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UNIONSWA
WA's PEAK UNION BODY

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Hon Dr Sally Talbot MLC
Chairperson
Standing Committee on Legislation
4 Harvest Terrace
WEST PERTH WA 6005

Dear Dr Talbot

Submission to the Standing Committee on Legislation - Work, Health and Safety Bill 2019

UnionsWA is the governing peak body of the trade union movement in Western Australia. UnionsWA represents 32 affiliate unions, who in turn represent approximately 140,000 Western Australian workers.

UnionsWA welcomes the opportunity to provide a submission to the Legislation Committee on the *Work Health and Safety (WHS) Bill 2019,* and looks forward to engaging with the Committee on Part 2 of the Bill.

UnionsWA has long supported having strong and harmonised WHS legislation across Australia. However, our support has always been conditional on the national approach not compromising or reducing the protections and standards for workers in any state or territory jurisdiction.

Workplace deaths continue to be a significant issue in both WA and Australia. Recent figures from Safe Work Australia have shown that as at 18 June, there have been 86 Australian workers killed at work in 2020. In 2019, 178 Australian workers were fatally injured while working (up from 144 workers in 2018), so with 2020 not even half over, we are already at 44% of last year's deaths.[1]

Unions also believe that due to the outdated reporting and collating of workplace fatalities in this state in which WA excludes traffic accidents that occur during the course of work from the fatality statistics that the real numbers of workplace deaths might be double or more the reported figures.

UnionsWA has participated in many reviews and consultations on Work Health and Safety Laws by both state and commonwealth governments. These include consultations on the development of the model laws in 2008, and representing workers and their unions on the State Government's Ministerial Advisory Panel (MAP) which began in 2017.

The consultations on WA's *WHS Bill 2019* have been the most comprehensive safety reform process in which we have participated. Throughout the MAP on Work Health and Safety reform process the key stakeholders had unparalleled input into the final draft of the Bill.

UnionsWA appreciated the opportunity to participate as one of the five voting members on the MAP. The process has resulted in a Bill that, while replicating the model laws, contains key changes that preserves important provisions from WA's current *Occupational Safety and Health Act 1984 (OSH Act)*, and incorporates lessons from the operation of model laws in other jurisdictions.

The road to harmonisation in WA has been a long one, with extensive consultation and involvement of both the public and stakeholder groups.

[1]Safe Work Australia Work-related traumatic injury fatalities (https://www.safeworkaustralia.gov.au/statistics-and-research/statistics/fatalities/fatality-statistics)

The Commonwealth, New Zealand and all states and territories except Western Australia and Victoria adopted the laws between 2011 and 2013. It seems that there is no appetite to harmonise with the model laws in Victoria, so WA will likely be the last state to adopt the model WHS laws.

Unfortunately, despite a number of attempts to harmonise, WA retains the *OSH Act 1984* which is out of date and needs to be urgently replaced.

The *OSH Act* contains a series of outdated interpretations and definitions of workplace safety. Workplaces look radically different in 2020 than they did in 1984. The *OSH Act* largely conceives of a workplace as having a single employer, with single category of employees (e.g. full-time, permanent, and directly employed).

However, with the proliferation of labour hire and sub-contracting, and the general fragmentation of employment relationships, it would now be rare that contemporary workplaces reflected the assumptions of the current Act. They are more likely to have multiple employers within one workplace, chains of contracting and/or labour hire arrangements.

The national model laws in this respect are more useful, as they provide a contemporary system of definitions that are more relevant for modern workplaces. For example: 'a Person Conducting a Business or Undertaking' (PCBU) and 'worker', replacing the previous terms 'Employer' and 'Employee'.

A significant improvement in the model laws is the introduction of duties for officers. These are significant for driving the values and culture of a company by those who make the relevant decisions, which in turn encourage appropriate attitudes and behaviours for health and safety.

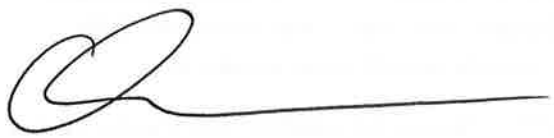
Another improvement for safety outcomes in WA are the officer and due diligence provisions in part 2 of the *WHS Bill 2019*. These will require that officers of PCBUs demonstrate a proactive approach to workplace health and safety.

The model Act, regulations and codes all make substantial improvements to our current laws which will save lives, benefit workplace safety, enforcement and compliance. However, given WA is likely to be the last state to harmonise, the *WHS Bill 2019* also contains a small number of important changes to the model laws that learn from the actual experience of other jurisdictions.

UnionsWA appreciates the opportunity to give evidence on the importance of harmonisation and the *WHS Bill* to the committee. We have consulted in detail with our affiliated unions on this submission and in all of our long participation in government processes on occupational safety.

UnionsWA would welcome the opportunity to appear to give evidence directly to the committee. Please contact me on 08 6313 6000 or owhittle@unionswa.com.au if you wish to discuss matters further.

Yours sincerely



Owen Whittle

Assistant Secretary

History of WHS Harmonisation in Western Australia

The WA Government's path to developing the *WHS Bill 2019* involved extensive stakeholder consultation that began in June 2017, and concluded with the introduction of the Bill in late 2019.

Harmonisation in Western Australia has been a long process, which has involved significant canvassing of stakeholder views on the model laws. Consultation on the model laws has been undertaken by the Carpenter, Barnett and McGowan Governments.

Over the past decade the State Government has had a series of inquiries and submission processes on the model laws that have involved input from UnionsWA and other stakeholder groups. These have included:

- Regulatory Impact Model *WHS Regulations and Codes of Practice*[2] (2012);
- Decision Regulatory Impact Statement: *Structure of Mining, Petroleum and Major Hazard Facility Legislation*[3] (2014);
- WHS Green Bill Consultation Process (2014);[4]
- Department of Mines and Petroleum Resources industry WHS Process (2015);[5]
- Ministerial Advisory Panel on Work Health and Safety Reform (2017-18); and
- Work Health and Safety Regulations for Western Australia (2019).

In addition to these formal inquiries and reviews, the Commission for Occupational Safety and Health, which includes representatives from employer organisations, unions and independent experts, has provided feedback to WorkSafe and Ministers in developing the government responses to the model laws.

National inquiries have also considered the model laws, including:

- Senate Inquiry Report - *They never came home* (October 2018);
- Safe Work Australia/Federal Government *Review into Model WHS Laws* (Feb 2019); and
- Consultation regulation impact statement: *Recommendations of the 2018 Review of the Model WHS Laws* (2019)

The consultation process on the model laws conducted by the State Government has been extensive. The intent for WA to harmonise, and the MAP process, were announced in 2017 and was progressed through meetings held between October 2017 and March 2018.

The *Modernising Work Health and Safety laws in Western Australia* report published by the panel provided a clear pathway for government to progress the model legislation in Western Australia. UnionsWA, along with many of our affiliates, provided submissions to the report about improving the laws to benefit workers.

During the consultation periods for both the MAP and the Commonwealth inquiries, there have been proposals to improve on sections in Part 2 of the model laws. In particular, industrial

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[2] Regulation Impact Statement Model Work Health and Safety Regulations and Codes of Practice in Western Australia (https://www.commerce.wa.gov.au/sites/default/files/atoms/files/final_report-ris.pdf)

[3] Decision RIS: Structure of Mining, Petroleum and Major Hazard Facilities Safety Legislation (http://www.dmp.wa.gov.au/documents/dangerous-goods/dgs_f_decisionrissafetylawreform.pdf)

[4] Worksafe WA, Developments in OSH in WA (https://www.commerce.wa.gov.au/publications/developments-osh-wa-green-bill)

[5] Mining safety in spotlight as WA moves towards adopting WHS harmonisation (https://www.lexology.com/library/detail.aspx?g=9719f325-a0a1-4428-9f01-30aa75771b90)

manslaughter was a major theme of submissions. These inquiries also provided opportunities for extensive public input from families, and others lobbying for change.

The Commonwealth Government's comprehensive review into the operation of WHS laws made a series of recommendations relevant to the final outcome of the *WHS Bill*. Unfortunately, it reported after the MAP meetings had concluded, and was not incorporated into the panel's process.

Consideration of Part 2 in Commonwealth WHS Reviews

Review of the Model Work, Health and Safety Laws 2018

In 2008 national WHS Ministers asked Safe Work Australia to review the operation of the model WHS laws. This was the first such review of the model laws.

The independent reviewer published the *Review of the Model WHS Laws Discussion Paper* in 2018, which invited submissions before publishing a final report in February 2019.

SWA's Review found that the model laws are operating largely as intended, and that their framework is effective and well supported.

The Discussion Paper posed questions to stakeholders and invited submissions over an 8 week period in February – April 2018. A number of the questions interact with Part 2 of the model act, including:

> *Question 5: Have you any comments on the effectiveness of the model WHS laws in supporting the management of risks to psychological health in the workplace?*
>
> *Question 11: Have you any comments relating to a PCBU's primary duty of care under the model WHS Act?*
>
> *Question 13: Have you any comments relating to an officer's duty of care under the model WHS Act?*
>
> *Question 33: Have you any comments on the effectiveness of the penalties in the model WHS Act as a deterrent to poor health and safety practices?*

Following submissions from unions, community members, employers and industry groups, the *Review of the Model WHS Laws Final Report* made extensive commentary on both the duties and the offence provisions in Part 2 of the model act.

After examining the duties of care the Review concluded that:

> *The duties framework is generally understood, settling in people's understanding and working well. Initial concerns with the introduction of the 'person conducting a business or undertaking' (PCBU) concept have been largely unfounded, and there is a general view that key definitions are sufficiently flexible to encompass changing work arrangements, emerging industries and new business models.*
>
> *While I note that the scope of the model WHS laws and their ability to deal with the future of work need to be monitored over the coming years, I recommend some relatively minor changes to clarify the circumstances where a person can be both a worker and a PCBU. The principles that apply to duties (ss 13–17 of the model WHS Act) are widely accepted, but many PCBUs find them difficult to apply in practice. The principle that more than one person can have a duty (s 16 of the model WHS Act) was seen as being particularly problematic.*

Confusion is increased when the s 16 principle is combined with the duty of multiple duty holders to consult, co-operate and co-ordinate (s 46 of the model WHS Act). This is an area where the laws are not operating as intended. I recommend the development of a new model Code providing practical guidance for PCBUs on how to meet the obligations associated with the principles in the model WHS Act and their s 46 duty to consult, co-operate and co-ordinate.

The establishment of officers' duties is one of the key successes of the model WHS laws, although more information is needed to demonstrate how regulators enforce the due diligence provisions (see my discussion in chapter 5, 'National Compliance and Enforcement Policy').[6]

While the model laws duties framework has been successful, unions have long held the view that improvements need to be made to its psychological health provisions. The consultation Regulatory Impact Statement on the Review noted that psychological health and safety was one of the most frequently raised issues by stakeholders during the review process[7].

The Review acknowledged that there was a consistent view amongst submissions that psychological health is neglected in the second and third tiers of the model WHS laws. It recommended that the model regulations be amended to identify psychological risks and appropriate control measures to manage those risks.[8]

In relation to the offence provisions, the Review recommended key changes to the WHS offence provisions. Recommendation 23b of the inquiry proposed the incorporation of a new offence of industrial manslaughter. The reviewer noted that:

Consultations for this Review (mirrored in submissions to the Senate inquiry into industrial deaths) revealed a clear and increasing view amongst a great many in the community that there should be an outcome-based offence in the model WHS laws where the death of another person occurs as a result of the gross negligence of either an individual or an organisation. The strong community expectation is that it should be possible to prosecute for the death of a person under a statutory offence of industrial manslaughter in the model WHS laws.[9]

The Review recommended that the new offence of industrial manslaughter should provide for gross negligence causing death, and include the following:

- The offence can be committed by a PCBU and an officer as defined under s 4 of the model WHS Act.
- The conduct engaged in on behalf of a body corporate is taken to be conduct engaged in by the body corporate.
- A body corporate's conduct includes the conduct of the body corporate when viewed as a whole by aggregating the conduct of its employees, agents or officers.
- The offence covers the death of an individual to whom a duty is owed.

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[6] Review of the Model Work Health and Safety Laws Final Report

[7] Safe Work Australia, Consultation Regulation Impact Statement: Recommendations of the 2018 Review of the Model Work Health and Safety Laws, p 11

[8] Review of the Model Work Health and Safety Laws Final Report p 7

[9] Review of the Model Work Health and Safety Laws Final Report p 120

This important recommendation was welcomed by unions and the family members of deceased workers who had made submissions to the Review in support of the provisions.

At the time of this recommendation Queensland and the ACT had an industrial manslaughter offence. Subsequently a number of states and territories progressed with industrial manslaughter offences with Queensland expanding their industrial manslaughter provisions to cover the resources industry and both Victoria and the Northern Territory enacting the offence.

Key Elements of Part 2 of the *WHS Bill 2019*

Psychological Health and Safety

As noted in the *Review of the Model WHS Laws Final Report,* there is express support from stakeholders for the psychological health provisions in the act, however they noted feedback that psychological health risk and hazards were not addressed in a consistent way throughout the model regulations and codes.

However, while acknowledging these deficiencies in the model laws, we recognise that the model laws and *WHS Bill* contains substantial improvements on psychological health compared to the *Occupational Safety and Health Act 1984*.

One of the biggest deficiencies in the *OSH Act* is that psychological health and safety is not adequately addressed, and there is no clear guidance on how to address psychological hazards in the workplace.

Critically the Legislative Assembly Education and Health Standing Committee Report into Mental Health Impacts of FIFO Work Arrangements recognised these flaws in the *OSH Act* and recommended that:

> *'... making mental health explicit within references to health, and including psychological hazards within references to hazards, will be a significant step forward in assisting companies and industry peak bodies to understand the full extent of their responsibilities'*[10]

Western Australia has led the nation on addressing workplace psychological health hazards with the adoption of the *Mentally healthy workplaces for fly-in fly-out (FIFO) workers in the resources and construction sectors* Code of Practice. However, the absence of clear provisions in the *OSH Act* and regulations have meant that the codes lack enforceability.

The model laws take important steps to include psychological health and safety in the definition of heath and in section 5(a) of the Bill. Further amendments has been made to the *WHS Bill* for an additional note to Section 19 specifying that 'Health means physical and psychological health'.

While UnionsWA supports this amendment made by the state government, we believe that the model WHS Laws and the *WHS Bill* have *not* established a minimum standard for the management of psychosocial hazards in workplaces. This failure will have a significant impact not only on workers and their families, but also on employers and the wider community.

In our day-to-day work we see no shortage of evidence that psychological health hazards are impacting workplaces. This includes the well documented toll of FIFO work, stress and burn out among university and public sector workers caused by high workloads and work intensification, the

[10] Education and Health Standing Committee, Report into mental health impacts of FIFO work arrangements, p iii

increasing level of occupational violence towards workers in education and healthcare workers, and widespread rates of sexual harassment in workplaces.

There have been a number of studies evaluating Australian WHS laws related to workplace psychosocial health or risk management. A 2016 study evaluating regulatory instruments concluded that 'there is poor inclusion of risk assessment, preventive action and poor coverage of exposure factors and psychological health outcomes'[11]. The same study found that duty-holders 'could easily overlook or under-rate the importance of psychosocial hazards', that the Model WHS Laws are 'lacking in clarity', and 'do not provide sufficient impetus for workplace parties to take psychosocial hazards seriously', and that overall there is 'reason to question the potential for the model WHS Act and regulations to reduce psychosocial hazards and their harmful effects[12].

An Australian National University (ANU) report commissioned by Safe Work Australia found that:

> *The limited studies of the effect of psychosocial legal obligations – for Europe generally, and for Sweden and Canada – suggest that legal obligations may help raise the profile of psychosocial hazards and contribute to the motivation in workplaces to take action on psychosocial hazards, which is likely to include establishing policies or procedures. These studies do not enable any conclusions to be drawn about the strengths or weaknesses of particular regimes, but they do suggest that organisational commitment and capacity, including resources, knowledge and skills, are predictors of organisational effort to address psychosocial hazards. To the 3 extent that evidence exists, and it is limited, the studies suggest that legal obligations contribute to motivation more than to capacity .*[13]

The consideration of psychological risk in the duties in the *WHS Bill* and the model regulations is an important step for improving workplace safety outcomes. The adoption of recommendation 2 from the *Review of the Model WHS Laws Final Report,* on expanding the duties in Part 2 of the act in the second and third tier of the model laws, would represent a significant improvement for workplace safety in Western Australia.

Duty of persons conducting business or undertakings that provide services relating to work health and safety – s26A

The *Modernising work health and safety laws in Western Australia* report recommended the incorporation of an additional duty of care to focus on the providers of workplace health and safety advice, services, and products.

The MAP considered the recommendation 89 from *National Review into Model Occupational Health and Safety Laws Second Report (national review)* which recommended that the model Act should include placing a duty of care on a person defined as an 'OHS service provider'[14]. This recommendation from the National Review was never incorporated into the model laws, however the MAP has recommended that it be incorporated in the *WA WHS Bill.*

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[11] Rachael Pottera et al, Analytical review of the Australian policy context for work-related psychological health and psychosocial risks, Safety Science 111 (2019) p 37–48

[12] Rachael Pottera et al, Analytical review of the Australian policy context for work-related psychological health and psychosocial risks, Safety Science 111 (2019) p 9 & 56

[13] Effectiveness of the Model WHS Act, Regulations, Codes of Practice and Guidance Material in Addressing Psychosocial Risks, Report to Safe Work Australia, National Research Centre for OHS Regulation, Australian National University, November 2016, p 6

[14] National Review into Model Occupational Health and Safety Laws Second Report to the Workplace Relations Ministers' Council January 2009, p 78-84

UnionsWA is a strong supporter of this improvement on the model Act. We have held concerns for some time that services provided to employers have lacked rigour, and have not adequately protected workers from hazards in the workplace. This has a significant impact not only on the worker exposed to the hazard, but also on the employer who may have contracted a service provider in good faith but who is now exposed due to inadequate or incorrect information, training or advice. We are particularly concerned that training providers who deliver unaccredited training are not adequately captured by any regulatory focus on the quality of the training they provide.

As noted by the National Review this duty is not intended to add to a PCBU's responsibilities, rather it is intended to make clear that a person who delivers the defined services, training, or information also has a duty of care.

Industrial Manslaughter 30A & 30B

There is an overwhelming and justifiable need for the offence of Industrial Manslaughter to be included in the *WHS Bill*.

The provisions introduced into the *WHS Bill* in sections 30A and 30B provide an important amendment compared to the model laws to introduce two fatality focussed offences into the Act.

There have been a series of preventable fatalities in Western Australia involving serious negligence resulting in the death of a worker. We believe that in both our current laws and the model laws have been inadequate in providing adequate justice in the aftermath of workplace fatalities, and little deterrent for negligence in the future.

There is also no acknowledgement that the families of workplace fatality victims have an inherent interest in the response by the justice system to the tragedy that has taken place. It needs to be as clear to them as to anyone that 'the system' is taking the death of their loved ones seriously.

The amendments in the *WHS Bill 2019* to the model laws combine offences which currently exist, and restructure the model provisions to ensure that fatality offences receive an appropriate focus.

Section 30A captures elements of the level 4 penalty offence in the current *OSH Act* which focus on gross negligence causing serious harm or death. Both the level 4 penalty offence and 30A require the following elements to be proven:

- That the person has a health and safety duty;
- A contravention of the duty held by the person/PCBU has taken place;
- The failure to comply with the duty has caused an individual's death; and
- The offender knew that the failure to comply with the duty was likely to cause the death of an individual and acted in disregard of that likelihood anyway.

Section 30B also incorporates parts of the level 3 penalty offence in the *OSH Act* which contain elements of a contravention of a duty leading to serious harm or death of an individual.

The major difference in Western Australia from the introduction of 30A and 30B is not the provisions themselves, but having an offence provision solely focused on fatalities to the exclusion of serious harm or injury.

Of concern to unions under our current laws is that the outcomes following prosecutions for fatalities have been woefully inadequate for what occurred, and have not provided a sufficient deterrent for failing to provide a safe workplace.

Without a fatality focussed offence the model laws will not fully remedy this issue. In other jurisdictions prosecutions of category 1 offences under the WHS laws have been few and far between, and do not act as an effective deterrent against the most serious breaches of the model laws.

In NSW the *Work Health and Safety Act 2011* came into operation in January 2012. However, despite between 50-85 workplace fatalities a year, it took until 2018 for the first category 1 conviction to occur.

The *Review of the Model WHS Laws Final Report* found that:

> *There have been very few successful Category 1 prosecutions in any of the jurisdictions that have implemented the model WHS Act, which may in part be due to the difficulties associated with proving 'recklessness.'*[15]

While the lack of a fatality focussed offence at the top tier of the WHS offence provisions continues, prosecutions of corporate entities will remain rare.

For a long time now, our laws have sent the wrong message. Currently the penalty for the death of a worker is less than the cost of compliance with the law. We cannot allow workplace fatalities to be seen as a mere cost of doing business.

While unions have long been outspoken about the low penalties given to employers, we will focus on a recent example.

The fatality of 17 year old Wesley Ballantine at the GPO Building in Forrest Chase has been a long concern for unions and the community, and has been at the forefront of public debate on industrial manslaughter.

The only prosecution to date of the incident, which occurred in January 2017, involved the principal contractor Valmont who was responsible for the management of the workplace.

WorkSafe's prosecution summary outlines the failures which occurred in the lead up to the fatality.[16] These include:

- The construction company installed some plywood boards over the open voids in the steel framework however there were a number of open voids that remained in the steel framework;
- Although these construction company workers were called down and told to wear their safety harness and PPE there was no adequate fall injury prevention system for them to connect their harnesses to. The Valmont Site supervisor did not follow the Valmont procedures for dealing with non-conformance and corrective action; and

[15]Review of the Model WHS Laws Final Report p 119

[16] WorkSafe WA Summaries of Successful Prosecutions database (https://prosecutions.commerce.wa.gov.au/prosecutions/view/1488)

- Valmont policy dictated that its foreman would conduct SWMS activity observations and also perform regular inspections. This did not occur in relation to the high risk work that the construction company were performing.

The *Prevention of Falls at Workplaces 2004 (Code of Practice)* is a straightforward and practical guide issued by WorkSafe, which sets out a range of common requirements for fall prevention systems.

However, despite practical guidance from the regulator being available and widely used in the construction industry, these practical steps were not taken by Valmont in relation to the GPO building and glass atrium.

UnionsWA and our affiliated unions estimate that the $38,000 fine to Valmont is less than the cost of implementing the best practice controls, such as a comprehensive scaffold system to protect workers in this workplace.

While the concept and application of an industrial manslaughter offence has involved significant public debate in recent years in both Western Australia and other states, the actual experience of states that have implemented the offence are worthy of consideration by the committee.

While acknowledging some differences between the proposed WA offences and those in other jurisdictions, the committee should understand that the application of industrial manslaughter provisions in other states have been reserved for the most serious workplace incidents.

As an example, following the horrific deaths at Dreamworld in Queensland there was considerable public debate workplace safety in Queensland. In response the Queensland Government commissioned the *Best Practice Review into Work Health and Safety Final Report.*

The review recommended the introduction of industrial manslaughter offences and Queensland Parliament in 2017 was the first state to introduce the offence of industrial manslaughter into occupational safety laws.

According to the latest Safe Work Australia data, Queensland has averaged 46 fatalities a year between 2014 and 2018.[17]. Despite Queensland incurring high levels of fatalities only one prosecution has been launched since 2017. It occurred in October 2019 against Brisbane Auto Recycling Pty Ltd.[18]

The facts of the workplace fatality are disturbing: this death was easily preventable with simple and commonplace safety systems that would be common amongst the industry. The worker involved was loading tyres when he was crushed between a forklift and a truck. The subsequent investigation revealed that the forklift driver did not hold the required high risk work licence, and that there were no safety systems in place.

One of the directors in the immediate aftermath of the incident mislead the Queensland Ambulance Service, treating doctors, and the daughter of the victim, about the nature of the incident. In the subsequent investigation the same director was found to have also misled the Work, Health and Safety Regulator.

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[17] SafeWork Australia fatality statistics by state/territory (https://www.safeworkaustralia.gov.au/statistics-and-research/statistics/fatalities/fatality-statistics-stateterritory)

[18] First prosecution under Queensland's pioneering industrial manslaughter laws media statement (http://statements.qld.gov.au/Statement/2019/10/25/first-prosecution-under-queenslands-pioneering-industrial-manslaughter-laws)

Judge Rafer in the judgement noted that:

> *Mr Hussaini admitted that there were no safety systems in place. Whether the inaction by the defendants was due to expedience for commercial gain or complacency, or both, the moral culpability of each is high. The defendants knew of the potential consequences of the risk, which were catastrophic. Steps to lessen, minimise or remove the risk posed by mobile plant were available. Those steps were neither complex nor overly burdensome.*[19]

Later in the decision Jude Rafer concluded that:

> *[129] The conduct of Brisbane Auto Recycling Pty Ltd caused the death of Mr Willis because it failed to control the interaction of mobile plant and workers at the workplace, failed to effectively separate pedestrian workers and mobile plant, and failed to effectively supervise operators of moving plant and workers.*
>
> *[130] Mr Hussaini and Mr Karimi were reckless as to the risk to workers and members of the public who had access to the workplace. They failed to ensure that Brisbane Auto Recycling Pty Ltd controlled the interaction of mobile plant and pedestrians, failed to ensure that Brisbane Auto Recycling Pty Ltd effectively separated pedestrians and mobile plant, and failed to ensure that Brisbane Auto Recycling Pty Ltd effectively supervised operators of moving plant.*

The forklift driver involved in the incident has been separately charged with an offence of the dangerous operation of a vehicle causing death.[20] The justice system in both Western Australia and Queensland have provisions to adequately capture the actions of a forklift driver, however what is missing in Western Australia is the offence to capture the negligence from the directors.

The consideration of this case is important as it outlines the need for industrial manslaughter provisions to keep directors accountable for decision making that has led to a workplace fatality, and to apply justice by ensuring that culpable decision making is taken into account. The infliction of unnecessary trauma and distress upon a victim's family members should also be acknowledged and redressed.

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[19] R V Brisbane Auto Recycling Pty Ltd & Ors [2020] QDC 113 (http://www.austlii.edu.au/cgi-bin/viewdoc/au/cases/qld/QDC//2020/113.html)

[20] Brisbane Times 'Brisbane business cops $3m fine in state's first industrial manslaughter sentence' (https://www.brisbanetimes.com.au/national/queensland/brisbane-business-cops-3m-fine-in-state-s-first-industrial-manslaughter-sentence-20200611-p551qp.html)