

## **Submission to the National OHS Review by the Queensland Government**

### **A National OHS System for the Modern World**

#### **Executive Summary**

Despite some differences in detail between jurisdictions, the Robens model serves as the foundation of OHS law in Australia. However, it is over 35 years since the Robens Report was tabled in the United Kingdom parliament (Bluff, Gunningham and Johnstone, 2004: 1, 2). The report was a product of its time and many of its underpinning assumptions were then and certainly are now questionable. The model presupposed a world of work based around the breadwinner model – unionised, permanent, male employees working for a single employer in large manufacturing and construction workplaces and exposed to physical and chemical hazards.

The work context is very different today. In many workplaces non-standard employment arrangements exist where regular employees work alongside employees from other businesses, workers leased from labour hire agencies, self-employed contractors and subcontractors, fixed-term consultants plus an array of part-time, temporary and casual workers. There may also be some workers operating from home or remote locations. The complexity of modern work arrangements is not effectively addressed by the Robens approach based on traditional employer-employee relationships at a single place of work.

A recent UK review encompassing the impact of 20 years under the Robens model (Institute of Employment Rights, 1999) noted that work-related death and injury rates are still high and highlighted the following as key variables in the continuing effectiveness of the model:

- changes in the organisation of labour and the growth of self-employment, contract, part-time and casual labour;
- growth in the number of small businesses and organizations;
- decline in union membership and density;
- a realisation that employers do not possess complete health and safety knowledge, expertise, or capacity to develop management systems; and
- a realisation that not all employers possess a willingness to adopt or effectively self-regulate.

The current review for the national harmonisation of OHS laws provides the opportunity in Australia to build on Robens by addressing today's complex work arrangements by designing a modern, uniform, OHS model, drawing on the best of the various Australian systems and international developments. The new OHS system should be built around key duties and defences that apply to all workplaces but be flexible enough to allow industry specific regulation to address the special hazards and circumstances in some sectors.

The Queensland government supports the development of nationally harmonised OHS laws addressing contemporary work arrangements and has identified some key issues that are critical to the design of the new national system. It is also acknowledged that work is being undertaken to harmonise OHS legislation in the mining industry (National Mine Safety Framework) under the auspices of the Ministerial Council on Mining and Petroleum Resources, and the rail industry under the auspices of the Australian Transport Commission.

## **1. Duties should be placed on all Parties in the Supply Chain**

Health and safety issues arising from work are influenced by the actions and decisions of various persons, items and materials entering the work environment and the work environment itself. It is the view of the Queensland government that, irrespective of the work arrangements, all parties in a supply chain should have an obligation in the conduct of their business or undertaking to ensure that other persons are not exposed to risks to their health and safety from the way the business or undertaking is conducted. Further these general duties to ensure safe work should be consistent across all industry sectors irrespective of whether the sector has industry specific OHS legislation. Duties on such a person should include the provision of a safe and healthy work environment, systems of work, plant and equipment, ensuring the safe use, handling, storage and transport of substances and providing information, instruction, training and supervision to ensure health and safety.

The Queensland Government contends that the parties upon whom general duties should be imposed should include:

- all persons conducting a business or undertaking, whether they do so as employers, self-employed persons or otherwise (and in the case of construction work in their capacity as clients, project managers and/or principal contractors);
- where premises are used as workplaces, buildings and associated areas – designers, owners, occupiers and persons otherwise in control of those premises, buildings and associated areas;
- in relation to plant and equipment – designers, manufacturers, suppliers, erectors/installers, owners and persons otherwise in control of plant and equipment; and
- in relation to hazardous substances/chemicals – manufacturers and suppliers.

For the sake of consistency and equity, general duties (and defences) should apply to all work environments, industries and hazards in the new OHS system. While jurisdictions may deem it desirable to have specific industry OHS legislation, the general duties and defences should be identical in such legislation and the general OHS Act. This can be achieved either by enacting identical provisions for general duties and defences in all OHS Acts or by industry-specific legislation deferring to the duties in the general OHS Act.

## **2. Business Undertakings and Workers**

The employer/employee relationship currently used for assigning duties in OHS legislation is inadequate to capture the complex array of modern working arrangements. To overcome the limitations of the employer/employee approach, the scope and application of the model OHS Act should be based on the concepts of *business or undertaking* and *worker* rather than *employer* and *employee*. To do otherwise creates a complex and potentially unjust hierarchy of working relationships, and regulatory incentives for organisations to structure their labour requirements in a way that does not ensure the OHS of all workers.

Central to the model Act should be a provision that a person conducting a business or undertaking has an obligation to ensure the health and safety of persons is not affected by the conduct of the person's business or undertaking: that is, persons must not be exposed to risks to their health and safety from the business or undertaking. The duty applies to anyone who operates a business, whether or not it is conducted for gain or reward without necessarily being confined to the physical boundary of a *workplace*. For example, a business or enterprise conducted by a municipal corporation may be seen to be conducting its operation, performing work or providing services at one or more places, permanent or temporary and whether or not possessing a defined physical boundary. This formulation places an obligation on the person who creates the risk, irrespective of whether the person is an employer or self-employed. It also eliminates opportunities for firms to organise their labour arrangements in an attempt to reduce their responsibility for OHS.

In workplaces where more than one business or undertaking is operating, hazards may arise simply from a failure to co-ordinate the activities of the various parties. The model Act should have as a central element that each party must also co-operate and consult with other duty holders to eliminate or minimise OHS risks.

The traditional OHS emphasis on *employee* should be replaced by a broader obligation to *workers*. Defining a worker more broadly ensures the concept encompasses the myriad of work arrangements operating in the business environment to capture employees, bailees, contractors, labour-hire workers, volunteers, apprentices and students on work experience. The benefit of this approach is that it extends beyond the limitations of expressing duties based on the employer/employee relationship. It also overcomes the necessity of deeming persons to be employees (for example, contractors) as is the case in Victoria, the Commonwealth, South Australia and Western Australia (which also deems labour hire workers to be employees).

### **3. Reasonable Practicability and Risk Management**

The key issue is not whether most jurisdictions will continue to support the notion of reasonable practicability but rather who should bear the onus of proof. In all jurisdictions except in the Queensland Workplace Health and Safety Act (WHSa), New South Wales as well as the United Kingdom, the prosecutor must prove a duty holder has not taken reasonable practicable measures for a breach of the legislation. In Queensland (except under industry specific mining legislation), New South Wales and the United Kingdom, the duty holder has to prove that the measures they took were reasonably practicable.

In addition, all of the OHS statutes currently qualify the otherwise absolute duties imposed on duty holders by only requiring duty holders to take measures that are reasonably practicable. The reasonable practicability calculus strongly resembles the risk management process. Indeed, the courts have in the past decade interpreted the employer's general duty to require that the employer not just respond to demonstrated risks but have a system of searching for and identifying all possible risks, and instituting reasonable and appropriate measures. Effectively the generally duties require duty holders to engage in systematic occupational health and safety management. The Queensland view is that to facilitate compliance, the model OHS Act should integrate the risk management process with the notion of practicability, and also integrate these with regulations and codes of practice.

The Queensland and New South Wales models provide greater clarity to duty holders of what is expected and the Queensland model, in particular, with its inclusion of regulations and codes of practice provides a comprehensive outline of how duty holders meet their requirements. This approach also translates more easily at the workplace level, avoiding disputes between employers and safety representatives to what might be practicable in any instance.

### **4. Control**

The concept of control is used in OHS legislation in two ways. Firstly, in the case of multiple duty holders it attempts to identify the extent of the duty owed by a person and apportion responsibility appropriately. For example, the Queensland WHSA recognises that more than one person may owe a duty and provides that a person must discharge their duty to the extent that the matter is within the person's control. A fundamental difficulty where there are multiple duty holders at any one time lies in the assumption that each of the concurrent duty holders is equally able to exercise control over the activity which gives rise to the relevant risk. The reality is that the capacity to control the activities which take place in a workplace will vary among the different duty holders.

Control is also implicit in the 'upstream' chain of responsibility provisions imposing duties on designers, manufacturers, suppliers, installers and erectors and owners of plant, manufacturers and

suppliers of substances used at a workplace and clients, designers, project managers and principal contractors of structures. The duty is limited to the sphere of activity over which they have control. Designers of plant, for example, are responsible for ensuring that ‘the plant is so designed and constructed as to be safe ... when used properly’. Designers are of the view that they should have no responsibility for the consequences of improper use of the plant in the workplace, over which they have no control.

The concept of non-delegable duties, imported from the common law, underpins the implicit obligation on each duty holder to exercise control and any attempt to determine who is in control of various aspects of the work is largely unhelpful and problematic. A much more useful and effective approach, it is suggested, is to marry the concept of reasonable practicability with the risk management process and articulate this specifically in the national model OHS laws. In this way each duty holder will determine appropriate reasonably practicable measures based on their respective assessments of the risk. This aspect is dealt with in sections 3.2, 4.1 and 4.2.

Also, control is used to denote some level of occupation or possession of premises in respect of which a duty is imposed on a person. In Queensland, these relate to workplaces, buildings within which workplaces are situated and associated areas, which are not generally under the control of an employer. The way in which the notion of control in this context is used in legislation across the country to determine who may hold duties, what those duties are, and in what circumstances those duties may be limited, differs between the States, Territories and the Commonwealth. Generally speaking, current legislation provides only minimal assistance in determining who is in control. The concept of control remains largely undefined in any occupational health and safety legislation across the country and it is left to duty holders to rely on judicial interpretation. This aspect is dealt with in section 3.7.

## **5. Worker Participation is Crucial to Good OHS Outcomes**

A number of studies have identified a relationship between objective indicators of OHS performance (such as injury rates or hazard exposures) in workplaces where structures of worker representation are in place (union presence, joint safety committees or worker/union safety representatives). Despite their diversity in terms of methods and other details, taken collectively these studies support the notion that joint arrangements and trade union representation at the workplace are associated with better health and safety outcomes. Generally, these studies found participatory workplace arrangements led to improved OHS management practices and compliance with regulatory standards (Walters, 2006). This research suggests that the model OHS statutes must provide a framework for worker participation in OHS, and must enable strong trade union involvement in, and support for, the various worker participation processes.

## **6. OHS Support for Organisations**

Qualified and experienced OHS professionals can play a critical role assisting businesses meet their OHS legal obligations as well as leading and supporting and preventive OHS initiatives to improve workplace OHS outcomes (Bluff, 2005). Research indicates that one of the strongest predictors of OHS success is whether organisations have the assistance of competent trained OHS personnel (Bluff, 2005). In contrast to the approach taken in the Scandinavian countries, and some other European countries, the Australian OHS statutes do not require firms to engage occupational health services to assist them to comply with their OHS obligations. The Australian OHS statutes take one or both of two broad approaches:

- extending the employer’s arrangements for first aid treatment to include some form of OHS advice or services – in-house or through an external agency (Cth, Qld, SA, WA); and/or
- requiring employers to obtain or access OHS information, or to appoint a person to perform OHS functions (NSW, Vic, Qld and NT).

The new model OHS legislation should require all businesses to have in place a system to access OHS information or to appoint a person with OHS expertise to assist them to comply with their OHS obligations.

## **7. Consistent Compliance and Enforcement Outcomes.**

Regulatory sanctions are an essential feature of a regulatory enforcement toolkit and are central to achieving compliance by signalling the threat of a punishment for firms that have offended. Sanctions demonstrate that non-compliance will not be tolerated and that there will be a reprimand or consequence that will put the violator in a worse position than those entities that complied with their regulatory obligations on time. It is important for Government to ensure that regulators have a flexible and proportionate sanctioning toolkit which ensures protection. That toolkit should provide appropriate options to handle the regulatory needs of legitimate business as well as those businesses that intentionally and knowingly fail to comply with regulatory obligations on time. This toolkit includes, improvement and prohibition notices, on-the spot-fines, enforceable undertakings and a broad range of prosecution penalty outcomes.

Uniformity in the behaviour of inspectors who monitor compliance and enforce non-compliance is central to the successful implementation of harmonised national OHS laws, as is consistency of penalty outcomes by the courts. The national model OHS laws should be constructed in such a way that they ensure uniform interpretation, approach and outcome.

### **Summary**

The Queensland government submission emphasises that the ultimate aim of OHS legislation is for the prevention of work-related injury and disease. The most appropriate and effective means of achieving this is through the adoption of a risk management approach by duty holders, the engagement of OHS stakeholders coupled with an effective regulatory framework. To this end, the submission draws on academic research, the findings of previous OHS reviews, case law, independent OHS reviews and direct experience as a regulator.

The Queensland government notes that there will continue to be duplication and overlap in the administration of national model OHS laws involving contractors to national self-insurers, who will be subject to regulation by the states and territories, where the national self-insurer will be subject to regulation by the Commonwealth's regulator Comcare. The Queensland Government is of the view that as part of giving effect to the national model OHS laws, the Commonwealth should remove OHS coverage for national self-insurers if they are to remain under the Comcare scheme.

## CHAPTER 1: LEGISLATIVE APPROACH

### 1.1 Regulatory Structure

An appropriate regulatory approach for the national model OHS laws will comprise a number of elements. A starting point for addressing this issue is the regulatory literature on the qualities of good regulatory standards. The regulatory literature (see especially Diver, 1983) suggests that good regulatory standards must be:

- transparent, using words with well-defined and universally accepted meanings;
- accessible and applicable to concrete situations without excessive difficulty or effort; and
- congruent with underlying policy objective so that the substantive content produces the desired behaviour.

This means that OHS standards should use the language, concepts and technical terms familiar to managers and workers they should be easy to apply to specific situations; and articulate and be consistent with the overall objective of ensuring that OHS risks are removed or mitigated.

One of the criticisms levelled at the general duties is that they are difficult to understand and to apply, particularly because of the qualification of ‘reasonable practicability’ of measures. At the same time the courts have interpreted the ‘principle-based’ general duties as having a substantial process-based content – namely systematic OHS management (OHSM). The cases interpreting the employer’s general duty indicate that the employer should not just be responding to demonstrated risks but should have a system of searching for and identifying all possible risks, and instituting reasonable and appropriate measures. In other words, the courts have effectively deemed that general OHS duties require duty holders to engage in systematic OHSM based on the risk management approach (Bluff and Johnstone, 2005). Risk management process standards are both more transparent and accessible than general duties and are potentially more congruent with the underlying policy objective of OHS regulation.

The national model OHS laws should provide general duties which are couched as risk management process standards, underpinned by performance standards in regulations where it is possible to specify a clear target or goal. Risk management requirements should be specified where no target is possible but where evidence suggests that a risk management process will be effective and with specification standards where a clear, proven and cost effective control is available. Queensland supports the approach advocated by Bluff and Gunningham (2004: 12-42). In complying with the general duties in the Act (expressed as risk management process standards), if there are detailed regulations applicable, the duty holder must implement those detailed provisions. Alternatively, if a code of practice is applicable, the duty holder should follow the provisions outlined in the code or implement other control measures that provide at least the same level of protection.

In terms of the extent to which there should be detailed provision for risk management in the Act versus the subordinate legislation, there must be a clear requirement of a risk management approach in the Act – if possible articulated clearly in the formulation of the general duties. Section 27A of the Queensland Act provides one possible model. Specific standards should be in regulations and where a lot of detail is required it should be in codes of practice. There should be provision for industry codes of practice to be developed in a tripartite process so that regulatory provisions can be particularised for the industry. The principal point of industry codes should be to make the contents of the general duties, regulations and codes even more transparent and accessible for people working in the industry.

## 1.2 Title, Objects and Principles

OHS statute needs to be ‘self-contained’ and easy to interpret. Objectives and methods to achieve the objectives should ensure that interpretation of the Act is framed and shaped by a robust best practice OHS approach, which ensures worker involvement in OHS.

Consistent with Queensland’s desire for the national model OHS laws to account for all work arrangements, the title of the Act should be broad and not limited to a narrow focus on the ‘workplace’. It is proposed the title of the model Act should be the *Work Health and Safety Act*.

The inclusion of objectives in the national model OHS laws is essential. Objectives have several related purposes. They provide guidance about the purpose of the Act (Maxwell, 2004: 23), set the tone of the Act and assist courts in interpreting the Act (ACT Occupational Health and Safety Council, 2005: 34). Most importantly, the objectives of the Act should ‘spell out what the statute aspires to achieve’ (Shaw et al., 2007).

In many Australian jurisdictions, the listed objects of the OHS Act include both the primary objective of the Act – to preserve health and safety at work – as well as a number of intermediate objectives, such as, consultative arrangements for example). These intermediate objectives are not ends in themselves but rather strategies in pursuit of the primary objective.

Greater clarity could be achieved by listing the primary objective separately from the strategies or intermediate measures pursued to attain it. This approach is similar to the approach suggested by Maxwell (2004: 23) who recommended including separate principles in the Victorian *Occupational Health and Safety Act* (OHSA). The primary objective should be concise and clearly stated. The Queensland Government recommends that the overarching objective of OHS law should be to *prevent death, injury or illness at work*. This objective is achieved by *preventing or minimising exposure to the risk of death, injury or illness*.

Accordingly, the Queensland government submission is seeking to focus the national model OHS laws on formalising the risk management approach which is the appropriate procedure to prevent and minimise exposure to risk at work. Further lower-order measures to promote and support a preventative risk management approach to preserving health and safety at work would include:

- imposing obligations on people at work;
- making subordinate legislation;
- establishing an advisory mechanism;
- facilitating industry participation;
- establishing consultative arrangements at the workplace;
- requiring employers to engage OHS expertise; and
- establishing an enforcement framework.

## CHAPTER 2: SCOPE, APPLICATION AND DEFINITIONS

### 2.1 Industry Sectors

One of central recommendations of the Robens Committee was for all OHS law to be integrated into a parent OHS Act (see discussion in ACT Occupational Health and Safety Council, 2005: 26). In all jurisdictions in Australia, a raft of antiquated statutes such as the factories and shops, machinery, scaffolding, boilers have been repealed and integrated as regulations into Robens style OHS legislation. Despite these major improvements, there still remains much industry and hazard specific legislation in all jurisdictions.

All jurisdictions in Australia currently have principal OHS legislation plus a raft of industry specific OHS Acts such as maritime and mining and specific hazards such as petroleum, explosives and radiation. Some indication of the extent of this legislation can be seen in Table 1 below (excluding regulations).

Table 1: OHS Laws in Australian Jurisdictions

	Cth	NSW	Vic	Qld	WA	SA	NT	Tas	ACT
General OHS Act	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mining		✓	✓	✓	✓	✓	✓		
Dangerous Goods			✓	✓	✓	✓	✓	✓	✓
Electrical Safety				✓	✓				
Explosive				✓		✓			
Maritime	✓	✓	✓	✓	✓	✓	✓	✓	
Radiation		✓	✓	✓	✓	✓	✓	✓	
Petroleum and Gas	✓	✓		✓					
Miscellaneous		✓	✓		✓				✓

A key issue with the multiplicity of industry or hazard specific OHS laws is that different protections relate to different industries and hazards. In Queensland, for example, under the *Workplace Health and Safety Act 1995* (WHS Act), duty holders are required to ensure the workplace health and safety of workers and others, subject to certain defences, whereas under the *Mining and Quarrying Safety and Health Act 1999* and the *Coal Mining Safety and Health Act 1999*, the duty is to ensure the risk to workers while at the operator's mine, and of others affected by the mine, is at an acceptable level. Under Queensland's *Dangerous Goods Safety Management Act 2001*, duty holders are required to take all reasonable precautions and care to achieve an acceptable level of risk.

There is public merit in simplifying the current complex arrangements to ensure greater consistency of OHS law across industries and hazards. This would produce greater transparency and certainty for all OHS stakeholders without reducing OHS outcomes for workers. The issue of consistency across industries has been considered in a number of recent OHS reviews in Australia. The Laing review of mine safety in Western Australia in 2003 argued that there was not logical or sensible reason for have different standards or arrangements between industries (Laing, 2003). Both the ACT and the NT reviews recommended greater consistency in OHS law (ACT Occupational Health and Safety Council, 2005: 97; Shaw et al., 2007: 22-40).

The Queensland government recommends that the central features of OHS legislation – duties and defences – should apply consistently to all undertakings, industries and hazards. Consistent with the findings of the Maxwell (2004: 71-88) in Victoria, the Queensland government also recognises, that specific industries have special regulatory requirements. In some cases, there may be differing needs for safety management systems, safety case, accreditation. There needs to be the capacity for industry-specific legislation to accommodate the unique requirements of particular industry sectors. Where possible, this industry specific legislation should be formulated nationally and adopted consistently by each jurisdiction as is proposed by the National Mine Safety Framework. States and territories with the OHS functions spread across several agencies should ensure they have in place appropriate mechanisms for the co-ordination of the OHS effort within their jurisdiction.

## 2.2 Workplaces and Non-workplaces

In principle, the touchstone should be prevention of exposure to risk arising from the conduct of the undertaking – regardless of whether the person placed at risk by the duty holder is at the workplace or away from it, and regardless of whether the person exposed to risk is working or not working.

Members of the public should be protected by the duties. This was a central principle in the Robens Report, which envisaged the protection of the ‘internal public’ (shoppers in a shopping centre, students in a university) as well as the external public. There is no reason to abandon this principle. If the duties are to be limited by reasonable practicability (or a clearly articulated risk management process), there is no reason to limit the duty to persons at the workplace (cf the NSW approach) or near the workplace (cf the Commonwealth and ACT approaches).

The protection of members of the public is best achieved by following the Queensland approach in s28 of the Queensland WHSA and the Queensland mining safety and health legislation impose an obligation on a ‘person who conducts a business or an undertaking’ to ensure the workplace health and safety of each of the person’s workers and any other persons is not affected by the conduct of the person’s business or undertaking: that is, these people must not be exposed to risks to their health and safety. The Victorian OHS Act (s23 and s24) substantially achieves the same protective reach, although it is preferred that the duty be imposed on persons conducting a business or undertaking, rather than on employers and self-employed persons.

The concept of *business or undertaking* enables the imposition of wide-ranging public safety obligations that extend beyond the traditional concept of a workplace. Clearly members of the public should be protected by the duties. There is no reason to limit the duty to persons at the workplace (cf the NSW approach) or near the workplace (cf the Commonwealth and ACT approaches) under OHS legislation. To do so, would create a gap in preventive regulation from workplace activities, leaving the common law as the only mechanism available to persons injured in these circumstances.

There are generally four circumstances where the regulator may play a role in managing public safety – that is, where a member of the public is exposed to risks of injury, ill health or death:

1. directly as a result of a work activity or in an incident involving high risk plant;
2. while being a spectator at an activity which forms part of a business or undertaking – for example, when members of the public are injured while viewing a fireworks display or motor car racing;
3. while actively participating in a high risk activity using equipment provided by the business operator; or
4. while actively participating in a high risk activity where the member of public uses their own equipment or where the business owner/operator has limited control over the level of risk to the participants – for example, amateur car racing, rodeo ventures and particular varieties of adventure parks.

In categories 1-3, there is a more clearly identifiable link between the conduct of the business or the undertaking and the risk to the public. In the fourth category the work or workplace connection is often remote. These are situations where there is voluntary assumption of risk, direct or implied, by members of the public. In many, the only connection with the business may be the payment of money to use premises which may (or may not) have been subject to some intervention by the obligation holder (for example by providing facilities such as ramps, jumps, barricades and so on).

An appropriate regime needs to be built into the model legislation which limits a facility operator’s liability in accordance with tests which seek to determine the scope of the operator’s undertaking, the degree of control the operator has over the activities of any participant and the level of a participant’s voluntary assumption of any risk inherent in the undertaking.

## 2.3 Responding to Change

### *Work Organisation*

The growth of more flexible forms of employment has been well documented in the literature and explored in some detail in number of recent OHS reviews in Australia (ACT Occupational Health and Safety Council, 2005: 97; Crittall, 2001; Maxwell, 2004). Flexible forms of employment have been variously labelled ‘contingent work’, ‘precarious employment’ and ‘non-standard work’. Maxwell (2004) notes that precarious forms of employment include self-employed subcontractors including mobile or home-based workers, temporary and on-call workers, agency labour, casual employees and fixed term contract workers. In Australia and overseas, there has been a significant growth in precarious forms of work in recent decades (see Campbell, 2008; Johnstone and Quinlan, 2006). The growth of flexible forms of employment is perhaps ‘the most significant change affecting work globally over the past 20 years’ (Quinlan, 2004a: 121).

Quinlan (2004a: 120) argues ‘[t]here is now a substantial body of international research indicating that many flexible work arrangements ... are associated with inferior outcomes in terms of worker safety, health and well-being’. Quinlan (2004a) undertook a major review of the 188 studies which examined the association of flexible forms of work and OHS. He found that some 78 per cent of studies linked precarious forms of employment with inferior OHS outcomes. The research (Johnstone, Quinlan and Walters, 2005; Quinlan, 2004a; Quinlan, 2004b) indicates that persons engaged in precarious forms of employments are less likely to:

- have knowledge of OHS requirements;
- comply with OHS requirements;
- receive OHS training;
- refuse dangerous work;
- be consulted about OHS issue;
- report incidents (for fear of losing work);
- raise concerns about OHS hazards and problems;
- be involved in OHS participative structures; and
- access entitlements (such as through workers compensation).

As Crittall (2001: 2) observed, the precariously employed ‘have dramatically affected the nature of the key relationships at work and have placed considerable pressure on the definitions and responsibilities of obligation holders’ under OHS law. On any given worksite there is likely to mixture of different employment types including regular employees, employees from other firms, labour hire, self-employed contractors and home-workers. The new model OHS laws need to sufficiently supple to accommodate these increasingly diverse working relations.

To achieve this, the scope and application of the model OHS Act should be based around ‘business or undertaking’ which is sufficiently broad and flexible to accommodate new and evolving types of work arrangements. A person conducting a business or undertaking should ensure the health and safety of all persons involved in, and who are affected by, the undertaking. There should be no incentive to firms to organise their labour arrangements so as to reduce their responsibility for OHS.

The guiding principle here is set out in the *R v Associated Octel Co Ltd* [1996] 4 All ER 846 case: an employer is free to decide labour arrangements but is under a duty to exercise control over the activity and to ensure that it is done without exposing non-employees to risks. The scope and application of the model OHS Act should be based around *business or undertaking* which is sufficiently broad and flexible to accommodate new and evolving types of work arrangements. A person conducting a business or undertaking should ensure the health and safety of all persons involved in, and who are affected by, the undertaking. That is, a person running a business or undertaking should be required to follow the same risk management processes in relation to all

persons whose health and safety might be put at risk by the operations of the business or undertaking. There should be no incentive for firms to organise their labour arrangements so as to reduce their responsibility for OHS.

Ensuring that all kinds of workers are protected by the general duty is best achieved by following the Queensland approach in s28 of the WHSA which imposes an obligation on a *person who conducts a business or an undertaking* to ensure the workplace health and safety of each of the person's workers (see the definition of worker below) and any other persons is not affected by the conduct of the person's business or undertaking: that is, these people must not be exposed to risks to their health and safety. The Victorian OHS Act s23 and s24 substantially achieves the same protective reach, but the Queensland Government would prefer imposing the duty on persons conducting a business or undertaking, rather than on employers and self-employed persons.

The general duty should be couched as requiring a proactive and systematic approach to OHS. Examples of how this duty applies to the various categories of workers should be provided in the Act and/or detailed examples in guidance material. The examples should cover contractor/subcontractor chains, franchising, consignments, labour hire, home-based work and the other working relationships detailed in 2.3 of the discussion paper.

In terms of emerging hazards and risks, within a risk management framework, a person conducting a business or undertaking has an overarching obligation to eliminate or minimise the exposure of workers and others to the risk of death, injury or illness as a result of their business or undertaking. This general obligation applies to all types of risks including traditional physical and chemical risks as well as more recently recognised psycho-social risks and risks associated with the organisation of work. As such, there is no need to make special reference to new or emerging hazards - fatigue, workload, bullying, stress and communicable diseases – as they are comprehensively covered by the general obligation of a person conducting a business or undertaking to eliminate or minimise exposure to risks to health and safety.

## 2.4 Definitions

There are a number of key definitions which are critical in ensuring a consistent national approach. Queensland government recommends that the following terms be defined in the model OHS Act:

- 'worker' should be defined in line with the new Northern Territory Act, which defines a 'worker' to include any person who works in a person's business or undertaking as an employee, apprentice, contractor or sub-contractor (or their employee), employee of a labour hire company, volunteer or 'in any other capacity';
- 'business or undertaking' should be used instead of 'employer' and 'self-employed person' as it gives greater and clearer coverage;
- 'person in control' needs to be defined as this concept is pivotal to the operation of the Act; and
- 'principal contractor' needs to be defined consistently to ensure the co-ordination of trade contractors undertaking construction work.

Consideration should also be given to whether certain activities undertaken by homeowners come within the ambit of an undertaking. The most predominant relate to:

- owner builders, who hold a licence and organise tradespeople to undertake various work activities relating to the construction of their home; and
- homeowners who have a requisite licence and undertake the removal of more than 10 square metres of bonded asbestos containing material in contravention of the national asbestos removal code of practice.

The concept of a ‘workplace’, although still useful and necessary in some contexts, is not considered to be a corner stone of contemporary OHS legislation and should be relegated to a secondary consideration in the national model OHS Act.

## **CHAPTER 3: DUTIES OF CARE – WHO OWES THEM AND TO WHOM?**

### **3.1 The Current Approach**

In the past, the typical workplace was controlled by a single employer, with whom each member of the workforce had a contract of employment. Today, the picture is altogether different. It is now common, especially in larger undertakings, for workers in a given workplace to be engaged under a range of different employment arrangements with different employers. There will often be a range of obligation holders whose safety duties under the Act overlap and apply simultaneously to the same workplace. For example, on a large building site one would expect to find:

- the principal building contractor and its employees;
- a number of sub-contractors, each with their own employees;
- workers supplied by one or more labour-hire companies; and
- one or more apprentices placed by a training organisation.

This type of situation is addressed in current Queensland OHS law as follows: each of the employers (and labour suppliers) will owe duties to their respective workers under s28 WHSA. In addition, the principal contractor will owe additional specified duties to each sub-contractor and their workers (s31). Each employer and self-employed person on the site will also have a duty to ensure that persons other than workers are not exposed to risks to their health or safety. Finally, the occupier of the workplace will have a duty to ensure that the workplace is safe.

The advantage of this approach was noted by Quinlan and Johnstone (2003) in their submission to the Maxwell Review of the Victorian OHSA:

*[o]ne of the real strengths of the current duties arrangement is that by specifying a range of duty holders they can accommodate complex and shifting work arrangements and indicate the need for responsible actions by all relevant parties. This is not to say that the level of responsibility should be identical.*

### **3.2 Control**

The Robens Report stated that as ‘... a matter of principle the legislation should not have the effect of imposing obligations on employers concerning circumstances over which they have no control’ (Robens, 1972: 51). However, what Robens meant is not clear and OHS legislation since that time has included the concept in a number of different ways.

Where there are multiple duty holders, in practice, each of the concurrent duty holders is not equally able to exercise control over the activity which gives rise to the relevant risk. The reality is that the capacity to control the activities which take place in a workplace will vary among the different duty holders and over time.

However, OHS duties are non-delegable. The concept of non-delegable duties is imported from the common law and underpins the implicit obligation on each duty holder to exercise control. At common law, whether an employer has a ‘special duty’ not only to take care but to ensure that care is taken by others depends on whether the employer has:

*undertaken the care, supervision or control of [employees]..or is so placed in relation to [them]... as to assume a particular responsibility for safety, in circumstances where [they] might reasonably expect that due care will be exercised.<sup>1</sup>*

The tension between the theory of non-delegability of duties and the reality of differential degrees of control is apparent in the differing approaches taken by the courts. In *Kondis v State Transport Authority*, for example, the High Court took a strict view of the responsibility of the principal employer in relation to risks created by the conduct of a sub-contractor:

*The employee's safety is in the hands of the employer; it is his responsibility. The employee can reasonably expect therefore that reasonable care and skill will be taken. In the case of the employer, there is no unfairness in imposing on him a non-delegable duty; it is reasonable that he should bear liability for negligence of his independent contractors in devising a safe system of work. If he requires his employee to work according to an unsafe system of work he should bear the consequence...In the result the [employer's] duty to provide a safe system of work was non-delegable and the [employer] was liable for any negligence on the part of the its independent contractor in failing to adopt a safe system of work.*

On the other hand, the House of Lords in *R v Associated Octel* [1996] 4 All ER 846 treated a duty holder's ability to control the activity giving rise to the relevant risk as being directly relevant to the question of what was (reasonably) practicable in the circumstances:

*The question of control may be very relevant to what is reasonably practicable. In most cases the employer/principal has no control of how a competent or expert contractor does the work. It is one of the reasons why he employs such a person – that he has the skill and expertise, including the knowledge of appropriate safety precautions, which he himself may not have. He may be entitled to rely on the contractor to see that the work is carried out safely, both so far as the contractor's workmen are concerned and others including his own employees or members of the public; and he cannot be expected to supervise them to see that they are applying the necessary safety precautions. It may not be reasonably practicable for him to do other than rely on the independent contractor.*

In his review of the Victorian OHS Act, Maxwell recommended (2004: para 499) that control be added to the list of practicability factors. In his view:

*The inclusion of an express reference to control would bring OHS Act into line with legislation in other States. In NSW and Queensland, it is a defence if a duty holder can show that the contravention occurred by reason of matters beyond its control. In my view, it is preferable for control to be addressed at the threshold, when the duties are imposed, so that the scope of individual duties can be determined. In this way, control issues are integrated with the other factors which determine what is "reasonably practicable".*

This recommendation, however, was not adopted in the new Victorian legislation.

Attempts to determine in advance who is in control of various aspects of the work are problematic. A much more useful and effective approach is to specify in the model OHS Act that reasonable practicability comprises a risk management procedure. In this way each duty holder will determine appropriate reasonably practicable measures based on their respective assessments of the risk/s.

### **3.3 Work Relationships**

#### ***Self-employed persons***

##### ***The treatment of workers in OHS laws***

The traditional OHS emphasis on *employee* should be replaced by a broader obligation to *workers*. Defining a worker broadly ensures the concept encompasses the modern work arrangements where employees work alongside bailees, sub-contractors, labour-hire workers, volunteers, apprentices

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<sup>1</sup> *Kondis v State Transport Authority* (1984) 154 CLR 672 at 687.

and so on. Regardless of their employment status, all workers are owed a duty of care by persons conducting businesses or undertakings. This approach extends beyond the limitations of expressing duties based on the employer/employee relationship and hence overcomes the necessity of deeming persons to be employees (for example, contractors) as is the case in Victoria, the Commonwealth, South Australia and Western Australia (which also deems labour hire workers to be employees).

Maxwell (2004: 136), in his review of the 1985 Victorian Act, commented that:

*In my view, the substantive provisions of the legislation should reflect the broader concept of 'persons at work', as embodied in the objects of the Act. The focus of health and safety protection, and therefore, of the corresponding obligations, must surely be to protect each person who is at work in a workplace. It hardly seems relevant, at least at this general level, to enquire into the precise legal basis of a person's employment...In the course of the consultations, it has been suggested that a definition of 'worker' should be introduced into the Act. Such a term could accommodate the whole range of different workplace relationships in the new economy – including contractors, casual workers, outworkers and labour hire workers – but would not seek to draw any distinctions between them where their rights and responsibilities with respect to occupational health and safety are concerned. In my view...[t]he introduction of the term 'worker' will have the advantage of sharpening the distinction between s.21 and s.22.*

This recommendation was not adopted in new Victorian legislation. Tooma (2005: 31) comments that “had the approach been adopted the awkward operation of s21(3) and its interaction and overlap with s23 could have been avoided.”

The Queensland Government recommends that the definition of worker be based on the new Northern Territory Act which defines a ‘worker’ to include any person who works in a person’s business or undertaking as an employee, apprentice, contractor or sub-contractor (or their employee), employee of a labour hire company, volunteer or in any other capacity. This broad definition would include bailees, franchisees and others currently excluded from OHS laws in some jurisdictions. Even if it does not, persons carrying put work who do not come within the expanded definition of *worker* will be protected by the duty to *others*.

The broader definition of *worker* rather than *employee* dovetails with Queensland’s preferred definition of a *person conducting a business or undertaking* rather than a definition of *employer*. The Queensland approach in s28 of the WHSA 1995 imposes an obligation on a *person who conducts a business or an undertaking* to ensure the workplace health and safety of each of the person’s workers and any other persons is not affected by the conduct of the person’s business or undertaking: that is, these people must not be exposed to risks to their health and safety. The Queensland mining legislation contains similar obligations. The Victorian OHSA (s23 and s24) substantially achieves the same protective reach, however, the process of deeming creates additional complexity and uncertainty for duty holders.

The general duty should be couched as requiring a proactive and systematic approach to OHS management. A person running a business or undertaking should be required to follow the same risk management processes in relation to all persons whose health and safety might be put at risk by the operations of the business or undertaking. Examples of how this duty applies to the various categories of workers should be provided in the Act and/or detailed examples in guidance material. The examples should cover contractor/subcontractor chains, franchising, consignments, labour hire, home-based work and the other working relationships detailed in 2.3 of the discussion paper.

### **3.4 Duties of Employers**

This issue is addressed in section 2.3 Work Organisation.

### **3.5 Duties of Workers and Others**

Workers should be subject to OHS duties commensurate with their level of control. All persons should have a duty to take reasonable care for their own OHS, and for the OHS of others, commensurate with the control they are able to exercise in relation to work activities. The duties of workers and other persons should be specified as per s36 of the Queensland OHS Act such that workers and anyone else at a workplace has an obligation:

- to comply with OHS instructions;
- use personal protective equipment;
- not to wilfully or recklessly interfere or misuse anything provided for workplace health and safety at the workplace;
- not to wilfully place at risk the workplace health and safety of any person at the workplace; and
- not to wilfully injure himself or herself.

The Queensland duty is preferred over other jurisdictions, which provide that workers take reasonable care because it does not take away from the business operator's (who is almost always invariably in control of the risk) primary responsibility of ensuring OHS, other than for the most blatant, wilful and deliberate conduct by a worker.

### **3.6 Appointed Persons and Officers**

The national model OHS laws should impose a requirement on a person conducting a business or undertaking to ensure they have the necessary OHS expertise to conduct risk assessments and to manage OHS prevention. A key element in getting OHS on the agenda is to have a person with the knowledge and skills to provide the necessary advice. Unfortunately, there is no Australian tradition of requiring employers to engage occupational health services as in Scandinavia and parts of Europe.

Qualified and experienced OHS professionals can play a critical role in assisting business meet their OHS obligations as well as leading and supporting preventive OHS initiatives to improve workplace OHS outcomes (Bluff, 2005). Research indicates that one of the strongest predictors of OHS success is whether businesses have the assistance of competent trained OHS personnel (Bluff, 2005). Given that for many businesses, there is much uncertainty as to how to discharge their general obligations to provide safe workplaces, organisations require the assistance of trained personnel to provide them with the skills and know-how to evaluate and design safe work systems.

In Australian jurisdictions, there has been a basic and piece-meal approach to the provision of OHS support services. The current provisions are not comprehensive, are vague and in some cases inconsistent (Bluff, 2005). Several jurisdictions have some provision for OHS support. Under the NSW *Occupational Health and Safety Regulations 2001* 16(1), employers are required to obtain information from an authoritative source to enable the employer to fulfil their risk management responsibilities. In Victoria, under (s22(2)) employer are required to employ or engage persons with OHS expertise, together with a proper provision in relation to OHS health services and advice. Employers have discretion in engaging directly employed or outside consultants with OHS expertise.

The Queensland Government recommends that the review panel consider the Queensland WHSA approach requiring larger employer to engage Workplace Health and Safety Officers (WHSOs) as appointed persons with specific OHS responsibilities. Since 1989, Queensland has made it a requirement that workplaces or principal contractors with more than 30 employees be required to appoint a WSHO. In Australia, while less than five per cent of workplaces have more than 30 employees, more than half of employees work in workplace with over 30 employees. WHSOs are

management appointees, unlike Health and Safety Officers (HRS) who are elected representatives of employees.

The functions of WHSOs include to inform employers about the state OHS; conduct inspections and identify and report hazards; establish educational programs; investigate OHS incidents; and assist OHS inspectors. Feedback from Queensland stakeholders indicates that WHSOs are strongly supported. Employers benefit from having an appointed officer with OHS training, expertise and authority. Unions also find it highly beneficial to have a designated officer responsible for OHS at the workplace as it clarifies lines of communication and ensure that unions can quickly locate and liaise with OHS specialists at the workplace. WHSOs also improve communication and co-operation between organisations and the OHS inspectorate.

WHSOs are required to complete compulsory training in two stages. In stage one, WHSOs complete five days instruction covering core elements including OHS legislation, risk assessment, incident investigation, occupation health and hygiene, consultative arrangements and basic ergonomics. Stage two comprises industry specific training: industrial, construction or services. Persons passing successfully the examinations can apply to become a registered WHSOs. The advantage of having state mandated, sponsored and controlled training is that provides duty holders with an assurance that competent OHS personnel are operating onsite in medium and large workplaces in Queensland.

Employers, for their part, have obligations to support the functions of the WHSOs under the Act. Employers are obliged to consult with WHSOs, provide them information and resources, assist them in their duties and to rectify unsafe conditions and practices identified by the WHSOs. Through the compulsory provision and recognition of appointed OHS personnel, the Queensland government is enabling businesses to more effectively fulfil their workplace health and safety obligations.

Research indicates that WHSOs have proven to be an effective means of improving knowledge and understanding about OHS issue within the workplace. (Crittall, 2001: 14). Vanderkruk (1999) reports that WHSO training significantly improved the knowledge and effectiveness of WHSOs. Vanderkruk (1999) also found the appointment of qualified WHSOs leads to more effective risk management, improved manual handling procedures, greater awareness and control of hazardous substances, more OHS induction training and more effective employee consultation and involvement.

WHSOs also have a high degree of support in industry. A study by Horstmanshof et al. (2002) found that a large majority of workers and management felt that WHSOs were:

- well prepared to deal the OHS hazards and incidents;
- trained well;
- supported by management;
- influential in OHS issues; and
- developed effective solutions to OHS problems.

Given the success of WHSOs in Queensland, it is proposed the provision of WHSOs be incorporated into the model OHS legislation. For employers with less than 30 employees, alternative extension programs need to be considered at the State and Territory level. This may include supporting employers associations to provide roving WHSOs to target particular industries, regions or small businesses. Other measures could include specialist services through the regulator's dedicated advisory function as well as the development of codes of practice to support small and medium businesses.

The appointed person should be accountable to senior management who bear the corporate officer's obligations. There should be no liabilities on a WHSO. Their role of the WHSO is to facilitate and assist the employer to comply with legislation. The experience in Queensland has been that employers had not viewed WHSO as an opportunity to displace their OHS obligations. Conversely, the presence of WHSOs has provided organisations with onsite awareness, expertise and advocacy for betterment of OHS outcomes. The appointment of a WHSO under the Queensland WHSA does not reduce in any way the obligations of duty holders.

### 3.7 Duties of Persons in Control

The notion of control is used in OHS legislation to denote some level of occupation or possession of premises in respect of which a duty is imposed on a person. In Queensland, this relates to workplaces, relevant workplace areas and fixtures, fittings and plant in relevant workplace area. In Victoria and NSW similar duties are enshrined in provisions dealing with occupiers of workplaces.

Generally speaking, though, current legislation across Australia provides only minimal assistance in determining who is in control and what, in effect, constitutes control. The way in which the notion of control is used to determine who may hold duties, what those duties are, and in what circumstances those duties may be limited, differs between the States, Territories and the Commonwealth. The concept of control remains largely undefined and it is left to duty holders to rely on judicial interpretation. Queensland's WHSA is the only Australian statute that attempts to affix a label to a particular class and states that in relation to a relevant workplace area, the person in control is the owner unless effective and sustained control has passed to another person by means of a lease, contract or other arrangement.

The Queensland approach is similar to the approach adopted by the courts. A majority of cases have held that the critical issue is the 'capacity of control' [or 'ultimate' or 'constructive' control]. This view was most clearly articulated in *Reilly v Devcon Pty Ltd* [2007] WASC 106, where Murray J in the Supreme Court of Western Australia stated that it:

*is the 'capacity to control' with which we are concerned...The defendant will have control in relation to the relevant hazard, firstly, if he has by reason of the contractual relationship or otherwise, a legal right to control in the sense that he has a right to give directions which must be obeyed (emphasis added).*

This 'capacity to control' approach was used by the courts in *WorkCover (NSW) v Rowson* [1994] NSWIRComm where an occupier engaged another person to undertake work at the premises. The defendant operated a chicken farm and engaged a contractor who was a licensed builder to perform repair work on a chicken shed on its premises with the assistance of two sub-contractors. One of the sub-contractors fell from the roof to the concrete floor of the shed and suffered fatal head injuries. The fall was not a result of a defect in the roof. Cullen J dismissed the charges against the defendant ostensibly on the basis that the defendant: 'had no control over the method of work which resulted in the fatality. This was a matter under the control of a licensed builder contracted to perform the work'.

A similar approach was adopted in *McMillan Britton & Kell Pty Ltd v WorkCover Authority (NSW)* (1999) 89 IR 464, where the Industrial Court of New South Wales held that (at 480):

*...the applicable meaning of "control" ...must, it seems to us, have about it the sense of not mere "sway", "checking" or "restraint" but rather controlling in the sense of "directing action" or "command" – the ability of the person to compel corrective action to secure safety (emphasis added).*

The Queensland Government recommends that it is the Queensland WHSA approach to person in control should be adopted in national model.

### 3.8 Activities Which Impact on Health and Safety

#### *Design, Manufacture, Supply, Import, Installation and Erection, Decommission and Disposal*

It has been widely accepted that upstream parties such as manufactures, suppliers and installers have an obligation to ensure safety at work as a result of their undertaking. In more recent years, several major reviews of OHS laws in Australia have examined the issue of safe design (ACT Occupational Health and Safety Council, 2005; Maxwell, 2004; Shaw et al., 2007). The growing consensus, expressed aptly by Maxwell (2005: 183) is that the: ‘case for a legislative obligation of safe design is ... a compelling one.

There is substantial research in a number of industries indicating that the upstream decisions can have a major impact on worker safety. In U.S. construction, Behm (2005) reviewed 240 fatality investigation reports and concluded that in 42 per cent of fatalities, risks associated with the incident could be traced back to the design phase involving architects and design engineers. Behm (2005) concluded that many safety hazards were ‘designed into’ construction projects and that by addressing safety in the design phase, many hazards can be eliminated or reduced during the construction stage. This research was given further credence when a panel of experts re-examined the evidence and overwhelmingly endorsed Behm’s original conclusions (Gambatese, Behm and Rajedran, 2008).

Similar design problems have been found in other industries such as the airline and nuclear industries (Kinnersley and Roelen, 2007). Kinnersley and Roelen, (2007) found that the root cause of 51 per cent of accidents and incidents in the aircraft industry could be traced to the design phase. For the nuclear industry, the percentage of accidents and incidents due to design faults was similar at 46 per cent. A further study of process industries, Taylor (2007) concluded that between 20 and 50 per cent of accidents and incidents could be attributed to design error.

The Queensland Government is of the view that the national model OHS laws should place a duty on all obligation holders over the full life cycle of plant, substances and structures, such as designers, manufacturers, suppliers (including hirers), erectors and installers, owners, as well as business operators. It should be acknowledged, though, that enforcing obligations on designers can be problematic in practice.

Health and safety issues arising from work are influenced by the actions and decisions of various persons in the workplace, items and materials entering the workplace and the workplace itself. It is the view of the Queensland government that, irrespective of the work arrangements, all parties in the supply chain, in the conduct of their business or undertaking, have an obligation to ensure that other people are not exposed to risks to their health and safety. OHS obligations should be placed on relevant parties in relation to:

- business or undertaking - persons who do so as employers, self-employed persons or otherwise (and in the case of construction work in their capacity as clients, project managers and/or principal contractors);
- premises used as workplaces – designers, owners, occupiers and persons otherwise in control;
- Plant and equipment - designers, manufacturers, suppliers, erectors/installers, owners and persons in control of plant and equipment; and
- hazardous substances/chemicals – manufacturers and suppliers.

All parties conducting the business or undertaking have general obligations to ensure the health and safety of others. These general duties impose strict liability on duty holders for the health and safety of workers and other persons affected by the business or undertaking, qualified by ‘reasonable practicability’. If more than one party has a health and safety obligation for a matter, the each parties retains responsibility for the health and safety of others as a result of their business

or undertaking. Each party must discharge their obligation to the extent the matter is within the duty holder's control. Each party must also co-operate and consult with other duty holders to eliminate or minimise OHS risks.

Upstream obligations can be prosecuted no matter what jurisdiction they are in, whether that be in a different jurisdiction in Australia or overseas. It is simply more difficult to execute the judgement against a duty holder if they are outside the prosecuting jurisdiction. The legislation should provide that jurisdictions recognise each other's judgements and be able to execute them as if they were their own.

Supply should be defined broadly: every time an item changes hands and also include loan or hire. In the case of plant, there should be the same obligations for suppliers of new plant, used plant and persons hiring plant. Following the approach in s32B of the Queensland WHSA, the obligations of supplier of new and used plant should be to provide information on proper use of plant and ensure that the plant is safe and without risk when used properly.

The model OHS Act should impose duties on all parties who can have an impact on OHS, including designers of buildings and structures to ensure that the structure can be safely built (Queensland WHSA s30B and Western Australia *Occupational Safety and Health Act 1984* s23(3a)) and that if it is to be used as a workplace, the structure is safe for people who will subsequently work in the structure (see Queensland WHSA 30B, South Australian *Occupational Health, Safety and Welfare Act 1986* s. 23A, the Victorian OHSA s28, and Western Australian *Occupational Safety and Health Act 1984* s23(3a)).

It is also argued that there is no need for the 'when used properly' qualifier given that the duties are already qualified by the reasonable practicability of control measures – using 'when properly used' means that duty holders don't have to be proactive and design out hazards if that is possible.

## **CHAPTER 4: 'REASONABLY PRACTICABLE' AND RISK MANAGEMENT**

### **4.1 Concept of 'Reasonably Practicable'**

The general duties and some regulations in Australian OHS Acts, and in the UK *Health and Safety at Work etc Act 1974*, are absolute duties, qualified by 'reasonable practicability' of measures. Some OHS statutes (most notably Victoria, but also Western Australia and the Northern Territory) set out the elements of reasonable practicability but do so as a number of factors to be balanced, not as a process to be followed by the duty holder. In effect, the general duties resemble the common law duties of care, and the standard of care required of duty holders strongly resembles the common law negligence standard.

There is now a well developed case law on the meaning of 'reasonable practicability' (Bluff and Johnstone: 204-212), and some good guidance material on how the expression should be operationalised (see WorkSafe Victoria, 2007).

With the exceptions of the New South Wales *Occupational Health and Safety Act 2000* and Queensland WHSA, in the event of a prosecution for a contravention of the general duties, the Australian OHS statutes place the onus of proving all elements of a general duties offence on the prosecutor. The onus on the defendant to prove measures were not reasonably practicable applies in the UK (*Health and Safety at Work Act 1974*), in New South Wales (OHSA) and Queensland (WHSA). This latter approach is supported by the Industry Commission (1995: 55, 56) (now the Productivity Commission) which concluded that it:

*considers it is more efficient for the holder of the duty of care rather than the prosecution to have to establish what was reasonably practicable. A duty holder could be expected to know more about the costs and benefits of the various alternatives open to him or her at any time, than anyone else.*

The Queensland WHSA has an absolute duty, but provides the duty holder with defences (s37): that the duty holder has complied with a relevant regulation, code of practice or, in the absence of relevant regulations/code, has taken reasonable precautions and exercised proper diligence (has taken measure which are ‘reasonably practicable’) to prevent the contravention.

The other OHS statutes generally provide that compliance with a regulation is compliance with an overlapping general duty; and either that compliance with a code of practice is evidence of compliance with an overlapping general duty; or that if a duty holder does not comply with a relevant code of practice the duty holder must show that they implemented an equivalent or better standard.

#### **4.2 Risk Management**

The Queensland Government is of the view that a model National OHS laws must integrate the reasonably practicable qualification with the risk management process. The reasonable practicability calculus strongly resembles the risk management process (see Bluff and Johnstone 2005) and indeed, as noted earlier in this submission, the cases interpreting the employer’s general duty indicate that the employer should not just be responding to demonstrated risks but should have a system of searching for and identifying all possible risks, and instituting reasonable and appropriate measures.

Effectively the general duties require duty holders to engage in systematic OHS management (Bluff and Johnstone, 2005: 212-219). Yet only the Queensland legislation and to some extent the Commonwealth Act *explicitly* include a requirement for a duty holder to implement a risk management process in complying with the general duties. For example, s27A of the Queensland Act provides that ‘to manage exposure to risks’ in the workplace, a duty holder ‘must identify hazards, assess risks that may result because of the hazards’, must work through a hierarchy of controls to choose and implement appropriate controls (s27A sets out a hierarchy of hazard controls) and must monitor and review the control measures. This is reinforced by a code of practice, the *Risk Management Code of Practice 2007*. All of the OHS regulations and codes of practice made under the Commonwealth, State and Territory OHS Acts institutionalise risk management approaches to addressing hazards (Bluff and Johnstone, 2005: 220-237).

After examining relevant case law and closely scrutinising the OHS statutes, regulations and codes of practice, Bluff and Johnstone (2005: 237) concluded that ‘the risk management provisions incorporated in Australian OHS legislation, while clearly having features in common with the general duties and (reasonably) practicable, also have some important differences in approach.’ Bluff and Johnstone (2005: 237) note that:

*for the casual reader of the statutory general duties or risk management provisions, the relationship between the two concepts would be far from clear. In our view there is a need to make the relationship between (reasonably) practicable and risk management explicit .... This requires review of the way that both the general duties and the risk management provisions are framed.*

There is, understandably, considerable confusion as to the relationship between the general duties and ‘reasonable practicability’, on the one hand, and risk management principles on the other. The model National OHS laws should *explicitly* require duty holders to undertake systematic OHS management in order to comply with their general duty obligations, and the Act should outline the approach to be taken in a way that integrates the concept of ‘reasonably practicable’ into the

process, and also shows how duty holders should use the provisions in regulations and codes of relevance to the issue being addressed.

In summary, the Queensland view is that to facilitate compliance, the national model OHS laws should integrate the notion of reasonable practicability with the risk management process, and also integrate these two with regulations and codes of practice (as the Queensland legislation does).

Drawing on Bluff and Johnstone (2005: 237-239), the recent decisions of the courts, especially the New South Wales Industrial Relation Commission interpreting the general duties as requiring systematic OHS management, the architecture of the current Queensland Act (especially sections 26, 27, 27A and 37), and the WorkSafe Victoria (2007) guidelines on interpreting 'reasonable practicably', Queensland submits that new provisions be inserted into the OHS statutes to capture the essence of (reasonably) practicable, but that the rather ambiguous concept of reasonably practicable is no longer included as a qualification of the duties. Rather, the Act should recast the general duties (as qualified by the notion of 'reasonably practicable') as risk management principles which are to be applied as a means of complying with all of the duties of care, apart from the duty owed by workers.

The provision would begin by requiring duty holders to identify all reasonably foreseeable hazards or risks that might arise from the conduct of their business or undertaking. The views of Bluff and Johnstone (2005: 238) are supported where they state:

*a full risk management process would then only need to be applied in relation to hazards and risks for which there are not more specific standards. If a regulation or code of practice has been made about the way to eliminate or minimise exposure to a particular hazard or risk, these would be implemented directly as the means of complying with the relevant duty of care, rather than applying risk management principles.*

If there are no specific provisions in regulations or codes of practice which apply to particular hazards or risks, the national model laws should require duty holders to implement risk management principles which would involve (Bluff and Johnstone, 2005: 238):

- assessing the risk (that is, the likelihood of the risk eventuating and the degree of harm if it did eventuate) to health, safety or welfare of workers and other persons (see above for our submission in relation to the scope of the general duties) arising from each hazard, as the basis for determining the measures necessary to eliminate or minimise risks;
- determining risk control measures, and giving preference to measures that eliminate or minimise risk at source, by redesign, substitution, isolation, engineering or organisational means;
- using safe work practices, administrative procedures, or personal protective clothing and equipment to supplement the risk control measures;
- implementing the relevant risk control measures unless the cost, time and trouble of doing so would be *grossly disproportionate* to the risk as assessed; and
- maintaining, monitoring and reviewing risk control measures to ensure their effectiveness.

The national model laws should clearly state that the requirements relating to risk management should be implemented in consultation with relevant workers, in order to fully understand risks and determine effective and suitable control measures. It should also specify that a life cycle approach to risk management should be adopted whereby hazard identification, risk assessment and implementation or modifications of risk control measures are undertaken (Bluff and Johnstone, 2005: 238):

- periodically in the ongoing operations of the business or undertaking;
- in the planning, design, manufacture, procurement, construction and modification of work premises, plant, substances or materials for use at work;
- before changes to work practices and systems of work are introduced;

- prior to the shut down, decommissioning, dismantling or demolition of premises or plant;
- when new or additional information becomes available from an authoritative source; and
- when a hazardous exposure or incident, injury or illness, or adverse result of work environment monitoring or health surveillance indicate that risk control measures are inadequate.

Further guidance to assist duty holders carry out effective systematic OHS management should be set out in a code of practice and in other guidance material, which should (Bluff and Johnstone 2005: 238-239):

- address the development of the necessary knowledge, skills and experience for OHS risk management within organisations or the need to engage OHS specialists to lead and support this process;
- explain how different methods can be used, in different life cycle phases, to identify all reasonably foreseeable hazards; and should emphasise that the key purpose of risk assessment is to understand the nature of risks in order to make well informed decisions about suitable risk control measures; and
- provide guidance about the application of the ‘gross disproportion test’, and how the factors of cost, time and trouble are taken into account in determining risk control measures.

In summary, as Bluff and Johnstone (2005: 239) argue:

*duty holders would be guided to comply with their statutory duties of care by applying a problem solving approach which encourages proactive, systematic and comprehensive attention to all foreseeable hazards and risks. The approach would be flexible rather than formulaic, would emphasise the elimination and control of risks rather than the ranking of risks, and would seek out opportunities to design or change work, work processes, equipment, substances and other aspects of the work environment to make them inherently safer and ensure that they meet human needs.*

If a prosecution is brought against a duty holder for failing to comply with this absolute duty to ensure the OHS of workers and others by following a rigorous risk management approach, the duty holder should be able to draw on the following defences, which place the onus of proof on the duty holder (on the balance of probabilities). The suggested defences are that:

- the duty holder fully complied with a regulation which addressed the risk and which specified a risk assessment process, a hierarchy of control and an evaluation process which were at least equivalent to the risk management processes set out in the Act;
- if there was no relevant regulation, that duty holder fully complied with a code of practice which addressed the risk and which specified a risk assessment process, a hierarchy of control and an evaluation process which were at least equivalent to the risk management processes set out in the Act; and
- if there is no relevant regulation or code, and the duty holder is seeking to comply with the risk management process outlined in the Act, that ‘the time, trouble or cost’ of implementing the possible control measures to mitigate or remove the risks was grossly disproportionate to the risk as assessed. That is, the duty holder must prove on the balance of probabilities that it attempted to implement the hierarchy of control and it was not possible to implement any of the possible control measures because the time, trouble or cost of doing so was disproportionate to the risk as assessed.

Submitting that the burden of proving the defences set out above should be on the duty holder is consistent with the recommendation of the Industry Commission in 1995 (see above), and with the UK *Health and Safety at Work Act 1974*, the New South Wales Act and the Queensland WHSA. The prosecutor has to prove all other elements of the offence. The duty holder, who is required under the Act to follow a systematic approach to OHS management, is in the best position to explain why the time, trouble or cost of control measures in the hierarchy of control was grossly disproportionate to the risk as assessed. Placing the onus of the duty holder will ensure that the duty

holder document the considerations that lead to the duty holder's conclusions. This also has the advantage, from the regulator's perspective, of reducing investigation and prosecution costs.

Couching the general duty in absolute terms (subject to defences) has the added advantage of fostering a far better culture of prevention for industry than merely providing subjective 'reasonably practicable' compliance criteria.

## **CHAPTER 5: CONSULTATION, PARTICIPATION AND REPRESENTATION**

### **5.1 Duty to Consult**

It is widely accepted within the literature that worker participation improves occupational health and safety outcomes (see: Walters, 2003, Walters and Nichols, 2006). As noted in Shaw et al. (2007: 102):

*workers have the most direct interest in OHS of any party; moreover, workers often know more about the hazards associated with their workplace than anyone else. In particular, the hazards at work need to be identified, assessed and controlled and worker's experience and knowledge is critical to successfully completing all these tasks.*

Participatory workplace arrangements improve OHS management practices and lead to improved OHS outcomes. Blewett (2001) asserts that consultation requires several key attributes to be successful, these include: sincerity in consultation, respectful relationships, understanding who's responsible for what, building a positive OHS culture, internal and external influences on senior management.

Some thirty years ago, the Robens Committee recommended that there should be a statutory duty to consult employees placed on every employer (Robens, 1972: 22; Maxwell, 2004: 194). Most jurisdictions followed this recommendation and all jurisdictions at least have consultation as a key concept in their OHS regimes. 'Consultation is required at key times such as when risks to health and safety arising from work are identified, and when decisions are made about the measures taken to eliminate or control those risks' (ACT Occupational Health and Safety Council, 2005: 52).

The aim of consultation provisions should be to foster workplace co-operation and partnership in the identification and resolution of OHS. Walters and Nichols (2006) suggest in general terms that worker consultation in the workplace is most successful when:

- Workers are informed by their employers/managers about health and safety matters in sufficient time;
- The information provided is adequate; and
- This process allows workers and/or their representatives an opportunity to digest understand and respond to the information.

Maxwell (2004) supports these findings in his review of the Victorian Act and suggests that consultation involves:

- sharing with the workers information about the matter on which the employer is required to consult;
- giving the employees a reasonable opportunity to express their views about the matter; and
- taking in account those views.

OHS consultation processes should embrace all workers in a direct working relationship with a firm (not upstream) where there is a duty of care or where there is a risk to the person's health and safety. As the 2005 ACT review council noted 'just as duties of care are owed to all workers when it comes to health and safety, the duty to consult should be extended to all workers.' It is essential

that whatever consultation mechanism is recommended that it includes provisions for all worker arrangement, not only employees. This can occur either through direct consultation or through representative consultation. It is unclear why a tiered approach would be proposed, as consultation is to ensure that persons in the working environment are aware of the hazards and risks and identified issues are resolved irrespective of whether the worker is a direct employee or an employee of a contractor.

## **5.2 Participation and Representation**

### ***Health and Safety Representatives***

Health and safety Representatives (HSR) play an important role in a systematic approach to occupational health and safety management. The value of health and safety representatives in relations to health and safety performance is supported by unions, employers and regulators alike. Walters' (1996: 629-634) comprehensive review of British worker participation research indicated that the effectiveness of joint arrangements in improving OHS outcomes is supported by:

- legislative provisions for workers' representation actively supported by regulatory inspectorates;
- management commitment both to better health and safety performance and participative arrangements, coupled with the centrality of the provisions for preventative OHS strategies and efficiency of production;
- worker organisation at the workplace that prioritises OHS and integrates it in other aspects of representation of representation on industrial relations;
- support for workers' representation from trade union outside workplaces, especially in the provision of information and training;
- consultation between worker health and safety representatives and constituency they represent
- well-trained and well-informed representatives.

There should be provisions in the national model OHS laws establishing Health and Safety committees (HSC) and Health and Safety Representatives. All workers at a business or undertaking should participate in consultation arrangements, it is equally important that the committee has representation by various forms of workers that have the potential influence safety outcomes. Provisions of the national model OHS laws should enable 'workers' to negotiate work groups and to elect HSRs, and define 'workers' very broadly, in the same vein of the new Northern Territory Act: to include 'any person who works in the employer's business' as an employee, apprentice, contractor or sub-contractor (or their employee), employee of a labour hire company, volunteer or 'in any other capacity.' By using broader definition of worker, awareness of health and safety issues may be improved across the work environment.

The primary function of health and safety representatives is to assist the employer in improving the management of health and safety. In doing this, the key duties include: inspection; to be informed / inform the person conducting the business or undertaking of any workplace incidents; to be present at interview of any worker following workplace incident; review workplace incidents; consulted by employer about issues that may affect health and safety of workers; assist in health and safety outcomes; and report any workplace incidents to relevant authority.

The health and safety representatives also provide a principal channel of communication between management and workers. The success of health and safety representatives is contingent on four conditions; strong encouragement of cooperation and participation through legislated requirements; the ability to issue Provisional Improvement Notices to secure compliance, a positive safety culture that values honest reporting and issue resolution and finally well informed representatives with appropriate knowledge and skills.

### ***Health and Safety Committees***

The establishment of HSCs should be encouraged by all persons conducting a business or undertaking. The establishment of the committee should be required in the model where there are in excess of 30 workers in the working environment. The election of worker members to HSCs should occur when requested by workers (or their representative, a health and safety representative) and should be repeated as necessary to ensure that possible turnover of staff does not affect the continuity of the committee. All workers should be entitled to vote including contractors working along side direct employees. The person conducting the business or undertaking should be required to facilitate and aid communication process through notifying all worker of the election of HSC, but not to conduct the elections. This could be done by non nominated workers or when requested by unions.

The structure of the committees should consist of at least two members and include both the employer and workers or representatives. The primary aim of HSC is to assist in decision making and resolution of health and safety issues and to champion health and safety awareness in the workplace. While no specific qualification to assume office is seen as necessary, persons conducting businesses or undertakings should encourage members to develop OHS knowledge and should provide time-off for training.

Across several jurisdictions, OHS committee issues feature in the principal Acts and in industry specific OHS Acts. The national model OHS laws could provide for having a health and safety committee but the specific requirements should be included in the regulation. Important issues to cover include: structure and functions of the committee, membership, election issues, times/frequency of meetings and proceedings at meetings.

### ***Right of entry to workplaces by authorised representatives of employee organisations***

The national model OHS laws should include right of entry provisions for Authorised Persons. The literature indicates that union involvement in facilitating worker participation may improve OHS outcomes (Walter, 2003). The Queensland experience is that the union right of entry provision in WHSA have not been abused and ensured that workers have had an additional source of advice on OHS issues. It is important that authorised representatives approved to enter workplaces for OHS related issues have had appropriate OHS training. The national model OHS laws should include adequate checks and balances such as: requirements for periodical issuing of permits; successful completion of training and refresher courses; as well as disciplinary action if necessary and appropriate.

Powers of authorised representatives should be similar to those of a WHS representative. After entering the place, the authorised representative may— inspect any plant, substance or other thing at the place relevant to their reasonable suspicion of a contravention of the Act. Other appropriate powers of authorised representatives include:

- observe workplace;
- speak to a person who is an eligible member of the employee organisation;
- speak to the occupier about suspected contravention;
- require the production for inspection of documents;
- copy a relevant document; and
- require the occupier to give the authorised representative reasonable help to exercise the authorised representative's powers.

### ***Issue Resolution***

Where there is a health and safety issue at the workplace to the extent where workers refuse to work due to grave health and safety concerns or there is a break down of communication due to these

issues, Queensland would support the inclusion of similar provisions to Victorian Act (s73) on issue resolution. The model act could require that HSC to develop issue resolution procedures. There should be a Code of Practice in two parts: first to guide parties through the process of developing agreed procedures at the workplace; and second, to provide a default procedure to resolve issues at the workplace.

### ***Right to Cease Unsafe Work***

The Model legislation should include a provision that clarifies a process of when and how a worker can cease unsafe work. The common law right of individual workers to refuse to do dangerous work should be codified to clarify the circumstances under which it can be exercised. The principal right to direct that work cease if it is an immediate and significant risk to health and safety, should be a collective right vested in the relevant health and safety representative. This collective right should supersede any individual right to refuse dangerous work exercised by an individual worker leading up to the health and safety representative's work cessation direction.

### **5.3 Protection from Discrimination and Victimisation**

Provisions enabling workers to participate in OHS decision-making will be ineffective unless all workers are robustly protected against any form of discrimination or victimisation on the basis that they participated in OHS processes or raised OHS issues.

The national model OHS laws should be consistent with the Federal IR law with respect to discrimination and victimisation. There may be a need to clarify the requirement of safety in Federal legislation (namely Sex, Racial, Age and Disability Discrimination Acts) in a similar way to the Qld Anti Discrimination Act s107 and s.108 (i.e. that you can discriminate for the purposes of safety at work or generally for public purposes)

The national model OHS laws must include protection from discrimination and victimisation provisions as not to deter workers from being involved in health and safety matters. The Act should be similar to the Qld WHSA namely s.174, but should cover all forms of workers. Any person affected by discrimination or victimisation should be entitled to bring an action and the legislation should allow for representative actions brought on behalf of workers. Contraventions of the victimisation provisions should also be enforced by the OHS inspectorate. The offence of victimising a worker for participating in any way in OHS should attract the highest maximum criminal penalty in the model Act.

The relevant standard of proof should be the civil standard for civil actions by workers; and the criminal standard for criminal prosecution. In each case once victimisation has been proved, the onus should be on the alleged discriminator to show on the balance of probabilities that another reason (other than involvement in OHS activities) was the *dominant* reason for the discrimination. In addition, the regulator should be able to order the alleged perpetrator not to discuss any aspect of a complaint with the victim or any witnesses unless it is through an appropriate channel such as conciliation or arbitration.

Monetary compensation or reinstatement should be similar to Federal industrial relations law. Where the proceedings have a civil component, a conciliation conference would benefit the parties.

## CHAPTER 6: REGULATOR FUNCTIONS, POWERS AND ACCOUNTABILITY

### 6.1 Role and Functions of Regulators, *Accountability, Education, Advice and Assistance, Compliance and Enforcement Policies*

Issues concerning the establishment and governance of regulatory agencies should be left to individual jurisdictions to determine. Currently there is not a unified approach to the design of the regulatory architecture. Some jurisdictions have established statutory authorities to administer OHS. Other jurisdictions have the OHS function spread across several departments or agencies. As such, it would not be feasible in the national model OHS laws to specify detailed requirements for of the establishment, functions, powers and accountability of regulators.

Regulators should publish enforcement and prosecution policies and guidelines. The Queensland government supports prosecution guidelines based on the Victorian ‘WorkSafe Compliance and Enforcement Policy and Prosecution Guidelines’. The guidelines should enable all levels of enforcement action (including prosecution) to be taken for ‘pure risk’ offences (contraventions in which workers and others are exposed to high levels of risk, but where no incident has yet occurred) and should also ensure that proactive inspection and enforcement measures are addressed to up-stream duty holders (designers, suppliers and so on).

The national model OHS laws should include provision for the making of interpretative documents.

The OHS regulator should possess several functions and power that are not exercised by inspectors including:

- appeal of inspectors decisions;
- review decisions of matters such as improvement notices, occupational licensing;
- decisions to accept enforceable undertakings; and
- the decision to prosecute.

In the course of their duties, inspectors fulfil a range of functions occur across the enforcement spectrum from education and advice to compliance monitoring and enforcement. In practice it is difficult to separate the advisory and enforcement functions, and in principle it is inappropriate, because inspectors must be able to use the full range of informal and formal enforcement measures to negotiate compliance with persons conducting a business or undertaking (see Gunningham and Johnstone, 1999, chapter 4, and Johnstone, 2004). Dedicated advisory services should be provided at the institutional level.

The national model OHS laws should ensure greater emphasis on proactive inspection, with targeted programs developed at national, state, and regional levels.

To promote consistency of enforcement approaches across the jurisdictions, the national model OHS laws should require each OHS regulator to produce a consistent and publicly available enforcement policy. This should be published as a guidance note. The national model OHS laws should also ensure that each State and Territory regulator produce annual reports outlining enforcement measures. They should also require regular meetings of inspectorates to discuss common approaches. It should also require evaluation of inspection and enforcement measures and programs by each OHS regulator, and peer reviewing and sharing of results.

### 6.2 Inspectors

The provision for the appointment, qualification, powers, functions and accountability of inspectors is similar in most jurisdictions, apart from the Commonwealth OHS Act. In general terms, the main functions of the inspectors should be to:

- enter workplaces for the purposes of inspection and enforcement;

- inquire into workplace issues;
- investigate workplace incidents; and
- issue notices.

The national model OHS laws should make it clear that inspectors should provide advice and assistance to duty holders to help them meet their compliance facilitation and enforcement obligations. The Act should also make it clear that inspectors do not assume any legal liability for doing so. There are no circumstances in which an inspector should be independent from direction, instruction or review by a regulator.

As a rule, inspectors should not be able to modify, amend or cancel any notice or instrument they or another inspector have issued. This should occur through an internal review process.

### **6.3 Internal Review of Inspectors' Decisions**

To ensure the transparency in the review of inspector decisions, it is appropriate to develop and publish a review protocol.

The powers of inspectors to enter domestic premises and undertake investigative activities when work is occurring there; e.g.: an inspector's powers are limited when a homeowner has a requisite licence and is undertaking the removal of more than 10 square metres of bonded ACM in breach of the national asbestos removal code.

## **CHAPTER 7: COMPLIANCE AND ENFORCEMENT**

### **7.1 Enforcement Measures**

The need for regulation in the area of OHS arises from an imbalance between risk reduction and cost. As employers do not carry the majority of the costs associated with injuries and diseases arising from their work-related activities, non-regulation does not lead to the socially and economically beneficial results that regulation achieves. The regulation of OHS is necessary in order to meet the community's objective to reduce work-related death, injury and illness. OHS legislation reflects the social objective of preventing or reducing death, injury and illness in a work-related context and seeks to achieve this primarily through imposing duties of care on various persons.

Enforcement includes a range of activities that regulators undertake to ensure compliance with legislation and standards and, for OHS, is undertaken by inspectors in response to identified breaches of duties under the legislation. Enforcement provides the incentive for duty holders to comply with OHS legislation, codes of practice and other advisory material produced by the regulator to assist them to discharge their duties. The UK Health and Safety Commission (2002), for example, envisage the purposes of enforcement as:

- ensuring that duty holders deal immediately with serious risks;
- promoting and achieving 'sustained compliance with the law'; and
- ensuring that duty holders who breach statutory provisions are 'held to account' through prosecution.

The aims of enforcement are twofold – justice and deterrence. For preventive legislation, deterrence is the more important. Deterrence can be either specific, seeking to deter an individual from committing further breaches, or general, seeking to set an example to others thereby deterring them from committing the same breach. General deterrence can be assisted by the publication of the outcomes of the prosecution of an offence, especially any subsequent penalty imposed.

Deterrence seeks to encourage compliance largely because it is instrumental – that is, it is based on the idea that an individual must be deterred from committing an offence by laws that impose punishments that outweigh the calculated benefits of the offence. If individuals calculate that the costs of punishment outweigh the benefits of the offence, they will naturally desist from offending. According to the deterrence model, the function of the justice system is to develop a systematic code of clear and rational rules that impose a proportional set of punishments that outweigh the benefits of each type of crime regulated by the system.

At the heart of the deterrence model is the notion of ‘economic man’, capable of rational calculation of the consequences of his actions. According to deterrence theory, compliance is a function of the probability of an offender being punished and the severity of the penalty. As the former Industry Commission (1995: 7) noted, the expected penalty (or deterrent) facing an individual OHS offender is determined by:

- the likelihood of being inspected (which it took as the number of inspections as a proportion of workplaces);
- the likelihood of a breach being detected, prosecuted and convicted (the number of fines and on-the-spot fines); and
- the average penalty imposed.

The Industry Commission commented that ‘...on its own, persuasion cannot ensure a commitment to compliance where compliance is not in the economic interests of those concerned’ (Industry Commission, 1995: 105, 109) and recommended that ‘inspectorates in each jurisdiction give a higher priority to deterrence in the enforcement of their OHS legislation’.

Influences identified in the research (see especially Andenaes, 1974 and Simpson, 2002) on the effect of penalties on deterrence include:

- the fear of the consequences of punishment;
- the educative influences of law and its application on citizens;
- the reinforcement of individuals’ pro-social habits;
- clarification of the boundaries of appropriate behaviour - for both the guilty offender and others observing the punishment - and a subsequent adjustment of future actions;
- educative and moralizing influences on those not complying with the law; and
- fear of prosecution leading to increased cooperation with regulatory agencies.

In order to maintain the integrity of an enforcement regime, Gunningham, Johnstone and Rozen (1996) suggest that a OHS regulatory agency needs to:

- undertake more prosecutions where there are defective systems of work, even though no injury or fatality has occurred (‘pure risk’ prosecutions);
- broaden the range of duty holders by bringing more prosecutions against manufacturers and suppliers of plant and equipment and against directors and top management who are responsible for OHS contraventions; and
- introduce a range of tougher and broader sanctions that will deter persons from contravening their obligations under the OHS legislation and that will also enable courts to make orders which require offenders to reform defective work systems.

A contemporary regulatory regime needs to contain as full a complement as possible of enforcement sanctions, based on an escalating hierarchy of enforcement measures from warnings through to punitive action such as prosecution. Such an approach is based on the enforcement pyramid model advocated by Gunningham and Johnstone (1999), which is premised on the notion of responsive regulation advocated by Ayres and Braithwaite (1992) that regulators ‘should be responsive to the conduct of those they seek to regulate’, or more particularly, be responsive ‘to how effectively corporations are regulating themselves’ before ‘deciding on whether to escalate

intervention'. Sanctions should be targeted to where persuasive measures have been ineffective and where sanctions are most likely to be justified.

The national model OHS laws should trigger responsive enforcement. It should include an escalating hierarchy of enforcement measures from warnings through to punitive action. In order to ensure a common approach to enforcement, the Model Act should be structured to ensure that the hierarchy of sanctions, and the way in which enforcement action will escalate in the face of non-compliance, is clear. Inspections and informal and formal enforcement measures should focus on extent to which firm has properly implemented systematic OHSM across the organisation. Regulators 'should be responsive to the conduct of those they seek to regulate', or more particularly, be responsive 'to how effectively corporations are regulating themselves' before 'deciding on whether to escalate intervention' (Ayres and Braithwaite, 1992). Enforcement should be a dynamic, interactive process.

Sanctions should be targeted to where persuasive measures have been ineffective, and where sanctions are most likely to be justified. (See Johnstone 2004). While enforcement should be responsive, it should also be proportionate to the extent of the contravention. In the national model OHS laws, there should be a clear statement of the enforcement principle that enforcement measures should be proportionate to the offence.

This approach accords with contemporary views of the use of regulatory sanctions. In 2005, the British Government commissioned a review of the use of sanctions in government regulatory activities in the UK. The review was conducted by Professor Richard Macrory, who made the following comment about financial penalties in the review's November 2006 report:

"Evidence presented to me over the course of the review has demonstrated that, in some instances, the fines handed down in court often do not reflect the financial gain a firm may have made by failing to comply with an obligation. This means that these penalties do not act as a deterrent and, in effect, give businesses an incentive to continue to fail to comply in return for a profit. In some cases fines do not fully reflect the harm done to society."  
(p.20)

Macrory (2005: 21) cited the following examples from cases he reviewed:

- an Oxfordshire man was fined £30,000 for abandoning 184 drums of toxic waste. The man received £58,000 for disposing of the material, and the Waste Authorities had costs of £167,000 to incinerate the waste properly;
- a fine of £25,000 was handed down to a small waste disposal company which was operating without a licence. The company saved £250,000 by operating illegally over a 2 year period; and
- the largest fine handed down to date for a health and safety offence is £15 million imposed against Transco (for breaches of regulations that resulted in the death of four members of the same family in a gas explosion). The financial penalty, while significant in absolute terms, represented five percent of after-tax profits and less than one percent of annual revenues for the company. This shows that even large fines can be absorbed by companies and may not carry the necessary deterrent effect or motivate a change in a firm's behaviour although Transco began an accelerated programme of pipe replacement as an outcome of the incident and did change its behaviour.

Commenting on the overall use of regulatory sanctions in the UK, Macrory (2005: 5) stated:

*My vision for the penalties system is a step change from where we are today. It allows for a flexible and proportionate approach with a broad range of sanctioning options, where regulators can respond to the needs of individual cases and the nature of the underlying offence. Improving the ability of regulators to apply appropriate sanctions will improve overall compliance and add credibility to the regulatory system and means that minor breaches are treated as such. Effective sanctions can also incorporate wider aims*

*such as restoring the harm caused by regulatory non-compliance and take into consideration the needs of victims, offenders and communities affected by regulatory breaches.*

This echoes the earlier recommendations of the Industry Commission (1995: xi) that:

*jurisdictions should consider a wider range of sanctions to make up for any limitations with monetary penalties. Possible penalties not currently in use are equity fines, publicity orders, internal discipline orders, preventive orders, corporate probation and community service orders.*

Macrory recommended (2005: 10) that, to be effective, an enforcement sanction regime should:

- aim to change the behaviour of the offender;
- aim to eliminate any financial gain or benefit from non-compliance;
- be responsive and consider what is appropriate for the particular offender and regulatory issue, which can include punishment and the public stigma that should be associated with a criminal conviction;
- be proportionate to the nature of the offence and the harm caused;
- aim to restore the harm caused by regulatory non-compliance, where appropriate; and
- aim to deter future non-compliance.

Macrory (2005) also recommended that, in an ideal regulatory sanctions regime, regulators should:

- publish an enforcement policy;
- measure outcomes not just outputs;
- justify their choice of enforcement actions year on year to stakeholders, Ministers and Parliament;
- follow-up enforcement actions where appropriate;
- enforce in a transparent manner;
- be transparent in the way in which they apply and determine administrative penalties; and
- avoid perverse incentives that might influence the choice of sanctioning response.

## **7.2 Measures Exercised at the Workplace**

### ***Safety Directions, Warnings and Cautions / Provisional Improvement Notices (PINs) / Improvement Notices / Prohibition Notices***

There is a reasonable degree of consistency between the jurisdictions for the provision of Provisional Improvement Notices (PINs), Improvement Notices and Prohibition Notices. These provisions are appropriate and work well. PINs, improvement and prohibition notices should not include recommendations about how to achieve compliance as notices may be invalidated if there are minor administrative errors. Inspectors should be allowed to provide recommendations in a separate document.

Some OHS Acts specify that improvement notices must allow more than a week for compliance, largely to give time for an appeal to be lodged, but in principle, a notice should be able to specify a shorter time period for compliance. In cases where notices are to be appealed, the notice should continue to operate until the appeal is determined.

### ***Infringement Notices***

Infringement notices should be reserved for non-complex, minor offences where the breach is clearly defined in law, the facts are easily verified, the evidence is non-controversial, and the offences have a direct bearing on risk control (see Bluff and Johnstone, 2003; Australian Law Reform Commission, 2002: 418). For example, infringement notices might be issued when exposure to noise exceeds exposure standards, portable electrical equipment is not RCD protected,

and machines are not guarded. Together with improvement and prohibition notices and prosecution, they can be used to rectify individual hazards, and to attract management attention.

To ensure progress towards systematic OHSM and the abatement of individual hazards, infringement notices should rarely be used on their own. The level of penalty should be 10 per cent and certainly not exceed 20 per cent of the maximum penalty that could be imposed by a court (ALRC, 2002: 418).

### **7.3 Measures Exercised beyond the Workplace**

#### ***Remedial Orders and Injunctions***

The national model OHS laws should provide for injunctions to ensure compliance with the model OHS Act.

#### ***Enforceable Undertakings***

OHS enforceable undertakings are a successful Queensland innovation modelled on enforceable undertakings in the areas of corporations and consumer protection. Enforceable undertakings are the result of negotiations, where an organization that is believed to be in breach of the law, offers to the regulator an undertaking to take certain action, and if accepted by the regulator, the undertaking is enforceable in court. This process allows for innovative, flexible and efficient solutions to breaches (Longo, 2002), and introduces restorative justice to regulation – empowering the person regulated as well as the regulator (Parker 2004).

Not only are enforceable undertakings less adversarial than prosecution, they also enable regulators to tailor the response to the particular circumstances and management capacities of the regulated enterprise. They can, for example, focus on defects in management systems and structures and how these might be overcome (for instance, a requirement to implement systematic occupational health and safety management, with implementation subjected to third party audit). Significantly, Braithwaite's research on mine safety found that safety leaders in the industry were companies that not only thoroughly involved everyone concerned after a serious accident, in order to reach consensual agreement on what must be done to prevent recurrence, but also did this after 'near accidents' (Braithwaite 1985, 67).

There is evidence that enforceable undertakings are quicker and more cost effective than court proceedings, yet still capable of being enforced and transparent (Australian Law Reform Commission 2002, Ch 16). According to Parker's research (2003, 8–9) in the context of trade practices, they provide regulators with:

*more innovative, expansive and preventive remedies than are available through court orders. They can both attract management attention, and then can capitalise on that by requiring the company to appoint appropriate staff and implement a compliance program to meet particular standards and by requiring ongoing attention to audits and reports. This will, however, only be done if enforceable undertakings require independent review or audit of compliance with the undertakings.*

Queensland was the first Australian jurisdiction to introduce enforceable undertakings for OHS offences under the Electrical Safety Act 2002 and the WHSA. The capacity to impose such undertakings has now been included in Tasmanian and Victorian legislation, but not, to date, in New South Wales, although a 2006 review of the OHS Act 2000 recommended its inclusion as part of the compliance regime (WorkCover NSW 2006, 52). In a modified and limited form, this concept has been introduced under amendments made to the Western Australian *Mines Safety and Inspection Act 1994* (s101C; see further Pt 9 Div 2). Courts are now able to make an order allowing an offender to pay a monetary penalty or enter into an undertaking with the State Mining Engineer

to take action such as fixing up the problem, publicising their wrongdoing or engaging in some broader OHS initiative.

Although enforceable undertakings can be found within the legislation governing various state and federal OHS regulatory agencies, Queensland appears to have been the only jurisdiction in which enforceable undertakings have been regularly used since their introduction in 2002. Other State OHS regulators are now beginning to implement enforceable undertakings, but it is Queensland that affords the best opportunity to examine the conceptualisation, implementation, and effectiveness of enforceable undertakings within a workplace health and safety context.

In Queensland, there is no evidence to suggest that enforceable undertakings have been adopted by employers as a 'soft option' in lieu of prosecution and penalties. Over the five year to mid 2008, there have been only 105 applications for enforceable undertakings. Leaving aside the enforceable undertakings which are currently under consideration, 51 per cent of enforceable undertakings have been accepted by WHSQ. Some 29 per cent of applications were rejected and 21 per cent were withdrawn.

In those cases where an enforceable undertaking was accepted, the average value of the undertaking (\$178,000) was five times greater than the average value of the court penalty (\$34,000). In some cases, the value of the undertaking was in excess of 30 times greater than the available maximum penalty. The largest sum for an enforceable undertaking was \$1.5 million.

As might be expected, enforceable undertakings have tended to be concentrated in the hazardous manufacturing and construction industries. Businesses agreeing to enforceable undertakings are widely dispersed throughout Queensland in the central, western and northern districts as well as in the Brisbane greater metropolitan region.

There are several measures which can enhance the transparency of enforceable undertakings. The regulatory literature and the Queensland experience with enforceable undertakings suggests that for undertakings to be effective enforcement measures, the regulator should issue publicly available guidelines indicating when enforceable undertakings will be accepted. The guidelines should specify that the regulator will not accept an undertaking if the alleged offender denies liability, and if the alleged offender's record suggests an undertaking will not be sufficient to deter it from future contraventions. Other key factors include the history of previous complaints and enforcement action against the company, prospects for rapid resolution of the issue, and the apparent good faith of the alleged offender.

Importantly, enforceable undertakings should not be seen as a 'soft option', and not to be available when there are strong reasons for preferring a deterrent or retributive sanction (for example, where there are fatalities or serious injuries), unless the regulator is confident that the firm is remorseful and has been induced to take radical action as a result of the incident. In serious matters enforceable undertakings might be used for 'supplementary remedies' that cannot be obtained through a court order, and might be used 'as a form of banning advisers and directors without the need for formal administrative action' (Parker, 2003a: 6). Enforceable undertakings should be consistently used, not over-utilised, open to public scrutiny (for example, via the regulator's website), entered into voluntarily and should require comprehensive systematic approaches to OHSM. OHS regulators must have specialist in-house staff to oversee the implementation of enforceable undertakings, and must develop auditing criteria, oversee the appointment of, and ensure the independence and quality of work of, auditors, and strongly enforce contraventions of undertakings.

The giving of an enforceable undertaking should not result in an admission of fault or liability (see Johnstone and King, 2007).

## CHAPTER 8: PROSECUTIONS

The single, most effective tool for deterrence is prosecution. In 2004 WHSQ found, through an independent survey of obligation holders that the promotion of prosecutions changed the way that over 70 per cent of these obligation holders managed OHS in the workplace (AC Nielsen, 2004).

### 8.1 Criminal or Civil Liability

The Queensland Government does not support decriminalisation of workplace incidents. This would undermine the deterrent effect of criminalisation and send the wrong messages about the importance of occupational health and safety to the community.

### 8.2 Where prosecutions should be heard

Prosecutions should be heard in industrial tribunals. The advantages of using the industrial tribunals are well documented. Generally, they are less costly, faster, less formal and staffed by workplace experts and hence probably far better suited to dealing with workplace safety incidents than the courts.

### 8.3 Who may commence prosecutions and relevant procedures?

Proceedings should be commenced by the safety regulator rather than the DPP or another person. Using the impartial regulator to instigate proceedings is desirable as the use of trade union officials to bring prosecutions could add to the adversarial nature of Australian industrial relations by undermining relations between management and unions within a workplace.

The appropriate time limit for the commencement of a prosecution should be 12 months from:

- the incident; or
- the time the authority becomes aware of the contravention; or
- any coronial findings.

This provides sufficient time to conduct an investigation and provides certainty for all parties involved or affected by the contravention.

The national model OHS laws should not include specific provisions for the conduct of prosecutions. These should be left to the relevant rules of the tribunal hearing the matter.

### 8.4 Evidence

The model national OHS laws should not contain specific evidentiary procedures. The proof of any elements of an offence should not be affected by specific provisions in the national model OHS laws.

A failure to follow either regulations or codes should be regarded as a failure to properly manage risk, or (more precisely) exposure to risk arising out of the conduct of a business or undertaking.

### 8.5 The Burden of Proof and Defences

As discussed in Chapter 4, reasonably practicability is an appropriate standard, but used as a defence rather than an element of the offence, with a reverse onus of proof. The *Health and Safety at Work Act 1974* (UK) and OHSA (NSW) place the onus on the defendant of proving measures were not reasonably practicable. This approach is supported by the Industry Commission (1995: 55, 56) which concluded that it considered that:

*it is more efficient for the holder of the duty of care rather than the prosecution to have to establish what was reasonably practicable. A duty holder could be expected to know more about the costs and benefits of the various alternatives open to him or her at any time, than anyone else.*

Queensland under the WHSA, has an absolute duty, but provides the duty holder with defences (s37): that the duty holder has complied with a relevant regulation, code of practice or, in the absence of relevant regulations/code, has taken reasonable precautions and exercised proper diligence (employing measures which are ‘reasonably practicable’) to prevent the contravention.

A prosecutor should have to establish a prima facie case of breach and the offender should then have to prove on the balance of probabilities that he/she complied with relevant regulations and/or codes and took all reasonably practicable steps to avoid the incident or that ‘the time, trouble or cost’ of implementing the possible control measures to mitigate or remove the risks was grossly disproportionate to the risk as assessed.

Defences in the national model OHS laws should be limited to:

- compliance with the Act, regulations and any other relevant subordinate legislation (eg: Qld Ministerial Notice provisions);
- compliance with a code of practice, or adopting a procedure which provides at least the same level of protection to persons as does a code for a risk or hazard; and
- that ‘the time, trouble or cost’ of implementing the possible control measures to mitigate or remove the risks was grossly disproportionate to the risk as assessed.

The burden of proof or defences should not be different for a corporation or an individual (officer or employee).

## **8.6 Liability of Officers**

There are currently a number of different models imposing duties on company officers for a range of offences, ranging from provisions derivative provisions (deeming company officers guilty of an offence if the corporation is found guilty, subject to defences) to accessorial liability confining corporate officers’ personal liability for corporate fault to instances where the individual personally aids, abets, counsels or procures the commission of the offence, or is otherwise privy to the misconduct. The use of reverse onus of proof provisions in legislation relating to the personal liability of corporate officers causes consternation in the business community (see the CAMAC report).

Glasbeek (2004) notes that in a corporation, especially a large corporation, as in any complex organisation, decision-making is diffuse. The breaching conduct sought to be criminalised may be the outcome of a series of disparate acts and thoughts spread over a number of departments and self-standing branches of the firm. It can become even more complicated when the enterprise acts through a set of connected corporate legal affiliates and subsidiaries.

Directors and other senior management officers have in the past escaped prosecution by distancing themselves from liability. For example, in *R v P&O European Ferries (Dover) Ltd* (the *Herald of Free Enterprise* case), the company was acquitted because the Crown could not show that the directing mind of the company had been grossly negligent. This was also the case in the Esso Longford disaster in Victoria.

As Johnstone (1997) puts it, under criminal law the lack of safety duties for directors not only allows them to remain unaccountable but it actually provides them with a disincentive to take a serious interest in the company’s safety strategies.

Corporate officers' personal liability should be derivative. Any shift to an accessorial model in which officers are only liable where they actively participate in, encourage or assist the commission of an offence will undermine good corporate OHS administration except for those large organisations for which reputational risk is a major issue. Such an approach also cuts across that significant body of research which indicates that the prospect of personal liability is a key compliance driver and that optimum OHS outcomes are obtained when the whole company board of directors is focused on and responsible for safety.

The term 'officer' of a corporation should be defined in a similar way to the definition adopted under s9 of the Commonwealth *Corporations Act 2000*. This is a broad definition but one which encompasses the many different forms of control exercised by individuals over corporate structures.

Volunteer officers should be in no different position otherwise, this might be used as a strategy to avoid liability as the officer might be a 'volunteer' receiving no salary for service, but is otherwise remunerated through shareholding or other means.

Unincorporated associations, including unincorporated joint ventures, should be treated as corporations.

## **8.7 Sentencing Options**

### ***Fines***

Monetary penalties should be applicable for all offences. In the national model OHS laws, rather than impose maximum fines, the imposition of a range of fines with a minimum and maximum penalty, depending on both culpability and outcome may be preferable. Fines should also increase for repeat offences or for failure to rectify an unsafe situation or process. There should be different fines for the various offences. More serious offences should attract higher fines. There should be a statutory minimum fine for some offences. Serious offences involving fatalities and serious injury should have a statutory minimum fine.

The level of penalty should theoretically depend on the degree of culpability rather than the outcome. However, this adds an additional dimension to the factors the prosecution has to establish and since OHS offences are offences of omission rather than commission, would not be present in many instances. It is expedient, therefore, to base the level of penalty on the seriousness of the outcome, with culpability to be considered by the court as an aggravating factor.

### ***Other Sentencing Options***

#### ***(i) Orders to publicise offence***

Corporate sensitivity to adverse publicity and fear of loss of corporate reputation have been identified as one of the two main drivers of corporate motivation in respect of OHS (KPMG). Particularly in the case of larger and reputational sensitive firms, there is evidence that managers care about their corporate image, and for this reason the threat of adverse publicity and loss of corporate image may be significant motivating factors. Wright (1998) concludes that:

*The strongest motivator identified by research is the fear that the adverse publicity, loss of confidence and regulatory attention subsequent to a serious incident will cause serious curtailment of operations, imposition of additional costs, loss of corporate credibility and loss of business/interruption of operations.*

There is evidence that prosecution, application of enforcement notices and experience of a major incident are all viewed as sources of adverse publicity that may have detrimental commercial consequences and fines, for example, are often viewed as a social 'sanction' of the firm.

An additional form of publication may be court orders requiring the offender to take specified action to publicise their offence, its consequences, the penalty imposed and any other related matter. The order may also specify who and how the information is to be publicised, for example the publication in an annual report or any other notice to shareholders of a company. Such an order could be considered in all cases of a guilty finding in regard to workplace fatalities and other incidents involving serious injury or illness. Courts in NSW can use s115 of the NSW Occupational Health and Safety Act 2000 to impose a publication order that requires the advertising of a OHS breach. This is a mandatory requirement that is in addition to normal publishing of prosecutions outcomes in WorkCover News.

The advantage of these approaches is they put the onus on the offender to publicise the offence rather than the regulatory body. Publication in media such as regional daily newspapers may be a more effective method of publicising the offence than the Department's current newsletter, increasing the general deterrence effect of prosecution. The orders would be best used in conjunction with traditional penalties, such as fines.

*(ii) Corporate probation*

A criticism of the traditional penalty imposed on OHS offenders (such as fines) is that it does not require the offender to investigate and remedy any deficiencies in the systems used at the workplace to manage OHS. Corporate probation allows the courts to require offenders to develop and implement appropriate OHS management systems or other appropriate measures that may exceed the bare minimum required by regulation, therefore producing tangible health and safety outcomes and offering additional protection for workers.

The concept of corporate probation is presently used under federal Comcare legislation, in NSW and in the Australian Capital Territory (ACT). In each of these jurisdictions, the court may make a remedial order to remedy any matter related to the offence. In the ACT for example, the courts may order an offender to 'take any steps that it considers are necessary and appropriate to rectify the state of affairs and that are within the person's power to take'.

The concept of corporate probation has also been recommended in numerous reviews of OHS legislation (Laing, 2002; Industry Commission, 1995; Crittall, 2001).

Generally three different forms of supervision are available for implementation depending on the severity of the breach (Gunningham and Johnstone, 1999: 262-277):

- internal discipline orders – the offending organisation investigate and provide a report to the court about disciplinary proceedings it has conducted
- organisational reform orders – involve a limited period of judicial monitoring of the activities of the offending organisation
- punitive injunctions – insist on the development of innovative OHS management systems or other appropriate measures

OHS management systems aim to:

*encourage organisations to progress from an ad hoc response to OHS issues (reacting to problems as they arise), to a systematic approach in which OHS is a primary organisational objective and problems are identified (before the event), prioritised, preventative action is planned, implemented and reviewed for effectiveness, and the organisation builds OHS 'know-how' (Zwetsloot 2000).*

Corporate probation orders can produce more tangible OHS outcomes than the traditional penalty of fines. The orders may be used in conjunction with, or as an alternative to, imposing traditional penalties, such as fines.

### *(iii) Community service orders*

Community service orders involve the duty holder undertaking or contributing to work or projects that benefit industry or the community in some way, using the obligation holder's resources and conducted during normal business hours.

Community service orders are a sentencing option in NSW. The NSW court may also order an offender under the *Occupational Health and Safety Act 2000* to carry out a specified project for the general improvement of occupational health, safety and welfare, under an order to undertake an OHS project. Under this type of order the court may fix a period for compliance and impose any other requirements the court considers necessary or expedient for enforcement of the order.

The Victorian Maxwell Report (2002), Western Australian Laing Report (2002) and the Industry Commission (1995) report have all recommend community service orders as a sentencing option. The orders may be used in conjunction with, or as an alternative to, imposing traditional penalties, such as fines.

## **8.8 Workplace Death and Serious Injury**

The national model OHS laws should contain a penalty regime which reflects the gravity of any exposure to risk. The Queensland legislation provides for fines and imprisonment on a sliding scale, with provisions for terms of imprisonment as well as fines. The Queensland legislation also provides for greater penalties in the case of multiple deaths.

The strict liability nature of offences under Queensland WHSA and NSW versions of the legislation avoids the problem of having to establish the 'directing mind' component of an allegation. Prosecuting under the Queensland WHSA, for example, also avoids any uncertainty relating to collective corporate conduct as s167 of the WHSA deems corporate officers guilty if the corporation commits the offence, subject to the defence of 'due diligence'.

## **8.9 Enforcement of Penalties**

In the national model OHS laws, enforcement should take into account the financial structure of a business, provision being made for enforcement of fines either against the principal officers of the corporation and their related parties or alternatively where there is a holdings/subsidiary company structure, the entity in any group structure that contains most of the assets of the corporation should pay the fine. Judgements from another jurisdiction should be enforceable throughout the federation.

# **CHAPTER 9: OTHER ISSUES**

## **9.1 Regulation Making Powers**

Regulation making power should not be limited.

The structure of penalties under the national model OHS laws should be proportional to the offence. A dual approach works well with lower penalties for administrative breaches but for not breaches of general obligations and specific hazard regulations (such as asbestos, hazardous substance, construction).

## **9.2 Codes of Practice**

To ensure national consistency, codes of practices developed nationally should be adopted automatically by all jurisdictions. However, should be capacity of states introduce their own codes of practices for specific industries/hazards. For example, sugar industry.

### **9.3 Notification of Incidents and Reporting**

Queensland Government would support a reporting system in the national model OHS laws based on the provision in the Victorian OHSA and the proposals in the National Mine Safety Framework.

### **9.4 External Appeals and Issue Resolution**

Current Queensland arrangements for the external review of regulatory decisions are satisfactory as decisions are subject to administrative and judicial review, scrutiny by the Ombudsman, appeal to courts and licence review committee.

The national model OHS laws should not include provisions for the resolution of OHS issues by conciliation or arbitration.

### **9.5 Tripartite Mechanisms**

Tripartism in the OHS context is commonly understood to refer to the ‘interest’ of the regulator and to the respective representative interests of employers and workers. It is fundamental to the success of the regulation of occupational health and safety that a culture of engagement exists between the safety regulator and stakeholders in the regulatory process, including the public sector. This was recognised by the Swedish Government in 2001 (Swedish Government, Budget Bill, 2002):

*The Government has begun work to formulate overall objectives for better health in working life. Objectives directed at getting more people into the labour market affect working life as a whole. This forms the basis for the strategies of the actors responsible to contribute to better health in working life. It is vitally important that the social partners participate in the formulation of the objectives if sufficient impact is to be made in practice.*

Tripartite mechanisms to engage stakeholders should be part of the replacement body for the ASCC. The replacement body for the ASCC should also have provision for tripartite committees to deal with OHS matters in particular industries. If this does not occur, then there should be the provision for tripartite committees included in the new OHS Act.

Provision should also be made in the national model OHS laws for States and Territories to establish tripartite mechanisms to advise the Minister on OHS matters. The participation of industry is an important component of the ‘framework for preventing or minimising exposure to risk’ under Queensland’s *Workplace Health and Safety Act 1995*. Among other things, participation is to be achieved via the establishment of a workplace health and safety board, the primary function of which is to ‘give advice and make recommendations to the Minister about policies, strategies, allocation of resources, and legislative arrangements...’ [s45(1)]. In addition, the Queensland WHSA establishes industry sector standing committees to advise the board and the Minister on health and safety matters to that industry.

### **9.6 Mutual Recognition 9.7 Cross-jurisdictional Cooperation**

The aim of the national model OHS laws should be to achieve as much consistency as possible between jurisdictions thereby reducing the need for mutual recognition arrangements. In terms of permits and licensing, there should be national licensing arrangements for the regulation of high risk occupations.

### **9.8 Interaction of Federal and State Laws**

In a national model OHS laws there should be no overlap between federal, State and Territory OHS laws. Once implemented the national model laws will ensure a consistent framework. However, there will continue to be duplication and overlap in the administration of national model OHS laws involving contractors to national self-insurers, who will be subject to regulation by the states and

territories, where the national self-insurer will be subject to regulation by the Commonwealth's regulator Comcare. The Queensland Government is of the view that as part of giving effect to the national model OHS laws, the Commonwealth should remove OHS coverage for national self-insurers under the Comcare scheme, through legislative amendment.

### **Injury Data**

The effectiveness of OHS regulatory regimes should be measurable by the reduction in injury, disease and fatality rates and through direct comparison of regulators across Australia using agreed criteria. However, direct comparison using the Comparative Performance Monitoring reports is difficult given current comparisons are based on accepted workers' compensation claims, which essentially measures the propensity to claim rather than the likelihood of injury.

While the workers' compensation claims data is considered representative as far as coverage of the workforce is concerned, Queensland has increasing concerns about the suitability of this data for injury prevention and intervention effectiveness assessment purposes. The behaviour of the data is very sensitive to both policy and administrative changes in the respective workers' compensation schemes. Discontinuities in the workers' compensation claims time series as a result of these changes are impacting on the reliability of trend analysis, making comparisons difficult to interpret. The outcome is uncertainty regarding what is actually being reflected by movements in claims data.

Further, WorkCover Queensland has over the past few years been making administrative changes to their claim management systems to improve performance in relation to scheme outcomes, such as increasing the durable return to work rate and increase injury notifications. Some of these changes have resulted changed the behaviour of claims lodged with WorkCover.

In the past four years the Queensland workers' compensation scheme has seen changes in its benefits structure, which has significantly increased benefits to injured workers. Both national and international literature has established that any substantial increase to benefits paid to workers will lead to increases in the claim rate and duration.

In February 2008, the Australian Safety and Compensation Council (ASCC) released the 9<sup>th</sup> Comparative Performance Monitoring (CPM) Report, which shows Queensland's performance in relation to occupational health and safety outcomes as below average. The CPM only report on a sub-set of accepted workers' compensation data which has been standardised and is deemed as comparable across jurisdictions (e.g.: claims more than 5 days duration, excluding journey claims, claims only by workers who are deemed as employees). An initial investigation of the data has concluded that the higher reported rate of injury for Queensland is due principally to the following factors:

- the methodologies used for reporting in the CPM report, such as the denominator (workers covered by the scheme) used by the ASCC to calculate the injury rate, which tends to inflate the rate of injury for Queensland;
- the better capture of all work-related injuries by the Queensland workers' compensation scheme;
- the Queensland workers' compensation scheme covering more people undertaking work and a broader range of circumstances leading to potential injury (such as journey and recess claims) than other State/Territory schemes;
- the higher propensity of workers to claim as a result of the WorkCover Queensland policy of encouraging workers' compensation claims;
- the legal requirement on all employers to report injuries to WorkCover Queensland and not deal with them internally;
- the ease of making a workers' compensation claim, facilitated by such initiatives as the introduction of the 'fax fee' by WorkCover Queensland on 1 July 2006;

- the recent increases in worker benefits; and
- the management of all claims by WorkCover Queensland, rather than employers managing shorter duration claims as in NSW and Victoria, which potentially leads to claims not being lodged.

As part of the development of the national model OHS laws consideration should be given to a evaluating the current National Data Set methodology with aim of developing a model that allows for a more accurate comparability of injuries and fatalities rates across jurisdictions.

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