They never came home—the framework surrounding the prevention, investigation and prosecution of industrial deaths in Australia
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Recommendations

Recommendation 1

3.14 The committee recommends that Safe Work Australia expand the work-related traumatic injury fatalities data set to capture data on deaths resulting from industrial diseases.

Recommendation 2

3.24 The committee recommends that Safe Work Australia maintain a public list of amendments that jurisdictions make to the model work WHS laws.

Recommendation 3

3.32 The committee recommends that Safe Work Australia work with WHS regulators in each jurisdiction to collect and publish a dataset which provides annually updated and detailed information on the prosecution of industrial deaths, including:

- the date of the prosecution;
- the nature of the entity prosecuted;
- the type of issue giving rise to the prosecution;
- the provision of the legislation under which the prosecution was taken;
- the plea entered by the defendant; and
- the sentence imposed by the court.

3.33 The committee also recommends that this data set be provided to:

- relevant Commonwealth and State and Territory government agencies so that it can be taken into account in the awarding of government contracts; and

3.34 The committee further recommends that corporations that repeatedly breach WHS obligations and cause death or serious injury should not be awarded Commonwealth, State or Territory government contracts.

Recommendation 4

3.38 The committee recommends that the Boland review consider the recommendations of this inquiry in its review into the model WHS laws.
Recommendation 5

3.62 The committee recommends that Safe Work Australia work with Commonwealth, State and Territory governments to:

- update the model WHS framework to cover precarious and non-standard working arrangements (including labour hire) to clarify the extent, scope and nature of the primary duty of care and the obligation under the model WHS Act on duty-holders to consult with each other, as well as workers and their representatives; and
- pursue approval of these arrangements in other jurisdictions through the formal harmonisation of WHS laws process.

Recommendation 6

4.39 The committee recommends that Commonwealth, State and Territory governments ensure that their WHS regulators are adequately funded and resourced to allow them to complete investigations in a timely, thorough and effective manner.

Recommendation 7

4.40 The committee recommends that Safe Work Australia work with Commonwealth, State and Territory governments and WHS regulators to develop and deliver standardised training modules to ensure that all investigators have the appropriate skills, experience and attitude to carry out high-quality investigations of industrial deaths and other serious breaches of WHS laws.

4.41 In the absence of a joint approach, the committee encourages all Commonwealth, State and Territory governments and WHS regulators to pursue this recommendation individually.

Recommendation 8

4.42 The committee recommends that Safe Work Australia work with all Commonwealth, State and Territory governments and WHS regulators to:

- establish best practice guidelines for the conduct and duration of investigations of serious WHS law breaches, including workplace deaths, which include guidance on the criteria that must be satisfied if an investigation needs to be extended past the usual allocated timeframe; and
- ensure that each jurisdiction is able to fully implement these guidelines.

4.43 In the absence of a joint approach, the committee encourages all Commonwealth, State and Territory governments and WHS regulators to pursue this recommendation individually.
Recommendation 9
4.44 The committee recommends that Safe Work Australia work with WHS regulators to develop a policy to formalise collaboration and evidence sharing between WHS regulators and law enforcement agencies during investigations following an industrial death.

Recommendation 10
4.45 The committee recommends that Safe Work Australia work with WHS regulators in each jurisdiction to develop a policy which stipulates that all industrial deaths must be investigated as potential crime scenes.

Recommendation 11
4.56 The committee recommends that Safe Work Australia pursue amendments to the model WHS laws to enable a WHS regulator or law enforcement agency in one jurisdiction to assist a second WHS regulator or law enforcement agency in a cross-border investigation, including in the sharing of evidence and other relevant information.

Recommendation 12
4.62 The committee recommends that Commonwealth, State and Territory governments ensure that adequate funding and resourcing is allocated to their WHS regulators to allow for increased, more effective preventative activities in workplaces.

Recommendation 13
5.54 The committee recommends that Safe Work Australia work with Commonwealth, State and Territory governments to:

• introduce a nationally consistent industrial manslaughter offence into the model WHS laws, using the Queensland laws as a starting point; and
• pursue adoption of this amendment in other jurisdictions through the formal harmonisation of WHS laws process.

Recommendation 14
5.66 The committee recommends that Safe Work Australia work with Commonwealth, State and Territory governments to:

• amend the model WHS laws to include the establishment of a dedicated WHS prosecutor in each jurisdiction, similar to the model introduced in Queensland; and
• pursue adoption of this amendment in other jurisdictions through the formal harmonisation of WHS laws process.
Recommendation 15

5.67 The committee recommends that Safe Work Australia work with Commonwealth, State and Territory governments to:

- amend the model WHS laws to provide that a WHS regulator must in all relevant circumstances provide a published, written justification for why it chose not to bring a prosecution following an industrial death; and
- pursue adoption of this amendment in other jurisdictions through the formal harmonisation of WHS laws process.

Recommendation 16

5.68 The committee recommends that Safe Work Australia work with Commonwealth, State and Territory governments to:

- amend the model WHS laws to provide that a WHS regulator must in all circumstances provide a published, written justification for why a coronial inquest following an industrial death was not conducted; and
- pursue adoption of this amendment in other jurisdictions through the formal harmonisation of WHS laws process.

Recommendation 17

5.76 The committee recommends that Safe Work Australia work with Commonwealth, State and Territory governments to:

- amend the model WHS laws to provide for unions, injured workers and their families to bring prosecutions; and
- pursue adoption of this amendment in other jurisdictions through the formal harmonisation of WHS laws process.

Recommendation 18

5.82 The committee recommends that Safe Work Australia work with Commonwealth, State and Territory governments to:

- amend the model WHS laws to revise the definition of 'officer' to better reflect the capacity of the person to significantly affect health and safety outcomes; and
- pursue adoption of this amendment in other jurisdictions through the formal harmonisation of WHS laws process.

Recommendation 19

5.89 The committee recommends that section 232 of the model WHS Act be amended to broaden the limitation period for prosecutions of industrial manslaughter.
Recommendation 20

5.106 The committee recommends that Safe Work Australia work with Commonwealth, State and Territory governments to:

- develop national sentencing guidelines, with direction from the UK experience, and look to undertake consultation with relevant stakeholders about the matter; and
- review the levels of monetary penalties in the model WHS legislation with consideration to whether there should be increased penalties for larger businesses or repeat offenders.

Recommendation 21

5.122 The committee recommends that Safe Work Australia work with Commonwealth, State and Territory governments to:

- amend the model WHS laws to make it unlawful to insure against a fine, investigation costs or defence costs where they apply to an alleged breach of WHS legislation; and
- pursue adoption of this amendment in other jurisdictions through the formal harmonisation of WHS laws process.

Recommendation 22

5.134 The committee recommends that the Commonwealth Government work to implement its announced reforms to combat phoenixing, such as the Director Identification Number scheme, as swiftly as possible.

Recommendation 23

6.14 The committee recommends that Safe Work Australia engage with WHS regulators and emergency services providers in each jurisdiction to develop clear guidelines for the notification of families of an industrial death, with a focus on timeliness and the manner in which the notification is made.

Recommendation 24

6.31 The committee recommends that Safe Work Australia collaborate with WHS regulators in each jurisdiction to review, improve and formalise their practices to make the investigation processes as transparent as possible to impacted families, including by providing written guidance on the formal stages of the investigation, regular updates on the progress of an investigation, the reasons for decisions and the future direction of the investigation.
Recommendation 25

6.32 The committee recommends that Safe Work Australia collaborate with the governments and WHS regulators in each jurisdiction to provide for dedicated liaison officers to supply information to families about the process of investigations, prosecutions and other formal processes following an industrial death.

Recommendation 26

6.33 The committee recommends that Safe Work Australia look to establish a forum for families to submit and publish impact statements in order to give them a voice and outlet for their experiences in the processes that follow an industrial death.

Recommendation 27

6.47 The committee recommends that Safe Work Australia work with the WHS regulator in each jurisdiction to establish advisory committees designed to give advice and make recommendations to the relevant minister about the information and support needs of persons who have been affected directly or indirectly by a workplace incident that involves a death, serious injury or serious illness.

Recommendation 28

6.62 The committee recommends that Safe Work Australia work with the WHS regulator in each jurisdiction to identify and formalise family outreach mechanisms to ensure that all impacted families receive information about the formal processes that follow an industrial death and the associated support that is available to them.

Recommendation 29

6.63 The committee recommends that Safe Work Australia work with the WHS regulator in each jurisdiction to create and maintain a centralised web portal which links to all relevant resources that impacted families may need in the aftermath of an industrial death.

Recommendation 30

6.64 The committee recommends that Safe Work Australia work with the WHS regulator in each jurisdiction to fund a support group or service that is experienced in working with people bereaved by a fatal workplace incident to support impacted families through all formal processes following an industrial death.
Recommendation 31

6.65 The committee recommends that Safe Work Australia work with the WHS regulator in each jurisdiction to make funding available for impacted families to access a range of mental health and counselling support options, including in rural and regional areas.

Recommendation 32

6.66 The committee recommends that Safe Work Australia collaborate with the WHS regulator in each jurisdiction to develop an initiative (similar to the Coronal Legal Assistance Service in operation in Queensland) to provide for pro bono legal assistance to families during coronial inquests.

Recommendation 33

6.67 The committee recommends that Safe Work Australia work with the WHS regulator in each jurisdiction to ensure that all staff with access to impacted families have adequate training in working with grieving family members.

Recommendation 34

6.68 The committee recommends that Safe Work Australia collaborate with each jurisdiction to review the adequacy of workers' compensation legislation with regard to all work related deaths.
Chapter 1
Introduction

1.1 On 26 March 2018, the Senate referred the following matter to the Education and Employment References Committee (the committee) for inquiry and report by 20 September 2018:

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

   (a) the effectiveness and extent of the harmonisation of workplace safety legislation between the states, territories and Commonwealth;
   (b) jurisdictional issues surrounding workplace investigations which cross state and territory boundaries;
   (c) issues relating to reporting, monitoring and chains of responsibility between states, territories and the Commonwealth;
   (d) safety implications relating to the increased use of temporary and labour hire workers;
   (e) the role of employers and unions in creating a safe-work culture;
   (f) the effectiveness of penalties in situations where an employer has been convicted of an offence relating to a serious accident or death; and
   (g) any other related matters.

1.2 On 16 August 2018, the Senate granted an extension of time to report until 4 October 2018. Subsequently, on 13 September 2018 the Senate granted a further extension of time to report until 17 October 2018.

Conduct of inquiry

1.3 Notice of the inquiry was posted on the committee’s website. The committee also wrote to key stakeholders to invite submissions.

1.4 The committee received 69 submissions, as detailed at Appendix 1.

1.5 The committee held eight public hearings:

   - 12 July in Sydney;
   - 17 July in Brisbane;
   - 31 July in Hobart;
   - 7 August in Canberra;
   - 28 August in Melbourne;
   - 29 August in Adelaide;
   - 30 August in Fremantle; and
   - 19 September in Canberra.

1.6 A list of witnesses who appeared at these hearings is at Appendix 2.
Structure of the report

1.7 During the course of the inquiry the committee identified several critical issues relating to the framework surrounding the prevention, investigation and prosecution of industrial deaths in Australia.

1.8 Chapter 2 of this report sets out a selection of family voices to the inquiry in an attempt to convey the profound sense of loss and pain experienced by families when a loved one is tragically killed at work.

1.9 Chapter 3 provides background information on the rate of industrial deaths in Australia, the legislative framework in place to deal with workplace fatalities, and the safety implications of the increased use of precarious employment practices.

1.10 Chapter 4 turns to matters relating to the investigation of industrial deaths, including investigation quality and cross-jurisdictional issues.

1.11 Chapter 5 examines a range of issues related to the prosecution of industrial deaths, including the offence of industrial manslaughter and the adequacy of the current financial penalties.

1.12 Chapter 6 identifies the core areas of support that impacted families require as they navigate their grief in conjunction with the numerous regulatory processes that arise after an industrial death.

Acknowledgments

1.13 The committee thanks those individuals and organisations who contributed to this inquiry by preparing written submissions and giving verbal evidence at hearings.

1.14 In particular the committee acknowledges the grief and pain of all those families that have lost a loved one in an industrial incident and chose to share their experience with the committee. The committee is keenly aware that the retelling of traumatic experiences takes an emotional and physical toll. The committee sincerely thanks those families for their courage and strength in sharing their stories and concerns for the purpose of informing the committee's deliberations on this very important topic.

1.15 The committee would also like to acknowledge the advocacy of Mrs Kay Catanzariti, whose 21 year old son Ben was killed on a Canberra construction worksite in 2012. Mrs Catanzariti has been tireless in her campaign to raise awareness of the issues impacting families who lose a loved one to an industrial incident. Her lobbying efforts contributed to the referral of this inquiry, and she is highly committed to seeking legislative change to improve the frameworks surrounding industrial deaths. The committee applauds her determination and courage in speaking out.
Notes on references

1.16 References in this report to the Hansard for the public hearings are to the proof Hansard. Page numbers may vary between the proof and official Hansard transcripts.
Chapter 2
Family voices

2.1 The human impact of an industrial death is catastrophic and far-reaching. For the families and friends of those individuals killed at work, the terrible and profound human cost and associated consequences they must suffer is lifelong.

2.2 In addition to written submissions, throughout the inquiry the committee heard verbal testimony from numerous families about the enormous impact caused by the death of their loved one. By setting out direct quotes of their lived experiences, this chapter seeks to build a picture of the immense grief, pain, anger and trauma that an industrial death leaves behind.

2.3 The committee acknowledges that given there are approximately 200 industrial deaths in Australia annually it is not possible to recount the circumstances of each individual case. The following quotes are listed in no particular order and have been used to illustrate the intense mental, emotional, physical, financial and long-lasting impacts that are caused by an industrial death.

Mr Jack Brownlee – killed at work in 2018, aged 21

2.4 Mr Dave Brownlee, Jack’s father:

I’m here with my wife and also representing my two sons, Mitchell Brownlee and Jack Brownlee. Jack was 21 years old, and he will always be 21 years old. He will never age. He went to work on 21 March and was caught in a trench collapse that covered the boy up to his neck, with one arm free. About 9.30 [am] on that day was the last time they [Jack and his co-worker Charlie Howkins] were seen and they weren’t found until 11.30 [am]. They weren’t rescued until 2.30 [pm]. In the first two hours, Jack would have had the most horrific time. His mate [Charlie Howkins], Lana [Cormie]'s husband, was dead beside him, metres away. Jack would have been screaming for help, and the other boys were at smoko. They were left on their own. There was no supervision of these boys. There was nothing. At the time, I was at the hospital with my wife, who was suffering severe migraines. We received no phone call from the company until 5.30 [pm] that afternoon.

Beforehand, I had a friend who worked in Geelong. He rang me and informed me. Things were on Facebook about a trench collapse in Ballarat and he thought our son Jack was involved. I raced up there to the site and was met at the roadblock by the police. We weren't allowed in. Jack had just been evacuated, they said, and they were putting him in an induced

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1 Audio recordings of some of these testimonies are available on the inquiry webpage. See www.aph.gov.au/Parliamentary_Business/Committees/Senate/Education_and_Employment/IndustrialDeathsinAus.
coma. I was informed by the police that the best thing to do was to hightail down to Melbourne and meet him at the hospital. We still had not heard from the company. We then had to go back to the hospital to get my wife out of hospital, pick up my other son Mitchell and drive down to Melbourne, getting updates along the way, in peak hour traffic... When we arrived at the hospital, Jack had already had his third operation. Every organ in his body was damaged. He was bleeding profusely. They could not stabilise Jack. He was operated on and operated on. They had to take him to ICU to stabilise the boy. His stomach was left open while they tried to stabilise the boy. They couldn’t stabilise him. He was getting worse by the minute. He was described by the nurse as the sickest boy in the state. They pumped every drop of blood of his type through his body and it just came out as quickly as it went in.²

2.5 Mrs Janine Brownlee, Jack’s mother:

The hardest thing for us was to leave our son to drive home. The hardest thing was to drive there in the first place, getting updates telling us, ‘Hurry up. Your son mightn’t make it.’ And then the hardest thing was to drive home the next day, leaving our boy at the hospital. That was one of the hardest things I've ever had to do: knowing he was there on his own; leaving my baby there. Those two boys [Jack and Charlie Howkins] just went to work. They should have come home. They were just two boys doing their job. The system needs to change. Things need to change. How we were treated was so wrong.³

…

They say it gets better as it gets along, but it’s actually getting worse. The longest Jack was ever away from us up until the incident was 10 days. As the days were getting on, you thought he was on a holiday, and then you start thinking: ‘Come on, Jack, you should be coming home now. You should be coming home.’ You're all numb. Then, after a couple of weeks, reality hits.⁴

Mr Charlie Howkins – killed at work in 2018, aged 34

2.6 Dr Lana Cormie, Charlie’s wife:

I am a doctor of veterinary science and I am married to Charlie Howkins, who was a registered building practitioner and worked in civil construction at the time of his death. I am—and we were—parents to two small children: Sophie, who is four, and George, who is one year old. Charlie went to work one day in March [2018], and he never came home. He became just another of the dead bodies which are carried out of a workplace every second day in Australia. Words simply cannot do justice to the devastation which has followed. His death is a result of a failure in the culture, values, systems and laws of our country. What is left in the wake of this failure is our broken family.

² Mr Dave Brownlee, private capacity, Proof Committee Hansard, 28 August 2018, p. 29.
³ Mrs Janine Brownlee, private capacity, Proof Committee Hansard, 28 August 2018, p. 29.
⁴ Mrs Janine Brownlee, private capacity, Proof Committee Hansard, 28 August 2018, p. 38.
What killed my husband? My husband died because our country is not committed to workers’ safety. My husband died because company directors are not held accountable for the safety of their workers. Not only this, but they can take out insurance for negligently causing death. He died because workers are not respected and they cannot stand up for what is right for fear of losing their jobs. He died because employers ask what is profitable before what is right. My husband died because the OH&S system foolishly relies on self-regulation. He died because of a toxic work culture which discourages reporting of incidents. He was killed by the inadequate safety framework in our country.5

Mr Robert Cunico – killed at work in 2018, aged 60

2.7 Ms Ashlea Cunico, Robert’s daughter:

My dad lived for almost an hour in the most horrific of conditions while being cradled in the arms of a work colleague before succumbing to his injuries. Despite the efforts made by the first responders and emergency services, his injuries were so catastrophic that he was never going to survive. My father should never have sustained even a paper cut whilst he was on the job, let alone injuries so severe that his life was ended.

My dad was a son, a brother, a husband, a father, a grandfather, an uncle and a friend to many. He leaves behind a wife of 35 years, three children and five grandchildren—the youngest only being one month old when he died. After the incident that morning, it took almost four hours for our family to be notified of my dad’s death when two police officers turned up at my parents’ home. My mother was then faced with the unthinkable task of having to ring her three children to tell us of our beloved father’s death—one of whom was in Thailand at the time.

Receiving that call was absolutely soul-destroying and unfathomable to say the least...How do you explain to a 12-year-old that his grandfather and best friend is never coming home? What do you say to a five-year-old who says he doesn’t want to live anymore, if his Pa can’t live?

From that moment on, our lives were shattered. You do not ever have a choice to survive grief...

...

We will never come to terms with the fact that my dad is gone. An entire future full of dreams and aspirations has been wiped from our lives. We are now forced to travel these journeys without him. This has been made harder to process by the fact that he deserved the right to come home that day. Every Australian deserves the right to come home safe and sound to their loved ones.6

5 Dr Lana Cormie, private capacity, Proof Committee Hansard, 28 August 2018, pp. 30–31.

6 Ms Ashlea Cunico, private capacity, Proof Committee Hansard, 30 August 2018, p. 17.
Mr Wesley Ballantine – killed at work in 2017, aged 17
2.8 Ms Regan Ballantine, Wesley’s mother:

You’re looking at a woman who, on her own, birthed, raised and buried her son. Nineteen months after my son fell 12 metres to his death through an uncovered opening on a construction site, I am here today in a federal Senate inquiry. The senselessness of his death and the injustices on top of it are so profound that it has become my human duty to have enough care for others that I speak out in the hope that, by sharing with you the story of Wesley’s death, it may help inspire you all to take real action and prevent another person from losing their young life and a mother her son.7

Mr Luke Murrie – killed at work in 2007, aged 22
2.9 Mr Mark Murrie, Luke’s father:

Luke was 22 when he was killed. He was killed in an unsafe work environment where inexperienced workers were instructed to do an unsafe lift. The unsafe method was quicker and therefore it was cheaper. There was no meaningful deterrent for the employer to do it safely. He put the dollar before safety. They know they can kill a worker and get away with it—history tells you this. The devastation to the family is horrendous. The employer gets a minor fine and goes home. We get a life sentence…

This does your head in. Since Luke was killed, I have trouble keeping my head on the same page—you go all over the place. That’s about it mate. It’s just bullshit. All these people went to work; they didn’t go to war. They went to work and they’re dead.8

2.10 Mrs Janice Murrie, Luke’s mother:

We never got justice for Luke. He was killed. It wasn’t an accident; he was killed. It made us feel that his life was worthless or that he wasn’t important. So you have to make the punishment fit the crime. We’re living with the fact that we will never see our son again. It’s 11 years this October, but the directors got a piddling fine. They’re off with their families. Good on them! I hope they rot in hell, because they didn’t hurt and they knew that it wasn’t going to hurt. So you have to make it fact that you can go to jail and you can sit in jail every day and remember why you’re sitting there—because you killed someone. If you shot someone with a gun, you’d go to jail because you’re a bad person. But if you kill them at the workplace you’re not a bad person.9

Mr Desmond Kelsh – killed at work in 2002, aged 47
2.11 Mrs Patricia Kelsh, Desmond’s wife:

My husband Des went to work and never came home. The next time I saw him, he was laid in the morgue and it was my job to identify him. It was

7 Ms Regan Ballantine, private capacity, Proof Committee Hansard, 30 August 2018, p. 13.
8 Mr Mark Murrie, private capacity, Proof Committee Hansard, 30 August 2018, p. 19.
9 Mrs Janice Murrie, private capacity, Proof Committee Hansard, 30 August 2018, p. 22.
then my job to tell our children that their dad was never coming home—ever. These are moments I will remember for the rest of my living life.

Des went to work as normal on that fateful day and was working on the roof with his co-worker. The building shook and imploded, bringing Desie down to his death. His co-worker, thankfully, got thrown over the wall to a safe distance and he lives. From that day to this present time, I have stepped off from the place I was, covered in grief from my husband and our two children, who had just lost one of the most important beings in their lives. Our journey through has been eventful—lawyers and the legal system, justice and then none. I lose faith in a system that fails and continues to fail. It needs to change so there is accountability. It's a moral law.10

Mr Gerard Bradley – killed at work in 2015, aged 29

2.12 Mr Jon-Paul Bradley, Gerard’s brother:

…it’s very, very difficult for us given that we’re back in Ireland. It’s almost like we’re detached from the whole situation. Obviously, because it’s so painful, I’ve taken it upon myself to deal with it, to almost keep my mum and dad and my sister and my other brother out of it.11

Mr Ben Catanzariti – killed at work in 2012, aged 21

2.13 Mrs Kay Catanzariti, Ben’s mother:

I’m here today not by choice. I’m here because my son Ben, who was 21 years old—sorry, it’s just overwhelming that today has finally come—was killed when a 39-metre, three-tonne concrete boom collapsed and crushed his skull in 2012. You senators have chosen this career to represent the Australian people first and foremost, to listen and protect all Australians and take responsibility for their health and wellbeing in our ever-changing world, and we need to unite regardless of which party we belong to. We are all the same. We are human beings. We have the right to live our lives without fear of going to work and not coming home.12

…

While driving to Canberra to view Ben’s body, my 16-year-old son [Jack]—he’d only just turned 16 three weeks before—said to me, ‘Mum, how can you believe in God now?’ I couldn't give Jack an answer... Unfortunately, to this day, my faith hasn’t returned. It’s in your hands, senators...

…

Preparing for today has been mentally, physically and emotionally draining as I’m afraid I’ve left something out, but I’ll keep going regardless because that’s what mums do.13

…

10 Mrs Patricia Kelsh, private capacity, Proof Committee Hansard, 30 August 2018, p. 20.

11 Mr Jon-Paul Bradley, private capacity, Proof Committee Hansard, 30 August 2018, p. 21.

12 Mrs Kay Catanzariti, private capacity, Proof Committee Hansard, 7 August 2018, p. 1.

13 Mrs Kay Catanzariti, private capacity, Proof Committee Hansard, 7 August 2018, p. 1.
To date we have laid out roughly $200,000 in legal fees. If we didn't get that death benefit from his super, we would have had to mortgage our house—we could have lost our house.\(^\text{14}\)

Mr Jason Garrels – killed at work in 2012, aged 20

2.14 Mrs Lee Garrels, Jason's mother:

My son Jason Garrels aged 20 years was fatally electrocuted on the 27th February 2012 in Clermont, Queensland. My son was employed as a labourer for approx 9 days with Daytona Trading Pty Ltd. As a mother and Registered Nurse (Rural Nurse Educator at the time) I went to assist at the resuscitation not knowing it was my own son. Words cannot describe the impact that it has had on me and my family; I was thrown into a life that was a surreal nightmare, which became my reality.\(^\text{15}\)

2.15 Mr Michael Garrels, Jason's father:

Jason was electrocuted doing a simple task on a wet and muddy constructions site. The state of the site meant he inhaled water after the fatal shock. This had a big effect on Jason’s chances of resuscitation and also delayed the paramedics in accessing Jason with their equipment. The 4-wheel drive ambulance had to be pushed off site. Given the conditions no one should have been working that day...

This is the loneliest, most isolated and devastating journey any family has to make. The support from government is pitiful and disgusting... The lack of transparency, the isolation, the lack of legal support, no access to government, or very little, the fact you are not classed as a stakeholder, the fact you seem to have no rights in this, the lack of networking amongst other affected families because there is no facility for that, the lack of say in governance, in preventatives, in justice, these are just a very few, the isolation you feel mentally, so many times you feel you’re about to go insane, suicide you feel at times is a real option.\(^\text{16}\)

Mr David Colson – killed at work in 2007, aged 24

2.16 Mrs Robyn Colson, David’s mother:

I’m the mother of David Colson who was killed in a workplace accident in Tasmania in 2007 when he was 24 years old. The boat he was working on sank and he swam for 5½ hours before dying of hypothermia. He was a wonderful person who did not deserve to have his life stolen from him...

Losing a child this way is unlike any other type of grief and it is permanent. A part of our soul is missing. We live a divided life: the time before the workplace accident and the time after.\(^\text{17}\)


\(^\text{15}\) Mrs Lee Garrels, *Submission 32*, p. 1.

\(^\text{16}\) Mr Michael Garrels, *Submission 41*, p. 1, 5.

Mr Max Logan – killed at work in 1999, aged 52
2.17 Mrs Edith Logan, Max’s wife:

I just wish that those in power could understand the utter heartbreak and desolation that comes with an industrial fatality. Maybe then we will get fairer laws and proper outcomes. My husband’s employers were found guilty and fined the sum of $34,000—not much for a man’s life. Life has not been easy for me, but I’ve battled on as we widows do.18

2.18 Mr Keith Logan, Max’s son:

I am the only son of Max Logan, who was tragically killed in a workplace incident at Meadows on 22 November 1999. He was 52. Like others that you will meet today, we are all members of an exclusive club we wish not to be a member of. We all have one thing in common in this room, and that is the total grief of losing a loved one through an accident which could have been avoided...

I miss you, dad. While I was building my life, my dad’s life was taken from him for a measly $30 an hour... My dad never saw my first house. He never spent one second as a grandfather. He never slowed down to look forward to retirement. He just never came home from work. People say, ‘You’ll get over it.’ Really? I deal with my dad’s death most every day and I’m learning to deal with it. But I will never forget it.19

Mr Brian Murphy – killed at work in 2006, aged 34
2.19 Mrs Susan Gallina, Brian’s sister:

From the time of the accident it was hours before we were notified. I heard it on the radio prior to even knowing that it was him. I heard someone had been injured/killed. When I got the call from my sister, I didn’t hear, ‘There’s been an accident.’ I didn’t hear ‘Something’s happened.’ I heard, ‘Brian is dead’. I don’t think that that’s something that I’ve ever been able to come to terms with.

The process of that day then evolved into me going back into a shopping centre where my dad was shopping, crying, trying to find him and eventually locking eyes with him and telling him the news that my brother was dead. We held onto each other as we walked out, confused, without knowing any of the details. We went home and we waited and nobody contacted us. We knew nothing. We didn’t know where he was. Where was his body? What was happening to him? Was he dead? I spoke to him the day before, and, between that contact and now, I never saw him. We were never given an opportunity to know where he was or to go and see him or to have any kind of ability to have closure on the fact that, ‘No, he actually is gone.’ I don’t think my mind has ever been able to make the connection of having spoken to him and then just being told he’s dead. Nothing else ever occurred in between that.20

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18 Mrs Edith Logan, private capacity, *Proof Committee Hansard*, 29 August 2018, p. 3.
Mr Matthew Fuller – killed at work in 2009, aged 25

2.20  Mr Kevin Fuller, Matthew’s father:

The circle of impact of not having safety switches installed in that home was wider than anyone ever imagined. The direct family, friends and acquaintances are obvious, but also think about the impact to the homeowner, the tenant, the people who had to cut Matt out of the roof, the medical people, the people that then worked with him in the hospital for a long time and the electrical safety people. The ripple effect just keeps going. You drop a stone in a pond—just one person that’s been severely injured or killed. It keeps going.21

Mr Dale Kennedy – killed at work in 2012, aged 20

2.21  Mr Daniel Kennedy, Dale’s father:

We have been fighting for justice since Dale’s death. Our son Dale was fatally electrocuted on 12 December 2012, when he came into contact with a non-compliant cable whilst working in the ceiling in G Block at Bentley Park College in Cairns, North Queensland… Dale was 20. He left behind a devastated family, including a 15-month-old son.22

…

We had to continue with life that was very exhausting and stressful. Dale’s shirt was in evidence, yet the inspectors did not take his shirt back to the scene to further measure the points of contact to establish an accurate shock path. They only use their poor, inconclusive testing results from the day of the incident. Dale’s host employer, Debbie and I went back with Dale’s shirt to the building, and I put on Dale’s shirt and established the point of contact. We needed to know the actual shock path, and it should not have been up to the family to do this.23

…

The most concerning thing is that our story is similar to other families across Australia, with lack of prevention, poor investigations, inadequate prosecutions and lack of support for the family. Moving forward, we want industrial deaths to be held in the same regard as other deaths.24

Mr Jorge Castillo-Riffo – killed at work in 2014, aged 54

2.22  Ms Pam Gurner-Hall, Jorge’s partner:

I am the widow of Jorge Castillo-Riffo, who was killed on the new Royal Adelaide Hospital site on 27 November 2014… In my opening statement, I’d like to say that I think it’s obvious that you’ve heard not just from this group of people but from others that the key difference between even an accidental death and a road death is the level of horror that’s involved in a workplace accident. There are very few workplace accidents which don’t

21  Mr Kevin Fuller, private capacity, Proof Committee Hansard, 17 July 2018, p. 11.

22  Mr Daniel Kennedy, private capacity, Proof Committee Hansard, 17 July 2018, p. 17.

23  Mr Daniel Kennedy, private capacity, Proof Committee Hansard, 17 July 2018, p. 18.

24  Mr Daniel Kennedy, private capacity, Proof Committee Hansard, 17 July 2018, p. 18.
involve some sort of absolute horror. It’s something that we as survivors have to manage right from the beginning. It’s not just the loss and the terror but the horror as well. Quite often, that’s the thing that lingers on for many years, and I’m sure that you’ve heard that. In talking about how things are dealt with, if a soldier is killed, even in a friendly-fire exercise, there’s quite a lot of notice taken and respect given for the fact that that soldier has died in service. But if a worker is killed on a site, the very first reaction of the company—particularly if it’s a large corporate company, as it is in the case of my husband’s death—is that every system available comes into play to bury the evidence.25

Mr Jack Salvemini – killed at work in 2005, aged 36

2.23 Mr Lee Salvemini, Jack’s father:

My push for an inquest is still ongoing. I don’t know how much longer I can go on. I am now 72 years of age. About six or seven years ago my doctor advised me to back off and that it was affecting my health. Two years ago I had a stent put in to unblock my main artery, and I was told that it was stress related. I’ve got some unanswered questions.26

Mr Daniel Madeley – killed at work in 2004, aged 18

2.24 Ms Andrea Madeley, Daniel’s mother:

We are not talking about grief here. If this were grief, I wouldn’t be sitting in front of you. I would have been able to deal with my loss, but instead this system had me hanging for seven years waiting for it to finish its stuff. I got to the end of it and my life was screwed. That’s not grief; that’s bureaucracy controlling people.27

... I hear this a lot: ‘We’ll never be able to give you enough money for what you’ve lost.’ I’ll never be a grandmother. You’re right: there isn’t a dollar amount that will make up for that. It kills me every day.28

Mr Glenn Newport – killed at work in 2013, aged 38

2.25 Mrs Jennifer Newport, Glenn’s mother:

I will tell you a little bit about Glenn. He was a big, athletic construction concrete worker. He’d always been very fit and very keen on lifting weights et cetera right from a very young age, so he knew his capacity. He knew a lot of his own body physiology and stuff like that, so he knew what he could do and what his body was capable of when it was under stress. On the particular day that he died, they were working outside in temperatures above 45 degrees Celsius. They were working out in western Queensland at Roma preparing concrete pads for the big gas pipelines that went up to Gladstone. They were working on black plastic. They were told

25 Ms Pam Gurner-Hall, private capacity, Proof Committee Hansard, 29 August 2018, p. 5.
26 Ms Pam Gurner-Hall, private capacity, Proof Committee Hansard, 29 August 2018, p. 2.
27 Ms Andrea Madeley, private capacity, Proof Committee Hansard, 29 August 2018, p. 13.
28 Ms Andrea Madeley, private capacity, Proof Committee Hansard, 29 August 2018, p. 13.
before they went out, 'Just go slowly and work as you can,' which they did. They didn’t do a lot of work because it was just so hot. At one stage, they were perspiring so much that there were pools of sweat on the black plastic, and they couldn’t hold their tools because it was so hot and their hands were just wet all the time.

... 

He was taken back to the camp clinic in the early afternoon suffering all the symptoms of severe heat stress—nausea, high temperature, cramps, pins and needles, unsteadiness, and disorientation. He was kept at the clinic for two hours, and then it was closed for the day. Then he was sent from the clinic back to his donga, even though he told them he was still having pins and needles in his hand and that he didn’t feel that he was well enough to leave the clinic. He was still unwell and unsteady on his feet. The medical staff did not accompany him or bother to check on him. I think he had to walk about 200 to 400 metres back to his donga unassisted. He was given a mobile phone number to ring if his condition worsened. In other words, he was to self-assess himself when he really was in no state to assess what sort of state he was in. It was well known throughout the camp that to be able to get reception on your mobile you had to walk outside your donga—walk a few metres away. They didn’t bother to come and check on him. He collapsed two hours later in his donga and died as he was being transported to hospital.

...

Only two or three weeks after Glenn’s death, the company issued gift presentations—I’m not even sure what they were—to every employee out there because they had reached, I think, 500,000 hours with no lost-time injuries. The company took those lost-time injury levels very, very seriously. It seemed amazing to the employees that they were not acknowledging Glenn’s death at all; trying to pretend that he’d somehow done something to himself. Glenn hated drugs and anything like that, and there was no sign of any drugs or anything in his body at the autopsy.29

29 Mrs Jennifer Newport, private capacity, Proof Committee Hansard, 17 July 2018, p. 22.
Chapter 3

Background

3.1 This chapter provides background information on the rate of industrial deaths in Australia, the current work health and safety (WHS) legislative framework in place, and the safety implications of the increased use of temporary and labour hire workers.

Rate of industrial deaths in Australia

3.2 Safe Work Australia (SWA) compiles several data sets that provide information on the number and circumstances of work-related deaths in Australia. The work-related traumatic injury fatalities data provides statistics about individuals who die each year from injuries caused by work-related injuries. The data include fatalities that result from an injury sustained in the course of a work activity (i.e. worker fatality) and as a result of someone else’s work activity (i.e. bystander fatality).¹

3.3 The scope of the data set includes individuals:

- who were fatally injured;
- whose injuries resulted from work activity or exposures;
- whose injuries occurred in an incident that took place in Australian territories or territorial waters.²

3.4 The data set does not include individuals who died:

- of iatrogenic injuries (where the worker died due to medical intervention);
- due to natural causes such as heart attacks and strokes (except where a work-related injury was the direct cause of the heart attack or stroke);
- as a result of diseases, such as cancer; and
- by suicide.³

3.5 SWA informed the committee that since a peak of 310 in 2007, the number of worker fatalities fell to 182 in 2016, and that the rate has halved from 3.0 fatalities per 100,000 workers to 1.5 fatalities per 100,000 workers in 2016.⁴

3.6 SWA also collects year-to-date data from initial media reports to gain preliminary estimates of the number of people killed while working each year. As at 4 October 2018, preliminary data showed that 97 Australian workers had been killed at work.\(^5\) In 2017, the preliminary data showed there were 191 Australian workers killed at work, while in 2016 there were 182 killed. Once the appropriate authority has investigated the death, more accurate information becomes available which SWA then uses to update details of the incident.\(^6\)

3.7 The Australian Council of Trade Unions (ACTU) raised concerns that the SWA work-related traumatic injury fatalities data set does not reflect those individuals who are killed by work-related diseases:

> While the number of fatal work injuries has declined over time in most developed countries, the state of our data continues to result in an underestimation of the true extent of work-related deaths, including those arising from work-related diseases. The fact is that any death at work is unacceptable. It is unacceptable that in Australia, a wealthy and developed country, about 200 people die [per year] from traumatic work-related injuries, and a further 2,000 are killed at work by work-related illnesses such as black lung, silicosis and cancers, including those associated with exposure to diesel, welding fumes and, of course, asbestos.\(^7\)

3.8 The Australian Manufacturing Workers’ Union (AMWU) also raised a similar concern:

> We’ve interpreted industrial deaths to include all work related deaths and not just traumatic fatalities. The reason we do this is that we think it’s absolutely essential if we’re to diminish the burden of ill health associated with poor working conditions. As a nation, we need to broaden our gaze. Using estimates from both Australia and overseas, it’s not outlandish to estimate that around 4,000 Australians die each year as a result of their exposures at work. There’s an absolute imperative to broaden the data used by regulators in their prevention and compliance activity. Whilst all those bodies recognise that workers’ compensation data is grossly inadequate, they still persist in relying upon this unrepresentative data.\(^8\)

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7 Mr Michael Borowick, Assistant Secretary, Australian Council of Trade Unions, *Proof Committee Hansard*, 28 August 2018, p. 9.

3.9 There are particular industries which are at a higher risk for worker fatalities. SWA outlined:

In 2016, almost 70 per cent of worker fatalities occurred in just three industries – the Transport, postal and warehousing industry (47 worker fatalities), the Agriculture, forestry and fishing industry (44 worker fatalities), and the Construction industry (35 workers fatalities). In terms of rates, the Agriculture, forestry and fishing industry recorded the highest rate in 2016 of 14.0 fatalities per 100,000 workers, almost 10 times higher than the all industry average (1.5 fatalities per 100,000 workers). This was followed by the Transport, postal and warehousing industry (7.5 fatalities per 100,000 workers).9

3.10 Industrial injuries and deaths impose a significant cost on the economy, which is largely borne by workers and the community. As the ACTU stated:

The total cost of work-related injury and disease in Australia was $AU61.8 billion in 2012-13, including the cost of productivity loss, additional hours of work, insurance, loss of earnings and funeral, carer, compensation, medical, litigation and prosecution costs. Employers bear 5% of these costs, workers bear 77% and the community 18%. These figures do not include the suffering, social dislocation and economic hardship endured by the families of those affected by work-related deaths.10

Committee view
3.11 The committee acknowledges that SWA data shows a steady decline in the number and rate of industrial deaths since 2007. This is an encouraging trend but by no means a reason for complacency. As numerous submitters reminded the committee, one industrial death is one death too many.

3.12 The committee is of the view that the community should not lose sight of the deaths that occur due to occupational exposure to substances that result in industrial diseases, such as asbestosis and mesothelioma, black lung disease and silicosis.

3.13 The committee sees merit in SWA collecting data on deaths from industrial diseases to complement its work-related traumatic injury fatalities data set.

Recommendation 1
3.14 The committee recommends that Safe Work Australia expand the work-related traumatic injury fatalities data set to capture data on deaths resulting from industrial diseases.

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**Legislative framework**

3.15 Australia has a set of model work health and safety (WHS) laws, developed in 2011 by SWA. The aim of the WHS model laws is to provide all workers in Australia with the same standard of health and safety protection, regardless of the work they do or where they work. The model WHS laws comprise the model WHS Act, model WHS Regulations, and model Codes of Practice. To date the model WHS laws have been implemented by the Commonwealth and all states and territories, apart from Victoria and Western Australia.11

3.16 The model WHS Act provides a framework to protect the health, safety and welfare of workers and is underpinned by the following aims:

- to protect the health and safety of workers and other people by eliminating or minimising risks arising from work or workplaces
- ensure fair and effective representation, consultation and cooperation to address and resolve health and safety issues in the workplace
- encourage unions and employer organisations to take a constructive role in improving work health and safety practices
- assist businesses and workers to achieve a healthier and safer working environment
- promote information, education and training on work health and safety
- provide effective compliance and enforcement measures, and
- deliver continuous improvement and progressively higher standards of work health and safety.12

3.17 Section 19 of the model WHS Act establishes a primary duty of care which requires duty holders to ensure health and safety, so far as is reasonably practicable, by eliminating risks to health and safety.13

3.18 The model WHS Act provides for general functions and powers of regulators and inspectors. Numerous compliance and enforcement tools are provided for, including:

- improvement notices;
- prohibition notices;
- non-disturbance notices;
- remedial action;
- injunctions;
- enforceable undertakings; and
- legal proceedings.14

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3.19 SWA advised the committee that there are three categories of criminal offences for breaches of health and safety duties under the model WHS Act:

The maximum penalties are different depending on the category of the offence and whether the offender is a worker, an individual as PCBU [person conducting a business or undertaking] or officer, or a body corporate...

Category 1 – a duty holder, without reasonable excuse, engages in conduct that recklessly exposes a person to a risk of death or serious injury or illness.

Category 2 – a duty holder fails to comply with a health and safety duty that exposes a person to risk of death or serious injury or illness.

Category 3 – a duty holder fails to comply with a health and safety duty.

3.20 It is important to note that the two most serious offences involve actions which expose a person to a risk of death or serious injury or illness, rather than those that cause the actual death of a worker. This later matter is often referred to as industrial manslaughter and is considered in detail in Chapter 5 of this report.

3.21 The penalties for breach of health and safety duty offences are as follows:

<table>
<thead>
<tr>
<th>Type order</th>
<th>Corporation</th>
<th>Individual as PCBU or officer</th>
<th>Individual as worker or other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1</td>
<td>$3 million</td>
<td>$600 000, five years in jail or both</td>
<td>$300 000, five years in jail or both</td>
</tr>
<tr>
<td>Category 2</td>
<td>$1.5 million</td>
<td>$300 000</td>
<td>$150 000</td>
</tr>
<tr>
<td>Category 3</td>
<td>$500 000</td>
<td>$100 000</td>
<td>$50 000</td>
</tr>
</tbody>
</table>

Source: Safe Work Australia, Submission 8, p. 6.

3.22 Chapter 5 of this report examines in more detail the use of compliance and enforcement tools and penalties for breaches of existing WHS laws which involve the death of a worker.

Committee view

3.23 Given that the model WHS laws have not been implemented in all jurisdictions and that a state or territory can also elect to amend the model laws as they apply in their own jurisdiction, the committee considers it may be worthwhile for SWA to maintain a public list of all amendments to the model laws.

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15 Safe Work Australia, Submission 8, p. 6.
Recommendation 2

3.24 The committee recommends that Safe Work Australia maintain a public list of amendments that jurisdictions make to the model work WHS laws.

Rate of prosecutions under the legislative framework

3.25 SWA publishes aggregate data provided by each jurisdiction on the number of WHS legal proceedings and the total amount of fines ordered by courts in relation to WHS breaches. A summary of the available data on compliance and enforcement activities in 2015-16 showed that there were 275 legal proceedings against duty holders finalised, 232 legal proceedings resulting in a conviction, order or agreement, and $12.2 million in fines issued by courts.16

3.26 SWA advised that it was not able to break down that data set to ascertain information on specific prosecutions, such as the level of prosecution or the fines produced, but noted that getting access to more granular data in that area was something it was ‘looking to explore’ with jurisdictions.17

3.27 The ACTU contended that the data kept by regulators on prosecutions was inadequate. It argued:

Regulators should keep a common, publicly available database of completed prosecutions, including information about the date of the prosecution, the nature of the entity prosecuted, the type of issue giving rise to the prosecution, the provision of the Model Act under which the prosecution was taken, the court in which the prosecution took place, the plea entered by the defendant, and the sentence imposed by the court. The database should also include links to all written court decisions.18

Committee view

3.28 The committee emphasises that the aforementioned SWA data in relation to compliance and enforcement activity results in 2015-16 (i.e. 275 legal proceedings against duty holders finalised, 232 legal proceedings resulting in a conviction, order or agreement, and $12.2 million in fines issued) does not reflect the prosecution outcomes for industrial deaths, which are a smaller but unquantified subset of this aggregated WHS data.

3.29 The committee is of the strong opinion that SWA must work with each jurisdiction to collect and maintain a data set with more detailed information on the prosecution processes and outcomes of industrial death incidents.


17 Mr Kris Garred, Director, Evidence, Safe Work Australia, *Proof Committee Hansard*, 7 August 2018, p. 36.

3.30 The committee also considers that it would be valuable for this information to be provided to relevant Commonwealth and State and Territory government agencies so that it can be taken into account in the awarding of public contracts. It would also inform other interactions with the Commonwealth such as applications for a self-insurance licence under the Safety, Rehabilitation and Compensation Act 1988.

3.31 The committee is of the opinion that corporations that repeatedly breach WHS obligations and cause death and serious injury should not be awarded government contracts.

Recommendation 3

3.32 The committee recommends that Safe Work Australia work with WHS regulators in each jurisdiction to collect and publish a dataset which provides annually updated and detailed information on the prosecution of industrial deaths, including:

- the date of the prosecution;
- the nature of the entity prosecuted;
- the type of issue giving rise to the prosecution;
- the provision of the legislation under which the prosecution was taken;
- the plea entered by the defendant; and
- the sentence imposed by the court.

3.33 The committee also recommends that this data set be provided to:

- relevant Commonwealth and State and Territory government agencies so that it can be taken into account in the awarding of government contracts; and

3.34 The committee further recommends that corporations that repeatedly breach WHS obligations and cause death or serious injury should not be awarded Commonwealth, State or Territory government contracts.

Review of model WHS laws

3.35 SWA recently commissioned a review of the model WHS laws, led by independent reviewer Ms Marie Boland. The review commenced in November 2017 after Commonwealth, state and territory ministers with responsibility for WHS asked SWA to conduct a review of the content and operation of the laws. The review is due to be finalised by the end of 2018.19

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19 Safe Work Australia, Submission 8, p. 5.
3.36 SWA outlined the direction of the review:

The Terms of Reference for the Review focus on the operation and content of the model WHS Act, rather than assessment of the policy objective underlying harmonisation or whether model WHS laws were the appropriate mechanism for achieving this objective. The Review is also not intended to examine in detail and compare the implementation of the model WHS laws across jurisdictions, or assess the performance of the regulators.

Committee view
3.37 The committee awaits with interest the outcome of the review of the model WHS laws and urges SWA to consider the findings and recommendations of this report in its deliberations.

Recommendation 4
3.38 The committee recommends that the Boland review consider the recommendations of this inquiry in its review into the model WHS laws.

Safety implications of the increased use of temporary and labour hire workers
3.39 The committee received evidence arguing there were negative safety implications relating to the increased use of temporary and labour hire workers. Evidence indicated that workers engaged under such employment practices were more vulnerable to adverse WHS outcomes due to a number of factors.

3.40 The ACTU advised that over 40 per cent of the Australian workforce is employed in some form of precarious or insecure employment. It stated these workers were more likely to be insecure at work for a range of reasons, including:

- inadequate training and induction;
- fear of employer reprisal for raising safety concerns;
- lack of access to participation and consultation processes;
- lack of regulatory oversight;
- poor supervision;
- inadequate access to effective safety systems; and
- exposure to frequent restructures and down-sizing.\(^{20}\)

3.41 Maurice Blackburn Lawyers (Maurice Blackburn) commented in a similar vein:

The rise in precarious work continues to be a significant factor increasing insecurity among the workforce. This uncertainty would undoubtedly influence the behaviour of workers where they would otherwise pursue

\(^{20}\) Australian Council of Trade Unions, Submission 39, p. 9.
their right to WHS coverage or access support and compensation if they are injured.  

3.42 The Queensland Government submission highlighted numerous studies and reviews which raised concerns about the WHS of labour hire workers. 

3.43 It summarised: 

A common characteristic of temporary work and labour hire employment, however, is the precariousness of the employment relationship. It is this feature that makes both groups susceptible to poorer health and safety outcomes with some of the worst cases of exploitation of workers evident among labour hire workers. Labour hire workers are younger on average than other workers and commonly from a non-English speaking background. These characteristics compound the risk of labour hire workers being harmed or injured at work.  

3.44 The Victorian Government pointed out that labour hire workers are among those disproportionately affected by hazardous employment. It drew the committee’s attention to findings from its 2016 inquiry into the labour hire industry and insecure work, which found that there were various ways in which labour hire workers were treated as a ‘second class’ of worker, with treatment ranging from outright exploitation to differential treatment in regard to WHS issues.  

3.45 The Northern Territory Government also expressed concern about the trend towards hiring temporary workers and using labour hire companies. It noted that the Northern Territory had had a number of cases of vulnerable workers being exploited or suffering death or injury.  

3.46 The Victorian Trades Hall Council (VTHC) emphasised that the increasing use of temporary workers poses a significant risk to Australia's WHS system: 

Temporary workers, such as those on working holiday or student visas, are often amongst the most vulnerable in our society. These workers are more often than not without a voice. They are scared to report safety incidents or hazard for fear of losing their job and potentially their visa.  

3.47 The Transport Workers’ Union (TWU) quoted research showing that the increasing use of temporary and labour hire work ‘can and does lead to dangerous outcomes’. 

21 Maurice Blackburn, Submission 23, p. 8. 


24 Northern Territory Government, Submission 50, p. 2. 

25 Victorian Trades Hall Council, Submission 14, p. 2. 

26 Transport Workers’ Union, Submission 7, p. 7.
3.48 The ACTU argued that improvements were required to the model WHS Regulations and the model Codes of Practice to better assist duty-holders in complex work arrangements to understand and comply with their duties:

The current Model Laws already provide for situations where multiple businesses have overlapping duties (see s 16 of the Model Act), and the ACTU has recommended an amendment to s 19 to ensure that labour-hire and supply chain arrangements are effectively covered by the primary duty of care. In addition, the Model Codes and Regulations must be updated to better explain the scope and nature of the primary duty of care as it applies in practice to ‘non-standard’ employment arrangements, such as labour hire arrangements, contractor arrangements, supply chains, joint ventures, alliances and franchise arrangements. There will be many situations in which more than one duty-holder will have an obligation to identify hazards and control risks. It is essential that roles and responsibilities between different duty-holders are clearly understood and coordinated. These arrangements are complex and uncertainty regarding which obligations lie with which duty-holder is likely. Duty-holders should be assisted to identify the major WHS problems associated with each type of working relationship and to develop a systematic approach to managing those issues. In light of the increasing prevalence and complexity of these arrangements in the new economy, the Model Regulations and Codes must provide clear and detailed guidance explaining which categories of workers and others are owed a duty in various non-standard working arrangements, and what steps must be taken by duty-holders to ensure their health and safety. Detailed guidance on the obligation in s 46 of the Model Act on duty-holders to consult with each other, as well as workers and their representatives, must also be included.27

3.49 Industry groups disagreed with the contention that there were negative safety implications relating to the increased use of temporary and labour hire workers. For example, the Australian Industry Group (Ai Group) argued that Australia is not experiencing an increase in the level of temporary and labour hire workers.28

3.50 The Australian Chamber of Commerce and Industry (ACCI) stated:

Irrespective of the number of ‘temporary’ and labour hire workers nationally, SWA data shows the overall number of worker fatalities and the fatality rate across all industries has been trending down since 2007. There is limited evidence to indicate that employment type correlates to risk, once other variables are accounted for.29

3.51 Master Builders Australia refuted that there has been increased use of temporary and labour hire workers and further asserted:

27 Australian Council of Trade Unions, Submission 39 (Attachment 1), p. 24 (citations omitted). The duty holder's obligation to consult with workers is contained in section 47 of the model WHS Act.


29 Australian Chamber of Commerce and Industry, Submission 24, p. 9.
It is our view that companies that employ or engage temporary and labour hire workers are aware of, and adequately administer their obligations under relevant legislative schemes that have been enacted to mitigate the potential risks.\(^{30}\)

3.52 The Department of Jobs and Small Business (the department) also made comment on this matter:

Having regard to data from the Australian Bureau of Statistics, the department does not agree with the notion that there is an ‘increased use of temporary and labour hire workers’. For example, workers paid by a labour hire firm/employment agency as a proportion of employed persons has been stable at around 2 per cent since 2008. Further, over the past 20 years the rate of casual employment has steady at around 25 per cent.

The WHS Act is clear: all workers are entitled to work in an environment where the risks to their health and safety are properly controlled. The laws require businesses to do what is reasonably practicable to ensure the health and safety of their workers. Where those workers are vulnerable (for example, because they are new to an unfamiliar workplace or job), additional steps should be taken to make them safe. That is what the law demands.\(^{31}\)

3.53 The Recruitment, Consulting and Staffing Association (RCSA) argued that there was ‘no evidence’ to suggest that there has been an increase in the number of people employed under labour hire arrangements in the past twenty years.\(^{32}\)

3.54 The RCSA also stated:

We believe that Section 46 of the Work Health and Safety Act 2011 provides sufficient specificity in relation to labour and on-hire arrangements and the sector does not require further dedicated consideration from a legislative perspective.

This position is supported by a range of work health and safety data sets, which by no means indicate that the labour hire sector is an outlier in relation to worker safety. To the contrary, they show that in most cases the labour hire sector is in line with the direct hire population and in many cases, labour hire outperforms the directly hired workforce in relation to safety.\(^{33}\)

Toxic corporate culture

3.55 The committee heard that the rise of precarious employment practices had led to a corporate culture where there is a distinct lack of care for safety of the worker.


\(^{31}\) Department of Jobs and Small Business, *Submission 49*, p. 5.

\(^{32}\) Recruitment, Consulting and Staffing Association, *Submission 12*, p. 3.

3.56 Maurice Blackburn detailed the situation:

Over the past two decades, business operators have continued to find new ways to avoid their responsibilities under Fair Work legislation and other legal and regulatory structure, including WHS and workers' compensation frameworks. ‘Gig economy’, sham contract and labour hire arrangements require the service provider to be a self-employed independent contractor, rather than an employee, thereby abrogating the business operators of employer responsibilities...

These business operators have moved the public discourse in this regard toward a discussion of 'who employs whom', rather than toward any genuine concern for the wellbeing of workers. By insisting that people who work for them be self-employed independent contractors, business operators avoid having to take responsibility for the provision of safety nets that Australians have come to expect, including the right to be safe at work.34

3.57 Ms Regan Ballantine, whose 17 year old son Wesley was killed at work in 2017, summarised the lack of care evident in such instances:

When you lose love so abruptly and so young, you come to understand that the root cause of that death wasn't really because of poor safety; it was because people didn't care—not about human life and certainly not for one another. I can tell you what the people in charge did care about though: gross profit. Are we really still there where profits are valued over and above everything else?35

3.58 Dr Lana Cormie, whose husband Charlie was killed at work in 2018, echoed a similar sentiment in her evidence to the committee:

What killed my husband?... He died because workers are not respected and they cannot stand up for what is right for fear of losing their jobs. He died because employers ask what is profitable before what is right.36

Committee view

3.59 The committee is persuaded by the evidence that there are negative safety implications relating to the increased use of temporary and labour hire workers and other forms of precarious work. Additionally, the committee agrees that the rise of such precarious employment practices has led in some instances to a corporate culture where there exists a distinct lack of care for the safety of the worker.

3.60 The committee recognises that it is important to assist duty-holders in complex or precarious work arrangements to understand and comply with their duties. It sees merit in SWA developing dedicated guidance on this topic to be incorporated into the model WHS framework.

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34 Maurice Blackburn, Submission 23, p. 6.
35 Ms Regan Ballantine, private capacity, Proof Committee Hansard, 30 August 2018, p. 19.
3.61 In Chapter 5 of this report the committee also makes recommendations to improve the use of compliance and enforcement tools and penalties for breaches of WHS laws which involve the death of a worker. If adopted, these recommendations will lead to a gradual improvement in WHS practices amongst certain companies and employers where there is a corporate culture of profit over worker safety.

Recommendation 5

3.62 The committee recommends that Safe Work Australia work with Commonwealth, State and Territory governments to:

- update the model WHS framework to cover precarious and non-standard working arrangements (including labour hire) to clarify the extent, scope and nature of the primary duty of care and the obligation under the model WHS Act on duty-holders to consult with each other, as well as workers and their representatives; and
- pursue approval of these arrangements in other jurisdictions through the formal harmonisation of WHS laws process.
Chapter 4
Investigations

4.1 Following an industrial death, a number of regulatory and judicial responses can be initiated. These can include a police investigation, a work health and safety (WHS) regulator investigation, a workers' compensation claim, a prosecution, a common law claim and a coronial inquest. Differences exist in the way these processes operate from jurisdiction to jurisdiction.¹

4.2 This chapter will examine the effectiveness of the investigation process following an industrial death. The matters covered include:

- the quality of investigations; and
- cross-jurisdictional investigations.

4.3 The chapter will also briefly touch upon the importance of regulators being adequately trained, funded and resourced to conduct preventative activities.

Quality of investigations

4.4 Throughout the inquiry concerns were raised about the investigative abilities and attitudes of the various state and territory WHS regulators. The committee heard evidence that indicated that the quality of investigations was at times highly deficient, a situation which ultimately led to poor prosecution outcomes.

4.5 Key issues that aggrieved families included:

- a lack of confidence in the skill set and resource levels of the investigating regulator;
- the length of time required to complete the investigation; and
- the regulator’s attitudes towards investigations.

4.6 Families were also concerned that they were not seen as valid stakeholders in the investigation and as a result were not kept up to date with the process. Chapter 6 of this report examines this issue in more detail.

Confidence in regulator

4.7 The committee’s attention was drawn to a 2017 report titled 'Death at Work: Improving support for families' conducted by researchers at the University of Sydney.² The study was conducted from 2012 to 2016 and included detailed interviews with approximately 50 representatives from institutions that deal

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¹ Australian Council of Trade Unions, Submission 39, p. 4.

with workplace fatalities (e.g. employers, government agencies, unions) and 44 family members, and a broader survey of 109 family members. It aimed to identify the health and financial consequences of fatal work injuries, assess the adequacy of institutional responses in meeting families' needs, and identify interventions and policy measures to improve these responses.³ Dr Lynda Matthews, one of the report authors and an Associate Professor in the Faculty of Health Sciences at the University of Sydney submitted:

More than half of the family members participating in this study indicated they were very dissatisfied with the fairness of processes and the outcomes reached in the investigation. They had difficulty being satisfied with the rigour of investigative processes due to inconsistencies in information, concerns of possible tampering with evidence, and the lack of explanations from authorities about decisions made during investigations, including the decision not to prosecute.⁴

4.8 Numerous impacted families informed the committee that they did not have confidence in the skills and resource levels of the regulator working on the investigation of their loved one’s death.⁵ The concerns were often centred on whether the investigator had the relevant skill set and knowledge required; whether the regulator had sufficient resources; unnecessary delays in securing work sites; whether critical evidence have been collected or tampered with; and delays in speaking to key witnesses.

4.9 For example, Mr Lee Salvemini submitted that in the investigation into his son Jack’s death on a commercial fishing boat in 2005 that the investigator involved did not have the appropriate skills to gather evidence:

The other thing is you’ve got to have the right people to investigate the accident. That didn’t happen in my son’s case. I’ve got the statement and a transcript here from the police officer who went out to the boat. He didn’t even go out to the boat, but they asked him, ‘Had you had a chance to get familiar with the layout of the operations of the vessel in any other way?’


⁴ Dr Lynda Matthews, Submission 60, p. 4.

⁵ See for example Dr Lana Cormie, private capacity, Proof Committee Hansard, 28 August 2018, pp. 31–32; Mr Jon-Paul Bradley, private capacity, Proof Committee Hansard, 30 August 2018, p. 16; Ms Ashlea Cunico, private capacity, Proof Committee Hansard, 30 August 2018, p. 18; Mrs Patricia Kelsh, private capacity, Proof Committee Hansard, 30 August 2018, p. 20; Ms Regan Ballantine, Proof Committee Hansard, 30 August 2018, pp. 20–21; Mr Mark Murrie, Proof Committee Hansard, 30 August 2018, p. 20; Mr Lee Salvemini, private capacity, Proof Committee Hansard, 29 August 2018, p. 2; Mrs Edith Logan, private capacity, Proof Committee Hansard, 29 August 2018, p. 3; Ms Pam Gurner-Hall, private capacity, Proof Committee Hansard, 29 August 2018, p. 6; and Mr Michael Garrels, Interim Chair, Interim Consultative Committee for Workplace Fatalities and Serious Incidents, Proof Committee Hansard, 17 July 2018, p. 2; Mrs Julie LeBrocq-Goggin and Mr Wayne Goggin, Submission 53, pp. 1–2.
'No.' 'Do you have any experience in respect of a commercial fishing vessel?' 'Not really of a commercial fishing vessel, no.' 'Have you ever been on a shark fishing vessel before?' 'Not a shark fishing vessel.' 'Do you have any experience in respect of net winches or net spools on board commercial fishing vessels? 'No."

4.10 Ms Pam Gurner-Hall informed the committee that seemingly basic steps were not taken in the aftermath of her partner Jorge's death on the site of the new Royal Adelaide Hospital in 2014:

SafeWork SA [South Australia] did not have any investigators go to the site on the day. They sent three staff members to 'have a look around'. On the same day, they removed the scissor lift from the site before any of the measurements had been taken, before any of the photographs had been taken, before anybody had had a chance to inspect the fact that the power pack used to bring down the machine was not working, was replaced by a SafeWork person to get the machine started. They put it on a freighter and they took it to SAPOL, which is the South Australian Police Force lockdown area, and they left it out in the rain where it rusted for the next three months before they got a full investigation into that machine in early March [2015]. There were no interviews taken by SafeWork SA of any of the witnesses until the first week of May [2015].

4.11 Mrs Jennifer Newport's son Glenn was killed in 2013 in central Queensland. She provided an account to the committee of the investigation that indicated it was not completed to a high standard:

Due to a number of excuses, the department prosecutor deemed that they could not take any action against the company. From further investigation, we've discovered that there was a coroner's inquest. There was also an ombudsman investigation into a series of different workplace deaths, and Glenn's case was one of them. It was shown that the initial investigation by WorkSafe [Queensland] was totally inadequate and underscoped. He died on the Saturday night; the investigators did not arrive until the Monday morning. The initial interviews were done by the police, who seemed to be under the impression, when they came and told us that Glenn had died, that he had taken something. Their investigation seemed to be skewed to the idea that he might have taken something in his donga, fallen over and hit his head. By the time the WorkSafe staff got out there, the company had sent all of his workmates home on bereavement leave, so they were not interviewed until well over a week later when they came back to work.

4.12 In another example put to the committee, Mr Daniel Kennedy described the inadequacies he saw in the investigation after his son Dale was killed in 2012 in Cairns, Queensland:

To date, there has been a clear message sent to our family and other affected families that indicates that an industrial death is of less

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importance than other deaths investigated by the Queensland Police Service. Dale’s incident was attended by two workplace health and safety officers, one ESO [Electrical Safety Office] principal inspector, two ESO senior inspectors, one regional inspector and four Queensland police officers, including a forensic officer. Yet important facts were disregarded and there was no thorough investigation. The Queensland Police Service should have overseen this investigation. The ESO admitted they questioned the initial testing the day after Dale’s death and visited the college some nine days later to check the results. Why wasn’t a crime scene established and a thorough investigation conducted? The college building was open for business some four hours after Dale’s death. The file from the principal ESO investigator, who clearly demonstrated a lack of investigative skills, was the determining factor in the direction of prosecutions.9

4.13 Mr Kennedy provided further detail on the ways in which the investigation was lacking and highlighted the adverse consequences of a poor quality investigation:

Statements were made in January 2013, six weeks later, from crucial first responders. These statements replicated each other word for word, and this is unacceptable. Another first responder gave his written statement in July. The principal investigator added at least three statements of the day. This certainly highlighted to us the lack of investigative skills and the lack of knowledge of the rules and regulations. We were searching and reaching out for answers for months and never receiving any information from the Office of Industrial Relations. Dale’s host employer had to answer to charges in August 2014. Investigators charged him with an offense that did not exist. This was thrown out as no case to answer. How does this happen?10

4.14 Mrs Debbie Kennedy, Dale’s mother, described for the committee the distress a poor quality investigation can have on the impacted family:

We were putting our trust—we weren’t thinking, ‘Gee, I hope a good investigation’s happening.’ Obviously, we were just thinking there must be an investigation going on. We were putting our full trust in it, because why wouldn’t an investigation have been thorough? We found so many times that people would use excuses for poor investigations. The track the prosecution went down was: ‘They were in an acting position. They were new to the role. They hadn’t had any training.’ I’m sorry, but if you’ve accepted a position and you don’t think you’ve had the correct training, especially if you’re a principal investigator, then you should be asking for training...11

9 Mr Daniel Kennedy, private capacity, Proof Committee Hansard, 17 July 2018, p. 17.
10 Mr Daniel Kennedy, private capacity, Proof Committee Hansard, 17 July 2018, p. 18. For more information see also Mrs Julie LeBrocq-Goggin and Mr Wayne Goggin, Submission 53, pp. 1–3.
11 Mrs Debbie Kennedy, private capacity, Proof Committee Hansard, 17 July 2018, p. 20.
Investigation length

4.15 In addition to concerns about the quality of investigations, the committee heard from some impacted families that they felt that the length of time taken to complete investigations was at times too long.\(^\text{12}\) In addition to prolonging the distress for families, drawn out investigations also had the potential to exceed the limitation period for prosecutions. Even if an investigation is completed within the limitation period, subsequent coronial inquests can then take some time.

4.16 Ms Regan Ballantine, whose son Wesley was killed on a Perth construction site in 2017, explained how the lengthy time frame in her son's case caused her additional unnecessary stress:

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\text{...it's obvious that WorkSafe [Western Australia] are under-resourced. The motivation to carry out their task is limited. I'm almost two years into the process, and the case is only just sitting with the Director of Public Prosecutions at the moment. We're 19 months in and it's still sitting with the Director of Public Prosecutions to determine whether they will bring about an action. Whilst there is an active WorkSafe investigation the coroner cannot conduct its formal inquiry, so it'll be six years from the date of my son's death before all of the process is scheduled to be completed, which is a very long time and has a huge impact on families, especially when there are no resources for support with respect to the type of counselling that you may need to support you through such a long and arduous process.}^{\text{13}}
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4.17 The committee was advised that in the Australian Capital Territory (ACT) there is a statutory two year limitation on bringing charges.\(^\text{14}\) As such, should an investigation take longer than two years, in some circumstances the window for bringing charges is effectively closed. The ACT Work Safety Commissioner Mr Greg Jones observed that for complex investigations, two years 'can go very rapidly'.\(^\text{15}\)

4.18 Chapter 5 of this report explores the issue of limitation periods in more depth.

4.19 The committee also received evidence from Dr Lynda Matthews of the University of Sydney that the lengthy period of time an investigation can take contributes to the trauma suffered by the family of a deceased worker. She noted that the bereavement of a family is in effect not dealt with while an

\(^\text{12}\) See for example Mrs Robyn Colson, Submission 29, p. 3; and Mrs Kay Catanzariti, private capacity, Proof Committee Hansard, 7 August 2018, p. 5.

\(^\text{13}\) Ms Regan Ballantine, private capacity, Proof Committee Hansard, 30 August 2018, p. 21.


\(^\text{15}\) Mr Greg Jones, ACT Work Safety Commissioner, Access Canberra, ACT Government, Proof Committee Hansard, 7 August 2018, p. 43.
investigation is ongoing, given they must be constantly vigilant and involved in what is happening.\(^\text{16}\)

4.20 Chapter 6 of this report examines further the impact of the investigation process on families.

*Regulators’ attitudes towards investigations*

4.21 Concerns were also raised with the committee regarding the attitudes with which regulators and their investigators viewed industrial deaths. It was argued that the attitude of a regulator or individual investigator ultimately dictates what kind of evidence will be gathered. If an industrial death is viewed as an accident, the direction of the investigation and the type of evidence gathered will be vastly different to what would occur if the death was viewed as a potential crime.

4.22 The following exchange between the committee and Mr Dave and Mrs Janine Brownlee and Dr Lana Cormie, whose son Jack and husband Charlie respectively were killed in the same trench collapse in 2018, illustrated the problems inherent with a regulator viewing a death as an accident, rather than a potential crime:

CHAIR: I know this is a subjective question, but do you think there is an attitude with the investigator or regulator that ‘accidents just happen’ and therefore will investigate it on that basis, or do you think they are treating it as, ‘This is a negligent act that has resulted in a death’?

Mr Brownlee: They’re restricted in what they can do and say, but there are other ways they could have gone about things. They filled that trench in four hours after. It was that night.

CHAIR: Who filled it in?

Mr Brownlee: They were directed by WorkSafe to fill it in. There was a lot of evidence still in that trench. I work at the mine in Ballarat. We have umpteen geos—geotechnical engineers—there. They could have got a geo out there. We have a bloke that worked there for 10 or 12 years. He knows Ballarat ground. He could have gone out and made an assessment on that ground until they got their so-called expert in with a bit of barricading, fencing or whatever and a guard on it. They could’ve got their expert up to see the site initially. But, once it’s filled in, that evidence is gone.

Mrs Brownlee: The coroner didn’t turn up. The geotech didn’t turn up. So—

Mr Brownlee: They’re going on one-dimensional photographs.

Mrs Brownlee: Yes. Somebody else took the photos. The geotech didn’t turn up to check the soil properly. Jack at that time was still in hospital. He was still fighting for his life. They should’ve kept it open for at least 24 hours to see the result with Jack. They actually had two deaths on their

\(^{16}\) Dr Lynda Matthews, Associate Professor, Faculty of Heath Sciences, University of Sydney, *Proof Committee Hansard*, 12 July 2018, p. 10.
hands. They should have waited. With Jack, they knew he was in critical condition. They knew Jack wasn’t going to survive. So that’s two deaths. They’ve really covered up the evidence. They’ve buried the evidence. They could’ve waited until the next day.

CHAIR: Again, our job isn’t to adjudicate on these things, but I guess what you’re saying to me is that the scene of the accident certainly was not treated as a potential criminal site.

Mr Brownlee: No.

Dr Cormie: It should be treated as a crime scene would be.\(^{17}\)

4.23 Dr Cormie elaborated on this point:

Our case is still ongoing but, looking back at previous cases, it seems quite evident that there appears to be quite a willingness to go down the easy path—’Unsafe workplace, section 21, easy. Tick the box, stamp that paperwork and get it off my desk.’ Is there evidence for higher charges? We either weren’t resourced or weren’t motivated to actually find the evidence to allow for that to be charged in court. So, when we take our case to our lawyers at WorkSafe or the appropriate body, they will find that there isn’t enough evidence. Why? It’s because no-one looked for it. It would appear, from our uneducated viewpoint, that they’re looking for evidence towards a crime or a charge. If the only thing you’re aiming for is an unsafe workplace charge, that’s all you’re going to find. But if you investigate as you would a crime scene, a murder, a suicide, a rape, a car accident or a child being molested at school, you would find more evidence. But to do that the personnel in the regulating body need to be trained properly, and they need to be motivated towards not just any prosecution but the greatest prosecution—the greatest charge.\(^{18}\)

4.24 The committee asked Mr Rod Hodgson, a principal lawyer with Maurice Blackburn Lawyers (Maurice Blackburn) for his opinion on the investigative abilities of regulators. In his response he emphasised the importance of regulators having adequate resources, the right investigative skills and the appropriate attitude:

In the Queensland context, I think it was recognised by the current Queensland government that...the less than optimal investigation structure, had led to some unacceptable outcomes. I think there are three elements to that. The first is that the investigation body charged with investigation and in due course, in some cases, prosecution of these offences needs to have probably three elements to it. The first is appropriate resources. There’s not much point having a new legislative framework and the new offence if the body charged with investigating these matters has inadequate resources. The next element is that they needed to have the right skills, not only enough people but enough people with the right skills to investigate thoroughly the cause of a workplace


\(^{18}\) Dr Lana Cormie, private capacity, *Proof Committee Hansard*, 28 August 2018, p. 32.
death and carry that through in the manner that you’ve described in a way that meets the standards imposed by courts.

The third element is perhaps a little more amorphous but no less important. That is an attitudinal factor. I think that probably workplace deaths have not been regarded as ‘true crimes’ in inverted commas by a lot of directors of public prosecutions, who have high constraints and other more conventional forms of crime to deal with. An attitudinal adjustment to reflect the community expectations that I referred to before is very important. The Queensland government is in the process of responding to those factors by setting up a separate entity to investigate and prosecute workplace deaths—industrial manslaughter. It is very important that if that Queensland and ACT legislation is to be expanded on in other jurisdictions, as Victoria has foreshadowed, that the government equip the authorities with people with the right skills, sufficient people as well as people with the right attitudinal approach to the investigation and pursuit of such an important prosecution.19

A way forward

4.25 The Maurice Blackburn written submission suggested that the committee consider a requirement that all workplace deaths be treated as criminal investigations, requiring a Director of Public Prosecutions (DPP) or analogous prosecutorial oversight. It observed that if that were to be the case, it would be essential that such authorities be properly funded and resourced.20

4.26 Mr Greg Jones, the ACT Work Safety Commissioner advised that in the past two years the ACT had made considerable improvements in the way investigations were conducted. He highlighted the importance of having an experienced investigation team to ensure quality evidence is gathered, and noted that the four major ACT investigators were ex-police officers with over 100 years of criminal investigation experience collectively.21

4.27 He also emphasised the importance of beginning the investigation in a timely manner in ensure the evidence collected is of the highest quality:

Securing the site at the earliest practical stage after an incident is absolutely critical and paramount. Those first 24 hours are absolutely critical in terms of securing the site, the evidence, taking witness statements – perhaps, as other witnesses may tell you, before they ‘lawyer up’, which is a comment I heard earlier. The quicker you get in and get statements before that occurs the better off you are, where that’s clearly appropriate. There’s the quality of the evidence. We have equipped ourselves with considerable technology

19 Mr Rod Hodgson, Principal Lawyer, Maurice Blackburn Lawyers, Proof Committee Hansard, 28 August 2018, p. 18.

20 Maurice Blackburn Lawyers, Submission 23, p. 15.

in terms of camera and video. We have a number of drones that we use to get whole-of-site footage very early in the piece.  

4.28 Mr Jones also elaborated on the importance of a cooperative and consultative relationship between the workplace regulator and other agencies (for example the police) that are involved in the aftermath of an industrial death. He outlined for the committee the typical process that occurs in the ACT:

Typically, when we [WorkSafe ACT] go to a major incident or certainly a fatality, we would immediately make contact with the ACT Policing. We would establish very early the priorities in terms of gathering evidence, based on the particular case of event, and that we would be there. Usually at that point we would establish who is the lead agency, and it would depends on the circumstances. That lead agency, as with all emergency services type protocols, would take the lead and call the shots. It's very cooperative and consultative in terms of what's happening. On site, we typically share resources on the day, in terms of gathering evidence, taking witness statements or whatever is necessary at that time. We have protocols in place between ACT Policing and WorkSafe ACT to share absolutely everything that we collect. Our investigations area genuine joint approach and we specialise in our own areas as we need to. We exchange information in terms of presenting evidence on the case or the experience to the coroner, as the coroner requests, so that there is always consistency between what ACT Policing and WorkSafe present to the coroner, so there is no conflict there because of the exchange of evidence that we do collect. As an investigation continues, sometimes that lead agency will change when one of the agencies finished their role. Then there'll be a complete handover, including evidence. Whichever agency is not in the lead role is kept informed regularly of where it’s going, progress and anything that may impact on their space. At the same time, especially if we feel that there's likely to be regulatory action taken due to people's decision-making at the time, we involve the DPP's [Director of Public Prosecutions] office at a very early stage. That can help guide the collection of evidence, in terms of where we see an investigation going. If it's going for a category 1 or an industrial manslaughter type charge, then, clearly, as you suggested, the level of evidence has to be pretty tight and very, very accurate. And we can help with consultation with ACT Policing, the coroner’s office and the DPP's office to make sure that we’re completely comprehensive in the range of evidence that we do in fact collect.

Committee view

4.29 The committee is of the strong opinion that an investigation into an industrial death must be of the highest quality. Additionally, workplace deaths must be investigated in a timely manner and as a matter of priority.

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4.30 The committee acknowledges the frustration of families when investigations take lengthy periods of time. The committee also acknowledges that it is difficult for families to find closure and deal with their grief when they do not have confidence in the investigative process that follows the death of the loved one.

4.31 The committee is greatly concerned by the evidence it received indicating that the investigations of industrial deaths are often haphazard or conducted by unskilled investigators. The committee does not think it appropriate that people with virtually no investigative experience or the appropriate logistical support from their employer could be tasked with investigating a death.

4.32 In addition, the committee finds it imperative that the regulators undertaking the investigation do so with the correct attitude; that is, that the death they are investigating is potentially a criminal matter, not merely an accident. Accordingly, the site must be initially treated as a crime scene and a thorough process of evidence gathering must be undertaken. The committee asserts that it is likely that all industrial deaths are preventable, and so each should be investigated as a potential crime scene.

4.33 The committee draws comparisons between the way an industrial death and a road vehicle accident death is investigated. The scene of a road vehicle accident death is treated as a crime scene and the incident is investigated on a basis that it may lead to criminal charges. From the evidence received during the inquiry, it would appear that such a rigorous and professional investigative approach is equally not applied to an industrial death incident.

4.34 The committee also notes that should the offence of industrial manslaughter be introduced into model WHS laws (a matter discussed in Chapter 5 of this report), this will necessitate a higher standard of investigation and prosecution than is currently acceptable in many jurisdictions.

4.35 The committee considers there to be merit in ensuring consistency in investigation processes between jurisdictions by ensuring differences do not arise simply because regulators are under-resourced, or due to differing practices between WHS regulators and law enforcement agencies.

4.36 The committee has also made a recommendation in relation to WHS regulators having adequate resources to carry out preventative activities. This is discussed later in this chapter.

4.37 The committee further considers there to be a pressing need for more effective collaboration and evidence sharing between WHS regulators and law enforcement agencies given both agencies often work in the same investigative space immediately following a workplace fatality.
4.38 The committee has also made a finding about the need for impacted families to be more effectively briefed as an investigation progresses. This matter is discussed in Chapter 6 of the report.

Recommendation 6

4.39 The committee recommends that Commonwealth, State and Territory governments ensure that their WHS regulators are adequately funded and resourced to allow them to complete investigations in a timely, thorough and effective manner.

Recommendation 7

4.40 The committee recommends that Safe Work Australia work with Commonwealth, State and Territory governments and WHS regulators to develop and deliver standardised training modules to ensure that all investigators have the appropriate skills, experience and attitude to carry out high-quality investigations of industrial deaths and other serious breaches of WHS laws.

4.41 In the absence of a joint approach, the committee encourages all Commonwealth, State and Territory governments and WHS regulators to pursue this recommendation individually.

Recommendation 8

4.42 The committee recommends that Safe Work Australia work with all Commonwealth, State and Territory governments and WHS regulators to:
   • establish best practice guidelines for the conduct and duration of investigations of serious WHS law breaches, including workplace deaths, which include guidance on the criteria that must be satisfied if an investigation needs to be extended past the usual allocated timeframe; and
   • ensure that each jurisdiction is able to fully implement these guidelines.

4.43 In the absence of a joint approach, the committee encourages all Commonwealth, State and Territory governments and WHS regulators to pursue this recommendation individually.

Recommendation 9

4.44 The committee recommends that Safe Work Australia work with WHS regulators to develop a policy to formalise collaboration and evidence sharing between WHS regulators and law enforcement agencies during investigations following an industrial death.
Recommendation 10

4.45 The committee recommends that Safe Work Australia work with WHS regulators in each jurisdiction to develop a policy which stipulates that all industrial deaths must be investigated as potential crime scenes.

Cross-jurisdictional investigations

4.46 The committee also heard concerns about the difficulty regulators encountered in collecting evidence from other jurisdictions, an issue which could severely hamper investigation outcomes.

4.47 For example, 21 year old worker Mr Ben Catanzariti was killed in 2012 when he was struck on the head by a collapsing concrete boom. Ben’s mother, Mrs Kay Catanzariti, advised that the investigation encountered cross-jurisdictional issues because while the company Ben worked for was based in the ACT and the work site where he died was in the ACT, the company that serviced the boom was based in New South Wales (NSW). Her written submission noted:

ACT WorkSafe had several issues with the complex interjurisdictional nature of the investigation. I believe there were concerns ACT WorkSafe could not obtain information from the NSW based company…

ACT WorkSafe attempted to liaise with the business or asked NSW WorkSafe to do so on their behalf. The AFP [Australian Federal Police] were required to request NSW Police to assist with the execution of two search warrants on the business premises on two separate occasions in order to obtain evidence that would be admissible in court for a criminal charge and collect evidence of the offence that hadn't been supplied.24

4.48 She provided further detail at a hearing:

WorkSafe ACT and the AFP were not permitted to go into New South Wales. They had to contact WorkSafe New South Wales and the New South Wales police. They then had to find time to go to the premises. They had to do the investigation. ACT, AFP and WorkSafe were there, but they were not permitted, to my understanding, to ask questions. The witnesses refused to speak to the AFP. They were lawyered up, basically. There were delays in obtaining evidence. What happens is, they can only take the evidence that they take at the time. They cannot take any other evidence after the two-year time limit. They couldn't go backwards and forwards.25

4.49 Mrs Catanzariti suggested that greater cooperation was needed between regulators and investigating bodies across jurisdictions, otherwise there was a risk that critical evidence 'on the ground' interstate would be missed by the principal investigators.26

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24 Mrs Kay Catanzariti, Submission 48, p. 2.

25 Mrs Kay Catanzariti, private capacity, Proof Committee Hansard, 7 August 2018, p. 5.

26 Mrs Kay Catanzariti, Submission 48, p. 2.
4.50 When the committee put this matter to the ACT Work Safety Commissioner Mr Jones, he responded that he was aware of the potential cross-jurisdictional problems that could arise during an investigation regarding collecting evidence and serving warrants. He noted that WorkSafe ACT did have arrangements in place with the NSW Police and ACT Policing to use NSW Policing to actually assist with the serving of warrants or obtaining evidence where necessary, although such arrangements also relied upon cooperation and resource levels.\footnote{Mr Greg Jones, ACT Work Safety Commissioner, Access Canberra, ACT Government, \textit{Proof Committee Hansard}, 7 August 2018, p. 45.}

4.51 Mr Jones also commented that there may be a benefit in more formal reform to solve cross-jurisdictional issues in a more timely manner:

I’m sure, if there was perhaps a legislative reform that would allow the immediate cross-jurisdiction without relying on MOUs [Memorandums of Understanding] or cooperation, that would be smoother and no doubt quicker. Sometimes time is of the essence in terms of collection of evidence.\footnote{Mr Greg Jones, ACT Work Safety Commissioner, Access Canberra, ACT Government, \textit{Proof Committee Hansard}, 7 August 2018, p. 45.}

4.52 The Department of Jobs and Small Business (the department) acknowledged the importance of genuine cross-jurisdictional cooperation between WHS regulators. It referenced a 2018 discussion paper prepared for the Safe Work Australia review of the model WHS laws which noted that although there were positive examples of cooperative compliance and enforcement between WHS regulators, there was no clear authority for inspectors in one jurisdiction to use their powers in another.\footnote{Department of Jobs and Small Business, \textit{Submission 49}, p. 5.}

4.53 The department suggested that further consideration be given to a framework and practices that better support and enable cross-border investigations:

In particular, the department submits that consideration should be given to amending the laws to specifically enable a regulator in one jurisdiction to assist a second regulator in the furtherance of the second regulator’s investigations.

The department also considers that it could be beneficial to include a specific power in the model WHS Act enabling regulators to more easily share information when performing their functions in accordance with the WHS laws.\footnote{Department of Jobs and Small Business, \textit{Submission 49}, p. 5.}

\textit{Committee view}

4.54 In the committee’s view it is unacceptable for the investigation of a workplace death (or other serious WHS law breaches) to be stymied by a lack of...
jurisdictional cooperation. As the Australian economy and Australian businesses increase their cross-jurisdictional interactions and linkages into the future, the proper investigation of workplace deaths will progressively rely on more productive interactions between WHS regulators and law enforcement agencies across jurisdictions.

4.55 Given the importance of industrial death investigations being completed in a timely manner and to the highest possible standard, the committee considers it necessary that formalised arrangements for cross-jurisdictional cooperation between WHS regulators be established.

Recommendation 11
4.56 The committee recommends that Safe Work Australia pursue amendments to the model WHS laws to enable a WHS regulator or law enforcement agency in one jurisdiction to assist a second WHS regulator or law enforcement agency in a cross-border investigation, including in the sharing of evidence and other relevant information.

Resourcing for preventative activities
4.57 Earlier in this chapter the matter of adequate resourcing for WHS regulators was discussed in regard to the ability for regulators to conduct quality investigations following a workplace fatality.

4.58 In addition to this matter, the committee received evidence urging better resourcing for WHS regulators to carry out preventative activities in order to minimise the risk of workplace deaths occurring in the first place.

4.59 The Australian Chamber of Commerce and Industry (ACCI) indicated that it would like WHS regulators to take a more hands-on approach to prevention activities, which would require increased resources:

Within our network we have a strong representation of small and medium businesses. Our members are telling us they don’t have a problem with the legislation and they don’t have an issue with enforcement: it’s more that employers just need to know where to find information specific to them and how to put this into practice. This would likely require more regulator resources and a more hands-on approach. It would be moving away from safety as a compliance exercise and towards real safety outcomes. Rather than directing employers to specific codes of practice or guidance, we need to create an environment where businesses are comfortable asking inspectors for practical assistance and inspectors are comfortable providing this.31

31 Ms Jennifer Low, Associate Director, Workplace Health and Safety and Workers’ Compensation Policy, Australian Chamber of Commerce and Industry, Proof Committee Hansard, 30 August 2018, p. 1.
Committee view

4.60 The committee is of the opinion that increased preventative activities on behalf of WHS regulators forms a crucial part of the broader framework of reducing the number of industrial deaths.

4.61 For this reason, the committee considers it necessary for the WHS regulator in each jurisdiction to allocate increased funding and resourcing to preventative activities, such as workplace inspections.

Recommendation 12

4.62 The committee recommends that Commonwealth, State and Territory governments ensure that adequate funding and resourcing is allocated to their WHS regulators to allow for increased, more effective preventative activities in workplaces.
Chapter 5
Prosecutions

5.1 This chapter examines in more detail the effectiveness of the prosecutions of, and penalties used in, workplace death legal proceedings. In particular it explores the following issues:

- industrial manslaughter as an offence;
- the operation of an independent statutory office for work health and safety (WHS) prosecutions;
- union right to prosecute;
- the personal liability of company officers;
- the limitation period for prosecutions;
- the adequacy of financial penalties;
- directors’ insurance against penalties; and
- phoenix activity.

Industrial manslaughter as an offence

5.2 As set out in Chapter 3 of this report, model WHS legislation has been implemented by the Commonwealth and all states and territories, apart from Victoria and Western Australia. There are three categories of criminal offence for the breach of health and safety duties under the model WHS Act. The two most serious offences relate to the exposure of a person (either a worker or a bystander) to a risk of death or serious injury or illness:

Category 1 – a duty holder, without reasonable excuse, engages in conduct that recklessly exposes a person to a risk of death or serious injury or illness.

Category 2 – a duty holder fails to comply with a health and safety duty that exposes a person to risk of death or serious injury or illness.\(^1\)

5.3 As mentioned in Chapter 3, it is important to recognise that these two most serious offences seek to address the risk of exposure of a person to death or serious injury or illness, rather than the outcome (the death of a worker) which results from failure to address the risks.

5.4 Throughout the inquiry a number of industry stakeholders insisted that the current penalty framework is sufficient. However, the committee received substantial evidence indicating that these provisions are not an adequate deterrent to prevent unnecessary workplace deaths, nor are they meeting community expectations, and that as a result a new offence of industrial manslaughter was warranted.

\(^1\) Safe Work Australia, Submission 8, p. 6.
5.5 For example, the Australian Manufacturing Workers’ Union (AMWU) stated:

Although breaching work health and safety laws is a criminal offence the penalties applied by the courts are generally much lower than the available maximum. The push for industrial manslaughter legislation has its origins in the failure of the courts and regulators to use the legal system as a deterrent.²

5.6 The Australian Council of Trade Unions (ACTU) acknowledged that while it was appropriate for the WHS regime to focus on risk management, there was also a need for a specific offence of industrial manslaughter:

All three offences in the Model Laws focus on the duty to manage risks, rather than the outcome of failures to meet such duties. The ACTU agrees that it is appropriate for Australia’s WHS regime to focus on risk-management, by placing a strict duty on persons conducting businesses or undertaking to manage WHS risks, regardless of the outcome of those failures. However, in circumstances where the consequence of negligent acts or omissions is the death of an individual or individuals, a specific offence focused on the outcome is also appropriate and necessary.³

Existing industrial manslaughter provisions
5.7 Industrial manslaughter provisions currently exist in Queensland and the Australian Capital Territory (ACT).

5.8 Other states have given varying degrees of support for the idea. For example, the Victorian Government advised the committee that if re-elected it would seek to create a new criminal offence of workplace manslaughter in the Occupational Health and Safety Act 2004 (Vic).⁴

5.9 In August 2018, media reports indicated that the Western Australian Government was considering the introduction of industrial manslaughter laws. The Premier, the Hon Mark McGowan MLA was quoted as saying the laws were ‘worthwhile’.⁵

5.10 The Law Council of Australia (Law Council) identified:

The Australian Capital Territory (ACT) is the only jurisdiction that has specific offences of industrial manslaughter under its Crimes Act 1900 (ACT). Queensland has also inserted an industrial manslaughter offences under the relevant Work Health and Safety Act 2011 (Qld) (as well as the Electrical Safety Act 2002 (Qld) and Safety in Recreational Water Activities Act 2011 (Qld)), discussed below.

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² Australian Manufacturing Workers’ Union, Submission 22, p. 5.
³ Australian Council of Trade Unions, Submission 39, p. 12, emphasis in original.
All other jurisdictions have general manslaughter offences, with varying maximum penalties. The offence of gross negligence manslaughter exists under common law. It has been noted that it is the crime most likely to be used to prosecute employers responsible for work-related deaths.6

5.11 A consolidated table of the differences between state and territory laws prepared by the Law Council of Australia is at Appendix 3.

**ACT jurisdiction**

5.12 The ACT introduced the criminal offence of industrial manslaughter in March 2004, the first Australian jurisdiction to do so. The ACT Government submission provided detail on the rationale and scope of the legislation:

The purpose of introducing the specific offence of industrial manslaughter was to ensure that employers can be appropriately held to account if their reckless or negligent behaviour results in the death of a worker, and to raise awareness of the duty of employers to provide a safe workplace. These provisions send a clear message to employers and the wider community that avoidable workplace deaths will be dealt with in the strongest possible way.

By amending Part 2A of the *Crimes Act 1900*, the ACT Government sought to ensure that employers and their senior officers can be held responsible where the death of a worker is caused by recklessness or negligence. This applies to all employers in the ACT, including the ACT Government. This provision does not, however, impose vicarious liability on employers and senior officers for the actions of others. An officer cannot be liable for prosecution just because they occupy a particular position in an organisation. Additionally, for liability under the industrial manslaughter provisions, an employer’s recklessness or negligence must be proven beyond reasonable doubt.

ACT industrial manslaughter laws include substantial penalties, including financial penalties which can be applied to either individuals or corporations. For both employers and senior officers the maximum penalty is $300,000 for an individual or $1.5 million for a corporation and/or a maximum of 20 years imprisonment. Courts can also order corporations to take actions including publicising the offence, notifying specific people about the offence and carrying out projects for the public interest.7

**Queensland jurisdiction**

5.13 In October 2017 the Queensland Parliament passed amendments which introduced a new offence of industrial manslaughter into the *Work Health and Safety Act 2011 (Qld).*8

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6 Law Council of Australia, *Submission 3*, p. 5 (citations omitted).


8 With mirror amendments to the *Electrical Safety Act 2002 (Qld)* and the *Safety in Recreational Water Activities Act 2011 (Qld).*
The amendments were in response to the Best Practice Review of Work Health and Safety Queensland (Best Practice Review) that was undertaken in response to the fatalities at the Dreamworld theme park and Eagle Farm construction site in 2016. The Best Practice Review found that a new offence of industrial manslaughter was appropriate and necessary. It concluded that such an offence would address a gap in the offence framework as it applied to corporations, finding that existing manslaughter provisions in the Queensland Criminal Code do not provide for individual conduct to be imputed to an organisation.

More specifically, the Best Practice Review stated that:

...these provisions extend corporate criminal responsibility to cases where a corporation’s unwritten rules, policies, work practices or conduct tacitly authorise non-compliance, or fail to create a culture of compliance consistent with its responsibilities and duties of care.

Under the amended WHS legislation a company can be prosecuted for the offence of industrial manslaughter. This is in contrast to if an action was taken by the Director of Public Prosecutions (DPP) under the Queensland Criminal Code, where only an individual can be prosecuted for manslaughter.

The Queensland Government submission provided further detail on the rationale for and operation of the offence:

The industrial manslaughter offence applies to both PCBUs [persons conducting a business or undertaking] and senior officers whose conduct negligently causes the death of a worker. This includes conduct that is either an act or an omission to perform an act. The penalties for industrial manslaughter are up to 20 years imprisonment for an individual or a maximum of $10 million for a corporation.

The offence of industrial manslaughter sends a clear message to duty holders about societal expectations on safety in the workplace and that companies, and the senior officers working for them, must do all that they can to ensure the safety of workers at their workplace. This in turn is likely
to increase proactive WHS management and encourage work health and safety to be managed as a cultural priority within businesses.

The introduction of the offence also provides an alternative avenue for recourse where the police decide not to pursue charges under Queensland’s Criminal Code. It also allows sentencing judges to have appropriate scope to deal with the worst examples of corporate or individual behaviour.

To ensure appropriate governance in decision making, prosecution decisions involving the offence of industrial manslaughter are subject to Director of Public Prosecutions approval in the same manner as Category 1 offences under section 31 of the WHS Act and that the Director of Public Prosecutions may take over any prosecutions for industrial manslaughter.14

5.18 Regarding the decision to insert the industrial manslaughter offence into the WHS legislation and not the criminal code, the Queensland Government emphasised that it was a conscious choice with a specific logic behind it. Mr Paul Goldsbrough, Executive Director of WHS Engagement and Policy Services for the Queensland Office of Industrial Relations explained:

...a decision was made to include it [industrial manslaughter offence] in the Work Health and Safety Act in the national model laws. That has been an important point in raising front and centre, quite rightly so for persons with duties, their obligations in relation to the Act. The government was of the view that it makes it very clear that this offence exists and that it is a tool that can be used in the case of particular conduct in the workplace.15

The need for the introduction of industrial manslaughter provisions

5.19 The committee received evidence both for and against the introduction of industrial manslaughter provisions.

5.20 The Department of Jobs and Small Business (the department) stated that the introduction of the offence of industrial manslaughter is ‘unwarranted’ and inconsistent with the ‘philosophy’ of WHS legislation, where culpability is established by unlawful exposure to risk of death, injury or illness, rather than by the final consequences of the exposure.16

5.21 The department explained its position in the following terms:

Introducing industrial manslaughter laws will have negative effects on the relationship between employers and employees on worksites and will diminish the capacity of businesses to implement an improved safety culture. Industrial manslaughter laws could punish employers who are linked to a death — but not necessarily those who have the power to control the circumstances leading to that death. Additionally, a punitive

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14 Queensland Government, Submission 47, p. 11.

15 Mr Paul Goldsbrough, Executive Director, WHS Engagement and Policy Services, Office of Industrial Relations, Queensland, Proof Committee Hansard, 17 July 2018, pp. 56–57.

16 Department of Jobs and Small Business, Submission 49, pp. 8–9.
approach is counterproductive and less effective than encouraging employers and workers to work together – it will be less of a deterrent and more of a punishment.\textsuperscript{17}

5.22 The department further stated that introducing industrial manslaughter laws 'may be a disincentive for people to own and operate a business'.\textsuperscript{18}

5.23 The Law Council stated that it did not support the introduction of specific industrial manslaughter offences in the form set out in the Queensland legislation or the ACT legislation. It opined that the Queensland legislation was inconsistent with traditional criminal law principles, and that the ACT legislation was 'in many ways' inconsistent with the model WHS laws.\textsuperscript{19}

5.24 The Law Council further stated that it:

\begin{quote}
...is not convinced that a specific industrial manslaughter offence needs to be introduced into the Model WHS Laws, given existing criminal law and WHS offences (which already include offences that can give rise to jail sentences for those who recklessly cause death at a workplace).\textsuperscript{20}
\end{quote}

5.25 However, the Law Council went on to say that if industrial manslaughter provisions were to be introduced they should be legislated in a 'consistent manner across the jurisdictions':

The Law Council is of the strong view that no such provisions be introduced other than in a consistent manner across the jurisdictions that have adopted the WHS Model Laws, which would necessarily require a consultation process and agreement from those jurisdictions. Different tests for liability and different penalties have a tendency to produce an inconsistency with a key component of the rule of law: that the law should be applied to all people equally. There is a need for the harmonisation of both WHS and the general criminal law to ensure that like cases are treated alike irrespective of jurisdictional boundaries.\textsuperscript{21}

5.26 The Australian Institute of Company Directors made clear it had several concerns regarding industrial manslaughter offences, including that it led to a misdirected focus on punishing wrongdoing (away from the core objective of WHS laws); that it undermines the efficacy of harmonised WHS laws; and that it would overlap with general law manslaughter offences.\textsuperscript{22}

5.27 The Minerals Council of Australia argued that as data indicates that workplace injuries and fatalities are decreasing in Australia, there is nothing to warrant the imposition of higher penalties, such as industrial manslaughter, in respect

\textsuperscript{17} Department of Jobs and Small Business, \textit{Submission 49}, p. 8.

\textsuperscript{18} Department of Jobs and Small Business, \textit{Submission 49}, p. 8.


\textsuperscript{20} Law Council of Australia, \textit{Submission 3}, p. 2.

\textsuperscript{21} Law Council of Australia, \textit{Submission 3}, p. 2.

\textsuperscript{22} Australian Institute of Company Directors, \textit{Submission 13}, pp. 2–3.
of offences under the model WHS legislation. It also asserted that there was a lack of evidence that a punitive approach would lead to improved WHS outcomes, and maintained that penalties must be part of a broader range of enforcement and compliance mechanisms.\footnote{Minerals Council of Australia, \textit{Submission 16}, pp. 10, 12.}

5.28 Master Builders Australia expressed concern that the introduction of industrial manslaughter offences, such as in Queensland and the ACT, detracted from the harmonised model WHS laws.\footnote{Master Builders Australia, \textit{Submission 20}, p. 18.} The Australian Industry Group also put forward similar concerns, stating that the amendments to the Queensland legislation in regard to industrial manslaughter have 'created a fissure which puts at risk the collaborative approach' of a harmonised system.\footnote{Australian Industry Group, \textit{Submission 19}, p. 9.}

5.29 Master Electricians Australia (MEA) stated that industrial manslaughter 'outside of the criminal code is not appropriate'.\footnote{Master Electricians Australia, \textit{Submission 9}, p. 12.} Specifically, it raised concerns that the model used in Queensland does not contain the controls and protections required to afford natural justice to those facing the industrial manslaughter charge.\footnote{Master Electricians Australia, \textit{Submission 9}, p. 12.} Mr Jason O'Dwyer, Manager of Advisory Services for MEA elaborated on this position:

\begin{quote}
...we do oppose industrial manslaughter existing outside of the Criminal Code when it comes to individuals. Our position is consistent with those of eminent professional law associations. However MEA, after reading the submissions, concede that prosecution of corporate entities may need to be facilitated in the Criminal Code but via a separate piece of legislation... The reason that we've had the position about industrial manslaughter being only in the Criminal Code is that we have concerns about the difference between the Criminal Code and the other pieces of legislation— not only the Criminal Code but a number of other pieces of legislation—that protect all parties in the process of investigating a situation where the maximum penalty is 20 years' imprisonment. It's a very serious situation. People do have the right to natural justice, and people do obviously need to be prosecuted when they do fall short of the law. We believe that the investigation processes and the best people to actually make those decisions is the DPP and the police, and that's why we've got that situation. We are not against industrial manslaughter per se and holding people accountable, but we do see and we do agree with organisations like the Law Council of Australia, the Queensland Law Society and the Bar Association of Queensland in saying that really should be located in the Criminal Code.\footnote{Mr Jason O'Dwyer, Manager, Advisory Services, Master Electricians Australia, \textit{Proof Committee Hansard}, 17 July 2018, p. 34.}
\end{quote}
5.30 Conversely, a number of stakeholders expressed support for the introduction of industrial manslaughter provisions.

5.31 The ACTU argued that a new offence of industrial manslaughter should be included in the model WHS laws, rather than in criminal law. It recommended the adoption of provisions based on the existing Queensland provisions, with the amendment that the offence should include any person killed by the negligence of the PCBU (person conducting a business or undertaking). The Australian Workers’ Union indicated that it supported the ACTU position on this matter.

5.32 The Victorian Trades Hall Council (VTHC) made clear that it supported the introduction of industrial manslaughter on a national scale. Its submission outlined the specific points it recommended on this matter:

VTHC and the Victorian union movement are advocating for legislation which will:

- insert a crime of corporate and industrial manslaughter into the Occupational Health and Safety system;
- adequately punish corporate negligence where the negligence results in the death of a person;
- adequately punish negligent decisions by senior managers in control of a substantial part of the business where that negligence results in the death of a person;
- bind the Crown in its role as an employer;
- provides two exceptions for:
  - emergency services employees operating in good faith; and
  - family run small business where the deceased is a family member of the business owner/operator.

5.33 The VTHC argued that it was imperative that the industrial manslaughter provision be included in WHS legislation, rather than in the criminal code.

5.34 Noting that Victoria has not implemented the model WHS legislation, the VTHC asserted that given WorkSafe Victoria is the expert in proving negligence in the occupational health and safety context, the offence should be inserted into the *Occupational Health and Safety Act 2004* (Vic) (OHS Act). The

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30 Australian Workers’ Union, *Submission 38*, p. 2.
VTHC provided the following table to illustrate why this should be the case in the Victorian context:

**Table 5.1—Why the OHS Act?**

<table>
<thead>
<tr>
<th>Investigation/Prosecution</th>
<th>Pro</th>
<th>Con</th>
</tr>
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<tbody>
<tr>
<td>VicPol [Victoria Police] &amp; DPP</td>
<td>Prosecute manslaughter under the Crimes Act.</td>
<td>No experience in proving negligence in a workplace OHS context. Likely to require assistance from WorkSafe to determine what is and is not negligent in a workplace OHS context.</td>
</tr>
</tbody>
</table>

*Source: Victorian Trades Hall Council, Industrial Manslaughter Policy Brief, 2018, p. 8 (tabled 28 August 2018).*

5.35 The Queensland Council of Unions (QCU) advised that it supports the introduction of the offence into the national model WHS laws, and that the offence is best placed in the WHS framework and not in the criminal code.\(^{34}\)

5.36 The Young Workers Centre also recommended that industrial manslaughter provisions be incorporated into the model WHS laws.\(^{35}\)

5.37 The Construction Forestry Maritime Mining and Energy Union (CFMMEU) argued that financial penalties on their own are not an effective deterrent

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\(^{34}\) Queensland Council of Unions, *Submission 10*, p. 15.

\(^{35}\) Young Workers Centre, *Submission 17*, p. 6.
strategy in ensuring better WHS outcomes in workplaces. Specifically it noted that financial penalties alone:

- do not ensure that offenders restructure their workplace to comply with WHS standards;
- only have an impact upon the financial returns of a corporation and do not impact the motivation and/or behaviour of the responsible managers;
- do not ensure any disciplinary action is ever taken against those who should have been held responsible and accountable;
- do not require management to review their systems of operation so that the offence will not reoccur; and
- can be easily avoided by restructuring the corporate structure or identities, or by moving the organisation’s assets to other corporate entities.\(^{36}\)

5.38 In light of these limitations, the CFMMEU argued that industrial manslaughter laws are needed as an effective deterrent that must ‘pierce the corporate veil’ and hold corporate businesses accountable both morally and legally.\(^{37}\)

5.39 Maurice Blackburn Lawyers (Maurice Blackburn) stated support for the introduction of industrial manslaughter provisions into workplace health and safety legislation across states and territories, based on national agreed benchmarks.\(^{38}\) In justifying this position they supplied the committee with eleven case studies which demonstrated the lack of appropriate punishment meted to employers following a workplace death due to ‘inadequacies in current criminal law pertaining to senior management’.\(^{39}\)

5.40 For example, in the following case study a worker was crushed to death and the company pleaded guilty to breaching its obligations under the Work Health and Safety Act 2011 for failing to ensure its workers were not exposed to risk. The company was ultimately fined $120 000:

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

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

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

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\(^{36}\) Construction Forestry Maritime Mining and Energy Union (CFMMEU), Submission 51, pp. 24–25 (citations omitted).

\(^{37}\) CFMMEU, Submission 51, p. 25.

\(^{38}\) Maurice Blackburn Lawyers, Submission 23, p. 2.

\(^{39}\) Maurice Blackburn Lawyers, Submission 23, pp. 14, 18–23.
The method involved placing a square plastic outrigger pad (dunnage) under the tank to enable the other forklift’s tines to fit under the end of the tank.

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

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

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

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

5.41 In another case study, the worker was killed due to fatal injuries received during an explosion. The company was fined $125,000, a conviction was not recorded and no person is a senior position was held criminally accountable:

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

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

The deceased was survived by a young son.

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

Again:

- This death was preventable,

40 Maurice Blackburn Lawyers, Submission 23, p. 19.
• The penalties are financial only – no person is a senior position has been held criminally accountable for the preventable loss of life
• The deceased’s family, including a young son, will never see the deceased again, and will live in the knowledge that the deceased died a horrible, violent death.41

5.42 Maurice Blackburn also stated that they would favour a coordinated state and territory based approach, rather than a Commonwealth scheme, and that the existing industrial manslaughter legislation in Queensland should be used as a template.42

5.43 Additionally, Maurice Blackburn made the following recommendations as to the drafting of industrial manslaughter provisions:

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

I. Recklessness; and
II. Industrial Manslaughter.

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

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

Maurice Blackburn submits that appropriate penalties for both might be:

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

Whilst community expectations demand serious criminal sanction for both types of conduct referred to above, in our view, the objective gravity of reckless conduct is arguably something greater than the objective gravity of negligent conduct.43

5.44 One of the issues explored during the inquiry was which model of industrial manslaughter offence may be best suited for broader adoption. It was submitted that the Queensland model is superior to the ACT model due to its more contemporary approach.

41 Maurice Blackburn Lawyers, Submission 23, p. 21.
42 Maurice Blackburn Lawyers, Submission 23, p. 2.
5.45 For example, the committee was informed that the ACT has not had any prosecutions under its industrial manslaughter legislation. ACT Work Safety Commissioner Mr Greg Jones provided context around this matter and drew attention to one particular case where the industrial manslaughter provision had not been used due to limitations around the employer-employee nexus:

Our legislation was first introduced—the first in Australia—in 2004. I think that, as a deterrent, it’s been quite effective. The fact that there have been no prosecutions under that—I don’t know the details of some of the very early cases about why that’s not the case. In this particular case, we have charged one party with manslaughter, but that was under our local Crimes Act and not the industrial manslaughter provisions. That’s because the very strong advice that we got from our prosecutor and our own solicitor’s office was that the nexus that our current legislation has between employer and employee didn’t work or wasn’t appropriate in the case that we had. The person that died as a result of that crane toppling over was not an employee of the main PCBU, the principal contractor. We don’t believe, in that case, that the death resulted from the principal contractor’s actions, although we believe there are a number of liabilities, if you like, or breaches, which we have laid charges about. But the immediate cause of death was not the employee’s immediate employer, and that nexus is strong in our industrial manslaughter provisions. My suggestion—and I guess that’s come out in our submission to the committee—is that that should be made easier to administer or to apply. My view is that the Queensland legislation is better drafted in terms of how it can apply.44

5.46 The ACT Government acknowledged that the current ACT provisions for industrial manslaughter are no longer the most contemporary model in existence. As such, it formally suggested that any inclusion of an industrial manslaughter offence into the national harmonised WHS laws be based on the Queensland legislation.45

5.47 Mr Michael Young, Executive Director of Workplace Safety and Industrial Relations for the ACT Government clarified why this recommendation had been made:

One of the primary advantages of the Queensland approach is that it is framed inside the WHS regime. WHS nationally harmonised laws were developed over an extensive period of time and it's been a great deal of effort and resources on understanding and coming to grips with the increasingly complex employment relationships that exist at the moment. They introduced that concept of the PCBU—'persons conducting a business or undertaking'—as a way to overcome some of those definitional limitations that were tied to the concept of 'employer'. The ACT legislated industrial manslaughter legislation that pre-dates that work and is still sort of caught up with those employer-specific relationships. By framing an


45 Ms Rachel Stephen-Smith MLA, Minister for Workplace Safety and Industrial Relations, ACT Government, Proof Committee Hansard, 7 August 2018, p. 43.
offence inside the WHS regime you get the advantage of potentially being able to apply the offence to a wider range of duty holders who owe a safety duty and that potentially would overcome the issue that I think Greg’s just been describing [see paragraph 5.45 of this report].

Committee view

5.48 The committee is of the strong view that there needs to be a nationally consistent industrial manslaughter provision introduced into the model WHS legislation.

5.49 While acknowledging the opposing views, the committee is persuaded by the evidence received during the inquiry illustrating that the current legislative and regulatory framework is inadequate. It is absolutely necessary for corporate entities to be held accountable for their actions, including facing prosecution for industrial manslaughter for the worst examples of corporate or individual behaviour. For those few organisations that wilfully flaunt the existing WHS arrangements and whose negligent actions result in a catastrophic outcome (the death of a worker or a bystander) the committee believes it is entirely warranted that serious consequences flow. This is particularly the case in organisations which are considered to be repeat offenders. These arrangements would also provide a strong and appropriate deterrent across the entire WHS regime.

5.50 The committee notes that the majority of impacted families that participated in the inquiry strongly support the introduction of industrial manslaughter as an offence.

5.51 The committee is of the opinion that the Queensland model of industrial manslaughter is worthy of consideration when drafting amendments for the model WHS legislation.

5.52 The committee is also of the opinion that the provision is best placed in the model WHS legislation, and not in the criminal code.

5.53 The committee is encouraged to see that several state governments have indicated they see the value in industrial manslaughter provisions and are moving in that direction.

Recommendation 13

5.54 The committee recommends that Safe Work Australia work with Commonwealth, State and Territory governments to:

- introduce a nationally consistent industrial manslaughter offence into the model WHS laws, using the Queensland laws as a starting point; and

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46 Mr Michael Young, Executive Director, Workplace Safety and Industrial Relations, ACT Government, *Proof Committee Hansard*, 7 August 2018, p. 47.
• pursue adoption of this amendment in other jurisdictions through the formal harmonisation of WHS laws process.

**Independent statutory office for WHS prosecutions**

5.55 Another issue explored during the inquiry related to the merits of establishing an independent statutory office for WHS prosecutions.

5.56 In October 2017, at the same time as introducing the offence of industrial manslaughter, Queensland established via legislation an independent statutory office for WHS prosecutions.47 This followed a recommendation in the report of the Best Practice Review of Workplace Health and Safety Queensland (Best Practice Review).48 The statutory office will be headed by a WHS prosecutor appointed by the Governor-in-Council for a five year renewable term.49 The WHS Prosecutor will sit outside the DPP and inside the Office of Industrial Relations, and the position is currently under recruitment.50

5.57 Mr Paul Goldsbrough, Executive Director of WHS Engagement and Policy Services for the Office of Industrial Relations explained the rationale behind the creation of the office:

> Under the national model laws, the prosecutions are generally taken by regulators, with the exception of category 1, where there has to be an engagement with the DPP in each jurisdiction, because it can have a jail time associated with it. The Lyons review [Best Practice Review] recommended that there be that separation so that at arm's length of the investigation and the regulator was a decision on prosecution. The government committed to that, and it was put into the work health and safety laws at the same time as industrial manslaughter was introduced.51

5.58 The QCU submitted that the creation of the statutory office was a ‘cogent, legislative response’ to the problem acknowledged in the report of the Best Practice Review that the regulator had been subject to external pressure in respect of the prosecution function.52 The QCU commented that the creation of

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50 Mr Paul Goldsbrough, Executive Director, WHS Engagement and Policy Services, Office of Industrial Relations, Queensland, *Proof Committee Hansard*, 17 July 2018, p. 57.

51 Mr Paul Goldsbrough, Executive Director, WHS Engagement and Policy Services, Office of Industrial Relations, Queensland, *Proof Committee Hansard*, 17 July 2018, p. 57.

the independent office will go some way to restoring public confidence in the enforcement of WHS matters.\(^{53}\)

5.59 On a broader level, the ACTU argued that there must be consistency, clarity and certainty regarding the prosecution policies of WHS regulators. It noted that this could include setting out exactly where responsibility resides for the decision to commence or not commence a prosecution:

> At present there is some uncertainty, at least in relation to criminal prosecutions for workplace fatalities, as to whether the decision ultimately rests with the relevant regulator (acting on advice from the DPP) or whether the views of the DPP are determinative, particularly given that under the Model WHS Act, both the regulator and the Director have standing to commence proceedings (s 230), and in practice in the Commonwealth jurisdiction at least, proceedings are regularly brought in the name of the Director. Families of deceased workers need to know with absolute certainty who is making the prosecution decisions and on what basis.\(^{54}\)

5.60 Section 231 of the model WHS Act currently sets out the procedure to be followed if a prosecution is not brought. It allows for a person to make a written request to the regulator that a prosecution be brought if they consider Category 1 or Category 2 offence has occurred and no prosecution has been brought within a specified time frame. Section 231 also sets out the steps the regulator must take in response, including advising the person in writing about the outcome of the request and any subsequent processes arising from the outcome.\(^{55}\) Section 231 also allows for a review by the DPP of a regulator's decision not to prosecute a Category 1 or Category 2 offence.

**Committee view**

5.61 The committee considers that there is merit in having an independent statutory office to act as a dedicated WHS prosecutor, as was established in Queensland in 2017.

5.62 The committee is of the view that it would be helpful for families if the WHS regulator had to provide a published, written justification when it decides not to proceed with a prosecution, without a person having to write to the regulator within the specified time frame as set out in Section 231 of the model WHS Act.

5.63 Related to this, the committee is also of the opinion that it would be beneficial for families if the WHS regulator, with input from the coroner if necessary, had to provide a published, written justification when a coronial inquest for an industrial death is not conducted.

\(^{53}\) Queensland Council of Unions, *Submission 10*, p. 16.

\(^{54}\) Australian Council of Trade Unions, *Submission 39*, p. 5.

\(^{55}\) *Work Health and Safety Act 2011*, s. 231.
The committee considers that these measures would assist addressing the above concerns set out by the ACTU and build the confidence of employers, employees and families of killed workers in the WHS prosecution system.

The committee is aware that the matter of Section 231 may be addressed in the Safe Work Australia review into the model WHS laws as Comcare explored issues surrounding the procedure if a prosecution is not brought in its submission to the review.\(^{56}\)

### Recommendation 14

5.66 The committee recommends that Safe Work Australia work with Commonwealth, State and Territory governments to:

- amend the model WHS laws to include the establishment of a dedicated WHS prosecutor in each jurisdiction, similar to the model introduced in Queensland; and
- pursue adoption of this amendment in other jurisdictions through the formal harmonisation of WHS laws process.

### Recommendation 15

5.67 The committee recommends that Safe Work Australia work with Commonwealth, State and Territory governments to:

- amend the model WHS laws to provide that a WHS regulator must in all relevant circumstances provide a published, written justification for why it chose not to bring a prosecution following an industrial death; and
- pursue adoption of this amendment in other jurisdictions through the formal harmonisation of WHS laws process.

### Recommendation 16

5.68 The committee recommends that Safe Work Australia work with Commonwealth, State and Territory governments to:

- amend the model WHS laws to provide that a WHS regulator must in all circumstances provide a published, written justification for why a coronial inquest following an industrial death was not conducted; and
- pursue adoption of this amendment in other jurisdictions through the formal harmonisation of WHS laws process.

Union right to prosecute
5.69 The role of unions in bringing WHS prosecutions was another topic discussed during the inquiry.

5.70 Under model WHS laws, only the WHS regulator is able to bring proceedings. However, a request can be made to the regulator (or later the DPP) if a prosecution is not brought for any offences other than Category 1 offences. Individuals and unions are unable to bring prosecution proceedings directly.57

5.71 The ACTU raised concerns about the 'steep decline' in prosecutions under WHS legislations over recent years. It contended that unions should have standing to bring proceedings for offences under the model WHS Act in circumstances where they have a member concerned in the breach in question:

A right for trade unions to commence prosecutions operates as an important supplement to address circumstances in which regulators are unwilling or unable to prosecute contraventions.

A qualified right of private prosecution (i.e. by a person other than a public official) for criminal matters already exists at common law. In the ACTU’s strong submission, it is reasonable, justified and necessary to confer a right of prosecution on workers affected by a breach of the Model Laws and their unions.58

5.72 The CFMMEU advised:

New South Wales is the only jurisdiction to retain access to union prosecutions. However these provisions are restricted to situations where the DPP has declined to bring proceedings. The application of the provision is problematic, not least of all because of the reluctance of the DPP to involve themselves in OHS matters (which means that the requisite referral cannot be made) and because, where penalties are ordered, they are unable to be retained by the prosecuting union (which exacerbates internal resourcing limitations within the unions who may seek to prosecute). Previously, between 1983 and 2011, union secretaries had standing to bring a prosecution under NSW laws and there is no evidence whatsoever that indicates that this ability was abused. To the contrary, all such proceedings were successful.59

5.73 The CFMMEU concluded that the model WHS Act should be amended so that unions have standing to bring proceedings for offences under WHS legislation.60

5.74 The QCU also noted that in Queensland unions are still unable to prosecute for breaches of workplace health and safety legislation. Research and Policy Officer Dr John Martin commented:

57 CFMMEU, Submission 51, p. 22.
59 CFMMEU, Submission 51, p. 22.
60 CFMMEU, Submission 51, p. 22.
We find this incongruous. Unions are able to prosecute an employer for failing to pay meal money when someone works overtime yet are not able to prosecute for breaches of health and safety legislation, which seems inordinate in terms of what unions can and can’t do.\textsuperscript{61}

\textit{Committee view}

5.75 The committee considers that the enforcement of WHS laws would be strengthened by allowing injured workers, their families and their unions to commence proceedings for the imposition of civil penalties where WHS laws are contravened.

\textbf{Recommendation 17}

5.76 The committee recommends that Safe Work Australia work with Commonwealth, State and Territory governments to:

- amend the model WHS laws to provide for unions, injured workers and their families to bring prosecutions; and
- pursue adoption of this amendment in other jurisdictions through the formal harmonisation of WHS laws process.

\textbf{Personal liability of company officers}

5.77 Another matter drawn to the committee’s attention during the inquiry was the personal liability of company officers. The ACTU argued that personal liability under the model WHS laws must be strengthened. Specifically, it contended that the definition of ‘officer’ should be amended so that it captures all senior managers who significantly impact on WHS outcomes:

The Model Act defines ‘officer’ by reference to the definition in s 9 of the \textit{Corporations Act 2001} (Cth). The key criterion is whether the person makes decisions affecting the whole, or a substantial part of, the business or undertaking. The Corporations Act definition is more extensive and detailed than the definition in the pre-harmonised NSW legislation, but in the ACTU’s submission, it is not necessarily more appropriate. This is because elements of the Corporations Act definition focus on management as it relates to the ‘financial affairs’ of a company. While this is clearly appropriate in the context of a legislative regime which imposes a number of financial management obligations on companies, it fails to effectively target senior decision-makers involved in health and safety governance in an organisation. It is of course completely inappropriate for managers who do not significantly influence WHS outcomes to be held personally liable for breaches of the Model Laws, and provisions need to be carefully drafted to ensure that such people are excluded and have a strong and clear defence available in the event that allegations are made.\textsuperscript{62}

\textsuperscript{61} Dr John Martin, Research and Policy Officer, Queensland Council of Unions, \textit{Proof Committee Hansard}, 17 July 2018, p. 27.

5.78 The ACTU cited the case of *Mckie v Al-Hasani and Kenoss Contractors Pty Ltd* to illustrate the inadequacy of the current definition:

In that case, a worker died when his truck connected with powerlines. The court considered whether the project manager was an ‘officer’ within the meaning of the Model Act. The court held that it is the person’s influence over the PCBU as a whole, not just over the particular project, undertaking, function or event relevant to the alleged breach of duty that must be assessed. Indicators such as the following were considered relevant to the question of whether or not the project manager was an ‘officer’ or not:

- Responsibility for hiring and firing employees;
- Capacity to allocate corporate funds;
- Capacity to direct the type of contracts to be pursued by the business;
- Responsibility for signing off on tenders;
- Responsibility for determining corporate structures and setting company policy;
- Attendance at Board meetings;
- Responsibility for compliance with legal obligations.63

5.79 The ACTU submission went on to explain the circumstances of the case which it argued demonstrates that ‘the current definition is excluding the very senior decision-makers whose behavior the Model Laws are seeking to change’:

The project manager was a well-qualified engineer and a senior manager in the company with substantial ability to influence the safety and health of workers and others on the project he managed. He had been personally served with a prohibition notice regarding work near power lines in August 2008 on another project. The court found that the project manager was fully aware of the risks associated with the live overhead power lines above the site he managed but failed to exercise due diligence in respect to safety compliance. Despite this, the court held that there was no evidence of any involvement in the matters listed…above [see paragraph 5.78 of this report], and therefore he had an operational role only and was not an ‘officer’ within the meaning of the Model Act. This decision indicates that the current definition is excluding the very senior decision-makers whose behavior the Model Laws are seeking to change. The purpose of these provisions is to improve WHS outcomes using the incentive of personal criminal liability. However, the exclusion of key decision-makers from the definition of officer seriously undermines this goal. The definition of officer must capture people with a significant level of influence over WHS outcomes; otherwise the purpose of the provision is defeated.64

5.80 The ACTU recommended that the definition of ‘officer’ in the model WHS laws, currently based on the definition in the *Corporations Act 2001*, be reconsidered. It recommended that a definition be based on the definition used in New South Wales prior to the adoption of the harmonised model WHS

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64 Australian Council of Trade Unions, *Submission 39*, p. 22.
laws, or otherwise a new definition created that focuses on the ‘capacity of the person to significantly affect health and safety outcomes’.65

Committee view
5.81 The committee considers there is merit in the definition of ‘officer’ in the model WHS laws being reconsidered to ensure that those individuals clearly engaged in and responsible for WHS decision-making are held properly accountable.

Recommendation 18
5.82 The committee recommends that Safe Work Australia work with Commonwealth, State and Territory governments to:

- amend the model WHS laws to revise the definition of 'officer' to better reflect the capacity of the person to significantly affect health and safety outcomes; and

- pursue adoption of this amendment in other jurisdictions through the formal harmonisation of WHS laws process.

Limitation period for prosecutions
5.83 As discussed in Chapter 4, a lengthy investigation into an industrial death has the potential to exceed the statutory limitation period, meaning that a prosecution would be unable to be brought. Even if an investigation is completed within the limitation period, subsequent coronial inquests can then be a necessarily lengthy process.

5.84 The committee received some evidence on this matter. For example, Mrs Robyn Colson, whose son David was killed in 2007 in Tasmania, advised the committee that by the time the coronial inquest into David’s death was finished, she was informed that the statute of limitation had expired and it was too late for a prosecution to be brought.66

5.85 Section 232 of the model WHS Act deals with the limitation period of prosecution:

232 Limitation period for prosecutions
(1) Proceedings for an offence against this Act may be brought within the latest of the following periods to occur:

(a) within 2 years after the offence first comes to the notice of the regulator;

(b) within 1 year after a coronial report was made or a coronial inquiry or inquest ended, or an official inquiry ended if it appeared from the report or the proceedings at the inquiry or inquest that an offence had been committed against this Act;

65 Australian Council of Trade Unions, Submission 39, p. 21.

66 Mrs Robyn Colson, Submission 29, p. 3.
(c) if a WHS undertaking has been given in relation to the offence, within 6 months after:

(i) the WHS undertaking is contravened; or

(ii) it comes to the notice of the regulator that the WHS undertaking has been contravened; or

(iii) the regulator has agreed under section 221 to the withdrawal of the WHS undertaking.\(^{67}\)

(2) A proceeding for a Category 1 offence may be brought after the end of the applicable limitation period in subsection (1) if fresh evidence relevant to the offence is discovered and the court in which the proceedings are brought is satisfied that the evidence could not reasonably have been discovered within the relevant limitation period.

5.86 The limitation period balances the needs of a duty holder to have proceedings brought and resolved quickly, with the public interest in having a matter thoroughly investigated by the regulator to ensure a sound case is brought.\(^{68}\)

5.87 In a submission to the Safe Work Australia (SWA) review of the model WHS laws, Comcare stated that it considers that section 232 could be amended to allow for a broader extension to the limitation period such as where the DPP provides written authorisation to allow a prosecution to be brought outside of the limitation period.\(^{69}\)

Committee view

5.88 The committee is concerned by evidence it received that indicated that in some circumstances by the time an investigation and inquest into a workplace fatality have been completed, the ability of a jurisdiction to prosecute may have expired.

Recommendation 19

5.89 The committee recommends that section 232 of the model WHS Act be amended to broaden the limitation period for prosecutions of industrial manslaughter.

Adequacy of penalties and the need for sentencing guidelines

5.90 The adequacy of the current financial penalties for contraventions of WHS laws, including the need for sentencing guidelines, was another topic addressed in the inquiry.

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\(^{67}\) Work Health and Safety Act 2011, s. 232.


5.91 Maurice Blackburn submitted that the penalties in WHS regimes across Australia for employers who have been found responsible for serious injury or death are 'manifestly inadequate'.

5.92 It gave the example of Queensland where fines imposed where a worker has been killed at work appear to typically range between $90 000 and $160 000. It asserted that in comparison to a breach of the Food Act 2006 (Qld), where no one is seriously harmed and the result could be a $30 000 fine, the disproportionality was obvious. To combat this the submission recommended:

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

5.93 The Queensland Government made clear that it considers the absence of national sentencing guidelines a significant impediment to achieving national harmonisation of WHS laws. It stated that consistency in court decisions and court awarded penalties is a core tenant of the harmonisation process.

5.94 It also drew attention to the findings of the Best Practice Review of Workplace Health and Safety Queensland:

The Best Practice Review suggested that courts could better exercise their discretion to impose penalties if they could refer to national sentencing guidelines that include guidance on appropriate sentencing ranges that would apply in all jurisdictions. It was suggested that the United Kingdom’s Health and Safety Offences, Corporate Manslaughter and Food Safety and Hygiene Offences Definitive Guideline could be used as a basis for an Australian guide.

5.95 The ACTU recommended that sentencing guidelines should be developed in consultation with stakeholders in order to ensure consistent and appropriate sentencing for serious WHS breaches across jurisdictions. It provided context for this recommendation by highlighting the differences between jurisdictions in terms of sentencing:

The main objects of the sentencing process are specific and general deterrence. Although the prosecution process is similar across jurisdictions, there are substantial differences between jurisdictions in

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70 Maurice Blackburn Lawyers, Submission 23, p. 13.
71 Maurice Blackburn Lawyers, Submission 23, p. 13.
72 Maurice Blackburn Lawyers, Submission 23, p. 13 (citation omitted).
75 Australian Council of Unions, Submission 39, p. 4.
terms of the courts that hear WHS matters, the maximum penalties available and the options available under general sentencing legislation (if any). For example, in New South Wales, the Commonwealth and the ACT, a court may decide to make an order without a conviction, and can dismiss the charge, or discharge the person on condition that the person enter into a good behaviour bond for a term not exceeding two years or enter into an agreement to participate in an intervention program. On the other hand, in Queensland where a court finds the charges to be proved, there is a conviction. The court has, however, a discretion not to record the conviction, and can also impose penalties, including fines and the kinds of non-pecuniary sanctions set out in sections 236 to 241 of the Model Act. Notwithstanding the fact that the court does not record a conviction, the fact that the defendant was ‘convicted’ may be taken into account by subsequent sentencing courts, and by the prosecuting authorities in later proceedings.\(^\text{76}\)

5.96 Additionally, the ACTU provided an example from the United Kingdom (UK) where the Sentencing Council is consulting on proposed new sentencing guidelines for manslaughter offences:

The Sentencing Council is proposing that where an employer has had a long-standing disregard for the safety of employees and is motivated by cost cutting, they can expect a prison sentence of 10 to 18 years should a worker be killed as a result. The Sentencing Council expects that in some gross negligence cases, sentences will increase, for example where a death was caused by an employer’s long-standing and serious disregard for the safety of employees which was motivated by cost-cutting.\(^\text{77}\)

5.97 Voice of Industrial Death (VOID), an advocacy group for families impacted by industrial death, also indicated it was in favour of sentencing guidelines having a place in WHS legislation.\(^\text{78}\)

5.98 The Department of Jobs and Small Business noted that nationally consistent sentencing guidelines (similar to those in the UK) were being considered by the Boland review.\(^\text{79}\)

5.99 In regard to the levels of financial penalties, the ACTU argued that given such monetary penalties are the principal sanction for offences under the model WHS laws, it is essential they are set at appropriate levels. It contended that the penalties as currently set were not an effective enough deterrent for large and profitable companies and moreover did not meet community expectations. The ACTU recommended that consideration be given to increased penalties for larger sized businesses and repeat offenders.\(^\text{80}\)

\(^{76}\) Australian Council of Trade Unions, Submission 39, p. 28.

\(^{77}\) Australian Council of Trade Unions, Submission 39, p. 28.

\(^{78}\) Voice of Industrial Death, Submission 41, p. 41.

\(^{79}\) Department of Jobs and Small Business, Submission 49.1, p. 3.

\(^{80}\) Australian Council of Trade Unions, Submission 39, p. 12.
A number of families informed the committee of their great disappointment and concern with the low level of financial penalties imposed in response to the death of their loved one.

For example, Mr Jon-Paul Bradley, whose brother Gerard was killed alongside a fellow Irish national workmate in Western Australia in 2015, explained:

'It's with regard to my brother Gerard Bradley and also his friend Joe McDermott. On 25 November 2015, they died at the same time as a result of concrete panel that fell from the crane. The concrete panel was being lifted over the top of them. The company have admitted fault. They have been charged. They entered an early guilty plea. We take serious issue with the small amount that they were fined. We feel that this amount doesn't actually change anything. It is a trivial amount. The maximum the amount could have been would have been $400,000. We were told that it is 25 per cent off for an early guilty plea, which is something that we also take issue with. For example, the fine could have been $300,000. Yet in this instance, it was only $160,000. We just ask what more did they need to do in order to get that maximum fine? Even if you have the laws, which we currently think are very, very weak and don't cause any accountability or change, why would you then only charge them half of what they could have actually been charged?'

Mr Mark Murrie, whose son Luke was killed in 2007 in Western Australia, expressed deep concern about the paltry level of fines imposed on the company and directors convicted in his son's case:

'Luke's death was not an accident; it was totally foreseeable. The packs had broken before and had been swept under the carpet. Convicted and fined in a trial, they [the company] wanted community service as their punishment. They had an appeal. You get 28 days to appeal. On the afternoon of the 27th day they lodged their appeal. The guilty conviction was upheld and the fines were cut in half—that's the law; cut the fines in half. What sort of message does that send? There was a second appeal. WorkSafe appealed against the fact the fines were cut in half. With the legal system, they have their appeal and then you've got to sit around and wait to have that handed down. We live 600 kays [kilometres] up the road and we were told at about 2.30 in the afternoon that at nine o'clock the next day they were going to hand down the decision. So we had to pack up and go six hours down the road and get it. With the second appeal, the convictions were still upheld and the fines were put back up to the original ones—$80,000 for the company and $45,000 for each director. We were told at the start of the system that, if they plead guilty, they get a lesser fine. I'm no lawyer, but, when you looked at all the evidence, you could see that they didn't have a leg to stand on. Yet they went through the whole process, the two appeals, and still only got fines of $80,000 for the company and $45,000 for each director. They would have spent more than that on lawyers.'

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81 Mr Jon-Paul Bradley, private capacity, Proof Committee Hansard, 30 August 2018, p. 16.

82 Mr Mark Murrie, private capacity, Proof Committee Hansard, 30 August 2018, p. 19.
Committee view

5.103 The committee is of the opinion that there is merit in developing national sentencing guidelines to ensure consistent and appropriate sentencing for serious WHS breaches across jurisdictions.

5.104 The committee observes that the low level of penalties handed down in the recent past does not meet community expectations about the gravity of workplace fatalities, nor do they effectively deter other organisations from disregarding the safety of workers.

5.105 In light of this, the committee also urges the government to review the levels of monetary penalties in the model WHS legislation and consider whether there should be increased penalties for larger business or offenders who repeatedly breach the laws.

Recommendation 20

5.106 The committee recommends that Safe Work Australia work with Commonwealth, State and Territory governments to:

- develop national sentencing guidelines, with direction from the UK experience, and look to undertake consultation with relevant stakeholders about the matter; and
- review the levels of monetary penalties in the model WHS legislation with consideration to whether there should be increased penalties for larger businesses or repeat offenders.

Directors' insurance against penalties

5.107 Another of the key issues the committee identified, and which is linked to the efficacy of financial penalties, is the availability of insurance for directors against penalties.

5.108 Associate Professor Neil Foster, a specialist in WHS law at the University of Newcastle who provided evidence in a private capacity, informed the committee:

Research shows that the prospect of personal liability for WHS breaches is one of the key 'drivers' for improvement of corporate safety, and the continued unlawful offering by insurance companies of insurance for directors against WHS penalties seriously undermines that incentive. 83

5.109 Associate Professor Foster elaborated on this concept at a public hearing and illustrated the common law principles which make this insurance 'unlawful':

The policy of the common law has for a long time been to regard insurance designed to avoid the payment of a criminal penalty by a person as contrary to public policy, and so contracts of insurance or contracts of indemnity are void if they purport to provide for coverage of a criminal liability.

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83 Associate Professor Neil Foster, Submission 52, p. 1.
penalty. There are a couple of cases, some of which I mentioned in my article, where this principle has been varied—where you’ve got truly strict liability. If somebody could simply, by virtue of their position, be held responsible for a criminal penalty, the law in the past has sometimes allowed insurance to be taken out for that. But that principle does not apply where there’s any degree of fault in the offence that’s committed by the director. In that situation, insurance should not be permitted, and is not permitted according to the common law.

Under our work health and safety legislation, the offences committed by company officers are matters which involve personal fault. You cannot be convicted under section 27 of the Work Health and Safety Act unless you’ve failed to exercise due diligence to ensure that the company has carried out its duties. As a result, insurance against a penalty imposed under section 27 must be void at common law. It’s an unenforceable contract, according to all the principles that have been in place for many years. That’s a view, I’m pleased to say, that was shared after I’d written my paper to the Chief Justice of New South Wales. Chief Justice Bathurst delivered a paper at a conference where he affirmed that that’s his view as well.84

5.110 Associate Professor Foster went on to identify why policies are still offered and why this had such an adverse impact on the WHS of workers:

The problem we have is this: insurance policies against criminal penalties are still being issued by insurance companies, and they are still being paid for by companies on behalf of directors, despite the fact that these insurance policies are void and unenforceable. Why is that the case? It seems that we’re in a situation where the self-interest of the two parties to the contract will support the availability, at least while no-one challenges it, of these contracts. So company officers would like to have insurance, insurance companies would like to provide these things and receive premiums for them, and so long as we’re at a stage where there’s not a significantly serious personal penalty that some insurance company decides are way too big, the insurance companies are going to keep on paying out. The people who are forgotten in that transaction are the workers; this insurance, as it were, insulates the directors of the company from the decisions they make in relation to workers.85

5.111 To resolve this situation, Associate Professor Foster suggested that Parliament needed to intervene:

...one possibility is to change the legislation to spell out very clearly that such arrangements are unlawful. We have a precedent for that in New Zealand; the 2015 New Zealand legislation explicitly says that such contracts are unlawful. We have a provision in the Work Health and Safety Act 2011, section 272, which broadly says that you can’t contract out of your obligations, but it really isn’t specific enough to cover this area. In my view, it would be advisable for parliament and the people who are dealing

84 Associate Professor Neil Foster, private capacity, Proof Committee Hansard, 7 August 2018, p. 26.
85 Associate Professor Neil Foster, private capacity, Proof Committee Hansard, 7 August 2018, pp. 26–27.
with the model legislation to roll out a provision that makes it absolutely clear that such contracts are unenforceable and illegal. I think that that will improve the incentive of officers when they realise that they may be personally liable for fines and that it can’t be covered by insurance arrangements.86

5.112 The ACTU also advised the committee that under the model WHS laws there is no provision expressly prohibiting contracts providing liability insurance against WHS penalties:

Section 272 provides that a term of any agreement or contract that purports to exclude, limit, modify or transfer any duty owed under the [WHS] Act is void. However, it is not clear whether a contract for directors’ and officers’ liability insurance indemnifying for penalties under the Model laws would be a contravention of s 272, and this matter is yet to be considered by the courts. As a matter of practice, corporations are readily able to, and frequently do, insure against WHS penalties. As a consequence, it is predominantly insurance companies rather than duty-holders paying fines following successful prosecutions.87

5.113 Similar to Associate Professor Foster, the ACTU further noted that New Zealand has a legislated measure to solve this problem:

While no Australian jurisdiction currently prohibits contracts providing liability insurance against WHS penalties, s 29 of New Zealand’s Health and Safety at Work Act 2015 provides a precedent. In New Zealand, an insurance policy or a contract of insurance which indemnifies or purports to indemnify a person for the person’s liability to pay a WHS fine or infringement fee is of no effect, and persons seeking to enter into such a contract commit an offence.88

5.114 The ACTU recommended that the model WHS Act be amended to include a new offence prohibiting contracts providing liability insurance against WHS penalties and fines.89 The Electrical Trades Union also recommended this approach.90

5.115 Maurice Blackburn also explored the issue of insurance against penalties in its submission:

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

86 Associate Professor Neil Foster, private capacity, Proof Committee Hansard, 7 August 2018, p. 27.
87 Australian Council of Trade Unions, Submission 39, p. 13.
89 Australian Council of Trade Unions, Submission 39, p. 13.
90 Electrical Trades Union, Submission 37, p. 9.
undermined where an insurer pays a penalty imposed instead of the defendant. This is contrary to good public policy.\footnote{Maurice Blackburn Lawyers, \textit{Submission} 23, pp. 13–14.}

5.116 Maurice Blackburn put forward two suggestions to combat the issue:

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

An alternative to this approach is to simply legislate that it is unlawful to insure against a fine, investigation costs or defence costs where they apply to an alleged breach of safety legislation.\footnote{Maurice Blackburn Lawyers, \textit{Submission} 23, p. 14.}

5.117 The Department of Jobs and Small Business commented that its view was that the model WHS laws should expressly prohibit insurance contracts which indemnify, or purport to indemnify, against penalties imposed for WHS breaches.\footnote{Department of Jobs and Small Business, \textit{Submission} 49.1, p. 4.}

\textit{Committee view}

5.118 The committee finds it utterly reprehensible that insurance policies are available to insure corporations and individual directors against financial penalties handed down for breaches of WHS legislation.

5.119 As numerous submitters identified, to have such policies available significantly undermines the deterrence value of the penalties. Companies that take out this directors and officers insurance show an inexcusable disregard for the consequences of their actions, and the committee finds this behaviour appalling.

5.120 Given that the prospect of personal liability for WHS breaches is one of the core drivers for the improvement of corporate safety, the committee is of the view there is an urgent need for reform to resolve this issue. It is of the strong opinion that the model WHS legislation must be amended to make clear that contracts which purport to offer insurance against criminal penalties are unenforceable and illegal.

Recommendation 21

5.122 The committee recommends that Safe Work Australia work with Commonwealth, State and Territory governments to:

- amend the model WHS laws to make it unlawful to insure against a fine, investigation costs or defence costs where they apply to an alleged breach of WHS legislation; and
- pursue adoption of this amendment in other jurisdictions through the formal harmonisation of WHS laws process.

Phoenix activity

5.123 Another matter the committee received evidence on was the prevalence of companies phoenixing to avoid paying penalty fines for WHS breaches. Phoenixing involves the stripping and transferring assets from one company to another by individuals or entities to avoid paying liabilities.\(^{95}\)

5.124 When asked by the committee whether the ACT Government had a problem with companies simply phoenixing if they have a WHS breach that may involve the possibility of fines, Mr Jones, ACT Work Safety Commissioner responded:

> From a regulatory perspective, absolutely. The idea of responsibility under work, health and safety is that everyone, as we say, from the gate to the boardroom, has a responsibility. If a company is just going to wipe the slate clean and start again, clearly that’s problematic. As a regulator, yes, I absolutely do have a problem with phoenixing. I think it’s a major issue and not just for work, health and safety; it’s the same with other parts of industry—construction, quality—as well.\(^{96}\)

5.125 Although Mr Jones conceded it was not possible for the regulator to do anything about actual phoenix activity, he advised that they did attempt to track some aspect of the behaviour from a WHS perspective:

> One of the factors that feeds into our risk profile that we have for our audit program and who we visit and how often is the intel from our inspectors in the field. If a business that has a poor work health and safety compliance record has folded and they pop up again, our guys will pick it up pretty quickly. The risk profile of the old company will follow the new person, and we will pay particular attention to that. We can do that from our own operational mechanisms.\(^{97}\)

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5.126 The ACTU observed to the committee that in many industries it was far too easy for companies to hide behind the ‘corporate veil’ and phoenix to avoid their liabilities for a WHS offence. It emphasised that there is little point in establishing offences and penalties for WHS breaches if the companies and individuals responsible for the breaches are able to easily evade accountability.98

5.127 An example of such behaviour occurred in 2016 when the company AB Recycling sought to evade $800 000 in criminal penalties by phoenixing; shutting down the company and soon after resurrecting it under another name. The fines had been incurred after AB Recycling was found guilty of serious safety violations that led to the death of worker Mr Steve Bower in 2014.99 An article in the Sydney Morning Herald on the matter included a quote from the then WorkSafe Victoria Executive Director of Health and Safety Ms Marnie Williams:

Their [AB Recycling] attempt to wash their hands of responsibility by shutting down the company once charges were laid, refusing to take part in court proceedings, and starting up a similar company just nine months after their employee died is utterly contemptible.100

5.128 The ACTU argued that the current legal and policy responses, as well as levels of coordination between relevant regulators were not sufficient to stop companies from phoenixing to avoid their legal obligations.101 It recommended the government consider a number of initiatives to strengthen the ability of regulators to enforce WHS laws against companies likely to phoenix, including:

- specific phoenixing offences and penalties;
- bans on being a company director if liability for a serious WHS breach is established by a court;
- personal liability for directors and shareholders where a company becomes insolvent because of a failure to maintain a safe work place; and

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• amendments to ensure penalties administered for safety breaches are enforced through a range of measures (e.g. director identification numbers and government licensing and procurement consequences).102

Committee view
5.129 The committee is concerned by evidence received that indicates the some companies attempt to evade accountability for WHS breaches through phoenixing.

5.130 The committee considers it necessary for stronger measures to be introduced to deal with such illegal activity.

5.131 The committee is aware of the work being done the Phoenix Taskforce, an initiative coordinated by the Australian Taxation Office comprising 32 federal, state and territory government agencies.103

5.132 The committee is also aware that in September 2017 the Commonwealth Government announced a ‘comprehensive package of reforms’ to address illegal phoenix activity, including the introduction of a Director Identification Number.104

5.133 The committee urges the government to implement such reforms as quickly as possible, and encourages the Phoenix Taskforce to focus part of its efforts on addressing phoenix activity specifically aimed at avoiding penalty fines for WHS breaches.

Recommendation 22
5.134 The committee recommends that the Commonwealth Government work to implement its announced reforms to combat phoenixing, such as the Director Identification Number scheme, as swiftly as possible.


Chapter 6
Family support

6.1 As illustrated in Chapter 2 of this report, the human impact of an industrial death is catastrophic and life-long. For the families of those individuals killed at work, the notification of the death of their loved one is just the beginning of a long and harrowing journey which can take many, many years to resolve and cause compounding trauma along the way. Research has shown that for every individual killed at work, there will be typically be 12 to 20 immediate family members, close friends and colleagues who will be affected.¹

6.2 Dr Lynda Matthews, an Associate Professor in the Faculty of Health Sciences at the University of Sydney who has undertaken in-depth research on the impact of industrial deaths on families, painted a compelling picture of the typical challenges families must face in the aftermath of a workplace fatality:

Without doubt, there are many stakeholders that have an interest in the frameworks surrounding the prevention, investigation and prosecution of industrial deaths in Australia but none more than the next of kin and families of the workers who have died at work. They are, without question, the most affected. Families place great value on the formal investigations and prosecutorial activities that follow a death, because they provide an opportunity to gain information about the context of the incident and what and who are responsible for the death. There is a strong desire for measures to be taken to ensure hazards are addressed so that something positive comes from the work tragedy and other families do not have to experience the same grief. They are often disappointed. Community expectations are that the system provides some type of legal justice for the death if it’s not identified as a true accident. In the eyes of many families, justice is rarely done.

Families frequently face significant challenges in navigating the system. It’s a new system. They don’t know. And the procedures tend not to deliver the information, justice and support they initially expect. The processes are not transparent. Families are frustrated by the wait times, timelines and delays that they face in getting information. It can often be up to eight years. The impact of this lengthy process increases the intensity and duration of families’ grief reactions and disrupts their ability to adapt to life without their loved ones.

Mental health problems are far too common and are influenced by the trauma of the death, which is often quite violent, the lack of timely information on matters related to the formal processes, the lengthy investigative and court proceedings, poor quality investigations and court procedures that hampered finding out what happened and why, little

opportunity to provide input to the formal procedures—that is, being completely powerless—poor outcomes, no-one being held accountable, lack of faith in the justice system and lack of good emotional support. This situation is often compounded by ongoing financial stress and strain following, generally, the loss of the main breadwinner, and inadequate workers compensation payments—if, indeed, they are eligible for this support.2

6.3 This chapter turns to matters that affect families in the aftermath of an industrial death, including:

- the notification of death;
- the engagement between work health and safety (WHS) regulators and families during the investigation and prosecution process;
- ways in which WHS regulators can learn from impacted families in order to improve their services; and
- the ongoing support families require to navigate the complexities of the legislative framework, whilst concurrently dealing with immense grief.

Notification of death

6.4 The committee received concerning evidence from impacted families about the manner in which they were notified that their loved one had been killed at work.

6.5 For example, Mrs Janine Brownlee, mother of Jack Brownlee who was one of two men killed by a trench collapse in Victoria in March 2018, described the distressing way her family was notified that Jack had been severely injured in the incident:

It was on social media. The boy’s grandmother was sitting there, seeing it on social media. She could not believe it. She was saying how tragic it was for those poor parents and how bad it was. She didn’t realise it was her grandson in the trench. Jack spent 3½ hours in that trench. They had to get the trench rescue equipment from Warrnambool. They did not even think to ring the Ballarat mine rescue squad, which is three kays [kilometres] away. They didn’t even think to ring. I don’t know what happened that they didn’t even think to ring Ballarat mine. They have trench rescue. They work underground. No-one rang. No-one even rang us. We weren’t at the scene. Lana [the partner of Jack’s co-worker Charlie Howkins who was also killed] worked around the corner. She was at the scene. She was there, but no-one updated her and told her.

Jack had only been working at that company eight weeks. He was there only eight weeks. They had protocols. When Jack first started, he had to fill out a form of emergency contacts. No-one contacted us and told us. I got a message from the manager at 23 past five, saying, ‘Janine, by the time you get this call, you’ll be sitting by Jack’s bedside.’ That’s the message I got

2 Dr Lynda Matthews, Associate Professor, Faculty of Health Sciences, University of Sydney, Proof Committee Hansard, 12 July 2018, p. 8.
left—‘sitting by his bedside’. The boy was fighting for his life. He fought so hard. It's just wrong...

Why didn’t they put Jack on the phone to us? They knew, once they released the boys, they only had a certain chance of survival. Why didn’t they put Jack on? He was there for three hours. He was conscious. Why didn’t they put Jack on the phone to his family so we could at least talk to him and tell him we’d meet him at the hospital? Why didn't they do it? There was no consideration. No-one rang us. They didn't ring any of the families. The three of us sitting here [Janine Brownlee, Dave Brownlee and Lana Cormie]—they never rang any of us to speak to us. It's wrong.³

6.6 Dr Lana Cormie, whose husband Charlie was killed in the same trench collapse, advised the committee that she was not notified in a timely or appropriate manner about the death. As she explained to the committee at a public hearing:

...in my case, I've just seen a helicopter hovering above my work, because my husband was dead underneath it, and no-one bothered to call me.⁴

6.7 Dr Cormie further elaborated on the matter in her written submission:

We were not notified at all.

I found out via a friend that there had been an incident in the area and had to go to the roadblock and stand by the side of the road to await the news that my husband had been killed HOURS earlier.

His workmate [Jack Brownlee], who was fatally injured and died the following day, was still alive and conscious at this time. If his family had been notified then they may have had the opportunity to say goodbye to their dying son and comfort him in his distress.

No workmate, employer, or member of the emergency services contacted either family.⁵

6.8 Ms Ashlea Cunico, whose father Robert was killed in Western Australia in 2018, advised that it took four hours for her family to be notified of the death, when two police officers turned up at her parents’ home.⁶

6.9 Mrs Susan Gallina, whose brother Brian was killed in 2006, emphasised to the committee the importance of notifying the next of kin about a death. She stated that it took a number of hours for her family to be notified of the death and that she heard the news of the incident on the radio prior to knowing it was her brother. She described telling her father that his son had died, and then the agonising wait to be contacted by the authorities:

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⁴ Dr Lana Cormie, private capacity, Proof Committee Hansard, 28 August 2018, p. 37.
⁵ Dr Lana Cormie, Submission 44, p. 5.
⁶ Ms Ashlea Cunico, private capacity, Proof Committee Hansard, 30 August 2018, p. 17.
The process of that day then evolved into me going back into a shopping centre where my dad was shopping, crying, trying to find him and eventually locking eyes with him and telling him the news that my brother was dead. We held onto each other as we walked out, confused, without knowing any of the details. We went home and we waited and nobody contacted us. We knew nothing. We didn’t know where he was. Where was his body? What was happening to him?\footnote{Mrs Susan Gallina, private capacity, \textit{Proof Committee Hansard}, 29 August 2018, p. 4.}

6.10 Dr Matthews drew the committee’s attention to the findings of a 2017 report titled ‘Death at Work: Improving support for families’ (Death at Work report) conducted by researchers at the University of Sydney between 2012 and 2016 on the various consequences of fatal work injuries on surviving families.\footnote{See Lynda R Matthews, Philip Bohle, Michael Quinlan et al, \textit{Death at work: Improving support for families}, July 2017, \url{http://sydney.edu.au/health-sciences/research/workplace-death/improving-support-for-families-final-report.pdf} (accessed 28 September 2018).} The findings indicated that families’ experiences of the formal responses to the death were negatively impacted by a lack of timely and accurate information:

> Increasing use of social media means that the formal notification of the death is sometimes provided after the family has been made aware of the fatality. The legal nature of the next of kin status also resulted in some immediate family members not being provided with information regarding legal decisions being made or about the progress of formalities following the death. Parents and siblings, in particular, found this distressing.\footnote{Dr Lynda Matthews, \textit{Submission 60}, p. 3.}

6.11 The Death at Work report also made several recommendations about how to remedy the problem:

Recommendation 1: In the context of increased use of and immediacy of social media, strategies should be developed to keep families sensitively informed during the time when often lengthy identification processes take place.

Recommendation 2: That workplaces keep a mandatory, up-to-date list of workers’ next of kin and immediate family (particularly parents).

Recommendation 3: That authorities responsible for notifying family about the death ask the next of kin, employers, and co-workers about immediate family members who should be provided with information about the death and ensuing formalities.

Recommendation 4: That policies, protocols and documents be revised to replace “next of kin” with “next of kin and immediate family members” – as determined by enquiries with next of kin, employers, and co-workers.
services) to adhere to when notifying a family that their loved one has been killed or severely injured in an industrial incident.

6.13 The experiences of many families that spoke to the committee clearly indicate that there are severe problems with the way in which this sensitive task is currently carried out. Such inadequacy only serves to compound the trauma for families whose lives are suddenly plunged into tragedy, and the committee finds it wholly unacceptable that this is the case.

Recommendation 23

6.14 The committee recommends that Safe Work Australia engage with WHS regulators and emergency services providers in each jurisdiction to develop clear guidelines for the notification of families of an industrial death, with a focus on timeliness and the manner in which the notification is made.

Engagement between WHS regulators and families

6.15 Dr Matthews highlighted the importance that families place on the formal processes that follow a death and the ways in which their engagement with the regulator can influence their experience of the system.10

6.16 Numerous families informed the committee that they were dissatisfied with the engagement they had with the relevant WHS regulator during the investigation and prosecution process. They advised they felt excluded, isolated and without a voice, which in turn led them to feel extremely frustrated and distressed. They indicated that they felt they were not classed as key stakeholders in the processes and had to push to get information every step of the way.11

6.17 In relation to the investigative process, Dr Matthews observed:

The investigation is something that families can be involved in. Families have a lot of information that currently is not being used, accessed or sourced. When families get two different bits of information, it raises their suspicions about the adequacy of the investigation—the factors that are been looking looked at, cover-ups that might be happening—and the problem is that they’re not able to get any information to quell their concerns. They’re not able to talk with the employer or with the people who were with their loved one at the time of death or the incident, because they’re lawyered up and things shut down, so they’re are excluded from that level of information. They try and talk with the inspectorate or

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10 Dr Lynda Matthews, Associate Professor, Faculty of Health Sciences, University of Sydney, Proof Committee Hansard, 12 July 2018, p. 8.

11 See for example Mrs Lee Garrels, Submission 32, pp. 1–3; Mr Kevin Fuller and Mrs Christine Fuller, private capacity, Proof Committee Hansard, 17 July 2018, p. 14; Mrs Debbie Kennedy, private capacity, Proof Committee Hansard, 17 July 2018, p. 17; Ms Ashlea Cunico, private capacity, Proof Committee Hansard, 30 August 2018, p. 21l; Mr Daniel and Mrs Debra Kennedy, Submission 42, p. 1; Mrs Linda Ralls, Submission 67, pp. 1–4.
regulators, and they tend not to get any information because the investigation’s ongoing. More often than not, it’s the families that have to be constantly reaching out and making contact, rather than the people that are doing the investigating keeping families informed of where they’re up to and what’s happening.\textsuperscript{12}

6.18 Ms Bette Phillips-Campbell, Program Manager for Uniting GriefWork, made a similar comment regarding how families can feel isolated during the legal process:

The bereaved are often forgotten in the legal processes that follow the workplace death. During the legal processes after the death, the families need to have answers to what has happened. WorkSafe do their best to do that, however the legal journey often means that answers may not come until the court case is over and even then some of the questions are not answered. We usually look to the coroner’s report for answers as to what really happened. It is not unusual for families to feel that they are forgotten, as the case can take a long time to be finalised... it can be several years down the track before it is heard in court.\textsuperscript{13}

6.19 Australian Capital Territory (ACT) Work Safety Commissioner Mr Greg Jones informed the committee it was absolutely critical for regulators to be completely open and transparent in order to provide the family with closure on the incident.\textsuperscript{14}

6.20 Mr Jones outlined in detail the interaction his team had with a family in order to illustrate the way this open and transparent engagement can be done:

We have a very open policy with the family. As a good example, it’s almost exactly two years ago that we had the fatality with a crane that tipped over on a hospital construction site. Within a couple of months of our investigation, we engaged with the family, which was based in Sydney. My senior investigators and I went up to Sydney. This was the first engagement that they’d had from anyone following the death of the father of the family. They didn’t know what caused the accident, what happened, what their father was doing at the time or what the results were. We booked a conference room right near their home and we took up all our videos, our drone footage and our diagrams. We spent the whole day with them, going through what happened with the accident, what their father did, who we were looking at at that very early stage and what the scope of our investigation would be. Importantly, we gave them some parameters about the difficulties as a family that they were going to face—firstly, from a time perspective and then, ultimately, when things got to a prosecution stage, which they did, what the defendants were likely to say. We advised

\begin{itemize}
\item \textsuperscript{12} Dr Lynda Matthews, Associate Professor, Faculty of Health Sciences, University of Sydney, \textit{Proof Committee Hansard}, 12 July 2018, p. 9.
\item \textsuperscript{13} Ms Bette Phillips-Campbell, Program Manager, Uniting GriefWork, \textit{Proof Committee Hansard}, 28 August 2018, p. 23.
\item \textsuperscript{14} Mr Greg Jones, ACT Work Safety Commissioner, Access Canberra, ACT Government, \textit{Proof Committee Hansard}, 7 August 2018, p. 46.
\end{itemize}
the family they would probably find it quite offensive in terms of the way they would talk about their father and the role of companies and things like that.

In the course of our 18-month investigation, we visited the family between three and four times. We went up to Sydney, booked the same conference centre and put that on for their convenience. At each stage we gave them a full and completely open and frank disclosure of where we were up to, where it was going, some of the constraints we had come across and some of the positives that we had made to the mobile crane industry back in Canberra as a preventative measure. We offered all the assistance and support in terms of the psychological support. We made suggestions about how they could get their own legal advice in terms of looking after the family from a financial perspective. Not only did we attend on those occasions but my senior inspectors also developed quite an open and robust telephone relationship with them in terms of any question that they had, any concerns or any rumours so that we could give them advice or tell them where to go for further advice.15

6.21 The Queensland Government advised that it had sought to make improvements to the way in which it engaged with families, and that it was an ‘evolutionary process’ to get better.16 In an answer to a question on notice, the Queensland Office of Industrial Relation described the role and duties of its two investigation liaison and support officers (ILSOs) within the coronial unit that interact with families:

The ILSO is responsible for informing the family around the major milestones including initial scene examination and gathering of any physical evidence, progress reports to the coroner on the investigation, completion of the investigation and the report and submission for legal review by Prosecution Services, when a copy of the investigation report has been provided to the coroner, decisions whether to prosecute a duty holder or to conduct no further investigation, the outcome of any prosecution.

The ILSO can inform the family about the mechanics of the investigation including an explanation of the health and safety duties under the legislation; the consequences should the investigation reveal evidence that a duty holder has failed in that duty and that prosecution of any offences must be proven beyond reasonable doubt.

ILSOs are not permitted to disclose evidentiary detail but can provide other information including: who the lead investigative agency is, the number of statements taken and still to be taken, and the seizure of plant and appropriate disclosure of action taken on site.17

16 Mr Paul Goldsbrough, Executive Director, WHS Engagement and Policy Services, Office of Industrial Relations, Queensland, Proof Committee Hansard, 17 July 2018, p. 59.
17 Queensland Government, answers to questions on notice, 17 July 2018 (received 17 August 2018), p. 3.
6.22 A number of families emphasised the importance of transparency and accountability from WHS regulators to help them deal with their grief and process.

6.23 For example, Mrs Kay Catanzariti, whose son Ben was killed in 2012, highlighted the need for open communication from regulators and specialised assistance for families, particularly in navigating the legal process:

Transparency is a key factor in life. You need to be told everything that’s going on. The unknown is what’s scary. With WorkSafe, I put my trust and faith in these regulators, but I have learnt so much over the last six years. Now I don’t trust anyone. I don’t believe anyone. People have failed me. People have promised. People need to follow through with what they have said. You need to be kept up to date with the inquiry on a regular basis—where it’s going, what they’re doing. You need someone to help you explain things. We have to keep a diary. We’re told to keep a diary of who you talk to, how long, what it’s relating to. You need to be kept up to date with the inquiry on a regular basis. You need someone specifically to guide you through the legal process. The coronial inquest alone is a nightmare.\(^{18}\)

6.24 Mr Jon-Paul Bradley, whose brother Gerard was killed in 2015, remarked on the additional difficulties he and his family faced in keeping informed of the investigation process because they were based in Ireland:

What would be ideal would be some sort of government link or to get some sort of resource page set up that gives us information about what we can do. Like you said, we’ve got a lot of international workers in Australia, especially a lot of Irish, and we do know that the other family involved—we’ve become very close to them—feel even more helpless because they are not as good on the internet and they are not as good with email. They feel like they’re completely out of the loop and that they’ve been left behind. It just so happens that I can keep on top of this because my job means I’m on the computer and I can email people. But for someone who can’t keep on top of this information, I feel for them even more so because they have no point of contact. All I have are emails going back and forth between myself and WorkSafe.\(^{19}\)

6.25 Dr Matthews also commented on the need to open up lines of communication for families in order to assist in alleviating their grief:

I guess I would say: put yourself in their shoes. If you are not getting any information about the death of your loved one, if nobody is telling you any information, of course you are going to seek it. To have information means you don’t lie in bed at night and imagine what happened— and that is soul destroying.\(^{20}\)

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\(^{19}\) Mr Jon-Paul Bradley, private capacity, \textit{Proof Committee Hansard}, 30 August 2018, p. 22.

\(^{20}\) Dr Lynda Matthews, Associate Professor, Faculty of Health Sciences, University of Sydney, \textit{Proof Committee Hansard}, 12 July 2018, p. 11.
6.26 The Death at Work report found that most, if not all, jurisdictions had mechanisms in place to provide families with information and assistance to understand the formal processes following an industrial death. However, the study noted that not all families are reached via these mechanisms, and some families did not consider the mechanisms to be effective.21

Committee view
6.27 The committee is of the strong opinion that WHS regulators must reassess and improve their current practices to ensure that impacted families better understand the formal processes that follow an industrial death and are kept better informed as each process progresses.

6.28 The committee is encouraged to see some jurisdictions making improvements in the way they proactively engage with impacted families and urges all jurisdictions to continue to evolve and find 'best practice' methods for this engagement.

6.29 The committee understands that in the aftermath of an industrial death, bereaved families put their faith in the WHS regulators. This trust must be upheld and the committee considers that a more open and transparent flow of communication should assist in this.

6.30 The committee also acknowledges the evidence from families that indicated that they often feel voiceless and forgotten in the aftermath of the death of their loved one. The committee considers there may be value in establishing a forum, separate from the investigative and legal processes, for families to submit and publish impact statements which describe their grief and experiences in their own words.

Recommendation 24
6.31 The committee recommends that Safe Work Australia collaborate with WHS regulators in each jurisdiction to review, improve and formalise their practices to make the investigation processes as transparent as possible to impacted families, including by providing written guidance on the formal stages of the investigation, regular updates on the progress of an investigation, the reasons for decisions and the future direction of the investigation.

21 Dr Lynda Matthews, Submission 60, p. 3.
Recommendation 25
6.32 The committee recommends that Safe Work Australia collaborate with the governments and WHS regulators in each jurisdiction to provide for dedicated liaison officers to supply information to families about the process of investigations, prosecutions and other formal processes following an industrial death.

Recommendation 26
6.33 The committee recommends that Safe Work Australia look to establish a forum for families to submit and publish impact statements in order to give them a voice and outlet for their experiences in the processes that follow an industrial death.

Leaning from the experience of impacted families
6.34 The committee received evidence about the establishment of the Queensland Interim Consultative Committee for Work-related Fatalities and Serious Incidents (consultative committee). The consultative committee was established in August 2017 as part of a Queensland Government election commitment and has a legislative mandate to give advice to the Queensland Government about the information and support needs of persons affected by work-related fatalities and serious incidents.\(^{22}\)

6.35 The consultative committee is made up of individuals from impacted families. It meets quarterly and regularly consults with various stakeholders, including the Office of the State Coroner, the Queensland Ombudsman, the Queensland Office of Industrial Relations, WorkCover Queensland, and the Queensland Department of Justice and Attorney-General.\(^{23}\)

6.36 Members of the consultative committee are not remunerated for the attendance at meetings; however, their travel expenses while undertaking official committee business are met by the Queensland Office of Industrial Relations.\(^{24}\) Consultative committee business can include meetings of the committee, attendance at meetings with ministers, regulators, departmental heads, public service officers or other agencies where the purpose is to advance the primary functions of the committee, and attendance at parliamentary committee hearings related to the primary function of the committee.\(^{25}\)

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\(^{22}\) Consultative Committee for Workplace Fatalities and Serious Incidents, Submission 33, p. 1.

\(^{23}\) Consultative Committee for Workplace Fatalities and Serious Incidents, Submission 33, p. 1.

\(^{24}\) Queensland Government, answers to questions on notice, 17 July 2018 (received 17 August 2018), p. 1.

6.37 The consultative committee aims to:

- provide a centralised, public voice regarding the support services required to assist injured workers, their families, and families affected by workplace death; and
- achieve a consistent response and approach by all government agencies involved in investigating fatal and serious workplace accidents.²⁶

6.38 The consultative committee also undertakes activities to support affected families as they work their way through the various processes that arise after an industrial death. For example, it administers a closed Facebook group where affected families can share their experiences and give each other support.²⁷ Additionally, its webpage collates resource documents which aim to assist family and friends in the aftermath of a death in a Queensland workplace.²⁸

6.39 In its submission to the inquiry the consultative committee outlined several major achievements since its establishment. For example, it identified gaps and prohibitive costs in accessing counselling following a workplace fatality or serious incident and drew attention to inconsistencies with accessing counselling through Medicare. As a result, an existing pilot program run by the Queensland Office of Industrial Relations to fund grief and trauma counselling following workplace fatalities has been extended to include social work support for individuals going through coronial inquests, as well as services following critical incidents.²⁹

6.40 The consultative committee also drew the Queensland Government’s attention to the financial and emotional impact of participating in a coronial inquest and the need for assistance in preparing submissions and victim impact statements. In response, the Queensland Department of Justice and Attorney General funded the Coronial Assistance Legal Service which provides free legal help for bereaved families going through the coronial process.³⁰

6.41 Mr Michael Garrels, interim chair of the consultative committee, whose son Jason was killed at work in 2012, emphasised the merits of such a group. He


²⁷ Mr Michael Garrels, Interim Chair, Interim Consultative Committee for Workplace Fatalities and Serious Incidents, *Proof Committee Hansard*, 17 July 2018, p. 46.


²⁹ Consultative Committee for Workplace Fatalities and Serious Incidents, *Submission 33*, p. 2.

³⁰ Consultative Committee for Workplace Fatalities and Serious Incidents, *Submission 33*, p. 2.
highlighted how the consultative committee gives impacted families the ability to network and submit preventative strategies to government:

It is due to our loved one’s death that we do become experts, no one anywhere, from any regulator or government agency will think about our loved one’s death from so many different angles as we do. In this way our unfortunate expertise can be an asset to any government that wishes to get it right. The ability to network with other affected families is soothing in a mental way that hopefully none of you reading this will ever have to understand.\(^{31}\)

6.42 Mr Paul Goldsbrough, Executive Director of WHS Engagement and Policy Services for the Queensland Office of Industrial Relations advised that the consultative committee had been of great assistance in improving how Queensland agencies engage with families:

One of the things that the [consultative] committee was instrumental with from my end was we suddenly realised that all departments were approaching workplace deaths and their engagement with families differently in Queensland. So, out of that advice, what we were able to do was come to some standardised materials and processes and so on, and that’s been really exciting. We’ve now got a learning situation with the families in terms of how we do things.\(^{32}\)

6.43 The consultative committee argued that the support for impacted families in Queensland had been greatly improved by its establishment, and set out the way in which the improvements could be replicated in other states and territories:

The success and effectiveness of our committee at a state level demonstrates the need to duplicate the establishment of committees in legislation, consisting of people affected by workplace fatalities, illness and serious incidents in each state and territory of Australia. The chair and deputy chair from each state and territory committees would then fill paid positions and meet at a national level to advise the Federal Government on policy and legislation relevant to workplace incidents. This would be a ground-breaking move and would provide a national voice for those who are unable to speak for themselves and are all too quickly forgotten.\(^{33}\)

Committee view

6.44 The committee considers the valuable contribution made by the Queensland Consultative Committee for Work-related Fatalities and Serious Incidents to be instructive for how other jurisdictions can work with impacted families to improve the system.

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31 Mr Michael Garrels, Submission 31, pp. 5–6.

32 Mr Paul Goldsbrough, Executive Director, WHS Engagement and Policy Services, Office of Industrial Relations, Queensland, Proof Committee Hansard, 17 July 2018, p. 59.

33 Consultative Committee for Workplace Fatalities and Serious Incidents, Submission 33, p. 2.
6.45 As Mr Michael Garrels, interim chair of the consultative committee stated, it is up to regulators to utilise the ‘unfortunate expertise’ garnered by the families through tragic circumstances outside of their control, to ensure that the support provided to impacted families is of the best possible quality.

6.46 As a result, the committee sees merit in other jurisdictions establishing parallel consultative committees with a similar mission as the one in Queensland.

Recommendation 27

6.47 The committee recommends that Safe Work Australia work with the WHS regulator in each jurisdiction to establish advisory committees designed to give advice and make recommendations to the relevant minister about the information and support needs of persons who have been affected directly or indirectly by a workplace incident that involves a death, serious injury or serious illness.

Ongoing support

6.48 Impacted families drew the committee’s attention to the ongoing challenges, both emotional and financial, they must face after their loved one is killed at work. Families spoke of the immense difficulties inherent in navigating complex formal processes that follow the death, in addition to dealing with overwhelming grief. Challenges mentioned included:

- dealing with the large amounts of paperwork that follow a death;
- understanding and accessing legal, insurance, superannuation and workers’ compensation entitlements;
- accessing and paying for legal representation through the coronial inquest and prosecution process; and
- accessing and paying for grief and mental health support services in a timely manner.  

6.49 The Death At Work report findings detailed the inadequate emotional and financial support available to grieving families:

Family members expressed concerns about the timing, availability, and outcomes of the emotional support provided by or funded by authorities. They valued the opportunity to receive counselling but those who were able to source and pay for professionals of their choice were more satisfied with the timing and outcomes of counselling than those funded by authorities or employers. Counselling incurred ongoing expense that some

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34 See for example Dr Lana Cormie, Submission 44, p. 6; Mrs Kay Catanzariti, Submission 48, pp. 3–4; Mr Dave and Mrs Janine Brownlee, Submission 30, p. 3; Mr Greg Zapelli, Submission 45, p. 4; Mrs Pam Gurner-Hall, private capacity, Proof Committee Hansard, 29 August 2018, p. 6; Mrs Edith Logan, private capacity, Proof Committee Hansard, 29 August 2018, pp. 14–15; Mr Keith Logan, private capacity, Proof Committee Hansard, 29 August 2018, p. 15; Mrs Susan Gallina, private capacity, Proof Committee Hansard, 29 August 2018, p. 15; Voice of Industrial Death, Submission 41, p. 6; Mrs Robyn Colson, Submission 29, p. 2.
found difficult to meet. Reliance on financial assistance placed a barrier to access once the funded sessions were complete.\textsuperscript{35}

6.50 Voice of Industrial Death (VOID), an advocacy group for impacted families referenced the Death At Work report and emphasised the challenges for families that arise from the processes following a workplace fatality:

It is important the committee recognises that these families often experience procedural difficulties well removed from the normal peripheries of grief. That is, the various levels of systems and controls may work to impede the normal grieving process. We utilised the excellent study conducted by a team of respected researchers at the University of Sydney headed up by Associate Professor Dr Lynda Matthews.

The importance of independent support cannot be overstated here. Getting support to families at the earliest opportunity is paramount to helping them in being better prepared and clearer on their rights as well as providing emotional support.\textsuperscript{36}

6.51 The committee was told of the work being done in Victoria by Uniting GriefWork (GriefWork), which for the past 20 years has run a harm-reduction program providing grief support services to bereaved individuals following the death of a loved one in a work-related incident. GriefWork is partly funded by WorkSafe Victoria and the services to clients are free and available anywhere in Victoria. GriefWork currently has approximately 55 clients, with a breakdown of the cohort as follows:

- approximately 75 per cent female (i.e. spouses, siblings, parents and some with young children);
- approximately half of clients are in regional and rural areas;
- referred primarily following deaths in the construction trades, farming, transport, and manufacturing sectors;
- causes of death include fatal injury from construction trades work, farm work, work-related truck crashes, work-related suicide and death following fatal occupational diseases (asbestos exposure but also heart disease and industrial cancers);
- acute grief may be experienced for up to six months; clients are usually in the program for two years, but some for more years depending on their needs and complications from intergenerational grief.\textsuperscript{37}

6.52 GriefWork put forward a summary of the core benefits the program provided clients, which included:

- reduced isolation, particularly in rural and regional areas;
- reduced risk of physical and mental harm;

\textsuperscript{35} Dr Lynda Matthews, Submission 60, p. 5.

\textsuperscript{36} Voice of Industrial Death, Submission 41.1, p. 2.

\textsuperscript{37} Uniting GriefWork, Submission 55, p. 4.
• connection and coordination with other services;
• connection with peer support networks and social groups; and
• assistance with accessing legal processes and death compensation processes.38

6.53 Mrs Janine Brownlee, whose son Jack was killed in Victoria in 2018, detailed the mental health difficulties she and her family faced after Jack's death:

They say it gets better as it gets along, but it’s actually getting worse. The longest Jack was ever away from us up until the incident was 10 days. As the days were getting on, you thought he was on a holiday, and then you start thinking: 'Come on, Jack, you should be coming home now. You should be coming home.' You’re all numb. Then, after a couple of weeks, reality hits. By God, when it hits you and you know your loved ones aren’t coming home, that’s when your mental health issues come. You can’t think. You hear a car horn and you just jump through the roof.39

6.54 She also detailed the difficulties they had in accessing mental health support:

It took us eight weeks to get a work number so we could get a psychologist. It was eight weeks before we could get support. We tried to get private support but we're on a waiting list. It was eight weeks before I could get a psychologist that dealt in grief. And it was eight weeks before we got a number. It was UnitingCare that gave us support in our grief. We’re so thankful that we have them. They do an amazing job. Without them, we’d be really lost. They are our biggest support.40

6.55 Dr Cormie also spoke of the value of GriefWork, which the Construction Forestry Maritime Mining and Energy Union (CFMMEU) connected her with:

The people who came through to help all of us weren't from a workplace or government organisation. It was a union, of which neither of our men were members. Through them, it was GriefWork. If it hadn’t been for them, God knows where we'd be at. And you just keep getting retraumatised by everything you have to do.41

6.56 Ms Phillips-Campbell from GriefWork noted that grief was not an illness, but it could become one if appropriate support was not available early. She mentioned that GriefWork had observed that the families that find their services a year or more after the traumatic death tended to struggle more, with conditions such as chronic fatigue, fibromyalgia and Post Traumatic Stress Disorder and suicide more prevalent among this group.42 GriefWork also

38 Uniting GriefWork, Submission 55, pp. 4–5.
40 Mrs Janine Brownlee, private capacity, Proof Committee Hansard, 28 August 2018, p. 38.
41 Dr Lana Cormie, private capacity, Proof Committee Hansard, 28 August 2018, p. 38.
42 Ms Bette Phillips-Campbell, Program Manager, Uniting GriefWork, Proof Committee Hansard, 28 August 2018, p. 23.
advised the committee that accessing mental health assistance in rural and regional Victoria could be difficult.43

6.57 Dr Cormie also highlighted this latter point:

Just in relation to a support person and accessing psychology, we're in a regional area and, although it is a well-resourced regional area, we have trouble accessing these services. I have a daughter who is screaming at night: 'I want my daddy. I want my daddy.' You think you're doing okay with coping with this and then all of a sudden you think: 'I can't do this anymore. I need some help. I don't know how to help her.' How long do you have to wait to see a child psychologist that knows anything about grief and trauma? Three months.44

6.58 GriefWork advised that other jurisdictions in Australia do not offer similar services and argued that the Victorian program should be adopted nationally.45

Committee view
6.59 Guided by the insights shared by impacted families and the findings of the University of Sydney Death at Work report, the committee is recommending a number of measures designed to improve families’ experience of the formal processes that follow an industrial death.

6.60 The committee is mindful that for impacted families navigating the myriad of formal processes following an industrial death in addition to dealing with their grief, the experience is overwhelming and can often lead to further trauma.

6.61 The committee hopes that if implemented, these measures will go some way to alleviating this distress.

Recommendation 28
6.62 The committee recommends that Safe Work Australia work with the WHS regulator in each jurisdiction to identify and formalise family outreach mechanisms to ensure that all impacted families receive information about the formal processes that follow an industrial death and the associated support that is available to them.


44 Dr Lana Cormie, private capacity, Proof Committee Hansard, 28 August 2018, p. 37.

45 Uniting GriefWork, Submission 55, p. 4; Ms Bette Phillips-Campbell, Program Manager, Uniting GriefWork, Proof Committee Hansard, 28 August 2018, p. 24.
Recommendation 29

6.63 The committee recommends that Safe Work Australia work with the WHS regulator in each jurisdiction to create and maintain a centralised web portal which links to all relevant resources that impacted families may need in the aftermath of an industrial death.

Recommendation 30

6.64 The committee recommends that Safe Work Australia work with the WHS regulator in each jurisdiction to fund a support group or service that is experienced in working with people bereaved by a fatal workplace incident to support impacted families through all formal processes following an industrial death.

Recommendation 31

6.65 The committee recommends that Safe Work Australia work with the WHS regulator in each jurisdiction to make funding available for impacted families to access a range of mental health and counselling support options, including in rural and regional areas.

Recommendation 32

6.66 The committee recommends that Safe Work Australia collaborate with the WHS regulator in each jurisdiction to develop an initiative (similar to the Coronial Legal Assistance Service in operation in Queensland) to provide for pro bono legal assistance to families during coronial inquests.

Recommendation 33

6.67 The committee recommends that Safe Work Australia work with the WHS regulator in each jurisdiction to ensure that all staff with access to impacted families have adequate training in working with grieving family members.
Recommendation 34

6.68 The committee recommends that Safe Work Australia collaborate with each jurisdiction to review the adequacy of workers’ compensation legislation with regard to all work related deaths.

Senator Gavin Marshall
Chair

Senator Catryna Bilyk
Member

Senator Deborah O’Neill
Member

Senator Mehreen Faruqi
Member
Coalition Senators' Additional Comments

Introduction
1.1 Coalition Senators are supportive of a wide range of recommendations in the majority report.

1.2 The health and safety of workers is of utmost importance to the Australian Government, particularly the prevention of serious injuries and deaths in Australian workplaces. It is the fundamental aim of Australian safety laws and associated frameworks to ensure workers come home safely after every day at work.

1.3 Workplace related injury and illness carry significant tangible costs to the community, individuals, families and workplaces. Coalition Senators know the real cost of a workplace death is immeasurable and tragic.

1.4 This inquiry has taken into consideration extensive evidence from a wide range of sources and witnesses, including those who have lost loved ones. Coalition Senators have listened carefully to the evidence given by the family members, colleagues, and friends of those who have died and thank them for their courage and resolve in sharing their stories and experiences. Their willingness to share very painful experiences has been critical in helping our understanding of the importance of support for victims’ families.

1.5 A diverse range of views and approaches were presented regarding the adequacy of current frameworks surrounding the prevention, investigation and prosecution of industrial deaths in Australia.

1.6 Coalition Senators acknowledge the release of the report and related findings as an important step. While we support many of the recommendations, we also believe that several recommendations are not the most effective policy responses in achieving the best possible health and safety outcomes for every workplace across the country.

1.7 The majority report also downplays the importance and effectiveness of harmonised laws already in place across most jurisdictions in Australia and the risk of further fracturing those laws when improved harmonisation is the goal.

Historical Background
1.8 Safety law commenced with various forms of industry, factory or jurisdiction specific compensation law. These laws were designed, in the main, to compensate workers in the event they were injured in a workplace or travelling to and from a workplace. It was compulsory for employers to ensure they had such insurance so as to provide cover and compensation to workers in the event they suffered a loss arising from a workplace injury.
1.9 Early iterations of such law tended to centre on what happened after an injury or death had occurred, rather than focus on the prevention of such injury or death in the first place. Community attitudes and safety law evolved rapidly delivering many improvements. The community rightly expects that those going to work will return every night and have embraced the contemporary focus on identifying risk and preventing serious injury and fatalities before they occur.

1.10 Modern safety law, both domestically and internationally, has improved markedly to now place priority on identifying and eliminating risk in the workplace and stopping serious injury and death before it happens – as opposed to a focus on what should happen once an injury or death has taken place. Put simply – it is better to focus on stopping injury and death in the first place – rather than focus on what to do after an injury or death has happened.

1.11 The Committee did explore in great detail matters and evidence that did adopt the contemporary focus of 'prevention'. Coalition Senators, in particular, adopted this approach while noting that many witnesses gave evidence that, in summary, looked at how the existing law and framework could be used in a more effective way to prevent serious injury or death.

Comments on Recommendations in Majority Report

1.12 Coalition Senators are supportive of a wide range of recommendations in the majority report.

1.13 Many of the recommendations are designed to improve the experience of families that have lost loved ones, including by improving communications, investigation processes, the capability of investigators, the transparency of processes, increased cooperation between agencies, improved timelines and better support.

1.14 There are some recommendations we support in part and others that we are not able to support.

Recommendation 1

1.15 We understand Safe Work Australia is currently investigating options to supplement its current data sets with other available data sources in relation to the incidence of occupational lung disease in Australia. Safe Work Australia currently maintains the Traumatic Injury Fatalities (TIF) data set as a measure of workplace fatalities. We understand it would not be appropriate for the TIF data set to capture data on death resulting from occupational disease because it is intended to only capture those who are fatally injured at work.

1.16 Safe Work Australia advised the Committee that there are some challenges compiling and reporting occupational disease statistics. The long latency periods of many of these diseases and the impact of multiple contributing risk factors in many cases, means linking occupational exposures to a diagnosis can
be challenging. The scope and the sources of data for such a register would be complex and would require the involvement of health agencies given the broader health aspects of occupational diseases.

1.17 We understand Safe Work Australia currently supplements its data with other relevant data sources, including for example:

- the Australia Bureau of Statistics’ Work-related Injuries Survey (which Safe Work Australia partly funds)
- the various Australian Institute of Health and Welfare data sets, and
- the Australian Mesothelioma Registry (which is funded by Safe Work Australia).

1.18 These data sources are utilised and incorporated into statistical and research reports produced by Safe Work Australia, and are used to inform its policy work. Safe Work Australia also undertakes and supports research into various work health and safety issues, including occupational diseases and exposures, and utilises expert research done in this area here in Australia and overseas.

Recommendation 2

1.19 We consider it would be appropriate for Safe Work Australia to maintain a public list of amendments that jurisdictions make to the model WHS laws, as one of Safe Work Australia’s primary functions is to develop, evaluate and revise, if necessary the model WHS laws.

1.20 We understand Safe Work Australia would need the agreement of all jurisdictions to provide this information and then collate and publish it centrally on the Safe Work Australia website.

Recommendation 3, paragraph 3.32

1.21 We understand that a national WHS prosecutions database that would capture this kind of information is already being developed through Safe Work Australia’s tripartite process. Again, Safe Work Australia would need the agreement of all jurisdictions to provide this information and then collate and publish it centrally on the Safe Work Australia website.

Recommendation 3, paragraph 3.33 and 3.34

1.22 The Australian Government is already using its purchasing power to improve work health and safety in the construction industry in several ways, including:

- through the Federal Safety Commissioner and the Australian Government Building and Construction WHS Accreditation Scheme which sets best practice standards on Commonwealth funded building projects. Companies accredited under the scheme as head contractors have better safety records; and
- through the Building Code 2016 which:
- requires companies to comply with work health and safety laws, including work health and safety training requirements and asbestos safety requirements (ss. 9(3)) and facilitate right of entry for work health and safety purposes (s. 14); and
- allows the Minister to impose an exclusion sanction where the company has failed to comply with work health and safety laws (s. 18).

1.23 At any one point in time, there are approximately $50 billion worth of contracts subject to these requirements. We suggest that other jurisdictions should consider a similar approach.

Recommendation 4

1.24 We understand the terms of reference of the 2018 Review of the model WHS laws that is being conducted by Ms Marie Boland (the Boland review) focus on the model WHS laws and the National Compliance and Enforcement Policy (NCEP). Ms Boland could consider those recommendations that relate to the model WHS laws and that might be relevant to the NCEP, but a number of the recommendations would be outside of the scope (for example, Recommendation 11).

Recommendation 5

1.25 In 2009, the panel conducting the National Review into Model Occupational Health and Safety Laws (the National Review), as part of making recommendations on the content and structure of the model WHS Laws, examined the nature and organisation of work in Australia. In this respect the model WHS laws were drafted with the various types of working arrangements in mind, including labour hire.

1.26 The WHS laws already require labour hire agencies and host employers to do what is reasonably practicable to ensure the health and safety of on hire workers.

1.27 Labour hire agencies and host employers both have responsibilities for the safety of hire workers:

- Host organisations have a clear duty to ensure the health and safety of all workers while at work, so far as is reasonably practicable. This includes making sure that temporary and labour hire workers are given necessary training and instruction so they can carry out their work safely.
- Labour hire agencies are also obligated to ensure the health and safety of workers during their placement with host organisations.

1.28 Labour hire workers have a duty to take reasonable care for their own health and safety and that of others.

1.29 Labour hire agencies and host organisations are also expressly required to consult, cooperate and coordinate activities with all other persons who have a health and safety duty in relation to the same matter.
Coalition Senators do not believe there is evidence to demonstrate that the use of temporary and labour hire workers has increased or that labour hire contributes to an increase in safety risk level or a greater likelihood of serious injury or fatality.

Evidence provided by Safe Work Australia, for example, demonstrates that safety outcomes in Australian workplaces have improved steadily over the last decade in all sectors of the economy. Rates of serious injury and fatalities have declined consistently throughout that period, particularly in sectors which are conventionally associated with being ‘high risk’.

In addition, no witness appearing before the Committee provided any factual evidence or data to demonstrate that the use of temporary or labour hire engagement was in and of itself a risk to workers so engaged.

The only conclusion to be drawn from the evidence is that even if there has been an increase in the use of temporary and labour hire workers, this has not affected the consistently downwards trend in fatality and serious injury rates about which witnesses commonly agreed and acknowledged.

Recommendations 9 and 11

The model WHS Act already includes provisions that allow for the sharing of information by WHS regulators in certain circumstances. Consistent with the object of recommendation 11, Safe Work Australia could first be asked to consider whether the existing provisions are sufficient; and if not, whether amendments are required.

We understand that the Boland review is considering these issues. Consistent with Recommendation 4, Safe Work Australia could consider this recommendation once Ms Boland has provided her report.

Recommendation 13

This recommendation is not supported. The introduction of industrial manslaughter laws would not take account of the serious, criminal sanctions already in place for workplace fatalities in the model Work Health Safety (WHS) laws and in general criminal laws.

It introduces potentially overlapping offences and are likely to complicate rather than support accountability, with no clear evidence of successfully reducing the risk of workplace fatalities.

Additionally, it promotes an adversarial legal approach based on a blame culture. It is punitive rather than preventative, which can ultimately distract from the core object of work health and safety laws in Australia. It is better to focus on the processes in preventing injury and death in the first place – rather than focus on the punishment and what to do after an injury or death has happened.
1.39 To introduce industrial manslaughter laws undermines the efficacy of existing harmonised work health and safety laws across Australia.

1.40 It is important not to adopt proposals that could result in poorer outcomes for Australian workers.

1.41 In addition, we are concerned that that industrial manslaughter laws would expose employers and managers to the risk lengthy prison terms even where they are unjustly accused of being responsible for incidents in the workplace.

1.42 For example, if an employer has the right policies and processes in place, yet these are not followed by a person who fails to wear protective clothing, works under the influence of alcohol or fails to take breaks, the employer should not face criminal conviction and jail time.

1.43 Industrial manslaughter laws would possibly have the opposite effect to what is intended – making companies and managers less likely to disclose and address risks.

1.44 A number of submitters have suggested to the Inquiry that no one has gone to jail for a workplace death. It is our understanding that in the last three years, two people have been sentenced to jail for workplace deaths under the general criminal law. We understand the following custodial sentences have been imposed in relation to workplace fatalities:

- 7 years for manslaughter and perjury (2018) (Queensland).
- 10 years and 6 months for manslaughter (2015) (following a retrial after an appeal of the original 12 year jail sentence) (South Australia).

1.45 In addition, significant financial penalties have been recently imposed by courts under the model WHS laws in relation to workplace fatalities. These include a fine of $900 000 for a lime products company and $405 000 building contractor, both in NSW.

1.46 Coalition Senators believe a balanced regulatory approach is the key to achieving safer workplaces, evidenced by the continued decrease in workplace fatalities along with serious injury claims in the country.

1.47 The current model WHS laws have helped achieve a significant reduction in the number and rate of workplace fatalities. Workplace fatalities have reduced by 48 per cent from 310 in 2007 to 190 in 2017. The rate of workplace fatalities has halved, from 3 fatalities per 100 000 workers in 2007 to 1.5 per 100 000 workers in 2016.

1.48 We believe the focus on holding companies and managers accountable for breaches in their WHS duties regardless of outcome, as is inherent in the existing model laws, is the appropriate approach to continue to drive a reduction in fatalities and injuries in the workplace.
Recommendation 15
1.49 We understand that where a person requests under s 231 of the model WHS Act that a prosecution for a Category 1 or 2 offence be brought by a regulator, s 231 already requires that the regulator advise the person within 3 months of what has happened, or is going to happen, and if there is to be no prosecution, the reasons why.

1.50 Safe Work Australia could be asked to consider whether this obligation should be extended and if so, whether amendments to the model WHS laws are necessary. Safe Work Australia could do this taking into account any relevant findings of the Boland review.

1.51 Further, we note that it is not within Safe Work Australia’s functions to pursue jurisdictions to implement amendments to the model WHS laws.

Recommendation 16
1.52 We understand that Safe Work Australia has no function in relation to coronial inquests. The functions and powers of coroners are covered under separate jurisdictional legislation.

1.53 There is no evidence before the Committee justifying an industrial death to be treated differently by a coroner to any other death.

Recommendation 17
1.54 This recommendation is not supported.

1.55 The National Review into Model Occupational Health and Safety Laws 2008 gave careful consideration to which parties should be able to bring prosecutions under the model WHS laws. The Second Report to the Workplace Relations Ministers’ Council found private prosecution to be problematic. For example, it can be seen as compromising the objectivity, credibility and effectiveness of enforcement. Further, it has serious practical difficulties. For example, a private prosecution will not be able to be brought with the same resources and capacity available to a regulator or Director of Public Prosecutions e.g., in relation to conducting proceedings or evidence collection.

1.56 These matters remain crucial to this issue. There is no evidence before the Committee justifying a departure from the current approach in the model WHS laws.

1.57 Further, we understand that it is not within Safe Work Australia’s functions to pursue jurisdictions to implement amendments to the model WHS laws.

Recommendation 18
1.58 The National Review into Model Occupational Health and Safety Laws 2008 also gave careful consideration to the definition of officer for the purpose of the model WHS laws. The definition was deliberately drafted to capture the
appropriate type of person to be required to exercise due diligence within the model WHS laws framework.

1.59 Again, we understand that it is not within Safe Work Australia’s functions to pursue jurisdictions to implement amendments to the model WHS laws.

Recommendation 19

1.60 It became clear during the inquiry that there are differing views on how section 232 of the model WHS Act operates and whether it is meeting its intended purpose. Safe Work Australia could first be asked to consider whether the existing provisions are sufficient, and working as intended, and if not, whether amendments are required. Safe Work Australia could do this taking into account any relevant findings of the Boland review.

Recommendation 20

1.61 We understand that the Boland review is considering these issues. Consistent with Recommendation 4, Safe Work Australia could consider this recommendation once Ms Boland has provided her report.

1.62 Again, we understand that it is not within Safe Work Australia’s functions to pursue jurisdictions to implement amendments to the model WHS laws.

Recommendations 23–33

1.63 It has been clear through Inquiry that there is the opportunity to significantly improve the treatment of families who are affected by the tragedy of workplace fatalities. A number of the proposals outlined in Recommendations 23–33 would clearly assist in improving the communication, support, involvement and care for families affected by traumatic loss of a loved one. To ensure that the relevant recommendations are taken forward effectively it is important to ensure they are dealt with by the agencies and authorities that are most appropriate to do so.

1.64 We are concerned that a number of recommendations may not properly take into account the role of Safe Work Australia and the purpose for which it was established.

1.65 The role of Safe Work Australia is to drive national policy in work health and safety and workers’ compensation. However, it is not responsible for whether jurisdictions act in accordance with it, e.g., whether a state implements the model WHS laws. Primarily, Safe Work Australia is a policy agency responsible for improving outcomes in national work health and safety and workers’ compensation. It is not a regulator and has no oversight role in relation to the jurisdictional WHS and workers’ compensation regulators.

1.66 WHS and workers’ compensation regulators have established Heads of Workplace Safety Authorities (HWSA) and Heads of Workers’ Compensation Authorities to co-operatively deal with matters that are within the remit of the
jurisdictional regulators, including operational and regulatory matters. It may be more appropriate for Recommendations 7 and 23–33 to be directed to HWSA, who could take into account each unique jurisdiction and its criminal legal system.

1.67 However, Safe Work Australia is responsible for the development of the NCEP and it could consider the recommendations of the Committee when next reviewing that Policy, particularly, in relation to working with stakeholders to develop content on investigation practices, including where there is a workplace fatality, to be adopted by WHS regulators as part of the NCEP, as proposed in Recommendation 24.

1.68 Consideration could also be given by jurisdictions to whether and how the systems they already have in place to support victims and persons affected by criminal offences could be extended, or further extended, to victims and persons affected by WHS offences.

Recommendation 34

1.69 Safe Work Australia has a function to develop proposals to improve workers’ compensation arrangements and to promote national consistency in such arrangements. It is not appropriate for Safe Work Australia to collaborate with each jurisdiction to review the adequacy of workers’ compensation legislation with regard to industrial deaths. Each jurisdiction has its own requirements in relation to review of its legislative framework.

1.70 Safe Work Australia has previously considered a national approach for death entitlement benefits. Safe Work Australia could re-consider this matter, and consistency of procedural arrangements for accessing those benefits.

Further Government considerations and suggestions

Independent Commonwealth Review into Jurisdictions

1.71 If not otherwise canvassed in the Boland Report, the Commonwealth should commission a review to examine and identify the extent to which jurisdictions are diverging from the model WHS framework and recommend strategies for the Commonwealth Government to pursue in arresting such divergence.

1.72 A further related issue arose during hearings in which witnesses observed a predisposition of some jurisdictions to include WHS or safety requirements within types of regulation that are focussed on matters aside from safety or WHS.

1.73 Coalition Senators suggest there is merit in this approach.
Recommendation 1

1.74 In the event it is not otherwise canvassed in the Boland Report, the Commonwealth should commission a review to examine and identify the extent to which jurisdictions are diverging from the model WHS framework and recommend strategies for the Commonwealth Government to pursue in arresting such divergence.

Work Health Safety Framework

1.75 The Committee heard evidence about cross-jurisdictional investigations from several witnesses. While it is clear that regulators make every effort to cooperate in such circumstances, the evidence suggested that when they do arise, there are frequently problems which are the cause of delay and uncertainty amongst all affected.

1.76 Coalition Senators are aware of endeavours to avoid such circumstances, including the NCEP. This policy exists exactly to minimise the prospect of delay and frustration when approaching cross-border matters.

1.77 The NCEP states that to fully realise the benefits of harmonised WHS laws, the States/Territories have recognised the need for harmonisation to be complemented by a nationally consistent approach to compliance and enforcement. The policy sets out the principles endorsed by the Workplace Relations Ministers’ Council that underpin the approach Regulators will take to monitoring and enforcing compliance with the WHS Act and Regulations.

1.78 Coalition Senators believe it would be appropriate for this Policy to be re-examined to ensure currency in light of the evidence heard before this Committee.

Recommendation 2

1.79 The National Compliance and Enforcement Policy should be reviewed and reconfirmed by the States and Territories to facilitate greater cooperation between regulators across the jurisdictions and expedite workplace investigations.

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

1.81 The role of employers, employees and worker representatives is important in creating a safe work culture in workplaces. Coalition Senators accept that everyone in a workplace has a role to play in ensuring work is undertaken safely, risks are identified and hazards are controlled and minimised. This approach is a fundamental part of international WHS frameworks and is based on the Robens principles, which acknowledge effective safety outcomes can only be realised once responsibility for safety is shared amongst all workplace participants.

1.82 Regrettably, the Committee heard evidence that showed instances where unions have acted in a manner which is inconsistent with the Robens
approach, or which undermined the importance of safety in workplaces. In most of these examples, safety was used as a tool to leverage or advance matters that were usually part of an unrelated industrial campaign or similar negotiation strategy.

1.83 Coalition Senators were unsurprised to hear that the bulk of such evidence arose in the building and construction industry and involved conduct displayed by the Construction Forestry Maritime Mining and Energy Union (CFMMEU).

1.84 Whilst there are numerous examples in court judgements, the point is summarised here:

This conclusion…is only further supported by the fact that after 17 March 2015, when agreement had been reached with the CFMEU there was no later inspection of the Site by the CFMEU. The expressed concerns as to safety which had warranted such peremptory and immediate access being granted to the premises on the morning of 11 March 2015 had, inexplicably, been resolved without the need for any further inspection being carried out to see if any of the expressed concerns had been satisfactorily addressed. Had the expressed concerns as to safety been genuinely held it would only have been expected that a subsequent inspection would have been carried out. There was no such inspection. And there was no subsequent inspection, it is concluded, because by 17 March 2015 the CFMEU had achieved the objective it had from the outset; it had secured agreement to the payment of a site allowance.¹

1.85 Coalition Senators also note that conduct of this type is not new, as evidenced in the Cole Royal Commission in 2003.²

1.86 Coalition Senators accept that unions have an inherently significant role in the Australian workplace relations system. We are not opposed to unions or their capacity to represent people in workplaces.

1.87 However, Coalition Senators are concerned conduct outlined above erodes and undermines the importance of safety, particularly in an industry where members undertake work that is conventionally associated with a higher level of risk. Genuine safety concerns may risk being treated less importantly if such conduct was allowed to continue.

1.88 There is no place for unions who do not adhere to the law or who exploit safety issues to achieve other purposes.

1.89 Coalition Senators agree that there is a need to improve the law to achieve the correct balance with safety as a priority. In doing so, such improvements will

¹ Australian Building And Construction Commissioner V Construction, Forestry, Mining And Energy Union [2018] FCA 42 (7 February 2018), emphasis added.

ensure that unions can play a larger role in terms of fostering a culture of ‘safe-work’ together with employers and all other persons who hold duties and responsibilities to foster safe workplaces and systems of work.

Recommendation 3
1.90 Only union officials who are ‘fit and proper persons’ should be entitled to exercise the right of entry under a permit issued by an independent government authority or judicial officer.

Recommendation 4
1.91 Model WHS laws should specify those individuals with criminal records or a history of breaches of right of entry and related provisions under Commonwealth or State and Territory law should not be eligible to obtain a permit.

Conclusion
1.92 While Australia has a robust, harmonised legislative framework to protect the health, safety and welfare of all workers, governments, regulators, employer and employee groups need to work together to ensure this framework is effective.

1.93 There is always room to improve WHS laws as evidence emerges about best practice.

1.94 Ineffective or ill-considered Commonwealth laws can actually be counter-productive to the ongoing harmonisation of the various State jurisdictions that have principal responsibility in this area.

Senator Slade Brockman
Deputy Chair

Senator James Paterson
Member
Australian Greens Senators' Additional Comments

1.1 The Australian Greens welcome this inquiry and support the recommendations made by the Committee. The creation of a new offence of industrial manslaughter has long been Greens policy and we welcome moves by the Committee and other political parties towards this end.

1.2 As a general principle, we have a preference for a model that puts industrial manslaughter into the Crimes Act, but we also note the broad support for the ‘Queensland model’ and the Greens welcome moves to have this extended throughout Australia.

1.3 We would also like to see as a general principle that industrial deaths include all work related deaths, and not just traumatic fatalities, as this would more accurately reflect the impact on workers and would allow their families access to appropriate remedies. In particular, deaths caused by work related diseases and suicides should be covered.

1.4 Consideration of workers who die by suicide, particularly after poor handling of compensation claims, is also currently inadequate and should be addressed in any new reforms. Further, there is a strong case for the collection of data and statistics regarding this matter.

1.5 With respect to recommendation 32 regarding the establishment of pro bono legal assistance to families, we think this should be extended to include “and any other assistance deemed necessary”, as we are aware of cases (including with Aboriginal families) where accessing inquests has been particularly difficult because of financial constraints.

Senator Mehreen Faruqi
Member
Appendix 1
Submissions and Additional Information

Submissions
1  Dr Christine Black
2  OzHelp
3  Law Council of Australia
4  Queensland Ombudsman
5  National Offshore Petroleum Safety and Environmental Management Authority
6  Housing Industry Association
7  Transport Workers' Union
8  Safe Work Australia
9  Master Electricians Australia
10  Queensland Council of Unions
11  ACT Government
12  Recruitment, Consulting and Staffing Association
13  Australian Institute of Company Directors
14  Victorian Trades Hall Council
15  NatRoad
16  Minerals Council of Australia
17  Young Workers Centre
18  Australasian Institute of Mining and Metallurgy
19  Australian Industry Group
20  Master Builders Australia
   • 20.1 Supplementary submission
21  Queensland Nurses and Midwives' Union
22  Australian Manufacturing Workers' Union
23  Maurice Blackburn Lawyers
24  Australian Chamber of Commerce and Industry
25  Confidential
26  Confidential
   • 26.1 Confidential supplementary submission
27  Confidential
   • 27.1 Confidential supplementary submission
28  Western Australian Government
29  Ms Robyn Colson
30  Mr Dave and Ms Janine Brownlee
31  Mr Michael Garrels
32  Mrs Lee Garrels
Consultative Committee for Workplace Fatalities and Serious Incidents

• 33.1 Supplementary submission
• 33.2 Supplementary submission

South Australian Government
Mr Kevin and Mrs Christine Fuller
Mr Bernard Corden
Electrical Trades Union
Australian Workers’ Union
Australian Council of Trade Unions
New South Wales Nurses and Midwives’ Association
Voice of Industrial Death
• 41.1 Supplementary submission

Mr Daniel and Mrs Debra Kennedy
Mrs Jennifer Newport
Dr Lana Cormie
Mr Greg Zappelli
Victorian Government
Queensland Government
Mrs Kay Catanzariti
Department of Jobs and Small Business
• 49.1 Supplementary submission

Northern Territory Government
Construction Forestry Maritime Mining and Energy Union
Associate Professor Neil Foster
• 52.1 Supplementary submission

Mrs Julie LeBrocq-Goggin and Mr Wayne Goggin
Mr Warwick Pearse, Mr Rod Noble and Mr Serge Zorino
Uniting GriefWork
Ms Ashlea Cunico
Mr Mark and Mrs Janice Murrie
Mr Jon-Paul Bradley
Ms Regan Ballantine
Dr Lynda Matthews
Confidential
Confidential
• 62.1 Confidential supplementary submission

Mr Andrew Collins
Dr Richard Gun AO
Mr David Miles
• 65.1 Supplementary submission

Australian Small Business and Family Enterprise Ombudsman
Additional Information

1. Death at work: Improving support for families report by Associate Professor Lynda Matthews, provided on 10 July 2018.
2. Correspondence received from the Tasmanian Department of Justice on 27 July 2018.
3. Letter of correction to the Hansard transcript from 12 July 2018 hearing in Melbourne from Dr Deborah Vallance, National Health and Safety Coordinator for the Australian Manufacturing Workers’ Union; received 7 August 2018.
4. Letter correcting evidence provided by Mr Trevor Gauld, National Policy Officer for the Electrical Trades Union at a public hearing in Hobart on 31 July 2018.
5. Letter of clarification relating to evidence given by Mr Rod Hodgson, Principal Lawyer, Maurice Blackburn Lawyers at a public hearing in Melbourne on 28 August 2018; received 7 September 2018.
7. Clarification of evidence provided by Mr Paul Fowler of WorkSafe Victoria at a public hearing in Melbourne on 28 August 2018.

Answer to Question on Notice

1. Answer to a question on notice by Associate Professor Lynda Matthews, asked at a public hearing in Sydney on 12 July 2018 by Senator O’Neill; received 8 August 2018.
2. Answers to questions on notice by the Queensland Council of Unions. Asked at a public hearing in Brisbane on 17 July 2018; received 14 August 2018.
3. Answers to questions on notice by the Transport Workers Union of Australia. Asked at a public hearing in Sydney on 12 July 2018; received 15 August 2018.
4. Answers to questions on notice by NatRoad. Asked by Senator Abetz at a public hearing in Sydney on 12 July 2018; received 15 August 2018.
5. Answers to questions on notice by the Queensland Government. Asked at a public hearing in Brisbane on 17 July 2018; received 17 August 2018.
6. Answers to questions on notice by Recruitment and Consulting Services Association. Asked at a public hearing in Melbourne on 28 August 2018; received 31 August 2018.
8. Answers to questions on notice by the Victorian Government. Asked at a public hearing in Melbourne on 28 August 2018; received 18 September 2018.
Answers to questions on notice by the Australian Chamber of Commerce and Industry. Asked at a public hearing in Fremantle on 30 August 2018; received 26 September 2018.

Answers to questions on notice by WorkSafe Victoria. Asked at a public hearing in Melbourne on 28 August 2018; received 2 October 2018.

Answers to questions on notice by the Victorian Trades Hall Council. Asked at a public hearing in Melbourne on 28 August 2018; received 15 October 2018.

Tabled Documents

1. Road safety article tabled at a public hearing in Sydney on 12 July 2018 by Mr Michael Kaine, National Assistant Secretary of the Transport Workers’ Union.

2. Documents tabled by Mr Michael Garrels at a public hearing in Brisbane on 17 July 2018.

3. Policy brief tabled at a public hearing in Melbourne on 28 August 2018 by Dr Paul Sutton of the Victorian Trades Hall Council.
Appendix 2
Public Hearings and Witnesses

Thursday, 12 July 2018
Corinthian Room
Sydney Masonic Centre
66 Goulburn Street
Sydney

Transport Workers’ Union
- Mr Michael Kaine, National Assistant Secretary
- Mr Sam McIntosh, Senior Political Campaigner
- Mr John Waltis, Member

Associate Professor Lynda Matthews, private capacity

NatRoad
- Ms Julia Collins, Industry Policy Advisor

Australian Manufacturing Workers’ Union
- Dr Deborah Vallance, National Health and Safety Coordinator

New South Wales Nurses and Midwives’ Association
- Mr Brett Holmes, General Secretary
- Ms Leslie Gibbs, WHS Professional Officer

Tuesday, 17 July 2018
Committee Room 1
Parliament of Queensland
Corner of George and Alice Street
Brisbane

Mr Michael Garrels, private capacity

Mrs Lee Garrels, private capacity

Mr Kevin and Mrs Christine Fuller, private capacity

Mr Daniel and Mrs Debra Kennedy, private capacity

Mrs Jennifer Newport, private capacity

Queensland Council of Unions
- Dr John Martin, Research and Policy Officer
Master Electricians Australia
- Mr Jason O’Dwyer, Manager, Advisory Services

Consultative Committee for Workplace Fatalities and Serious Incidents
- Mr Michael Garrels, Interim Chair
- Mrs Lee Garrels, Interim Member
- Mr Sean O’Connor, Interim Deputy Chair
- Mr Kevin and Mrs Christine Fuller, Interim Members
- Mr Daniel and Mrs Debra Kennedy, Interim Members
- Mr Don and Mrs Julie Sager, Interim Members
- Ms Louisa Wilson, Interim Member
- Mr David Miles, Interim Member

Queensland Government
- Mr Paul Goldsbrough, Executive Director, Workplace Health and Safety, Engagement and Policy Services, Office of Industrial Relations

Tuesday, 31 July 2018
Gretel Room
Hobart Function and Conference Centre
1 Elizabeth Street Pier
Hobart

Electrical Trades Union
- Mr Michael Anderson, State Secretary
- Mr Trevor Gauld, National Policy Officer

Tuesday, 7 August 2018
Committee Room 2S3
Parliament House
Canberra

Mrs Kay Catanzariti, private capacity

Master Builders Australia
- Mr Shaun Schmitke, Deputy Chief Executive Officer and National Director Safety, Contracts, Workplace Relations

Mrs Julie LeBrocq-Goggin and Mr Wayne Goggin, private capacity

Associate Professor Neil Foster, private capacity

Safe Work Australia
- Ms Michelle Baxter, Chief Executive Officer
- Ms Amanda Grey, Deputy Chief Executive Officer
- Mr Kris Garred, Director, Evidence
• Mrs Jackii Shepherd, Director, Occupational Hygiene Policy
• Ms Bianca Wellington, Director, WHS Framework, Principal Government Lawyer
• Ms Amanda Johnston, General Counsel

**Australian Industry Group**
• Mr Mark Goodsell, Head, NSW

**ACT Government**
• Ms Rachel Stephen-Smith MLA, Minister for Workplace Safety and Industrial Relations
• Mr Dave Peffer, Deputy Director-General, Access Canberra
• Mr Michael Young, Executive Director, Workplace Safety and Industrial Relations Division
• Mr Greg Jones, ACT Work Safety Commissioner

**Tuesday, 28 August 2018**
Plaza Ballroom
Vibe Savoy
630 Little Collins Street
Melbourne

**Recruitment, Consulting and Staffing Association**
• Mr Charles Cameron, Chief Executive Officer

**Australian Council of Trade Unions**
• Mr Michael Borowick, Assistant Secretary
• Ms Sophie Ismail, Legal and Industrial Officer
• Mr Paul Garrett, Assistant Branch Secretary, Sydney Branch, Maritime Union of Australia

**Maurice Blackburn Lawyers**
• Mr Rod Hodgson, Principal

**Uniting GriefWork**
• Ms Bette Phillips-Campbell, Program Manager

**Dr Lana Cormie, private capacity**

**Mr Dave and Mrs Janine Brownlee, private capacity**

**Victorian Trades Hall Council**
• Dr Paul Sutton, Lead of the Occupational Health and Safety Team
Victorian Government
- Mr Paul Fowler, A/g Executive Director, Health and Safety Business Unit, WorkSafe Victoria

Wednesday, 29 August 2018
Hindley Room 1
Hotel Grand Chancellor
65 Hindley Street
Adelaide

Voice of Industrial Death
- Ms Andrea Madeley, Founder

Panel of impacted VOID families
- Mr Lee Salvemini, private capacity
- Mrs Edith Logan, private capacity
- Mr Keith Logan, private capacity
- Mrs Susan Gallina, private capacity
- Ms Pam Gurner-Hall, private capacity

Thursday, 30 August 2018
King Sound Room
Esplanade Hotel
Corner of Marine Terrace and Essex Street
Fremantle

Australian Chamber of Commerce and Industry
- Ms Alana Matheson, Deputy Director, Workplace Relations
- Ms Jennifer Low, Associate Director, Workplace Health and Safety and Workers' Compensation Policy

Construction Forestry Maritime Mining and Energy Union
- Mr Mick Buchan, State Secretary

Panel of impacted families
- Mr Mark and Mrs Janice Murrie, private capacity
- Mrs Debra and Ms Ashlea Cunico, private capacity
- Mr Jon-Paul and Mr Gerald Bradley, private capacity
- Ms Regan Ballantine, private capacity
- Mrs Patricia Kelsh, private capacity

Maritime Union of Australia
- Mr Thomas Mayor, Branch Secretary, Northern Territory Branch
Wednesday, 19 September 2018
Committee Room 2S3
Parliament House
Canberra

Ms Robyn Colson, private capacity
Appendix 3
Consolidated table of differences in Commonwealth, state and territory work health and safety laws

<table>
<thead>
<tr>
<th></th>
<th>Model Work Health and Safety Act, s 31(1) reckless conduct offence?</th>
<th>Work Health and Safety Act or equivalent max penalties</th>
<th>Industrial manslaughter criminal offence?</th>
<th>Industrial manslaughter max penalty</th>
<th>General manslaughter offence max penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cth</td>
<td>Yes</td>
<td>$300,000 or 5 years imprisonment for an individual, $600,000 or 5 years imprisonment for an individual as a person or officer conducting a business or undertaking, $3 million for a body corporate</td>
<td>No</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td>Yes</td>
<td>As above</td>
<td>Yes – <a href="#">Crimes Act 1900 (ACT) ss 49C-49D – industrial manslaughter</a> employer and senior officer offences</td>
<td>2 000 penalty units ($300,000 for an individual, $1.5 million for a corporation), imprisonment 20 years or both</td>
<td>20 years imprisonment or 28 years imprisonment (aggravated offence)</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>As above</td>
<td>No</td>
<td>N/A</td>
<td>25 years imprisonment</td>
</tr>
<tr>
<td>---</td>
<td>-----</td>
<td>----------</td>
<td>----</td>
<td>-----</td>
<td>-----------------------</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>As above</td>
<td>No</td>
<td>N/A</td>
<td>Life imprisonment</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>As above</td>
<td>Yes – Work Health and Safety Act 2011 (Qld) s 34C – industrial manslaughter – person conducting business or undertaking and s 34D – industrial manslaughter – senior officer</td>
<td>20 years imprisonment for an individual or 100 000 penalty units for a body corporate ($10 million)</td>
<td>Life imprisonment</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>As above</td>
<td>No</td>
<td>N/A</td>
<td>Life imprisonment</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>As above</td>
<td>No</td>
<td>N/A</td>
<td>21 years imprisonment, or by fine, or both.</td>
</tr>
<tr>
<td></td>
<td>No – has Occupational Health and Safety Act 2004 (Vic) s 32 offence – duty not to recklessly endanger persons at workplaces</td>
<td>1,800 penalty units ($285,426) or 5 years imprisonment for an individual, 20,000 penalty units for a body corporate ($3,171,400)</td>
<td>No</td>
<td>N/A</td>
<td>20 years imprisonment</td>
</tr>
<tr>
<td>WA</td>
<td>No – has Occupation Safety and Health Act 1984 (WA) offences relating to breaches of duties in circumstances of gross negligence or breaches that cause death of, or serious harm to an employee, by employers, body corporates and persons who have control of workplaces</td>
<td>Gross negligence offences For individuals: $250,000 fine and imprisonment for 2 years for a first offence, $312,500 fine and imprisonment for 2 years for a subsequent offence For body corporates: $500,000 fine for a first offence, $625,000 fine for a subsequent offence Breach of duty causing death or serious harm to an employee For individuals: $200,000 fine for a first offence, $250,000 for a subsequent offence For body corporates: $400,000 fine for a first offence $500,000 for a subsequent offence</td>
<td>No</td>
<td>N/A</td>
<td>Life imprisonment</td>
</tr>
</tbody>
</table>

Source: Law Council of Australia, Submission 3, pp. 9-10.