensure those responsible for WHS breaches are covered;
    - The standard for a Category 1 offence should include 'negligence' as well as recklessness;
    - WHS disputes should only be heard by courts and tribunals with expertise in WHS and industrial matters;

- Sentencing guidelines should be developed in order to ensure consistent and appropriate sentencing for serious WHS breaches across jurisdictions.

Reform to address these problems with the WHS regime must be complemented by reforms in other areas to hold corporations accountable for reckless or negligent practices that cause work-related deaths, including:

- Reforms to Corporations Law to limit the ability of companies to liquidate to avoid WHS penalties, and to hold officers who engage in these practices to account;
- Government licensing and procurement consequences for corporations who repeatedly breach their WHS obligations.

The effectiveness and extent of the harmonisation of workplace safety legislation between the states, territories and Commonwealth

The Model Work Health and Safety Act, Regulations and Codes of Practice - collectively referred to in this submission as 'the Model WHS laws' - were developed in 2009-10 following an independent review process by the National Occupational Health and Safety Panel. The ACTU supported and fully participated in the processes that led to the development of the harmonised Model WHS laws. Strong, nationally consistent WHS standards are in the public interest. The ACTU continues to support nationally consistent WHS laws, as long as they do not compromise or reduce WHS protections or standards in any Australian jurisdiction. The ACTU also supports the maintenance of special regimes where the WHS risks are particularly high and/or unique, for example the electricity sector or transport industry, so long as protections are at least as good as the Model WHS laws. For example, given the disproportionately high number of deaths in the transport industry, the ACTU strongly supports the reinstatement of the Road Safety Remuneration Tribunal.[6]

A fatal injury at work in Australia may initiate a number of regulatory and judicial responses, including a police investigation, a workers' compensation claim, an investigation by the regulator, a prosecution, a common law claim and a coronial investigation. There are differences in the way these processes operate from jurisdiction to jurisdiction. The WHS harmonisation process has resulted in much greater consistency in the WHS legal framework. However, inconsistences in law and practice between different jurisdictions persist. Notably in the context of this inquiry, some jurisdictions have an offence of corporate manslaughter and some do not. Unions have retained a (limited) right to prosecute in NSW only. There are also some differences in consultation and participation requirements, including rights for health and safety representatives.

[6] The submission of the TWU to this Inquiry addresses this matter in detail.

There remain differences between jurisdictions in the approach to fatal injury investigations and proceedings. In some smaller jurisdictions such as the ACT, the Australian Federal Police, as opposed to the regulator, play the major role in the investigation and prosecution process. This may simply be because of resourcing issues. There is a need to ensure consistency in investigation processes, including by making sure that differences do not arise simply because regulators are under-resourced or because of different practices between WHS regulators and police law enforcement agencies. There must also be consistency, clarity and certainty regarding the prosecution policy of WHS regulators. This should include setting out exactly where ultimate responsibility resides for the decision to commence or not commence a prosecution. At present there is some uncertainty, at least in relation to criminal prosecutions for workplace fatalities, as to whether the decision ultimately rests with the relevant regulator (acting on advice from the DPP) or whether the views of the DPP are determinative, particularly given that under the Model WHS Act, both the regulator and the Director have standing to commence proceedings (s 230), and in practice in the Commonwealth jurisdiction at least, proceedings are regularly brought in the name of the Director. Families of deceased workers need to know with absolute certainty who is making the prosecution decisions and on what basis. There also remain differences between jurisdictions in relation to the conduct of coronial inquests into workplace fatalities. These processes need to be examined and to the greatest extent possible, harmonised to ensure that there are no inferior procedural or substantive rights accorded to families who are involved in a coronial inquiry merely because they happen to be in one jurisdiction rather than another. These issues are discussed in more detail below.

Jurisdictional issues surrounding workplace investigations which cross state and territory boundaries

There is a need to strengthen the WHS regime's capacity to effectively investigate, monitor and enforce compliance when cross-border issues arise. In light of technological advances and the increasing complexity and interconnectedness of work arrangements, such issues are increasingly likely to occur. Two studies of work-related fatalities that occurred in New South Wales and Victoria between 1984 and 1990 found that incidents that involved multi-jurisdictional coverage, such as road transport deaths, were more likely to fall between the cracks or attract less extensive investigation and prosecutorial follow-ups.[7] There are currently a number of regulators enforcing WHS legislation around the country. Nationally, the powers of inspectors and investigators are similar. However, there are differences in approach as well as levels of resource and expertise from jurisdiction to jurisdiction.

[7] Quinlan. M, Matthews. L, Fitzpatrick. S and Bohle. P, *Investigation and prosecution following workplace fatalities: Responding to the needs of families*, The Economic and Labour Relations Review, Vol. 25(2) 253– 270 (2014)

The extent to which the Model Laws would apply outside of a jurisdiction is not entirely clear. Provisions of the Model Laws which are not criminal offences do not automatically have extra-territorial application. PCBUs have WHS duties in relation to 'any place where a worker goes, or is likely to be, while at work, including a vehicle, vessel, aircraft or other mobile structure, any waters and any installation on land, on the bed of any waters or floating on any waters'. In the ACTU's submission, Entry Permit Holders (**EPHs**) and Inspectors must have powers to inquire into potential breaches, regardless of their location. The ACTU recommends amendments to confirm that the powers of EPHs and Inspectors in Parts 7, 9 and 10 of the Model WHS Act have extra-territorial application, to the extent that a jurisdiction's legislative powers allows. In addition, EPHs should be recognised nationally, across jurisdictional borders. EPHs should not be required to hold multiple entry permits in order to perform their functions effectively. It is inefficient and inconsistent with the policy intention of national harmonisation of WHS laws. This amendment is required to strengthen the WHS regime's capacity to effectively monitor and enforce compliance when cross-border issues arise.

The ACTU also supports the development of a detailed, overarching national regulatory strategy and methodology (including a strategic national approach to investigations and prosecutions) to assist regulators to determine their priorities, achieve a more appropriate and effective balance between positive motivators and deterrence, and take a consistent national approach. A process and mechanism for regular and meaningful consultation and information sharing between the regulators should be established, and specifically for managing cross-border matters, including the most appropriate means by which investigative powers relevant to an inquiry being undertaken by a regulator in one jurisdiction can be exercised in a second jurisdiction.

At a general level, an increase in the capacity of WHS inspectorates is required. As the population and workforce grows in size and working arrangements continue to increase in complexity, the number of workplaces without HSRs or union representation is also likely to increase, along with the number of cross-border incidents. Regulators should plan to increase the capacity of their inspectorates (including improving the quality and training of inspectors), and the number of workplace inspections, to manage this. Inspections should be based on a proactive strategic plan and focused on sectors and workplaces identified as problematic or high-risk. A consistent approach should be taken in similar fact situations and circumstances to achieve consistent outcomes.

Issues relating to reporting, monitoring and chains of responsibility between states, territories and the Commonwealth

Case study – Austral Fisheries

The death of young Northern Territory seafarer Ryan Donoghue raises a number of serious issues relating to reporting, monitoring and chains of responsibility between states, territories and the

Commonwealth, the effectiveness of penalties and the failure of regulators to provide information or conduct adequate inspections to ensure compliance.

Ryan was a 20 year old crew member on a prawn trawler in the Gulf of Carpentaria operated by Austral Fisheries Pty Ltd (**Austral Fisheries**), a well-established company with a $100m annual turnover. Ryan was electrocuted and killed while using an angle-grinder aboard the trawler. The vessel was inspected in Cairns by Maritime Safety Queensland Officers and Senior Electrical Safety Inspectors. The inspection found that the socket was not protected by a safety switch, known as a 'residual current device' (**RCD**). The Coroner found that not only was Ryan's death preventable, it was similar to an earlier death on a fishing trawler 'from which no lessons seemed to have been learned'. The Coroner investigating the earlier death had made nine recommendations, including the use of appropriate clothing and footwear, training, supervision and regular pre-season inspection of all fishing vessels, including their electrical systems. The recommendations were not followed. The Coroner investigating Ryan's death found that Ryan 'would be alive today, had those recommendations been followed, even in part'. The Coroner found that Austral Fisheries did not follow their own Safety Management System and failed to reduce the risk of electrocution as low as reasonably practical or at all.

In addition to the failure of the regulators to take steps to prevent the death of Ryan Donoghue, the response after his death was also inadequate. Initially, there was a dispute between the Northern Territory and Queensland Work Health and Safety authorities regarding jurisdiction. After a number of months, it was determined that Queensland had jurisdiction. Queensland Work Health and Safety's investigation found that there had been no substantial failure by the employer. The Queensland Department of Transport and Main Roads found that possible offences had been committed, but that the vessel was not within the jurisdiction of Queensland at the time. Neither the Australian Maritime Safety Authority nor WorkSafe NT took any action. The matter was only followed up after the Coroner referred the matter back to NT WorkSafe for 'further and better' action. NT WorkSafe eventually commenced a prosecution but has recently dropped charges against Austral in exchange for an enforceable undertaking.[8]

Nationally Consistent Enforcement

The overwhelming and consistent feedback from our affiliates is that regulators in all jurisdictions are disproportionately focusing on 'positive motivators' at the expense of deterring non-compliance

[8]http://www.abc.net.au/news/2018-06-22/austral-fisheries-over-prawn-trawler-death-charge-dropped/9899732?pfmredir=sm

through monitoring and enforcement activities. The National Compliance and Enforcement Plan (**NCEP**) sets out the approach regulators are supposed to take to WHS compliance and enforcement, including the criteria used to guide enforcement decisions. In principle, the ACTU supports a national policy setting out a consistent set of principles and operating protocols to guide compliance and enforcement. However, the ACTU has serious concerns about the adequacy and effectiveness of the NCEP as currently drafted. Firstly, the NCEP lacks detail and specificity. It does not provide adequate guidance on when and how the available compliance and enforcement tools should be used in practice. Secondly, the NCEP does not set out a comprehensive, effective enforcement strategy or methodology.

The NCEP states that *'regulators seek to use an effective mix of positive motivators, compliance monitoring and deterrents to encourage and secure the highest possible levels of compliance with work health and safety laws'*. The adoption of the constructive compliance model is reflective of a trend in policy development in regulatory bodies in many other like-minded countries. The ACTU does not oppose in principle the graduated compliance enforcement model. However, the balance between positive motivators and deterrence must be appropriate. Voluntary compliance is being allowed over too long a period - the effectiveness of voluntary compliance activities should be more carefully monitored and outcomes documented. Importantly, a stronger response is needed when duty-holders repeatedly breach WHS laws. In particular, there are not enough prosecutions being undertaken. To be an effective deterrent, there must be a 'credible risk' of prosecution and this is not currently the case. For example, in Victoria less than 1% of accepted WorkCover claims result in a prosecution of an employer for failing to maintain a safe and healthy workplace. Enforcement activity needs to be undertaken more often and earlier, in accordance with a clear strategic plan setting out priority areas for focus and performance indicators and targets. While education and encouragement are undoubtedly important, they can never be a substitute for strong and consistent enforcement of the rules by the regulator.

The NCEP should clearly articulate a national regulatory strategy to be adopted by regulators to determine their priorities for compliance and enforcement activities, including a strategic national approach to prosecutions. Currently, the NCEP places the obligation to develop such a strategy on individual regulators. This approach does not do anything to encourage a consistent national approach or effective targeting of high-hazard, high-risk industries, occupations and sectors and common injury types. The NCEP must also include mechanisms and measurable indicators to ensure that regulators better understand how to achieve an appropriate balance between education and encouragement on the one hand, and enforcement activity on the other. The NCEP should set out more clearly the processes, expectations and consequences for non-compliance. The focus of the regulators should be on sectors and industries where there are large numbers of vulnerable employees (e.g. low paid and with limited capacity to complain), and deterrence should be prioritised.

Prosecutions should target serious and repeated breaches, and/or breaches by high-profile or influential duty-holders and market-leaders, and details should be prominently publicised.

Data collection and classification

The data kept by regulators on prosecutions is inadequate. Regulators should keep a common, publicly available database of completed prosecutions, including information about the date of the prosecution, the nature of the entity prosecuted, the type of issue giving rise to the prosecution, the provision of the Model Act under which the prosecution was taken, the court in which the prosecution took place, the plea entered by the defendant, and the sentence imposed by the court. The database should also include links to all written court decisions.

There is also a number of problems with the collection and classification of data relating to deaths at work, including the discrepancy between the categories of 'notifiable fatalities' and 'traumatic deaths at work', complete exclusion of non-traumatic injuries from the work fatalities data – for example work-related cancers (Mesothelioma Registry is the one exception), cardiovascular disease etc, and the regulators' reliance on workers compensation data to inform enforcement activity, when this is neither comprehensive nor reliable. The submission of the AMWU addresses these matters in detail. Adequate data collection and classification is crucial to enable regulators and social partners to take effective action to prevent death and injury at work.

Safety implications relating to the increased use of temporary and labour hire workers

Over 40% of the Australian workforce is employed in some form of precarious or insecure employment. These workers are more likely to be injured at work for a range of reasons, including inadequate training and induction, fear of reprisals for speaking out about safety concerns, lack of access to participation and consultation processes, lack of regulatory oversight, poor supervision, inadequate access to effective safety systems and exposure to frequent restructures and down-sizing. Precarious workers experience a range of sub-standard working conditions in Australia, from lack of rights to participation and consultation and job insecurity at best, to slavery-like conditions in certain sectors and industries at worst.

WHS failures in precarious employment situations are primarily a result of a failure of enforcement, not the adequacy of existing laws. However, improvements can and must be made to the Model WHS laws to better assist duty-holders operating in complex work environments to understand and comply with their duties. The Model Laws must make it clear that powerful actors (such as retailers and head contractors) at the top of complex industry structures (such as labour hire arrangements, contractor arrangements, supply chains, joint ventures, alliances and franchise arrangements) are required to identify who is performing work right down to the bottom of these structures and to consult, cooperate and coordinate with workers and other duty-holders to identify and eliminate the WHS risks facing all

these workers. A number of suggested amendments are outlined in the ACTU's submission to the 2018 Review of Model WHS laws to address this issue, including an amendment to s 19 of the Model Act to ensure that labour-hire and supply chain arrangements are effectively covered by the primary duty of care, and updates to the Model Codes and Regulations to better explain the scope and nature of the primary duty of care as it applies in practice to 'non-standard' employment arrangements.

The role of employers and unions in creating a safe-work culture

Worker and union participation at all levels plays a pivotal role in the effective implementation of WHS legislation in Australia. The National WHS Review acknowledged that effective participation and representation of workers are crucial elements in improving WHS performance. A recent Harvard University study confirms that unionisation is associated with significantly lower workplace fatality rates.[9] The consequences of inadequate consultation and participation of workers and unions in WHS matters can be fatal. In its submission to the Model WHS Laws review, the ACTU recommends a number of improvements to the powers of Health and Safety Representatives (**HSRs**) and union Entry Permit Holders (**EPHs**) to strengthen their capacity to represent workers in a changing work environment. In particular, reforms are needed to ensure that HSRs are able to operate without interference, including accessing appropriate training of their choice, and to improve the functioning of Health and Safety Committees. The ACTU refers the Committee to these recommendations.

In the specific context of industrial deaths, other relevant parties should also be empowered to play a role, in particular the families of those killed at work. In 2017, the Queensland Parliament passed laws to establish the Persons Affected by Work-Related Fatalities and Serious Incidents Consultative Committee. This committee has the legislative mandate to give advice to the Queensland Government about the information and support needs of persons affected by work-related fatalities and serious incidents. Families have long advocated for a greater voice in how Government responds to families and injured workers. The ACTU welcomes the establishment of this Committee and recommends that all jurisdictions be required to establish such a body.

The effectiveness of penalties in situations where an employer has been convicted of an offence relating to a serious accident or death

The need for regulatory change in Australia arises from repeated failures or withdrawals of prosecutions and the awarding of manifestly inadequate financial penalties in cases of workplace death and serious injury. There are many examples:

[9] Zoorob M, *Does 'right to work' imperil the right to health? The effect of labour unions on workplace fatalities*, *Occupational Environmental Medical*, Published Online First: 13 June 2018. doi: 10.1136/oemed-2017-104747

- On 25 September 1998, an explosion occurred at the Esso natural gas plant at Longford in Gippsland. Two workers were killed and eight injured. Esso was prosecuted, found guilty and fined $2 million.[10] This was the largest fine for a workplace offence at the time, but realistically was a drop in the ocean for the company, whose Bass Strait operations generated a similar amount each day.
- The submission of the CFMEU to this inquiry details repeated WHS breaches by the John Holland Group causing death and serious injury. In a case involving a death at the Mount Whaleback mine in Western Australia, the court commented on the insignificant nature of the maximum penalty available under WHS laws, noting that large corporations such as John Holland might be expected by the community to be subjected to substantially higher penalties for WHS breaches causing loss of life.[11]
- In 2013, three pedestrians were killed when a section of a wall on Grocon's CUB construction site on Swanston Street in Melbourne collapsed in high-winds. Grocon, a multi-million dollar corporation, faced a maximum fine of only $305,000 when the case against it was heard in the Magistrates Court rather than the County Court. Ultimately, Grocon was fined only $250,000 for failing to ensure the structural integrity of the wall.[12]
- WHS regulators are being subjected to ongoing criticism in numerous jurisdictions around the country for failing to take adequate or appropriate preventative and/or response action following death and serious injury at work.[13]

Model WHS Act

Currently under the Model laws, there are three categories of offences for failure to meet a WHS duty. Category 1 is a crime. It applies when a duty holder, without reasonable excuse, engages in conduct that recklessly exposes a person to a risk of death or serious injury or illness. The maximum penalty is five years' imprisonment for individuals and monetary penalties of up to $3 million for corporations, $600,000 for officers, and $300,000 for workers and other persons.

Categories 2 and 3 offences do not have the element of recklessness and there is no capacity to rely on a 'reasonable excuse'. A Category 2 offence occurs when a duty holder fails to comply with a

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[10] *DPP v Esso Australia Pty Limited* [2001] VSC 263
[11] *Comcare v John Holland Pty Ltd* [2012] FCA 449
[12] http://www.abc.net.au/news/2014-11-21/grocon-fined-250000-over-fatal-wall-collapse/5908292
[13] For example, in South Australia - https://www.sbs.com.au/news/icac-scrutinises-safework-sa-investigation; Tasmania - https://www.theadvocate.com.au/story/5479622/gorrie-inquest-hears-no-prosecutions-over-penguin-mans-2014-death/; the ACT - http://www.abc.net.au/news/2016-12-06/industrial-prosecutions-under-fire-in-case-of-cleaner-who-fell/8096476; NT - http://www.abc.net.au/news/2016-06-03/ryan-donoghue-prawn-trawler-death-inquest-findings/7475586; and WA - https://www.watoday.com.au/national/western-australia/young-workers-deaths-spark-update-of-out-of-date-wa-work-laws-20170712-gx9xtt.html

health and safety duty that exposes a person to risk of death or serious injury or illness. A Category 3 offence occurs when a duty holder fails to comply with a health and safety duty. Penalties for Category 2 and 3 offences are monetary only. For a corporation, a maximum of $1.5m for Category 2 offences and of $300,000 for Category 3 offences. For an individual as a PCBU or officer, a maximum of $300,000 for Category 2 and of $100,000 for Category 3 offences. For an individual as a worker or other, a maximum of $150,000 for Category 2 and $50,000 for Category 3.

Volunteers cannot be liable for a failure to comply with a health and safety duty except in their capacity as a worker or other person at a workplace. An unincorporated association is not liable for prosecution although its officers (other than volunteers) may be prosecuted for a failure to comply with an officer's duty, and its members may owe duties in their capacities as workers or other persons.

All three offences in the Model Laws focus on the duty to *manage* risks, rather than the *outcome* of failures to meet such duties. The ACTU agrees that it is appropriate for Australia's WHS regime to focus on risk-management, by placing a strict duty on persons conducting businesses or undertaking to manage WHS risks, regardless of the outcome of those failures. However, in circumstances where the consequence of negligent acts or omissions is the death of an individual or individuals, a specific offence focused on the outcome is also appropriate and necessary.

Fines

Monetary penalties are likely to continue to be the principal sanction for offences under the Model WHS laws, so it is essential that they are set at appropriate levels. The level at which penalties are currently set in legislation does not act as an effective deterrent, particularly for large and profitable companies. Penalties under the Model laws do not meet community expectations and must be reviewed and substantially increased to ensure that they are appropriate given the grave consequences of WHS breaches, and commensurate with penalties applicable in other jurisdictions such as environmental and consumer law. Consideration should be given to increased penalties for larger sized businesses and/or repeat offenders.

Large businesses in particular must bear penalties which are appropriate to their size, in order to achieve specific and general deterrence. Courts should be able to impose larger penalties depending on the size of the business which has committed the offence, based for example on a percentage of annual turnover. This would be consistent with the approach taken by other corporate regulators. For example, the Australian Competition and Consumer Commission has recently announced an intention

to seek bigger fines for big business in an attempt to change corporate culture.[14] Under new laws before Parliament, the penalty for consumer breaches by a company will rise from $1.1 million to $10 million, or 10 per cent of turnover. Fines for individuals will increase from $220,000 to $500,000. While it is absolutely appropriate that companies are heavily penalised for misleading consumers, it is totally inappropriate that penalties imposed for breaches causing death and harm to workers and others are comparably so low.

The inadequate deterrent effect of low maximum penalties available under the Model WHS laws is exacerbated by the fact the level of fines imposed by courts is consistently low, even for the most serious of breaches. For example, in NSW from 2014-16, penalties for breaches resulting in fatality have averaged just 12% of the maximum fine. This is further compounded by the lack of capacity for unions to pursue legal action for breaches of the Model laws, the failure of the current national enforcement strategy, the absence of an offence of corporate manslaughter, and the ability for companies to insure against, or liquidate in order to avoid, any fines that are imposed. This is discussed in more detail below.

Insurance again WHS fines

The deterrent effect of penalties is almost entirely undermined if insurance companies, rather than duty-holders themselves, are able to pay fines. Under the Model laws, there is no provision expressly prohibiting contracts providing liability insurance against WHS penalties. Section 272 provides that a term of any agreement or contract that purports to exclude, limit, modify or transfer any duty owed under the Act is void. However, it is not clear whether a contract for directors' and officers' liability insurance indemnifying for penalties under the Model laws would be a contravention of s 272, and this matter is yet to be considered by the courts. As a matter of practice, corporations are readily able to, and frequently do, insure against WHS penalties. As a consequence, it is predominantly insurance companies rather than duty-holders paying fines following successful prosecutions. While no Australian jurisdiction currently prohibits contracts providing liability insurance against WHS penalties, s 29 of New Zealand's *Health and Safety at Work Act 2015* provides a precedent. In New Zealand, an insurance policy or a contract of insurance which indemnifies or purports to indemnify a person for the person's liability to pay a WHS fine or infringement fee is of no effect, and persons seeking to enter into such a contract commit an offence. The ACTU recommends that the Model WHS Act include a new offence prohibiting contracts providing liability insurance against WHS penalties and fines.

[14] http://www.abc.net.au/news/2018-02-20/larger-fines-for-big-business-tops-accc-priority-list/9465346

Phoenixing

In many industries, it is far too easy for companies to hide behind the 'corporate veil', including 'phoenixing' to avoid their liabilities for a WHS offence (see the recent example of AB Recycling). There is little point in establishing offences and penalties for WHS breaches if the companies and individuals responsible for breaches can easily escape accountability. Current levels of coordination between relevant regulators and policy and legal responses are not sufficient to stop companies phoenixing to avoid their legal obligations. Strategies, mechanisms and forums to improve cooperation between WHS regulators and other relevant regulatory bodies, including ASIC, must be considered. Government must consider a range of initiatives[15] to strengthen the ability of regulators to enforce the Model laws against companies likely to go into liquidation or otherwise seek to avoid liability, including specific phoenixing offences and penalties, bans on being a director if liability for a serious breach is established by a court, personal liability for directors and shareholders where a company becomes insolvent because of a failure to maintain a safe work place, and amendments to ensure penalties administered for safety breaches are enforced through a range of government options, including tracking the operations of a company and its directors through mechanisms such as Director Identification Numbers, and government licensing and procurement consequences (see below).

Comcare Licensing and Government Procurement

Case Study – John Holland

The John Holland Group of companies (**JHG**) is a significant player in the Australian construction industry. Major construction contracts worth hundreds of millions of dollars have been awarded to the JHG by the Commonwealth Government over the last ten years. Since 2007, it has held a self-insurance licence under the Comcare scheme. This allows it to manage all its own workers' compensation claims and accept liability for compensation payments in cases of work-related injury or death. The licence is granted by a Commonwealth agency called the Safety Rehabilitation and Compensation Commission. Over recent years, JHG has been repeatedly prosecuted and penalised for WHS breaches caused by systemic WHS failures, including four fatalities. Despite this, JHG continues to enjoy its privileged status as a Commonwealth self-insurance licence holder and recipient of lucrative Commonwealth government contracts.

Case Study – McConnell Dowell

[15] Hedges, Jasper and Anderson, Helen L. and Ramsay, Ian and Welsh, Michelle Anne, *No 'Silver Bullet': A Multifaceted Approach to Curbing Harmful Phoenix Activity*, Company and Securities Law Journal, Vol. 35, No. 4, pp. 277-282, 2017.

Another example which illustrates the failings of the current framework is the death of 32 year old Tim Macpherson at the Barangaroo Ferry Hub construction site. The Ferry Hub was a major, government-funded piece of public infrastructure. In around 2015, the NSW Minister for Transport and Infrastructure put the project out to tender and McConnell Dowell, after winning the tender, sub-contracted Brady Marine & Civil Pty Ltd to use a barge called the *Maeve Anne* to assist in the construction phase. On 30 May 2016, the barge was issued a prohibition notice by the Australian Maritime Safety Authority and taken offline, because it did not have the required safety certification under maritime laws. Between June and October 2016, the barge was issued with exemptions by NSW Roads and Maritime Services and the Australian Maritime Safety Authority so that it could continue to operate on the project. In November 2016, McConnell Dowell refused two MUA officials permission to enter the site under NSW WHS legislation. On 1 March 2017, Tim Macpherson was struck and killed while working aboard the *Maeve Anne*. On 7 March 2017 the MUA inspected the *Maeve Anne* under NSW WHS legislation, and multiple deficiencies were identified.

These case studies illustrate numerous shortcomings with the current legal and regulatory environment, including inadequate preventative and response action by the regulators and the failure of government procurement standards. Government must ensure that corporations receiving substantial public funding must comply with at least basic WHS standards. Corporations which repeatedly breach WHS duties and cause death and serious injury through their negligence must have their licenses suspended or cancelled, and must not be permitted to tender for government work.

Enforceable Undertakings

Enforceable undertakings should be prohibited when the contravention is connected to a fatality, involves reckless conduct or where the applicant has a recent prior conviction connected to a work-related fatality, or more than two prior convictions arising from separate investigations.

Category 1 offences

To prove an employer or individual was reckless, a regulator must prove "foresight on the part of the offender that the conduct (to be) engaged in would probably have the consequence that another person at the workplace was placed, or could be placed, in danger of serious injury" (*Orbit Drilling Pty Ltd v R* [2012] VSCA 82, [24]) and that the offender displayed "indifference as to whether or not those consequences occur" (*R v Nuri* [1990] RV 641, 643). That is, the regulator must prove the accused knew their act or omission would have or could have placed a person at risk of serious injury and continued regardless. It has proven too difficult to prove the standard of recklessness required for a Category 1 offence. It should not be necessary to prove both foresight and indifference in order to secure a Category 1 prosecution. It should be sufficient to prove a failure to take reasonable steps to ensure the health and safety of workers and others. The ACTU recommends that the standard

should instead (or alternatively) be 'negligence'. It should also be clarified that Category 1 and Category 2 offences in the alternative can be pursued in any one prosecution.

Corporate Manslaughter

Common Law

Principles governing corporate criminal liability in Australia derive mainly from the common law. The general principle is that a corporation is 'personally' liable for the mental state and conduct of a 'guiding mind' (the board of directors, managing director or another person to whom a function of the board had been fully delegated) acting on the corporation's behalf.[16] In addition, where an employee or agent acting within the actual or apparent scope of his or her employment commits the physical element of the offence, a company may be held criminally liable if it had expressly, tacitly or impliedly authorised or permitted the commission of the offence.

Liability of a corporation depends on whether the acts in question were the actions of persons representing the directing mind and will of the enterprise. The court in the key case on this issue, *Tesco Supermarkets Ltd v Nattrass*, held that the acts of the manager of one store in a supermarket chain could not be considered to be the acts of the corporation, because the manager was too far down the chain of command to be part of the 'nerve-centre' of the corporation. The board of directors had not delegated any of their functions that far down the chain of command and so 'remained in control'.[17] Some significant public policy problems arise from the doctrine in this decision, including the fact that the Board's retention of 'control' insulated the corporation from criminal liability for the acts of any person outside the inner circle. This presents a significant problem in the context of WHS duties, which are generally not managed at the Board level. Breaches of WHS duties generally occur at the level of middle management, often caused by unrealistic work targets set by senior leaders. The *Tesco* principle means that companies with large and complex operations are – through a legal technicality – able to avoid criminal liability, whereas smaller businesses and individuals can be held to account. This result is highly unfair and undesirable.[18] The current legal framework is also incapable of responding when no particular person is at fault, but rather a poor workplace culture has created a situation where an incident causing death or serious injury was bound to happen.

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[16] *Tesco Supermarkets Ltd v Nattrass,* which has been followed in many Australian decisions, including *Trade Practices Commission* v *Tubemakers of Australia Ltd* and *Entwells Pty Ltd* v *National and General Insurance Co Ltd*

[17] Hill. J, *Corporate Criminal Liability in Australia: An Evolving Corporate Governance Technique?*, Journal of Business Law 1 (2003)

[18] Compare *R v Denbo Pty Ltd*, in which a small family company was successfully prosecuted under the Victorian Crimes Act, with *DPP Reference No 1 of 1992* [1992] 2 VR 405, in which the majority of charges failed following the collapse of a wall at a local swimming pool which resulted in serious injury to a number of school children due to the complexity of demonstrating, in the context of a large bureaucracy, that the City Engineer was both responsible for the disaster and the 'directing mind and will' of the Council.

Commonwealth Criminal Code

Part 2.5 of the Commonwealth Criminal Code (**the Code**), which commenced operation in late 2001, provides a statutory framework for corporate criminal responsibility at the federal level. The provisions have general application to all Australian Commonwealth offences, although a number of important offences have been exempted from the regime. The regime was a significant reform in corporate liability law, because it recognises concepts of organisational due diligence and responsibility, and the importance of maintaining a good corporate culture, rather than simply focusing on directors' individual responsibilities.

The reforms were implemented following the findings of a sub-committee of the Standing Committee of Attorneys-General from Commonwealth, State and Territory Governments (**the Committee**). Significantly, the Committee concluded that the *Tesco* principle was 'no longer appropriate' to underpin corporate criminal liability because of more disintegrated and complex governance structures and delegation to middle managers.[19] The concept of 'corporate culture' was considered by the Committee to mirror the notion of 'intent' as it relates to personal responsibility, and to be a fair and reasonable way in which corporations could be held liable for their policies and practices. Relevantly, the Explanatory Memorandum for the Code explains that the provisions were intended to overcome the problems in *Tesco*, by covering management practices such as where employees are given production deadlines which cannot be met without breaches of safety legislation, and impliedly threatened with dismissal if they do not comply.

Under the Code, the physical element of an offence will be attributed to a body corporate where it is committed by an employee, agent or officer acting within the actual or apparent scope of his or her employment. The fault element of intention, knowledge or recklessness will be attributed to a company if the 'company expressly, tacitly or impliedly authorises or permits the commission of an offence', which is proved when:

- the corporation's board of directors intentionally or knowingly carried out the relevant conduct or expressly, tacitly or impliedly authorised or permitted the commission of the offence;
- a high managerial agent of the corporation intentionally or knowingly engaged in the relevant conduct or expressly, tacitly or impliedly authorised or permitted the commission of the offence;
- a corporate culture existed within the body corporate that directed, encouraged, tolerated or led to noncompliance with the offence provision;

[19] Standing Committee of Attorneys-General, Criminal Law Officers Committee, Model Criminal Code, Chapter 2, Final Report: General Principles of Criminal Responsibility (AGPS, Canberra, 1993), Part 5.

- the body corporate failed to create and maintain a corporate culture that required compliance with the relevant provision.

'Corporate culture' is defined in the Code to mean an attitude, policy, rule or practice existing in the corporation generally or in the part of the corporation where the relevant offence was committed. Significantly in the context of WHS risk management, the conduct of any number of a corporation's employees, agents or officers can be aggregated. Negligence may be proved by the fact that the prohibited conduct was substantially attributable to inadequate corporate management, control or supervision of the conduct of one or more of its employees, agents or officers or a failure to provide adequate systems for conveying relevant information to the relevant persons in the body corporate.

Why is a new offence of corporate manslaughter needed?

In the absence of an offence of corporate manslaughter, criminal prosecutions of medium and large corporations are effectively impossible, and therefore the current laws do not and cannot act as an effective deterrent or incentive for better practices.

A new offence of corporate manslaughter is necessary to ensure that corporations which cause, or substantially contribute to, the death of a person through a negligent act or omission, are held accountable and incentivised to improve unsafe practices and corporate cultures. Corporations are not merely private ventures, they have a relationship with society more broadly and perform various socially important functions. They have the potential to impact on the well-being of the community in profound ways. This justifies the need for regulation which recognises this profound social impact and protects the community from adverse effects (such as work-related death) when it is caused by negligent or reckless corporate behaviour.

While individual liability is crucial, it is essential that the capacity to prosecute at an organisational level also exists given the pressing social nature of these matters. Under the current framework, corporations are able distance themselves from offences and avoid consequences. Individuals are allowed to become scapegoats for poor and unsafe workplace corporate cultures. This is not only grossly unfair, but it also fails to act as an effective deterrent or an incentive for better, safer corporate cultures.

A new offence would complement and strengthen the existing personal liability provisions in the Model Act by acting as a strong deterrent against the worst kind of WHS failures – namely those that result in the death of a worker or other person. The creation of the new offence would convey in no uncertain terms the important message that WHS failures can and do have the most serious of consequences and, if this occurs, corporations will be held accountable. A new offence of corporate manslaughter would be highly effective in promoting awareness and understanding of existing duties to manage risks, and in ensuring that these duties are taken seriously. In the ACTU's strong submission, a new offence of corporate manslaughter - if effectively publicised and prosecuted - will

become a valuable tool to assist in the deterrence of the negligent conduct that is leading to workplace fatalities.

Existing corporate manslaughter laws

Two Australian jurisdictions have already introduced corporate manslaughter provisions following parliamentary inquiries,[20] and another has indicated its intention to do so.

In 2004, the ACT became the first jurisdiction in Australia to introduce an offence of corporate manslaughter via the *Crimes (Industrial manslaughter) Act 2003*, which added a new Part 2.5 to their Criminal Code. 'Industrial manslaughter' is defined as causing the death of a worker while either being reckless about causing serious harm to that worker or any other worker; or being negligent about causing the death of that or any other worker.

On 12 October 2017, the Queensland Parliament introduced new corporate manslaughter provisions into their WHS legislation. Under these laws, a PCBU found guilty of corporate manslaughter may be liable for a fine of up to $10 million, while an individual may be liable to a term of up to 20 years' imprisonment. There are two new criminal offences of corporate manslaughter: for a PCBU and/or a senior officer, if a worker dies (or is injured and later dies) in the course of carrying out work and the PCBU or senior officer's conduct (either by act or omission) causes the death of the worker; or the PCBU or senior officer was negligent about causing the death of the worker by the conduct. A 'senior officer' is defined as an executive officer of a corporation (i.e. a person who is concerned with, or takes part in, the corporation's management); or for a non-corporation, the holder of an executive position who makes, or takes part in making, decisions affecting all, or a substantial part, of a PCBU's functions.

On 26 May 2018, the Victorian Premier announced his plans to introduce corporate manslaughter offences in Victoria if re-elected. The new Victorian offences would attract maximum penalties of 20 years' imprisonment for individuals or a fine of up to approximately $16 million for corporations. Each of these penalties is significantly higher than the existing maximum penalties under the Victorian *Occupational Health and Safety Act 2004* for reckless endangerment—currently set at five years' imprisonment or a fine of approximately $285,000 for individuals and a fine of approximately $3.2 million for corporations. The offences appear likely cover circumstances in which a member of the public (not just a worker) has died. If elected, the Victorian Government has signaled an intention to

[20] ACT Standing Committee on Legal Affairs, *Crimes (Industrial manslaughter) Amendment Bill 2002*, Report No. 6, September 2003; Queensland Parliament Finance and Administration Committee, *Work Health and Safety and Other Legislation Amendment Bill 2017*, Report No. 46, 55th Parliament, October 2017

establish an Implementation Taskforce, including business and unions, to consult on the detail of the proposed laws.

In light of the number of jurisdictions which have already, or are likely to, introduce new corporate manslaughter provisions, an amendment should be made to the Model Laws to introduce a new offence of corporate manslaughter. It is not fair that the family of a worker killed at work may or may not have access to justice depending on the jurisdiction they happen to be in. The ACTU submits that this reform is essential in order to change workplace cultures (particularly in medium and larger companies which currently cannot be held accountable) and prevent workplace deaths.

Operation of the provisions

A new offence of corporate manslaughter should be included in WHS laws, rather than the criminal law. The framework for placing duties on workplace actors, including importantly those beyond the traditional employment relationship, is already established in WHS law. The Model WHS Act should be amended to include a specific offence of causing the death of a worker or another person in the workplace through a negligent act or omission. The offence should apply to duty-holders and officers and should be subject to appropriate penalties, including substantial periods of imprisonment.

The ACTU recommends the adoption of provisions based on the existing Queensland provisions, with the amendment that the offence should include *any person* killed by the negligence of the PCBU. This would be consistent with a PCBU's duty under s 19(2) of the Model Act and would cover situations like the fatal wall collapse at the Grocon site in Carlton, Victoria in 2014, which killed three pedestrians. It also addresses the challenges present in the building and construction industry, which is characterised by numerous principal contractors and subcontractors working alongside each other at a worksite. In such circumstances, it is reasonably foreseeable that a PCBU may negligently cause the death of a worker who carries out work for *another* PCBU.

While the introduction of a new offence in WHS law will overlap with the existing criminal law when an individual is prosecuted, it is to be expected that in practice, an individual causing the death of a worker will be pursued under the WHS law, unless the police wish to progress charges under the criminal law instead. As there is no effective way in which to prosecute a medium or large corporation under the criminal law currently, WHS law would in practice always be used.

There is a question about how a new offence would interact with existing Category 1 offences. Under the current framework, a Category 1 offence is committed where a person exposes an individual to death or serious injury, regardless of the actual outcome. A new offence of corporate manslaughter would apply only in circumstances where the *outcome* of the conduct is that a worker dies, or is injured and later dies as a result of that injury. If the person or corporation's negligent conduct causes the death of the worker, the person or corporation may be prosecuted for corporate manslaughter. The standard of criminal negligence would apply, meaning that the prosecution must prove beyond

reasonable doubt that the person or corporation's conduct departed so far from the standard of care expected to avoid danger to life, health and safety, and the conduct substantially contributed to the death.

Strengthening personal liability under the WHS Act

As accepted by the National WHS Review Panel, personal criminal liability of company officers with involvement in relevant decisions plays a key role in encouraging company compliance with WHS obligations. Prior to harmonisation, almost all Australian jurisdictions provided for some form of personal liability for breaches of WHS duties of care. Four of those regimes (NSW, Queensland, South Australia and Tasmania) placed the onus on the accused to prove a defence of 'due diligence' or similar. The definitions of 'officer' varied between jurisdictions. During the harmonisation process, the ACTU supported a model similar to the pre-harmonisation NSW provisions, which deemed a 'director' and those concerned in the management of the corporation to be liable for the offence of the corporation, unless they could make out the defences of due diligence or not being in a position to influence the contravention. The onus of proving a failure to meet the standard of due diligence was on the prosecution.

Although provisions for personal liability are included in the Model laws, the Model laws did not adopt the ACTU's preferred model. Instead, s 27(1) of the Model Act places a positive duty on an officer of a corporation to ensure that the PCBU complies with its duties under the legislation. That duty is qualified by a requirement to exercise due diligence, and the officer is liable for their own conduct or omission, not that of the corporation. Section 27(5) of the Model Act sets out the elements of the duty of due diligence in the WHS context, which essentially codifies the content of the due diligence obligation as interpreted by the courts. The National Review Panel justified this model on the basis that it was more likely 'to ensure appropriate, proactive, steps are taken by an officer for compliance by the company with the duties of care placed on the company'. The ACTU submits that the NSW formulation was appropriate and adequate; but does not oppose the 'positive duty' formula in the Model Laws.

To the ACTU's knowledge, there have been no successful prosecutions of officers under the Model Laws to date. In the ACTU's submission, there are four aspects of the personal liability regime that require reconsideration. Firstly, the definition of 'officer' should be amended so that it captures all senior managers who significantly impact on WHS outcomes. Secondly, the list of matters in the definition of due diligence should be *inclusive*, not exclusive. Thirdly, due diligence should be a defence to the duty of care offences, not a qualifier to the primary duty, and the onus of proof should be on the defendant to make it out. Fourthly, the Model Regulations and Codes should be updated to include detailed information for directors and senior managers on how they can meet their obligations and what 'due diligence' means. These matters are discussed in further detail below.

The definition of 'officer'

The Model Act defines 'officer' by reference to the definition in s 9 of the *Corporations Act 2001* (Cth). The key criterion is whether the person makes decisions affecting *the whole, or a substantial part of*, the business or undertaking. The Corporations Act definition is more extensive and detailed than the definition in the pre-harmonised NSW legislation, but in the ACTU's submission, it is not necessarily more appropriate. This is because elements of the Corporations Act definition focus on management as it relates to the 'financial affairs' of a company. While this is clearly appropriate in the context of a legislative regime which imposes a number of financial management obligations on companies, it fails to effectively target senior decision-makers involved in health and safety governance in an organisation. It is of course completely inappropriate for managers who do not significantly influence WHS outcomes to be held personally liable for breaches of the Model Laws, and provisions need to be carefully drafted to ensure that such people are excluded and have a strong and clear defence available in the event that allegations are made. The inadequacy of the current definition is demonstrated by the case of *Mckie v Al-Hasani and Kenoss Contractors Pty Ltd (in liq) [2015] ACTIC 1*. In that case, a worker died when his truck connected with powerlines. The court considered whether the project manager was an 'officer' within the meaning of the Model Act. The court held that it is the person's influence over the PCBU as a whole, not just over the particular project, undertaking, function or event relevant to the alleged breach of duty that must be assessed. Indicators such as the following were considered relevant to the question of whether or not the project manager was an 'officer' or not:

- Responsibility for hiring and firing employees;
- Capacity to allocate corporate funds;
- Capacity to direct the type of contracts to be pursued by the business;
- Responsibility for signing off on tenders;
- Responsibility for determining corporate structures and setting company policy;
- Attendance at Board meetings;
- Responsibility for compliance with legal obligations.

The project manager was a well-qualified engineer and a senior manager in the company with substantial ability to influence the safety and health of workers and others on the project he managed. He had been personally served with a prohibition notice regarding work near power lines in August 2008 on another project. The court found that the project manager was fully aware of the risks associated with the live overhead power lines above the site he managed but failed to exercise due diligence in respect to safety compliance. Despite this, the court held that there was no evidence of any involvement in the matters listed at paragraph 56 (i)-(vii) above, and therefore he had an operational role only and was not an 'officer' within the meaning of the Model Act. This decision indicates that the current definition is excluding the very senior decision-makers whose behavior the Model Laws are seeking to change. The purpose of these provisions is to improve WHS outcomes using the incentive of personal criminal liability. However, the exclusion of key decision-makers from the definition of officer seriously undermines this goal. The definition of officer must capture people with a significant level of influence over WHS outcomes; otherwise the purpose of the provision is defeated.

The ACTU recommends that the use of the Corporations Act to define an 'officer' for the purposes of the Model Act be reconsidered. Use of the earlier NSW formulation, or alternatively, a new definition focused on *the capacity of the person to significantly affect health and safety outcomes* should be developed in consultation with stakeholders, should be considered.

Due Diligence and a partial Reverse Onus of Proof

The National Review Panel explained that the standard of due diligence:

…should be a high one, requiring ongoing enquiry and vigilance, to ensure that the resources and systems of the entity are adequate to comply with the duty of care of the entity—and are operating effectively. Where the officer relies on the expertise of a manager or other person, that expertise must be verified and the reliance must be reasonable.

The ACTU supports this statement. The due diligence formulation should be retained, but as a defence to an alleged breach, with the onus on the accused to prove it on the balance or probabilities. (See the discussion below regarding partial reverse onus of proof). Also, the definition of due diligence in the Model Act should be an inclusive list, not an exhaustive list, to allow for consideration of other matters that may need to be considered in a particular case. For example, in addition to the matters listed in s 27(5) of the Model Act, courts have also referred to the need for an officer to demonstrate that they had laid down a proper system for dealing with the issues and provided adequate supervision to ensure the system was carried out, and other cases have suggested that officers are required to personally respond to incidents that are drawn to their attention. Courts should not be prevented by the drafting of s 27(5) from considering such additional matters where relevant in the circumstances of a case.

Regulations and Codes

There is no guidance provided in the Regulations or Codes on what proactive performance indicators would assist officers to meet their obligations under the Model Act. Officers fall into different categories and have different responsibilities within an organisation, for example, human resources, legal, finances, strategic leadership etc. Officers responsible for ensuring adequate staffing, for example, must consider different matters to officers responsible for financial management. The ACTU recommends that the Regulations and Codes be updated in consultation with stakeholders to ensure that they address the different roles and responsibilities of different categories of officer, as well as standards for reporting on an organisation's health and safety compliance and performance.

Union prosecutions

The ACTU is concerned about the steep decline in prosecutions under WHS legislation over recent years. Under the Model Laws, unions cannot bring prosecutions and the Minister cannot authorise a prosecution by an individual. A request can be made to the regulator, and later the DPP, if a

prosecution is not brought for any offences other than Category 1 offences. The ACTU strongly submits that unions must have standing to bring proceedings for offences under the Model Act in circumstances where they have a member concerned in the breach in question. There should be no requirement for the regulator or the DPP to review a decision to commence a prosecution (as there currently is in NSW), as long as an Australian legal practitioner lodges the application on behalf of the union. Additionally, a court should not be prohibited from allowing the moiety portion of any penalty to be directed to the industrial organisation, where it can be shown that the fine will used in accordance with the rules to better the interests of members. The Model laws should include a limitation period of 3 years for the commencement of proceedings for offences. This would ensure that proceedings are commenced in a timely manner, but provide sufficient time to investigate and prepare complex proceedings. A variation to the standard time limit should be able to be sought in special circumstances.

A right for trade unions to commence prosecutions operates as an important supplement to address circumstances in which regulators are unwilling or unable to prosecute contraventions.
A qualified right of private prosecution (i.e. by a person other than a public official) for criminal matters already exists at common law. In the ACTU's strong submission, it is reasonable, justified and necessary to confer a right of prosecution on workers affected by a breach of the Model Laws and their unions. WHS law is not traditional criminal law, and unions are equipped with a deep knowledge of the WHS issues confronting particular workplaces, industries and sectors. Additionally, the inspectorate may have limited visibility of WHS breaches, particularly in 'non-standard' workplaces, and limited resources to pursue all breaches worthy of prosecution. The option of union prosecutions also addresses the potential conflict of interest presented by a state regulator having to enforce compliance by government PCBUs. There is strong evidence that union prosecutions are effective in bringing about cultural and organisational change and do not present a risk of misuse. For these reasons, a state monopoly on prosecutions for breaches of WHS laws cannot be justified. Union secretaries had standing to bring a prosecution under NSW laws from 1983 until 2011, when the right was curtailed. There is absolutely no evidence of abuse of the right during that period of time. In fact, all prosecutions commenced by unions under the NSW legislation were successful.
Union-initiated prosecutions are subject to the same legal checks and balances as any other prosecution. Prosecutions are invariably conducted by experienced legal practitioners who have professional obligations as officers of the Court that require adherence to the obligations applying to prosecutors in all criminal proceedings. The conduct of prosecutions is also subject to the supervision of the Court. If a prosecution is instituted or maintained or conducted in an improper manner, the Court can take appropriate action to dismiss the proceedings and order the union to pay costs. In the usual way, cases which are frivolous or vexatious are not permitted to proceed, and courts determine the merits of all matters which do proceed in accordance with established and transparent principles. The cost, complexity, delays and risk associated with legal proceedings operate in the usual way to deter unmeritorious actions.

In both NSW and NZ, the right of prosecution has been used by union secretaries sparingly and successfully and has resulted in systemic and industry-wide improvements in safety standards, conferring a significant and lasting benefit on workers, duty-holders and the public more broadly. In particular, trade unions have been able to assist in bringing cases that addressing emerging areas of concern such as psychological injuries, repetitive strain injuries and the commission of criminal acts in the workplace, and in relation to high-risk sectors.[21]

The ACTU submits that the pre-harmonised NSW legislation struck an appropriate balance between the promotion of workplace safety, the encouragement of participation in WHS management and the appropriate protection of defendants. Unions are already empowered to commence proceedings seeking the imposition of penalties for contraventions of industrial laws affecting the interests of their members. For example, trade unions have the capacity to bring proceedings for contraventions of the *Fair Work Act 2009*. While these proceedings involve the imposition of civil rather than criminal sanctions, contraventions can give rise to very substantial monetary penalties. This has not undermined the capacity of employers and unions to work together to ensure compliance with industrial laws.

Partial Reverse Onus of Proof

Generally, a person cannot be convicted of committing an offence unless the prosecution can prove a 'guilty mind'. However, a number of laws, including the Model Act [s 12F(2)], impose 'absolute' or 'strict' liability for offences, meaning that proof of a guilty mind or fault is not required. The creation of offences of absolute or strict liability is common under corporate, environmental and WHS legislation for example, which seek to deter certain behaviour for a compelling social purpose, such as protecting the health and safety of people at work. Under the Model Laws, strict liability applies to non-compliance with a duty of care, qualified by a standard of reasonable practicality. The ACTU submits that both the way in which the primary duty of care is framed, and which party should bear the burden of proving that the standard of reasonable practicality has been met, require reconsideration.

Under the Model Laws, the regulator is required to prove all elements of a breach, including that the duty-holder has *not* taken reasonably practicable measures, or exercised due diligence in the case of an officer, to prevent the breach. This is unreasonably onerous and has, predictably, made it more

[21] The ACTU's submission to the National Review details case studies of union prosecutions in NSW, including on behalf of teachers and banking workers. Unions have had the right to prosecute in New Zealand for approximately 15 years. During that time, only a handful of prosecutions have proceeded to final determination, including two successful prosecutions in the forestry industry after 13 forestry workers died in one year: http://www.scoop.co.nz/stories/AK1508/S00251/ctu-wins-second- forestry-private-prosecution.htm; https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11522865.

difficult for prosecutions to succeed. The National Review Panel justified the removal of the reverse onus (and the right to union prosecutions) that had previously existed for NSW and Queensland workers by referring to 'substantial' increases in the size and range of penalties in the Model Laws. Notwithstanding the ACTU's view that penalties (both the maximums in the Model Act and the levels awarded by courts) are manifestly inadequate to deter breaches, particularly for larger corporations, the deterrent effect of any penalty is almost entirely undermined if the legal framework makes it too hard to successful prosecute breaches. In *WorkCover Authority of NSW v Eastern Basin Pty Ltd* [2015] NSWDC 92, the judge considered the meaning of reasonably practicable in the context of a prosecution of PCBU for a breach of their duty to ensure the safety of workers. The judge held that the prosecution needed to prove the following elements beyond a reasonable doubt:

- That a risk arose from work carried out as part of the business or undertaking; and
- That the measure particularised in the summons would cause that risk to be eliminated or minimised; and
- In all the circumstances (including but not limited to those listed in the legislation) it was reasonably practicable for the PCBU to adopt the measure.

In the ACTU's submission, it is unreasonably onerous for the prosecution to bear the burden of proving these *all* these matters beyond a reasonable doubt. The onus of demonstrating that it was not reasonably practicable to reduce or eliminate the risk occasioning the offence must be borne by the defendant. The matters required to prove whether or not a duty-holder has taken reasonably practicable measures are matters entirely within the duty-holder's knowledge. The duty-holder is in the best position to provide evidence of the conduct engaged in and the reasons for it. While no Australian jurisdiction currently has a partial reverse onus of proof for duty of care offences, Queensland and NSW previously had such provisions. Under the model in those jurisdictions, the prosecutor was still required to prove non-compliance with the elements of the offence beyond a reasonable doubt, but the onus was on the defendant to make out a defence on the balance of probabilities. The NSW legislation did not include the qualifier of reasonable practicability in the duty of care, but included it as a defence to duty of care offences. The onus was on a duty-holder to prove (on the balance of probabilities) that it was not reasonably practicable to comply with the law or that the offence resulted from causes outside the defendant's control. In Queensland, a duty-holder could seek to prove (on the balance of probabilities) that it had applied a relevant Code or Regulation or taken other reasonable precautions and exercised proper diligence to prevent the contravention. In the UK, the *Health and Safety at Work etc Act 1974* places a similar onus on an employer to make out a defence on the balance of probabilities.

The ACTU recognises that this is a contentious matter. The right to be considered innocent until proven guilty is a fundamental aspect of the right to a fair trial. However, like most human rights, it can be limited if the limitation is reasonable, necessary, justified and proportionate in the circumstances. The ACTU submits that the partial reverse onus is necessary and justified in this case

because of the public interest in ensuring the health and safety of people at work. The measure is proportionate and reasonable in light of the practical difficulty of achieving successful prosecutions when the PCBU has, by definition, all or most of the relevant evidence regarding its own conduct in its possession or control. It is not unfair or unreasonable to require a PCBU to demonstrate to a court how and why it had a reasonable excuse for non-compliance.

Courts have considered the reasonableness of a partial reverse onus when it is associated with legislation aimed at achieving a compelling social purpose. For example, the English Court of Appeal has considered whether the reverse onus in UK WHS Act was incompatible with the presumption of innocence enshrined in the European Charter of Human Rights. In *Davies v Health and Safety Executive* [2002] EWCA Crim 2949, the Court found the imposition of the legal burden of proof on employers was justified, necessary and proportionate having regard to the social and economic purposes of the legislation, that duty holders are persons who have chosen to engage in work or commercial activity and that the facts relied upon in support of the defence will be within the knowledge of the defendant. In *R v Wholesale Travel Group* (1991) 3 SCR 154, the Canadian Supreme Court explained why a reverse onus of proof was justified, fair and reasonable in the context of regulatory legislation creating criminal offences:

> *If the false advertiser, the corporate polluter and manufacturer of noxious goods are to be effectively controlled, it is necessary to require them to show on the balance of probabilities that they took reasonable precautions to avoid the harm which actually resulted. In the regulatory context there is nothing unfair about imposing that onus; indeed it is essential for the protection of our vulnerable society.*

In addition, the earlier NSW model was repeatedly endorsed by a series of inquiries into WHS legislation in that State, including the 1995 Federal Industry Commission Report, the 1997 McCallum Report, the Report of the 1998 NSW Parliamentary Inquiry and the Stein Report. The ACTU recommends amendment of the Model Act to place the onus of demonstrating that it was not reasonably practicable to reduce or eliminate a risk giving rise to a WHS duty of care offence on a defendant.

Specialist Courts and Tribunals

There are significant differences between jurisdictions in relation to the type of court in which prosecutions are conducted. Prosecutions for offences under the Model laws should be heard in specialist courts by judges with expertise and experience in industrial and WHS matters. This approach would enable the effective identification and consideration of systemic failings that may be occurring in a workplace, industry or sector, which is vital to the effective enforcement of WHS matters. General criminal courts are traditionally concerned with a particular act or omission of an individual, making them less suited to the determination of offences involving systemic failings and the liability of corporate employers. Proceedings brought in courts with appropriate expertise are likely

to be more efficient and cost-effective and improve the quality and consistency of the interpretation of the Model laws and sentencing outcomes. The use of courts with appropriate expertise benefits all persons involved in proceedings under occupational health and safety legislation, including prosecutors, victims and their families and defendants.

Sentencing Guidelines

The inadequacy of penalties imposed in matters involved serious injury or death at work have already been discussed in this submission. The main objects of the sentencing process are specific and general deterrence. Although the prosecution process is similar across jurisdictions, there are substantial differences between jurisdictions in terms of the courts that hear WHS matters, the maximum penalties available and the options available under general sentencing legislation (if any). For example, in New South Wales, the Commonwealth and the ACT, a court may decide to make an order without a conviction, and can dismiss the charge, or discharge the person on condition that the person enter into a good behaviour bond for a term not exceeding two years or enter into an agreement to participate in an intervention program. On the other hand, in Queensland where a court finds the charges to be proved, there is a conviction. The court has, however, a discretion not to record the conviction, and can also impose penalties, including fines and the kinds of non-pecuniary sanctions set out in sections 236 to 241 of the Model Act. Notwithstanding the fact that the court does not record a conviction, the fact that the defendant was 'convicted' may be taken into account by subsequent sentencing courts, and by the prosecuting authorities in later proceedings.

The ACTU considers that national sentencing guidelines (developed in consultation with stakeholders) to guide the consistent administration of justice under the WHS regime would be valuable. Such guidelines should aim to ensure that sentencing properly and consistently reflects the culpability of the offender and the seriousness of the harm caused.

In the UK, the Sentencing Council is currently consulting on proposed new sentencing guidelines for manslaughter offences. The Sentencing Council is proposing that where an employer has had a long-standing disregard for the safety of employees and is motivated by cost cutting, they can expect a prison sentence of 10 to 18 years should a worker be killed as a result. The Sentencing Council expects that in some gross negligence cases, sentences will increase, for example where a death was caused by an employer's long-standing and serious disregard for the safety of employees which was motivated by cost-cutting.

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