Submission to the inquiry into the framework surrounding the prevention, investigation and prosecution of industrial deaths in Australia

June 2018

Maurice Blackburn Lawyers submission to the framework surrounding the prevention, investigation and prosecution of industrial deaths in Australia.

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Introduction

Maurice Blackburn Pty Ltd is a plaintiff law firm with 31 permanent offices and 29 visiting offices throughout all mainland States and Territories. The firm specialises in personal injuries, medical negligence, employment and industrial law, dust diseases, superannuation (particularly total and permanent disability claims), negligent financial and other advice, and consumer and commercial class actions.

Maurice Blackburn employs over 1000 staff, including approximately 330 lawyers who provide advice and assistance to thousands of clients each year. The advice services are often provided free of charge as it is firm policy in many areas to give the first consultation for free. The firm also has a substantial social justice practice.

Our lawyers regularly analyse the causative factors behind deaths at work, and support bereaved partners and children. Our experience is that the vast majority of workplace deaths are entirely preventable, and commonly arise from grossly deficient workplace practices, underpinned by a culture of giving, at best, lip service to effective safety standards.

The accountability for such deaths rarely matches the lifelong impacts upon families, co-workers and the communities in which they live and work.

Our Submission

Maurice Blackburn supports the introduction of industrial manslaughter provisions into workplace health and safety legislation across states and territories, based on nationally agreed benchmarks. We submit that the Committee should consider the development of two separate categories of offence under which sanctions including imprisonment can be imposed on an individual:

I. Recklessness; and

II. Industrial Manslaughter.

Maurice Blackburn would favour a coordinated state/territory based approach, rather than a Commonwealth scheme. We believe that each jurisdiction should be empowered to meet its own governance responsibilities in a manner best suited to their circumstances. The authority of state/territory regulators should be retained.

Maurice Blackburn believes that the existing industrial manslaughter legislation in Queensland should be used as a template for a national regime.

Maurice Blackburn encourages the Committee to not just consider industrial manslaughter as applying to fatalities of workers, but to other deaths caused by the negligent decisions of employers and business owners, such as visitors and customers. The Dreamworld incident is one recent example.

Maurice Blackburn believes that the thinking on industrial manslaughter should be extended to include deaths caused by industrial illnesses such as mesothelioma and silicosis. We believe that benchmarked industrial manslaughter provisions should include a requirement that all workplace deaths be treated as criminal cases, with Director of Public Prosecutions (DPP) or analogous prosecutorial oversight.

Maurice Blackburn suggests that, in order for any new laws to achieve the desired deterrent effect, defendants to Workplace Health and Safety (WHS) related prosecutions should be required to disclose to the Court if they are insured against penalty, investigation and defence costs.

Maurice Blackburn congratulates the Committee on its focus on the increases in temporary work and labour hire processes, in relation to workplace injury. We believe that many employers are shirking their responsibilities to workplace safety through sham contracting arrangements and utilising dubious definitions of 'worker'. We would be keen to ensure that such methods cannot allow employers to abrogate their responsibilities in the tragic event of a workplace death.

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Responses to Specific Terms of Reference

The framework surrounding the prevention, investigation and prosecution of industrial deaths in Australia, with particular reference to:

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

- Maurice Blackburn submits that the process for implementing consistent workplace health and safety legislation, through the integration of nationally agreed standards into state/territory legislation has proven to be successful.

- The rates of workplace injuries has continued to fall since Safe Work Australia commenced compiling the National Data Set in 2000. In the 2014/15 year, there was a serious injury rate of 10 injuries per 1000 employees. This is down from 16.3 injuries per 1000 employees in 2000[1]. The increased focus on WHS culture and processes continues to inspire this fall.

- Statistics on fatalities at work, however, seem to be heading in the other direction. As at 20 April, there have already been 40 Australian workers killed at work in 2018. In 2017, data suggests there were 186 Australian workers killed at work, compared with 182 workers in 2016[2]

- Harmonisation of WHS legislation across the country has meant that there is now broad commonality and language across jurisdictions, enabling predictability of outcome without the states and territories having to cede powers to the Commonwealth.

- We believe that each jurisdiction should be able to meet its own governance responsibilities in its own manner.

- We believe that the authority of state/territory regulators should be retained.

- Maurice Blackburn thus prefers a model of state/territory based legislation, founded on nationally agreed benchmarks, than any attempt to have these matters come under Commonwealth jurisdiction. In our experience, the federation of such matters generally results in the adoption of a lowest-common-denominator approach. Moreover, as an example of a nationalised scheme, Comcare's approach to WHS enforcement has been, and remains; lax, ineffective, woefully-resourced and culturally insipid.

- Maurice Blackburn submits that this is also the best model for industrial manslaughter legislation. We believe that consistent state/territory based legislation, underpinned by national standards, will be easier to achieve than a national scheme.

- Maurice Blackburn believes that there is an important role for the Council of Australian Governments (COAG) in driving and monitoring this process.

- Maurice Blackburn further notes that Queensland and ACT both have existing industrial manslaughter regimes in place. This experience should be built upon, not replaced.

[1] Australian Workers Compensation Statistics 2015-16; (p.23)
https://www.safeworkaustralia.gov.au/system/files/documents/1801/awcs_2015-16_report-20171023_v3_0.pdf
[2] https://www.safeworkaustralia.gov.au/statistics-and-research/statistics/fatalities/fatality-statistics

- Maurice Blackburn notes that similar legislation is under consideration in Victoria, and that calls for industrial manslaughter legislation are being made in the Northern Territory[3]. We believe that this reflects a national appetite for change.

Our Submission

- That the Committee continue to endorse a model of coordinated state/territory based workplace safety legislation, underpinned by agreed national standards.

2. Jurisdictional issues surrounding workplace investigations which cross state and territory boundaries

- Maurice Blackburn submits the following case study for Committee consideration:

  Maurice Blackburn is assisting the family of an 18 year old man who was killed on the 19th April 2016 whilst participating in a work for the dole program.

  He was required to clear rubbish at the local showgrounds administered by the Royal Agricultural Society of Queensland. He and two other co-workers had to sit on the back of a trailer which was towed throughout the showgrounds behind a 1971 Massey Ferguson tractor that was in an appalling mechanical state including effectively no foot brakes.

  The tractor picked up speed on a declining internal roadway and when the driver tried to apply a handbrake the tractor slid out of control and caused the young man to be thrown from the trailer. He landed on the bitumen surface of the roadway and sustained a fatal head injury. There were no restraints and no protective head gear provided.

  Workplace Health and Safety Queensland (WHSQ) have still not provided a copy of their investigation file two years after the event. Not knowing exactly what happened and who was responsible has been very distressing for the young man's mother.

  Nevertheless, the facts known to us now, allow us to conclude that the death occurred in circumstances which were negligent: not even the most basic of safety measures were deployed. The death was preventable.

  When we complained to the Federal Minister responsible for the Work for the Dole scheme about the lack of action by WHSQ we were told there was nothing they could do as it was a State matter.

- Maurice Blackburn submits that any new Industrial Manslaughter legislation must provide clarity as to who bears responsibility when there is overlap between the state/territory authority and a federal service.

- Maurice Blackburn also submits that penalties and sentences imposed in one state or territory must be taken into account for the purposes of informing the Court if a defendant has a prior history of breaching health and safety laws. This is to ensure the consistent and appropriate escalating of workplace safety laws across Australia.

[3] See, for example, article "Industrial manslaughter laws crucial to save lives". NT News, 2 June 2018.

- This would ensure that many employers and businesses operating in more than one jurisdiction are unable to take advantage of offences occurring in different states and territories and claim first offender status when they may well have committed serious safety offences across multiple jurisdictions in Australia.

- Maurice Blackburn further recommends that related entity provisions be adopted in relation to penalties and sentences imposed for safety offences by corporations in Australia to avoid large corporations from evading the safety legislation by, for example, deliberately interposing subsidiary entities in between those responsible for the offending conduct in the parent company and the ultimate employing entity. The test should be predicated on which individuals and which entities have ultimate genuine control on the operations which have resulted in a death in a workplace.

- The controlling minds of entities which preside over preventable workplace deaths must be held criminally accountable.

Our Submission

- That any new Industrial Manslaughter legislation provide clarity as to who bears responsibility when there is overlap between the state/territory authority and a federal service.

- That penalties and sentences imposed in one state or territory must be taken into account for the purposes of informing the Court if a defendant has a prior history of breaching health and safety laws.

- That related entity provisions be adopted in relation to penalties and sentences imposed for safety offences by corporations in Australia.

- That criminal provisions must attach to, and hold accountable, senior management and directors.

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

No specific response is provided for this Term of Reference.

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

- Maurice Blackburn agrees that any review of workers' safety needs to consider the changing nature of the workforce. Increases in precarious and temporary work and contracting, labour hire arrangements and the increasing use of technology in the allocation of work all magnify the effects of poor workplace practices, which include the proper coverage for workers under WHS systems and processes.

- Over the past two decades, business operators have continued to find new ways to avoid their responsibilities under Fair Work legislation and other legal and regulatory structures, including WHS and workers' compensation frameworks. 'Gig economy', sham contract and labour hire arrangements require the service provider to be a self-

employed independent contractor, rather than an employee, thereby abrogating the business operators of employer responsibilities.

- In its report on its inquiry into Corporate Avoidance of the Fair Work Act, the Senate Education and Employment References Committee noted that for workers employed under such arrangements:

> *"There is also no security of income, no insurance for the worker in case of accident, no superannuation, no personal, annual or paid leave of any description."* [4]

- These business operators have moved the public discourse in this regard toward a discussion of 'who employs whom', rather than toward any genuine concern for the wellbeing of the workers. By insisting that people who work for them be self-employed independent contractors, business operators avoid having to take responsibility for the provision of safety nets that Australians have come to expect, including the right to be safe at work.

- Sham contracting arrangements are especially prevalent in low-paid sectors where those doing the work have little market power, such as cleaners, construction workers, beauticians, call centre workers, those in the agricultural sector and drivers.

- These new work arrangements are typically discussed in the context of entrepreneurship, technology and customer convenience, but they are merely another way in which employers are able to abrogate their responsibilities.

- Labour Hire and particularly the rogue, 'invisible' labour hire operators, operate outside employment and WHS frameworks and routinely exploit workers. While a number of states are implementing Labour Hire Licensing schemes[5], there is still the outstanding issue of how federal laws intersect with these schemes, while other states continue to be without a framework.

- Technology, and particularly peer-to-peer services, have accentuated the impact of many of these sham contractor arrangements and insecure roles.

- There is a mismatch between how gig economy platforms perceive themselves and how they 'stack up' against industry expectations. In its report from its inquiry into Corporate Avoidance of the Fair Work Act, the Senate Education and Employment References Committee cites the case of Deliveroo.[6] In its report, it noted that:

> *Deliveroo describes itself as a 'food delivery tech business:*
> *Our online delivery platform joins up customers who want great food, restaurants who seek additional revenue and riders who are looking for well-paid, flexible work. Customers order via our app from one of our partner restaurants, the vast majority of whom had never considered deliveries before Deliveroo. Riders then collect the prepared food and deliver it to the customer by bicycle or scooter.*

[4] https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Education_and_Employment/AvoidanceofFairWork/Report/c08, section 8.2.
[5] See, for example, https://www.worksafe.qld.gov.au/news/2018/regulation-of-the-labour-hire-industry-in-queensland; https://economicdevelopment.vic.gov.au/inquiry-into-the-labour-hire-industry; https://www.sa.gov.au/topics/business-and-trade/licensing/labour-hire/labour-hire-licence.
[6] https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Education_and_Employment/AvoidanceofFairWork/Report/c08, section 8.20.

It goes on to note that:

> *From the company's perspective, the platform benefits all involved. Riders enjoy a 'hyper flexible way of working', customers enjoy choice and convenience, and restaurants are able to expand their customer base (and revenue) by offering food delivery.*
>
> *Food delivery riders, Deliveroo confirms, engage with the company as independent contractors. Seventy-five per cent of Deliveroo riders are 18 to 29 years old.* [7]

But what the Committee found was that Deliveroo offers no minimum hourly wage, no minimum shift lengths, no penalty rates, no superannuation, and contracts which absolve the company of responsibility for WHS.[8]

We would further observe that the workers on bicycles and motorcycles engaged by Deliveroo and similar entities bear a higher risk of injury and death compared to many other sectors.

- That same Committee heard of reports relating to Airtasker, a site which matches logged tasks with a service provider, which describes itself as:

  > '*a trusted community marketplace for people and businesses to outsource tasks, find local services or hire flexible staff in minutes—online or on your mobile'*.[9]

  The Committee noted that tasks which contain significant safety risks appear on the Airtasker website. They cited an example of a logged job seeking 'help with stacking and wrapping pallets'. The Committee, in its report, noted:

  > *'It is worth noting that, as independent contractors, whoever "won" the above task to lift and move heavy objects would not have been covered by workplace health and safety laws. It is also worth noting that Airtasker, despite considering workers to be independent contractors, does not in fact verify whether workers have ABNs.'*[10]

  The Committee went on to note that skills sought on the Airtasker website also included 'installing a rangehood kit', 'families to host overseas students', 'plumbing work', and 'laying synthetic grass'. It found that '*businesses are increasingly turning to Airtasker to find workers, saving considerable money in the process and undercutting regular workers in the process*'.[11]

- The rise in precarious work continues to be a significant factor increasing insecurity among the workforce. This uncertainty would undoubtedly influence the behaviour of workers where they would otherwise pursue their right to WHS coverage or access support and compensation if they are injured.

[7] Ibid, sections 8.21 and 8.22.
[8] Ibid, sections 8.27 to 8.35.
[9] Ibid, section 8.38
[10] Ibid, sections 8.49 & 8.50.
[11] Ibid, section 8.58.

- Businesses which engage people but abrogate their legal responsibilities for workplace safety are being given an unfair commercial advantage over business which play by the conventional rules. The playing field must be levelled.

- Maurice Blackburn has been a vocal advocate for encouraging governments to consider ways through which gig economy platforms, Labour Hire firms and those engaging in sham contracting can be held to the same account as other employers.

- It is worth noting that, in its final report[12], the Senate Education and Employment References Committee inquiry into Corporate Avoidance of the Fair Work Act made the following recommendation:

> *Recommendation 29*
> *The committee recommends that the federal government work with state and territory safety regulators to review health and safety and workers' compensation legislation to ensure that companies operating in the gig economy are responsible for the safety of workers engaged in the gig economy.*

- Maurice Blackburn believes that ensuring a common definition of 'worker', which includes those working in temporary and labour hire roles, would be a good first step.

- While the common law jurisprudence on the definition of 'worker' is helpful to an extent, it is our view that clearer statutory and regulatory framing of the definition of 'worker' is warranted, to reflect contemporary circumstances.

- Ideally the definition would be agreed nationally, and implemented at the state/territory level. The review process to which this submission responds is an excellent opportunity for government to craft a suite of policy responses to the escalating threats and risks that these developing arrangements pose to WHS, and to many workers across Australia.

- Those risks are also apparent to our state and federal taxation systems, to the revenue bases of workers' compensation authorities, and to the health of our superannuation system.

- It is important that any consideration of harmonised industrial manslaughter laws take into account the need for these rules to apply fully in temporary and labour hire employment relationships.

Our Submission:

- That the Committee recommend investing resources in determining a 'definition of worker' which will satisfy the national context. Such a definition should draw on, but not be constrained by, common law jurisprudence on the question of 'worker'.

- That the Committee seek to ensure clearer statutory and regulatory framing of the definition of 'worker', to reflect contemporary circumstances. This process may involve consultation with Senior Counsel.

[12] https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Education_and_Employment/AvoidanceofFairWork/Report.

- That the Committee explore the possibility of legislating a deeming provision, which would give the regulator the capacity to deem certain cohorts as 'workers' in the context of access to WHS and related protections.
- That the Committee seek alignment between the outcomes of recent state/territory based labour hire reform initiatives and issues relating to access to WHS legislation.

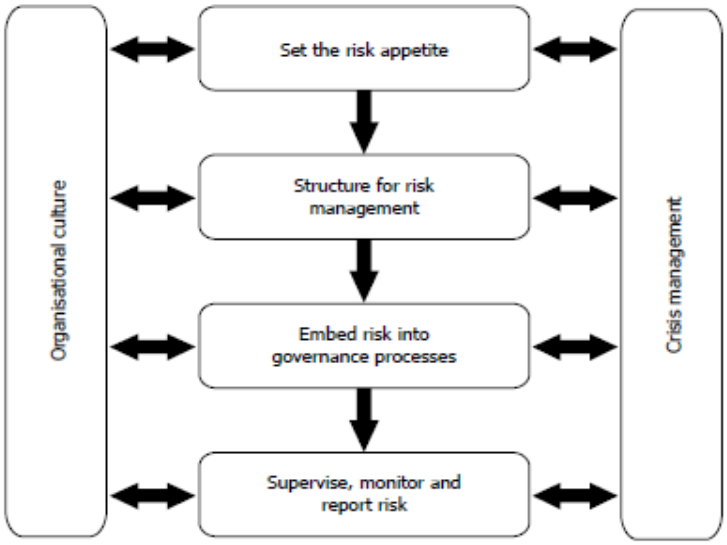
Maurice Blackburn would be pleased to offer to work closely with the Committee in its ongoing investigations into protecting the rights of workers in temporary and labour hire environments. We would be pleased to offer our experience and expertise in workplace law to ensure that the Commonwealth capitalises on a timely opportunity to provide national leadership in this critical matter.

5. <u>The role of employers and unions in creating a safe-work culture</u>

a. Employers:

- Section 19 of the *WHS Act* (2011) places the primary duty of care for workplace health and safety with the person conducting a business or undertaking.
- Aside from setting the policy parameters within the workplace, employers also set the culture for how their organisation responds to safety concerns and challenges.
- Placing WHS within the broader risk framework, the Australian Institute of Company Directors (AICD) notes the importance of risk being a function of governance. Figure 1 sets out how AICD encapsulates this relationship.

Figure 1: The role of the Board in Risk Management[13]



[13] From AICD, Risk: Issues for Boards (p.29)

- The diagram demonstrates how the firm's risk appetite, its policies and procedures (embedded within its risk management frameworks), its governance processes and the ongoing monitoring of risk all contribute to the culture of the workplace.

- The maintenance of a safety culture is not a passive process. It does not happen by accident or serendipity. It requires employers taking purposeful steps to embed a culture of prioritising safety over other concerns.

- Specific to WHS risks, it is incumbent on employers to stay up to date in WHS legislation and regulations, and to ensure that its policies and procedures reflect current expectations. Adherence with WHS best practice should be rewarded and promoted.

- Clause 47 of the Model Work Health and Safety Bill[14] requires the person conducting a business or undertaking to, so far as is reasonably practicable, consult with their workers who may be directly affected by matters relating to work health or safety. So consultation with workers is not only good practice, in places where the model legislation has been adopted, it's a legal requirement. The attitude displayed by the employer to this clause will have an impact on the WHS culture of the organisation – whether the consultation is seen as genuine, or merely a compliance issue.

- Worksafe Victoria also reminds us that the monitoring and public reporting of WHS by employers can be a powerful tool in ensuring transparency and enhancing workplace safety culture. They remind us that: "*Effective public reporting on health and safety will show an organisation:*
    - *is committed to managing and improving its health and safety;*
    - *measures and compares its WHS performance;*
    - *has achieved improvements in workplace safety and employee welfare;*
    - *takes a systematic approach to WHS risk management; and*
    - *is committed to broad-based, corporate performance improvement*" [15].

- In summary, Maurice Blackburn believes that employers play an instrumental leadership role in developing and maintaining an organisational culture of workplace safety. The extent to which this culture is productive and positive will depend on the degree to which the employer prioritises the safety of its workers over other matters, the degree to which it accepts responsibility for mitigating risk, and the degree of genuineness in its motivations.

- The authenticity of a "top-down" safety culture is critical. We have seen many examples of workplace deaths which have occurred in the context of a veneer of documentary "compliance" with safety, and slogans emblazoned on work clothing: yet the substance of the culture was geared entirely to profit outcomes, with unsafe practices tolerated, acquiesced in and often encouraged.

b. Unions:

- Research indicates that workers in a unionised workplace are 70 per cent more likely to be aware of WHS hazards and issues[16]. This should not be surprising. Unions have provided significant and long-term leadership in improving the safety of their members, and holding employers to account for their risk-taking actions.

[14] Model Work Health and Safety Bill (2016)
[15] Good Health And Safety Means Good Business Public Reporting Of Occupational Health And Safety By Organisations (July 2006)
[16] ACTU research, ref https://www.actu.org.au/ohs/about-us/union-movement

- Every major union has workplace safety as core to its stated reasons for organisational existence.[17]

- Unions have been able to achieve outcomes in workplace safety that would not have happened without their involvement. It is self evident that workers collectively will push harder for a safety culture, and rights that have been long fought for have been historically met with resistance from many employers.

- The union movement rightly takes credit for the embedding of nationally agreed workplace health and safety standards. Historically, unions were instrumental in winning health improvements in the 1960s and 1970s such a regular breaks, accident make-up pay, proper lifting process and advances in Personal Protective Equipment. This constant focus on health and safety in the workplace eventually led to the development of the National Occupational Health and Safety Commission (NOHSC) in 1985 – the forerunner to Safework Australia.

- Unions have played a major role in campaigning on specific health and safety matters in particular industries over time. Pressure put on James Hardie by unions led to the establishment of a fund for victims of mesothelioma and like illnesses. Unions have been instrumental in having strict health and safety protocols embedded for the mining sector.

- Unions' commitment to creating and maintaining a safe-work culture is described as a five-point blueprint[18]:

    i. Giving workers a say: Unions recognise that the success of embedding a safe-work culture lies in the willingness of workplaces to have honest conversations about safety. Two way communication is an essential element in reducing workplace death and injury.

    ii. Making employers responsible: The current workplace safety regime in Australia is predicated on the notion that the highest level of decision of a firm - the person conducting a business or undertaking (PCBU) - carries responsibility for ensuring a safe workplace.

    iii. Empowering health and safety representatives: The introduction of Health and Safety Representatives (HSRs) has been an important part of workplace safety. Empowered and autonomous HSRs are a critical element of the information flow, and the hazard identification / mitigation process.

    iv. Respecting the role of unions: According to the ACTU website[19]: "*Research shows that unionised workplaces in Australia are three times more likely to have an OHS committee and are twice likely to have done an OHS workplace audit than those that had no union representatives*". This is an important additional and ongoing presence.

    v. The right to take court action: Unions argue that the right for unions to prosecute has been proven to improve health and safety in workplaces. The deterrent effects of these processes is useful, along with the corrective actions that result from the actions.

[17] See for example: https://www.cfmmeu.org.au/workplace-safety; https://www.amwu.org.au/health_and_safety; http://www.sda.org.au/resources/workplace-health-safety/; https://www.nuw.org.au/health-and-safety
[18] Derived from ref https://www.actu.org.au/ohs/about-us/union-movement
[19] www.actu.org.au

c. A joint approach:

- Importantly, it is the ability of employers and workers (and/or their representative bodies) to work together in the interest of workplace safety that dictates the result. Comcare's website notes the following:

  "Frequent and informal communication between workers and management on safety and injury management raises workers' awareness of health and safety matters and can potentially contribute to a positive preventative safety culture. Statistics show that people work more safely when they are involved in the decision making process and have immediate feedback about their work. Managers that model behaviour by making a personal contribution to WHS consultation can significantly change the way their team thinks about health and safety in the workplace".[20]

- Whilst both employers and unions can play a major role in promoting a workplace culture of safety, only the employers can control it. Unions cannot set policy for a workplace, nor directly take action against negligence or non-compliance. Unions cannot determine work practices nor the equipment provided.

- In the context of Industrial Manslaughter, then, Maurice Blackburn believes that the imposition of significant deterrents on employers in relation to negligence and malpractice is necessary and warranted. If the suite of deterrents includes the possibility of jail time for the controlling minds of entities which have unsafe workplaces, this will greatly focus employers' minds on improving the authenticity of safety cultures.

6. <u>The effectiveness of penalties in situations where an employer has been convicted of an offence relating to a serious accident or death</u>

- Maurice Blackburn submits that the penalties in WHS regimes across Australia for employers who have been found responsible for serious injury or death are manifestly inadequate. For example, the fines imposed where a worker has been killed at work in Queensland appear to typically range between $90,000 and $160,000. This is seriously inadequate, when one compares these offences with, for example, breaches of the *Food Act (2006)* which result in fines of $30,000 - where no one is seriously harmed. The disproportionality is obvious.[21]

- We submit that there is a requirement for sentencing guidelines or at the very least 'suggested' penalties in the vein of that which occurs in the UK [22] so that judicial officers are given specific guidance about the appropriate sentencing range. It must be remembered that the legislation is somewhat unfamiliar ground for many members of the Judiciary.

- A further consideration in the context of the efficacy of penalties is the commercial reality that many corporations are readily able to, and do, insure against the imposition of a fine for a breach of workplace health and safety legislation. The effectiveness of a

[20] https://www.comcare.gov.au/preventing/governance/creating_a_culture_of_health_and_safety
[21] Neil Foster, '*Insuring Directors Against Criminal OHS Wrongdoing'* (Working Paper 80, Australian National University, February 2011).
[22] *Sentencing Council, Health and Safety Offences, Corporate Manslaughter and Food Safety and Hygiene Offences Definitive Guideline*, effective 1 February 2016. Available at: https://www.sentencingcouncil.org.uk/wp-content/uploads/HS-offences-definitive-guideline-FINAL-web.pdf

fine as a deterrent is significantly undermined where an insurer pays a penalty imposed instead of the defendant. This is contrary to good public policy.

- Maurice Blackburn submits that defendants to WHS related prosecutions should be subject to a legislative requirement to disclose to the Court if the defendant is insured against penalty, investigation costs or defence costs. Where a defendant discloses the existence of such insurance, the Court should have the option of imposing significantly higher fines, or alternative sentences.

- An alternative to this approach is to simply legislate that it is unlawful to insure against a fine, investigation costs or defence costs where they apply to an alleged breach of safety legislation.

- Maurice Blackburn notes the relatively low occurrence of prosecution of board members and executive officers under current regimes. Experience in other regulatory environments strongly suggests that unless board members and executive officers know that they can be prosecuted, then an insufficient deterrence exists. Proper investigation and prosecution of board members and executive officers will ensure that there is robust safety culture and leadership at the helm of corporate entities.

- Again, with respect to board members and executive officers, the courts are not given any real legislative guidance about the appropriate level of punishment. In contrast to standard criminal offences, the courts are not well placed to see the prevalence of safety breaches "on the ground", nor are they well placed to understand the significance of factors such as the absence of any risk assessment or the failure to pass on safety information to workers.

- Highlighting the relevance of such factors as the aggravating features of criminal conduct provides clear guidance to judicial officers that a higher penalty may be justified.

- We would submit that current prosecution and compliance policies pay insufficient heed to deterrence.

- In Appendix 1, we have supplied eleven case studies, demonstrating the lack of appropriate punishment meted to employers following a workplace death – simply as a result of the inadequacies in current criminal law pertaining to senior management.

- For the reasons outlined above, we would support the introduction of an offence of Industrial Manslaughter and the introduction of mandatory guidelines about an appropriate penalty quantum. Crucial to the offence and guidelines, must be the realistic prospect of custodial sentences for those convicted.

- Maurice Blackburn suggests that the Committee might consider the development of two separate categories of offence under which appropriate sanctions, including incarceration, can be imposed on an individual:

  I. Recklessness; and
  II. Industrial Manslaughter.

- The key difference for present purposes, putting aside the fact that the elements of each offence are substantially different, is that the recklessness offence is predicated on *exposing* an individual to "risk of death or serious injury or illness" whereas the Industrial Manslaughter provision requires that the conduct result in the actual death of a person.

- In other words the recklessness offence merely requires *the creation of risk* (without actual harm being caused) whereas the Industrial Manslaughter offence requires that the conduct complained of has actually resulted in a death.

- Maurice Blackburn submits that appropriate penalties for both might be:

  I. Recklessness attracting a maximum jail term of 5 years; and
  II. Industrial Manslaughter attracting a maximum jail term of 20 years.

- Whilst community expectations demand serious criminal sanction for both types of conduct referred to above, in our view, the objective gravity of reckless conduct is arguably something greater than the objective gravity of negligent conduct.

- Maurice Blackburn suggests that the Committee consider a requirement that all workplace deaths be treated as criminal investigations, requiring DPP or analogous prosecutorial oversight. It is essential that such authorities be properly funded and resourced.

- Tim Lyons, in his Best Practice Review of Workplace Health and Safety in Queensland[23] noted the following:

  "In deciding whether to prosecute (or not prosecute), the Legal and Prosecution Services Unit are guided by the Director of Public Prosecutions Guidelines (DPP guidelines) and the National Compliance and Enforcement Policy (National Policy). The National Policy, adopted by WHSQ, contains three criteria from the DPP guidelines that need to be met. These include:

  - *the existence of a prima facie case, that is, whether the evidence is sufficient to justify the institution of proceedings;*
  - *a reasonable prospect of conviction, that is, an evaluation of the likely strength of the case when it is presented in court;*
  - *a public interest test which may include the following considerations:*
  - *the seriousness or, conversely, the triviality of the alleged offence or whether it is only of a technical nature;*
  - *any mitigating or aggravating circumstances*
  - *the characteristics of the duty holder—any special infirmities, prior compliance history and background;*
  - *the age of the alleged offence;*
  - *the degree of culpability of the alleged offender;*
  - *whether the prosecution would be perceived as counter-productive, that is, by bringing the law into disrepute;*
  - *the efficacy of any alternatives to prosecution;*
  - *the prevalence of the alleged offence and the need for deterrence, both specific and general; and*
  - *whether the alleged offence is of considerable public concern.[24]"*

- Maurice Blackburn submits that the abovementioned criteria would be a reasonable starting place for any national standards in prosecution on industrial manslaughter offences.

- The report notes that the Queensland Office of Industrial Relations is currently considering the establishment of a prosecutions board, following a process review conducted by PwC[25]. Maurice Blackburn encourages the Committee to track the

[23] Best Practice Review of Workplace Health and Safety Queensland (April 2017), p.19
[24] National Compliance and Enforcement Policy, p.10
[25] Best Practice Review of Workplace Health and Safety Queensland (April 2017), p.20

outcomes of the Queensland process, and identifying appropriate components to replicate.

Our Submission:

- That defendants to WHS related prosecutions should be subject to a legislative requirement to disclose to the Court if the defendant is insured against penalty, investigation costs or defence costs.
- That where a defendant discloses the existence of such insurance, the Court should have the option of imposing significantly higher fines, or alternative sentences.
- That the Committee consider the development of two separate categories of offence under which a jail term can be imposed on an individual:

  I. Recklessness; and
  II. Industrial Manslaughter.
- That the Committee consider a requirement that all workplace deaths be treated as criminal investigations, requiring Director of Public Prosecutions (DPP) oversight.

7. <u>Any other related matters.</u>

- There are a number of initiatives which we believe the Committee should consider as part of its deliberations in relation to industrial manslaughter. These are listed below.

I. Maurice Blackburn encourages the Committee to consider that industrial manslaughter should not only provide for the deaths of workers, but to others affected by the decisions and actions of PCBUs.

- Passers-by, consumers and visitors can and do die due to the negligence of PCBUs and their senior officers. It seems an absurd outcome that the exact same act(s) of negligence will result in a drastically different penalty, simply because a person is, or is not, a worker.
- This is especially the case given that the introduction of the industrial manslaughter provisions in Queensland was motivated in part by the deaths of four Dreamworld customers not workers.
- Even before that, the need to extend workplace safety provisions to visitors and customers was well established. In 2009 the Workplace Relations Ministers' Council in the establishment of the model rules noted:

  "The (WRMC) panel recommends that the primary duty of care should be owed by any person conducting a business or undertaking. The objective of this recommendation is to move away from the traditional emphasis on the employment relationship as the determiner of the primary duty, to provide greater health and safety protection for all persons involved in, or affected by, work activity. Care needs to be taken during drafting to ensure that the scope of the

duty is limited to matters of occupational health and safety and does not further extend into areas of public safety that are not related to the workplace activity." [26]

- Maurice Blackburn suggests that the extension of industrial manslaughter provisions to passers-by, consumers and visitors could be implemented by including a new section in state/territory legislation. This new section would be similar to that suggested by the Australian Lawyers Alliance in its June 2017 supplementary submission to the Best Practice Review of Workplace Health & Safety in Queensland, which simply requires a "*negligent failure by a [senior] Officer, to exercise due diligence, which causes or results in a death at the workplace*"[27].

II. Maurice Blackburn encourages the Committee to extend its thinking on industrial manslaughter to include deaths caused by industrial illnesses such as mesothelioma and silicosis.

- It seems quite arbitrary to provide for the prosecution of a business for the death of a worker due to an injury that reasonably could have been prevented, but not to allow for prosecution when a worker dies due to an industrial illness that reasonably could have been prevented. If an asbestos removal company failed to provide its workers with adequate PPE, this would clearly be negligent, yet that business and its management may not be able to be charged with industrial manslaughter.

- A way to resolve this issue would be to ensure that the wording in relevant clauses covers an employee who "is injured or contracts an industrial illness or occupational disease in the course of carrying out work for the business or undertaking and later dies."

- Maurice Blackburn notes that the delay between exposure and onset of industrial illnesses like mesothelioma may mean that proving guilt beyond a reasonable doubt is a very difficult task. But we maintain that it is a topic worthy of consideration by the Committee.

III. Maurice Blackburn encourages the Committee to ensure that any industrial manslaughter regime includes volunteers, both:

a. When the volunteer is in the role of PCBU, and

b. As (unpaid) workers.

- Volunteers can and do hold positions of authority where their negligence has the potential to result in a workplace death.

- Maurice Blackburn notes that some jurisdictions have a volunteer exemption enshrined in relevant legislation. We would encourage the Committee to consider whether this exemption should be removed in cases of industrial manslaughter.

[26] Communiqué of the Workplace Relations Ministers' Council (May 2009) p.1
[27] https://www.lawyersalliance.com.au/documents/item/927

Appendix 1 Case Studies

Below we present eleven case studies, drawn from cases that Maurice Blackburn has been involved with. Although the names of the deceased have been removed, it is important to remember that these are real stories, and involved real people.

In each of the cases, the only legal recourse available to the families was through the imposition of fines on the employer following Workplace Health and Safety investigations, actions resulting from Coroners inquests and Workcover investigations.

None of these has proven to be a successful deterrent against the provision of unsafe workplaces. We believe that, if any of these case studies had occurred under a jurisdiction which had the Industrial Manslaughter provisions which currently exist in Queensland and the ACT, then executive offers, senior managers and board members would be facing the real prospect of criminal sanctions.

Case 1

The deceased was working as a process technician.

The deceased was involved with unloading a train loaded with zinc into the tippler shed (unloading shed). Because of the positioning of the tippler shed and the Index Arm, he was required to manually unload the first two wagons of the train. Manually unloading the first two wagons allowed the train to be placed far enough through the tippler shed, to enable the Index Arm to control the train for the remainder of the unloading process. The Index Arm controlled the unloading process by moving each wagon along. In the course of completing this task, the deceased was crushed by the hydraulic Index Arm and subsequently passed away. The system of work was plainly unsafe, and proved to be lethal.

We assisted the de-facto partner of the deceased with the statutory process in relation to obtaining entitlements under the Workers' Compensation Scheme for benefits that she was entitled to as a result of her partner's death during the course of his employment.

A co-worker who was in charge of the train at the time of the subject incident was informed by the control operator that there had been an incident and was asked to put the train brake on. He proceeded to check the wagons to ensure that he had performed his work tasks correctly, and notified his employer. During this time, the co-worker witnessed the deceased's body trapped by the Index Arm. He proceeded to return to the train, where he noticed emergency personnel releasing the deceased's body and he therefore witnessed the body fall.

Following the subject incident, the co-worker was diagnosed with Post Traumatic Stress Disorder. His life will never be the same.

Case 2

The deceased worked for an organisation which manufactures and services large water tanks.

Three employees were working on a repair job for a customer on a large polyethylene cylindrical tank which was leaking. The employees were tasked with moving the tank, which they had previously moved on a number of occasions on the subject morning.

The tank was lifted and moved using two forklifts, known as the “dual lift method”. This is a high risk task under the Work Health and Safety Regulation 2011.

The method involved placing a square plastic outrigger pad (dunnage) under the tank to enable the other forklift’s tines to fit under the end of the tank.

The tank was being moved from the yard into the workshop. Entry to the workshop was by a ramp with an incline. When the tank was on the ramp, the deceased’s supervisor had to briefly attend to other duties. At this time, the deceased was operating the forklift positioned on the ground and facing the lower end of the ramp. The other forklift was positioned at the higher end of the ramp.

The deceased asked another worker to assist him and that worker commenced operating the forklift at the higher end of the ramp. The deceased asked the other worker to lift the tank slightly. At this time, the deceased was out of the sight of the other worker, as he was adjusting the dunnage by crouching in an area between the forklift mast and the load.

The tank moved towards the deceased and trapped his head between it and the mast. He died at the scene from fatal crush injuries. The system was unsafe. It should have been identified as unsafe, but the employer risked the deceased’s life.

The company pleaded guilty to breaching its obligations under the *Work Health and Safety Act 2011*, for failing to ensure its workers were not exposed to risk. They were fined $120,000.00.

Case 3

The deceased was employed by a labour hire firm.

It is believed the deceased was driving a forklift on the worksite about 11:30pm, placing concrete pads on reclaimed sand for a mobile crane to move over.

For unknown reasons the more than 20 tonne crane became unstable and while the deceased jumped from the forklift to avoid the falling crane, he was fatally struck by a jib.

It is believed he saw the crane tumble and tried to make a run for it but the crane toppled on him.

The workplace death led to a WPHS investigation, and a statutory Workcover claim. Again, the system of work was unsafe, and should have been known to the host employer, and labour hire entity as being unsafe.

Case 4

The employer was wanting to move a boom spray from its position inside a shed. The deceased was instructed by her employer to move a cherry picker to the site of the boom spray. The unit was outside the open area, however the bucket was manoeuvred by the deceased so that it was underneath the roof of the structure (near to the boom spray).

A rope was attached to the bottom of the operator platform of the cherry picker. The other end was attached to the boom spray. In essence, the cherry picker was (incorrectly) used as a crane so as to lift the boom spray.

The deceased operated the cherry picker so that the operator platform moved upward (toward the roof of the structure) but it unexpectedly moved swiftly toward the roof. The claimant's head, neck and chest struck a timber beam of the roof. The cherry picker toppled over.

The deceased was survived by two daughters. They will never see their mother again, and live in the knowledge that their mother died in violent circumstances, made immeasurably worse by those circumstances being preventable.

Case 5

The deceased was employed as a deckhand on a barge. He worked FIFO, one month on and one month off.

On the day in question the deceased's barge returned to port. Later that day, the deceased left the barge with a number of co-workers to have a couple of beers at a local pub. One of the co-workers was dropped to the ferry terminal to go home for the night. On the return to the wharf, the other co-worker returned to the barge. However, the deceased stayed onshore at a shed adjacent to the barge as he was drinking and drinking was not permitted on the barge.

At 7.35am the following day when one of the co-workers returned to the barge he observed the body of the deceased alongside the barge floating in the water face down.

The Coroner found that the deceased died when attempting to negotiate the climb to get off the barge at about 6.00am. In essence there was no gangway from the barge to the wharf and the workers fashioned a rope to climb up and down from the barge. The autopsy found the injuries of the deceased to be consistent with a heavy fall from height followed by drowning.

The Inquest made the following observations:

- This death illustrates the vast difference between the levels of safety existing for those that work on domestic commercial vessels and those that work on land;
- As at the date of the inquest there was no evidence to suggest that any mode of access of egress to and from the barges was compliant or safe;
- *"Where there is death resulting from unsafe practices the community is entitled to expect that the unsafe practices be denounced in the strongest possible terms".*

Plainly this death arose from lax safety practices, and was preventable.

The deceased is survived by a de facto wife and two dependent children. They will never see their father again.

WorkSafe issued a press release stating that the company and the Master of the vessel had been charged with breaches of the Work Health and Safety (National Uniform Legislation) Act. If found guilty, the company will face a maximum penalty of $1,500,000 and the Master will face a maximum penalty of $150,000.

Case 6

The deceased was employed by a not for profit body established to provide employment and training for people with disabilities and disadvantaged job seekers.

On only his second day on the job, the deceased was directed to build a funnel for the top of a large waste oil tank, however the tank was not empty at the time of the incident and still contained the remains of liquid, fuel waste and other flammable substances. When the deceased was welding the drum, the materials (high grade mono diesel oil) ignited and exploded. As a result of the explosion, the deceased received fatal injuries and passed away.

The deceased was survived by a young son.

The company was fined $125,000 for not identifying the risks in a workplace at which an employee was killed, entered a guilty plea for failing to comply with a health and safety duty – Category 2. A conviction wasn't recorded against the company but they were placed on a good behavior bond and a training order. These are a mere slap on the wrist and entirely inadequate for the gross breach of safety which directly caused the death.

Again:

- This death was preventable,
- The penalties are financial only – no person is a senior position has been held criminally accountable for the preventable loss of life
- The deceased's family, including a young son, will never see the deceased again, and will live in the knowledge that the deceased died a horrible, violent death.

Case 7

The deceased was employed as an industrial refrigeration mechanic. On the date of death he was working on a machine inside a roof in a building which was in a state of poor repair. The roof gave way and he fell to his death. The roof was in a warehouse style building and the roof height was significantly higher than a standard house ceiling. No effective fall protection – a basic safety precaution when working at heights – had been provided.

The deceased was survived by his wife and two adult children.

A Worksafe prosecution of the employer continues.

Case 8

The deceased was employed by a major national transport firm. He was crushed at work by a prime mover in the course of his employment. He had picked up a mat and was facing away from a prime mover. The driver of the prime mover could not see the deceased, who could not hear people yelling at him to move out of the way as he was wearing earplugs.

He is survived by his wife and three dependent children.

There was a coronial enquiry and a WorkSafe prosecution for a breach of OH&S Act. The company convicted and fined $1,000,000.00

The Court held that: "*the measures [which could have prevented the death] are fairly simple, logical and could not be said to be prohibitively expensive, which begs the question as to why such steps had not been taken before [the deceased]'s death*."

A similar incident had occurred previously in Tasmania, alerting the company to the unsafe system of work. However, measures weren't put in place to prevent the risk.

Case 9

The deceased had been employed by a bus company for more than three years, first as a maintenance assistant, later as an apprentice mechanic and finally as a qualified mechanic.

The deceased suffered fatal injuries in the course of his employment when a bus he was working under moved off one of the supporting structures that had been supporting the bus in an elevated position and fell and crushed him. He was killed instantly.

He was survived by his wife and 13 year old daughter.

There was no WorkSafe prosecution despite a plainly unsafe system of work. The Claim for Compensation resolved in the maximum sum payable under the legislation to the dependent widow and the dependent child.

Case 10

The deceased worked as a cleaner at an abattoir. He died from injuries received when he was crushed by the equipment he was cleaning. At the time he was cleaning a rotating knocking box which is a large machine used in the halal slaughter of cattle. The deceased died nine days after the original injury.

He was survived by his wife and dependent children. The deceased and his wife were born in Sudan. They were refugees living in Kenya before coming to Australia.

There was a successful WorkSafe prosecution of this matter. The defendant was found guilty by a jury of broaching Section 21(1) and (2)(a) of the Occupational Health and Safety Act 2004 in relation to the lack of a safe system of work while cleaning the knocking box and was also found guilty in relation to a failure to provide information, instruction and training to employees in relation to cleaning the knocking box.

The Defendant was convicted and fined $125,000 for the first offence and $225,000 with respect to the second offence. In total a fine of $350,000 was imposed.

Case 11

The deceased was a 26 year old third year apprentice at the time of his death. He was working on an extension at the rear of the premises.

An electrical current entered through the third digit on the deceased's left hand which blistered the finger. There was also a touch point on the left hand thumb. The deceased was electrocuted.

The majority of the work on the day of death was believed to consist of running a power cable to install a smoke detector in the next extension part of the premise. The owner of the property became curious to the location of the deceased and started to call for him.

The cause of the electrocution is alleged to be because the power was left on. The deceased is alleged to have believed the line was inactive, and touched it only to be fatally electrocuted. The safety switch failed.

Subsequently the deceased's father took his own life from not coping with the loss of his son. This family of four tragically lost two members in the space of 10 months.