



BEST PRACTICE REVIEW OF WORKPLACE HEALTH AND SAFETY QUEENSLAND

Final Report

3 July 2017

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The Hon Grace MP
Minister for Employment and Industrial Relations,
Minister for Racing
Minister for Multicultural Affairs,
1 William Street
BRISBANE QLD 4000

Dear Minister

I am pleased to present you with the report of the Best Practice Review of Workplace Health and Safety Queensland.

I express my thanks to the members of the Reference Group, all stakeholders who contributed to this Review and to the officers of your Department who provided secretariat support to me during this process.

Thank you for the opportunity to contribute to the important task of ensuring public safety and safety at work for all Queenslanders.

Yours sincerely

TIM LYONS
Independent Reviewer

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Glossary

AiGroup	Australian Industry Group
AMWU	Australian Manufacturing Workers' Union
ASMC	Australian Sugar Milling Council
ASQA	Australian Skills Quality Authority
AWU	Australian Workers' Union
CBRC	Cabinet Budget Review Committee
CCF	Civil Contractors Federation
CCIQ	Chamber of Commerce and Industry Queensland
CPM	Comparative Performance Monitoring
DGSM Act	<i>Dangerous Goods Safety Management Act 2001</i>
DJAG	Department of Justice and Attorney-General
DPP	Director of Public Prosecutions
DTMR	Department of Transport and Main Roads
ES Act 2002	<i>Electrical Safety Act 2002 (Qld)</i>
ESO	Electrical Safety Office
FLPs	Fundamental Legislative Principals
FW Act	<i>Fair Work Act 2009 (Cth)</i>
HaSIC	Health and Safety Inspector Checklist
HCSA	Health Care and Social Assistance
HIA	Housing Industry Association
HSE	Health and Safety Executive
HSR	Health and Safety Representative
HWSA	Heads of Workplace Safety Authorities
IP Act	<i>Information Privacy Act 2009</i>
IPaM	Injury Prevention and Management Program
IR Act	<i>Industrial Relations Act 2016</i>
ISCRR	Institute of Safety, Compensation and Recovery Research
ISSC	Industry Sector Standing Committee
IWH	Institute for Work and Health
IWH-OPM	Institute for Work and Health Organisational Performance Metric
MBQ	Master Builders Queensland

MEA	Master Electricians Australia
MHF	Major Hazard Facility
MOU	Memorandum of Understanding
NER	National Engineers Register
NZ Act	<i>Health and Safety at Work Act 2015 (NZ)</i>
OIC	Office of the Information Commissioner
OIR	Office of Industrial Relations
ORGG	Organisational Response Governance Group
PCBU	Persons Conducting a Business or Undertaking
PERform	Participative Ergonomics for Manual Tasks
PINs	Provisional Improvement Notices
PWC	PricewaterhouseCoopers
QAS	Quality Assurance System
QCAT	Queensland Civil Administration Tribunal
QCU	Queensland Council of Unions
QIRC	Queensland Industrial Relations Commission
QNMU	Queensland Nurses and Midwives Union
QPS	Queensland Police Service
QTIC	Queensland Tourism Industry Council
RAM	Risk Assurance Map
RPL	Recognition of Prior Learning
RTI Act	<i>Right to Information Act 2009</i>
RTI	Right to Information
RTO	Registered Training Organisation
SFARP	'So far as reasonably practical'
SIM	State Investigations Manager
SWA	Safe Work Australia
SWRA Act 2011	<i>Safety in Recreational Water Activities 2011 (Qld)</i>
VET	Vocational Education Training
WCU	Workforce Capability Unit
WHS Act 1995	<i>Workplace Health and Safety Act 1995</i>
WHS Act 2011	<i>Work Health and Safety Act 2011</i>

WHS Board	Work Health and Safety Board
WHS Regulation 2008	<i>Workplace Health and Safety Regulation 2008 (Qld)</i>
WHS Regulation 2011	<i>Workplace Health and Safety Regulation 2011</i>
WHSMS	Work Health and Safety Management System
WHSQ	Workplace Health and Safety Queensland
WRMC	Workplace Relations Ministers Council

General findings

The *Work Health and Safety Act 2011* (WHS Act 2011) is a very important piece of legislation. It is explicitly designed as “protective legislation”: the objects begin with the intention of “protecting workers and other persons against harm to their health, safety and welfare through the elimination or minimisation of risks.”¹

The Act sets out core safety obligations the Queensland community, via its Parliament, has placed on business operators across the state. This framework is about protecting Queenslanders at work and delivering on the expectation of workers and their families that we are all entitled to go to work and return home safe. It is also highly relevant to broader issues of public safety: for Queenslanders, the huge number of other Australians who holiday in the state, and international visitors.

It is vital that the workforce, industry and the broader public have confidence in the law and in the way it is administered. The latter is at least as important as the words on the statute book. As leading academics noted in a recent paper on enforcement and compliance under nationally harmonised work health and safety laws, “how regulators support, inspect and enforce” work health and safety laws is vital to understanding impacts on workers, employers and the public.²

WHS outcomes are a function not just of the law itself but of the human capital, systems and processes of the regulator. Each of these elements is critical to the system functioning properly, and of the WHS Act 2011 operating as intended. Accordingly the findings and recommendations of the Review focus not just on the legislation itself, but the way Workplace Health and Safety Queensland has been performing its vital task.

The general findings of the Review are as follows:

- Some of the changes to Queensland work health and safety laws that occurred as a result of the national harmonisation process were not positive – a range of existing arrangements that had worked well in Queensland and were broadly supported by stakeholders were repealed.
- While WHSQ performs many of its functions well, there is need for a significant re-balancing of organisational priorities to ensure the expectations of Queenslanders about safety at work are met.
- There is a need to re-focus operations on the core functions of WHSQ as a labour inspectorate.
- There is a need, expressed in clear terms by both unions and employees for a greater level of visibility in workplaces by inspectors.
- While considerable improvements have been made, particularly following criticisms from the Queensland Ombudsman, there is an ongoing need to improve the human capital, systems and processes of WHSQ, particularly in relation to the inspectorate, investigations and prosecutions. Unfortunately, implementation of some improved systems around the auditing of enforcement activity resulted in many inspectors becoming reluctant to issue compliance notices, leading to a very large and inappropriate drop off in enforcement activity.
- In moving to increase its use of engagement, educative and capacity building strategies, WHSQ “overshot” and has placed insufficient emphasis on “hard” compliance and enforcement. This requires a re-balancing. There is an ongoing need to ensure that the balance between “directing compliance” and “encouraging and assisting compliance” is appropriate. This is not a once off exercise, but a matter that requires ongoing monitoring and adjustment.
- While there is no evidence of regulatory capture or of political interference in prosecutions or other regulatory decisions, there is a need to ensure that the reality and perception of independence is maintained and delineation of functions is clear. Some structural separation of the WHSQ’s operations into three streams 1. Prosecutions & Investigations, 2. Inspectorate, and 3. Capacity Building/ Engagement is appropriate.

¹ *Workplace Health and Safety Act 2011* s 3(1)(a).

² Bluff & Johnstone, *Supporting and Enforcing Compliance with Australia’s Harmonised WHS Laws*, (2017) 230 AJLL 30.

- There has been inadequate emphasis placed on the role Health and Safety Representatives play, and an urgent need to develop a program to support them in their statutory role.
- Partly as a result of budget cuts (in particular in 2012-13) there has been increasing pressure on WHSQ in its role delivering a State-wide program of sufficient breadth and depth. This is a particular challenge in Queensland, given the mix of economic activity and the decentralised population. Reliance on legacy IT systems and machinery of government changes has delayed or restricted the ability of WHSQ to deploy best-practice tools including for on the ground inspectors.
- It is strongly arguable that the organisation has not had the full benefit possible from the stakeholder based Work Health and Safety Board (WHS Board) in recent years. There is a need, and an opportunity (given that appointments to the WHS Board were recently renewed) for a higher level of engagement and activity by the WHS Board. In particular, the WHS Board should develop, monitor and review a five year strategic plan.
- The Families Forum established to provide a forum for advice and input from the families of victims of serious workplace accidents is a very valuable initiative and should be given appropriate support.

General recommendations:

In support of these general findings, and in addition to the recommendations in the report, it recommended that:

1. WHSQ re-balance its priorities in favour of “hard” compliance work and redeploy some resources away from the capacity building area, with a view to increasing on the ground visibility and activity of the inspectorate.
2. The inspectorate be structurally separated within WHSQ away from the corporate services, capacity building and engagement work of WHSQ (see also recommendations in relation to prosecutions and investigations).
3. The *Work Health and Safety Act 2011* be amended to require the Work Health and Safety Board to develop, monitor and review a five year strategic plan, and consistent with its role in the WHS Act 2011 provide advice to the Minister on a more regular and systematic basis.
4. That the Families Forum continue to be actively supported and consulted, including by their involvement in relevant internal working groups and committees. Given the nature of the role, a representative of the Families Forum should be included on the selection committee for staff members of WHSQ allocated to any roles supporting the Forum.

Recommendations

The review recommends:

General recommendations

1. WHSQ re-balance its priorities in favour of “hard” compliance work and redeploy some resources away from the capacity building area, with a view to increasing on the ground visibility and activity of the inspectorate.
2. The inspectorate be structurally separated within WHSQ away from the corporate services, capacity building and engagement work of WHSQ (see also recommendations in relation to prosecutions and investigations).
3. The *Work Health and Safety Act 2011* be amended to require the Work Health and Safety Board to develop, monitor and review a five year strategic plan, and consistent with its role in the WHS Act 2011 provide advice to the Minister on a more regular and systematic basis.
4. That the Families Forum continue to be actively supported and consulted, including by their involvement in relevant internal working groups and committees. Given the nature of the role, a representative of the Families Forum should be included on the selection committee for staff members of WHSQ allocated to any roles supporting the Forum.

Queensland work health and safety laws

5. The status of codes of practice be clarified by restoring the previous requirements in section 26(3) of the *Workplace Health and Safety Act 1995*.
6. The *Work Health and Safety Act 2011* be amended to require a mandatory review of each Code of Practice in operation in Queensland every five years.
7. The Queensland Government raise the issue of reintroducing a reverse onus of proof as part of the 2018 review of the model work health and safety laws. The 2018 review should consider what effect the change has had nationally on patterns of enforcement, the success rates of prosecutions and safety outcomes.
8. Section 171 of *Work Health and Safety Act 2011* be amended to provide that:
 - a. the exercise of the power be extended to an inspector who has entered a workplace on a previous occasion;
 - b. section 171(1)(b) apply where a document is located at any place, not just the workplace;
 - c. the production of the document to be made at any place, not just the workplace;
 - d. require a relevant person to answer questions at any time and place convenient; and
 - e. provide that anything done by an inspector who has not entered a workplace is lawfully done if another inspector has entered the workplace.

WHSQ’s compliance and enforcement policy

9. WHSQ develop a compliance and enforcement policy (new policy) in supplement to the National Compliance and Enforcement Policy that provides sufficient detail about enforcement actions to be utilised in certain circumstances to ensure compliance. In developing the compliance and enforcement policy it is recommended that WHSQ:
 - a. more precisely identify the use a “directed compliance” as a vital, widely available tool to ensure safe workplaces;
 - b. consult with stakeholders and the Work Health and Safety Board in developing the new policy;
 - c. publish the new policy on their website;

- d. review the new policy at least every five years;
- e. measure and report on compliance and enforcement performance against the policy, annually; and
- f. The Work Health and Safety Board include reviewing WHSQ's performance against the policy as part of their five year strategic plan to ensure that the balance of WHSQ's compliance and enforcement activities are continually monitored.

Development of the *Australian Work Health and Safety Strategy 2012-2022 and Queensland health and safety strategies*

10. WHSQ include the Health Care and Social Assistance industry sector as a priority industry and develop an explicit Queensland strategy for this issue.
11. WHSQ and the Work Health and Safety Board consider establishing a specific strategy to address key occupational health risks, including examining international approaches that ensure longitudinal data on current and emerging risks are utilised as part of a health surveillance framework.

Evidence-based compliance and enforcement activities

12. WHSQ develop a standardised set of reporting metrics which reflect the full range of regulatory activity, and outcomes achieved.
13. WHSQ consolidate and upgrade their regulatory databases to support this modernised set of measures.
14. WHSQ pursue standardised national data capture and reporting by Safe Work Australia, through the review and updating of the Comparative Performance Monitoring measures, or alternate means of national reporting, so that the reporting metrics reflect regulatory activity and outcomes to achieve legislative and Australian Strategy aims.
15. WHSQ progress the development and implementation of the holistic assessment process, which includes lead indicators, and pilot with key stakeholders in the priority industries.
16. The Work Health and Safety Board monitor the progress of the implementation of the IT and systems upgrades, to ensure that the necessary information is collected, collated and analysed to assist in strategic planning and resource allocation, and provide any recommendations it considers appropriate to the Minister.

WHSQ capability

17. The Queensland Government remove the staff ceiling (FTE cap) on WHSQ and instead apply a staffing model which keeps pace with increases in economic activity, population growth and regulatory responsibility. The staffing level at 2010/11 and 2011/12 should be used as a basis for this calculation.
18. The Queensland Government re-examine the funding formula for provision of funds to WHSQ by WorkCover and consolidated revenue to ensure that funding is available to increase the inspectorate numbers and capability to a level commensurate with the increased economic activity and complexity of WHSQ in Queensland. This examination should establish a historical base (for example the funding provided in 2010/11 and 2011/12) and use the annual changes in State Total Demand and Total Income Factor to calculate the level of funding that WHSQ should currently receive. Annual funding adjustments should be on the basis of changes to State Total Demand and Total Income Factor.
19. WHSQ review its allocation of staffing in advisory programs such as the Injury Prevention Management Program and, where possible, reallocate staff to inspector functions with statutory powers.
20. WHSQ continue its skills development program with a view to bringing inspector qualifications and competencies up to a level of leading regulators such as the Health and Safety Executive in the United Kingdom. Further to this, that WHSQ examine the recommendations of the Queensland University of

Technology regulatory research with respect to inspector skills, when this becomes available, and progresses a program to implement relevant findings.

21. WHSQ identify, in consultation with Industry Sector Standing Committees, sectors where specialised knowledge is required to allow an inspector to adequately perform their role, and to allocate staff resources in a way that minimises, wherever possible, the use of non-specialised inspectors in circumstances where specialised skills and knowledge are required.

Inspectorate activity

22. WHSQ increase the data analytics from inspector workplace activity and implement improvement programs which optimise the efficiency and effectiveness of this activity.
23. WHSQ develop a plan to increase inspector visibility, including in priority industries, and seek stakeholder feedback, including via the Industry Sector Standing Committees, after implementation.
24. WHSQ take additional steps to ensure all Inspectors have a clear understanding of the availability of directed compliance as tool and of the systems used to track and support its use.
25. The Work Health and Safety Board include inspectorate activity as a core element its five year strategic plan, monitor patterns of activity (including directed compliance) and provide feedback to WHSQ and advice to the Minister accordingly.

Investigations

26. Consistent with recommendation 31 to functionally separate the compliance and business engagement functions of WHSQ, the State Investigations Manager should report to the Director of Work Health and Safety Prosecutions.
27. WHSQ implement a formal policy regarding the release of information about the status of investigations to all affected parties.
28. WHSQ update the Memoranda of Understanding with the Queensland Police Service and the Department of Transport and Main Roads so that agency responsibilities during investigations are clearly delineated.
29. WHSQ determine the effectiveness of investigations by collecting and analysing quality and timeliness data.
30. WHSQ use findings from collected investigations data to best direct resources and establish 'best practice' timelines for various categories of investigations.

Prosecutions

31. A new independent statutory office be created to exercise all functions in relation to work health and safety prosecutions under the *Work Health and Safety Act 2011*. The new independent statutory office should:
 - a. be headed by a Director of Workplace Health and Safety Prosecutions (Senior Executive Service level) to be appointed by the Governor-in-Council for a five year renewable term and be supported by existing Office of Industrial Relations prosecutions staff reporting to the Director.
 - b. not affect the current referral process by WHSQ to the Director of Public Prosecutions for category 1 offences under section 31 of the *Work Health and Safety Act 2011*.
32. As the Office of Industrial Relations has a centralised function for prosecutions, consideration be given to transferring prosecutions under the *Electrical Safety Act 2002* and the *Safety in Recreational Water Activities Act 2011* to the new Director of Workplace Health and Safety Prosecutions.

33. The Office of Industrial Relations develop a formal policy regarding the release of information on the status of prosecutions to affected families and those individuals and companies under investigation.
34. The Director of Public Prosecutions Guidelines be mandated under the *Work Health and Safety Act 2011* to ensure that they are followed when decisions are made about whether to initiate a prosecution.
35. The Office of Industrial Relations collect and use data on its investigations (including the length of time and outcomes of investigations) to regularly analyse the effectiveness of prosecution decisions. This regular analysis by the Office of Industrial Relations should be used to better focus prosecution resources and establish best practice timelines for different categories of incidents.
36. The Work Health and Safety Board monitor patterns and trends relating to WHSQ's prosecutions, including success rates and penalties awarded.

Enforceable undertakings

37. In relation to the enforceable undertakings framework:
 - a. The *Work Health Safety Act 2011* be amended to expressly prohibit enforceable undertakings being accepted for contraventions or alleged contraventions of the WHS Act 2011 that relate to circumstances involving a fatality.
 - b. The *Guidelines for the acceptance of an enforceable undertaking* be amended to provide a general exception (unless exceptional circumstances exist) where the applicant has a recent prior conviction connected to a work-related fatality; the applicant has more than two prior convictions arising from separate investigations, or the application relates to an incident involving a very serious injury.
 - c. For consistency, 'very serious injury' should be defined as stated in the WorkCover New South Wales Enforceable undertakings: Guidelines for proposing an enforceable undertaking.
 - d. The Queensland Government consider making similar amendments to the enforceable undertaking requirements under the *Electrical Safety Act 2002* and the *Safety in Recreational Water Activities Act 2011*.
 - e. The Queensland Government consider recommending similar amendments be made to the national model Work Health and Safety Act as part of the 2018 review.

Licensing framework

38. In respect of the licensing framework, it is recommended that:
 - a. the *Work Health and Safety Regulation 2011* be amended to include a competency assessment in the approval process for new accredited high risk work assessors, while existing assessors will sit an abridged version as a validation of their competency;
 - b. WHSQ develop an industry guideline or code of practice so that Registered Training Organisations understand the standards of training required to obtain a licence or authorisation under the *Work Health and Safety Regulation 2011*, potentially including the extent of practical learning needed for the particular licence and the plant and equipment that should be used to ensure applicants receive a minimum quality of training before they can be assessed for or apply for a licence;
 - c. WHSQ investigate the feasibility of developing, implementing and administering a Registered Training Organisation approval process whereby the Regulator could approve Registered Training Organisations (as eligible to deliver certain training) in addition to the Australian Skills Quality Authority granting their approval, subject to their achieving a number of quality indicators relating to the expertise of their trainers and assessors, training and assessment processes and resources, and an ongoing cycle of review and renewal; and
 - d. the Queensland Government consider mandating that a Registered Training Organisation cannot both train and assess for high risk work licences.

Issues resolution

39. In relation to dispute resolution it is recommended that:
- a. the jurisdiction for the review of reviewable decisions (under Schedule 2A of the WHS Act 2011) as currently vested in QCAT, be transferred to the QIRC;
 - b. the QIRC's jurisdiction be expanded to hear and determine the following categories of disputes:
 - i. a dispute in relation to the provision of information by an employer to a HSR;
 - ii. a dispute in relation to any rights or functions that may be exercised by WHS entry permit holders;
 - iii. a dispute in relation to a request by a HRS for assistance;
 - iv. a dispute in relation to WHS issue resolution process; and
 - v. a dispute in relation to cease work matters;
 - c. notification of a dispute may be provided by an employer, affected employee, affected HSR, or a relevant registered organisation;
 - d. notifications can only occur if a request has been made to an inspector for assistance, however if the matter is not resolved 24 hours after such a request is made, a notification can be made to the QIRC;
 - e. the QIRC be able to exercise all its powers (including conciliation, requiring the production of documents or compulsory attendance and the issuing of orders) in settling the dispute;
 - f. the QIRC should also have the power to dismiss a matter without conducting a hearing or conference where it believes the matter is frivolous, vexatious or lacks substance; and
 - g. appeal rights from decisions of the QIRC should apply in the normal way.

WHSQ's effectiveness in relation to providing compliance information and promoting WHS awareness and education

40. That WHSQ and WorkCover examine the opportunity and benefits of WorkCover providing additional funding for awareness and engagement activities undertaken by WHSQ, thus releasing base funding for more direct compliance activities.

Public safety

41. The *Work Health and Safety Regulation 2011* be amended to require that:
- a. mandatory major inspections of amusement devices, by competent persons, are conducted;
 - b. competent persons are nominated to operate specified amusement devices; and
 - c. details of statutory notices are recorded in the amusement device logbook and made available to the competent person inspecting the amusement device.
42. WHSQ, in consultation with stakeholders, determine the level of competency required for the inspection of specified types of amusement devices, and the level of competency required for the operation of specified amusement devices (including the potential need for formal licensing arrangements to apply in respect of certain categories of device), and that the *Work Health and Safety Regulation 2011* be amended accordingly .
43. The *Work Health and Safety Regulation 2011* be amended to require, for operators of amusement devices, a similar regulatory approach to that taken for operators of facilities which use, generate, handle or store hazardous materials. That is, for operators and facilities whose amusement devices collectively present a high risk, require preparation of a Safety Case (which includes a work health and

safety management system) and application of a licensing regime. For operators and facilities whose amusement devices collectively present a medium risk, require preparation of a work health and safety management system and application of a lower level licensing regime.

44. WHSQ and the Work Health and Safety Board consider the level of resourcing necessary to address the increasing risk to the public from work activities, and ensure PCBUs, particularly in the tourism, services and health care and social assistance sectors, are complying with their section 19(2) duty to ensure the health and safety of others.
45. Consideration be given by the Queensland Government to establish a Public Safety Ombudsman.

Negligence causing death

46. That:

- a. two new offences be created in the *Work Health and Safety Act 2011* to give effect to the policy decision to create the offence of negligence causing death to be called 'Industrial Manslaughter' in line with the following objectives:
 - i. create a 'senior officer' offence and an 'employer offence' where conduct negligently or recklessly causes death of a worker;
 - ii. apply the existing standard in Queensland law for criminal negligence;
 - iii. ensure that prosecution decisions in relation to these offences by the new Director of Work Health and Safety Prosecutions is subject to DPP approval as for Category 1 offences and that the DPP may take over any prosecutions under these sections; and
 - iv. provide for the same maximum custodial sentence for an individual as available for manslaughter under the Criminal Code (life imprisonment) and a fine of up to 100,000 penalty units (\$10 million) for a body corporate.
- b. the Queensland Government consider making equivalent amendments to *Electrical Safety Act 2002* and the *Safety in Recreational Water Activities Act 2011* which mirror the offence provisions in the *Work Health and Safety Act 2011*.

Penalties for work-related fatalities and injuries

47. In relation to the payment of work health and safety penalties and fines by insurance companies that:
 - a. the *Work Health and Safety Act 2011* be amended to expressly prohibit insurance contracts being entered into which cover the cost of work health and safety penalties and fines;
 - b. contravention of the prohibition to enter into an insurance contract which covers the cost of work health and safety penalties and fines should be made an offence;
 - c. section 29 of the *Health and Safety at Work Act 2015 (NZ)* be considered as a model for the new statutory requirement; and
 - d. similar amendments be considered for the *Electrical Safety Act 2002* and *Safety in Recreational Water Activities Act 2011*.
48. The new Director of Work Health and Safety Prosecutions (refer to recommendation 31) adopt a strategy to seek to increase the penalties ordered by the courts in appropriate cases over time.
49. In view of inter-state differentials, the Queensland Government seek to include in the 2018 review of the national model work health and safety laws consideration of the development of sentencing guidelines that outline 'suggested penalties' to apply in all jurisdictions. The UK Health and Safety Offences, Corporate Manslaughter and Food Safety and Hygiene Offences Definitive Guideline could be used as a starting point for development of such guidelines.

Further measures

50. WHSQ develop a comprehensive plan to support Health and Safety Representatives and Health and Safety Committees, and encourage uptake in industry, particularly within the priority industry sectors.
51. The *Work Health and Safety Act 2011* be amended to:
 - a. reinstate the repealed provisions relating to the requirement for a person conducting a business or undertaking to provide to the regulator with a list of Health and Safety Representatives and deputy Health and Safety Representatives for each work group;
 - b. require mandatory training for Health and Safety Representatives within six months of a HSR being elected to the role and refreshed at three yearly intervals; and
 - c. require persons conducting a business or undertaking to forward to the regulator a copy of all PINs issued by Health and Safety Representatives.
52. The Government further consider the decision in *Australian Building and Construction Commissioner v Powell* and, if necessary take steps to amend the *Work Health and Safety Act 2011* to ensure that the right to seek assistance is unaffected by permits. A possible amendment to achieve that objective may be to clarify that any right created by the operation of section 70(1)(g) of the *Work Health and Safety Act 2011* is one for the worker concerned and not an invitee.
53. The *Work Health and Safety Act 2011* be amended to provide a framework for the appointment of Work Health and Safety Officers. The appointment of Work Health and Safety Officers should not be mandatory. Work Health and Safety Officer provisions from the *Workplace Health and Safety Act 1995* could be used as a basis for the new framework.
54. As per the current arrangements for codes of practice under the *Work Health and Safety Act 2011*, the appointment of a Work Health and Safety Officer should be permissible as evidence that a duty holder has taken action to mitigate health and safety risks at a workplace. This should also apply to duty holders whose workplaces have an elected trained health and safety representative.
55. In regards to right to information, that:
 - a. the Office of Industrial Relations adopt a more open and transparent approach to information with the default being that information be provided to applicants unless access would genuinely jeopardise an investigation or prosecution, and
 - b. the Office of Industrial Relations formalises and publishes a policy to this effect.
56. The *Work Health and Safety Act 2011* be amended to clarify that a PCBU's duty to allow a health and safety representative access to relevant information under section 70(c) only be subject to claims that involve genuine commercial confidentiality.
57. In relation to WHSQ's response to, and notification to industry of, serious incidents:
 - a. WHSQ refocus the content of incident alerts to address the public interest and stakeholder desire for information by providing information about the investigation process, communicating how further information about incident causation and preventative action will be provided (i.e. incident updates, eSAFE articles, safety alerts) and providing information about previous incidents similar in scope that might offer a relevant safety learning;
 - b. WHSQ expand the scope of incident alerts to include all matters required to be notified to the regulator under the *Work Health and Safety Act 2011*;
 - c. WHSQ publish the refocussed incident alerts on its website;
 - d. WHSQ, through the Organisational Response Governance Group process, apply a coordinated and consolidated approach to reporting organisational responses to notified fatalities in which all

responses to notified fatalities and serious incidents in their entirety are reviewed at six monthly intervals and reported to the Work Health and Safety Board and Industry Sector Standing Committees and published on the WHSQ website;

- e. the Work Health and Safety Board and Industry Sector Standing Committees adopt, as a matter of routine business, a review and advice function with respect to WHSQ's response to notified fatalities and serious incidents in which they review the six monthly reports and provide further advice about additional activity to be pursued; and
- f. WHSQ regard enforceable undertakings in the same light as successful prosecutions and apply the same communication tactics to both.

58. That WHSQ and the new Labour Hire inspectorate develop a formal co-operation arrangement including the exchange of information and technical support. Over time, Inspectors under the Labour Hire Licensing system should be trained and appointed as work health and safety inspectors.

Chapter 1: Introduction

In October 2016, the Premier, the Honourable Anastacia Palaszczuk MP and the Honourable Grace Grace MP, Minister for Employment and Industrial Relations, Minister for Racing and Minister for Multicultural Affairs, announced that a best practice review of work health and safety laws is to be undertaken in response to the recent tragic fatalities at Dreamworld and an Eagle Farm worksite in 2016.

In particular, the high profile incident at Dreamworld, which resulted in four fatalities due to the catastrophic failure of an amusement device, raised concerns about the regulation of public safety matters in Queensland. Additionally, the multiple fatalities at both Dreamworld and Eagle Farm Race Course, where two workers were crushed when a ten tonne precast concrete slab toppled over, raised concerns about the effectiveness of current offences and penalties under the *Work Health and Safety Act 2011* (WHS Act 2011).

Minister Grace announced the commencement of the Review and the terms of reference on 5 April 2017, with a report to be provided by 30 June 2017. The Minister also appointed a tripartite Reference Group to provide commentary and advice on the matters to be considered as part of this review. The reference group was comprised of two technical experts, Dr Linda Colley, Senior Lecturer Industrial Relations, CQ University and Dr Margaret Cook, Discipline Coordinator and Program Advisor – Occupational Health and Safety Science, University of Queensland, and representatives from the Australian Industry Group, Master Builders Queensland, the Queensland Council of Unions, the Australian Workers Union and the Queensland Tourism Industry Council.

1.1 Scope of Review

Under the terms of reference (a full copy of which appears as **Appendix 1**) the Review is to consider WHSQ effectiveness in light of contemporary regulatory practice. The scope of the Review encompasses all WHSQ's functions including inspections, investigations, prosecutions, enforceable undertakings, research, strategy and policy development, information and education and awareness campaigns.

The review and subsequent recommendations specifically considered:

- the appropriateness of WHSQ's Compliance and Enforcement Policy;
- the effectiveness of WHSQ's compliance regime, enforcement activities, and dispute resolution processes;
- WHSQ's effectiveness in relation to providing compliance information and promoting work health and safety awareness and education;
- the appropriateness and effectiveness of the administration of public safety matters by WHSQ; and
- any further measures that can be taken to discourage unsafe work practices, including the introduction a new offence of gross negligence causing death as well as increasing existing penalties for work-related deaths and serious injuries.

1.2 Review Process

A discussion paper on the review, providing background information and containing fifty-eight discussion questions relevant to the terms of reference, was issued in April 2017, with written submissions sought from interested stakeholders. A range of unions, employer organisations, agencies and academics provided written materials. In addition to the meetings of the reference group, discussions were held with a large number of interest groups and relevant Queensland Government agencies and statutory office holders. A full list of organisations consulted and submissions received are contained in **Appendix 2 and 3**.

The Reviewer had extensive discussions with key staff across WHSQ, met with construction industry inspectors, and spent two days 'on the road' with inspectors in Brisbane and the Lockyer Valley.

In May 2017, after having considered submissions in relation to the question of a new “industrial manslaughter” offence, I concluded that further consultations in relation to the fundamental question of the creation of the offence would not result in any alteration to fixed and long held positions of key stakeholders. Having formed a view that I did intend to include in my report a recommendation that an offence of negligence causing death (i.e. an offence equivalent to manslaughter) be created in Queensland, I wrote to the Minister requesting her advice as to the Government’s in principle position on the matter.

The Minister was able to advise that the Government supported this approach, allowing further consultations to focus on the design of the offence. I am grateful to the Minister and the Premier for their support for this approach. On that basis, further written submissions were accepted on this question.

The Review also considered a large volume of statistical information, and policy and operational material provided by WHSQ at their initiative or upon my request.

The views expressed in this report are those of the reviewer and not the Reference Group.

1.3 Acknowledgements

First, I would like to thank members of the Families Forum who provided valuable input on the experiences of the victims of fatal workplace accidents and the effects on families and loved ones. I am particularly grateful they made time to meet with me while in Brisbane to attend the commemoration for international Workers’ Memorial Day.

I would like to acknowledge the contribution of members of the Reference Group and industry stakeholders who met with me to outline their views and provide written submissions. This input, which often went to detailed industry specific issues that bear on the operations of the legislation and WHSQ, was invaluable in ensuring I was able to have a clear picture of the key issues and the ability to formulate appropriate recommendations.

I particularly acknowledge the work of the Queensland Council of Unions (QCU) in co-ordinating the input of unions, Master Builders Queensland (MBQ) for facilitating employer organisation input from their industry, and the Queensland Tourism Industry Council for arranging round-tables of employers to discuss the review.

I would like to thank Dr Simon Blackwood, all the staff of WHSQ and the broader Office of Industrial Relations (OIR) who assisted with the conduct of the review. I also acknowledge the input and views provided by a range of other agencies of the Queensland Government.

Finally, the support from Renee McCarroll, Principal Policy Officer at OIR, in leading the Secretariat function for the Review was indispensable. Her diligence and professionalism have been a key factor in enabling the completion of this review within a challenging timeframe.

Chapter 2: The appropriateness of WHSQ's compliance and enforcement policy

As part of the terms of reference for the review, the Review is required to consider the appropriateness of WHSQ's compliance and enforcement policy. There are three key factors that influence WHSQ's compliance and enforcement policy, these include:

- the legislative framework, which includes the Queensland *Work Health and Safety Act 2011* (WHS Act 2011) and associated regulations, codes of practice and guidance;
- the National Compliance and Enforcement Policy, which has been adopted by state regulators as part of the national harmonisation process; and
- the Australian and Queensland work health and safety strategies, which include commitments to targets for a reduction in injuries and fatalities as well as the identification of key priority industries and disorders.

These factors will be discussed in turn below.

2.1 Queensland's work health and safety laws

Queensland adopted the national model work health and safety laws through the WHS Act 2011 and *Work Health and Safety Regulations 2011* (WHS Regulation 2011) on 2 January 2012. These model laws have been adopted in all Australian jurisdictions except for Victoria and Western Australia.

The WHS Act 2011, while largely consistent with Queensland's previous work health and safety legislation, introduced a number of key changes. These included:

- Qualifying the duties of care under the WHS Act 2011 by the 'reasonably practicable' standard.
- Removing the reverse onus of proof which means the regulator is now required to prove all elements of the breach and demonstrate that the employer has not taken reasonably practicable measures to prevent the breach. Previously under the absolute duty of care, with defences, the onus of proof was on the defendant.
- Introducing three categories of penalties for a failure to comply with a duty of care which are categorised by the degree of seriousness or culpability involved. In addition a number of new sanctions were introduced including court ordered undertakings, injunctions, adverse publicity orders, project orders and training orders.
- Placing a positive duty of due diligence on an officer of a corporation or an unincorporated body to ensure compliance through sound corporate governance. An officer must be proactive in taking steps to ensure compliance by the company. Previously executive officers of a corporation could only be found to have committed an offence if the corporation committed an offence.
- Establishing a new duty on persons conducting a business or undertaking to consult with workers and specifying when consultation is required. This gives workers the opportunity to raise work health and safety matters that directly affect them. The WHS Act 2011 also introduced a legislated issues resolution procedure and provisions allowing a worker to cease work if exposed to a serious and imminent risk.

The model work health and safety laws are supported by 23 model codes of practice, 20 of which have been adopted in Queensland. Additionally, Queensland has 21 preserved codes of practice where there is no equivalent model code of practice or the codes support a number of regulations that were carried across from the *Work Health and Safety Regulation 2008* (i.e. construction regulations relating to falls from height and falling objects).

In considering the appropriateness of WHSQ's enforcement and compliance policy stakeholders identified a number of areas where the legislative framework should be reviewed to ensure it is effective in improving work health and safety outcomes. These areas include:

- restoring the status of codes of practice;
- restoring the reverse onus of proof;
- amending section 171 of the WHS Act 2011 to resolve drafting issues that have resulted in unintended consequence; and
- restoring the principal contractor duty for common plant.

Each of these matters will be discussed below in turn.

2.1.1 Status of codes of practice

During consultation for the Review it was identified that there is a difference of view between stakeholders about the status of codes of practice and their ability to be enforced by inspectors. In particular, there is a long standing view from the Building Trades Group of Unions (BTGUs) that the transition to the model work health and safety laws in Queensland resulted in a watering down of the legislative status and enforceability of codes of practice. In particular, the BTGUs are of the view that codes of practice are no longer enforceable under the current regime and that compliance with a code of practice should be explicitly prescribed under the WHS Act 2011 (as was the case under the *Workplace Health and Safety Act 1995* (WHS Act 1995)). This has led to a process where regulatory amendments are being pursued to call up specific requirements from codes of practice and make them regulations. The end goal of this action is to ensure specific requirements currently contained in codes of practice are enforceable, and ensure that the legislative framework supports inspectors being able to enforce safety standards.

Conversely, MBQ are of the view that the current legal standing of codes of practice is sufficient and effective if correctly interpreted and exercised by inspectors and industry. In particular, MBQ are of the view that:

“Codes of Practice still hold relevant legal standing for employers and workers to rely on a Code of Practice, both from a practical and a legal perspective. Additionally, it is not evident that there is an overwhelming gap in the law that would suggest that the provisions at section 275 of the WHS Act should be amended or that the Codes themselves need to be referred in the Regulations or called up in their entirety”³.

MBQ did however call for this matter to be subject to review so it can be resolved clearly in an effort to avoid unnecessary restructuring of current codes of practice and the WHS Regulation 2011.

The status of Codes of Practice under the *Work Health and Safety Act 2011*

Codes of practice are practical guides that assist duty holders to achieve the standards of health, safety and welfare required under the WHS Act 2011 and the WHS Regulation 2011. Codes of practice apply to anyone who has a duty of care in the circumstances described in the code and, in most cases, following a code of practice will achieve compliance with health and safety duties in relation to the subject matter of the code.

Section 275 of the WHS Act 2011 provides that codes of practice can be used in proceedings:

- as evidence of whether or not a duty holder has complied with their obligations,
- as evidence of what is known about a hazard or risk and how to control it, and
- to determine what is reasonably practicable in the circumstances.

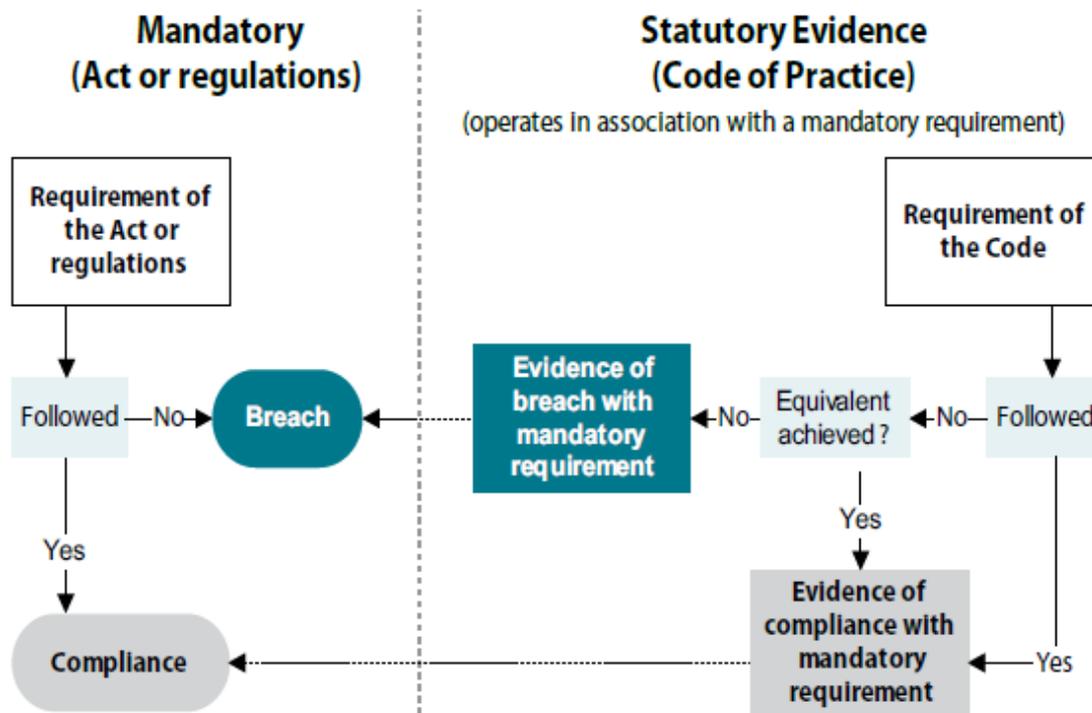
Section 275 further provides that duty holders can demonstrate compliance with the WHS Act 2011 by another method which provides an equivalent or higher standard of health and safety than that provided in

³ Master Builders Queensland submission, p12.

a code of practice. This allows duty holders to take into account innovation and technological change in meeting their duty and to implement measures most appropriate for their individual workplaces without reducing safety standards.

The diagram below⁴ indicates how codes of practice can be used as evidence in determining whether a duty holder is managing a risk to the standard of ‘reasonably practicable’ in relation to a health and safety duty.

Figure 1 – How codes of practice should apply



From an enforcement perspective, under the WHS Act 2011, an inspector may issue an improvement notice for a contravention, a prohibition notice in circumstances where an activity involves a serious and imminent risk to person’s health and safety, and an infringement notice where a person has committed an infringeable offence. While these enforcement tools provide options for remedying breaches of mandatory requirements under the WHS Act 2011, they are not applicable to circumstances where a requirement in a code of practice is breached. This is despite the fact codes of practice can be used as evidence of the minimum safety standards required to discharge health and safety duties. Importantly however, codes of practice can be referred to in improvement and prohibition notices if an inspector directs a duty holder to follow the requirements of a code of practice to remedy a mandatory requirement in the WHS Act 2011. For example, relevant requirements of the *Managing the Risk of Falls at Workplaces Code of Practice 2011* can be referred to where a duty holder has failed to manage the risk of a fall under section 78 of the WHS Regulation 2011. It should be noted however, that the ability to issue a direction by an inspector is discretionary, but where a direction to follow the requirements in a code of practice is issued, compliance with this direction is mandatory.⁵

WHSQ have advised the Review that current operational policies encourage inspectors to make reference in compliance notices to relevant codes of practice where applicable.

⁴ Stewart-Crompton, R, Mayman, S, and Sherriff, B, *National Review into Model Occupational Health and Safety Laws: Second Report to the Workplace Relations Ministers’ Council*, January 2009, p449.

⁵ *Work Health and Safety Act 2011* ss 192(2), 193, 196(2), and 197.

The status of Codes of Practice under the *Workplace Health and Safety Act 1995*

Under the WHS Act 1995, section 26(3) provided that if a code of practice states a way of managing exposure to a risk, a person discharged their health and safety duty only by:

- a. adopting and following a stated way that manages exposure to the risk; or
- b. doing all of the following—(i) adopting and following another way that gives the same level of protection against the risk; (ii) taking reasonable precautions; (iii) exercising proper diligence.

This provision had the effect of making it mandatory to follow a code of practice to the extent that equal to or better than risk management strategies were not employed.

Similar to the WHS Act 2011, codes of practice were admissible as evidence in proceedings (a) where the proceeding related to a contravention of an duty imposed on a person; (b) it was claimed the person contravened the duty by failing to manage exposure to a risk; and (c) where the code of practice was about managing the exposure to the risk.⁶

Codes of practice under the WHS Act 1995 expired 10 years after their commencement.⁷

In terms of enforcement of codes of practice under the WHS Act 1995, inspectors could issue an improvement notice where they reasonably believed a person has contravened a provision of the WHS Act 2011.⁸ As adopting and following the requirements in a code of practice was a legislative requirement under section 26 (unless equal to or better than risk management could be demonstrated), failure to do so would have constituted a contravention. This subsequently enabled improvement notices to be issued for failure to comply with a code of practice in the absence of alternative safety measures. Failure to comply with an improvement notice was an offence under the WHS Act 1995.

Findings

While both the 1995 and 2011 work health and safety regimes provide a framework where compliance with a code of practice can be used as evidence that a duty holder has complied with their safety obligations, the regimes are markedly different in relation to their enforceability.

The WHS Act 1995 made it explicitly clear that a code of practice had to be followed as a minimum and in doing so provided a specific provision that improvement notices could be issued against. Conversely, while the WHS Act 2011 continues to promote codes of practice as the minimum standard (this is evidenced by the application of codes of practice to court proceedings), there is no standalone provision that enables failure to reach this minimum standard to be enforceable by inspectors. While there is an ability for inspectors to refer to codes of practice in compliance notice directions (which would have the effect of making following a code of practice mandatory), this power is discretionary and requires a link back to an overarching duty of the WHS Act 2011 or Regulations, a somewhat more convoluted process than in the WHS Act 1995.

Given the strong stakeholder support for the role of codes of practice, it is appropriate to clarify their status to give certainty to employers, unions and the regulator. The aim is to ensure that codes of practice operate in a manner which assists all industry participants to manage work health and safety risks, including the inspectorate.

It is the view of the Review that a specific legislative provision, such as existed in the WHS Act 1995, is required to make it clear that codes of practice are the minimum standard and provide a clearer avenue for enforcement action by inspectors. Additionally, an approach similar to the WHS Act 1995 would eliminate

⁶ *Workplace Health and Safety Act 1995* s 42.

⁷ *Ibid* s 41(5).

⁸ *Ibid* s 117.

the suggested need by unions for requirements in codes of practice to be brought up into the WHS Regulations 2011 - a review process that was commenced to facilitate enforcement action and provide clarity to duty holders regarding their obligations.

In addition to providing clarity regarding the legislative status of codes of practice, it is prudent to ensure the content of codes of practice remains relevant and responsive to emerging safety issues, changes in industry work practices and technological advances. To this end, codes or practice must be regularly reviewed and updated in consultations with key industry stakeholders. For consistency, such reviews should be conducted every five years as is the case for the model codes of practice administered by Safe Work Australia (SWA).

Recommendations

5. The status of codes of practice be clarified by restoring the previous requirements in section 26(3) of the *Workplace Health and Safety Act 1995*.
 6. The *Work Health and Safety Act 2011* be amended to require a mandatory review of each Code of Practice in operation in Queensland every five years.
-

2.1.2 Restoring the reverse onus of proof

In their submission to the Review the BTGUs proposed that the reverse onus of proof should be restored to promote the ability for WHSQ to be proactive about bringing prosecutions for breaches of the work health and safety laws.

What is the onus/burden of proof?

In criminal proceedings, the burden (or onus) of proof lies with the prosecution, i.e., the prosecution must prove the elements of the offence beyond reasonable doubt (legal onus). Where an accused person raises a defence, they must satisfy the evidential onus supporting the defence raised. Where the prosecution seeks to disprove the evidence put forward by the defence, it bears the onus of negating the defence evidence beyond reasonable doubt. This general principle, that the onus of proof (both legal and evidential) lies with the prosecution, is a long-standing common law principle that “reflects the balance struck between the power of the State to prosecute and the position of an individual who stands accused.”⁹ However, it is also a long-standing principle that the onus of proof may be regulated (i.e. reversed) by explicit legislative provision.¹⁰

Queensland Work Health and Safety legislation – onus of proof

Under the WHS Act 1995, the defendant (duty holder), not the prosecution, had to establish that they had taken all reasonably practicable steps to prevent the risk to health and safety occurring. In essence, the WHS Act 1995 provided for a reverse onus of proof. However, defences were open to the defendant.¹¹ New South Wales also had a similar provision in its occupational health and safety legislation.

With the national harmonisation of work health and safety laws, the resulting model Work Health and Safety Act (which was adopted in Queensland) provided that the onus of proof rests with the prosecution. Even though the previous reverse onus had been removed, the WHS Act 2011 still includes some provisions which expressly place the evidential (not legal) onus on an accused. However, the prosecution retains the legal onus of proof, i.e. it must prove each element of an offence.

⁹ *Lee v The Queen* [2014] HCA 20 (21 May 2014) [32].

¹⁰ *Kuczborski v Queensland* [2014] HCA 46 [240] (Crennan, Kiefel, Gageler and Keane JJ).

¹¹ *Workplace Health and Safety Act 1995*, s 37.

Onus or proof and the *Legislative Standards Act 1992*

The *Legislative Standards Act 1992* sets out principles that underpin a parliamentary democracy which is based on the rule of law (the fundamental legislative principles, or FLPs). These principles include a requirement that legislation has sufficient regard to the rights and liberties of individuals.¹² Whether this requirement is met depends on whether, among other things, the legislation reverses the onus of proof in criminal proceedings *without adequate justification*.¹³ If the reverse onus of proof were to be reinstated in the current legislation, adequate justification would need to be provided.

Prosecution bears the onus v reverse onus of proof

The issue of onus of proof was canvassed during the consultation between jurisdictions and stakeholders leading up to national harmonisation. Prior to harmonisation, only the Queensland and New South Wales work health and safety Acts provided for a reverse onus of proof in relation to duty of care offences, however the duties under these Acts were absolute and not qualified by ‘reasonably practicable’.

The National Review into Model Occupational Health and Safety Laws (National OHS Review) found that there were conflicting views in relation to this issue with industry bodies and employers strongly opposing a reverse onus of proof and unions strongly supporting the proposal.¹⁴

The case for the prosecution bearing the onus of proof relies on the generally accepted principle that in a criminal prosecution, the onus of proof beyond reasonable doubt normally rests on the prosecution. The instances in which a reverse onus is provided for do not usually involve heavy penalties or imprisonment.

The case for reversing the onus relies on the view that a defendant will be in the best position to know how the defendant has met the duty at issue and that it is not unfair for the defendant to be required to prove on the balance of probabilities that the defendant did so to a ‘reasonably practicable’ standard. It has also been suggested that it will make securing a conviction unnecessarily burdensome if the prosecution has to show this beyond a reasonable doubt.¹⁵

On the basis that the qualification of ‘reasonably practicable’ was being recommended by the national review, it was concluded that the onus should be placed on the prosecution to prove this standard wasn’t met.¹⁶

Findings

The review considers that there is a not-insignificant case for the restoration of the reverse onus of proof being restored as an aid to compliance and enforcement and to ensure the positive obligations of persons conducting a business or undertaking (PCBUs) to maintain a safe system of work. However, given the issue of onus of proof is a core part of the model work health and safety laws, a change to this requirement is problematic if pursued in Queensland alone and it is appropriate that the matter be further considered as part of the national review of the model work health and safety laws being undertaken in 2018.

Recommendation

7. The Queensland Government raise the issue of reintroducing a reverse onus of proof as part of the 2018 review of the model work health and safety laws. The 2018 review should consider what effect the

¹² *Legislative Standards Act 1992*, s 2(a).

¹³ *Ibid* s 4(3)(d); https://www.legislation.qld.gov.au/Publications/OQPC/FLP_Reversal_of_Onus1.pdf

¹⁴ *National Review into Model Occupational Health and Safety Laws - First Report to the Workplace Relations Ministers’ Council*, October 2008, p152.

¹⁵ *Ibid* p154.

¹⁶ *Ibid* p155.

change has had nationally on patterns of enforcement, the success rates of prosecutions and safety outcomes.

2.1.3 Use of inspector powers under section 171 of the WHS Act 2011

Under section 171 of the WHS Act 2011, inspectors have the power to require a person to produce documents, provide information on the whereabouts of documents, and answer any questions put by the inspector. Subsection (2) provides that ‘a requirement [to produce documents] must be made by written notice unless the circumstances require the inspector to have immediate access to the document’. Use of inspectors’ powers under section 171 first requires an inspector to identify themselves and issue certain warnings.¹⁷ Once these have been given, non-compliance without a reasonable excuse is an offence.¹⁸

Practical issues

The wording of section 171 has raised some issues about how the powers are used regarding time and place. Specifically, the issues focus on whether the powers, including the issue of the section 171 written notice, must be exercised at the workplace at the time of the workplace entry or at another place later, and whether they can be used by the inspector who first entered the workplace or another inspector at a later time. Some of the practical quandaries in relation to section 171 include:

- the text of section 171 limits the power to “an inspector who enters a workplace”;
- entry into one workplace (such as a regional office of an employer) does not necessarily permit the use of inspectors’ powers at associated workplaces (e.g. a head office);
- the extent of inspectors’ ability to make use of the requirement to answer questions at locations other than a person’s ordinary workplace is unclear;
- currently, the section 171 powers appear to be tied to physical entry into each individual workplace, which potentially limits both the speed and effectiveness of inspectors’ investigations.

Findings

The current wording of section 171 may result in some unintended consequences that have the potential to limit and/or complicate the use of inspector powers in a manner not intended by Parliament. This has ramifications for the management of WHSQ investigations, particularly in the case of remote workplaces and the increasing trend of decentralised workplaces. It is the view of the Review that this is contrary to the intention of the inspector powers and that minor amendments should be made to the WHS Act 2011 to clarify that section 171 powers are not strictly limited to circumstances where an inspector ‘enters’ a workplace. This is intended to ensure that investigations are not inappropriately limited by a legal technicality.

Recommendation

8. Section 171 of *Work Health and Safety Act 2011* be amended to provide that:
 - a. the exercise of the power be extended to an inspector who has entered a workplace on a previous occasion;
 - b. section 171(1)(b) apply where a document is located at any place, not just the workplace;
 - c. the production of the document to be made at any place, not just the workplace;
 - d. require a relevant person to answer questions at any time and place convenient; and
 - e. provide that anything done by an inspector who has not entered a workplace is lawfully done if another inspector has entered the workplace.

¹⁷ *Work Health and Safety Act 2011*, s 173.

¹⁸ *ibid*, s 171(6).

2.1.4 Principal Contractor Obligations for Common Plant

The BTGUs have called for the principal contractor's duty for common plant under the now repealed *Workplace Health and Safety Regulation 2008* (WHS Regulation 2008) to be restored in the WHS Regulation 2011.

Principal contractors' duty in the 2008 Regulation

Section 278(1) of the WHS Regulation 2008 stated that if a principal contractor provided common plant, the principal contractor must--

- a) ensure the plant is safe for the purpose for which it is provided when it is provided; and
- b) keep the plant effectively maintained while it is provided; and
- c) comply with the provisions of this regulation about plant of the same type as the common plant as if the provisions applied to the common plant.

Duties in current WHS legislation

Plant is defined in Schedule 5 of the WHS Act 2011 as machinery, equipment, appliance, container, implement and tool, and any component of any of those things and anything fitted or connected to any of those things. This definition is inclusive of items of common plant.

The WHS Act 2011 has no explicit provisions for principal contractor obligations for common plant but does have comparative provisions. Section 21 requires a PCBU having control of plant to 'ensure, so far as is reasonably practicable, that the fixtures, fittings and plant are without risks to the health and safety of any person'.¹⁹ Likewise, section 26 imposes a responsibility on PCBUs who install, construct or commission plant to be used at a workplace to ensure that the persons who install, use, dismantle or are in the vicinity of are not put at risk by the plant.²⁰

The WHS Regulation 2011 also contains additional responsibilities regarding PCBUs, principal contractors and plant. In particular, a PCBU that installs, constructs or commissions plant at a workplace must have regard to information provided by the designer, manufacturer, importer or supplier, and any instructions provided by a competent person with regard to health and safety.²¹

The WHS Regulation 2011 also specifies various additional control measures for general plant for the person with management or control of plant at a workplace.²² This includes control measures for particular plant, such as powered mobile plant,²³ industrial lift trucks,²⁴ plant that lifts or suspends loads²⁵ and scaffolding.²⁶

Findings

Taken together, the current provisions exceed the requirements of section 278(1) of the WHS Regulation 2008. Accordingly, the Review is satisfied that the responsibilities placed on principal contractors with regard to the commissioning, maintenance and operation of plant are above those contained in the WHS Act 1995 and the WHS Regulation 2008. Consequently, no legislative action is required, however WHSQ should take appropriate steps to clarify the issue with relevant industry stakeholders.

¹⁹ *Work Health and Safety Act 2011*, s 21(2).

²⁰ *Ibid*, s 26(2).

²¹ *Work Health and Safety Regulation*, s 201.

²² *Ibid*, ss 204-213.

²³ *Ibid*, ss 214-215.

²⁴ *Ibid*, s 218.

²⁵ *Ibid*, s 219.

²⁶ *Ibid*, s 225.

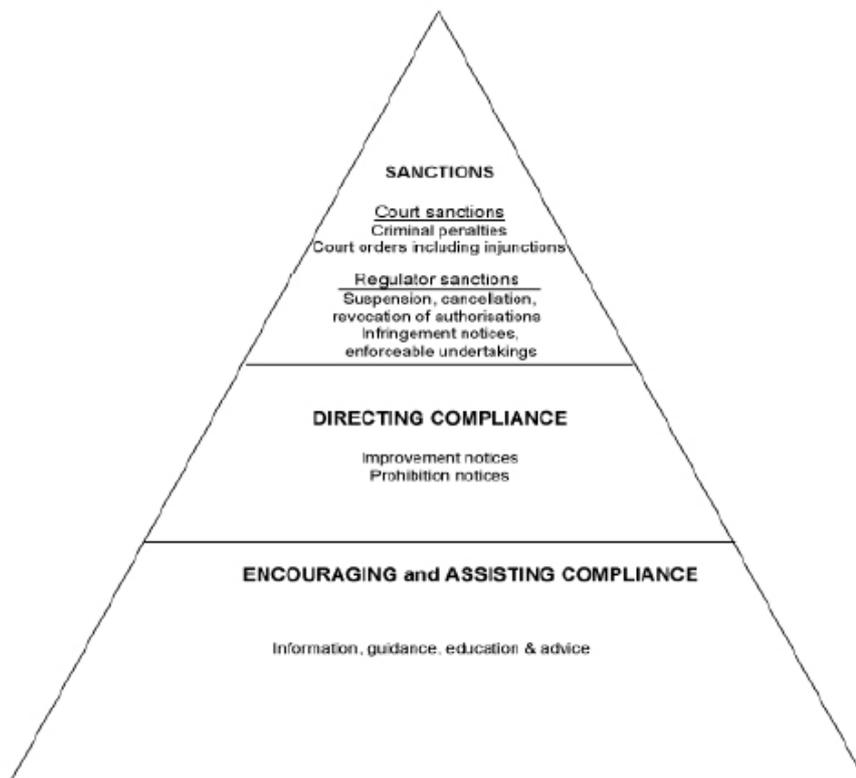
2.2 WHSQ’s compliance and enforcement policy

In determining the most appropriate enforcement action to undertake, WHSQ are currently guided by the need to balance the community’s expectations that duty holders will be monitored and held accountable for non-compliance and the need to work with industry to support and build compliance capacity.²⁷

WHSQ’s approach to enforcement and compliance is based on the *National Compliance and Enforcement Policy*²⁸ (National Policy) and seeks to encourage compliance through a responsive regulatory model that combines deterrence and accommodative regulation into a multifaceted enforcement regime. This approach recognises that regulatory tools such as persuasion and cooperation are just as important to achieving compliance as the imposition of punitive sanctions. This approach is aimed at achieving a balance between the two forms of regulation which acknowledges that the willingness and ability of a duty holder to comply is a key driver in determining the most appropriate enforcement action to be taken in a particular circumstance.

In deciding what the most appropriate regulatory response is, WHSQ are guided by the National Policy and its enforcement pyramid (see Figure 2).

Figure 2 – National Compliance and Enforcement Policy Pyramid



The regulatory pyramid represents what is described as a “proportional approach” to the application of enforcement tools and shows that, as a regulator escalates up the pyramid, the regulatory strategy intensifies from persuasion through to sanctions of increasing severity. The premise behind the regulatory pyramid is that where an individual being regulated is being cooperative, the regulator in turn should attempt to achieve compliance through cooperative ‘persuasive’ measures. Conversely, where an individual is being

²⁷ National Compliance and Enforcement Policy, p2.

²⁸ <http://www.safeworkaustralia.gov.au/sites/swa/about/publications/pages/national-compliance-enforcement-policy>.

uncooperative the regulator should escalate through the pyramid until punitive sanctions are required thus creating a framework where refusal to comply will result in increasingly severe enforcement action. This approach is not intended to suggest that enforcement and compliance action should always commence with persuasive measures, but rather it acknowledges that more often than not compliance can be achieved through cooperative measures.

Other factors considered by WHSQ in determining the most appropriate enforcement action to undertake include:

- the severity or extent of the potential risk or harm;
- the seriousness of the potential breach and the culpability of the duty holder;
- the duty holder's compliance history, attitude and the likelihood that the offence will be repeated;
- whether the duty holder was licensed or authorised to undertake the work;
- whether the enforcement tool used will encourage compliance or deter non-compliance;
- whether the duty holder has taken action to try and control a risk and whether the risk is imminent; and
- whether immediate action or a plan to take action will address the safety issue.²⁹

Progressively, and particularly since the introduction of the WHS Act 2011, WHSQ have used a broader range of mechanisms such as utilising information, guidance education and advice to obtain compliance. Subsequently, the focus of inspectors and advisors has increasingly been to address overall poor performance rather than simply addressing point in time and obvious unmanaged risks. This acknowledges that continuous improvement of poor performance requires a systematic and sustained approach to work health and safety management. Programs such as the Injury Prevention and Management (IPaM) program and the Small Business Program, which deliberately take a cooperative approach to achieve compliance, are primarily aimed at achieving this.

Other activities undertaken by WHSQ such as compliance campaigns use a combination of directive measures, such as improvement notices, and other mechanisms to achieve outcomes. Often an educative phase is used initially, with the workplace given the information, tools and opportunity to voluntarily address their issues before an inspector visits. In instances where the inspector still finds significant unmanaged risks, notices will be issued. The likelihood of there being outstanding risks however is considered to be lessened. In these cases, it is the combination of the educative phase and the likelihood of a site visit by an inspector which achieves widespread improvements even if an inspector does not select that particular workplace to visit.

Stakeholder feedback on WHSQ's compliance and enforcement policy

In response to the issue of whether WHSQ have achieved the appropriate balance between enforcement and providing industry with the right tools, information and ability to make workplaces safer, stakeholder views were mixed. Employer representatives, the Australian Sugar Milling Council (ASMC), the Australian Industry Group (AiGroup) and MBQ were generally supportive of the current approach taken by WHSQ, it was noted however by MBQ that the policy outlined above is not how the process works out the in the field. In particular, MBQ noted that:

"Although there is an effort by most inspectors to follow the policy, provide education where necessary and use punitive options as required, it is our understanding from our members feedback that there is a large amount of inconsistency in the approach taken across the board."³⁰

²⁹ National Compliance and Enforcement Policy, p7.

³⁰ Master Builders Queensland submission p12.

In terms of addressing this issue, MBQ recommended:

*"[WHSQ] review their current internal monitoring processes to ensure that the inspectorate is consistently and appropriate (sic.) applying the enforcement framework policy to all situations and where this is not happening, provide appropriate training or counsel to improve consistency."*³¹

The Housing Industry Association (HIA) also acknowledged that the WHSQ policy was based on the National Policy, but submitted based on that fact, it was unclear what the policy actually was:

*"...the National Compliance and Enforcement Policy simply provides guiding principles to jurisdictions on how they should approach the implementation and enforcement of WHS laws. From an industry perspective it is vital that a detailed policy is developed that provides clarity in relation to how the regulator intends to undertake compliance and enforcement activities."*³²

In contrast, a number of stakeholders noted that there is an over-reliance on the provision of information, guidance, education and advice to employers, and that more deterrent enforcement, such as prosecution, is needed. In particular, the QCU submitted:

*"...there is insufficient deterrence associated with current strategies...deterrence will improve compliance outcomes."*³³

This was also noted by the BTGUs who submitted:

*"WHSQ blindly follows the National Compliance and Enforcement Policy...which presupposes that persuasion and cooperation are just as important to achieving compliance as the imposition of punitive sanctions. This is clearly nonsense."*³⁴

Findings

The review finds that although the WHSQ compliance and enforcement policy, which is based on the National Policy, is an appropriate approach where it is properly and consistently applied, it is currently not adequately balanced between assisting and directing compliance. The review also finds that there is currently a lack of clarity and visibility to stakeholders about the substance of the policy and its application.

To improve compliance, WHSQ have used a broad range of mechanisms such as utilising information, guidance, education and advice, particularly through programs such as the IPaM program, to address overall poor performance rather than simply addressing point in time and obvious unmanaged risks. However, there is a tendency when trying to balance regulatory enforcement for a 'pendulum effect' to occur that can change the emphasis of compliance and enforcement activities and ultimately overshoot its optimal setting, as is the case here.

The review finds that WHSQ has overemphasised "encouraging and assisting compliance" at the expense of appropriate use of powers to "direct compliance" when necessary. Directed compliance also plays a role in ensuring that assistance and encouragement is effective – where employers are clearly on notice that directed compliance will be used where necessary there is a single sent that encourages voluntary improvement in standards.

Inspectorate activity data reported by SWA in the Comparative Performance Monitoring reports indicates that there have been significant changes in compliance and enforcement behaviours by WHSQ (see section

³¹ Ibid p13.

³² Housing Industry Association submission p1.

³³ Queensland Council of Unions submission p1.

³⁴ Building Trades Group of Unions submission p11.

3.3 – Inspectorate Activity) which are unrelated to changes in legislation, and therefore must be attributed to internal operational policies and procedures.

For these reasons, the Review finds that WHSQ should develop a compliance and enforcement policy in supplement to the National Policy. The supplementary policy should provide sufficient detail so that inspectors are able to consistently apply it, and industry is able to understand the circumstances in which enforcement actions will be escalated in order to achieve compliance.

Recommendations:

9. WHSQ develop a compliance and enforcement policy (new policy) in supplement to the National Compliance and Enforcement Policy that provides sufficient detail about enforcement actions to be utilised in certain circumstances to ensure compliance. In developing the compliance and enforcement policy it is recommended that:
 - a. WHSQ more precisely identify the use a “directed compliance” as a vital, widely available tool to ensure safe workplaces;
 - b. WHSQ consult with stakeholders and the Work Health and Safety Board in developing the new policy;
 - c. WHSQ publish the new policy on their website;
 - d. WHSQ review the new policy at least every five years;
 - e. WHSQ measure and report on compliance and enforcement performance against the policy, annually; and
 - f. The Work Health and Safety Board include reviewing WHSQ’s performance against the policy as part of their five year strategic plan to ensure that the balance of WHSQ’s compliance and enforcement activities are continually monitored.

2.3 Development of the *Australian Work Health and Safety Strategy 2012-2022* and Queensland health and safety strategies

The *Australian Work Health and Safety Strategy 2012-2022* (the Australian Strategy) builds on the *National Occupational Health and Safety Strategy 2002–2012* and provides a framework to help improve work health and safety in Australia. The Strategy’s vision is *healthy, safe and productive working lives* and its purpose is to drive key national activities, through collaboration between governments, industry, unions and other organisations, to achieve improvements in work health and safety.³⁵

Development of the Australian Strategy was informed by consultation with work health and safety experts and the wider community, and the final strategy was endorsed by all ministers responsible for work health and safety (including Queensland), the Australian Council of Trade Unions, the Australian Chamber of Commerce and Industry, and the AiGroup.

The Australian Strategy sets out four outcomes to be achieved by 2022, these include *reducing the incidence of work-related death, injury and illness; reducing exposure to hazards and risks; improving hazard controls; and improving work health and safety infrastructure*³⁶. To achieve these outcomes, the Australian Strategy highlights a number of priority industries and disorders that should be the focal point of prevention activities. It also provides national targets and performance indicators to determine the success of these activities. These targets and priority areas are outlined in Table 1 below.

³⁵ *Australian Work Health and Safety Strategy 2012-2022*, p4.

³⁶ *ibid* p6.

Table 1 – National targets and priority industries/disorders

Targets ³⁷	Priority industries ³⁸	Priority disorders ³⁹
A reduction in the number of worker fatalities due to injury of at least 20%	Agriculture	Musculoskeletal
	Road transport	Mental disorders
	Manufacturing	cancers (including skin cancer)
A reduction in the incidence rate of claims resulting in one or more weeks off work of at least 30%	Construction	asthma
	Accommodation and food services	contact dermatitis
A reduction in the incidence rate of claims for musculoskeletal disorders resulting in one or more weeks off work of at least 30%.	Public administration and safety	noise-induced hearing loss
	health care and social assistance	

In line with its commitment to the Australian Strategy, WHSQ have identified, through the use of an evidence-based approach (see discussion at section 3.1), a number of priority industries and priority disorders that align with the Australian Strategy and which require targeted and sustained action to improve safety outcomes.

Priority industries identified by WHSQ include four broad industry groups and seven industry sub-groups that have the highest risk of work-related injuries or fatalities in Queensland. These industries include manufacturing (sub-sectors: meat processing and metals manufacturing), transport (sub-sector: road freight transport), rural (sub-sectors: horticulture and livestock) and construction (sub sectors: civil construction and construction trades).

In addition to the priority industries, WHSQ have identified a number of priority disorders. These include musculoskeletal disorders, mental health disorders, asbestos-related disorder, ultraviolet radiation and heat-related disorders, chemical, dust and infectious-related disorders, noise-induced hearing loss disorders and disorders arising from lifestyle chronic disease risk factors. These disorders were identified as priorities because of the severity of consequences for workers; the estimated high overall cost to businesses and workers; the overall number of workers estimated to be directly and indirectly affected; and the existence of known prevention options.

To drive improvements in the incidence of injuries and fatalities in these priority areas, WHSQ have developed individual action plans for each industry sub-sector and disorder. These can be found at <https://www.worksafe.qld.gov.au/about-us/about-workplace-health-and-safety-queensland/our-focus>.

These action plans are a core element of WHSQ's enforcement and compliance framework and outline key deliverables WHSQ will undertake to achieve sustained improvements in work health and safety outcomes.

Stakeholder feedback on the relevance and appropriateness of WHSQ's priority industry and disorder action plans

There were no submissions suggesting that the current industry focus by WHSQ is inappropriate or that WHSQ is wrongly targeting the identified industries however feedback was received from the Queensland

³⁷ Ibid p7.

³⁸ Ibid p17.

³⁹ Ibid p17.

Nurses and Midwives Union (QNMU) that “health and community services needs to be classified as a priority industry to reflect the continued growth of employees in this sector”⁴⁰. In particular, QNMU noted that:

“the highest percentage of total employment in Queensland was recorded in the health care and social assistance industry (12.9%) and this was also the case in total employment in Australia (12.8%).”⁴¹

In relation to priority disorders, submissions identified concerns around the low level of focus on occupational disease, especially respiratory diseases. In particular, the re-emergence of black lung demonstrates that a robust framework for health surveillance is required. Gunther Paul, from James Cook University, submitted

“The discussion about reoccurrence of Black Lung in Queensland, as expertly documented in Prof Malcolm Sim’s report to the Queensland Parliamentary inquiry, has provided evidence of a failed system in managing respiratory health in Queensland’s mining and mining logistics industry. The report provides ample proof of systemic issues, which have not been identified in the WHS Strategy nor Queensland’s strategy. This lack of analysis must be seen as a significant concern. Overarching, the lack of a robust health surveillance framework, integrating data from different sources with a capability to infer issues of significance requires much more attention in WHS policy. While limited health surveillance, incidence notification, health service provision, inspection and workers compensation/return-to-work are handled as uncoordinated and independent services, no meaningful and rigorous data is available to assess the most serious industrial health concerns. Given these systemic issues identified, there is absolutely no reason to assume that other occupational health problems similar to Black Lung would be managed to the expected standard.”⁴²

The QCU had a similar view, submitting:

“The major area of concern for the union movement with the Australian Work Health and Safety Strategy 2012-2022 is the lack of activity by regulators and Safe Work Australia on priority areas, for example occupational cancer, asthma and dermatitis. The recent events involving Coal Worker Pneumoconiosis cases provides an excellent opportunity to rectify the deficiencies in reporting system for occupational lung disease. No Australian jurisdiction or government body has a reporting mechanism for suspected occupational lung disease – there is no reporting anyway. The Australian Work Health and Safety Strategy 2012-2022 and learnings from CWP in Queensland should have been used to start discussions about a reporting system for occupational lung disease however regulators have been silent to date. There has been no pressure from any jurisdiction to review and lower the exposure standards for cancer or lung diseases causing substances.”⁴³

Health and Social Assistance Industry

The Health Care and Social Assistance (HCSA) industry (Division Q under ANZSIC 2006 previously coded as Division O, Health and Community Services, under ANZSIC 1993) includes both private and public organisations and hospitals, medical and other health care services such as allied health, dental, residential care services including nursing homes, and social assistance services, such as, child care and disability assistance services.

⁴⁰ Queensland Nurses and Midwives’ Union submission p3.

⁴¹ Ibid p3.

⁴² Submission from Dr Gunther Paul, James Cook University.

⁴³ Queensland Council of Unions submission p16.

WHSQ currently focuses on this industry through its priority disorder action plans, particularly for musculoskeletal disorders and mental disorders, and through specific programs such as the IPaM Program and the Small Business program. There is also specific consultation and liaison with the industry through the Industry Sector Standing Committee (ISSC) for health and community services. Prior to 2014, specific action plans for this industry were developed in partnership between WHSQ and the ISSC. These action plans were focussed on improving industry knowledge and capability rather than having a focus on compliance and enforcement.

In March 2016, following further data analysis, WHSQ identified that the HCSA industry was emerging as a potential target for preventative interventions due to strong growth in employment and in serious workers' compensation claims. Key points in this analysis were that HCSA:

- Is forecast to be one of the fastest growing industries in Queensland over coming decades. In Queensland, employment in this sector grew 64% from 2004-05 to 2014-15 compared to 23% for overall State employment.
- Was the largest industry sector in Queensland in 2014-15, with 291,450 employees who represented 12% of the State's workforce.
- Generated more serious injury workers' compensation claims (3,830 claims representing 15% of Queensland workers compensation claims) than any other industry during 2014-15. As at 2013-14, the serious injury claim rate per 1,000 workers in the HCSA industry was 13.9%. This was above the state average of 12.0% and ranked immediately below that of the construction industry (16.5%).

An environmental scan of the HCSA industry, identified a number of key issues unique to this industry which impact on the health, safety and wellbeing of its workers. Issues included:

- A high percentage of musculoskeletal disorder claims caused by the performance of hazardous manual tasks including people handling and slips and trips.
- The highest percentage of mental disorder claims (23%) compared to other industries in Queensland. Mechanisms of injury include work-related stress, violence, bullying and exposure to a traumatic event.
- Increasing demand for health care services as a result of changes in population health (chronic disease), an ageing population and longer life expectancy.
- Increasing proportion of high care needs clients/patients resulting in higher physical and mental work demands for workers.
- Greater demands for home and community based care, for example, services provided under the National Disability Insurance Scheme and "consumer directed care" in aged care.
- The workforce profile, such as a higher proportion of ageing workers in residential care services and a higher percentage of younger workers in child care services as compared to all other industries.
- Precarious employment of lower skilled, English as a second language, mostly female workers.

The factors identified in the environmental scan, along with the growth in employment and increasing numbers of serious workers' compensation claims, provides a strong case for the HCSA industry to become a WHSQ priority for action along with the other priority industries of construction, manufacturing, agriculture and transport. This will provide for a strategic and targeted response to these issues, as well as appropriate allocation of resources and skills development for WHSQ staff. Further work is occurring to develop a HCSA strategy and action plan and identify the resources required. This work will build on the environmental scan and include broader consultation with industry stakeholders and the other Australian Work Health and Safety authorities in respect to resourcing models and strategies being implemented.

Findings

The review finds that WHSQ has a strong focus on the priority industries and priority disorders identified in the Australian Strategy. There are specific industry action plans for the priority industries of construction,

manufacturing, agriculture and transport. Focus on other industries occurs more broadly, particularly through specific programs such as IPaM and the Small Business Program, and through a focus on priority disorders, such as musculoskeletal disorders. The priority disorders identified by the Australian Strategy are well-aligned with WHSQ's priority disorder action plans. The growth in the HCSA industry sector, and the level of serious workers' compensation claims, warrant a similar focus to that afforded to the other priority industries in Queensland. Risks of occupational disease, as highlighted by the re-emergence of black lung, warrant WHSQ putting an additional focus on health surveillance and organisational response to occupational health risks.

Recommendations:

10. WHSQ include the Health Care and Social Assistance industry sector as a priority industry and develop an explicit Queensland strategy for this issue.
11. WHSQ and the Work Health and Safety Board consider establishing a specific strategy to address key occupational health risks, including examining international approaches that ensure longitudinal data on current and emerging risks are utilised as part of a health surveillance framework.

Chapter 3: The effectiveness of WHSQ's compliance and enforcement activities

As part of the terms of reference for the review, the Review is required to consider the effectiveness of WHSQ's enforcement and compliance activities. WHSQ's effectiveness in undertaking its compliance and enforcement activities is impacted by its organisational approach and capabilities. Some of the key features include:

- using an evidence-based approach to ensure that regulatory efforts focus on high risk industry, hazards, and poor performers and evaluating the effectiveness of these efforts;
- working with industry including 'poor performers', priority industries and small business to improve their safety systems and provide advice on compliance;
- working with industry to address issues associated with priority disorders and 'at risk' groups;
- working collaboratively with key stakeholders to reduce injuries and fatalities; and
- using sanctions including prohibition notices, penalty infringement notices (on the spot fines), prosecutions, enforceable undertakings and licensing and registration powers.

3.1 Evidence-based compliance and enforcement activities

WHSQ uses evidence, both quantitative and qualitative, to drive resource allocation, select priority areas for enforcement activity, inform regulator interventions and monitor and evaluate the effectiveness of these actions. This is done by analysing a range of information sources including: incident notification and workers' compensation data, learnings from past interventions and incidents, academic and industry driven research, information from other regulators and other jurisdictions, and recommendations arising from independent sources such as the State Coroner or Queensland Ombudsman.

In 2002, WHSQ shifted to an evidence-based approach by using a combination of incident notifications and workers' compensation data to identify high risk employee groups, industry sectors with high risk profiles and poor performing industries and enterprises for targeted assessments and compliance audits. Since then, WHSQ have modified their data capture and use to include occupational injury blackspot analysis, heat mapping, use of the harm index approach to measure risk and use of the Queensland Employee Injury Database and the Compliance and Investigation System Refresh database to inform resource allocation and targeted activities.

Analysis of this data enabled WHSQ to identify the construction, manufacturing, agriculture and transport sectors as priority industries that are at the highest risk of work-related injuries or fatalities in Queensland. Incorporating this information into their strategic planning enables WHSQ to develop targeted action plans aimed at driving improvements in the incidence of injuries and fatalities in these priority areas. Evaluation of all major interventions, campaigns and programs is used by WHSQ to improve program delivery and to inform development of policy and strategy.

WHSQ also utilizes leading research to inform development of their regulatory strategy, capability and organisational performance. The intention is to ensure that planned regulatory activities are grounded in a strong evidence-base and the practical application of modern regulatory theory.

Stakeholder feedback on WHSQ's evidence-based approach to enforcement and compliance activities

While it is recognised that WHSQ's regulatory activities are driven by quantitative and qualitative information and particularly workers' compensation data, a number of stakeholders noted the limitations of this data and the need for a greater focus on lead indicators. In particular, the BTGUs submitted:

"Reliance on statistical evidence is extremely fraught. In particular, it is widely recognised that reliance on workers' compensation data is not an accurate means of tracking workplace injuries."⁴⁴

This was also noted by the Queensland Law Society who submitted:

"...considering only accepted claims is problematic. The true number of workplace incidents may be higher than these figures suggest including incidents involving workers who do not put in claims or whose claims are rejected..."⁴⁵

A submission by Worklaw Health and Safety Pty Ltd relates this to the effectiveness of regulatory efforts, noting:

"Currently Qld WorkSafe inspectorate activity seems to be driven by WorkCover injury statistics and by 'industry' for targeted audits and appears to be reactive. This entrenches a culture amongst business operators of an incident-based response to safety. There is no concept of risk assessments."⁴⁶

In terms of addressing this issue, Master Electricians Australia (MEA) submitted:

"Industry lead indicators should begin to be collected by WHSQ and industry...Lead indicators in WHS generally include indicators that report on proactive actions and tasks targeting safety. These include frequency and results of risk assessments, safety observations and different training and consultative activities."⁴⁷

This was reiterated by MBQ who submitted:

"The use of lead indicators as a measure of WHS performance helps to prioritise where effort is needed..."⁴⁸ and "the Department look further into the creation of a leading indicators platform."⁴⁹

⁴⁴ Building Trades Group of Unions submission p13.

⁴⁵ Queensland Law Society submission p2.

⁴⁶ Worklaw Health & Safety Pty Ltd submission p2.

⁴⁷ Master Electricians Australia submission p2.

⁴⁸ Master Builders Queensland Submission, p14.

⁴⁹ Ibid.

The Review further identified that the way in which information about regulatory activity is collated and reported nationally, has limitations and may reinforce a reactive incident-based approach to work health and safety regulation. These issues are further examined below.

Lead indicators

Work health and safety performance has traditionally been measured by the number or rates of harmful incidents or near harmful incidents, such as fatalities, serious injuries, all injuries, illnesses and 'near-miss' incidents. These are lag indicators because they measure incident or harm which has already occurred. That is, they indicate where there has already been a failure. In the last ten years there has been increasing interest in the concept of lead indicators. These are indicators of work health and safety performance which are the measures of the positive steps that organisations are taking to prevent incidents. Lead indicators are drawn from the activities which support systematic work health and safety management and include: level of management commitment; consultation; training; number of risks assessments, number of employees trained; number of safety meeting. Although lead indicators appear promising, until recently, difficulties in identifying a core set of indicators and ways to effectively measure them has limited their practical use.⁵⁰

In 2012, the Institute for Work and Health (IWH) in Canada developed a leading indicators scale, the Organisational Performance Metric (IWH-OPM) which they validated across multiple industries and at the employer level.⁵¹ In 2016, this scale was adapted and tested across a number of Australian industries by the Institute of Safety, Compensation and Recovery Research (ISCRR) at Monash University. They conclude that their adapted version, the OPM-MU, has the potential to be a leading indicators benchmarking tool within and across organisations.⁵²

Working with WorkSafe Victoria, ISCRR has taken this one step further with development of a simplified version, the Health and Safety Inspector Checklist (HaSIC) which can be used by work health and safety inspectors to assess the potential of a workplace to ensure the health and safety of workers and others. The HaSIC is a seven item scale with an additional global work health and safety assessment element. Assessment of the HaSIC shows that it has the potential to provide a reliable and valid high-level assessment tool and that this could be further enhanced if the HaSIC was included in training for inspectors as a guide towards a uniform approach to workplace assessment. Further investigation is needed to determine the correlation between HaSIC scores (assessment by inspector) and self-assessment by the business or organisation using the OPM-MU, but potentially these could be used in unison as an effective way to assess current work health and safety performance and identify the areas where development is required.⁵³

WHSQ has identified that using the HaSIC, and/or the OPM-MU, as separate activities or adjuncts to normal inspectorial assessments, is likely to be counterproductive to obtaining good compliance outcomes. The checklist needs to be integrated into a holistic assessment process that is broadly aligned to the higher-level compliance requirements of the WHS Act 2011 (PCBU and Officer Duties), whilst still providing the detail to address the most significant work health and safety hazards and risks. This could be structured in a way which will effectively and quickly address breaches related to unmanaged hazards and risks, while also supporting sustained correction of non-compliance and encouragement of work health and safety improvement. Such a process could provide the inspector with specific compliance checks, ways in which an inspector can determine whether a PCBU is complying, guidance on the evidence needed to substantiate non-compliance

⁵⁰ De Cieri, H., Shea, T., Pettit, T., & Clarke, M. (2012). Measuring the leading indicators of occupational health and safety: A snapshot review.

⁵¹ IWH [Institute of Work & Health] (2011) Benchmarking organizational leading indicators for the prevention and management of injuries and illnesses: Final report. Toronto, Ontario: Institute of Work & Health.

⁵² Shea, T., De Cieri, H., Donohue, R., Cooper, B., & Sheehan, C. (2016). Leading indicators of occupational health and safety: An employee and workplace level validation study. *Safety Science*, 85, 293-304

⁵³ Donohue, R., De Cieri, H., Sheehan, C., Shea, T., & Cooper, B. (2016). Final Report: Development and Validation of the Health and Safety Inspector Checklist (HaSIC) with WorkSafe Victoria inspectors.

and, access to materials to assist the PCBU understand what compliance looks like and how to achieve it. It would also provide an objective lead indicators assessment of the current work health and safety performance of that business or workplace (and that this be in the form of a rating which is recorded on workplace history).

Planning for development and implementation of this holistic assessment process has commenced. The approach involves substantial changes to the way that inspectors currently operate. Development and implementation will involve piloting the approach with small groups of inspectors and key industry stakeholders in the priority industries. It is estimated that it will take approximately 18 months to fully develop and implement the new process to the point where it becomes part of the business as usual approach to assessments. This timeframe is designed to ensure successful adoption of new work practices.

Standardised National Data Capture through Safe Work Australia

Regulatory activity is currently recorded against long standing agreed criteria which are reported to SWA and published as the Comparative Performance Monitoring (CPM) annual report. Generally, “what gets measured gets done” or, at least, it receives more focus. To effectively regulate WHS, it is crucial that the measurements reflect the activities which achieve outcomes for the protection of the health and safety of workers and others. That is, those regulatory activities which achieve the aims of ensuring that obvious risks to the health and safety of workers and others are being managed and that any breaches with legislative requirements are quickly addressed and that businesses and other organisations are fulfilling their duties to ensure WHS by implementing systematic WHS management. The current CPM report uses metrics which are most effective at explaining activity which is focused on achieving the point-in-time compliance of the first aim outlined above. Although, even with this, much activity which achieves this aim is not obvious from the CPM metrics. For the second aim, although the CPM does report ‘proactive’ activities, the level of detail is not sufficient to determine the effectiveness of these activities or provide an indication of the compliance levels with the WHS Act 2011 obligations (duties).

The number of workplace visits and number of notices issued are key performance measures. However, these are somewhat limited since these metrics do not capture the level of risk managed or the degree to which workers health and safety were safeguarded. Whilst a notice generally only addresses one unmanaged hazard or risk, the workplace visit may have addressed a multitude of issues which, individually and collectively, may have posed significant risk. Broad proactive activities effectively address multiple hazards and achieve a sustained and long-term improvement in the protection of workers and others health and safety, but again, the extent to which they do this is not reflected in the ‘proactive’ metric reported.

As a result of these limitations, the CPM performance measures do not reflect the full range of regulatory activity undertaken to achieve legislative objectives and the outcomes sought under the Australian Strategy. In particular, the CPM measures are not well suited to recording of inspector or advisor activity which result in correction of non-compliances without the need for notices (e.g. where corrective action is performed while the inspector/advisor is still onsite; or actions which the PCBUs agree to carry-out in an agreed timeframe following an inspectors or advisors visit) or activities which result in an improved systematic approach by the PCBU (e.g. as a result of discussion and information provided by the inspector/advisor, the PCBU implements increased consultation with workers or implementation of an improved hazard identification and risk management process). Although good data is not available to demonstrate the extent of use of non-notice regulatory actions, WHSQ’s estimate to the Review is that each visit by an inspector or advisor to a workplace will result in better management of more than 10 individual hazards or risks.

Examples of regulatory compliance activity which are not adequately reflected in reporting, include:

- Hazards and risks are identified by an inspector/advisor and are immediately addressed by the PCBU whilst the inspector is still on site. For example, a missing machine guard is replaced; faulty electrical

equipment is rendered inoperable by severing the power cord; poorly coupled scaffolding components are corrected; incompatible chemicals are separated and stored correctly.

- An inspector/advisor provides information, guidance and tools to the PCBU which result in the PCBU substantially improving their systematic management of work health and safety and effectively managing a multitude of poorly managed hazards and risks, and workers being more aware of, and involved in, management of these risks.
- An inspector/advisor identifies multiple hazards at the workplace, which are currently not presenting a risk to workers or the risk is low, but where the risk may increase in the future or under certain conditions, and the PCBU agrees to systematically address all of these risks within a reasonable time period. In these cases, the inspector/advisor notes the issues in their notebook and the PCBU also independently takes note of them. The inspector/advisor then follows up to ensure that the issues have been addressed.
- An inspector/advisor identifies a serious issue at one business or workplace (and it is addressed with or without the issuing of a notice) and WHSQ works with the industry to ensure that the issue is also addressed at all other workplaces through safety alerts and follow-up campaigns. For example, ladder platform brackets; vehicle stabilisers and outriggers; unsafe electrical equipment; unsecured stabilisers on trucks; multi-cutters on power tools; and, securing of concrete wall panels.

Since adoption of the harmonised legislation, Queensland has been seeking review and updating of the CPM measures so they reflect regulatory activity to achieve legislative and Australian Strategy aims. Although some changes were implemented for the most recent CPM, these changes fall well short of the changes needed. Queensland has been liaising with other jurisdictions, notably Worksafe Victoria, to identify a better set of metrics and how they could be implemented.

Achieving National agreement on a fully modernised set of measures is made more difficult by the individual and somewhat disparate IT systems and databases used by each jurisdiction to collect and collate this information. Queensland is no exception to this and WHSQ's current recording methods and systems are cumbersome and time consuming. Currently, there are a multitude of systems of varying age that are spread across the various functions and work groups of the Office of Industrial Relations (OIR), of which WHSQ is a part. These disparate systems do not readily interface. This provides a lack of transparency for field staff when trying to establish the status of various interactions with an entity. In addition it creates issues trying to collate accurate data on WHSQ's activities more broadly. Updating these systems and databases, or creating new ones, is a complex and potentially expensive endeavour and OIR ICT have been looking at strategies to economically address these issues. Reductions in the real level of funding over the last ten years appear to have hindered this progress. One of the primary initiatives to be progressed in the coming 12 months will be the development of a new ICT platform which will administer the key business and service delivery activities of the entire OIR. This should make it easier to record, collate and report against a modernised set of measures.

Findings

The review finds that WHSQ makes broad use of evidence, including but not limited to workers' compensation data, to identify priority areas and target regulatory activity towards these areas. This is further supplemented by an expanding use of research and evaluation to ensure that regulatory strategies maintain currency. Additionally, it is found that WHSQ recognises that a greater focus on lead indicators is needed as part of regulatory activities and has commenced work on a program to implement this. To support and progressively improve regulatory activities, a modernised set of measures, which facilitate comparison and evaluation, needs to be developed and implemented.

WHSQ's evidence-based approach needs to continue, and be extended, in order to support regulatory activity which integrates the two regulatory aims of ensuring that obvious risks to the health and safety of workers and others are being managed and that any breaches with legislative requirements are quickly

addressed, and that businesses and other organisations are fulfilling their duties to ensure work health and safety by implementing systematic work health and safety management. There is a clear need to further develop lead indicators and integrate them into planning and resourcing decisions. The finding and recommendation regarding occupational diseases and a health surveillance framework are also relevant here (see [Section 2.3](#) above).

The issues with national reporting of a standardised set of data for regulatory activity and outcomes are acknowledged by WHSQ. These are closely associated with issues of achieving national consistency and IT legacy issues, both nationally and within WHSQ. An improved approach is needed to support effective regulatory activity and to enable meaningful national reporting and evaluation to occur.

Legacy issues with WHSQ's IT system, and the use of various systems by different work areas, has prevented optimal allocation of resources, management of risks and visibility of outcomes and these issues must be addressed by WHSQ as a priority.

Recommendations:

12. WHSQ develop a standardised set of reporting metrics which reflect the full range of regulatory activity, and outcomes achieved.
 13. WHSQ consolidate and upgrade their regulatory databases to support this modernised set of measures.
 14. WHSQ pursue standardised national data capture and reporting by Safe Work Australia, through the review and updating of the Comparative Performance Monitoring measures, or alternate means of national reporting, so that the reporting metrics reflect regulatory activity and outcomes to achieve legislative and Australian Strategy aims.
 15. WHSQ progress the development and implementation of the holistic assessment process, which includes lead indicators, and pilot with key stakeholders in the priority industries.
 16. The Work Health and Safety Board monitor the progress of the implementation of the IT and systems upgrades, to ensure that the necessary information is collected, collated and analysed to assist in strategic planning and resource allocation, and provide any recommendations it considers appropriate to the Minister.
-

3.2 WHSQ capability (resources and training)

As at the end of June 2016, there were 426,000 businesses operating in Queensland.⁵⁴ Of these, 164,000 were employing businesses. Additionally, between 2009-10 and 2012-13 the number of workers in Queensland grew by 3.3%, representing an annual average growth of 1.1% over the three year period. These figures are important as the number of operating businesses impacts on WHSQ's services and, assuming the trend in the growth rate of workers continues, demand for WHSQ's services will continue to increase.

As at the end of 2016, WHSQ had over 300 inspectors, advisors and investigators, or 1.1 per 10,000 employees in Queensland (see Table 2).

Table 2 - WHSQ inspector and advisor numbers

WHSQ Inspector and Advisor numbers (FTE)	2007-08	2011-12	2016-17
<i>WHSQ Inspectors</i>	246.0	216.0	237.5
Construction inspectors	N/A	51.0	52.0
General industry inspectors	N/A	165.0	185.5
<i>WHSQ Advisors</i>	45.0	81.0	65.6
Total number of inspectors and advisors	291.0	297.0	303.1

⁵⁴ Count of Australian Businesses, ABS Cat. No. 8165.0.

WHSQ uses the national ratio of field active inspectors to employees as a key benchmark for the number of inspectors that should be employed and have also benchmarked the number of inspectors against performance in the two other major Australian jurisdictions – New South Wales and Victoria.

As per Table 3, in comparison to these jurisdictions, Queensland is equal with the national average and Victoria, and slightly higher per 10,000 employees than New South Wales.

Table 3- Number of field active inspectors per 10,000 employees

Number of field active inspectors per 10,000 employees		NSW	Vic	Qld	Australian average
	2007–08	1.0	0.9	1.2	1.1
	2011-12	1.0	0.9	1.1	1.1
	2014-15	1.0	1.1	1.1	1.1

WHSQ operates within the constraints of Queensland Government policy of Core Government agencies working within staff ceilings. This means that the Office of Industrial Relations, within which WHSQ operates, has a Full Time Equivalent (FTE) ceiling of 823 officers across all aspects of its business. WHSQ staffing in 2016-17 is 471, which is the same as it was in 2008-09. Increasing the pressure on this staffing has been the establishment and integrated of a number of new functions during this period in response to changing/new government priorities. Further to this is an increasing demand for WHSQ to take action in areas which have been traditionally viewed as public safety rather than work health and safety.

Additionally, significant budget and staffing cuts occurred in recent years with WHSQ’s funding in 2016-17 being \$65.05 million, compared to \$68.95 million in 2011-12. Further detail on the funding of WHSQ is provided below.

WHSQ funding and budget

WHSQ receive grant and contribution funding based on two main sources, Insurer Grant funding (provided by WorkCover Queensland) and consolidated funding.

Figure 3 - WHSQ funding source by financial year

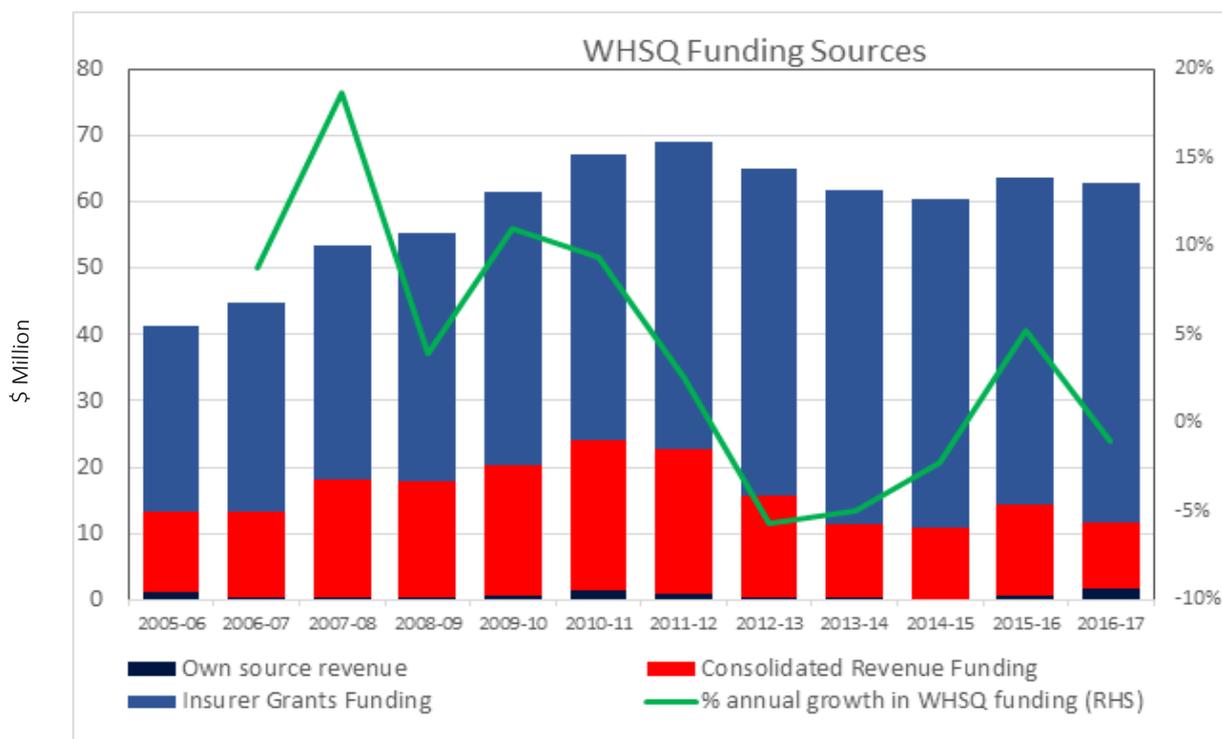


Table 4 - Funding contribution by financial year

	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Grants Funding	28.1	31.6	35.3	37.6	41.14	43.19	46.22	49.32	50.44	49.52	49.19	50.44
Consolidated Revenue Funding	12	12.87	17.7	17.44	19.88	22.8	21.88	15.42	11.09	10.8	11.71	9.98
Consolidated Deferred Revenue											2.0	
Own source revenue/other	1.2	0.46	0.34	0.39	0.5	1.29	0.85	0.3	0.3	0.11	0.7	1.58
Total	41.3	44.93	53.34	55.43	61.52	67.28	68.95	65.04	61.83	60.43	63.6	62

Consolidated Deferred Revenue for 2015-16 was the project funding for the Healthy Worker Initiative and the Renewable and Photographic Licensing project. Reduction in Grant Funding in 2014-15 was due to the conversion of Self-Insurer grant funding to user charge funding.

Insurer Grant Funding

WorkCover Funding to WHSQ is legislated under section 481A of the *Workers' Compensation and Rehabilitation Act 2003* which allows WorkCover to make annual payments to assist in workplace injury prevention, management and rehabilitation and employer and worker education.

To enable WHSQ to keep pace with the growing labour market and changing nature of work, workplace injuries and diseases, a growth funding component has been applied to funding sourced through the Insurer grant, since 2004-05.

Compensation of employees has been used in the past to index WHSQ's funding, and Queensland Treasury has indicated their preference for this benchmark since the growth methodology was developed as part of the 2004-05 Cabinet Budget Review Committee (CBRC) submission. Since 2004-05, a five year average annual growth of 'Compensation of Employees' from the Queensland State Accounts has been used as a basis to increase the Grant in any given year, with this being the maximum possible amount by which WHSQ can increase the grant per year.

The increase in the grant is not solely based on the level of the increase in Compensation of Employees. Rather, WHSQ has developed a model which takes into account a number of other factors when determining the appropriate level of increase. These include such variables as current and future wage costs, current and future increases in accommodation and all other costs associated with service delivery, current and future trends in the composition of the economy based on industries and occupations, the changing nature of the Queensland workforce, the changing nature of injuries sustained by Queensland workers and emerging issues.

Further, increased community expectation about WHSQ's role in public safety continues to put pressure on budget and resources.

The below table identifies the growth of Insurer Grant Funding rate increases across the financial years.

Table 5: Insurer Grant Funding Growth to WHSQ by financial year

2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
12.46%	11.71%	6.52%	9.41%	4.98%	7.02%	6.71%	2.27%	2.56%	4.60%	2.49%

Consolidated Revenue Funding

WHSQ receives consolidated funding also known as appropriation from Queensland Treasury, the annual appropriation bills which, when passed as acts by Parliament, authorise the payment of amounts from the consolidated fund to provide for the operations of government departments. This funding also includes a User Charge component over the years which have included revenue received through small items including, sales of goods and services, sales from seminars, rental subsidies through shared accommodation, contributions from federal bodies including ComCare for goods and services or any Service level Agreements with other government agencies.

The consolidated funding is based on Queensland Treasury and may increase from year to year based on Enterprise Bargaining Agreements (EBA) or through initiatives approved by the CBRC during the Mid-Year

Fiscal Review. WHSQ receives only part supplementation for EBAs, given the majority of revenue for WHSQ is based on the Insurer Grant funding.

In 2009-10 consolidated funding reduced by \$2.1 million based on whole of government savings this was based on the transfer of WHSQ to the Department of Justice and Attorney-General.

In 2010-11 consolidated revenue increased based on carryover from 2009-10 for ongoing initiatives including \$0.9 million for the 'Homecomings' Campaign.

In 2012-13 WHSQ received a reduction in consolidated funding of approximately \$6.4 million based on:

- Voluntary Separation Program savings including supplementation provided in the 2011-12 budget period (\$2.8 million);
- Whole of Government Savings Measure - which included the reduction in WHSQ staffing across the state (\$2.6 million, including a 20% reduction in Travel and Contractors); and
- Whole of Government savings based on reductions in both grants and contribution payments, including deferral of Health Worker Initiative (\$1 million).

Additionally in 2013-14 consolidated funding reduced by a further \$2.7 million which included:

- Whole of Government Saving Measures - reduction in WHSQ staff based on full year contribution (\$1.52 million);
- deferral of the Healthy Worker Initiative from the previous year (\$0.6 million); and
- an annual, ongoing savings target of \$0.58 million.

Own Source Revenue

Own source revenue includes funding received from items including revenue from Legal recovery fees including prosecutions and funding from Enforceable Undertakings, this funding has reduced from 2011-12.

Administered Revenue

WHSQ remits revenue (administered) to Queensland Treasury consolidated funds across a number of levies and fees, the variance in the fees fluctuates due to a number of factors especially for the construction notification fees based on the construction industry work in Queensland.

The levies and fees that remit administered revenue back to Queensland Treasury includes:

- licences, including High Risk Work Licences, Asbestos and Demolition Licences;
- High Risk Plant Registrations and renewals;
- Construction Notifications fees (fees based on a proportion of QLeave Construction notifications on behalf of WHSQ);
- Fines & Prosecutions; and
- Workplace Registrations (which ceased in 2006).

WHSQ inspectors and advisors

WHSQ inspectors and advisors are positioned within three regional areas, containing sixteen regional offices. Each region contains multidisciplinary teams which include specialists in areas such as construction, ergonomics, asbestos, plant design, psychosocial, occupational health and hygiene, chemicals and diving.

WHSQ inspectors and advisors carry out a broad range of regulatory activities which result in substantial improvements to work health and safety management in Queensland workplaces and substantially reduce the risk of work-related fatalities, injuries and illnesses occurring. WHSQ regulatory approach is designed to ensure two main aims:

- that obvious risks to the health and safety of workers and others are being managed and that any breaches with legislative requirements are quickly addressed; and,

- that the businesses and other organisations are fulfilling their duties to ensure work health and safety by implementing systematic work health and safety management.

The skills required by inspectors and advisors to achieve these two aims are somewhat different.

The first aim requires sufficient technical skills, in the industry being regulated, to recognise when hazards and risks are not being adequately managed, and then well-developed regulatory skills to secure compliance, such as by directing compliance with improvement and prohibition notices. This involves a high-level understanding of the requirements in the WHS Act 2011, WHS Regulation 2011, codes of practice and associated documents such as Australian Standards, combined with skills to write and serve legally compliant notices in a way that the PCBU can readily understand what is required and take the necessary action to comply. Associated with this are high level communication, negotiation and interpersonal skills.

Achieving the second aim is more complex, both in terms of assessment and in taking action to ensure and sustain compliance. The skill set required to do this requires a higher-level understanding of systematic work health and safety management and the legislative requirements in the WHS Act 2011 which support this. WHSQ and other work health and safety regulators are continually evolving and improving the approaches used to achieve this aim. In this respect, in combination with regular inspection and audit programs, WHSQ uses strategies such as:

- the IPaM Program;
- Safety Improvement Plans for Major Hazard Facilities;
- Participative Ergonomics for Manual Tasks (PERforM);
- the Medium-Sized Business Initiative; and
- industry specific focus using a combination of strategically placed notices and agreed approaches to rectification (agreed actions).

Increasingly, these approaches actively involve workers, either to explain the hazards and risks at the workplace or to independently verify that risk controls are implemented and systematic management is being practiced at the workplace. Required skill-sets for inspectors and advisors include:

- advanced understanding of work health and safety management and legislative requirements;
- the ability to write, serve and assess compliance with more complex notices based the duties and due diligence aspects of the WHS Act 2011; and,
- the ability to effectively communicate with, negotiate with and educate a broad range of stakeholders, including senior executives and worker representatives.

Increased focus on the second aim has required professional development and training, for inspectors and advisors, in facilitating the process of problem solving and understanding good regulatory decision making. WHSQ advises that this training has resulted in inspectors and advisors actively working with industry to seek sustainable solutions to health and safety problems rather than simply identifying non-compliance issues. Additionally, WHSQ plan to provide ongoing training and development to support these modern aims of work health and safety regulation.

Up until August 2014 the base level qualification for all WHSQ inspectors was a Certificate IV in Government (Investigation). A review at that time concluded resources should be directed into developing the Diploma of Government (Workplace Inspection) to bring Queensland in line with the benchmarked standards of all other jurisdictions.

After the development of the Diploma of Government (Workplace Inspection) and the completion of the quality audit by Queensland TAFE, WHSQ formally commenced the partnering arrangement for the issue of this Diploma in October 2016. WHSQ currently have 60 staff enrolled in the Diploma of Government program with the remaining field based inspectors forecast to have completed the Diploma of Government program by June 2017.

WHSQ's service delivery approach has also been adjusted through the introduction of mobile work teams. These teams provide WHSQ with greater flexibility in the delivery of state-wide services and supports its multifaceted approach to compliance. Mobile work teams include representatives from areas such as the hazardous industries and chemical branch, the construction inspectorate, engineering services and the occupational health unit who work together to assess compliance and engage and educate stakeholders. In establishing a mobile work team, WHSQ match inspectors, advisors and engineers with high-risk tasks that are being performed at a workplace or within a particular industry and dispatch the team to undertake compliance audits or provide health and safety advice.

For example, in 2014-15 WHSQ used mobile work teams to service a number of large infrastructure sites in Queensland. In particular, the Coal Seam Gas and Liquefied Natural Gas industry was the target of a mobile work team campaign due to the significant growth the industry was experiencing within Queensland. Use of mobile work teams has also doubled as a learning opportunity for WHSQ staff where departmental expertise is shared between mobile work team members.

To improve service delivery, WHSQ have also introduced the use of electronic tablets within the inspectorate. The intention of this is to:

- provide a flexible mobile workforce that can work anywhere at any time;
- provide the ability for inspectors to access advice and support from internal technical experts in real time;
- provide the ability for inspectors to access their desktop environment while in the field; and
- increase effective communication between inspectors and external clients, through the presentation of information.

Use of these electronic tablets has enabled better sharing of work health and safety resources when WHSQ's staff visit workplaces. In particular, when used in the field, electronic tablets enable the inspectorate to show businesses where information can be found on the website, show videos of best practice safety measures, and demonstrate products and tools available to businesses that will assist them with improving safety at their workplace. As noted elsewhere, IT legacy issues have limited the way in which mobile technology can be used to support more efficient and effective regulatory activity.

Stakeholder feedback on WHSQ's capability (resources, service delivery and training)

Submissions on WHSQ's capability in terms of resources, service delivery and training were mainly concerned with three areas:

1. the number of inspectors;
2. the technical, educative and regulatory skills of inspectors; and,
3. the time spent by inspectors in the field.

The number of inspectors, particularly construction inspectors drew mixed submissions. For example, the HIA submitted:

"There is a need to further resource WHSQ with more construction inspectors"⁵⁵

While MBQ held a contrary view, submitting:

"Based on [construction] statistics, it could be said that other industries could benefit from a greater inspectorate presence, therefore giving justification for additional inspectorate resources or reallocation of current resources"⁵⁶

⁵⁵ Housing Industry Association submission p3.

⁵⁶ Master Builders Queensland submission p14.

For inspectors across all industries, there was a more consistent call for additional resources, with the Queensland Law Society submitting:

*“...demand for inspectors (and advisors) is increasing as Queensland’s workforce continues to grow. We consider that 1.1 inspectors and advisors per 10,000 employees is insufficient to provide proper oversight and support”.*⁵⁷

This was a view shared by the AWU, the QNMU, the QCU and Warren Kelly, Townsville City Council, who submitted:

- with cuts to WHSQ staff over recent years we have seen less inspectors available to conduct visits, it is hard to get an inspector to come out; and
- more inspectors are required, particularly with specific industry experience and associated skills.

A more pragmatic approach was submitted by the AiGroup who claimed that:

*“...there will never be enough inspectors to touch every workplace so it is necessary to adopt other more practical and constructive approaches.”*⁵⁸

The skills of inspectors drew a number of submissions. The Queensland Tourism Industry Council (QTIC) submitted:

*“Non-technical inspectors are performing outside their level of expertise and there is a need for improved training for inspectors and assessors.”*⁵⁹

This was supported by the HIA and the QCU who submitted that:

*“There is a need to continue with inspector training programs and up-skilling.”*⁶⁰

*“A probable reason for reluctance to prosecute would be organisational culture and a lack of skills.”*⁶¹

The MBQ also noted that:

“Historically inspectors have been employed to play a punitive role, for example to play the “police officer” and implement punitive actions. Following the enforcement review of 2008 and the changes with harmonization, the Government has expected the inspectorate to shift their approach from one of punitive action to a balanced approach of punitive and educative/advisory action. This shift in approach has been very positive in improving the safety outcomes in workplace as it allows the inspector to not only play the role of police offer but also one of educator.

*Whilst this changes over the last 10 years has been gradual, the inspectorate has had very little turnover in their staff base, so those that were employed in the early years (years of punitive action) are still in the inspectorate and are expected to be performing the dual punitive/educative role. Although this sounds simple, those two roles are very different and require inherently different skillsets, some of which the longer standing inspectors were not employed for or inherently do not have.”*⁶²

⁵⁷ Queensland Law Society submission p3.

⁵⁸ Australian Industry Group submission p2.

⁵⁹ Queensland Tourism Industry Council submission p5.

⁶⁰ Housing Industry Association submission p2.

⁶¹ Queensland Council of Unions submission p17.

⁶² Master Builders Queensland submission p15.

The Chamber of Commerce and Industry Queensland (CCIQ) referred to the regulatory research project currently being undertaken between WHSQ and the Queensland University of Technology and the insight that this would provide:

“At present, [Professor Jeremy Davey] is undertaking a three year research review project of the training of WHS inspectors. Any changes made to WHSQ policy prior to the conclusion of the research would compromise the integrity of the study and effectively waste tax payer’s money.”⁶³

Submissions also noted that the place for inspectors was in the field and there was concern voiced that this was not occurring. For example, MBQ submitted

“Triaging may be bogging down inspectors (and the paper work involved). Would like to see inspectors back out spontaneously visiting sites. Great if regional guys could drive around a pop in on site.”

This was supported by the Asbestos Disease Support Society who submitted:

“...difficult to get an inspector to a site in a timely manner. Have to email photos of issue before WHSQ will do anything about”

The submissions provided prompted the Review to seek further information from WHSQ regarding the approach taken with respect to qualifications, induction training and skills development for inspectors and advisors. This information is presented below.

Inspector Induction Program

Upon commencing a role as inspector with OIR, which WHSQ is a part of, new workplace health and safety inspectors are required to complete the Inspector Induction Program. The program content is delivered by relevant subject matter experts, which include OIR technical experts and advisors within specialist units including: Engineering Services, Chemicals and Major Hazards, Asbestos, Construction, and Occupational Health.

The program is currently delivered in three stages, with each stage building on the knowledge gained in the preceding stage. Each stage is delivered through structured in-class learning (‘off job’) and field experience with a mentor (‘on job’).

The timeframes for each stage are represented below.

Stage 1 off job	Stage 1 on job	Stage 2 off job	Stage 2 on job	Stage 3 off job
2 weeks	4 weeks	3 weeks	4 months	3 week

Stage 1 (Inspector 101) - provides new inspectors with an insight into the role of an inspector and outlines the responsibilities and governing legislation for the role. Introductory information is provided relevant to:

- overview of the department, including code of conduct and ethics;
- inspector’s role and responsibilities; and
- legislation and enforcement, including inspector powers and tools; conducting inspections, including taking statements.

⁶³ Chamber of Commerce and Industry submission p4.

Stage 2 (Technical component) – specifically informs the workplace health and safety inspector role, by targeting specific hazard and risk factors in various industries. This stage provides inspectors with knowledge and skills to effectively assess and manage risk inherent to plant, asbestos, noise, electrical, construction, hazardous chemicals, biological hazards, and manual tasks. The skills are further embedded through site visits during this stage, to industrial and construction workplaces, and abattoirs.

Stage 3 (Investigations) - addresses the investigation and first response skills required of the inspector role. Content covers such matters as first response, investigating incidents, investigation management, elements of offences, interviewing and photographic evidence.

Upon successful completion of the Inspector Induction Program, new inspectors are issued with inspector powers (inspector instrument of appointment and identity card) and are able to formally undertake their role as an inspector.

The Inspector Induction Program has been designed specifically to meet the requirements of Queensland TAFE qualification – Diploma of Government (Workplace Inspection). New inspectors that successfully complete the Inspector Induction Program also gain the Diploma of Government (Workplace Inspection) qualification. See below for a summary of the diploma program.

Recognition of Prior Learning

The Recognition of Prior Learning (RPL) program is designed to assist the cohort of inspectors who completed their inspector induction prior to the implementation of the Diploma of Government qualification. The RPL program is optional for inspectors wishing to be recognised to gain the diploma qualification. The RPL program is managed by Workforce Capability Unit (WCU) who provides relevant materials to Queensland TAFE to assess and grant RPL before the inspector attains the diploma of government.

Staff opting to undertake the RPL process attend compulsory RPL workshops administered by WCU and complete required documentation to demonstrate requisite knowledge and skills required for the attainment of the diploma. The learning and assessment involves both theory and practical aspects, of which may involve questioning, observation of performance in simulated environments, structured assessment and mapping of previous learning outcomes from prior inspector induction programs completed within the last two years.

The compulsory RPL workshops consists of two 1-week sessions conducted in regional offices, involving refresher training on: notebooks, statements, duty holders and elements of offences. Inspectors are required to develop a portfolio of evidence following the workshop and practical field application stages.

The portfolio of evidence is designed to exemplify evidence of competence that achieves recognition of the relevant knowledge and skills, and is key to assessing each inspector's RPL to gain the diploma qualification.

Diploma of Government (Workplace Inspection)

The Diploma of Government (Workplace Inspection) program is implemented by WCU in partnership with Queensland TAFE. Queensland TAFE is a registered training organisation that is registered with and is monitored to meet the requirements of the national Vocational Education and Training standards, under the Australian Skills Quality Authority (ASQA) - the national Vocational Education and Training regulator.

Queensland TAFE, therefore acts as the registered training organisation delivering and assessing the diploma qualification as undertaken by inspectors. WCU practically implements the Inspector Induction Program and the RPL Program course structure and content that is approved by Queensland TAFE.

The material and evidence required to gain this qualification are developed and assessed by WCU, and have been mapped against the diploma requirements. The moderation and issuing of the qualification is conducted by Queensland TAFE.

Currently, all inspectors who successfully complete and graduate from the Inspector Induction Program, or conversely, all inspectors who are recognised to have the requisite knowledge and skills, via completing the RPL program, are eligible to be deemed to have completed the Queensland TAFE course content and be issued with a PSP50116 Diploma of Government (Workplace Inspection).

Heads of Work Safe Authorities (HWSA) Learning and Development Framework – ‘Field Ready Inspector’

Following the introduction of the WHS Act 2011, WHSQ subscribed to the Heads of Work Safe Authorities (HWSA) Learning and Development Framework - ‘Field Ready Inspector’ component. This Framework was developed and agreed by HWSA members to provide a common approach to inspection work. In so much as, a ‘field ready’ inspector for any work health and safety jurisdiction, should possess behavioural attributes, skills and qualifications similar to their counterparts in other jurisdictions that are also subscribed to the Framework.

The main principles of the framework concern ‘inspector attributes’ required to be able to effectively carry out the role of an inspector in a responsive regulator environment. WCU monitors adherence to the framework via the implementation of the programs, discussed above, to ensure the training and core competency requirements meet the requirements set out under this framework.

Particularly relevant to this framework are the behavioural traits, and ‘soft skills’ of inspectors, including ethical, confident, respectful and engaging behaviour, and traits associated with being a good listener, communicator and negotiator. An ability to build rapport and take a collaborative approach is also valued.

Other aspects of the framework require workplace health and safety inspectors to be competent across regulator specific skills. These include:

- incorporating regulator policies and operational procedures;
- incorporating knowledge of work health and safety legislation relevant to jurisdiction;
- knowledge of the role of the regulator and role of an inspector;
- ability to deliver client service (provide assistance, advice, information, education);
- incident response and management;
- risk management;
- communicating as an inspector, particularly, negotiation, dealing with aggression and interviewing techniques using PEACE model; and
- general public sector skills, incorporating expectations of working in the public sector including conduct and ethics.

Across the WHSQ programs, inspectors receive training in human capability (soft skills) including conflict resolution, negotiation, dealing with difficult clients, resilience, communication techniques, interviewing, and public speaking and information delivery.

The need for further development, outside of the mandatory WHSQ programs, for relevant soft skills and capacity building within the inspectorate is identified by individual business units, regions and managers and implemented locally as needed. This would usually involve the whole team. A further avenue for the development of soft skills is via personal recognition and request of the inspector, or the inspector’s manager, and implementation approval and commitment through the mandatory process surrounding performance effectiveness plans and discussions.

Qualifications within the WHSQ inspectorate and technical advisors

WHSQ’s inspectorate is comprised of field based inspectors employed either within generalist work health and safety professional capacities (e.g. Industrial and Construction), or within roles that require specific skills and abilities within the field, such as hygiene and ergonomics.

All inspectors are supported to undertake study in the Diploma (Occupational Health and Safety) which provides a benchmark across the inspectorate regarding knowledge and application of health and safety management principles. This diploma is commonly attained by generalist inspectors.

Inspectors that are employed to specialist roles usually have attained a relevant degree in their field prior to commencing with WHSQ. A relevant degree is viewed as desirable during the recruitment process for certain roles within the inspectorate. WHSQ is supportive of continued professional development and has processes to support inspectors with further study as required to maintain specific qualifications and skills. WHSQ has recently supported the attainment of degree level (and higher) qualifications in the hygiene field to ensure the regulator response to these matters is sound and credible within the industry.

Additional to the field based inspectorate, WHSQ provides regulator services through specialist principal advisors placed in technical units covering discrete hazard fields, including Engineering Services, Chemicals and Major Hazards, Asbestos, and Occupational Health. The principal advisors within these roles all have relevant degree, or higher, qualifications attained either prior to commencing with WHSQ or whilst employed with WHSQ as part of WHSQ's support for continued professional development.

To ensure the inspectorate, across all business units, has relevant knowledge, skills and experience to undertake the role of inspector WHSQ now implements, as mandatory for new inspectors, the Diploma of Government (Workplace Inspection) Program, which provides inspectors with a recognised qualification to undertake their role as inspectors. The scope and implementation of this program is discussed above.

Many inspectors are employed into the role because of relevant work experience or specific trade certificates and qualifications within a targeted priority industry. This provides them with a higher level of knowledge of the industry and its inherent risks. WHSQ values trade qualifications and supports further development as required to ensure inspectors maintain relevant skills and recognition within their field.

This approach can be compared to what is arguably the best practice approach to work health and safety inspector recruitment and training, that is, the approach taken by the Health and Safety Executive (HSE) in the United Kingdom:

"HSE places great emphasis on recruitment and training of all its staff, relying as it does on a wide range of professional skills. Some health and safety inspectors are trained in systems and principles applicable to a wide range of activities, while others specialise in a single high-hazard industry, for example, mining, explosives or offshore oil and gas. All are highly trained to use discretion in applying the law and to feed information back to the policy and technical centres of HSE. All can call, where necessary, on the experience and expertise within their own and other inspectorates and elsewhere in HSE.

Almost all HSE [Field Operations Directorate] inspectors are graduates who undertake four years of training. This programme of field training under the supervision of experienced inspectors, together with HSE-led tutorials, is integrated with a specially designed academic course, which leads to the award of a post-graduate diploma in occupational health and safety.

Following on from this there is ongoing access to programmes of competence related mid-career training which keep them professionally well-equipped and in tune with the latest thinking in HSE and outside."⁶⁴

⁶⁴ Health and Safety. 2013. A guide to health and safety regulation in Great Britain. Page 15. Accessed 28 June 2017. <http://www.hse.gov.uk/pubns/hse49.pdf>

Findings

The number of field active inspectors has not kept pace with increases in working population of Queensland. Although inspector numbers per worker are comparable with New South Wales and Victoria, Queensland has a far greater level of decentralisation than either of those states and the travel distances, and time, for inspectors in Queensland will be substantially greater. More time spent travelling means less time ensuring work health and safety at worksites. The highly decentralised nature of some key industries (which also include a high number of small enterprises) for example agriculture and tourism, further complicates the issue. Queensland specific factors should be considered in determining the appropriate number of field active inspectors, rather than simply matching the situation in other Australian jurisdictions.

Growth in advisory programs, such as the IPaM program, has meant that, although there has been a slight increase in the number of WHSQ field officers (up from 291 in 2007/08 to 303 in 2016/17), there has been a decrease in in field officers who have statutory powers to ensure compliance (down from 246 to 237.5). This has implications for WHSQ's ability to utilise the full suite of regulatory tools provided for under the WHS Act 2011. Although advisory programs form part of the approach to achieve improved work health and safety outcomes, these should not be at the expense of WHSQ's ability, through application of statutory powers, to ensure that businesses in Queensland are meeting their statutory obligations to ensure work health and safety for workers and others.

The complexity of work is increasing and although there have been efforts to increase the skill level of inspectors, it appears that, as this is mainly targeted at WHSQ's first aim, obvious risks to the health and safety of workers and others are being managed and that any breaches with legislative requirements are quickly addressed. Technological and industry composition changes, along with increasing complexity in the hazards and risks that workers face, mean that demand for a wide technical knowledge by inspectors has increased and is likely to continue to do so. There is a need to ensure that highly skilled and qualified inspectors are attracted and retained, and that general inspectors are continually building their skills to keep pace with these changes. This will necessitate additional focus on skills attraction and development. Achieving, the second, and arguably more important aim, that the businesses and other organisations are fulfilling their duties to ensure work health and safety by implementing systematic work health and safety management, will require a change in the approach taken to recruit new inspectors and provision of ongoing training and re-skilling of existing inspectors. WHSQ's research partnership with the Queensland University of Technology is likely to provide valuable information regarding the skillset required. The approach taken by leading regulators, such as the HSE, also warrant consideration and further information should be sought from such agencies.

Information technology and other administrative supports are needed to ensure that inspector time is spent at workplaces rather than in a WHSQ office. As discussed elsewhere, a greater level of data analytics from inspector workplace activity is needed so that improvements in the efficiency and effectiveness of inspectors can be made. However, this information provision needs to be supported by IT systems and processes to ensure that inspector time is not consumed by administrative activity.

Funding for WHSQ has fallen in real terms and this has seriously hampered the ability of WHSQ to perform its role and keep pace with changes in the nature of work and the modernisation of work health and safety regulation. Growth in employment and high growth in key risk sectors will mean need for additional resources (particularly on the ground inspectors). The funding base factor used to calculate the contribution from WorkCover is total Compensation for Employees. This gives a lower rate of increase than the measurable increase in economic activity (a driver of demand on inspectors) and also fails to capture the unincorporated sector and other demands such as scope creep into public safety. Reductions in WHSQ's funding from consolidated revenue further exacerbates the issue.

Funding is only one aspect of resourcing and WHSQ is restricted in its ability to employ more inspectors, even if funding was available, by the FTE cap. WHSQ's inspectorate activity is direct frontline activity which ensures

the health and wellbeing of Queensland workers and members of the public who may be affected by work being conducted. In this regard, it should be treated in the same way as other essential services such as police, emergency services, hospitals and schools, with staffing keeping pace with population growth and demand rather than being included in a perception of community expectation of keeping a cap on the bureaucratic element of government.

Recommendations:

17. The Queensland Government remove the staff ceiling (FTE cap) on WHSQ and instead apply a staffing model which keeps pace with increases in economic activity, population growth and regulatory responsibility. The staffing level at 2010/11 and 2011/12 should be used as a basis for this calculation.
18. The Queensland Government re-examine the funding formula for provision of funds to WHSQ by WorkCover and consolidated revenue to ensure that funding is available to increase the inspectorate numbers and capability to a level commensurate with the increased economic activity and complexity of WHSQ in Queensland. This examination should establish a historical base (for example the funding provided in 2010/11 and 2011/12) and use the annual changes in State Total Demand and Total Income Factor to calculate the level of funding that WHSQ should currently receive. Annual funding adjustments should be on the basis of changes to State Total Demand and Total Income Factor.
19. WHSQ review its allocation of staffing in advisory programs such as the Injury Prevention Management Program and, where possible, reallocate staff to inspector functions with statutory powers.
20. WHSQ continue its skills development program with a view to bringing inspector qualifications and competencies up to a level of leading regulators such as the Health and Safety Executive in the United Kingdom. Further to this, that WHSQ examine the recommendations of the Queensland University of Technology regulatory research with respect to inspector skills, when this becomes available, and progresses a program to implement relevant findings.
21. WHSQ identify, in consultation with Industry Sector Standing Committees, sectors where specialised knowledge is required to allow an inspector to adequately perform their role, and to allocate staff resources in a way that minimises, wherever possible, the use of non-specialised inspectors in circumstances where specialised skills and knowledge are required.
22. WHSQ increase the data analytics from inspector workplace activity and implement improvement programs which optimise the efficiency and effectiveness of this activity.

3.3 Inspectorate activity

WHSQ inspectors and advisors work with industry to ensure health and safety standards are met and sustained, and contribute to WHSQ's compliance activities by:

- responding to work health and safety complaints and incident notifications;
- undertaking workplace assessments;
- providing practical guidance and compliance support to businesses;
- participating in state-wide compliance campaigns; and
- working with industry to seek solutions to work health and safety problems through a variety of programs and interventions (see [section 3.2](#)).

WHSQ takes a regulatory approach which is designed to ensure two main aims:

- that obvious risks to the health and safety of workers and others are being managed and that any breaches with legislative requirements are quickly addressed; and
- that a PCBU is fulfilling their duties to ensure work health and safety by implementing systematic health and safety management.

Visits to workplaces by WHSQ's inspectors and advisors remain a key part of engagement with business and it is only during these visits that an assessment of compliance can be made. The focus on particular industries

depends on the risk profile of that industry and the number of workplaces or worksites that the industry represents. The dominant focus on construction reflects the number of workers employed in this industry, the temporary nature of workplaces and the rapid change in the nature and environment of these workplaces as construction proceeds.

During workplace visits, the inspector or advisor may be focussed on particular workplace issues or risks (e.g. falls from height, ergonomic issues, storage and use of chemicals, machinery guarding, UV radiation or asbestos) or they may focus more broadly on the overall work health and safety performance of the workplace and compliance with legislative requirements by the PCBU. The location of the workplace, the inspector or advisor's familiarity with that particular workplace, the complexity of the workplace and the complexity of the issues encountered, all contribute to high variability in the time taken for the inspection and the regulatory tools used to gain work health and safety improvement and regulatory compliance.

Where an inspection or audit reveals that a PCBU must take action to ensure that they comply with requirements in the legislation, inspectors and advisors can ensure that immediate action is taken to address the issue while they are still on-site or, in the case of inspectors, by issuing notices where immediate compliance cannot be achieved or there is a likelihood the non-compliance will continue or recur. Advisors cannot issue notices but they can seek the support of an inspector to do so. Actions which provide immediate protection to workers or others (e.g. prohibition notices) are used where a serious, imminent risk exists. Where there is evidence of a breach, but there is less risk, and that risk has some level of management, improvement notices are warranted. For issues which *may* become a risk to workers or others, or where comprehensive work health and safety management improvements need to be made, but clear evidence of a breach is not apparent, a documented agreed actions approach is warranted. In many cases, a PCBU will immediately address an issue identified by an inspector; compliance is then achieved without the need to issue a notice.

The period since 2011-12 has seen the development of new programs and interventions aimed at securing compliance. In the 2000s, inspectors' compliance activities included a substantial reliance on the issuing of improvement notices. In industries such as red meat processing where performance was often poor, the compliance approach adopted was one where inspectors visited on a periodic basis and often issued a raft of improvement notices. The feedback from the inspectorate and industry was that this approach was not effective in bringing about sustained improvements in safety.

For all programs to be effective, both notice-issuing and non-notice-issuing approaches are needed to secure compliance. It is not a matter of one or the other being used exclusively or in isolation. When used together in a congruous and complementary manner, compliance and improved work health and safety management are achieved in the most effective and efficient way. WHSQ uses three regulatory approaches, in combination, to ensure compliance:

- focused attention on the most significant risks, ensuring that unmanaged risks are quickly addressed, either immediately by the PCBU or under direction of a notice;
- agreed actions to identify and document all unmanaged hazards and risks, and ensuring that the PCBU either addresses them immediately or in a set timeframe, which is discussed and followed up by the inspector until all are addressed; and
- intensive work with selected employers with poor workers' compensation claims experience, under the IPaM program, to ensure that they are addressing all hazards and risks and improving their overall management of work health and safety.

The last two dot points are discussed further below.

Safe Work Australia Comparative Performance Monitoring

WHSQ benchmark and monitor their performance against other Australian and New Zealand jurisdictions through the Comparative Performance Monitoring (CPM) report administered by SWA. The CPM is used by WHSQ to facilitate improved work health and safety service outcomes and identify best practice to support

policy making. The latest CPM Report (CPM18) was released by SWA on 24 March 2017 and provides comparative data on the five years from 2010-11 to 2014-15.

After the release of CPM18, WHSQ reviewed its methodology in quantifying proactive and reactive inspectorate activity so that it was more consistent with CPM reporting categories as defined by SWA in its data reporting standard. In June 2017, WHSQ provided revised data to SWA, outlining the limitations in its previous methodology calculations. SWA has agreed to include the amended WHSQ data into a revised version of CPM18.

Table 5 shows inspectorate activity data for the past decade.

Table 5 – Inspectorate Activity Data

Inspectorate Activity	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17 (YTD 30 June)
Number of workplace visits: Proactive	24,134	27,577	20,319	25,733	22,645	26,343	27,844	18,818	17,775	22,467	16,414
Number of workshops/presentations/seminars: Proactive	1,669	1,306	2,580	5,115	4,151	4,593	2,876	2,815	5,138	5,028	3,818
Number of workplace visits: Reactive	3,688	3,053	2,416	1,999	2,717	2,533	1,711	6,212	6,026	6,552	7,415
Other intervention activities: Reactive	15,023	14,864	14,045	12,648	13,143	12,342	8,924	6,424	6,437	6,340	5,668

It should be noted that the CPM data does not reflect the full range of regulatory activity undertaken to achieve legislative objectives and compliance and enforcement outcomes. In particular, the CPM measures are not well suited to recording inspector or advisor activity that results in the correction of non-compliances without the need for enforcement notices (e.g. where corrective action is performed while the inspector/advisor is still onsite; or actions which PCBU agree to carry out in an agreed timeframe following an inspector's or advisor's visit) or activities which result in an improved systematic approach by the PCBU (e.g. as a result of discussion and information provided by the inspector/advisor, the PCBU implements increased consultation with workers or implementation of an improved hazard identification and risk management process). Although data is not available to demonstrate the extent of the use of non-notice issuing regulatory actions, it is estimated that each visit by an inspector or advisor to a workplace will result in better management of more than 10 individual hazards or risks.

Decline in issue of enforcement notices

The issue of improvement, prohibition and infringement notices are enforcement approaches used by WHSQ inspectors in securing compliance with work health and safety legislation. Table 6 shows the steady decline in the issue of enforcement notices from 2006-07 to 2011-12. A further, sharper decline was seen in 2012-13 after the introduction of harmonised work health and safety laws, and this decline continued to its lowest point in 2014-15 for infringement notices and 2015-16 for improvement and prohibition notices. Preliminary figures for 2016-17 indicate that the number of enforcement notices issued by the WHSQ inspectorate is once again increasing and is expected to continue to do so.

Table 6 - Issue of enforcement notices

Enforcement Activity for Qld	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17 (YTD 20 June)
Number of improvement notices issued	14,631	14,390	8,162	9,072	6,196	7,049	5,495	4,430	1,752	1,746	2,340
Number of prohibition notices issued	2,434	2,784	2,283	2,291	1,847	1,759	1,363	1,222	759	536	610
Number of infringement notices issued	612	643	507	390	316	207	61	58	30	60	115

Table 7 records a substantial decline in the number of improvement and prohibition notices issued by WHSQ inspectors from 2006-07 to 2015-16. In the period post-harmonisation, the number of improvement notices issued reduced by 62%, prohibition notices by 44% and infringement notices by 90%. In 2014-15, the number of infringement notices issued was 95% less than in 2006-07. For the same period, the number of improvement and prohibition notices issued reduced by 88% and 78% respectively.

Possible reasons for this decline are highlighted below.

Legislative change – harmonised work health and safety laws

Improvement notices

On 1 January 2012, the current WHS Act 2011 replaced the WHS Act 1995.

The enlivening belief required of an inspector to issue an improvement notice did not change, the constant requirement being:

(1) This section applies if an inspector reasonably believes that a person—

(a) is contravening a provision of this Act; or

(b) has contravened a provision in circumstances that make it likely that the contravention will continue or be repeated.

Contraventions (or offences) underpin improvement notices. All contraventions in the WHS Act 1995 changed under the harmonised laws. Queensland, New South Wales and South Australia all had similar percentage falls in the number of improvement notices issued over the period spanning harmonisation.

The change of contraventions may have led to decreased improvement notices due to:

- contraventions being more difficult to prove/assert as the notion of ‘so far as reasonably practical’ (SFARP) was introduced;
- a lack of familiarity or confidence in asserting when a contravention exists or may continue or be repeated; and
- many contraventions being drafted with undue complexity.

The harmonised laws introduced the notion of SFARP. Under the WHS Act 1995, all offences could be described as strict liability and effectively reversed the onus of proof upon obligation holders (as they were then called). Offences were drafted in terms of ‘must ensure the workplace health and safety of persons’ or ‘must provide and maintain safe plant’. The obligation was not qualified, it was absolute.

Under the WHS Act 2011, all Act contraventions include the qualifying condition SFARP. This lowers the likelihood of an offence occurring in a particular circumstance when compared with the provisions of the WHS Act 1995. Fewer identifiable contraventions would mean fewer improvement notices, as a contravention is required to issue an improvement notice.

Further, under the WHS Act 1995, where a code of practice stated a way of managing exposure to a risk, an obligation holder could only discharge their obligation by either following the stated way or by adopting a better way. This effectively meant that any identified breach of a code of practice constituted a contravention. The need for compliance with codes of practice was removed from the harmonised laws.

The WHS Act 1995 was in effect for 17 years before it was repealed. Over this time, it can be expected that inspectors become familiar and confident with the provisions of the WHS Act 1995 and its contraventions. The commencement of the WHS Act 2011 could be expected to have fewer compliance responses due to this lack of familiarity and confidence. In particular, inspectors were very familiar with identifying non-compliances with codes of practice under the WHS Act 1995.

Many regulation offences under the WHS Act 2011 are drafted with great complexity. For example, managing risks from hazardous manual tasks requires a PCBU to manage those risks under part 3.1 of the WHS Regulation 2011. Part 3.1 has 12 sections which intersect and the notion of SFARP is raised eight times. An inspector, when considering whether to issue an improvement notice, must also have regard to all matters impacting the musculoskeletal hazard including the seven matters listed in subsection 60(2) of the Regulation. Having done this, the requirement must then be linked to the elements of s.19 of the WHS Act 2011, which in turn requires consideration of the elements of s.18 (reasonably practicable) and section 17 (management of risks).

The complexity of drafting of this and many similar offences leads to confusion amongst the inspectorate and may both decrease the number of improvement notices issued and narrow the issued notices to those offences the inspector can navigate.

Inspectors had become familiar and confident with the provisions of the WHS Act 1995 and its contraventions; less so with the provisions of the WHS Act 2011. Inspectors have reported confusion and difficulty in drafting notices due to the new harmonised notice template itself and further difficulties in correctly articulating regulatory non-compliances.

Prohibition notices

Analysis of the issuing of prohibition notices in Australian work health and safety jurisdictions over a ten year period from 2005-06 to 2014-15 reveals a number of trends. These include:

- a reduction in prohibition notices issued across four jurisdictions (NSW, Qld, Victoria and Western Australia); and
- the much greater number of prohibition notices issued by Queensland between 2005-2010 and by South Australia between 2010-2015 when compared with other jurisdictions.

Table 8 shows the total number of notices issued across all jurisdictions between 2005-06 and 2014-15.

Table 8 – Number of Prohibition Notices Issued

Financial year	NSW	Vic	Qld	WA	SA	Tas	NT	ACT	Aus Gov	Seacare	Total Aus
Number of prohibition notices issued											
2005–06	1,212	1,876	2,243	708	623	125	54	68	10	6	6,925
2006–07	1,127	1,538	2,434	629	732	105	65	57	6	4	6,697
2007–08	994	1,043	2,784	676	588	113	61	94	19	3	6,375
2008–09	767	1,078	2,278	721	630	112	69	101	16	4	5,776
2009–10	856	928	2,277	705	628	167	51	103	26	3	5,744
2010-11	834	754	1,847	603	885	139	82	139	5	5	5,293
2011-12	601	645	1,759	401	857	132	72	135	13	0	4,615
2012-13	551	476	1,363	553	832	122	109	177	18	1	4,202
2013-14	498	499	1,222	550	629	121	122	195	14	0	3,850
2014-15	673	542	759	427	832	106	131	133	7	0	3,610

Source: CPM report

There is no evidence of a national harmonisation effect, with prohibition notice numbers issued having reduced in two jurisdictions (Victoria and Western Australia) where harmonisation has not occurred. The majority of jurisdictions are converging in terms of declining prohibition notice issue rates and Queensland is consistent with this trend. The exception to this trend is South Australia, where the issue of prohibition notices has increased. This is likely a result of the approach taken by the regulator and inspectors to the issuing of prohibition notices in that state.

The observation that there has not been a national harmonisation effect is supported by the fact that WHSQ’s organisational policy on when inspectors should issue a prohibition notice has remained unchanged since 2012:

‘It is OIR policy that inspectors will issue a prohibition notice in all cases where they reasonably believe that an activity is occurring or may occur involving a serious risk to the health or safety of a person emanating from an immediate or imminent exposure to a hazard.’

Training for all WHSQ inspectors on notice writing has been delivered three times in 2015-16, emphasising organisational expectations around when notices should be issued. It is possible that there have been changes in industry and associated technological developments that have had some impact on the number of prohibition notices issued. For example, consultation with inspectors indicated that guard risks at meatworks plants are being increasingly controlled through emerging technologies. Such technologies allow guards to detect approaching body parts and to cut power automatically during a breach. However, the impact of industry and technological change should not be overstated.

Infringement notices

Under the WHS Act 1995 and the *Dangerous Goods Safety Management Act 2001* (DGSM Act) there were 190 infringement notice offences. Historically, the vast majority of infringement notices issued were in the construction industry. Under the harmonised laws, the WHS Act 1995 and the DGSM Act were replaced and the number of infringement notice offences decreased to 141.

Two significant outcomes for infringement notice offences arose under the nationally harmonised laws. The first outcome was that only minor or less serious offences were infringeable. The second outcome was that offences with qualifying clauses such as SFARP became unfringeable. As a result, the number of infringement notice offences in total declined. The decrease for the construction sector was from 58 to 31 offences.

The reduction in the number of offences available likely led to the significant decrease in the number of infringement notices issued by WHSQ since harmonisation. The New South Wales regulator commenced harmonised laws at the same time as WHSQ and an interjurisdictional comparison showed a similar trend between the states. WHSQ has experienced a 93 percent reduction in infringement notices issued from 2005-2006 to 2014-2015. In the same time period, New South Wales had a 92 percent decrease.

In December 2016, Queensland introduced 18 new infringement notice offences in high risk areas including asbestos, hazardous chemicals and construction. Eight of these infringement notice offences relate to construction work and include the reintroduction of a number of offences previously applied for construction matters. It is thought that future data on the issue of infringement notices will reflect the extra activity brought on by the introduction of these new infringement notice offences.

Enforcement notice audit program

The decline in the number of enforcement notices issued may be in part due to the introduction of new governance and auditing procedures in 2014-15.

The enforcement notice audit program (the program) audits approximately ten percent of improvement, prohibition and electrical safety protection notices (notices) issued by inspectors under the WHS Act 2011 and the *Electrical Safety Act 2002* each month.

Notices have previously been rated 'valid' or 'not valid' against the notice audit standard by regionally-based Principal Inspectors and Managers, with a sample quality assured by the Inspectorate Governance unit, which in turn manages and reports on the program.

The audit standard is based on:

- relevant legislative requirements;
- OIR policies and procedures; and
- organisational expectations.

In June 2017, WHSQ formed a group to review the notice audit standard. The audit standard had not been formally reviewed since its creation in 2014. The review group included inspectors, an operational manager and a regional director, as well as representatives from Inspectorate Governance, Inspectorate Policy and Support, and Queensland Treasury's risk management advisory team.

Key changes as a result of the review were:

- changing the findings scale from 'valid/invalid' to 'meets audit standard/does not meet audit standard' to clarify that legal validity was not being assessed;
- clarifying the requirements around fields for PCBU address, ABN, ACN and trading name;
- simplifying requirements for descriptions of how persons are contravening stated provisions; and
- clarifying recording requirements around the date of issue of a notice.

Some matters have been referred to the WHSQ policy area for further clarification. Once organisational expectations on these matters are resolved, the notice audit standard will be further amended. In the interim, notice auditors will not consider these matters when auditing notices. These further matters are:

- wording for directions and recommendations, including references to codes of practice; and
- omitting the requirement for inspectors to state the matters giving rise to the risk on a prohibition notice.

Policies and procedures regarding issuing notices

Enforcement notes

Prior to harmonisation, WHSQ inspectors would issue a prohibition notice where the inspector had formed a reasonable belief that a workplace activity, process or piece of plant had the potential to cause harm, even where, at the time of issue, no risk of harm was present. For example, where an unlicensed person undertook asbestos demolition work, albeit it in a competent manner, or where a forklift had rolled or scaffolding collapsed and although it was not in use, the inspector prohibited its use until a competent person (e.g. manufacturer, engineer) had deemed it safe. Post-harmonisation, the ability of an inspector to issue a prohibition notice in circumstances where there was an absence of present risk, was drawn into question.

The WHS Act 2011 allows an inspector to issue a prohibition notice to direct an activity at a workplace be stopped or prevented if they reasonably believe an activity is occurring or may occur that will involve a serious risk to the health or safety of a person. WHSQ has developed an enforcement note on issuing prohibition notices when no work is occurring, to clarify its position on how the WHS Act 2011 should be applied.

The enforcement note emphasises the inspector's ability to issue a prohibition notice to prohibit an activity that is not occurring at the time of their visit if they reasonably believe it may occur in the future. Inspectors will still need to make sufficient enquiries and observations to enable them to establish a reasonable belief the activity may reoccur, including talking to other people at the work site.

Codes of Practice

While the WHS Act 2011 allows directions included in notices to refer to a code of practice, it has been WHSQ policy that where inspectors include a direction in a notice, it must only refer to a mandatory requirement in the legislation and not a code of practice, due to concerns that it is difficult to do so lawfully.

WHSQ has revised its operational procedures on issuing notices and removed the policy requirement to refer only to legislation in directions. The procedures will now allow inspectors to refer to risk control measures identified in codes of practice in directions where appropriate. The direction must still be clear and unambiguous, so the person issued with the notice can comply with it.

WHSQ has also created example notices that apply the revised procedure, for ease of reference by inspectors. These changes will enable inspectors to exercise their powers when responding to high risk activities to the fullness allowed under the WHS Act 2011.

WHSQ is cognisant of the matters raised above that have affected the number of enforcement notices issued. Changes have been made, or are in the process of being made, in a number of areas, which should see a progressive increase in the number of notices issued. It is noted that WHSQ expects the number of enforcement notices issued will continue to increase in 2016-17, with notice numbers in 2017-18 being closer to the numbers issued immediately post-harmonisation (i.e. in 2012-13 and 2013-14) and that this trend will continue in 2018-19.

Prior notice of inspectorate activity

The WHSQ operational procedure *Entry to workplaces and related powers and obligations* provides guidance to inspectors exercising their powers of entry and related powers, including whether notice of impending visits is to be provided. This procedure applies to all inspector workplace visits irrespective of whether the work is proactive or reactive in nature.

WHSQ has recently reviewed the procedure and adopted the policy that all WHSQ visits will be undertaken without prior notification unless specific circumstances determine otherwise. These limited circumstances include:

- when executive approval is granted for certain pro-active campaigns;

- when entry to a workplace would simply not be possible without prior notice; or
- when entering a workplace *with* prior notice would clearly outweigh the case for *not* doing so, due to compelling operational considerations endorsed by regional management for a specific workplace visit (e.g. an inspector is required to travel to a very remote location, investing significant time and resources), and the potential value and effectiveness of the visit hinges on a degree of certainty around cooperation from a PCBU.

Previously, the procedure recognised that entry without notice had the benefit of the inspector being able to see the workplace in its 'natural' state but specified that inspectors were not required to provide prior notice of their entry to a workplace, though they could do so. It instructed inspectors not to provide prior notice of a visit where an inspector had reason to believe that prior notice would afford the workplace the opportunity to attempt to frustrate the purpose of the visit. At the same time, the procedure advised that for efficiency purposes, prior notice/making an appointment was appropriate if it was necessary to ensure that specific persons were in attendance or for other reasons (e.g. interviewing particular persons or observing specific plant, equipment or processes in operation).

Compliance initiatives

It has been the experience of WHSQ, as highlighted above, that the issue of enforcement notices, predominately improvement notices for singular risks or hazards, does not address the underlying causes of identified non-compliances.

While attempts have been made by WHSQ to use improvement notices to address systemic non-compliance or safety issues requiring change over a period of time, improvement notices have not been found to be suited to these situations. For example, a single investigation following an incident at a sawmill business resulted in 172 notices being issued. Longer term systemic changes were needed at this sawmill as well as addressing more immediate hazards.

To effectively address systematic safety failures such as this, WHSQ has implemented other initiatives and ongoing support, which is not incorporated into or recognised by the National Policy and not measured by SWA through the CPM.

Some of the strategies being used by WHSQ include agreed outcomes and the IPaM program.

Agreed actions and safety performance improvement plans

Agreed actions (sometimes referred to as agreed outcomes) is a term loosely used to describe the giving of advice and seeking of monitored compliance. It is a flexible and discretionary way in which inspectors can achieve compliance. Actions range from an inspector identifying a hazard at a workplace and it being rectified immediately, to long term strategies of continuous improvement that are recorded in an action plan and closely monitored. If a PCBU fails to achieve identified outcomes within the prescribed timeframes the inspector can quickly move to using directive measures, such as issuing enforcement notices, to achieve compliance. The decision to utilise an agreed action approach rather than write an enforcement notice is based on the evidentiary requirements for the notice and a risk management approach. That is, agreed actions are only appropriate for lower level risks, e.g. an unregistered pressure vessel, no chemical register, an unguarded piece of plant which has limited access/hard to reach and can be rectified in a day or two, no asbestos register, test and tag out of date on power tools. Higher-level risk justifies an improvement or prohibition notice being issued and the time and resources required to satisfy the evidentiary requirements.

In addition to the statistics provided regarding the number of assessments, advisories and notices issued, WHSQ have achieved significant long-term and industry-wide sustainable outcomes by securing compliance through the use of agreed actions and safety performance improvement plans. These are not captured in the recorded statistics relating to assessments, advisories and notices.

WHSQ's move to agreed actions and safety performance improvement plans is clearly seen in the data with a decrease in the number of improvement, prohibition and infringement notices issued since this period. However this decline is offset by the number of agreed actions and safety performance improvement plans that were successfully delivered.

In 2015 and 2016 the construction inspectorate in the South West Gold Coast region completed 2483 agreed actions. Based on approximately 16 field-based construction inspectors, this is approximately 77 agreed actions issued per construction inspector, per year. For the same region, the industrial and agricultural inspectorate (a sample of 17 inspectors) initiated 1420 agreed actions over the same time period. Based on this sample, this equates to approximately 41 agreed outcomes being completed per inspector, per year.

For the period between 1 March 2015 and 1 March 2017, the North Queensland/Central Queensland region completed approximately 2103 response assessments and 8942 proactive assessments, which resulted in approximately 911 agreed actions. In addition, as part of the red meat processing campaign during 2013-2015, WHSQ applied 1100 agreed actions across 18 meat processing plants in Queensland.

Robust data on the extent of use and outcomes achieved by virtue of agreed actions is not readily available as the current information technology system is unable to effectively record them. However, interviews conducted with inspectors and advisors in 2016, which took place as part of a regulatory research study being conducted as a collaboration between WHSQ and the Queensland University of Technology, revealed that inspectors find that agreed actions are an effective way of getting results and that they are used extensively.

Injury Prevention and Management program

In 2010, it was recognised that employers with comparatively poorer work health and safety performance and claims experience would benefit from a sustained improvement approach. It was evident that issuing hazard-focused improvement notices was not going to address the entrenched failures to systematically address work health and safety management. As a result, the Work Health and Safety Board supported WHSQ in establishing the IPaM program in 2011.

The IPaM program currently has a team of 26 advisors and has worked with around 1000 individual businesses with a combined workforce of approximately 164,000 FTEs or 215,000 workers. Of these, 569 (57 percent) of the organisations reside within priority industries (agriculture, construction, manufacturing and transport) with 51,000 FTEs or 67,000 workers.

In delivering the program, IPaM advisors work intensively with businesses for an initial period of 12 months. During this period the advisor makes multiple visits to the business to:

- review the current safety management systems;
- review existing injury management arrangements;
- verify workplace hazards; and
- evaluate workplace safety climate by seeking the views from both managers and employees on the efficacy of safety management in the workplace.

Through this assessment and engagement process, employee participation is improved, as is the businesses capability to comply with legal obligations since legislative requirements and codes of practice are outlined to the business as part of the process. Worker involvement in this process and feedback through participation in safety climate assessments ensures that real improvements are made and are delivered on the ground as safer working conditions and processes.

Following completion of the assessments, the outcomes are then incorporated into a tailored improvement plan for the business. This plan outlines the key opportunities for improvement and sets out activities and milestones for improving the businesses' management of work health and safety and injury management. After the initial 12 month period, the IPaM advisor continues with regular onsite reviews to support and

coach the employer in implementing the plan and monitoring progress. Once the employer has completed the 24 month program, a review is undertaken to identify areas that need ongoing attention, future opportunities for continued improvement and lessons learned through the process.

Since commencement, IPaM has resulted in a \$26 million reduction in workers compensation premiums, a seven percent reduction in statutory costs, an eight percent reduction in claims and \$8 million in business savings.

Stakeholder feedback on WHSQ's inspectorate and advisor activities

Term of reference two requires the Review to consider the effectiveness of WHSQ's enforcement and compliance activities, including inspectorate and advisor activities.

There were very mixed responses from stakeholders about the activity of WHSQ inspectors and advisors. Some were in favour of WHSQ's use of compliance programs, industry partnerships and education campaigns as a means of improving WHS. MBQ submitted:

*"These programs are generally well received by industry and are seen as a positive way to educate the industry, encourage compliance and bring businesses onto a level playing field."*⁶⁵

Others were critical that WHSQ inspectors and advisors were too focused on engagement and education. The QCU noted:

"...it appears that extensive resources are being expended by the government to undertake risk management and safety systems development for PCBU's, without also applying sanctions to these employers for failing to undertake this work themselves.

...

*...given that risk management activities are fundamental to meeting the objectives of the Act, PCBU's should not be excused from risk management activities, nor should these be performed by inspectors in preference for enforcement methods."*⁶⁶

The union groups were highly critical of the work ethic and practices of WHSQ inspectors and advisors. In their submission, the BTGU described inspectors and advisors as 'partisan', stating that their work practices were inconsistent, displayed varying levels of skill and care, and often resulted in the interests of workers being sidelined.

Several stakeholders had no strong opinions about the activities of the inspectors and advisors, but noted that there was no inspectorate presence at many workplaces unless a complaint was made or there was a notifiable incident. These stakeholders believed more site visits would have beneficial effects on WHS.

Feedback from WHSQ construction inspectors for the Review was particularly critical of organisational positions on issuing enforcement notices. These inspectors cite the compliance and enforcement policy's focus on facilitation and the overstated notice audit standard as two reasons for the decline in 'harder' enforcement methods.

Findings

The review finds that there is a need to increase the level of on the ground inspectorate activity, in line with the views of nearly all stakeholders. While some organisational decisions have contributed to these issues, funding cuts and an increased potential demand caused by economic growth and industry change have also

⁶⁵ Master Builders Queensland submission p13.

⁶⁶ Queensland Council of Unions submission p15.

contributed. The drop-off in the use of directed compliance notices seen in recent years indicates an inappropriately low level of use of these critical tools to ensure safe workplaces. The audit system implemented in response to the Ombudsman's report, while well-intentioned, was excessively bureaucratic, and had the perverse effect of discouraging inspectors from issuing notices of various kinds. A combination of real and perceived policy shifts by WHSQ and internal processes that "seconded-guessed" the professional judgement of inspectors compounded these issues and reduced the confidence and morale of some inspectors. While significant improvements have been made to processes during this review, they require ongoing monitoring to ensure effectiveness. There is a need to ensure that internal processes operate in a way which is supportive and encouraging of the work of inspectors, given the important powers and wide discretion they possess under the legislation. Improved technology and other systems (discussed elsewhere in this report) should also reduce the administration workload of Inspectors and increase opportunities for on the ground visibility of activities.

Recommendations:

23. WHSQ develop a plan to increase inspector visibility, including in priority industries, and seek stakeholder feedback, including via the Industry Sector Standing Committees, after implementation.
 24. WHSQ take additional steps to ensure all Inspectors have a clear understanding of the availability of directed compliance as tool and of the systems used to track and support its use.
 25. The Work Health and Safety Board include inspectorate activity as a core element its five year strategic plan, monitor patterns of activity (including directed compliance) and provide feedback to WHSQ and advice to the Minister accordingly.
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3.4 Partnerships and collaboration

Working with industry, the community and other government departments to develop and implement health and safety strategies is a core pillar in regulatory efforts to build sustainable improvements in work health and safety outcomes. Through collaboration and partnerships, WHSQ is able to incorporate input and feedback from key stakeholders – an approach that has the ability to translate into a willingness to participate, engage and implement safe work behaviours and initiatives.

It is recognised that some work health and safety issues overlap with, or are part of a complex mix of societal issues (so-called "wicked problems") which require collaboration, or the adoption of a multi-agency approach. Examples of these include disadvantaged and vulnerable workers, indigenous communities, large projects such as commonwealth games, competency of apprentices, the use and disposal of asbestos, quad bikes, silica, counselling and providing coronial liaison services for impacted families, and investigations of workplace deaths and serious incidents. Collaboration across agencies to address these issues is the hallmark of every high performing state and federal government department. Collective information sharing, insights and problem solving, achieved through partnerships and collaborations, provide for the development of sustainable solutions to health and safety problems rather than simply identifying non-compliance issues.

Other WHSQ partnerships, such as with industry employer and employee representatives, allow collaborative thinking to occur about the redesign of industry practices and processes, which cause or have the potential to cause harm, and the development of better industry guidance material (e.g. the tunnelling code of practice). WHSQ's partnerships with universities are informing the development of effective regulatory strategies and the skill sets required by inspectors.

WHSQ's broadening of its strategies to include partnerships and collaborations from 2012 is supported by the decline in serious injury rates (e.g. from 29,430 serious injuries in 2012 to 24,710 in 2015).

Recent partnerships and collaborations include the Asbestos Interagency Group, Quad Bike Interagency Group, Horticulture Worker Interagency Group, and safety networks.

Asbestos Interagency Group

The Asbestos Interagency Group, comprised of six Queensland Government departments and the Local Government Association of Queensland, was established in 2012 in response to the outcomes of an investigation by the Queensland Ombudsman into the management and regulation of asbestos by State Government departments and local councils. The Ombudsman's report *The Asbestos Report: An investigation into the regulation of asbestos in Queensland* was highly critical of the lack of coordination and cooperation between agencies in situations of jurisdictional overlap, specifically, the significant confusion about the limits of each agency's jurisdiction, overlap between agencies' responsibilities and a number of areas where no agency claimed responsibility. The report recommended that a lead agency be established to coordinate the whole of government management and regulation of asbestos in Queensland including the development of a strategic plan to guide and coordinate interventions. WHSQ was charged with this role. Since its establishment, the Asbestos Interagency Group has been working to provide a more responsive and collaborative approach to the regulation and management of asbestos in Queensland and established a number of initiatives in the *Statewide Strategic Plan for the Safe Management of Asbestos in Queensland 2014-2019*. Examples of outputs include:

- WHSQ and Queensland Health providing training for over 380 environmental health officers to ensure councils have the capacity to respond to the public health risks associated with asbestos;
- the development of a guide to agency response and management of asbestos incidents so it is clear which agency has lead responsibility;
- the establishment of a mechanism for ensuring priority clean-up of asbestos incidents that satisfy certain criteria; and
- the development of a public asbestos disposal pilot scheme for local councils to improve the way homeowners can dispose of small quantities of asbestos waste, including asbestos from minor renovation projects or scrap asbestos pieces found in yards.

Quad Bike Interagency Group and Quad Bike Industry Reference Group

The Quad Bike Interagency Group and Quad Bike Industry Reference Group was established in 2015 in response to coronial recommendations for quad bike safety. Quad bikes have posed a significant safety issue for the Queensland community, being the leading cause of injuries and fatalities on Queensland farms and having caused nearly 70 fatalities over the past 15 years and approximately 1,500 hospitalisations between 2009 and 2013; the highest injury and fatality rate for all Australian jurisdictions. The Quad Bike interagency Group was established to ensure a more consistent and coordinated response to quad bike safety given several Queensland Government agencies have various regulatory oversight for quad bikes in areas across land management, transport safety and work health and safety. Key achievements of the Quad Bike Interagency Group include:

- the development of the *Statewide Plan for Improving Quad Bike Safety in Queensland 2016-2019*;
- development of the *Ride Ready* quad bike safety awareness campaign; and
- mandating helmet use for quad bikes operated on road or road-related areas.

Horticulture Worker Interagency Group

The Horticultural Workers Interagency Group was established in 2015 to address issues surrounding the exploitation of backpackers and students on working visas and itinerant workers, in particular 417 visa holders working in the Queensland horticultural industry. This interagency group is comprised of representatives from 13 Queensland Government and three Commonwealth Government agencies. Recent outcomes include:

- a forum in Bundaberg which was supported by local council, Grow Com and the Bundaberg Fruit and Vegetable Growers Association where delegates including government, backpackers, horticulture

growers, backpacker hostels and labour hire organisations gained a better understanding of each other's issues;

- pop up information standards in most major horticulture growing areas in Queensland to provide backpackers with information on their workplace rights and responsibilities and personal safety; and
- stronger links with local councils in the major horticulture growing areas, where a multi-faceted approach is necessary to improve the safety and wellbeing of workers.

Safety networks

Various safety networks within industries have been formed to provide a forum for industry stakeholders to share knowledge and identify simple safety solutions to common problems. The safety networks facilitate conversations that foster openness, frankness and the exchange of ideas between authorities, suppliers and customers in a manner that accelerates the resolution of day to day safety issues. They allow employers and workers to share ideas and stay up to date with health and safety concerns in their industry and ensure members are hands on when developing guidance materials and other activities initiated by WHSQ. Often the safety networks are an extension of the work of the industry sector standing committees and are held at various geographic locations across the state. Some safety networks have been operational since the 1980s (construction industry), 1990s (meat industry), and others established in recent years (e.g. transport). Details of safety networks are published on the WHSQ website and interested parties encouraged to attend. The transport safety showcase is one initiative delivered through a safety network. Others relate to audit campaigns, design issues, forums, case studies and short films.

Stakeholder feedback on partnerships and collaboration

Limited feedback was provided by stakeholders regarding WHSQ's use of partnerships and collaboration, it was noted however that:

"WHSQ's collaborative approach is commended." (Gunther Paul, James Cook University)

The QCU and BTGUs however stated that:

"WHSQ places too much emphasis on partnerships and collaboration and not enough on deterrence."

and

"WHSQ should strive to coordinate with workers, HSRs and unions."

Findings

The Review considers partnerships and collaboration to be an effective approach to address complex issues and to improve work health and safety outcomes. The current approach and resourcing for partnerships and collaborations is appropriate and has delivered positive outcomes for systemic workplace health and safety issues. This could be further improved by ensuring that workers and worker representatives are included.

Care must be taken to ensure that partnerships and collaboration are not seen as a replacement for ensuring that PCBUs and other duty holders meet their legislative responsibilities, or that resourcing of these types of initiatives come at the expense of frontline inspector activity.

3.5 Investigations

WHSQ undertake investigations for a number of reasons, including to examine the causes of an incident, to assess compliance with work health and safety laws, to decide what action may be needed to prevent further occurrences of similar incidents and to determine what action may be appropriate to enforce compliance with work health and safety laws. Lessons learnt from investigations also inform the development of work health and safety guidance and policy and may be the impetus for future changes to work health and safety laws.

In 2015, the Queensland Ombudsman undertook a review to determine the adequacy of WHSQ's investigation work and processes, following complaints and critical commentary from coronial inquests regarding the quality of these processes.⁶⁷ The review focused solely on work-related deaths and found that WHSQ's *process for notification and referral, triaging, responding to a workplace death and initial investigation activities were generally appropriate and greatly improved.*⁶⁸ Systemic shortcomings were however identified in *investigation planning, issue identification and evidence gathering, and the sufficiency of advice provided by legal officers to support prosecution decisions.*⁶⁹

In response to the findings from the Ombudsman's review, and various findings from internal audits, WHSQ have implemented a range of business improvement strategies for their comprehensive investigations. These include:

- repositioning of the reporting relationships within the investigations function into a more centralised model providing for better coordination of investigation resources across the state and standardisation and consistency of outcomes;
- appointing a State Investigations Manager (SIM) with responsibility for WHSQ investigative services to ensure the delivery of quality, consistent and professional services;
- reviewing and updating investigations manager and investigator role descriptions;
- introducing mandatory investigation qualifications for investigations manager and investigator positions;
- consolidating the number of investigations manager positions across the state, reducing the number from seven to four;
- benchmarking the investigations process and model against interstate work health and safety agencies;
- commencing training and skills development in fundamental investigation skills (including areas of deficiency identified in the Ombudsman's review and results from a WHSQ individual training needs analysis);
- initiating an annual investigators' forum to discuss contemporary work health and safety investigation procedures and practices;
- introducing a contemporary investigations training manual;
- creating a suite of new templates for investigation planning, case management and reporting;
- developing a risk assurance map for the work health and safety investigation process;
- introducing a quality assurance system that includes audits by both internal and external auditors; and
- establishing an Inspectorate Governance unit, which has oversight of the quality assurance system.

Risk assurance map

In 2016, WHSQ engaged a contractor to facilitate the development of a risk assurance map (RAM) for investigations. In developing the RAM, risks were identified primarily through discussions with key WHSQ investigations stakeholders. Risk control activities were subsequently identified and categorised into one of three lines based on the ownership of the activity.

The RAM comprises a 'three lines of defence' matrix to ensure investigation quality is measured using different methodologies at the business unit, internal review and audit, and external audit levels. When considered together, these provide a robust system for WHSQ to identify and manage organisational risks associated with the investigation process in a framework that supports continual improvement.

⁶⁷ Queensland Ombudsman, *The workplace death investigations report: An investigation into the quality of workplace death investigations conducted by the Office of Fair and Safe Work Queensland*, September 2015, p.xi.

⁶⁸ Queensland Ombudsman, p.xii.

⁶⁹ Queensland Ombudsman, p.xii.

Quality assurance system

The WHSQ investigations quality assurance system (QAS) uses the RAM to assure the quality of investigations. The SIM, Inspectorate Governance unit, and investigations managers each have complementary responsibilities in administering the QAS.

WHSQ internal investigations audits form part of the second and third lines of defence in the RAM. These audits are conducted quarterly by the Inspectorate Governance unit and sample approximately 20 percent of ongoing and finalised investigations for the relevant period. The internal audit standard addresses adherence to processes in five key areas of investigations: timeliness, planning, case management, preliminary legal advice, and reporting.

WHSQ external investigations audits form part of the third line of defence in the RAM. These audits are conducted twice-yearly by specialised work health and safety external auditors and sample approximately 10 percent of finalised investigations for the relevant period. The external audit standard addresses 14 key areas of investigation quality, as well as overall investigation quality.

Reports with findings, analysis and recommendations are produced by the Inspectorate Governance unit for both internal and external audits. These reports are provided to relevant parties and are used to inform key performance indicators for investigations managers and investigators.

Timeliness

Section 232 of the WHS Act 2011 allows WHSQ a period of two years to institute proceedings against a work health and safety duty holder for an alleged offence. WHSQ has adopted a best practice approach to timeframes and requires all investigations to be finalised within six months of commencement. A finalised investigation is one that has been submitted to the Prosecution Services unit for a decision regarding further action. Prosecution Services is required to make a decision on matters within three months of receipt of the investigation brief.

Where an investigation exceeds six months, the investigations manager submits an exception report to the SIM with reasons for the delay. The SIM will only deem an exception report satisfactory in circumstances where an acceptable reason is provided e.g. the investigation is complex and cannot proceed further until an expert report is received.

Table 9 shows the number of investigations finalised within six months (or were over six months but had an exception report rated satisfactory by the SIM) for the last three reporting periods.

Table 9 - Number of investigations

Reporting period	Investigations finalised	Investigations finalised within 6 months	Investigations finalised within 6 months or has satisfactory exception report
July-Sept 2016	41	31 (76%)	36 (88%)
Oct-Dec 2016	23	15 (65%)	19 (83%)
Jan-March 2017	59	32 (54%)	47 (79%)

Memoranda of Understanding

A memorandum of understanding (MOU) is a formal agreement between certain parties that outlines terms and responsibilities. WHSQ currently has 16 MOUs with various organisations published on its website, including MOUs with the Queensland Police Service (QPS) and the Department of Transport and Main Roads (DTMR). The QPS and DTMR MOUs are particularly relevant in determining agency responsibilities in relation to investigation management. WHSQ is currently in the process of updating these MOUs.

Stakeholder feedback on WHSQ investigations

Term of reference two requires the Review to consider the effectiveness of WHSQ's enforcement and compliance activities, including investigations.

Stakeholders were almost uniformly critical of the investigative performance of WHSQ, particularly the timeliness of investigations. Stakeholders observed there were often delays between the initial incident inquiries and the conclusion of the investigation, and that there was a need for a more transparent and timely process for informing affected parties. The QLS submitted:

"...investigations need to be progressed in a more timely manner to achieve better outcomes for all parties involved.

...

*This will ensure evidence is obtained as soon as practicable and that all parties are made aware of the outcome quickly to ensure the safety of workers."*⁷⁰

A number of stakeholders believed investigative delays may be due to under-resourcing. The QCU submitted:

*"The time taken to undertake and conclude investigations is of concern. This may be a result of resource issues."*⁷¹

Comments made by the State and Deputy State Coroner and Families Forum during face to face meetings were unfavourable in relation to the quality of investigations and investigators. These groups noted that investigations lacked forensic depth, and investigators may not have the requisite expertise, particularly with regard to initial evidence taking.

The DPP, and State and Deputy State Coroner also raised issues around confusion about agency responsibilities and incident site control, that may in some cases lead to a loss of continuity of evidence.

In relation to measuring the effectiveness of WHSQ investigations, QLS submitted:

*"The effectiveness of the investigation process could be measured through the collection and analysis of statistics detailing the length of the investigations and whether the outcome of the investigation had a positive, measurable impact on the workplace."*⁷²

Findings

The review finds that there is a need for ongoing improvement in WHSQ's investigations performance. Undoubtedly, the quality of investigations significantly impacts, and in many cases determines the possibility of a successful prosecution. Historically, there have been significant problems with the quality, timeliness and consistency of investigations conducted by WHSQ. These were highlighted in the Ombudsman's review and in many ways reflect the broader perceptions of stakeholders involved in this review, including employers, unions and the Families Forum. While significant additional quality assurance mechanisms and governance measures have been introduced since the Ombudsman's review, it is currently too soon to confirm whether these business improvement strategies have resulted in an investigations system that is efficient, timely and thoroughly professional.

⁷⁰ Queensland Law Society submission to the Best Practice Review of Workplace Health and Safety Queensland, May 2017, p.5.

⁷¹ Queensland Council of Unions submission to the Best Practice Review of Workplace Health and Safety Queensland, May 2017, p.18.

⁷² Queensland Law Society submission to the Best Practice Review of Workplace Health and Safety Queensland, May 2017, p.5.

The review also finds that there is a need for WHSQ to improve its communication with parties affected by investigations by providing ongoing information to work health and safety duty holders and the families of victims, about the status of investigations.

Further, the Review finds there is a need for WHSQ to review its current arrangements regarding investigative responsibilities with other agencies so that the quality of cooperation can be improved.

Recommendations:

26. Consistent with recommendation 31 to functionally separate the compliance and business engagement functions of WHSQ, the State Investigations Manager should report to the Director of Work Health and Safety Prosecutions.
27. WHSQ implement a formal policy regarding the release of information about the status of investigations to all affected parties.
28. WHSQ update the Memoranda of Understanding with the Queensland Police Service and the Department of Transport and Main Roads so that agency responsibilities during investigations are clearly delineated.
29. WHSQ determine the effectiveness of investigations by collecting and analysing quality and timeliness data.
30. WHSQ use findings from collected investigations data to best direct resources and establish 'best practice' timelines for various categories of investigations.

3.6 Prosecutions

Part 13 of the WHS Act 2011 provides the framework for WHSQ to undertake work health and safety prosecutions. Legal proceedings can be commenced against a person or corporation under the WHS Act 2011 for alleged reckless conduct (category 1 offence), for a failure to comply with a health and safety duty that exposes an individual to a risk of death or serious injury or illness (category 2 offence), or a failure to comply with a health and safety duty (category 3 offence).⁷³

WHSQ's Prosecution Services unit is responsible for making enforcement decisions and undertaking prosecutions on behalf of the regulator under the WHS Act 2011. This includes contributing to case management through investigations into incidents and the assessment of evidence, prospects and public policy matters.

Prosecution Services is also responsible for undertaking prosecutions under the *Electrical Safety Act 2002* and the *Safety in Recreational Water Activities Act 2011* which have mirror offence provisions.

How decisions to prosecute under the *Work Health and Safety Act 2011* are made

In deciding whether or not to prosecute, the Prosecution Services unit are guided by the Director of Public Prosecutions Guidelines (DPP Guidelines) and the National Compliance and Enforcement Policy (National Policy).

The National Policy, adopted by WHSQ, outlines the following three criteria from the DPP Guidelines that need to be met when determining whether to prosecute:

1. the existence of a prima facie case, that is, whether the evidence is sufficient to justify the institution of proceedings;
2. a reasonable prospect of conviction, that is, an evaluation of the likely strength of the case when it is presented in court;
3. a public interest test which may include the following considerations:

⁷³ *Work Health and Safety Act 2011* (Qld) ss 31-33.

- a) the seriousness or, conversely, the triviality of the alleged offence or whether it is only of a technical nature;
- b) any mitigating or aggravating circumstances;
- c) the characteristics of the duty holder—any special infirmities, prior compliance history and background;
- d) the age of the alleged offence;
- e) the degree of culpability of the alleged offender;
- f) whether the prosecution would be perceived as counter-productive, that is, by bringing the law into disrepute;
- g) the efficacy of any alternatives to prosecution;
- h) the prevalence of the alleged offence and the need for deterrence, both specific and general; and
- i) whether the alleged offence is of considerable public concern.⁷⁴

The Queensland Ombudsman’s Workplace Death Investigations Report

As previously noted in section 3.5, on 18 November 2015, the Queensland Ombudsman tabled a report entitled *The Workplace Death Investigations Report: An investigation into the quality of workplace death investigations conducted by the Office of Fair and Safe Work Queensland* (now the OIR).

The report made a number of recommendations to improve the way WHSQ exercises its duties to prosecute breaches of the WHS Act 2011. In particular, the Ombudsman recommended that an independent person should be engaged to conduct a comprehensive review of the Prosecution Services unit.

In response to this recommendation, the Government engaged PricewaterhouseCoopers (PWC) to assess the appropriateness of the operating model and key functions of the Prosecution Services unit.

On 28 March 2017, PWC presented its review report to the OIR. A key recommendation of this report was to establish a prosecutions board consisting of key stakeholders (including the Senior Director of Prosecution Services) that would consider legal advice and other relevant considerations when determining whether an incident should be prosecuted. Other recommendations related to enhancing staff engagement, investing in enhanced technology solutions to assist file management practices and strengthening legal analysis contained in final legal advices. The OIR is currently considering the recommendations and findings contained in the report.

To date WHSQ have implemented the following improvements relating to prosecutions arising out of the Ombudsman’s report:

- a written advices procedure has been developed which includes target timeframes to make prosecution decisions;
- a commitment to publicly report on target timeframes for investigations and decisions about prosecutions as part of WHSQ’s Annual Report;
- introduced a case and file management procedure to ensure consistency in case management advice provided to the Senior Director of Prosecution Services; and
- ensuring that next of kin receive a letter providing reasons for decisions not to commence prosecutions and advising them of their right to request a prosecution under section 231 of the WHS Act 2011.

Stakeholder feedback on the proposed Prosecutions Board

In responding to the issue of whether a Prosecutions Board should be established stakeholders were almost unanimously opposed to its introduction. The dominant reason related to this was that a prosecutions board

⁷⁴ National Compliance and Enforcement Policy, p10

could be viewed as a partisan body and would add an unnecessary layer of complexity to the current prosecutions framework. MBQ also suggested that a prosecutions board is likely to have an adverse impact on the integrity and independence of the regulator, specifically noting:

“If members of the prosecutions board are chosen by the government of the day, there is a real risk of perceived political bias, which of course will undermine the integrity and independence of the regulator.”⁷⁵

The Civil Contractors Federation (CCF) also highlighted that a decision to commence a prosecution requires careful consideration of the law and relevant evidence and should be decided by those with appropriate legal skills in interpreting legislation.⁷⁶ While the HIA had concerns about the qualifications of candidates who might be appointed to a possible prosecutions board.⁷⁷

There was however some support for the creation of a prosecutions board. The QNMU noted that a board could improve the quality of legal advice to facilitate effective decision making about the appropriateness of prosecutorial action. They also considered that a prosecutions board could also improve transparency and timeliness in making prosecutorial decisions.⁷⁸

It is the view of the Review that the establishment of a prosecutions board is inappropriate due to conflicts of interest with potential members of such a board noting it is likely they would need to be legal practitioners. Additionally, a prosecutions board is considered to be an overly complex response to issues surrounding prosecutorial decision making and that there are other alternative approaches to ensuring the efficacy and independence of the decision making process.

Other issues raised by stakeholders

In considering whether WHSQ’s current approach to prosecutions is appropriate and effective a number of common criticisms were raised by stakeholders. This includes issues regarding the timeliness and transparency of prosecutions, the number of, and success of, prosecutions undertaken by WHSQ, and the independency of prosecutorial decision making.

Timeliness and transparency of decisions

Many submissions to the Review raised concerns regarding the time it takes WHSQ to make prosecution decisions and believed more transparency was needed to inform relevant parties during the investigation and prosecutorial decision making process.

Both MBQ and the QTIC noted that decisions to prosecute are often being made just prior to the two year limitation period to initiate prosecutions under section 232 of the WHS Act 2011. In its submission to the Review, MBQ specifically noted that:

“there needs to be greater accountability for the regulator for ensuring that the decision to prosecute is done in the shortest possible timeframe so that the best safety outcomes can be achieved.”⁷⁹

The Queensland Law Society also submitted that WHSQ’s prosecutions have not been conducted in a timely or efficient basis in their experience. The Society recommended that WHSQ consider implementing a policy to provide specific deadlines for considering briefs of evidence.⁸⁰

⁷⁵ Master Builders Queensland submission, p7

⁷⁶ Civil Contractors Federation submission, p3

⁷⁷ Housing Industry Association submission, p2

⁷⁸ Queensland Nurses and Midwives Union submission, p8-9

⁷⁹ Master Builders Queensland submission, p16

⁸⁰ Queensland Law Society submission, p6

Further, the QNMU believes there is a need for a more transparent and timely process for informing relevant parties about investigations and decisions to commence prosecutions.⁸¹ This point was also supported by the Families Forum, which recommended to the Review that WHSQ should be more transparent in its dealings with affected families regarding investigations and prosecution decisions.

Number of prosecutions

The Review also heard a number of concerns from stakeholders regarding the low number of prosecutions initiated by WHSQ under the WHS Act 2011. The Queensland Law Society noted that the number of prosecutions appeared to be low, and that there seemed to be a low success rate (i.e. prosecutions which resulted in a conviction, order or agreement).⁸²

In its submission, the QCU also noted that WHSQ prosecutions remain rare and submitted that failures to prosecute for breaches of the legislation will bring about a normalisation of non-compliant conduct.⁸³ The Union also raised concerns that only one prosecution for a category 1 offence (under section 31 of the WHS Act 2011) has commenced in Queensland since the model work health and safety laws were introduced, specifically stating that:

“Given the number of workplace fatalities that have occurred since the introduction of this legislation, it is difficult to imagine that there would not have been other circumstances that could have given rise to such a prosecution.”⁸⁴

Independence of decision making

In addition to the issue noted above, some concerns were raised by stakeholders regarding the independence of WHSQ’s current prosecutions framework. For example, the CCF believes there is potential for inconsistencies in prosecution decisions due to a reliance on public interest considerations rather than a sole evidence-based approach.⁸⁵ There was also a perception that the regulator could be influenced by the government of the day when deciding whether to commence prosecutions. Although there was no evidence provided to the Review to suggest that this occurs, this perception has the potential to damage the credibility of the regulator as an independent and consistent decision maker for work health and safety prosecutions.

Workplace Health and Safety Queensland’s prosecutions performance

Prosecution numbers

Following the introduction of the model work health and safety laws in 2012, there was a reduction in the number of prosecutions commenced in Queensland. WHSQ has cited a number of factors for contributing to this reduction, including:

- several court decisions which have had led to defendants appealing and challenging particular matters; and
- the removal of the absolute duty of care in the now repealed WHS Act 1995, which was replaced with the defence of ‘so far as is reasonably practicable’ under the WHS Act 2011 from 1 January 2012.

For example, WHSQ assert that in 2010 the High Court decision of *Kirk & Anor v Industrial Court of New South Wales & Anor*⁸⁶ had effects on the progress of prosecutions under the WHS Act 1995 as well as the WHS Act 2011, causing delays due to applications and appeals to the Court of Appeal, the Supreme Court and the

⁸¹ Queensland Nurses and Midwives Union submission, p9

⁸² Queensland Law Society submission, p5

⁸³ Queensland Council of Unions submission, p 3

⁸⁴ Queensland Council of Unions submission, p 18

⁸⁵ Civil Contractors Federation submission, p3

⁸⁶ (2010) 239 CLR 531

Industrial Court. It was also claimed that a subsequent 2013 decision of *NK Collins Industries Pty Ltd v The President of the Industrial Court and Anor*⁸⁷ led to some prosecutions not being commenced, further contributing to a decline in prosecution numbers.

The 2014 decision in *Bell v Hendry*⁸⁸ under the *Mining and Quarrying Safety and Health Act 1999* also attributed to causing delays in finalising prosecutions as defendants continued to challenge the adequacy of particulars. During this period, the matter of *Archer v Simon Transport Pty Ltd* *Simon Transport Pty Ltd*⁸⁹ was litigated and finally determined in the Court of Appeal in April 2016. The decision was a successful outcome for WHSQ and there has been an increase in the number of finalised and current prosecutions since this decision. Of significance, there have been no applications for particulars or validity of complaints since this decision.

A breakdown of the total number of WHSQ’s prosecutions for each year since 2006/07 is provided in the table below. It is clear from this data that the number of prosecutions commenced by WHSQ declined in alignment with the introduction and enforcement of the WHS Act 2011 in 2012 but has started to increase in the last year. Between 2015/16 and 2016/17 (to 20 June 2017), there has been a 39.5% increase in the number of WHSQ prosecutions.

Table 10: Prosecutions Data - Number of All Prosecutions*

2006/ 07	2007/ 08	2008/ 09	2009/ 10	2010/ 11	2011/ 12	2012/ 13	2013/ 14	2014/ 15	2015/ 16	2016/ 17**
102	83	133	96	93	98	98	53	54	48	67

*Includes all prosecutions regardless of status. That is Successful, Unsuccessful, Withdrawn and Withdrawn – EU.

**Data on 2016/17 is for 1 July 2016 to 20 June 2017.

Success rate of prosecutions

Queensland’s rate of successful finalised prosecutions (i.e. prosecutions which have resulted in a conviction, order or agreement) has remained reasonably steady over the last ten years, ranging from a low of 77% (in 2008/09) to a high of 89% (in 2013/14).

In 2016/17 (to 20 June 2017), 57 of 67 finalised prosecutions were successful (a success rate of 85%). A breakdown on the rate of successful legal proceedings for each year since 2006/07 is provided in the table below.

Table 11 – Prosecutions Data – Success Rate of Finalised Prosecutions

2006/ 07	2007/ 08	2008/ 09	2009/ 10	2010/ 11	2011/ 12	2012/ 13	2013/ 14	2014/ 15	2015/ 16	2016/ 17*
81%	81%	77%	89%	81%	80%	80%	89%	78%	88%	85%

*Data on 2016/17 is for 1 July 2016 to 20 June 2017.

Timeframe from incident to decision of whether to prosecute

WHSQ provided the Review with data on the average time between an incident occurring and a decision by WHSQ to prosecute in relation to an incident (i.e. filing a complaint and summons in court). The graph below shows an analysis of the average time to commence a prosecution in each year from 2007 to 2015. The analysis identifies that:

⁸⁷ [2013] QCA 179

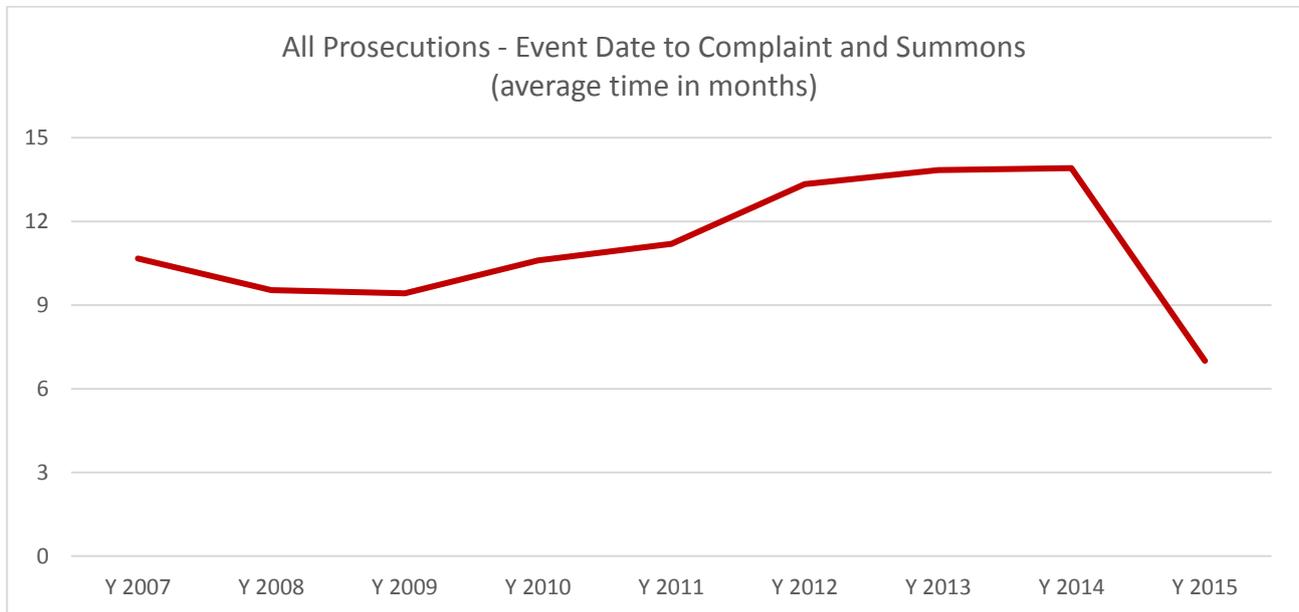
⁸⁸ [2014] ICQ 018

⁸⁹ [2016] QCA 168

- prior to 2012, the average time for a complaint and summons to be filed after an incident was nine to 11 months from the incident. The average time has increased since 2009.
- since 2012, the average time has increased further from 13 to 14 months.

The Review notes that the results for prosecutions in the 2015 calendar year are not reliable as they are still under development by WHSQ.

Figure 4 - Average time from event to complaint and summons filed



Findings

The Review agrees with the majority of stakeholder submissions that a prosecutions board would add an unnecessary level of complexity and uncertainty to the prosecution process. A prosecutions board would also create potential conflicts of interest and perceptions of bias if members of the board are appointed by the government of the day. Such a body would additionally require members to be qualified as legal practitioners to ensure that decisions were made with the appropriate level of legal scrutiny. For these reasons, the Review does not believe that a prosecutions board should be created to provide a decision making function for the commencement of prosecutions.

While the regulator is not subject to Ministerial direction when deciding whether to commence prosecutions, there is some perception from both employee and employer groups that the regulator has been subject to external pressure in respect of the prosecution function. This is so, despite the fact that prosecution decisions are delegated to the Director (LPS) applying the DPP Guidelines and that the Enforceable Undertaking scheme includes a step for independent advice and provides for judicial review. The Review finds that there is a need to strengthen the formal governance framework to ensure public confidence in the prosecutions system. These findings and related recommendations are not criticisms of any individuals involved in the current process, but reflect an in-principle' view of about the optimal policy settings that should apply to this vital function.

The Review believes that the proper administration of justice requires that prosecutions be conducted independently of government, and even a perception that they are not can be significantly damaging. The Review believes there is some inherent conflict in the regulator being responsible for both engagement and capacity building functions as well as prosecution decisions. Structural separation of some aspects of enforcement from other functions will improve the operation of the system as a whole.

It is the position of the Review that an independent statutory office to exercise all functions in relation to prosecutions would provide a more transparent, effective and consistent decision making process for

prosecutions. It is noted that the creation of such an office should not change the relationship between WHSQ and the Director of Public Prosecutions (DPP) in relation to category 1 offences. Currently, prosecutions for category 1 offences are commenced by way of indictment and are referred by WHSQ to the DPP who initiate the prosecution actions.

The creation of a new independent statutory office should be headed by a Director of Workplace Health and Safety Prosecutions (Senior Executive Service level) to be appointed by the Governor-in-Council for five year renewable terms. A five year renewable term will provide independence to the role as it will not be aligned to political cycles and will ensure consistency in decision making. The Director should be supported by existing departmental staff from Prosecution Services including Legal Officers and support staff.

The Review finds that the overall level of prosecutions has been below that which would indicate that an appropriately robust approach was being adopted. There is an ongoing need to monitor the number of prosecutions and benchmark success rates (the latter measure serving partly as a proxy “quality measure”: for both the investigation and prosecutions functions).

Although not raised as an issue by the majority of stakeholders, the Queensland Ombudsman, in his discussions with the Review and in his 2015 *The Workplace Death Investigations Report*, raised concerns that the DPP Guidelines are not being followed by Prosecution Services in WHSQ when they are determining whether to commence a prosecution.

The DPP Guidelines outline well-established and detailed criteria to assist in making decisions about whether to commence a prosecution action. While noting that WHSQ has taken commendable additional steps to incorporate the DPP Guidelines in its written procedures, it is the position of the Review that the DPP Guidelines should be mandated under the WHS Act 2011 to ensure that they are followed when determining whether to initiate a prosecution.

Several stakeholders also advocated for the right of unions to bring prosecutions on behalf of workers or where WHSQ has decided not to initiate a prosecution. New South Wales is currently the only Australian jurisdiction in which unions can prosecute under work health and safety legislation. Under section 230 of the NSW *Work Health and Safety Act 2011*, the secretary of an industrial organisation is able to bring proceedings for an offence against the WHS Act 2011. However, if the offence concerned is a category 1 or 2 offence, the secretary of an industrial organisation can only bring proceedings if the regulator has (after referral of the matter through the procedure outlined under section 231 of the WHS Act 2011) declined to follow the advice of the DPP to bring proceedings.

While the Review acknowledges the position of particular stakeholders on this issue, it is believed that a better course is to ensure a more independent and robust prosecution approach through the establishment of an independent statutory office to exercise all functions in relation to prosecutions.

Recommendations:

31. A new independent statutory office be created to exercise all functions in relation to work health and safety prosecutions under the *Work Health and Safety Act 2011*. The new independent statutory office should:
 - be headed by a Director of Workplace Health and Safety Prosecutions (Senior Executive Service level) to be appointed by the Governor-in-Council for a five year renewable term and be supported by existing Office of Industrial Relations prosecutions staff reporting to the Director.
 - not affect the current referral process by WHSQ to the Director of Public Prosecutions for category 1 offences under section 31 of the *Work Health and Safety Act 2011*.
32. As the Office of Industrial Relations has a centralised function for prosecutions, consideration be given to transferring prosecutions under the *Electrical Safety Act 2002* and the *Safety in Recreational Water Activities Act 2011* to the new Director of Workplace Health and Safety Prosecutions.

33. The Office of Industrial Relations develop a formal policy regarding the release of information on the status of prosecutions to affected families and those individuals and companies under investigation.
34. The Director of Public Prosecutions Guidelines be mandated under the *Work Health and Safety Act 2011* to ensure that they are followed when decisions are made about whether to initiate a prosecution.
35. The Office of Industrial Relations collect and use data on its investigations (including the length of time and outcomes of investigations) to regularly analyse the effectiveness of prosecution decisions. This regular analysis by the Office of Industrial Relations should be used to better focus prosecution resources and establish best practice timelines for different categories of incidents.
36. The Work Health and Safety Board monitor patterns and trends relating to WHSQ's prosecutions, including success rates and penalties awarded.

3.7 Enforceable undertakings

Enforceable undertakings are written, legally binding agreements where a person agrees to take certain specified actions to rectify an alleged breach of the law or improve their performance through the implementation of initiatives that are designed to deliver tangible benefits for workers, industry, and the community. Enforceable undertakings operate as an alternative to court imposed sanctions and, where appropriate, are considered to achieve long term sustainable improvements and provide significant benefits, not only to the immediate workplace and workers, but to the industry as a whole.

Enforceable undertakings were introduced by WHSQ in 2004 as a way to achieve sustainable health and safety outcomes as opposed to providing an immediate sanction for non-compliance through the courts. In particular, enforceable undertakings enable WHSQ to apply a graduated approach to compliance and enforcement by allowing restorative efforts to be customised while also reserving the right to pursue enforcement action in the event of failure to comply with the undertaking.

How enforceable undertakings operate under the *Work Health and Safety Act 2011*

Currently, in Queensland, an enforceable undertaking may be accepted by the regulator where a contravention, or alleged contravention, of the WHS Act 2011 has occurred.⁹⁰ Enforceable undertakings are not however permitted to be accepted where the contravention, or alleged contravention, involves a Category 1 offence of reckless conduct.⁹¹ Failure to comply with an enforceable undertaking may result in renewed prosecution and penalties up to \$50,000.

In deciding whether to accept an enforceable undertaking, WHSQ follow their '*Guidelines for the acceptance of an enforceable undertaking*' (the Guidelines). The Guidelines are published on WHSQ's website to promote transparency around the decision-making process for enforceable undertakings and to set clear expectations around the factors the Regulator will consider in deciding whether to accept an undertaking. These factors include:

- the gravity of the contravention and the nature of the alleged misconduct;
- submissions from affected parties in relation to the contravention;
- any remedial action taken by a party in relation to a contravention;
- the applicants past work health and safety performance and compliance history; and
- any other relevant matters.⁹²

The Guidelines are currently silent on whether enforceable undertakings should be specifically excluded where the contravention or alleged contravention relates to a Category 2 offence that results in a fatality. Historically however, applications for enforceable undertakings that involve a fatality have largely been

⁹⁰ *Work Health and Safety Act 2011* s 216(1).

⁹¹ *Ibid* s 216(2).

⁹² *Guidelines for the acceptance of an enforceable undertaking*, p4.

rejected by WHSQ with only one undertaking for a fatality being accepted since the inception of the program in 2004.

Prior to 2014, WHSQ's Guidelines required an applicant to "demonstrate that exceptional circumstances exist where the alleged contravention involved a serious injury or fatality"⁹³. This requirement was, however, removed in early 2014 when WHSQ streamlined its published material on enforceable undertakings and replaced it with one document. The new document better aligned the published material with the provisions of the safety Acts, which include an obligation to publish a general guideline in relation to the acceptance of an undertakings.

Since the removal of the exceptional circumstances requirement and the acceptance of the first fatality-related enforceable undertaking, WHSQ have experienced an increase in applications for enforceable undertakings that involve fatalities or very serious injuries, all of which have either been rejected by the regulator or withdrawn. Two of these decisions have however been challenged and are currently subject to judicial review.

Given this outcome, in early 2017 WHSQ decided to reintroduce the exceptional circumstances requirement to reflect the general stance of the regulator that enforceable undertakings for fatalities and very serious injuries will generally not be accepted. In reintroducing this requirement, WHSQ are giving consideration to adopting the approach used in Victoria where the guidelines specifically state that fatalities are generally excluded except where a case can be made that exceptional circumstance exist. This is a similar but stronger approach than previously used in Queensland.

Since the inception of enforceable undertakings by WHSQ in 2004, 141 applications to enter into an enforceable undertaking have been accepted, which WHSQ estimate has translated into over \$28.8 million in safety benefits provided to workers, workplaces and the community.

Similar regimes for enforceable undertakings can be found in the *Electrical Safety Act 2002* and the *Safety in Recreational Water Activities Act 2011*.

Enforceable Undertaking Programs in other jurisdictions

All harmonised jurisdictions, including New South Wales, South Australia, Tasmania, Northern Territory, the ACT and the Commonwealth, mirror Queensland's work health and safety provisions relating to enforceable undertakings. This means that enforceable undertakings can be accepted for contraventions, or alleged contraventions, of the WHS Act 2011 except where the contravention or alleged contravention relates to a Category 1 offence for reckless conduct.

Similar to Queensland, the majority or harmonised jurisdictions are silent on the application of enforceable undertakings to circumstances involving a Category 2 offence which results in a fatality. New South Wales and South Australia however state in their guidelines that:

*"The enforceable undertaking proposal must identify whether the alleged contravention involves a fatality or very serious injury. If it does, the proposal must be supported by a claim that demonstrates exceptional circumstances exist for the enforceable undertaking to be considered despite the injury outcomes."*⁹⁴

A very serious injury is defined as "an injury that has caused nervous system damage liable to lead to mental incapacity or permanent restriction of mobility or involves a major amputation of a limb or parts of the body – for example amputation above the knee or elbow"⁹⁵.

⁹³ Enforceable undertaking-guidelines for proposing a WHS undertaking, December 2011, p.6.

⁹⁴ *Enforceable undertakings: Guidelines for proposing an undertaking* p5.

⁹⁵ *Ibid* p2.

Non-harmonised jurisdictions (Victoria and Western Australia) go further than this. In Victoria, the regulator may accept a written undertaking given by a person in connection with a matter relating to a contravention or alleged contravention of the WHS Act 2011. Victoria’s *Policy on Enforceable Undertakings pursuant to section 16 of the Occupational Health and Safety Act 2004*, however, goes on to provide general exclusions that enforceable undertakings will usually not be appropriate where:

- the contravention is connected to a fatality,
- the contravention involves reckless conduct,
- the applicant has a recent prior conviction connected to a work-related fatality, or
- the applicant has more than two prior convictions arising from separate investigations.⁹⁶

If the proposed enforceable undertaking or applicant falls into a category of general exclusion in Victoria, the applicant will be advised of the category of general exclusion applicable to the undertaking. The applicant is then afforded the opportunity to address those issues by identifying any exceptional circumstances that demonstrates that an enforceable undertaking would be more appropriate than prosecution.

Conversely, in Western Australia, an enforceable undertaking can only be entered into if a person is convicted of one or more relevant offences and the court orders as an alternative to paying the fine that an undertaking be entered into.⁹⁷ Additionally, enforceable undertakings can only be entered into for minor offences where there has been no physical harm to any person.⁹⁸

Table 12 provides an overview of the key differences between each jurisdictions enforceable undertakings scheme.

Table 12 - Key differences between each jurisdictions enforceable undertakings scheme

	Qld	NSW	Vic	Tas	SA	WA	NT	ACT	Cwth
Regulator can accept EU	X	X	X	X	X		X	X	X
Court can order EU as an alternative to a fine						X			
Act excludes fatalities or serious injuries (only allowed for minor offences)						X			
Guidelines require a case for exceptional circumstances to be made where a fatality is involved		X	X		X				
Act and guidelines silent in relation to fatalities	X			X			X	X	X

Stakeholder feedback

Support for enforceable undertakings in general varied depending on the viewpoint of stakeholders. The QTIC and AiGroup were supportive of enforceable undertakings being part of the suite of enforcement tools available to the regulator with the AiGroup specifically noting that:

*“Enforceable undertakings should be encouraged because they have potential to achieve significant work health and safety outcomes as long as they are subject to appropriate constructive and sustained scrutiny by WHSQ”.*⁹⁹

⁹⁶ Victorian WorkCover Authority, *Policy on Enforceable Undertakings pursuant to section 16 of the Occupational Health and Safety Act 2004*, October 2014, p.3.

⁹⁷ *Occupational Safety and Health Act 1984 (WA)*, s 55I(1).

⁹⁸ *Ibid* s 55I(2).

⁹⁹ Australian Industry Group submission, p.3.

The Queensland Law Society also considered enforceable undertakings to be appropriate due to their ability to encourage behavioural change.

Conversely, the QCU and the BTGUs both indicated in their submissions that enforceable undertakings provide a soft option for enforcement and have the potential to undermine efforts to deter non-compliance.

In relation to the application of enforceable undertakings to contraventions, or alleged contraventions, of the WHS Act 2011 that involve a fatality, the QTIC, QCU, BTGUs, the Queensland Bar Association, an academic from James Cook University, and members of the Families Forum, which is comprised of families affected by work-related fatalities, all indicated that enforceable undertakings should not be permitted for fatalities. In particular the Families Forum stated that:

“Under no circumstances should an Enforceable Undertaking be offered or considered following a work-related fatality or serious incident because history will show that 5 years after the event an Enforceable Undertaking is no longer adhered to in most cases. This process is an injustice to families affected by such tragic events”.

The AiGroup however were of the view that decisions regarding the acceptance of enforceable undertakings should be determined by the level of the breach and not by whether there has been a fatality.¹⁰⁰ Additionally, the Queensland Law Society were of the view that enforceable undertakings in circumstances where there has been a fatality should not be opposed provided the enforceable undertaking satisfies the concerns of the subject’s family.¹⁰¹

Findings

According to Parker's research¹⁰², in the context of trade practices, enforceable undertakings provide regulators with:

“more innovative, expansive and preventive remedies than are available through court orders. They can both attract management attention, and then can capitalise on that by requiring the company to appoint appropriate staff and implement a compliance program to meet particular standards and by requiring ongoing attention to audits and reports.”

Other arguments supporting the use of enforceable undertakings also include that:

- enforceable undertakings are consistent with a graduated approach to enforcement;
- they provide a speedier and more predictable response to non-compliance than court proceedings;
- by involving the alleged offender in the development of the conditions of the enforceable undertaking, ongoing commitment to sustainable improvements is more likely and by allowing affected persons to express views, the principles of restorative justice will (to that extent) be applied; and
- depending on the nature of the undertaking it can provide significant benefits, not only to the immediate workplace and workers, but to the industry as a whole.

It is the view of the Review that enforceable undertakings are an effective enforcement tool when utilised in appropriate circumstances. The ability of enforceable undertakings to achieve long term sustainable improvements in health and safety and to provide significant safety benefits to workplaces, and industry as a whole, demonstrates the benefits of such an enforcement tool being available to work health and safety

¹⁰⁰ Australian Industry Group submission, p3.

¹⁰¹ Queensland Law Society submission, p6.

¹⁰² Parker C. (2003) ‘Arm Twisting, Auditing and Accountability: What Regulators and Compliance Professionals should know about the Use of Enforceable Undertakings’, presentation to the Australian Compliance Institute, Melbourne, 28th May.

regulators. Additionally, no court proceedings means WHSQ's enforcement dollar can be stretched further. The merits of this enforcement option however comes down to the circumstance in which an enforceable undertaking should apply.

There is a strong view from the majority stakeholders that submitted to the Review that enforceable undertakings should not be permissible in circumstances where a fatality is involved. The genesis of this view is that public perception dictates that there should be a prosecution or punishment for a fatality and that an enforceable undertaking does not reflect the seriousness of the incident. The Review supports this assertion and is of the view that there is a need for clear expectations around when an enforceable undertaking will be accepted and that the acceptance of enforceable undertakings should be mindful of community expectations.

To this end, it is the view of the Review that the current enforceable undertakings framework should be amended to provide a clear position on the treatment of fatalities and very serious injuries. In relation to fatalities, this could potentially be done in two ways:

1. Consistent with the approach being considered by WHSQ, the *Guidelines for the acceptance of an enforceable undertaking* could be amended to include a similar approach to Victoria where an application for an enforceable undertaking that relates to a fatality is generally excluded unless a case for exceptional circumstances can be made.
2. Alternatively, the WHS Act 2011 could be amended to exclude enforceable undertakings from being permissible for fatalities. This would be in addition to the current exclusion for Category 1 offences but would ensure Category 2 offences, where a fatality is due to a person's failure to comply with a duty, is explicitly excluded.

While replication of the Victorian guidelines would provide a general exception for fatalities, this approach would still enable applications for fatality-related circumstance to be made where exceptional circumstances exist. While there may be a case for this approach, it is the view of the Review that this does not reflect the seriousness of incidents involving a fatality and that this approach leaves the door ajar for a costly and timely process to be undertaken which is historically proven to rarely be approved. On this basis, and to provide clear expectations regarding the application of enforceable undertakings to fatalities, it is the view of the Review that circumstances involving fatalities should be expressly prohibited from the enforceable undertakings framework. Consideration should however be given to strengthening the Queensland enforceable undertaking guidelines to align with Victoria, New South Wales and South Australia as they relate to circumstances involving very serious injuries and applicants with recent prior work health and safety-related convictions.

Recommendations:

37. In relation to the enforceable undertakings framework:

- a. The *Work Health Safety Act 2011* be amended to expressly prohibit enforceable undertakings being accepted for contraventions or alleged contraventions of the WHS Act 2011 that relate to circumstances involving a fatality.
- b. The *Guidelines for the acceptance of an enforceable undertaking* be amended to provide a general exception (unless exceptional circumstances exist) where the applicant has a recent prior conviction connected to a work-related fatality; the applicant has more than two prior convictions arising from separate investigations, or the application relates to an incident involving a very serious injury.
- c. For consistency, 'very serious injury' should be defined as stated in the WorkCover New South Wales Enforceable undertakings: Guidelines for proposing an enforceable undertaking.

- d. The Queensland Government consider making similar amendments to the enforceable undertaking requirements under the *Electrical Safety Act 2002* and the *Safety in Recreational Water Activities Act 2011*.
- e. The Queensland Government consider recommending similar amendments be made to the national model Work Health and Safety Act as part of the 2018 review.

3.8 Licensing framework

WHSQ administers licensing and accreditation frameworks as a form of regulatory intervention to control high risk activities and ensure these activities are undertaken by competent individuals. Activities that require a licence or accreditation in Queensland under the WHS Regulation 2011 include high risk work (including accredited assessors), asbestos assessing or removal, demolition work and major hazard facilities.

The decision-making frameworks for licensing and accreditation applications include eligibility considerations in accordance with the WHS Regulation 2011. These considerations include the qualifications, compliance history and evidence of industry experience of the person seeking approval.

Stakeholder feedback on licensing and accreditation frameworks

While current licensing frameworks require validation of license holders' qualifications and evidence of experience, some stakeholders raised concerns regarding the assessment processes, the quality of training delivered by the Vocational Education Training (VET) sector, as well as the need for further oversight by the department on VET training.

In summary key concerns with the quality of training raised relate to:

- a lack of structural separation of training and assessment, which may create a conflict of interest within an Registered Training Organisation (RTO) where assessors are employees of the RTO;
- very short course lengths, which are perceived as too short to meet the unit of competency requirements;
- increasing reliance on online delivery, with candidates having limited opportunities to build practical skills;
- RTOs teaching to the National Assessment Instruments for high risk work licensing and not covering the breadth of material in the unit of competency;
- poor quality assessment, including a lack of access to appropriate plant and equipment; and
- limited audit activity/intervention by the Australian Skills Quality Authority (ASQA).

In particular, MEA submitted that, whether real or perceived:

*"...RTO's have a conflict of interest. The conflict arises where their payment is linked to a students successful completion of training. The industry's perception is that participants are "pushed through" to ensure the RTO receives their payment..."*¹⁰³

Similarly, the BTGUs also questioned the quality of licence frameworks since the inclusion of the VET sector, stating:

*"Ever since the licensing regime was placed into the Vocational Education Training Sector licenses are merely bought."*¹⁰⁴

¹⁰³ Master Electricians Australia submission to the Best Practice Review of Workplace Health and Safety Queensland, p.4.

¹⁰⁴ Building Trade Group of Unions submission to the Best Practice Review of Workplace Health and Safety Queensland, May 2017, p.9.

The Asbestos Disease Support Society also noted during face to face consultations that:

“There is an issue with the quality of training in asbestos removal. There needs to be some oversight from the department on the quality of training.”

It is recognised that this is not only an issue for Queensland stakeholders and has been identified as a national issue. This has been acknowledged by the Strategic Issues Group – Work Health and Safety who are also considering possible solutions to address concerns regarding the quality of training for licensing outcomes.

Regulatory powers and functions

The standard content to be delivered by RTOs in the VET sector has been endorsed by work health and safety agencies in all Australian jurisdictions, however RTOs are regulated by ASQA in accordance with the *National Vocational and Training Regulator Act 2011* (National VET legislation). Therefore any initiatives designed to enhance the quality of training delivered by RTOs must be centred on WHSQ’s powers as a work health and safety regulator to grant or refuse to grant a licence or accreditation.

When issuing authorisations under the WHS Act 2011 and the WHS Regulation 2011, WHSQ rely on VET training certification to validate the competence of applicants for high risk work, asbestos and demolition authorisations.

Findings

The Review finds that the high risk work licence and accredited assessor frameworks should be designed so that only competent applicants are approved for a licence or accreditation and that the validation of the competence of accredited high risk work assessors could be improved by WHSQ including a formal assessment component for accredited assessors.

The concerns relating to the quality of VET sector training support investigation into the use of existing legislative considerations relating to the ability of the applicant to undertake work safely and competently, to refuse to grant a licence or accreditation.

These considerations also have relevance as to whether training was of a standard to ensure the applicant is able to carry out the licensed work safely and competently. Use of the considerations in this way is consistent with the objects in section 3 of the WHS Act 2011 in particular, to protect workers and other persons from harm to their health, safety and welfare. Promotion of these decision making processes may be achieved through the development of an industry guideline or code of practice.

Recommendations:

38. In respect of the licensing framework, it is recommended that:
- a. the *Work Health and Safety Regulation 2011* be amended to include a competency assessment in the approval process for new accredited high risk work assessors, while existing assessors will sit an abridged version as a validation of their competency;
 - b. WHSQ develop an industry guideline or code of practice so that Registered Training Organisations understand the standards of training required to obtain a licence or authorisation under the *Work Health and Safety Regulation 2011*, potentially including the extent of practical learning needed for the particular licence and the plant and equipment that should be used to ensure applicants receive a minimum quality of training before they can be assessed for or apply for a licence;
 - c. WHSQ investigate the feasibility of developing, implementing and administering a Registered Training Organisation approval process whereby the Regulator could approve Registered Training Organisations (as eligible to deliver certain training) in addition to the Australian Skills Quality Authority granting their approval, subject to their achieving a number of quality indicators relating

- to the expertise of their trainers and assessors, training and assessment processes and resources, and an ongoing cycle of review and renewal; and
- d. the Queensland Government consider mandating that a Registered Training Organisation cannot both train and assess for high risk work licences.

3.9 Issue resolution process

As part of their submissions to the 2015 review of the industrial relations frameworks in Queensland, a number of union organisations sought to expand the jurisdiction of the Queensland Industrial Relations Commission (QIRC) to include an increased role in the resolution of work health and safety matters.¹⁰⁵ This included a request that the QIRC *‘assume the necessary jurisdiction to properly deal with work health and safety disputes within a designated “stream”*.¹⁰⁶ While the jurisdiction of the QIRC was within scope of the review, it was determined by the reviewer, Mr Jim McGowan, that the review was limited to industrial relations laws and matters concerning the expansion of QIRC’s functions in relation to work health and safety were out of scope.¹⁰⁷ In response to this outcome, union organisations indicated that they would refer this matter directly to the Queensland Government for consideration.¹⁰⁸

In mid-2016, the QCU approached the Government with a proposal for unresolved work health and safety disputes between parties to go to the QIRC for resolution. Effectively seeking removal of inspectors and the internal review process from the resolution process.

This matter has been referred to the Review for consideration.

Issues resolution

Under the WHS Act 2011, Part 5, Division 5 establishes a process for resolving work health and safety issues where the parties to the matter are unable to reach a satisfactory outcome. Issues may relate to whether or not hazards or risks arise from particular work, whether risks are adequately controlled, or whether other risk controls may be required.

In particular, the WHS Act 2011 provides that, failing resolution of an issue during preliminary discussions between parties:

- health and safety issues should be resolved in a timely, final and effective manner, either in accordance with an agreed procedure or in line with the default procedure contained in the WHS Regulation 2011,¹⁰⁹
- where an issue about work health and safety is still unresolved, a party to the issue may ask the regulator to appoint an inspector to attend the workplace to assist in resolving the issue.¹¹⁰ The inspector can decide on the issue at hand by exercising any of their compliance powers available to them under the WHS Act 2011.¹¹¹ This may include providing advice, investigating contraventions, or issuing an improvement or a prohibition notice; and
- Where parties remain dissatisfied, and the inspector’s decision is reviewable, parties can apply for the decision to be internally reviewed by the regulator¹¹² and then may go on to external review. The

¹⁰⁵ J McGowan AM, A review of the industrial relations framework in Queensland, A report of the Industrial Relations Legislative Reform Reference Group, December 2015, p132.

¹⁰⁶ Building, Engineering and Maintenance Unions, Submission to the review of the industrial relations framework in Queensland, p12.

¹⁰⁷ J McGowan, 2015, p133.

¹⁰⁸ Ibid.

¹⁰⁹ *Work Health Safety Act 2011* (Qld) s 81(2).

¹¹⁰ Ibid.

¹¹¹ Ibid s 82(4).

¹¹² Ibid s 224.

external review of inspectors' decisions to issue notices currently sits with the Queensland Civil Administrative Tribunal (QCAT).¹¹³

Under this framework, parties to an issue are required to make all reasonable efforts to resolve the dispute as quickly as possible to ensure the health and safety of their workers and workplace.

Other circumstances where an inspector may assist with the resolution of a dispute

Other circumstances where an inspector may assist with the resolution of a dispute include the following:

Cease work

Under the WHS Act 2011, a worker may cease work, or a Health and Safety Representative (HSR) may direct a worker to cease work. This would occur where they have a reasonable concern that to carry out the work would expose the worker to a serious risk to their health or safety emanating from an immediate or imminent exposure to a hazard (e.g. falls from height, release of asbestos fibres, unguarded plant).¹¹⁴

Where a dispute arises over the cessation of work, similar to the issues resolution process, the WHS Act 2011 enables HSRs or the PCBU most directly involved in the engagement of the workers to request that an inspector attend the workplace to assist in resolving the issue.¹¹⁵

Similar to issues resolution, inspectors can exercise any of their compliance powers available to them under the WHS Act 2011.¹¹⁶ Where parties remain dissatisfied and the inspector's decision is reviewable, parties can currently apply to have an internal review of the decision by the regulator¹¹⁷ and then an external review with QCAT.¹¹⁸

Request by health and safety representative for employer information

Under section 70(1)(c) of the WHS Act 2011, the PCBU must allow any HSR for the work group to have access to information that the person has relating to:

- hazards (including associated risks) at the workplace affecting workers in the work group; and
- the health and safety of the workers in the work group.

Where a PCBU has not provided the HSR access to relevant information, the issue resolution provisions outlined above may be enlivened and an inspector may be requested and appointed to assist in resolving the issue.¹¹⁹

Rights exercised by a work health and safety entry permit holder

Under section 118 of the WHS Act 2011 work health and safety entry permit holders, while at the workplace, may do various things where a contravention of the WHS Act 2011 is suspected. This includes consulting with relevant workers or the PCBU, or requiring the PCBU to allow them to inspect and make copies of documents directly relevant to the suspected contravention.

As above, a dispute about the exercise of any of these rights may give rise to issues resolution and an inspector may be appointed to assist in resolving the issue.

¹¹³ Ibid s 229.

¹¹⁴ Ibid ss 84-85.

¹¹⁵ Ibid s 89.

¹¹⁶ Ibid s 82(4).

¹¹⁷ Ibid s 224.

¹¹⁸ Ibid s 229.

¹¹⁹ Ibid s 82.

Request by health and safety representative for assistance

A PCBU must allow a person assisting a HSR to have access to the workplace,¹²⁰ however a PCBU may refuse to grant such access on reasonable grounds.¹²¹ If access is refused to a person assisting a HSR, the HSR may ask the regulator to appoint an inspector to assist in resolving the matter.¹²² As with the matters outlined above, inspectors can exercise any of their powers to assist in resolving the dispute. Where parties remain dissatisfied and the inspector's decision is reviewable, parties can apply for internal review, and then external review.

Reviewable decisions

After an inspector has been appointed and attended a workplace to assist in resolving a dispute about the matters set out above (including resolving work health and safety issues, cease work, or contravention of obligations to provide HSRs information or allowing access for persons assisting HSRs), an inspector can exercise their compliance powers under the WHS Act 2011. This includes the decision to issue an improvement notice (where an inspector reasonably believes the WHS Act 2011 is being contravened)¹²³ or a prohibition notice (where an inspector reasonably believes an activity involves a serious and imminent risk to a person's health and safety).¹²⁴

These decisions are reviewable under Schedule 2A of the WHS Act 2011, including decisions which involve refusing to make a decision¹²⁵ or refusing to do any other act or thing¹²⁶ (i.e. refusing to issue a notice). Other decisions which are reviewable under Schedule 2A include decisions by the regulator to forfeit or return seized things.¹²⁷ There are also reviewable decisions prescribed under the WHS Regulation 2011,¹²⁸ including decisions about high risk licences, accreditation of assessors, and licences for demolition work.¹²⁹

Review procedures

Currently, reviewable decisions made by inspectors are reviewable by the regulator internally in the first instance, and then may go on to an external review. Whereas reviewable decisions made by the regulator proceed directly to an external review.¹³⁰

Internal review

The WHS Act 2011 establishes procedures for reviewable decisions to be internally reviewed by the regulator. Eligible persons can apply for a decision by an inspector to issue (or not issue) a notice to be internally reviewed.¹³¹ For example in relation to a decision to issue an improvement notice, eligible persons include a person who received the notice, a PCBU whose interests are affected by the decision, or a worker or HSR who represents a worker whose interests are affected by the decision.¹³²

¹²⁰ Ibid s 70(1)(g).

¹²¹ Ibid s 71(5).

¹²² Ibid s 71(6).

¹²³ Ibid s 191.

¹²⁴ Ibid s 195.

¹²⁵ Ibid s 223(2)(a).

¹²⁶ Ibid s 223(2)(g).

¹²⁷ Ibid ss 179, 180.

¹²⁸ Ibid Schedule 2A, item 13.

¹²⁹ *Work Health and Safety Regulation 2011*, s 676.

¹³⁰ *Work Health and Safety Act 2011* (Qld) ss224, 229; Explanatory Notes, Work Health and Safety Bill 2011, p.99.

¹³¹ Ibid s224; Schedule 2A.

¹³² Ibid s 223; Schedule 2A, item 7.

External review

Following an internal review, an eligible person may apply to the relevant external review body for a review of the internal review decision.¹³³ Through the National OHS Review, jurisdictions were given the ability to designate the relevant court or tribunal for any matters conferred on a court or tribunal under a provision of the Model Work Health and Safety Act.

QCAT jurisdiction

QCAT is the external review body for the majority of reviewable decisions made under the WHS Act 2011 and the WHS Regulation 2011.¹³⁴ This includes a decision by an inspector to issue an improvement notice¹³⁵ or a prohibition notice.¹³⁶

Unlike the QIRC, QCAT is not a specialist workplace tribunal. Rather, QCAT resulted from the amalgamation of a number of tribunals and, as a result, QCAT deals with matters which are wide-ranging. One component of QCAT's jurisdiction is its review jurisdiction, where it reviews various administrative decisions made by government decision-makers.

The purpose of the review of a reviewable decision is to produce the correct and preferable decision and QCAT must hear and decide a review of a reviewable decision by way of a fresh hearing on the merits.¹³⁷ In a proceeding for a review of a reviewable decision, QCAT may:

- confirm or amend the decision;
- set aside the decision and substitute its own decision; or
- set aside the decision and return the matter for reconsideration to the decision-maker for the decision, with the directions QCAT considers appropriate.¹³⁸

QCAT may make written recommendations to the chief executive of the entity in which the reviewable decision was made, regarding policies, practices and procedures applying to reviewable decisions of the same kind. A party to an external review may appeal to the Appeal Tribunal against a decision of QCAT.

QCAT hears a limited number of work health and safety related cases each year. Since 2012, QCAT has heard 14 matters in relation to their external review functions under the work health and safety laws. WHSQ's records indicate that no reviews have been sought in relation to any improvement or prohibition notices issued in relation to the cessation of work over the last three calendar years. Similarly, no reviews of notices were sought in relation to requests for assistance regarding work health and safety issues during 2016.

QIRC jurisdiction

The QIRC is a specialist workplace tribunal for Queensland and it derives its powers from the *Industrial Relations Act 2016* (the IR Act).

Queensland has conferred limited jurisdiction on the QIRC to review decisions under the WHS Act 2011. These include an inspector's decision relating to a failure to commence negotiations,¹³⁹ training HSRs,¹⁴⁰ or

¹³³ Ibid s 229(1)(b).

¹³⁴ Ibid s 229; Schedule 2A; *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 24.

¹³⁵ Ibid s 223; Schedule 2A, item 7.

¹³⁶ Ibid s 223; Schedule 2A, item 9.

¹³⁷ *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 20.

¹³⁸ Ibid s 24.

¹³⁹ *Work Health and Safety Act 2011* (Qld) s54(2); Schedule 2A *Work Health and Safety Act 2011* (Qld), item 1.

¹⁴⁰ Ibid s 72(6); Schedule 2A, item 2.

health and safety committees.¹⁴¹ The review process undertaken by the QIRC is set out at Part 12, Division 4 of the WHS Act 2011.

In addition to the external review of these matters, the QIRC is currently vested with separate jurisdiction to deal with disputes regarding the exercise or purported exercise by a work health and safety entry permit holder of a right of entry under the WHS Act 2011.¹⁴² A dispute application can be made by a number of relevant persons including a WHS entry permit holder, a relevant union, a PCBU, or the regulator.

The QIRC may deal with such a dispute in any way it thinks fit, including by means of mediation, conciliation or arbitration.¹⁴³

If the QIRC deals with the dispute by arbitration, it can make any of the following orders:

- an order imposing conditions on a work health and safety entry permit;
- an order suspending a work health and safety entry permit;
- an order revoking a work health and safety entry permit;
- an order about the future issue of work health and safety entry permits to 1 or more persons;
- or
- any other order it considers appropriate.¹⁴⁴

The QIRC can also hear applications to disqualify HSRs.¹⁴⁵

External review in other work health and safety jurisdictions

Currently the Commonwealth,¹⁴⁶ New South Wales,¹⁴⁷ South Australia¹⁴⁸ and Western Australia¹⁴⁹ all confer power to conduct external review of reviewable decisions on their industrial relations commission or tribunal body.

Similar to Queensland, Victoria and the Australian Capital Territory have conferred jurisdiction for the external review of decisions on the Victorian Civil Administrative Tribunal and the ACT Civil and Administrative Tribunal respectively.¹⁵⁰ These are similar bodies to QCAT as they deal with a variety of civil disputes.

In Tasmania, the Magistrates Court has external review jurisdiction and in the Northern Territory, this jurisdiction is vested in the Work Health Court (which is a presided by a Magistrate).¹⁵¹

Stakeholder feedback

Polarised views amongst stakeholders centred on the length of time to resolve disputes given the requirement to involve an inspector and the need for an internal review process; the view that there is a lack

¹⁴¹ Ibid s 76(6); Schedule 2A, item 3.

¹⁴² Ibid s 142.

¹⁴³ Ibid s 142(2).

¹⁴⁴ Ibid s 142(3).

¹⁴⁵ Ibid s 65.

¹⁴⁶ Ibid s 229.

¹⁴⁷ s229 *Work Health and Safety Act 2011* (NSW) provides an eligible person may apply to the Industrial Relations Commission for an external review.

¹⁴⁸ s229 *Work Health and Safety Act 2012* (SA) provides an eligible person may apply to Senior Judge of the Industrial Relations Commission for an external review.

¹⁴⁹ s51G *Occupational Safety and Health Act 1984* (WA) provides that the Industrial Relations Commission is to be called the Occupational Safety and Health Tribunal when exercising jurisdiction under the Act.

¹⁵⁰ s129 *Occupational Health and Safety Act 2004* (Vic); s229 *Work Health and Safety Act 2011* (ACT).

¹⁵¹ *Work Health and Safety Act 2012* (TAS) s 229; *Work Health and Safety (National Uniform Legislation) Act* (NT) s229.

of resolution available where an inspector has refused to issue a decision; and the appropriateness of expanding jurisdiction of the QIRC to deal with certain work health and safety disputes.

The QCU, the AWU, the BTGUs all submitted that parties should have an ability to lodge disputes with the QIRC to hear and determine work health and safety matters at issue.

The QCU also indicated that the current arrangements were inadequate given the length of time it takes to resolve matters, or the lack of resolution under the current scheme, submitting that:

“...there should be the capacity to refer disputes concerning WHS matters to the QIRC for quick resolution. Under current arrangements workers are often faced with the prospect of taking industrial action in cases where they believe there is a potential safety risk. The establishment of a mechanism that allows an existing tribunal to quickly deal with matters in dispute, in relation to the Act and Regulation, is a step towards dispute resolution rather than prosecution. Such a mechanism would be beneficial to workers, their union and industry.”¹⁵²

Insofar as the role of the inspector, the BTGUs asserted that the key problems with the current issue resolution process are two-fold:

“a. The provisions do not confer any power on the Inspector to actually resolve or arbitrate the dispute; and

b. The Inspector’s primary function under the WHS Act is compliance and enforcement. The Inspector’s focus is not dispute resolution. The Inspector’s enforcement function means that the parties are unlikely to place their trust and confidence in the Inspector to resolve their dispute.”¹⁵³

Conversely, MEA, HIA, the CCIQ, CCF, AiG and MBQ opposed expanding the QIRC’s jurisdiction to hear such disputes, especially in the event where this would override the current ability for inspectors to assist with dispute resolution.

The CCIQ were also of the view that referring work health and safety issues to the QIRC would create further delays to resolution.

In relation to the appropriateness of the external review body, MBQ submitted that the current review process in QCAT is sufficient and there is no evidence necessitating a transfer of these matters to the QIRC.¹⁵⁴

The AiGroup also considered the current process should not be altered as inspectors on site are the most effective way to deal with work health and safety disputes. In addition, the HIA and the CCF were of the view that allowing disputes to proceed directly to the QIRC, bypassing the inspectorate and internal review, would undermine the authority of inspectors and may lead to vexatious claims resulting in deliberate and excessive site stoppages.¹⁵⁵ The CCIQ also considered it to be pre-emptive to send matters to the QIRC without first utilising the internal review process under the WHS Act 2011.

Where a matter has remained unresolved due to an inspector’s refusal to make a decision, the AiGroup asserted that section 223(2) of the WHS Act 2011 currently provides that an application for review of a decision can also be made if an inspector decides not to issue a notice.¹⁵⁶

¹⁵² Queensland Council of Unions submission, p19.

¹⁵³ Building Trades Group of Unions submission, p18.

¹⁵⁴ Master Builders Queensland submission, p7.

¹⁵⁵ Civil Contractors Federation submission, p.4.

¹⁵⁶ Australian Industry Group submission, p.3.

Findings

It is the view of the Review that the jurisdiction for the review of reviewable decisions (under Schedule 2A of the WHS Act 2011) as currently vested in QCAT, be transferred to the QIRC given that:

- the QIRC is the specialist workplace tribunal established for Queensland;
- the QIRC currently has jurisdiction to hear some work health and safety matters (including disputes regarding the right of entry of work health and safety entry permit holders and worker's compensation appeals); and
- other states and the Commonwealth have vested external review jurisdiction in industrial commissions.

However, reviewable decisions prescribed under the WHS Regulation 2011 should appropriately remain with QCAT, as these matters are more administrative in nature and better align with QCAT's jurisdiction.

Given concerns raised by stakeholders around securing a timelier method of dispute resolution about key work health and safety matters, it is considered appropriate to expand the QIRC's jurisdiction to hear and determine the following categories of disputes:

- a dispute in relation to the provision of information by an employer to a HSR;¹⁵⁷
- a dispute in relation to any rights or functions that may be exercised by work health and safety entry permit holders;¹⁵⁸
- a dispute in relation to a request by a HSR for assistance;¹⁵⁹
- a dispute in relation to work health and safety issue resolution process;¹⁶⁰ and
- a dispute in relation to cease work matters.¹⁶¹

It is envisaged that this will be treated as a separate category of dispute under the WHS Act 2011 with jurisdiction vested in the QIRC to deal with the dispute.

A dispute under one of these new categories should not however be notified to the QIRC until 24 hours after assistance from an inspector is requested and the dispute remains unresolved. This recognises the important role the inspector plays and the intention of the WHS Act 2011 for disputes be resolved as quickly and as effectively as possible between the parties and preferably at the workplace.¹⁶²

Additionally, for the classes of disputes identified above it proposed that following the 24 hour resolution period, the dispute can be progressed immediately to the QIRC without need for an internal review process. Part 7, Division 6 of the WHS Act 2011 which deals with disputes in the QIRC about workplace entry by work health and safety entry permit holders may provide helpful guidance for development the proposed dispute avenue.

The QIRC, in settling a dispute, may consider any decision that has been made by an inspector in relation to the dispute (for example, issuing a notice). It is intended that where a notice has been issued by an inspector and that decision has formed part of the QIRC's consideration in settling the dispute, this will not be a reviewable decision for the purposes of the WHS Act 2011 and therefore will not give rise to internal and external review procedures as currently required.

¹⁵⁷ *Work Health and Safety Act 2011* (Qld), s70(1)(c).

¹⁵⁸ *Ibid* s118.

¹⁵⁹ *Ibid* s71(6).

¹⁶⁰ *Ibid* s82.

¹⁶¹ *Ibid* s89.

¹⁶² *Ibid* s81; Explanatory Notes, *Work Health and Safety Bill 2011*, p.54.

Where an inspector's decision to issue a notice relates to another work health and safety matter, it is intended that it will continue to be a 'reviewable decision' and be required to follow the current internal review process, with the external review process conducted by the QIRC not QCAT as currently occurs.

It is the view of the Review that there remains an important role for inspectors in attending at the workplace to assist in resolving these categories of disputes, prior to external review or disputation avenues being sought. It is considered appropriate then that after an inspector's assistance has been requested and the matter remains unresolved, that a party may seek external resolution of the issue by notifying the QIRC of the dispute.

To allay stakeholder concerns that the removal of internal review procedures in relation to these disputes may result in vexatious or frivolous claims, the QIRC should have the power to dismiss a matter without conducting a hearing or conference where it believes the matter is frivolous, vexatious or lacks substance.

Matters unresolved where inspector does not make a decision

The Review agrees with the AiGroup that it is likely that the WHS Act 2011 currently allows an application for a review of an inspector's decision not to issue a notice.¹⁶³ However, given this ability to seek a review of a refusal to issue a notice has not been utilised by parties to date, the Review is of the view that this further supports establishing an additional dispute avenue to provide clarity to parties.

Recommendation

39. In relation to dispute resolution it is recommended that:
- a. the jurisdiction for the review of reviewable decisions (under Schedule 2A of the WHS Act 2011) as currently vested in QCAT, be transferred to the QIRC;
 - b. the QIRC's jurisdiction be expanded to hear and determine the following categories of disputes:
 - a dispute in relation to the provision of information by an employer to a HSR;
 - a dispute in relation to any rights or functions that may be exercised by work health and safety entry permit holders;
 - a dispute in relation to a request by a HRS for assistance;
 - a dispute in relation to work health and safety issue resolution process; and
 - a dispute in relation to cease work matters;
 - c. notification of a dispute may be provided by an employer, affected employee, affected HSR, or a relevant registered organisation;
 - d. notifications can only occur if a request has been made to an inspector for assistance, however if the matter is not resolved 24 hours after such a request is made, a notification can be made to the QIRC;
 - e. the QIRC be able to exercise all its powers (including conciliation, requiring the production of documents or compulsory attendance and the issuing of orders) in settling the dispute;
 - f. the QIRC should also have the power to dismiss a matter without conducting a hearing or conference where it believes the matter is frivolous, vexatious or lacks substance; and
 - g. appeal rights from decisions of the QIRC should apply in the normal way.

¹⁶³ Ibid s223(2) *Work Health and Safety Act 2011* (Qld)

Chapter 4: WHSQ's effectiveness in relation to providing compliance information and promoting work health and safety awareness and education

Awareness and education activities and the provision of information and guidance about what compliance looks like and how to build a mature safety culture is a core element of the regulatory model applied by WHSQ.

Awareness and education activities

The OIR, including WHSQ, use advertising, public relations, celebrity and 'real life' endorsement, social media, industry forums, print and a strong web presence to raise awareness of the importance of work health and safety, provide advice through educative resources and influence positive behavioural change.

Advertising campaigns are used to promote positive attitudes towards safety and remind people that if they do not work safely, they risk impacting more than just their own lives, but those of their colleagues and family too. Campaigns are driven by serious injury statistics and coronial recommendations and are subject to rigorous independent pre- and post-campaign market research to ensure their effectiveness.

Electrical safety campaigns are funded by the Queensland electrical entities and work safety and return to work campaigns are part funded by WorkCover Queensland.

There are mixed opinions globally on the effectiveness of the use of fear in safety advertising and so to date, OIR has followed in the footsteps of the *Homecomings* campaign conceived in Victoria. The first iterations of this campaign relied on reminding people (including workers, employers and the community) of the positive motivations for working safely, although later phases have moved on to the impact of a real injury or death. WHSQ advised the Review that this step has not yet been taken in Queensland but serious consideration has been given to running WorkSafe Victoria's *Really bad day* campaign which not only portrays workers in serious workplace incidents, but goes on to remind employers that if they aren't proactively ensuring their workers' safety, then they will be punished by the regulator. Advertising campaigns in Queensland have included:

- *Homecomings* – to highlight the potential impact of a workplace injury on family members. Post campaign, 19% of those surveyed said they had made changes to their behaviour at work and 46% said the adverts had positively impacted on work health and safety perceptions at their organisation.
- *Stay safer up there, switch off down here* – to urge people to turn off the mains power before going into the roof space. Post campaign research showed 72% would turn off the power first and a further 15% wouldn't go up there at all.
- *One safety switch may not be enough* – to encourage people to have electrical safety switches to all sub-circuits in their home. Post campaign research showed a 5% increase in people checking for safety switches when buying a home and a 3% increase in homeowners intending to have additional switches fitted.
- *Getting back* – to show the benefits of returning injured workers to meaningful work as soon as they are cleared to do so. Post campaign research showed a 7% increase in the belief of this key message and an increase of 12% in the frequency of injured worker contact with their employer.
- *Ride ready* – to improve quad bike safety in Queensland. Although still in its early stages, the campaign has shown significant increases in the beliefs that doubling on quads is dangerous, training is valuable, helmets are a must, and side by side vehicles are safer than quads.

Safety ambassadors provide celebrity endorsement of health and safety messages. Each has a commitment to health and safety driven by a personal experience that they speak about to workers at industry forums. For Shane Webcke and Trevor Gillmeister, this is the death of their fathers. For Libby Trickett, it is her battles with her own mental health. All three inspire workers to listen and learn from the celebrities' experiences

with ‘cut through’ that the regulator would not otherwise be able to achieve. To spread their influence wider still, OIR has published films about each ambassador’s experiences to YouTube which have been watched tens of thousands of times.

Safety advocates were not famous before a workplace injury or death changed their lives forever, but the stories they tell to workers really drive home to workers what the consequences of not taking safety seriously can really mean to the individual, their families, their friends and their colleagues. Year round, OIR sends them to workplaces all over the state speak directly to workers at toolbox talks and safety meeting. Feedback has been 100% positive.

Social media and other online channels are used to spark community conversations about work health and safety – whether this is positive reinforcement of businesses who are exceling in keeping their workers safe, or publishing the outcomes of a successful industrial prosecution as a strong deterrent to others not doing the right thing.

Safe Work Month and other industry forums ensure work health and safety professionals come together to hear about health and safety compliance directly from the regulator, systems and solutions from others in their industry who experience similar health and safety challenges, and from occupational health and safety experts and academics. Registrations and industry sponsorship ensure many forums run cost neutral.

Provision of compliance information and promoting work health and safety awareness and education is an essential part of WHSQ’s regulatory role. Active promotion to workplaces and the community ensures that requirements and expectations are clearly understood and the legitimacy of the inspector to take action to secure compliance is generally not challenged. This enables the inspector to focus on ensuring that the workplace is adequately managing hazards and risks to workers and others and that all aspects of the legislation are being complied with.

Compliance information

WHSQ provides information, tools and other resources to assist industry to understand their compliance requirements and the means to achieve them. Web-based delivery is used to ensure easy access by all. The one-stop-shop website, www.worksafe.qld.gov.au, provides a standalone resource that unites the previously separate sites of WorkCover Queensland, WHSQ, ESO and the Workers’ Compensation Regulator and provides a single point of reference for comparable services and resources. It also seeks to promote collaborative initiatives and cross-promote resources and services across agencies.

High quality information and guidance is provided on the website to support understanding of and compliance with the work health and safety laws. There is particular focus on:

- the duties of PCBUs to ensure the health and safety of workers and others;
- due diligence requirements for officers of corporations;
- penalties for breaches;
- the rights, duties and role of work health and safety entry permit holders; and
- the duty for PCBUs to consult with workers and the collaborative process this involves.

Industry specific information, aimed at supporting PCBUs and workers to understand and collaboratively manage the hazards and risks specific to their industry type, is provided on tailored industry microsites. These microsites contain information about common hazards and risks and ways to effectively manage them, case studies about how work health and safety has been improved, compliance campaigns and their outcomes, and key compliance requirements specific to the industry. There is a microsite for each of the priority industries.

The website also provides a number of tools which focus on allowing businesses and workers to make more informed health and safety decisions, enable them to take control to drive improved safety outcomes and

provide the means for ensuring compliance with legislative requirements. Key tools include the web-based return on investment calculator, Participative Ergonomics for Manual Tasks (PERforM) program, People at Work risk assessment toolkit and the young worker toolkit.

Return on investment calculator

The web-based return on investment calculator seeks to assist businesses to estimate an indicative return on their investments in work health and safety by providing an indication of whether a particular investment will improve their bottom line and have other positive impacts on the workforce.

PERforM program

The PERforM program seeks to build industry capacity to control hazardous manual tasks risks by actively involving in the risk management process, the workers who do the tasks (i.e. identifying problem tasks, assessing risk and developing control ideas). A suite of freely available online resources has been developed as part of the PERforM program including training materials (PowerPoint presentations for managers, trainers and work teams, resource manual, handbook), case studies with cost benefit evaluations, films, fact sheets, webinars and an online PERforM risk assessment tool which can be used on mobile devices.

People at Work risk assessment toolkit

People at Work is a free psychosocial risk assessment tool designed to assist organisations identify and manage risks to the mental health of their workers and consider some of the health impacts of exposure to hazards such as burnout, musculoskeletal symptoms and sleeping difficulties. It applies a five stage risk management process to independently assess risks to the psychological health of workers and provides a tailored organisational report to businesses that highlights specific workplace risks to psychological health.

Young worker safety toolkit

The young worker safety toolkit serves to inform employers of the unique risk profile of young workers and provide practical resources to manage these risks through good work design. The toolkit is designed to assist employers of young workers, education and training providers, youth service providers and parents and caregivers engage with young people about work health and safety.

Programs which provide information, tools and other resources at the workplace

It is recognised that while the website is an effective means of making information, tools and other resources available, active promotion and explanation about how they can be used is needed, particularly for types of industries, workers or business owners who may not actively seek such support. While inspectors promote the information, tools and resources which are available on the website as part of their broad suite of tools to secure compliance, time constraints and the compliance oriented role of the inspector mean that in-depth support and guidance is limited.

To address this, WHSQ operates various programs designed to provide workplaces with information that is practical, relevant and easy to use for their specific industry as a means to enable workplaces, particularly small to medium sized businesses, to implement their own safety strategies. The Small Business Program is targeted at small businesses (those with fewer than 20 workers) and focusses on providing on-site visits where the existing safety management system of a business is reviewed and discussed and opportunities for improvement identified. In addition to the on-site visits, the Small Business Program also provides assistance with toolbox talks, presentations and ongoing support by phone or in person, and offers a suite of information and tools. These include a self-assessment and advisory pack, web-based information, guides and templates. Likewise, the Healthy Worker Initiative undertakes a range of targeted evidence-based activities to support workplace health and wellbeing programs, policies and services which have been shown to be essential in the overall reduction of work-related fatalities, injuries and illnesses. The Safety Leadership at Work program also operates on a similar basis by working with and encouraging front line management,

supervisors and workers to develop their safety leadership capacity. This is achieved by profiling and promoting businesses that have committed to safety leadership and inspiring other businesses to do the same, encouraging industry to share learnings and work together to develop solutions to significant industry sector and supply chain safety challenges, working directly with organisations to increase awareness of leadership practices that can influence positive safety outcomes, and providing a range of tools and resources to support organisations working towards a stronger safety culture.

Stakeholder feedback on WHSQ’s effectiveness in providing compliance information and promoting work health and safety awareness and education

Limited feedback was provided by stakeholders in relation to the issue of WHSQ’s effectiveness in providing compliance information and promoting work health and safety awareness and education. However submissions that did touch on this issue noted that:

- there is support for the use of compliance programs, industry partnerships and education campaigns as a means of trying to improve work health and safety;
- programs are generally well received and by industry and are seen as a positive way educate the industry, encourage compliance and create a level playing field for business;
- there are tangible results, advantages and benefits from WHSQ’s awareness campaigns;
- education and awareness is important in conjunction with men on the ground; and
- there is strong support for these types of campaigns to be continued and improved upon.

It was noted by the AMWU however that:

“There needs to be greater emphasis on developing and implementing strategies that directly involve the workforce in education about WHS issues.”¹⁶⁴

The QCU also noted that:

“the approach being undertaken by WHSQ over focuses on awareness and engagement which is a detriment to the deterrence strategies”.¹⁶⁵

This is a theme that was generally raised as part of the feedback on WHSQ’s enforcement and compliance policy and approach.

Findings

The feedback offered by stakeholders, albeit minimal, indicates in principle support for the compliance information and work health and safety awareness and education initiatives delivered to date. Notwithstanding, stakeholder comment about the over focus on awareness and engagement at the detriment of deterrence strategies is consistent with the general findings of the Review that there is an overreliance on engagement, education and advice rather than the traditional enforcement measures to instil compliance. It is the view of the Review that, while WHSQ is performing well in relation to providing compliance information and work health and safety awareness and education, the increased use of these strategies has over shot the mark and place insufficient emphasis on hard compliance approaches. This is not to say that there is not a place for awareness and engagement, but that regulatory efforts need to be balanced to ensure both awareness and engagement and the use of hard enforcement tools by the inspectorate are being applied.

In restoring this balance, there is a need to ensure information, education and awareness efforts deliver measurable and practical outcomes and that resources are proportionately allocated to support and reinforce this focus. Further to this, it is noted that there may be greater capacity and benefit (i.e. measurable

¹⁶⁴ Australian Manufacturing Workers’ Union p3.

¹⁶⁵ Queensland Council of Unions submission p20.

financial return) for WorkCover to contribute more for awareness and engagement campaigns which are likely to reduce incidents which lead to workers' compensation claims (e.g. Homecomings) or which minimise the costs of claims (e.g. Getting Back). If additional specific funding for media campaigns is provided by WorkCover, it may be possible to reallocate some of the existing base funding from WHSQ's engagement and awareness area towards frontline inspector activity.

Recommendation

40. That WHSQ and WorkCover examine the opportunity and benefits of WorkCover providing additional funding for awareness and engagement activities undertaken by WHSQ, thus releasing base funding for more direct compliance activities.

Chapter 5: The appropriateness and effectiveness of the administration of public safety matters by WHSQ

Public safety refers to a broad responsibility by the government to provide for the safety and security of the community.

The relationship between public safety and work health and safety is complex and influenced by many factors, including the state of legislation at any point in time, its interpretation and enforcement by regulatory agencies, coronial findings, the expectations of the community, and the political environment. Public safety in the work health and safety regulatory context is generally addressed by provisions in work health and safety legislation that seek to protect third parties, such as members of the public, from harm occurring from the performance of work or the escape of harmful things at a workplace, such as scaffolding at a construction site collapsing on an adjacent footpath.

The statutory duty of care owed by a person conducting a business or undertaking to members of the public, also referred to as 'other persons', was established in Queensland work health and safety legislation in 1989 and continues to exist today. Section 19 of the WHS Act 2011 establishes the primary duty of care of a person conducting a business or undertaking. Section 19(1) provides for the duty owed to workers while section 19(2) is the duty owed to 'other persons'.

However, significant changes in the workforce, workplaces and the economy in Queensland are testing the boundaries of the duty of care owed to 'other persons' under work health and safety legislation. The growth of tourism and the impact of business operators providing recreational services and experiences, such as theme park entertainment, underwater diving and snorkelling, and adventure activities, are significant factors.

Various stakeholders hold different legal, policy and sociological views on WHSQ's role and function in relation to incidents which could be considered on the fringe of the work health and safety jurisdiction. Due to notification requirements for work-related fatalities, WHSQ's response may be triggered through notification of a fatality where there is a connection, however remote, with a person conducting a business or undertaking. WHSQ's practice has tended towards an initial response to determine jurisdiction. Depending on the circumstances, WHSQ may investigate and take enforcement action, and, on other occasions, the incident may be regarded as beyond WHSQ's jurisdiction with no further action taken.

Stakeholder feedback on public safety

Term of reference four requires the Review to consider the appropriateness and effectiveness of the administration of public safety matters by WHSQ. Potential overlaps and gaps in the regulation of work health and safety and public safety, as well as the potential to distract WHSQ from their core responsibility of work health and safety, were of concern to several stakeholders. For example, the QTIC submitted:

“Lack of jurisdictional clarity has left WHSQ under-resourced and uncertain on where to focus their attention. Greater clarity regarding the scope of WHS laws is needed.”¹⁶⁶

This was put even more strongly by Gunther Paul, of James Cook University:

“WHSQ should not be distracted and weakened by overburdening with public health or public safety issues.”

A counter view was provided by the AWU, which stated:

“Consideration should be given to the extension of the health and safety regime to address consumer and public interest.”¹⁶⁷

Stakeholders also provided comment for particular circumstances or issues. For example:

“Jurisdictional boundaries of WHS and public safety are vague, especially in the instance of an injury or fatality on a sporting field, golf course or bowling green provided by a club or community organisation.”¹⁶⁸ Club’s Queensland.

“A complete re-examination of the amusement device regulations is necessary to ensure that maintenance, inspection, testing and reporting of amusement devices is at the best standard. In particular, operator numbers and competency should be considered.”¹⁶⁹

Additionally, there was support for more specificity regarding work health and safety and public safety, including:

“Further clarity regarding the jurisdictional overlap between WHS and public safety is needed;”¹⁷⁰ and

“The approach of the WHSQ legislation should specify the protection provided under the WHSQ legislation to members of the public who may be incidentally connected to a work activity.”¹⁷¹

For public safety issues which do not appear to be in the scope of work health and safety, the following submissions are relevant:

“An expansion of powers in regards to the WHS Act over public is not advocated but if further legislation is required, this should be separate from the WHS Act.”¹⁷²

“Consideration should be given to establishing an independent agency to deal with public safety matters”

Fatalities involving members of the public

Since 2006, about a quarter of the 393 work-related fatalities notified to SWA by Queensland involve members of the public (recorded for data purposes as bystanders). Of these 97 bystander fatalities, 26 (27%) were participating in recreational water/diving/swimming activities, such as white-water rafting, scuba/snorkelling or swimming in a public pool. Sixteen were involved in motor vehicle fatalities where the bystander was a driver or passenger in a vehicle involved in an accident. Eleven occurred in Health Care and Social Assistance. Table 13 provides a breakdown of worker and bystander fatalities across the major industry sectors. Figure 5 shows the proportion of bystander fatalities as a proportion of total fatalities.

Of the 97 bystander fatalities, 25 were children 15 years or younger (some are included in the swimming fatalities) from mainly pool drowning (both public and private) and agricultural activities due to mobile plant (tractors, forklifts). Twenty bystander deaths occurred where the person was aged 80 years and over, all in

¹⁶⁶ Queensland Tourism Industry Council submission p4.

¹⁶⁷ Australian Workers’ Union submission p5.

¹⁶⁸ Clubs Queensland submission p2.

¹⁶⁹ Australian Workers’ Union submission p5.

¹⁷⁰ Clubs Queensland submission p2.

¹⁷¹ Australian Lawyers Alliance submission p14.

¹⁷² Queensland Tourism Industry Council submission p4.

residential care facilities, as a result of falling when being moved or being struck by vehicles, and while their age was not the reason for their death it is likely to have been a contributing factor.

In 2016 there was an unusually large number of bystander fatalities with almost 50% of all notified fatalities being bystanders. One of the dominant features during 2016 was 7 bystander fatalities in Arts and Recreational Services, four of which were from the Dreamworld incident. Another was a 3 year old killed at Inflatable World in Toowoomba. The other two were a motor vehicle accident where a truck carrying a carnival ride had a steel supporting arm swing out into oncoming traffic killing the driver, and the death of a recreational diver.

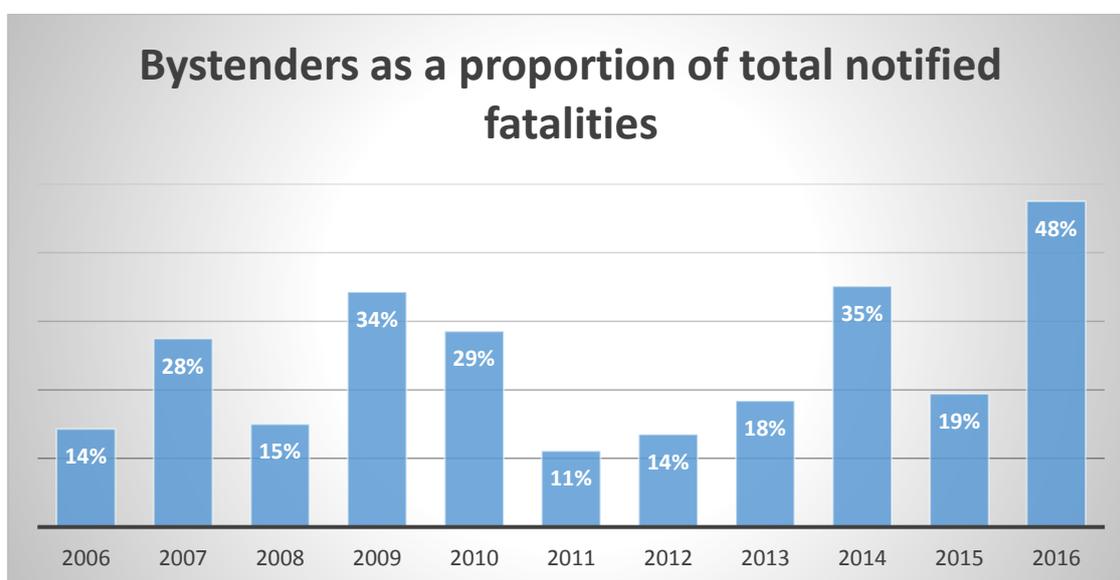
Table 13 - OIR Notified Work-related fatalities by worker type and Industry by calendar year

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Total
Bystander												
Accommodation & Food Services	1	1	1		2						1	6
Administrative & Support Services									1			1
Agriculture, Forestry & Fishing		2	1						2	2	4	11
Arts & Recreation Services	1	5	2	6	2	1	1	1		2	7	28
Construction				2		1	1		1			5
Education & Training	1									1		2
Electricity, Gas, Water & Waste Services								1				1
Health Care & Social Assistance	1	1		2	2		2		2		1	11
Other Services			1	1	3							5
Public Administration & Safety						1				1		2
Rental, Hiring & Real Estate Services							1	1	1	1		4
Retail Trade		1			1			1				3
Transport, Postal & Warehousing		1	1	1				3	6		6	18
Total Bystander	4	11	6	12	10	3	5	7	13	7	19	97
Worker												
Accommodation & Food Services		1							1		1	3
Administrative & Support Services							1			1	1	3
Agriculture, Forestry & Fishing	5	5	11	10	8	9	11	8	9	9	7	92
Arts & Recreation Services	1	1	1			1	1	3	2	1	4	15
Construction	7	9	9	2	6	5	6	4	9	6	3	66
Education & Training	2					1	1					4

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Total
Electricity, Gas, Water & Waste Services	1		1				2			4		8
Health Care & Social Assistance	1											1
Manufacturing	3	4	2	2	4	4	5	1		5	1	31
Mining						1	1					2
Other Services	2	3		3	1		1	5				15
Professional, Scientific & Technical Services							1					1
Public Administration & Safety		1	1	1		1		3		1	1	9
Rental, Hiring & Real Estate Services	1	1		1				1	1		1	6
Retail Trade			2	1	1		1	1		1	1	8
Transport, Postal & Warehousing		3	5	1	2	1	1	5	2	1	1	22
Wholesale Trade	1	1	2	2	3	1						10
Total Workers	24	29	34	23	25	24	32	31	24	29	21	296
Total Fatalities	28	40	40	35	35	27	37	38	37	36	40	393

* Changes to the industry classification in 2011 means that it is not possible to directly compare industry figures with the years prior to 2012

Figure 5 - Proportion of bystander fatalities as a proportion of total fatalities



The classification of recreational diving fatalities into an industry depends on whether the operator is a charter boat (Transport) or a tour operator (Arts and Recreational). Not all work-related motor vehicle accidents are reported to WHSQ (many go to the QPS and/or Transport Safety) and WHSQ is only able to report to SWA when a notification occurs. This leads to slight anomalies. For example in Transport, no bystander fatalities were reported in 2015 but of the 6 bystander fatalities in 2014, 3 were road traffic fatalities involving trucks (one was a double fatality). The remaining 3 were recreational diving.

Tourism in Queensland

The nature of Queensland's popular tourist attractions and their importance to the economy heightens the need to ensure the 'tourism experience' in the state, whether it is experiencing thrill rides at a theme park, or snorkelling on the Great Barrier Reef, is safe.

The Queensland Government has recognised the importance of tourism for the state's economy and identifies Queensland's competitive advantages as including a 'safe, clean and green environment'.

Based on a broad definition which includes travel for business and education, Queensland's tourism sector's direct output was \$10.2 billion in 2014-15, 3.6% of the state output. While tourism is important throughout the state, the Great Barrier Reef and the theme parks of the Gold Coast are particularly significant, attracting many visitors every year. Visitation numbers to the Great Barrier Reef Marine Park are growing with approximately 2.2 million visitor days indicated for the financial year ending 30 June 2016.

Commercially provided recreational diving and snorkelling experiences have been regulated in Queensland for many years due to the incidence of recreational diving and snorkelling fatalities that had prompted government action to improve safety standards in the sector in the 1990s.

Initially, this was done through regulations and codes of practice made under the now repealed WHS Act 1995. These regulations and codes were developed and amended over time as a result of extensive consultation with the diving industry.

Leading up to 2011, the development of the national model work health and safety laws for Australian jurisdictions did not include national model regulations and codes dealing with recreational diving and snorkelling. The absence of regulation in this area was particularly an issue for Queensland due to the strong recreational diving and snorkelling sector that has evolved in far north Queensland.

The Queensland Government at that time recognised the need to maintain high safety standards for the recreational and diving snorkelling sector. This resulted in the introduction of the *Safety in Recreational Water Activities Act 2011* (SRWA Act), and supporting regulations and codes of practice for recreational diving and snorkelling. When the SRWA Bill was introduced to the Queensland Parliament, the Australian recreational diving market was estimated to contribute \$1.4 billion into the economy each year, with the majority of this activity occurring in Queensland.

To support the regulatory framework, WHSQ undertakes a range of activities to assist industry to comply with the relevant regulatory provisions. The establishment of the WHSQ Diving Unit in January 2009 increased WHSQ's ability to provide enhanced services to the recreational dive industry. The WHSQ Dive Unit is currently comprised of three full-time equivalent inspectors.

In the first half of 2016-17, there were 10 recreational diving and snorkelling fatalities, which is higher than the annual average for the past five years. Due to concerns about these recent fatalities, the Minister for Employment and Industrial Relations held a Reef Safety Roundtable in February 2017 for industry operators and experts to consider improvements to the codes of practice for recreational diving and snorkelling.

The majority of the recent fatalities involved snorkelling activities, and it should be noted that common factors contributing to risk when snorkelling include age, lack of experience, lack of physical fitness, pre-existing medical conditions such as obesity, heart disease, high blood pressure, breathing difficulties and pre-existing injuries. As a result of the Roundtable, the Minister for Employment and Industrial Relations announced working groups would be established to oversee a series of improvements to the snorkelling and diving code of practice.

Australia has an extremely low risk of fatality by drowning compared to many other countries. However, the number of fatalities in Queensland from snorkelling and diving is anticipated to rise, due to the correlation between these activities and the projected rise in the number of overseas visitors to Queensland. The number

of overseas visitors to Queensland has risen by 3.2% per annum over the past five years to 2015-16. Tourism Research Australia projects a rise of 4.7% in the number of visitors coming to regional Queensland for holiday purposes in 2016-17. In particular, the number of international visitors to North Queensland rose from 1,062,000 in 2011-12 to 1,381,000 visitors in 2015-16. This increase of 319,000 visitors or 30%, represents the biggest growth across the state, higher than south-east Queensland and the outback. Also over this period, international visitors to the North Queensland region accounted for approximately one-third of all visitors.

The SRWA Act and WHSQ's operational activities in relation to the recreational diving and snorkelling sector are aimed at ensuring high standards of public safety in this sector. Without this legislative intervention, the relationship between the dive customer and dive tour operator would be governed by a contractual relationship and any remedies would lie in contract and tort. While there is a regulatory framework which can be updated to reflect changes identified in consultation with industry, the regulator must operate within budget limitations in providing resources dedicated to the recreational diving and snorkelling sector.

Amusement Devices

Amusement devices are a pivotal attraction at many events in Queensland where members of the public can experience the enjoyment and thrill of riding on these devices. In addition to amusement devices that are assembled, dismantled and moved between events, Queensland has several major theme parks with fixed amusement devices. WHSQ has also advised the Review of plans for a new major 'active sports theme park' to be built on the Sunshine Coast. In theme parks and major shows, such as the the Royal Queensland Show (the Ekka), there will be a different mix of older style rides with manual systems and newer ICT based rides. It is generally acknowledged that public confidence in the amusement rides industry is presently low, patrons are worried about ride safety, and theme parks are experiencing lower patronage at their gates.

The WHS Regulation 2011 specifically regulates amusement devices as well as other high risk plant. WHSQ has proactively audited amusement devices at major agricultural shows, local carnivals and school fetes for a number of years with more than 700 assessments conducted over a 12 month period up to October 2016. WHSQ also meets with amusement device stakeholders twice a year to discuss safety issues relevant to the industry and to encourage the adoption of systematic approaches to maintaining equipment in a safe condition.

Due to Queensland's tourism sector and the emergence of a significant theme park sector in south-east Queensland over the last three decades, there may be a need for WHSQ to dedicate more resources to amusement devices than regulators in other jurisdictions.

Following the incident at Dreamworld in October 2016 when four people died on the Thunder River Rapids ride, WHSQ carried out systems audits at major south-east Queensland theme parks. WHSQ conducted separate ride safety audits at each of the six major theme parks in Queensland. These audits commenced in October 2016 and entailed over 90 rides being audited in total, across Dreamworld (including WhiteWater World), Wet 'N' Wild, Sea World, Aussie World, Australia Zoo and Movie World.

A nationally-recognised audit tool for amusement devices was used as the basis of the audits. The audits involved a desktop review of the ride documentation, followed by on-site testing and verification of operation and emergency procedures on the ride itself. The desktop component involved the inspector reviewing the documentation for each ride in relation to plant and design registration, maintenance and operating manuals, instruction and training of operators, annual inspections by competent persons, repairs and alterations, critical components and associated non-destructive testing, emergency plans, asbestos, noise and electrical hazards and risks. The site verification component involved the inspectors observing the operation of the ride, talking to the ride operators and other relevant persons, and assessing the actual operation of the ride against the systems outlined in the documentation. In addition to the inspector assessment of the ride, engineers also review the current risk assessment documentation. WHSQ engineers

also provided technical assistance to inspectors as required during the site verification, and interpret the engineering report.

Both the investigation of the incident at Dreamworld and the audits of the major theme parks required a high level of resources with the involvement of investigators, inspectors with expertise in plant, engineers, and electrical safety inspectors.

Risks emanating from amusement devices, to workers and the public, include their design, installation, maintenance, testing and the way in which they are operated. While newly manufactured and constructed devices are generally engineered to higher standards and provide greater safeguards, it is essential to ensure that they meet international technical standards for amusement devices, and that international standards and Australian standards are both rigorous and consistent. WHSQ's Chief Safety Engineer has recently met relevant stakeholders (including chairpersons from the Australian and American Standards Committees) to identify differences in the various standards and also map out strategic options to ensure rigor and consistency. Amusement devices manufactured overseas for the Australian market, under an internationally agreed standard, are more likely to operate safely under Australian environmental conditions.

Poor mechanical integrity and lack of modern safety control measures are a significant concern for older devices. Although annual inspections of amusement devices are mandated in the WHS Regulation 2011 (section 241), this falls short of the "major inspection" required for other plant such as cranes. A major inspection should include:

- an examination of all critical components of the amusement device, if necessary stripping down the amusement device and removing paint, grease and corrosion to allow a thorough examination of each critical component; and
- a check of the effective and safe operation of the amusement device¹⁷³.

Such an inspection should be conducted by a competent person who has formal engineering qualifications and experience similar to those of the designer; and who should be in a position to make engineering judgements regarding the severity of faults determined through such inspections, intervals for inspections and appropriate repairs¹⁷⁴. To support this competency, WHSQ is in discussions with the engineer's professional body (Engineers Australia) to re-activate the National Engineers Register (NER) for in-service inspection of amusement devices. WHSQ is also proposing to the Board of Professional Engineers, Queensland, to set-up a similar register.

Currently, there is not a specific requirement for amusement device owners/operators to carry out major inspections of their amusement device/s, although the majority of owners have indicated to WHSQ that this is done. It is also believed that at school fetes and small local shows some very old amusement rides (over 30 years) are still being used and there is a need to mandate major inspections in the regulation to ensure that all rides, especially older ones, are maintained and undergo major inspections at prescribed intervals to ensure that they remain in a safe condition.

When third party engineers are inspecting amusement devices they require information about any enforcement notices issued by the regulator about the amusement device to enable them to make informed decisions about the safety of the amusement device. They may not have access to this information unless it is supplied by the owner of the amusement device. A requirement (in the Regulation or code of practice) for owners to disclose details of all notices issued for their amusement device/s in the logbook for the device/s would address this.

It was indicated to the Review by WHSQ that, out of a total of 111 serious amusement devices incidents around Australia from 2001 to 2016, a significant number may be attributed to inadequate training or

¹⁷³ Section 235 Work Health and Safety Regulation 2011

¹⁷⁴ Australian Standard 3533.3:2003 – Competent persons to conduct inspections.p.20

operator error. High turnover of operators (especially for mobile amusement devices at smaller shows) and lack of effective operator training are significant contributing factors to amusement device incidents.

The inclusion of a requirement in the Regulation or code of practice for the owner to specify persons who are competent to operate particular amusement devices will enhance safety in the amusement devices industry. This could be done as part of the plant item registration process (i.e. owners to nominate competent operators for their registered ride during registration or renewal of registration) or a requirement for owners to specify the competent person/s in the logbook.

The level of competency required to operate amusement devices, particularly large amusement devices, warrants consideration. By way of comparison, a high risk work licence is required to operate a forklift truck and arguably the risk associated with the operation of certain large amusement devices is significantly higher than for a forklift.

Further, there have been calls for even stronger action. Michael Tooma, a partner with Clyde and Co, has called for the establishment of a specialist regulator for amusement parks. He states:

“The industry is highly specialised. The assessment of the effectiveness of controls requires relevant specialist expertise. As such, regulators often defer to the expertise of external advisers and the processes of the industry itself... In other specialised high-risk industries such as oil and gas, mining, rail and aviation, the need for a specialist regulator with the oversight of the industry has been long recognised. The same is required in relation to amusement parks. Amusement parks should be required to develop a “safety case” for their operation setting out the processes, resources and performance assurance systems that will be implemented to secure the safety of members of the public. That safety case would then form the basis of the licence to operate that park. The safety case should then be verified by regular external independent audits and regulator audits. Accountability for the implementation of the safety case must be both corporate and personal. A breach of the safety case would represent a breach of trust and penalties must be significant and commensurate with the revenue of the corporation. The accountability must also extend to the officers of that company and its parent companies so that the attention of executives and boardrooms of amusement companies is focused on guaranteeing public safety. Only then can public trust be restored in the industry.”¹⁷⁵

Amusement Devices – potential additional regulatory arrangements

Operators of single or multiple high risk amusement devices or multiple lower risk amusement devices are responsible for managing a significant risk to workers and the public. The relative inherent risk of these amusement devices can be calculated using the equations in *Australian Standard 3533.1:2009 - Amusement Devices*. Amusement devices which cause the patrons to be subjected to high speed, height, or acceleration, present higher levels of risk. The number of patrons that a device can cater for at one time also increases the risk level. This risk can be effectively managed through the design, operation and maintenance of the amusement device and the included risk controls such as fail-safe patron support systems, patron restraint systems, over-speed controls, emergency stopping controls, and loss of power controls.

The level of risk to the general public from amusement devices can be compared to that of facilities which use, generate, handle or store hazardous materials. At the upper end, the risk posed by Major Hazard Facilities is the potential for multiple fatalities, with a sliding scale of risk proportionate to the type and quantity of hazardous materials at the workplace. It is therefore arguable that a similar regulatory approach

¹⁷⁵ <http://www.theaustralian.com.au/business/legal-affairs/we-need-a-specialist-regulator-for-amusement-parks/news-story/8f6eb409d6a314b64322e46a3cb16aad> 23 June 2017

should be taken for operators of amusement devices where the collective risk for those devices exceeds certain thresholds.

A facility is determined to be a Major Hazard Facility (MHFs) if it meets certain criteria of risk associated with the types and amounts of hazardous materials stored at a particular location. This is primarily determined on the basis of threshold quantities of specified substances or classes of hazardous materials. Facilities which exceed the threshold level are considered MHFs, facilities which notify 10% or more of the threshold amount may also be classified as MHFs if they pose a significant risk of a major incident (i.e. on public safety grounds). The calculation of threshold amounts has some complexity associated with it as the risk presented by hazardous materials depends on a number of factors, including potential for fire or explosion and toxicity to humans and the environment.

Facilities determined to be MHFs are required to submit a Safety Case to the regulator. The Safety Case is to demonstrate that the operator has a comprehensive and integrated system for managing risk at the MHF. The Safety Case must detail:

- that the operator's hazard identification provides a sound foundation for reduction of the risk of major incidents at the MHF by identifying all major incident hazards and major incidents that could occur at the MHF, and all of the possible routes that could lead to the major incidents;
- that the operator has a detailed understanding of all the risks to health and safety associated with major incidents, including the nature of the major incident and major incident hazards, the likelihood of each major incident hazard causing a major incident, and the possible magnitude and severity of health and safety consequences of each major incident;
- that the MHF operator's control measures reduce the risk of a major incident occurring at a MHF, either by reducing the likelihood of the possible cause of a major incident leading to that incident, or by reducing the consequences of a possible outcome of a major incident if that incident were to occur;
- that the operator's Safety Management System (SMS) for the MHF provides a comprehensive and integrated system to manage all aspects of the safe operation of the MHF, particularly with reference to major incident prevention and control; and
- that the operator has systems in place to address all health and safety consequences of a major incident.

The Safety Case is reviewed by the regulator to determine whether a licence to operate will be granted and the conditions of that licence, if any. Conditions on a licence do not provide dispensation from compliance with the Regulations, but may be a mechanism to address identified deficiencies.

Facilities which use, generate, handle or store hazardous materials, but do not meet the criteria for a MHF, are subject to a sliding scale of regulatory requirements based on the risk. Table 14 provides an indication of the approaches taken.

Table 14 - Hazardous chemical regulatory framework

	Workplace category (No. of workplaces)	Category threshold	Regulatory requirements	
Quantity of hazardous chemicals increases More hazardous, and complex. Greater risk potential ↑	MQW			Regulatory requirements proportionate to hazards / potential risks ↑
	Major hazard facilities	Hazardous chemicals exceed Schedule 15 quantities / type	<ul style="list-style-type: none"> - MHF notification to WHSQ - MHF determination and licensing by WHSQ 	
	(Around 40 workplaces)			
	MQW			
	Potential major hazard facilities	Hazardous chemicals exceed 10 percent of Schedule 15 quantities / type	<ul style="list-style-type: none"> - Notification to WHSQ - Assessment and determination by WHSQ 	
	MQW			
	Manifest quantity workplaces	Hazardous chemicals exceed Schedule 11 quantities / type	Notify and provide a manifest to WHSQ and emergency plan to QFES	
	(2500–5000 workplaces)			
	Non-MQW			
	Workplaces that use, handle, generate and store hazardous chemicals	Hazardous chemicals at the workplace	Notification not required	
	(over 10,000 workplaces)			

Applying the MHF approach to operators of amusement devices has a similar level of complexity, but different calculations to establish the risk and therefore whether a facility or an operator meets the threshold criteria. The existing requirements for registration of amusement devices provide a good basis for identifying the facilities and operators who are likely to meet the additional regulatory requirements.

It is considered that there are two broad types of operators of amusement devices: those that operate one or more rides at fixed facilities (e.g. Dreamworld, Movie World, Sea World); and, those who transport their amusement devices to various locations (e.g. carnival rides at the Ekka and major regional shows, local ride operators for school and community fairs, amusement device hire companies). It is therefore proposed to cover both types of operators with a system which requires licencing when a certain risk level is reached and a sliding scale of requirements below the threshold risk level. An indicative approach to this is shown in Figures 6 and 7, noting that, similar to MHFs, the risk determination is complex and will need to be established through consultation with industry, professional and community stakeholders.

Figure 6 - Proposed risk management regime for fixed location amusement devices

RISK	LOW → MEDIUM → HIGH		
	Category 3	Category 2	Category 1
Risk	LOW	MEDIUM	HIGH
Who is affected?	Operators of facilities with: <ul style="list-style-type: none"> • less than 5 low risk (Class 1 or 2) devices 	Operators of facilities with: <ul style="list-style-type: none"> • 1 – 4 moderate risk (Class 3) devices or • 5 or more low risk (Class 1 or 2) devices 	Operators of facilities with: <ul style="list-style-type: none"> • 1 or more high risk (Class 4 or Class 5) devices; or • 5 or more moderate risk (Class 3) devices
Requirement on the operator	<ul style="list-style-type: none"> • Trained attendants listed in log book 	<ul style="list-style-type: none"> • Mandatory Work Health and Safety Management System • Category 2 Licence 	<ul style="list-style-type: none"> • Mandatory Work Health and Safety Management System • Safety Case • Category 1 Licence
WHSQ involvement	<ul style="list-style-type: none"> • Inspection by non-specialist WHSQ inspectors 	<ul style="list-style-type: none"> • 12 monthly audit by specialist WHSQ inspectors 	<ul style="list-style-type: none"> • 6 monthly audit by specialist WHSQ inspectors

Note: Design and item registration will continue to apply on all registrable amusement devices

Figure 7 - Proposed risk management regime for temporary location amusement devices

RISK	LOW → MEDIUM → HIGH		
	Category 3	Category 2	Category 1
Risk	LOW	MEDIUM	HIGH
Who is affected?	Operators with: <ul style="list-style-type: none"> • less than 5 low risk (Class 1 or 2) devices 	Operators with: <ul style="list-style-type: none"> • 1 – 4 moderate risk (Class 3) devices or • 5 or more low risk (Class 1 or 2) devices 	Operators with: <ul style="list-style-type: none"> • 1 or more high risk (Class 4 or Class 5) devices; or • 5 or more moderate risk (Class 3) devices
Requirement on the operator	<ul style="list-style-type: none"> • Trained attendants listed in log book • Provide information about the device/s to event organisers 	<ul style="list-style-type: none"> • Mandatory Work Health and Safety Management System • Category 2 Licence • Provide information about the device/s to event organisers 	<ul style="list-style-type: none"> • Mandatory Work Health and Safety Management System • Safety Case • Category 1 Licence • Provide information about the device/s to event organisers
WHSQ involvement	<ul style="list-style-type: none"> • Inspection by non-specialist WHSQ inspectors 	<ul style="list-style-type: none"> • 12 month audit by specialist WHSQ inspectors 	<ul style="list-style-type: none"> • 6 Monthly Audit by specialist WHSQ inspectors

Note: Design and item registration will continue to apply on all registrable amusement devices

In the case of temporary location amusement devices, a third party is also involved: the organiser of the event. Events can be very large, (e.g. the Ekka), and organised by corporate organisations, or be quite small, (e.g. a school fete), and organised by community volunteers. It is considered that no matter what the size, the event organisers have responsibilities. Where the size of the event, and risk level of amusement devices at the event, reaches a certain threshold it would be reasonable to require the event organiser to notify WHSQ in advance about the timing and size of the event and a list of operators and rides being provided. Currently this is the approach taken by Education Queensland. Schools even use the Education Queensland guideline to quiz ride operators on basic regulatory requirements so, in effect, the notification system helps the system self-regulate. Again the risk level at which this would be required would need to be established through consultation with industry, professional and community stakeholders.

Applying a safety case and licensing regime for high risk operations, and a more basic licensing regime for medium risk operations, would replace the need for consideration of individual High Risk Work Licences for operators. The mandatory work health and safety management systems (WHSMSs) would need to specify the competency requirements and procedures to be followed for attendants and supervisors of each amusement device. While it would still be advisable to specify the minimum standards required for inspection and maintenance in regulation, specific requirements, tailored to each amusement device, would need to be specified in the WHSMS.

The licensing regime for MHFs require WHSQ to employ qualified chemical engineers (or equivalent) as specialist inspectors. The workload associated with the licensing regime equates to one specialist inspector per five licenced MHFs with additional staff required for the below threshold facilities. It is anticipated that, at least, an additional two qualified mechanical engineers (or equivalent) would be required to be appointed as specialist inspectors to administer the licensing regime, including conducting the Safety Case assessments and required statutory audits. Additional specialist plant inspectors would be required in each of WHSQ's regions. These inspectors would need strong engineering credentials, e.g. engineering para-professionals with suitable trade qualification and tertiary qualification in an engineering-related discipline. These inspectors would have the depth of technical knowledge and skills to work closely with the new amusement device engineers. The MHF licensing regime includes a sliding scale licence fee which provides for partial cost recovery for the resources required. A similar approach could be taken with amusement devices.

Economic and Demographic Changes

Significant economic and demographic changes are occurring in Queensland. The primary industries sector (e.g. agriculture, forestry and fishing) in Queensland has reduced its share of total employment by 5.28% and the secondary industries sector (e.g. manufacturing and construction) has reduced its share of employment by 2.99%. In contrast, the tertiary industries sector (health care, education and training, retail and recreational services) has increased its share of total employment by 8.29%. Overall, 77.42% of employment in Queensland is in the tertiary sector. All industries in Queensland have grown between March 1985 and March 2017 with the exception of Agriculture, forestry and fishing. The average rate of growth for service industries over the period was nearly twice that of non-service industries at 206% compared to 121%. Figure 8 shows the employment growth by industry from 1985 to 2017, highlighting the growth in the services industries.

Figure 8 - Queensland Employment growth by Industry - March 1985 and 2017

Industry	Employment Growth
Administrative & Support Services	385%
Professional, Scientific & Technical Services	351%
Arts & Recreation Services	286%
Health Care & Social Assistance	257%
Accommodation & Food Services	246%
Public Administration & Safety	219%
Mining	209%
Construction	181%
Education & Training	166%
Retail Trade	125%
Rental, Hiring & Real Estate Services	122%
Other Services	116%
Transport, Postal & Warehousing	86%
Information Media & Telecommunications	79%
Electricity, Gas, Water & Waste Services	73%
Financial & Insurance Services	71%
Manufacturing	35%
Wholesale Trade	8%
Agriculture, Forestry & Fishing	-35%

Source: Econ dX from ABS employment data, extracted 22/06/2017

As well as growing, the nature of the service industry is changing. There has been a substantial increase in work being undertaken outside clearly delineated workplaces and into public and private (domestic) areas. The service oriented economy also substantially increases interactions between workers and the general public. The likelihood that work-related risks also impact on the general public is therefore increased.

The growth in the Health Care and Social Assistance industry has been highlighted as a likely pressure on the risk to the health and safety of workers in that industry. Given the historical rate of bystander fatalities in this industry, increased growth is likely to also place pressure on the risk to the health and safety of the public who interact with this industry, including health care residents.

There has also been substantial growth in technology-enabled businesses that are transforming service provision through app-based, smart phone technology, for example, Uber, AirBnB, AirTasker. These modern service industries have made traditionally expensive and/or inaccessible services cheaper and more convenient¹⁷⁶. While they can introduce flexibility and the opportunity for self-direction in work, there is also a significant risk that the workers involved are placed in an increasingly precarious position, not only in terms of employment security and conditions, but also in terms of the knowledge, skills and resources to ensure their own health and safety, and the health and safety of their clients and others that they interact with while conducting their work.

In addition to these workforce and industry changes, Queensland's population is ageing. The Australian Bureau of Statistics states:

“At June 2015, the median age (the age at which half the population is older and half is younger) of Queensland's population was 36.9 years, up from 36.4 years at June 2010. The median age of males in 2015 was 36.1 years, compared with 37.6 years for females.

¹⁷⁶ Isaac, E., 2014. Disruptive Innovation: Risk-Shifting and Precarity in the Age of Uber. Berkeley Roundtable on the International Economy BRIE Working Paper, 7.

... In the five years to June 2015, the number of people aged 65 years and over in Queensland increased by 129,000 people (23%) to reach 686,200. This age group accounted for 14% of the state's population in 2015.¹⁷⁷

The implications of an ageing population for work health and safety and public safety are unknown, although broadly it is understood that older people are more vulnerable to risks to their health and safety, and are likely to be more seriously affected by public safety incidents. Currently, WHSQ is a partner in an Australian Research Council funded study being led by the Australian National University, *Working longer, staying healthy and keeping productive*.¹⁷⁸ This will examine the broad nexus between work and the health and safety of older workers. As such, it will provide greater understanding of the risks to an older population.

Jurisdiction of WHS Act 2011 versus contractual and other civil relationships

Principles expressed in the WHS Act 2011 are useful in various human endeavours, whether part of an undertaking within jurisdiction, or domestic chores done by householders, clearly outside jurisdiction. The principles reflect common sense.

Different stakeholders hold different legal, policy and sociological views as to WHSQ's proper role and function. If principles of hazard identification/risk assessment familiar to work health and safety assist in understanding 'failures' or systems, they do not translate into acceptance of jurisdiction.

If a real need is seen to regulate any recreational activity conducted as a result of contract between parties, WHSQ has done so (e.g. diving/snorkelling in particular circumstances) and has produced legislation, codes and guidelines to achieve this. Recreational diving has a clear definition due to legislated framework and capture. But for the relevant legislative intervention, the relationship between a dive customer and the tour operator would be governed by contractual relationship and any remedies (with respect to either party) would lie in contract and tort.

Similar to intervention into civil jurisdiction with respect to organised recreational diving, relevant statutory provisions exist with respect to 'Amusement devices' and 'escalators' which are 'high risk plant'.¹⁷⁹ In the first instance, the legislature has seen fit to intervene in a contractual relationship (and duties in tort) with respect to payment by a customer to go on a "ride". In the second, the legislature has seen fit to intervene in what is, of essence, a matter of occupier's liability (and duties in tort). This is not the case with virtually all other public and recreational activities, including sporting and competitive pursuits. Voluntary involvement, and contractual and civil relationships between/amongst parties will make any incident questionable in the work health and safety jurisdiction, better investigated by others, and will give rise to circumstances from which it may be very difficult to prove any offence. Such incidents are better dealt with under the common law and the law of tort.

Regulations at Chapter 12 of the WHS Regulation 2011 address 'public health and safety' by reference to Schedule 1, Part 1 of the WHS Act 2011. Chapter 12 does not in any way capture a wide range of public interactions with businesses, nor any other matter arising from a clear common law or contractual relationship. The Chapter is about 'high risk plant', 'relevant activities' (limited to dangerous goods and operation of high risk plant) and "relevant premises" which are premises, other than a workplace, where a 'relevant activity' happens.

¹⁷⁷ ABS 2017

<http://www.abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/3235.0Main%20Features252015?opendocument&tabname=Summary&prodno=3235.0&issue=2015&num=&view=>

¹⁷⁸ <https://researchers.anu.edu.au/projects/3630>

¹⁷⁹ WHS Act 2011, sch 1 pt 1; WHS Regulation 2011, ch 5 pt 5.2.

Reinforcing that view is the fact that section 19(2) is framed in terms of “others” not being “put at risk from work carried out” as opposed to “ensuring health and safety” or that things are “without risk”.¹⁸⁰ Extracting section 19(2) from the WHS Act 2011 and applying it to all facets of a ‘business or undertaking’ and its relations with the public and those with whom it might contract is taking the work health and safety jurisdiction beyond its intended boundaries.

Such regulatory scope creep is of concern to all work health and safety regulators in Australia. This issue was discussed at the SWA meeting on 1 October 2015,¹⁸¹ with a decision being made for SWA to lead the development of national guidance material to assist jurisdictions in applying a consistent approach to incidents that could be considered to fall within the context of regulatory scope creep. Recognising the complexity of the issue, little progress has been made to date.

Findings

The work health and safety legislation is clear in addressing some matters of public safety where there is a clear nexus with work, for example, the requirements for ‘others’ to use personal protective equipment if required when entering a workplace, or the provision of gantries/fencing and exclusion zones during construction work.

Beyond the clearly delineated areas of work health and safety law designed to have some element of public health and safety protection, the common law in terms of civil liability or remedy might be relevant and the criminal law remains applicable. In some circumstances there may be appropriate Criminal Code offences, for example in relation to ‘dangerous acts’, ‘dangerous things’ and ‘negligent acts causing harm’.

Incidents testing the boundaries of work health and safety legislation and public safety will continue to occur. WHSQ has clear jurisdiction in certain areas, for example commercially provided recreational diving and snorkelling, and amusement devices. Given their significance to the Queensland economy, both of these areas warrant ongoing monitoring to ensure standards are rigorous and there is an appropriate level of resourcing for education, compliance and enforcement activities.

The WHS Act 2011 should not be seen as a default setting for all human conduct. Extracting section 19(2) of the WHS Act 2011 and applying it to all facets of a ‘business or undertaking’ and its relations with the public and those with whom it might contract is taking the work health and safety jurisdiction beyond its intended boundaries. Some examples where work health and safety regulators would not typically consider jurisdiction applies include:

- a child injured playing on playground equipment at a council park;
- a member of the public tripping and falling at a shopping centre;
- a person drowning in a resort pool; and
- a member of the public injured while climbing or abseiling in a national park.

In these cases, there may be merit in the Queensland Government considering the establishment of a Public Safety Ombudsman. Ombudsmen are accessible free of charge to individuals who could not afford to pursue their complaints through the courts. They are neutral arbitrators, not advocates or consumer champions. They seek to resolve disputes without resort to formal investigations where this is possible. They are committed to achieving redress for the individual but also where systematic failures are identified, they seek changes to address the failings.¹⁸²

For amusement devices, there is a clear need to increase the level of protection to the public by ensuring that these devices are properly designed, maintained, inspected and operated. A graduated scale of

¹⁸⁰ WHS Act 2011, ss 19-20.

¹⁸¹ Safe Work Australia members’ meeting 27, Agenda item 3, Regulatory scope creep – NSW 1 October 2015

¹⁸² <http://www.ombudsmanassociation.org/about-the-role-of-an-ombudsman.php>

additional regulation for operators of amusement devices is warranted, particularly where the collective risk of those devices presents a medium or high risk to workers and the public.

Recommendations:

41. The *Work Health and Safety Regulation 2011* be amended to require that:
 - a. mandatory major inspections of amusement devices, by competent persons, are conducted;
 - b. competent persons are nominated to operate specified amusement devices; and
 - c. details of statutory notices are recorded in the amusement device logbook and made available to the competent person inspecting the amusement device.
42. WHSQ, in consultation with stakeholders, determine the level of competency required for the inspection of specified types of amusement devices, and the level of competency required for the operation of specified amusement devices (including the potential need for formal licensing arrangements to apply in respect of certain categories of device), and that the *Work Health and Safety Regulation 2011* be amended accordingly.
43. The *Work Health and Safety Regulation 2011* be amended to require, for operators of amusement devices, a similar regulatory approach to that taken for operators of facilities which use, generate, handle or store hazardous materials. That is, for operators and facilities whose amusement devices collectively present a high risk, require preparation of a Safety Case (which includes a work health and safety management system) and application of a licensing regime. For operators and facilities whose amusement devices collectively present a medium risk, require preparation of a work health and safety management system and application of a lower level licensing regime.
44. WHSQ and the Work Health and Safety Board consider the level of resourcing necessary to address the increasing risk to the public from work activities, and ensure PCBUs, particularly in the tourism, services and health care and social assistance sectors, are complying with their section 19(2) duty to ensure the health and safety of others.
45. Consideration be given by the Queensland Government to establish a Public Safety Ombudsman.

Chapter 6: Further measures that can be taken to discourage unsafe work practices

In announcing the Review, the government committed to examining whether any further measures could be undertaken to discourage unsafe work practices. This includes consideration of:

- the merit of introducing a new offence of negligence causing death: and
- whether existing penalties for work-related deaths and serious injuries should be increased.

Stakeholders were also asked in general whether, in addition to the above, there were any other measures that could be taken to discourage unsafe work practices that should be considered as part of the review.

6.1 Negligence causing death

In 2016, two workplace incidents occurred in Queensland resulting in multiple fatalities. On 6 October 2016 two construction workers were killed at Eagle Farm Racecourse (it is alleged that concrete slabs fell into a pit where they were standing), and on 25 October 2016, four people died at Dreamworld Theme Park on the Gold Coast after an incident involving a catastrophic failure of an amusement device. These incidents have seen calls for the current penalty and offences regime under Queensland's work health and safety laws to be reviewed, particularly whether current offences are sufficient in circumstances where actions or omissions allegedly involving negligence result in fatalities.

The terms of reference for the Review specifically require the Review to consider whether a new offence of gross negligence causing death (also known as industrial manslaughter) should be introduced.

Stakeholder feedback

Stakeholder responses to the issue of an offence of gross negligence causing death were polarised with stakeholder views continuing to coincide with long held entrenched views on the issue.

As with previous existing views on the matter, worker representatives and plaintiff lawyers continue to favour the creation of an offence of gross negligence causing death, while industry groups and other legal professional groups favoured retaining the status quo.

Submissions in favour of the offence supported this outcome on the basis that it would incentivise PCBU's to do all that they can to ensure health and safety at the workplace and that it would send a clear message to PCBU's about the societal expectations around safety in the workplace.

Conversely, employer representatives did not support the introduction of a new offence on the basis that:

- the current penalty and offences framework is sufficient;
- there is no identified gap between the current Category 1 offence and manslaughter under the Criminal Code; and
- the current Category 1 offence is largely untested.

Having considered submissions in relation to the question of a new offence of gross negligence causing death, it was concluded that further consultations in relation to the fundamental question of the creation of the offence would not result in any alteration to the fixed and long held positions of key stakeholders. However, the Review formed a preliminary view, based on consultation and research, that an offence of negligence causing death should be introduced in Queensland.

In May 2017, the Review advised the Government of this preliminary position and sought an in principle position on the creation of the new offence. Given the enormity of the impact on families, workers, businesses and the community of fatalities in the workplace, and the feedback received through consultation, in principle support was provided by the Government. Consequently, it was requested that consideration instead be given to the design of the offence as opposed to the merit of its introduction.

Current offence framework for work-related injuries and fatalities

Currently under the WHS Act 2011, there are three categories of offences for failure to meet a work health and safety duty. These offences focus on the failure to meet the safety duty, rather than the actual occurrence of a work-related fatality or injury.

Category 1 is a crime. It has three elements: the existence of a duty; breach of that duty without reasonable excuse exposing a person to a risk of death, serious injury or serious illness; and recklessness by the offender as to the risk of harm. The maximum penalty is five years' imprisonment for individuals and monetary penalties of up to \$3 million for corporations, \$600,000 for officers, and \$300,000 for workers and other persons.

Unlike Category 1 offences, Categories 2 and 3 offences do not have the element of recklessness and there is no provision for reliance on a 'reasonable excuse'. The elements in common are that there is a duty owed and that duty is breached. Category two, however, has an additional element, this being that the breach exposes a person to a risk of death or serious injury or illness. Category 2 and 3 offences do not attract a penalty of imprisonment, only a sliding scale of monetary penalties according to the status of the offender (corporation, officer, or other individual).

Under section 230(1AA) of the WHS Act 2011, proceedings for offences (other than category 1 offences) must be taken in a summary way. The provisions of the *Justices Act 1886* apply to these proceedings. Summary

proceedings are heard in the Magistrates Court¹⁸³ and may be commenced by the regulator or an inspector who has express written authorisation.

Conversely, prosecutions for category 1 offences are dealt with on indictment¹⁸⁴ and therefore are heard before the District Court. These matters are referred by the regulator to the Director of Public Prosecutions (DPP) – under section 230(4) the DPP also has the power to bring proceedings for an offence against the WHS Act 2011.

The reason Category 1 offences are referred to the DPP is that indictments can only be signed and presented to the court by a person holding a commission to prosecute, i.e. Crown Law officer, a Crown prosecutor or some other person appointed in that behalf by the Governor in Council.¹⁸⁵

A person can also be charged with manslaughter and prosecuted under the Criminal Code for a work-related fatality. The Criminal Code defines the offence of manslaughter as being the unlawful killing of a person under circumstances that do not constitute murder, i.e. without the intention to cause the death or grievous bodily harm of a person.¹⁸⁶ However, manslaughter is usually a result of a careless, reckless or negligent act. The maximum penalty for manslaughter is life imprisonment.¹⁸⁷

Industrial manslaughter provisions in other jurisdictions

Currently, the only Australian jurisdiction which has a specific industrial manslaughter type offence is the Australian Capital Territory. These offences are contained in part 2A of the *Crimes Act 1900 (ACT)* and commenced on 1 March 2004.

Part 2A of the *Crimes Act 1900 (ACT)* (the Crimes Act) contains two offences which in effect are industrial manslaughter offences. However, the term ‘industrial manslaughter’ is not defined, nor is it used in the substantive provision. These offences provide that employers (corporations) and senior officers can be prosecuted for the work-related death of workers and carry a maximum penalty of 20 years’ imprisonment. In addition, the WHS Act 2011 allows the acts of workers, officers and agents of a corporation to be aggregated to determine whether a corporation has been reckless or grossly or criminally negligent in causing the death of a worker, and to provide for the possibility of officers being prosecuted for recklessly or grossly negligently causing the death of a worker. These ‘industrial manslaughter’ offences are criminal offences. The standard of proof required to establish these offences is that of beyond reasonable doubt.

The rationale for addressing industrial manslaughter as a new and separate offence in the ACT was based on the view that the existing manslaughter provisions in criminal law could only be applied to individuals rather than to corporations. This meant that, before a corporation could be found criminally responsible, an individual director or employee must be identified as the directing mind and will of the corporation and have, in effect, committed the offence. This generally required proof of fault by a top-level manager or director that is difficult to establish in the case of large corporations, where offences are generally only visible at the middle-management level. Similar limitations exist for manslaughter under the Queensland Criminal Code.

In addition, under the Crimes Act, the only penalty for manslaughter is imprisonment (as is the case under the Queensland Criminal Code) – clearly this penalty can only apply to a natural person, not a corporation. Subsequently, the ‘industrial manslaughter’ provisions provide for maximum fines of \$200,000 and/or imprisonment for 20 year for corporate entities, and allow the courts to combine fines with orders for companies to undertake ‘community service’ projects, up to a total cost of \$5 million.

¹⁸³ Justices Act 1886 s 139.

¹⁸⁴ Criminal Code (Qld), ss 1, 3, 560.

¹⁸⁵ *Ibid*, ss560, 561.

¹⁸⁶ *Ibid*, s303

¹⁸⁷ *Ibid*, s310

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. Corporations are required to have management arrangements in place that positively promote safe systems of work.

The senior officer offence applies to senior officers of corporations, to executives and senior decision makers of other types of employers, such as unincorporated associations, and to Ministers of the Crown and senior executives of government bodies. In the case of corporations that are also government entities, such as territory-owned corporations, both senior corporate officers and senior government officers, such as Ministers, may be held responsible for an offence.

Similarly, there are industrial or corporate manslaughter offences in Canada and the United Kingdom (UK).

In Canada, federal legislation which came into effect in 2004 amending the Canadian Criminal Code (Bill C-45) established new legal duties for workplace health and safety, and imposed serious penalties for violations that result in injuries or death.¹⁸⁸ The legislation provided new rules for attributing criminal liability to organizations, including corporations, their representatives and those who direct the work of others. Penalties include terms of imprisonment for responsible persons, including corporate officers.

In the UK, corporate manslaughter was introduced in April 2008. As outlined in the *Report into the Referral of the Work Health and Safety (Industrial Manslaughter) Amendment Bill*:

“The UK Corporate Manslaughter and Corporate Homicide Act 2007 applies to corporations, departments, partnerships and employer as well as employee associations that cause the death of a person resulting from a gross breach of a duty of care below that reasonably expected in the circumstances... Prior to the enactment of the Corporate Manslaughter and Corporate Homicide Act, an organisation could only be convicted of manslaughter if a person who was the 'directing mind' of the organisation such as a senior individual was also guilty of an offence (the identification principle), which meant that smaller companies were most likely to be charged.”¹⁸⁹

Design and statutory location of the offence

There are two statutes in which an offence of negligence causing death could appropriately be placed. The first is within the WHS Act 2011, the second the Queensland Criminal Code.

Upon analysis of the two statutes it is considered that the WHS Act 2011 would be the most appropriate on the basis that it provides for imputing a person's conduct to a corporate entity.

Sections 244, 245 and 251 of the WHS Act 2011 apply to bodies corporate, States and the Commonwealth, and public authorities respectively ('organisation'). These sections apply where there is an employee/agent/officer ('individual') of the relevant organisation who engages in conduct either within the actual or apparent scope of their employment, or within their actual or apparent authority. In these circumstances, any conduct by the individual is to be taken to be conduct by the organisation.

This imputation also applies to proving elements of an offence that need to be proved, e.g. knowledge, intention, and recklessness. Likewise, any (reasonable) mistake of fact made by the individual is attributable to the organisation.

This mechanism (imputing individual conduct to an organisation where the criteria are met) enables the relevant elements of an offence to be proved in prosecution for an offence, e.g. a category 1 offence.

¹⁸⁸ <http://www.ccohs.ca/oshanswers/legisl/billc45.html>

¹⁸⁹ Parliamentary Committee on Occupational Health and Safety, Rehabilitation and Compensation, 1 November 2016, p.17.

Prosecution of the organisation would not prevent prosecution of the individual where the conduct of the individual in failing to comply with their own duties (e.g. as an officer or worker) could also be imputed to the organisation. Of course, if the individual acted outside the scope of their employment or authority, they could still be prosecuted.

Conversely, the Criminal Code does not have any provisions analogous to those in the WHS Act 2011 regarding imputation of conduct to a corporate entity. Of course, responsible individuals (chief executive officers and the like, or even workers) could be prosecuted for manslaughter, even if they are also prosecuted under section 31 of the WHS Act 2011 for a failure of a duty.¹⁹⁰

Findings

As previously identified, there are long standing entrenched views from stakeholders regarding the offence of industrial manslaughter which are unlikely to change or resolve the debate. It is however the view of the Review that, following consultation and research, a case supporting the introduction of an offence of negligence causing death can be made. In particular, it is considered that, despite the view of some stakeholders, there is a gap in the current offence framework as it applies to corporations, specifically that existing manslaughter provisions in the Queensland Criminal Code only apply to individuals as opposed to corporations which makes it challenging to find a corporation criminally responsible. Additionally, a new offence is considered necessary and appropriate to deal with the worst examples of failures causing fatalities, the expectations of the public and affected families where a fatality occurs, and to provide a deterrent effect. In May 2017, the Queensland Government provided in principle support for this view.

In terms of terminology, it is the view of the Review that the offence should be that of 'negligence' causing death as opposed to 'gross negligence' causing death. The rationale for this view is that gross negligence has a particular legal meaning that requires more than negligence. The consequence of this is that it may make prosecutions more difficult to pursue and may be the reason minimal prosecutions have been pursued in jurisdictions who have industrial manslaughter provisions. Subsequently, proving negligence to the criminal standard of proof is considered to be the appropriate framing for the new offence.

The review believes it is important, from the point of view of the public message sent in relation to the new offences, that they be called 'industrial manslaughter'.

In terms of the design and statutory location of the offence, as previously stated, the Review considers the offence would be best placed in the WHS Act 2011 on the basis that it would send a clear message to PCBU's about the standard of safety required and the expectation on senior management to proactively manage health and safety risks. Additionally, the provisions under the WHS Act 2011 relating to the imputation of an individual's conduct to a corporation will ensure corporations are liable and reduce barriers to attributing criminal liability to a corporation in instances involving the most serious health and safety breaches. It is appropriate to provide for a maximum custodial sentence that matches the equivalent offence in the *Crimes Act* and for a greatly increased maximum fine for a body corporate. These measures will allow sentencing judges to have the appropriate scope to adequately deal with the worst examples of corporate or individual behaviour.

While it will be necessary to seek the advice of the Queensland Parliamentary Counsel in drafting the appropriate Bill, the Review believes that the drafting in Sections 45C and 45D of the *Crimes Act 1900* (ACT) is a relevant and appropriate reference point for the drafting of the proposed Queensland offences.

¹⁹⁰ Criminal Code (Qld) s 16.

Recommendation:

46. That:

- a. two new offences be created in the *Work Health and Safety Act 2011* to give effect to the policy decision to create the offence of negligence causing death to be called 'Industrial Manslaughter' in line with the following objectives:
 - create a 'senior officer' offence and an 'employer offence' where conduct negligently or recklessly causes death of a worker;
 - apply the existing standard in Queensland law for criminal negligence;
 - ensure that prosecution decisions in relation to these offences by the new Director of Work Health and Safety Prosecutions is subject to DPP approval as for Category 1 offences and that the DPP may take over any prosecutions under these sections; and
 - provide for the same maximum custodial sentence for an individual as available for manslaughter under the Criminal Code (life imprisonment) and a fine of up to 100 000 penalty units (\$10 million) for a body corporate.
 - b. the Queensland Government consider making equivalent amendments to *Electrical Safety Act 2002* and the *Safety in Recreational Water Activities Act 2011* which mirror the offence provisions in the *Work Health and Safety Act 2011*.
-

6.2 Penalties for work-related fatalities and injuries

The structure of offences and the penalty amounts in Queensland changed significantly when the national model work health and safety legislation was implemented in January 2012.

Under the WHS Act 1995, penalties were aligned with the number of fatalities and/or severity of the injury. Under the WHS Act 2011, penalties are based on the behaviour or issue rather than the outcome, and the penalties were increased substantially to:

- be proportionate and relevant to the seriousness of the conduct and reflect the consequences that may result from failure to remedy serious risks to health or safety, i.e. risk to personal safety and potential loss of life arising from any breaches;
- reflect the recommendations from the national review of work health and safety legislation to strengthen the deterrent effect of the penalties;
- extend the ability of the courts to impose more meaningful penalties, where appropriate; and
- emphasise to the community the seriousness of the offences under the work health and safety legislation.

In comparison with penalties under the WHS Act 1995, the maximum fines under the WHS Act 2011 are four times greater for corporations, officers and PCBUs as individuals. Under categories 1 and 2, offences and penalties for workers have doubled in most instances. Penalties are a maximum and the courts retain their discretion to impose lesser penalties depending on the circumstances of the breach and mitigating factors. The maximum penalties under the WHS Act 1995 and WHS Act 2011 are shown below in Table 15.

Table 15 – Penalties under work health and safety legislation

WHS Act 1995	WHS Act 2011
Multiple deaths, maximum penalty: \$750,000 corporation \$150,000 individual;	Category 1 reckless conduct offence: \$3,000,000 corporation \$600,000 or 5 years imprisonment for an individual who is a PCBU or an Executive Officer \$300,000 or 5 years imprisonment for other individuals e.g. workers.
Single fatality, maximum penalty: \$375,000 corporation \$75,000 for an individual	Category 2 Failure to comply with health and safety duty and exposing a person to a risk of death or serious injury or illness: \$1,500,000 corporation \$300,000 for an individual who is a PCBU or an Executive Officer \$150,000 for other individuals e.g. workers.
General breach of duty of care, maximum penalty: \$225,000 corporation \$37,500 for an individual	Category 3 Failure to comply with health and safety duty: \$500,000 corporation \$100,000 for an individual who is a PCBU or an Executive Officer \$50,000 for other individuals e.g. workers.

Penalties in other jurisdictions

New South Wales, South Australia, the Australian Capital Territory, the Northern Territory and Tasmania have all adopted the model work health and safety laws and have the same offences and penalties as Queensland.

Victoria and Western Australia have not adopted the model laws and their offences and penalties differ from those in Queensland and the other harmonised states. In Victoria penalties for a general breach of a duty of care and reckless endangerment are similar to the maximum penalties for Category 1 and 2 offences in Queensland. Victoria increased the maximum penalty for reckless endangerment by a body corporate to \$3,109,200 (20,000 penalty units) on 29 June 2016. The maximum penalty for an individual for reckless endangerment was not changed.

Like Queensland, Western Australia has three categories of offences however the maximum penalties are much lower. The maximum penalty for a breach involving gross negligence by a body corporate is \$500,000 for a first offence and \$625,000 for subsequent breaches, significantly lower than the maximum penalty of \$3,000,000 for reckless conduct by a body corporate under the WHS Act 2011.

Penalties and the Courts

A significant increase in maximum fines under legislation does not mean courts will automatically increase the level of fines they impose. The increase in penalties under the WHS Act 2011 has taken time to be reflected in the penalties imposed by the courts. Courts are more likely to impose fines around the same level as they have for previous matters with only incremental increases. This has not been such an issue in other jurisdictions as they had substantially higher penalties prior to the model work health and safety laws. For example, New South Wales had a maximum penalty for reckless conduct causing death of \$1,650,000 for a corporation under their repealed legislation and South Australia had a maximum fine for risk of death or serious harm of \$1,200,000 for a corporation.

Importantly, however, in a recent landmark decision, the Queensland District Court found that an employer's fatality-related fine should have been nearly 40% higher than the one imposed, after examining cases from other harmonised jurisdictions.¹⁹¹ The District Court accepted WHSQ's submission that the WHS Act 2011

¹⁹¹ *Williamson v VH & MG Imports Pty Ltd* [2017] QDC 56.

permitted sentencing courts to have regard to decisions from other harmonised states and territories, given that the main object of the WHS Act 2011 was to provide for a “balanced and nationally consistent framework” for work health safety.¹⁹² Referring to similar cases in New South Wales and South Australia – with penalties between \$87,500 and \$425,000, the District Court judge found that the company should have been fined roughly \$250,000 based on an appropriate range of \$200,000 to \$400,000 “depending on the circumstances of the case”. However, the judge found it was necessary to ameliorate the penalty that would otherwise be appropriate for a number of reasons, including that this was the first appeal “to address the issue of the harmonised national work health and safety laws”. Consequently, the employer was re-sentenced with a fine of \$125,000 as opposed to the initial \$90,000 fine.¹⁹³

Additionally, amendments to the *Penalties and Sentences Act 1992* came into effect on 9 May 2016 that reinstate the ability of a court to receive submissions from parties to the proceedings on the range of penalties the party considers appropriate to be imposed. This allows WHSQ to provide submissions to the court on the appropriate penalty range.

Stakeholder feedback

In responding to the issue of whether the current penalties under the WHS Act 2011 are an effective deterrent and proportionate to the seriousness of the offence, stakeholder views were largely polarised. Employer representatives considered the current regime to be appropriate and that increasing penalties would have minimal effect on deterring non-compliance. In particular, the AiGroup claimed that it is:

*“...simplistic and unacceptable to consider imposing higher penalties simply by reference to the number of fatalities involved in an incident...”*¹⁹⁴

And that:

*“It is reasonable to expect following the recent appeal decision in Queensland [that] this may lead to a significant increase in penalties.”*¹⁹⁵

MBAQ also claimed that:

*“Better education, accurately focused compliance campaigns, keeping codes of practice up to date, having an active and experienced inspectorate and providing balanced advice and punitive options are a far more effective deterrent [than increasing penalties], and is more likely to result in improved safety outcomes”.*¹⁹⁶

Conversely, other stakeholders including the AMWU, the Queensland Law Society and the Australian Lawyers Alliance criticised the current regime and noted that penalties imposed since the introduction of the WHS Act 2011 have been inadequate. They stated that it is not clear that penalties for reckless conduct are proportionate, particularly in matters involving fatalities. In particular, the Australian Lawyers Alliance stated that:

*“The fines actually imposed for breaches of the WHSA where a worker has been killed at work in Queensland appear to typically range between \$90,000 and \$160,000. This is seriously inadequate.”*¹⁹⁷

¹⁹² Ibid.

¹⁹³ Ibid.

¹⁹⁴ Australian Industry Group submission, p3.

¹⁹⁵ Ibid.

¹⁹⁶ Master Builders Queensland submission, p10.

¹⁹⁷ Australian Lawyers Alliance submission p.7.

Further:

“...there is a requirement for [mandatory] sentencing guidelines or at the very least ‘suggested’ penalties in the vein that occurs in the UK so that judicial officers are given specific guidance about the appropriate sentencing range.”¹⁹⁸

It was further raised by the AWU and the Australian Lawyers Alliance that the effectiveness of penalties as deterrent to non-compliance is significantly undermined if insurance companies, rather than employers, are able to pay fines. In particular, the AWU submitted that:

“Evidence from legal practitioners who regularly represent employers in WHSQ prosecutions indicates that it is insurance companies rather than employers that are often paying fines following successful prosecutions. The issue of whether a penalty is adequate or should be increased is not particularly relevant if the employer is not in fact paying the fine”¹⁹⁹.

The Australian Lawyers Alliance also submitted that:

“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”²⁰⁰.

Members of the Families Forum, which is comprised of families affected by work-related fatalities, also indicated that if penalties are capable of being paid by insurance companies or used as tax deductions, then this should not be allowed. The Families Forum also expressed a general view that penalties ordered by the courts in relation with fatalities and serious incidents were too low, and inconsistent with the severity of impact on workers and their families.

Payment of work health and safety penalties by insurance companies

Under the current work health and safety laws in Queensland, there is no express provision that prohibits contracts being entered into for liability insurance against penalties imposed for breaches of the WHS Act 2011. Section 272 of the WHS Act 2011 goes so far as to prohibit contracting out of, or transferring, duties under the WHS Act. However, as liability insurance neither limits or transfers duties under the WHS Act 2011, and the duty is still the duty of the duty holder, it is considered to be unlikely that a contract for directors and officers liability insurance would be a contravention of section 272. The applicability of section 272 to these type of insurance contracts is also yet to be considered by the courts.

Entering into a contract for directors and officers liability insurance which covers failure to comply with a regulation or law is also considered to be permissible under the *Corporations Act 2001* (the Corporations Act). Specifically, section 199B of the Corporations Act permits contracts for director and officer liability insurance to be entered into provided the policy does not cover liability for wilful breaches of a duty. Effectively this means that an insurance policy can cover the payment of statutory penalties and fines under the WHS Act 2011, so long as the breach was not intentional.

From a public policy perspective, there is conjecture about whether insurance policies covering failure to comply with a regulation or law would be held to be contrary to public policy and therefore be considered illegal or void. There is a view from stakeholders who submitted to this review that this is the case, however this issue is yet to be considered by the courts.

¹⁹⁸ Ibid.

¹⁹⁹ Australian Workers' Union submission, p.3.

²⁰⁰ Australian Lawyers Alliance submission p.6.

In the matter of *Hillman v Ferro Con (SA) Pty Ltd (in liq) and Anor*²⁰¹ the Magistrate became aware that the director involved was covered by insurance for the payment of fines imposed by the court, however the magistrate was not required to consider whether the insurance contract itself was valid. The Magistrate did, however, note that existence of the insurance “undermined the Court’s sentencing power by negating the principles of both specific and general deterrence”²⁰².

The *Hillman* case highlights that there is a view from the Court’s that such insurance contracts have a detrimental impact on the effectiveness of penalties to act as a deterrent to non-compliance however whether these contracts are contrary to public policy, and therefore void, is still yet to be considered. Unfortunately, such consideration by the Courts is unlikely as it is not in the commercial interest of an insurer to question the validity of their own product nor is it likely those insured will challenge the validity of a contract they may want to claim on.

Options

To address this issue, stakeholders have suggested that either of the following approaches could be taken:

1. A legislative requirement could be imposed that would require a defendant to disclose to the court if they are insured against fines or pecuniary penalties. Where such insurance exists, the court should be enabled to impose significantly higher fines or alternative sentences.
2. Alternatively, similar to the *Health and Safety at Work Act 2015 (NZ)* (the NZ Act), the WHS Act 2011 could be amended to make it unlawful to insure against fines or penalties in a work health and safety prosecution.

Under section 29 of the NZ Act, it is unlawful to insure against fines. Specifically, section 29 states:

29 Insurance against fines unlawful

- (1) *To the extent that an insurance policy or a contract of insurance indemnifies or purports to indemnify a person for the person’s liability to pay a fine or infringement fee under this Act,—*
 - (a) *the policy or contract is of no effect; and*
 - (b) *no court or tribunal has jurisdiction to grant relief in respect of the policy or contract, whether under section 7 of the Illegal Contracts Act 1970 or otherwise.*
- (2) *A person must not—*
 - (a) *enter into, or offer to enter into, a policy or contract described in subsection (1); or*
 - (b) *indemnify, or offer to indemnify, another person for the other person’s liability to pay a fine or an infringement fee under this Act; or*
 - (c) *be indemnified, or agree to be indemnified, by another person for that person’s liability to pay a fine or an infringement fee under this Act; or*
 - (d) *pay to another person, or receive from another person, an indemnity for a fine or an infringement fee under this Act.*
- (3) *A person who contravenes subsection (2) commits an offence and is liable on conviction,—*
 - (a) *for an individual, to a fine not exceeding \$50,000;*
 - (b) *for any other person, to a fine not exceeding \$250,000.*

Section 29 of the NZ Act not only declares contracts for insurance against the payment of fines and penalties to be void, but also makes it an offence to enter into such a contract. The benefit of this approach is that it ensures such contracts are void, and also enables parties that enter into such a contract to be prosecuted.

²⁰¹ [2013] SAIRC 22.

²⁰² *Ibid* at [80].

This would open the doors for the courts to consider the public policy implications of such contracts which is currently hindered by the unlikelihood that either the insurer or insured would challenge the validity of the contract.

Findings

The issue of whether the current penalties under the WHS Act 2011 are an effective deterrent and proportionate to the seriousness of the offence is very much polarised. Understandably, there is a view from stakeholders that the current penalties imposed by the courts are low and considered inadequate. It is important to note however that increasing penalty levels under the WHS Act 2011 will not necessarily equate to increased penalties imposed by the courts, as has been clearly seen since the introduction of the WHS Act 2011.

The issue is that Queensland courts, in line with some other areas of law, have shown a tendency to sentence at a lower level than some courts in other jurisdictions (in respect of both fines and custodial sentences). The outcome from the District Court decision *Williamson v VH & MG Imports Pty Ltd* may, however, go a long way to ensuring that, at a minimum, penalties imposed in Queensland are at least proportional to those imposed for similar offences in harmonised jurisdictions.

Additionally, the Review is of the view that a greater use of the existing discretion of the courts to impose existing penalties would be appropriate. This may be aided by adopting a similar approach to the work health and safety laws in the United Kingdom where discretionary sentencing guidelines provide judicial officers with specific guidance about an appropriate sentencing range. Adoption of such guidelines should be developed nationally to encourage a consistent approach across all harmonised jurisdictions.

In relation to the issue of work health and safety penalties being paid by insurance companies, it is the view of the Review that the ability for duty holders to insure themselves against fines or pecuniary penalties imposed for work health and safety offences:

- undermines the sentencing process and justice system;
- undermines the deterrence effect of the current penalty regime under the WHS Act 2011; and
- is likely to have a significant detrimental impact on the health and safety of workers due to lack of fear it creates for the consequences of failing to comply.

While the effect of increased fines and alternative sentences for holding insurance against work health and safety penalties and fines has the potential to discourage such insurance contracts being entered into, it is the view of the Review that a more effective solution is to expressly prohibit such contracts being entered into in the first place. While this is the preferred position of the Review, other steps such as requiring disclosure to a court in relation to the existence and effect of a policy would also have some utility.

Recommendations:

47. In relation to the payment of work health and safety penalties and fines by insurance companies, that:
 - a. the *Work Health and Safety Act 2011* be amended to expressly prohibit insurance contracts being entered into which cover the cost of work health and safety penalties and fines;
 - b. contravention of the prohibition to enter into an insurance contract which covers the cost of work health and safety penalties and fines should be made an offence;
 - c. section 29 of the *Health and Safety at Work Act 2015 (NZ)* be considered as a model for the new statutory requirement; and
 - d. similar amendments be considered for the *Electrical Safety Act 2002* and *Safety in Recreational Water Activities Act 2011*.
48. The new Director of Work Health and Safety Prosecutions (refer to recommendation 31) adopt a strategy to seek to increase the penalties ordered by the courts in appropriate cases over time.

49. In view of inter-state differentials, the Queensland Government seek to include in the 2018 review of the national model work health and safety laws consideration of the development of sentencing guidelines that outline 'suggested penalties' to apply in all jurisdictions. The UK Health and Safety Offences, Corporate Manslaughter and Food Safety and Hygiene Offences Definitive Guideline could be used as a starting point for development of such guidelines.

6.3 Further measures

In response to the issue of whether there were any other measures that could be taken to discourage unsafe work practices, the following topics were identified by the Review or raised by stakeholders:

- Health and Safety Representatives;
- Work Health and Safety Officers;
- Right to information;
- HSRs' right to access employer information;
- WHSQ's response to, and notification to industry of, serious incidents; and
- expanding the role of the proposed new labour hire inspectorate to include dual work health and safety powers.

Each of these matters will be discussed in turn.

6.3.1 Health and Safety Representatives

Stakeholder consultation has identified opportunities for WHSQ to support and grow the compliance capability of HSRs as an area for attention. The QCU is of the view that a greater emphasis, in terms of training, funding and protection of HSRs is necessary to bring about improvement in compliance in the workplace, and advocates that WHSQ should fund programs and initiatives focussed on actively assisting and promoting the role of elected HSRs and HSR committees in the workplace. Similar views have been expressed in the submission by the QNMU which values HSR training but notes its lack of compulsory nature impedes a HSR from carrying out functions without the threat of reprisal. In this context, the QNMU has called for increased statistical information on provisional improvement notices (PINs) by contemporaneous provision of all PINs issued to WHSQ. This will provide a more comprehensive reporting system reflective of the true extent of workplace hazards and incidents. Other submissions have acknowledged the value of HSRs but noted the underuse of this resource by WHSQ in terms of resources allocated to provide training (Queensland Law Society) and general failure of inspectors to draw on HSRs as a pseudo regulator (Professor Richard Johnstone).

HSR concept and support

HSRs facilitate worker voice for health and safety matters in the workplace. The benefits of worker participation are well-documented in academic literature, for instance Frick (2011)²⁰³ refers to the findings of Walters and Nichols (2007) that

- worker participation has a positive effect on work health and safety outcomes;
- any worker participation is good for work health and safety;
- participation through elected representatives with sufficient rights is even better; and
- union support for HSRs and worker participation achieves the best results.

Walters and Nichols report that, for HSRs to be effective, they must not be too dependent on management attitudes and this is why it important that HSRs are elected and given rights to paid time to carry out their function, and access to all relevant information.

²⁰³ Frick, K. (2011). Worker influence on voluntary OHS management systems—A review of its ends and means. *Safety Science*, 49(7), 974-987.

MacEachen et al. (2016)²⁰⁴ found, in their systematic review, that since management inherently hold more power than workers, worker involvement and influence was stronger when the HSR was effective in giving voice to worker concerns, rather than acting in a workplace inspector role.

Frick takes this further and explains that for HSRs to influence managers they have access to three types of means:

- normative power: to advise, inform and convince managers to follow their suggestions;
- economic power: to back up their requests with possible economic benefits, such as reduced labour costs, increased motivation and/or productivity or less worker turnover; and
- physical power: HSRs often have a right to alert the labour inspection and can then (at best) press the inspectors to require improvements, and these are supported by the state's legal enforcement.²⁰⁵

Frick further states that HSRs mostly use normative power. This is most effective in an organisation which has an active and systematic approach to work health and safety management. This is supported by HSRs who have:

- sufficient rights to act as representatives (including paid time for training, information, inspection of work health and safety conditions, and meeting and getting answers from management); and
- good arguments to convince managers, based on research and development about work health and safety risks (as gained through ongoing education and training).

The latter point emphasises that HSR training needs to extend beyond the legal aspects of being a HSR and encompass training about systematic work health and safety management and training specific to the hazards and risks present in the specific industry and effective controls for those hazards and risks.

In summary, properly trained and supported HSRs, who are working in an organisation which has a comprehensive and active work health and safety management system in place, will provide support for good health and safety outcomes through effectively representing and giving voice to workers in the organisation.

Legislative framework

Legislative requirements for HSRs are contained in Part 5, Division 3 of the WHS Act 2011. Section 68, which outlines the powers and functions of HSRs, is of particular relevance when considering WHSQ efforts to support HSRs. The powers and functions under section 68(1) indicate a pseudo inspector role concentrated to the workgroup represented (e.g. to monitor measures, investigate complaints or inquire into anything that appears to be a risk to the health and safety of workers arising from the conduct of the business or undertaking). It is the detail in section 68(2) around how a HSR may exercise these powers or functions that provide supportive opportunities for WHSQ. For instance, a HSR may:

- accompany an inspector during an inspection of the workplace;
- with appropriate consent, be present at an interview concerning work health and safety between the worker or group of workers represented and an inspector;
- request the establishment of a health and safety committee;
- receive information concerning the work health and safety of workers in the work group;
- whenever necessary request the assistance of any person;
- direct work to cease in certain circumstances; and
- issue provisional improvement notices.

²⁰⁴ MacEachen Ellen, A. Kosny, Christian Ståhl, F. OHagan, L. Redgrift, S. Sanford, C. Carrasco, Tompa Emile and Q. Mahood, Systematic review of qualitative literature on occupational health and safety legislation and regulatory enforcement planning and implementation, 2016, Scandinavian Journal of Work, Environment and Health, (42), 1. <http://dx.doi.org/10.5271/sjweh.3529>.

²⁰⁵ Above 203, p 983.

The *Work Health and Safety and Other Legislation Amendment Bill 2014* omitted the previous section 74(2) of the WHS Act 2011, thereby removing the requirement for a PCBU to provide a list of HSRs and deputy HSRs for each work group to the regulator. The reasons cited related to the then Queensland Government's goal of reducing red tape and regulatory burden for business, and concerns raised by business representatives about the cumulative compliance costs associated with red tape and the preference to reduce this burden where it could be achieved without reducing safety standards. Pursuant to this, since 2014, there are no legislative requirements for workplaces to notify the regulator when a HSR is elected. This creates a gap in the ability of WHSQ to directly connect with HSRs and provide advice and support on a proactive basis.

WHSQ efforts to support HSRs

WHSQ efforts to support HSRs primarily rely on the HSR-inspector interface in the course of inspectorate activity and web-based dissemination of information. These efforts are detailed below.

HSRs invited to accompany WHSQ inspectors on workplace inspections and attend relevant interviews

WHSQ inspectors interact with HSRs in differing forums. For example, when attending Major Hazardous Facility and Dangerous Good sites, the HSR is always asked to accompany the inspector during the site inspection and is present when workers are asked to provide details about any health and safety concerns. More routinely, all WHSQ and ESO inspectors have been instructed, via an operational procedure, to inform the relevant HSR of the presence of the inspector upon entry to the workplace. This instruction gives effect to sections 164(2) of the WHS Act 2011 and section 138A(2) of the *Electrical Safety Act 2002*, and requires the inspector to "...inform the relevant HSRs of their rights under s68(2) of the WHS Act on the first occasion of meeting with the HSR and, for each inspection, offer the HSR(s) the opportunity to accompany the inspector in relation to the matters affecting the HSR's work group." During these interactions, HSRs may discuss with the inspector any work health and safety issues, including those relating to their function to request the establishment of a health and safety committee and any information concerning the work health and safety of workers in the work group.

WHSQ/ESO website and electronic newsletter

Without a list of appointed HSRs, outside of workplace visits, the WHSQ and ESO website becomes the point of contact between WHSQ and HSRs. Presently, the WHSQ website contains a range of advice and information specific to the election, training and duties of HSRs, in addition to the broader advice contained in case studies, and hazard and industry based information. HSRs can also subscribe to the work health and safety and electrical safety newsletters online for general work health and safety and electrical safety information.

Cessation of work

Where an inspector is required to attend a workplace to resolve a matter relating to the cessation of unsafe work, the WHSQ operational procedure for the cessation of unsafe work includes discussions with the HSR as means to inform the inspector of the particulars of the matter. The procedure specifically instructs inspectors to "[d]iscuss the issue with any relevant person. This may include any relevant HSR if a worker has ceased or refused to carry out the work."

Provisional Improvement Notices

Where a request is received to review a PIN, WHSQ reverts to the HSR in the first instance for a resolution to the issue/s. This practice seeks to reinforce the role of the HSR in the workplace by reverting to them to consider the issues raised and cancel or make minor changes to the PIN or clarify matters such that the request for the PIN review is withdrawn. Where the request for the PIN review continues and an inspector attends a workplace to inquire into the circumstances of the PIN, WHSQ policy is for the inspector to make

contact with the HSR first to obtain as much information about the basis on which the PIN has been issued before discussing the matter with the person who requested the PIN review.

Other forums where information and support is provided to HSRs

WHSQ has established a number of networks with industry and union groups where information and support is provided to delegates and in turn to HSRs. For example, HSRs participate on a regular basis in the Construction Industry Leadership Networking Forum on topical subjects and have encouraged their managers to also participate. The Construction Strategy Unit of WHSQ also attends and presents at regular meetings hosted by unions for HSRs in the construction industry on a variety of topics including drafting PINs, election of HSRs, legislative updates, young worker safety and regular campaign updates. HSRs have also attended the Construction Work Health forum and benefited from information presented by keynote speakers, industry case studies, expert panel discussion and workshops. WHSQ is finalising the development of a two-year initiative commencing in 2017 expected to lead to the development of resources to build the capability of HSRs in the construction industry (e.g. case studies, self-assessment tools, workshops, information sessions, and reviewing training).

The IPaM Program also embeds legislative requirements for HSRs in the reviews of employer safety management systems. Specific elements of audit include whether workers have been informed of their right to elect a HSR, election processes comply with the provisions of the WHS Act 2011, training has been provided when requested and whether any Health and Safety Committees established at the request of a HSR complies with the requirements of the WHS Act 2011.

WHSQ has a number of specific industry interventions which include supporting HSRs and safety committees to work to their full potential as intended by the legislation. Current examples include the *Queensland Civil Construction Industry Action Plan 2014 – 2017*, the *Queensland Construction Trades Industry Action Plan 2014 – 2017*, and the Construction Work Health forum 2016.

WHSQ has indicated that it is currently looking at ways to better capture HSR information so that relevant and timely advice and education can be disseminated, and WHSQ assistance requested as needed.

Supplementary matters

Supplementary matters for consideration have arisen independent of the terms of reference of the Review and issues identified during the stakeholder consultation process. These supplementary matters relate to mandated compulsory training for HSRs and entry permit requirements for persons providing assistance to HSRs.

Mandated compulsory training for HSRs

The Minister for Employment and Industrial Relations referred Petition 2685-2017, requesting an amendment to the WHS Act 2011 to mandate compulsory training for HSRs, for consideration as part of the review process. Existing provisions of the WHS Act 2011 entitle a HSR to attend an initial training course of five days and one day's refresher training each year, although it is not mandatory. If a HSR makes a request to attend this training, the PCBU must allow them to attend.

Currently, the WHS Act 2011 allows a HSR to carry out some, but not all, functions without training. The PCBU must allow each representative paid time off to attend training, equivalent to the entitlements they would normally receive for working during that period. The WHS Act 2011 does not impose mandatory duties on HSRs to carry out all of their powers and functions, affording the HSR the ability to choose which of their potential powers and functions they wish to exercise.

In addition to their training entitlement, the PCBU must provide any resources, facilities and assistance that are reasonably necessary to enable the representative to carry out functions and exercise their powers. While training is beneficial and encouraged, an untrained HSR can still perform all their functions except for those

relating to the issuing of PINs and directing work to cease. Where a decision on training cannot be reached between the PCBU and the HSR, either party can ask an inspector to decide on the matter as a reviewable decision under the WHS Act 2011.

Entry permit requirements for persons providing assistance to HSRs

An appeal by the Australian Building and Construction Commission upheld by the Federal Court on 2 June 2017²⁰⁶ has implications for entry permit requirements for persons providing assistance to HSRs. The Full Court of the Federal Court unanimously confirmed that where a State work health and safety law allows a HSR to invite a union official on to site to assist them, the union official must personally hold a valid federal right of entry permit under the *Fair Work Act 2009* (FW Act). The case related to invitations by a HSR under sections 58 and 70 of the Victorian *Occupational Health and Safety Act 2004*. Equivalent provisions are contained in section 68(2)(g) of the WHS Act 2011 permitting HSRs to request the assistance of any person and section 70(1)(g) requiring the PCBU to allow a person assisting a HSR to have access to the workplace if it is necessary for the assistance to be provided. These sections have not traditionally been considered as ‘right of entry’ provisions to which section 494 of the FW Act relating to the exercise of State or Territory work health and safety rights, applies.

The full court considered that there was no policy or “common sense reason” for distinguishing between provisions which provide entry rights to investigate a suspected work health and safety contravention and for those assisting a HSR with a work health and safety matter, which may be connected to such a contravention. The court’s justification for reaching this view was to provide a clear, common sense interpretation that could be applied practically, without fine distinctions on the characterisation of the entry to a site and noted that to treat them differently would “lead to practical confusion at the workplace site in circumstances where such confusion may lead to allegations of trespass and the involvement of police”.

As a result of this decision, union officials wanting to enter a site to provided assistance to a HSR in Queensland will need to hold an entry permit under the FW Act. This decision only affects union officials who do not currently have a FW Act permit or have had their permit revoked or suspended or if the person has been disqualified from holding a permit. It has no bearing on the ability of a HSR to request assistance from other specialists who are not union officials.

Relatedly, the PCBU has the right, under section 71(4) of the WHS Act 2011, to refuse entry to a union official assisting a HSR if they have had their entry permit revoked, suspended or the person is disqualified from holding a permit. A PCBU can also refuse entry on any reasonable grounds under section 71(5) of the WHS Act 2011, in which case the HSR may draw on section 71(6) of the WHS Act 2011 to ask the regulator to appoint an inspector to assist in resolving the matter.

The Federal Court’s decision may also have implications for the issues resolution process provided under section 81 of the WHS Act 2011. Section 81(3) provides that “a representative of a party to an issue may enter the workplace for the purpose of attending discussions with a view to resolving the issue”, and that a union official can be such a representative. It is possible that, on the Full Court’s interpretation of the Victorian work health and safety Act and FW Act, such a union official must also hold a FW Act permit.

Findings

While there is clear evidence of the important role HSRs can play in improving and maintaining safety performance at a workplace, it is the view of the Review that there is insufficient emphasis by WHSQ on supporting HSRs to fulfil their role. Accordingly, it is the finding of the Review that further funding and support is required to actively assist and promote the HSR role. Such efforts could be tailored to the priority industries and undertaken as part of the industry action plan activities of WHSQ.

²⁰⁶ Australian Building and Construction Commissioner v Powell [2017] FCAFC 89.

The unavailability of a comprehensive list of current HSRs in Queensland workplaces also limits the breadth of support that can be provided by WHSQ. Tailored and targeted communications are only possible where the HSRs are known, and it is unknown whether WHSQ's current understanding of HSR appointments, as gleaned from inspector workplace visits, is reflective of industry-wide practice. In the absence of legislated provisions for HSR notification, it is likely that any intelligence relating to HSR appointments will continue to be less than comprehensive. Consequently, there is a need to reinstate the requirement for HSR appointments to be notified to the regulator to ensure WHSQ can direct access each HSR and proactively provide relevant support and information.

In relation to the training undertaken by HSRs, the current discretionary nature of course completion detracts from the important role HSRs have in securing work health and safety compliance. The WHS Act 2011 clearly embeds the role of HSRs. Further, as communicated in academic literature and in various stakeholder submissions, without proper education and training in this regard, HSRs are limited in their capacity to achieve baseline work health and safety outcomes, let alone advance towards best practice. For this reason, HSRs should be further supported in their role through the introduction of legislative provisions for mandatory HSR training required to be funded by PCBUs, both in terms of course fees and in-kind contributions of time for HSRs to attend the training course (as per current requirements for discretionary training). For the training to be effective, it should be completed within six months of a HSR being elected to the role and refreshed at three yearly intervals, as advocated in Petition 2685-2017.

In relation to PINs, these notices are an important record for HSRs to formalise health and safety changes required in the workplace. The scope and quantity of PINs issued by HSRs historically and in present time is unknown, due to nil legislated or otherwise notification requirements for PINs. If collected, information relating to PINs could be used as a supplementary evidence base for WHSQ, used to inform inspectorate activity, particularly in relation to the key HSR-identified hazards and risks within each industry sector. The same data could also be analysed to evaluate the effectiveness of PINs when considering the number of PINs issued and the outcomes solicited with and without inspector involvement through inspector PIN reviews.

The decision of the Federal Court in *Australian Building and Construction Commissioner v Powell* has significant potential to disturb existing arrangements as they apply in Queensland, particularly in respect of requests for assistance. The Review believes that the logic of the decision may produce a perverse outcome where union officials are subject to a different test than any other person if a worker requests their assistance. Given that the decision was recent, a concluded view on this has not been formed. However, the matter should be further considered and to ensure the status quo in Queensland is preserved.

Recommendation

50. WHSQ develop a comprehensive plan to support Health and Safety Representatives and Health and Safety Committees, and encourage uptake in industry, particularly within the priority industry sectors.
51. The *Work Health and Safety Act 2011* be amended to:
 - a. reinstate the repealed provisions relating to the requirement for a person conducting a business or undertaking to provide to the regulator with a list of Health and Safety Representatives and deputy Health and Safety Representatives for each work group;
 - b. require mandatory training for Health and Safety Representatives within six months of a HSR being elected to the role and refreshed at three yearly intervals; and
 - c. require persons conducting a business or undertaking to forward to the regulator a copy of all PINs issued by Health and Safety Representatives.
52. The Government further consider the decision in *Australian Building and Construction Commissioner v Powell* and, if necessary take steps to amend the *Work Health and Safety Act 2011* to ensure that the right to seek assistance is unaffected by permits. A possible amendment to achieve that objective may

be to clarify that any right created by the operation of section 70(1)(g) of the *Work Health and Safety Act 2011* is one for the worker concerned and not an invitee.

6.3.2 Work Health and Safety Officers

The reintroduction of Workplace Health and Safety Officers (WHS Officers), as existed under the WHS Act 1995, has been identified by a number of stakeholders as an area where the current work health and safety framework could be improved to enhance work health and safety outcomes in Queensland. In particular, representatives from the sugar industry indicated that industry would benefit from the reintroduction of the WHS Officer role.²⁰⁷ A Health and Safety Development Officer from the Townsville City Council also indicated that:

“... one area of the WHS legislation that has created greater exposure to risk at work was the removal of the requirement for businesses to employ WHS Officers (WHSO). It is my opinion as well as others in my circle, that since the requirement for businesses to hire licensed WHSO’s [sic] was removed, the compliance issues of many businesses has risen. There is a tendency to think that the requirement to elect HSR’s [sic] will somehow ensure compliance and many HSR’s [sic] don’t have business authority that a dedicated WHSO did. I like many others feel that the introduction of WHSO’s [sic] with not only the minimum employee requirement of 30 but also capping the number of employees per WHSO at something like 50 would help drive compliance.”²⁰⁸

In considering whether there were any other elements of the work health and safety legislative framework that should be reviewed to ensure it is effective in improving work health and safety outcomes, the Queensland Law Society also contended that it is prudent to consider whether the removal of the WHS Officer requirement in 2012 has had a negative impact on compliance and safety in Queensland workplaces.²⁰⁹

Workplace Health and Safety Officer concept

A WHS Officer, in effect, is a management appointee who performs a safety advocate role for a workplace. WHS Officers complete regulator-approved training and undertake legislated work health and safety functions to assess and improve the performance of a workplace. They are a designated safety resource for a workplace with some businesses previously establishing WHS Officers as a dedicated full time role, and others opting to integrate the WHS Officers role into a human resources, operational manager or other function.

WHS Officers are distinct from the HSRs required in current work health and safety legislation. HSRs are worker-elected and only appointed when requested by workers whereas WHS Officers were management-appointed and mandatorily appointed based on the number of workers employed. Whilst the functions of both WHS Officers and HSRs were/are legislatively prescribed, the WHS Officer role is focussed on informing and influencing management and workers about the health and safety performance of the workplace and enacting improvement across the organisation, whereas HSRs are limited in scope to providing an employee voice for work health and safety issues specific to the particular workgroup they represent.

²⁰⁷ Australian Industry Group submission, p1.

²⁰⁸ Email from the Health and Safety Development Officer, Townsville City Council, 18 May 2016.

²⁰⁹ Queensland Law Society submission, p.2.

Previous requirement for a Workplace Health and Safety Officer

From 1989 to 2011, Queensland had a mandatory statutory requirement for employers to appoint a qualified person as a WHS Officer where the workplace normally employed 30 or more workers and operated in the following industries:

- building and construction;
- community services;
- electricity, gas and water;
- financial, property and business services;
- manufacturing industry;
- public administration;
- recreational, personal and other services;
- retail and wholesale trade; and
- transport and storage.

This requirement evolved from the introduction of project safety officers in the *Construction Safety Act 1971* and most recently, was contained in the WHS Act 1995.

Under the WHS Act 1995, a qualified person meant a person who held a certificate or authority prescribed under a Regulation for appointment as a WHS Officer, and normally referred to a minimum of 30 workers being employed or likely to be employed at the workplace for a total of any 40 days during the current year. The WHS Officer provisions also required principal contractors to appoint a WHS Officer if they built a minimum of 30 domestic premises during the previous financial year, or if 30 or more persons worked at the workplace during any 24 hour period.²¹⁰

Under the WHS Act 1995, WHS Officers had the following functions:

- telling the employer or principal contractor about the overall state of health and safety at the workplace;
- conducting inspections at the workplace to identify any hazards and unsafe or unsatisfactory workplace health and safety conditions and practices;
- reporting in writing to the employer or principal contractor any hazard or unsafe or unsatisfactory workplace health and safety practice identified during inspections;
- establishing appropriate educational programs in workplace health and safety;
- investigating or assisting in the investigation of all workplace incidents at the workplace;
- helping inspectors in the performance of the inspectors' duties;
- reporting any workplace incident or immediate risk to work health and safety to the employer or principal contractor; and
- conducting, at specified intervals for the workplace, an assessment at the workplace to identify any hazards and unsafe or unsatisfactory workplace health and safety conditions and practices.²¹¹

Employers had various obligations under the WHS Act 1995 in support of these functions. In particular, they were obliged to consult with WHS Officers, provide them with information and resources, assist them in their duties and rectify the unsafe conditions and practices identified by the WHS Officers.

The training and certification requirements for WHS Officers were specified in section 57 of the *Workplace Health and Safety Regulation 2008*. WHS Officers were required to apply to WHSQ for a certificate of authority of appointment of a workplace health and safety officer. This certification was only granted upon successful completion of the approved workplace health and safety officer course or recertification course

²¹⁰ *Workplace Health and Safety Act 1995* s 94.

²¹¹ *Ibid* s 96.

by a registered training organisation, or if the applicant could demonstrate other qualifications or experience that would enable the applicant to satisfactorily perform the functions of a WHS Officer. WHSQ approved all WHS Officer certification and recertification courses as required under section 32 of the WHS Act 1995 to ensure the course provided adequate instruction about the legislated functions of WHS Officers.

The compulsory training was completed in two stages. Stage one involved a five day course covering core elements including work health and safety legislation, risk assessment, incident investigation, occupational health and hygiene, consultative arrangements and basic ergonomics. In Stage two, participants completed an industry specific module relevant to their industry of operation, choosing from industrial, construction or services. This state-mandated, sponsored and controlled training provided duty holders with assurance that competent work health and safety personnel were operating onsite in medium and large workplaces in Queensland where WHS Officers were legislatively required.

Impact of national harmonisation

The issue of WHS Officers was considered as part of the National OHS Review in 2009.

In its Submission to the National OHS Review, the Queensland Government proposed that WHS Officers be incorporated into the model work health and safety legislation. This proposal was based on strong stakeholder support and research which indicated the effectiveness of the WHS Officer framework.²¹²

In particular, the then Queensland Government asserted that:

“Employers benefit from having an appointed officer with OHS training, expertise and authority. Unions also find it highly beneficial to have a designated officer responsible for OHS at the workplace as it clarifies lines of communication and ensures that unions can quickly locate and liaise with OHS specialists at the workplace. WHS Officers also improve communication and cooperation between organisations and the OHS inspectorate.”²¹³

The submission outlined that in the Queensland experience, WHS Officers facilitated and assisted employers in ensuring legislative compliance and did not displace or reduce the WHS obligations of duty holders.²¹⁴ The Queensland Government’s submission also highlighted research demonstrating the value of WHS Officers in improving knowledge and understanding in workplaces about work health and safety issues.²¹⁵

The National OHS Review recommended that the model Act include provisions requiring a person conducting a business or undertaking to employ a suitably qualified person to provide health and safety advice.²¹⁶ It was recommended that these provisions be based on the Queensland WHS Officer model as Queensland was the only jurisdiction at the time with mandatory requirements for WHS Officers.

Ultimately, the Workplace Relations Ministers Council (WRMC) opposed this recommendation. The primary ground for opposing the incorporation for WHS Officers into the harmonised work health and safety laws was that an unintended consequence could result, such that persons conducting a business or undertaking would be encouraged to delegate their responsibilities.

Subsequently, the introduction of nationally harmonised work health and safety legislation in Queensland in 2012 saw the removal of the mandatory requirement for WHS Officers in Queensland workplaces.

²¹² National Review into Model Occupational Health and Safety Laws, Second Report, January 2009, p. 225.

²¹³ Queensland Government Public Submission to the National OHS Review, No. 32, p. 16; National Review into Model Occupational Health and Safety Laws, Second Report, January 2009, p225.

²¹⁴ Ibid.

²¹⁵ Ibid; Crittall J. (2001) *Review of the Workplace Health and Safety Act 1995: Issues Paper*, Division of Workplace Health and Safety, Queensland Government of Industrial Relations, December, p14.

²¹⁶ National Review into Model Occupational Health and Safety Laws, January 2009, Recommendation 139.

Findings

In both the consultation for the national harmonisation of work health and safety laws and the Review, stakeholders have consistently expressed support for mandatory legislative provisions for WHS Officers in Queensland. The recent support is of particular interest given it is unsolicited and has arisen in response to a general request to identify elements of the health and safety legislative framework that should be reviewed.

During the National OHS Review, the opposition to including WHS Officers into the harmonised work health and safety laws focused on the argument that mandating WHS Officers would encourage persons conducting a business or undertaking to delegate responsibility for work health and safety.²¹⁷ The Queensland experience and stakeholder feedback is contrary to this view, as the appointment of a WHS Officer does not diminish the work health and safety responsibilities of an employer or principal contractor given that a WHS Officer does not take on the obligations of the duty holder. Rather, WHS Officers adopt an advisory role accountable to senior management. There are no liabilities on the WHS Officer, whose role exists to facilitate and assist their employer to comply with work health and safety legislation.

It is the view of the Review that WHS Officers should be reintroduced in Queensland as a potential option for employers to enhance health and safety management at their workplace. The intention of this approach is for WHS Officers to be optional so employers can assess the appropriateness of engaging such an officer at their workplace. Employer should however be incentivised to engage WHS Officers by making it clear in the WHS Act 2011 that engagement of a WHS Officer can be used as evidence by a duty holder that steps have been taken to manage health and safety risks at their workplace. This incentive approach should be applied to employers who engage HSRs as well.

Recommendations:

53. The *Work Health and Safety Act 2011* be amended to provide a framework for the appointment of Work Health and Safety Officers. The appointment of Work Health and Safety Officers should not be mandatory. Work Health and Safety Officer provisions from the *Workplace Health and Safety Act 1995* could be used as a basis for the new framework.
54. As per the current arrangements for codes of practice under the *Work Health and Safety Act 2011*, the appointment of a Work Health and Safety Officer should be permissible as evidence that a duty holder has taken action to mitigate health and safety risks at a workplace. This should also apply to duty holders whose workplaces have an elected trained health and safety representative.

6.3.3 Right to information

In their submission to the Best Practice Review, the AWU identified difficulties in gaining access to relevant documents related to safety at Dreamworld. Their submission stated that:

“The management of the Right to Information (RTI) process within Workplace Health and Safety Queensland (WHSQ) has in our experience highlighted systemic issues within the disclosure process. In this context our experience relates specifically to the failure of the RTI process relating to our applications to access documents relating to safety at Dreamworld. The AWU initiated Right to Information applications following safety concerns raised by our organisers at the Dreamworld site. The AWU challenged the paucity of documents that were deemed fit for release, and the employer challenged the release of any documents. The Office of the Information Commissioner ... ultimately determined that a substantial number of documents should have been released. The reluctance to allow public disclosure of documents relating to workplace health and safety could lead to a perception that WHSQ does not operate in a transparent manner. Our experience suggests that rather than a pro-

²¹⁷ Ibid p225.

disclosure bias existing within WHSQ, a culture exists in which the views of the employer are prioritised at all stages of the RTI process. In a system that requires open and transparent processes, this culture is contrary to the best interests of workplace safety.”²¹⁸

Other stakeholders did not raise RTI as an issue.

Right to Information

The primary object of the *Right to Information Act 2009* (the RTI Act) is to give a right of access to information in the government’s possession or under the government’s control unless, on balance, it is contrary to the public interest to give the access. The object is intended to promote a ‘push model’ of information release, requiring agencies to proactively push information out to the community, with the goal of making formal applications a last resort. Providing administrative access to documents whenever possible is another important part of the push model, as are publication schemes and disclosure logs.

Decision-makers apply a public interest test when deciding an application for access to information. The public interest test involves weighing up factors favouring disclosure, factors favouring nondisclosure and also lists factors favouring nondisclosure because of a particular harm in disclosure.

Information Privacy

The primary purpose of the *Information Privacy Act 2009* (IP Act) is to protect the personal information of individuals, and to enable individuals to access and amend their own personal information. It also sets out agencies’ obligations about how personal information is collected, managed, used and disclosed.

Office of the Information Commissioner

The Office of the Information Commissioner (OIC) is an independent body within the Queensland Government and administers both the RTI and IP Acts. The functions and powers of the Information Commissioner include monitoring and reporting on agencies’ compliance with the legislation, conducting external reviews and providing information and assistance to agencies, applicants and third parties about the operation and administration of the legislation.

The OIC website provides considerable information to the public, including fact sheets for applicants on ‘applying for workplace investigation documents’, ‘accessing documents to pursue a legal remedy’ and ‘applications for legal and court-related documents’.

Rights of review

Applicants are provided with rights of internal and external review of access decisions.

In accordance with the RTI Act, an internal review can be sought within 20 business days of receiving a RTI decision if the applicant is dissatisfied with the decision. That review is conducted by an officer within the agency who is no less senior to the original decision-maker.

Alternatively, an applicant can request an external review by writing to the OIC. The OIC will seek to resolve external review applications informally wherever possible. However, if the matter remains unresolved, the Information Commissioner may confirm, vary, or set aside the original decision and make a new decision in its place.

Where questions of law are raised, the Information Commissioner may refer such matters to the Supreme Court or to QCAT and similarly, applicants may appeal to QCAT.

²¹⁸ Australian Workers Union submission p2.

Workplace Health and Safety Queensland's Right to Information Framework

On its website, the OIR provides an overview of RTI as the Queensland Government's approach to giving the community greater access to information, equal access across all sectors of the community and appropriate protection for individual's privacy. According to the OIR website, OIR will provide access to information it holds, unless it is not in the public interest to do so. Further, OIR states that every person has a general right to request access to documents held by government agencies.

OIR's website outlines the process for an RTI application. Once the application and fee is received, OIR has 25 business days to notify the applicant of its decision. The applicant is also notified of the right to review the decision.

The majority of applications made under the RTI Act and the IP Act which are received by OIR are made by injured parties or their solicitors. However, applications are also made in other circumstances, such as by:

- media and unions following significant incidents;
- entities, injured parties or the deceased's family seeking information or outcomes from WHSQ investigations;
- landowners or potential land purchasers seeking records (including dangerous goods licences) for a particular site; or
- insurers wanting copies of documents on WHSQ files.

During 2016, the RTI team processed over 500 applications, with only three internal and three external reviews.

RTI and Dreamworld

The AWU's submission raised concerns about the management of its application relating to Dreamworld, as well as concern that further 'in scope' documents were only released following correspondence from the union to the Under Treasurer. The AWU's original application was made in April 2015 and sought access to all documents from 2004 to 2015 relating to the safety of persons and workers at Dreamworld. At that time, the Department of Justice and Attorney-General (DJAG) processed all RTI applications on OIR's behalf.

In July 2015, DJAG made its decision to give the AWU access to 304 pages (full access to 70 pages, with partial access to 234 pages, and refused complete access to 67 pages). However, no documents were provided to the AWU at that point as DJAG had deferred access (as required by legislation), given that Dreamworld objected to the release of the documents. This deferred access allowed Dreamworld the option to exercise their right to review the decision.

The AWU subsequently applied to the OIC for an external review of the DJAG decision. Over the course of the next 12 months, the OIC conducted the external review which included:

- an assessment that the DJAG decision had not been made within the statutory timeframe which meant under the legislation that it was deemed that DJAG had made a decision refusing access to all of the documents;
- numerous interactions with Dreamworld, the AWU and OIR between 5 August 2015 and 26 May 2016;
- agreement with the AWU to narrow the scope of its application (from 371 pages to 143 pages);
- agreement to Dreamworld's request to suspend the external review for 6 weeks due to its ongoing negotiations with the AWU;
- agreement to the AWU's subsequent request to suspend the external review to undertake negotiations with Dreamworld (which suspended matters for approximately another month); and
- proceeding with the external review on the AWU's advice that its negotiations with Dreamworld had not been successful.

It should be noted that from January 2016, responsibility for processing OIR's RTI and IP applications transferred from DJAG to Queensland Treasury.

In July 2016 the OIC released its decision and, once the review period from that decision had expired in September 2016, the OIR RTI team provided 143 pages to the AWU in accordance with the OIC's decision. The 143 pages did not include a document which recorded a concern raised by the AWU in 2015 that Dreamworld had reduced the number of ride attendants on all its major amusement rides.

The RTI process was likely exhausted by the OIC's external review as in order to appeal to QCAT, the AWU would have had to establish there had been an error of law. In any event, the AWU did not raise any concerns about 'sufficiency of search' with the OIC or OIR RTI, even if it were only to ask what they could do about it.

Following the Dreamworld incident in October 2016, the AWU raised its concerns publicly about reduced staffing levels on rides. At that time, OIR responded on several occasions to the effect that:

"Under the Work Health and Safety Act 2011, Workplace Health and Safety Queensland does not approve staffing levels for theme park rides. Because of the range of factors that must be taken into account such as number of patrons and competence of staff, the duty is on the person conducting a business or undertaking to assess the risks and put in place appropriate controls to ensure any risks to health and safety are minimised. This would include the number of staff required to operate a ride safely".

The AWU's second key concern relates to the union's correspondence to the Under Treasurer in November 2016, stating that not all documents relevant to the AWU's RTI application had been provided. Subsequent searches were conducted and in December 2016, a further 93 pages (78 pages of employer history report and 15 pages from various sources) were administratively released to the AWU, with a copy also provided to Dreamworld. While the majority of the 93 pages included information that had been previously made public, it also contained some new information. This information tended mostly to be historical in nature, with most of it at least 10 years old, with some other information at least 6 years old. However, the new information included the abovementioned concern raised by the AWU in 2015.

OIR administratively released this information to the AWU and Dreamworld as the most appropriate means to give access to the documents in the circumstances. As the OIC had finalised the AWU's RTI application with its external review, it was not an option for OIR to amend its original decision.

The RTI team has already taken steps to build its profile within OIR and identify opportunities for improvement. For example:

- in December 2016, regional administrative officer contacts were trained on the RTI Act as well as how applications are actually processed by the RTI team;
- applicants are regularly contacted to clarify exactly which documents or information is sought;
- the RTI team continues to build relationships with regions particularly to ensure searches are thorough and that documents are captured at the first request;
- the RTI team are currently part of the pilot for the introduction of Sharepoint (new recordkeeping software for OIR); and
- the Document Search Request form has recently been updated to clarify exactly what the relevant OIR Manager/Director is certifying – i.e. that searches have been conducted, all documents have been located and provided and where documents have not been located, an explanation is provided. This wording is consistent with that used by the OIC.

In parallel, a key priority for OIR is the development of a new ICT platform which will also allow the rationalisation of old and antiquated systems and better management of data. The RTI Team rely on OIR's business areas to provide information in line with their search request. Unfortunately, as there are many and varied databases and systems operating across workgroups which have little interface or data integration, there have been instances where documents have not been located at the first request.

Occasionally an RTI applicant has contacted OIR RTI after a decision has been made and advised that they believed there were further documents that were located and included in the scope of the application. The

RTI applicant usually had some further information to support their belief. In such instances, OIR RTI has requested that the business unit conduct further searches, and, if further information was provided, made an amended decision under the Acts Interpretation Act, which included the additional information.

As OIR transitions and modernises to its new ICT framework, this will enable greater efficiencies in recordkeeping and searches for documents for RTI purposes. More efficient, integrated systems may also significantly contribute to allaying any applicant's concerns about OIR's approach to RTI and its legislative obligations.

Findings

The intention of the RTI legislation, when it was introduced in 2009, was to enable greater access to government information by the public. As stated above, the object of the RTI Act was to promote a 'push model' to information release, requiring agencies to proactively push information out to the community, with the goal of making formal applications a last resort.

This 'push model' however must be balanced against agencies' responsibilities to protect an individual's personal information under the IP Act, particularly noting that the majority of OIR's applications are made by injured parties or their solicitors seeking information relating to their own case.

When considering RTI requests, OIR must also have regard to the objects of the WHS Act 2011 which aims to provide for a balanced and nationally consistent framework to secure the health and safety of workers and workplaces by:

"Encouraging unions and employer organisations to take a constructive role in promoting improvements in work health and safety practices, and assisting persons conducting businesses or undertakings and workers to achieve a healthier and safer working environment."

The intention of both the RTI and work health and safety laws is to allow access to information on work health and safety issues by all parties unless disclosure is not in the public interest.

In the event that access to information is denied, there are clear rights of review under the RTI legislation, including external review by the OIC. However, there may be an opportunity to further clarify information about review rights and the role of the OIC in this review process.

The AWU's experience also highlights that there are opportunities to improve systems for data capture and recordkeeping within OIR. The RTI team are entirely reliant on the information provided by business areas which currently use legacy systems that are cumbersome and time consuming. Any improvements to these systems will in turn, provide greater efficiencies for processing RTI applications. While the AWU was the only organisation to raise a concern about RTI, OIR needs to remain vigilant to ensure that all searches are thorough and efficient. More integrated and efficient data capture and recordkeeping systems will enable OIR and RTI applicants to have greater confidence that all documents are provided with the first request.

Recommendation

55. In regards to right to information, that:

- a. the Office of Industrial Relations adopt a more open and transparent approach to information with the default being that information be provided to applicants unless access would genuinely jeopardise an investigation or prosecution; and
 - b. the Office of Industrial Relations formalises and publishes a policy to this effect.
-

6.3.4 Access to PCBU information by Health and Safety Representatives

In addition the concerns raised regarding disclosure of documents by WHSQ, it was also noted by the AWU that initial efforts by a HSR to obtain risk assessment documents from Dreamworld were blocked on the basis that the information was commercial-in-confidence. It is the view of the AWU that this is unacceptable and that disclosure of relevant documents to a HSR is pertinent to their role and ability to represent workers in regards to safety matters at the workplace.

The current legislative framework for HSR right to information from PCBUs

Under section 70(1)(c) of the WHS Act 2011, a PCBU must allow the HSR for a relevant work group to have access to information that the person has relating to—

- hazards (including associated risks) at the workplace affecting workers in the work group; and
- the health and safety of the workers in the work group;

The information a HSR may require can differ between workplaces, for example, a HSR may request access to:

- information relating to any work-related incident or disease, including statistical records, such as an injury register;
- an asbestos register and asbestos management plan, which a person with management or control of a workplace must ensure ready access to the HSR at any time;
- health and safety policies and procedures, including Safe Work Method Statements;
- safety data sheets for the chemicals that are used in the workplace;
- technical specifications for equipment regarding noise, vibration or radiation emission;
- results of occupational hygiene measurements, including dust levels, noise levels or chemical fumes;
- reports on work health and safety matters, including reports prepared by consultants for the PCBU;
- minutes of health and safety committee meetings;
- information provided by manufacturers and suppliers about plant, equipment or substances at the workplace; and
- health monitoring information that does not contain personal or medical information about a worker.

In addition, a HSR can choose to exercise their power to inquire into a work-related risk that could affect the health and safety of their work group. For example, a HSR may inspect the licence of a person who will operate a forklift where they believe that person is not qualified to operate the forklift. In this circumstance, the HSR has the power to be provided with the licence for inspection.

Also, under section 38(4) of the WHS Regulation 2011, a HSR may request a review of a control measure:

- if they reasonably believe that the control measure does not control the risk;
- before a change at the workplace that is likely to give rise to a new or different risk; or
- where a new hazard or risk is identified that affects, or may affect, the health and safety of a member of the work group represented by the HSR, and the PCBU has not adequately reviewed the control measure in response to one of these points.

In the event that access is denied, a HSR can commence the issue resolution process under Part 5 of the WHS Act 2011 (see [section 3.9](#) for detail on this process). If the issue of access is not resolved through this process, either party to the dispute can request the intervention of a WHSQ inspector to assist in resolving the issue. If parties do not support an inspectors decision (i.e. to issue, or not to issue, an improvement notice ordering relevant documents to be provided to the HSR) parties may currently apply to QCAT/QCAT to have the inspector's decision reviewed and a final determination be made.

Findings

It is the view of the Review that the WHS Act 2011 already contains extensive provisions to allow HSRs to access relevant information from their employer relating to the health and safety of their work group. The WHS Act 2011 also allows disputes regarding an inspector's decision in relation to a HSR's access to information to be reviewed externally.

While this framework is considered robust, it is the view of the Review that the WHS Act 2011 should explicitly clarify that failure of a PCBU to disclose information to a HSR should only be subject to genuine commercial confidentiality.

It should be noted that it is the intention of the Review that external review of an inspector's decision in relation to a HSR's access to information be transferred from QCAT to the QIRC and to confirm that the QIRCs powers include the production of documents or other relevant records (see discussion in [section 3.9](#)).

Recommendation:

56. The *Work Health and Safety Act 2011* be amended to clarify that a PCBU's duty to allow a health and safety representative access to relevant information under section 70(c) only be subject to claims that involve genuine commercial confidentiality.
-

6.3.5 WHSQ's response to, and notification to industry of, serious incidents

Term of Reference three requires the Review to consider WHSQ's effectiveness in relation to providing compliance information and promoting work health and safety awareness and education. In relation to the issue of the provision of compliance information, while WHSQ's compliance programs, industry partnerships and education campaigns were generally supported by employer groups, a number of construction industry associations, including MBQ and MEA noted that improvements could be made to the timeliness and detail of WHSQ's notification to industry of fatal incidents. In particular, MBQ submitted that:

*"Currently, when an incident occurs the majority of information is garnered from media reports and social media that may or may not be accurate on fact. While the Department will release a notice (sometimes several days after the event) that an event or fatality has occurred, they do not release any detailed facts or advice that will assist employers in immediately reviewing their own safety practices to ensure that the risk is managed accurately."*²¹⁹

MEA also noted that:

*"MEA recognises that publication about an ongoing investigation can affect future prosecutions and legal proceedings, however we believe a balance can be struck that protects the rights of those involved by not prejudicing a case, but allows the regulator to inform the broader industry to ensure, as reasonably practicable, no other persons are placed at risk and hazards are controlled."*²²⁰

Current process for advising industry of a dangerous incident, serious injury/illness or fatality

WHSQ's current approach is to advise industry of recently notified fatalities and events and the preventative measures they should consider when undertaking similar work. This organisational response is tiered according to the information that is known at the time, complexity of the matter, nature of the inherent risk(s), availability of suitable controls, and likelihood of recurrence. The responses are:

²¹⁹ Master Builders Queensland submission to the Best Practice Review of WHSQ, p.16.

²²⁰ Master Electricians Australia submissions to the Best Practice Review of WHSQ, p.2.

1. Initial response (immediate usually within 48 hours):
 - Incident alerts for fatalities
2. Investigation-informed response (usually within 1-2 weeks):
 - Safety alerts regarding key risks and hazards for equipment, workplaces or work situations
 - Safety advisories (ESO only)
3. Considered response (medium term to long term response):
 - Audit campaigns
 - Product safety recalls
 - Successful prosecutions and enforceable undertakings
 - Other incident-specific response.

Incident alert

The purpose of an incident alert is to inform people that a worker has been fatally injured and allow the tragedy to be communicated without being reduced to an annual statistic. Incident alerts are issued within 48 hours of a fatality once it has been confirmed that a worker has died and the circumstances in which he or she was fatally injured have been roughly established. This timeframe is necessary to ensure the accuracy of information about the incident.

Wherever possible, incident alerts include links to related information and resources such as Codes of Practice. However, this is with the caveat that there can be a lengthy period of time before an investigation reaches its conclusions and it could be misleading and potentially damaging to report extensively on details prior to confirmation.

Incident alerts are distributed to the subscription email database of WHSQ and the ESO, however, are presently are not published on the website.

Safety alert

A safety alert seeks to inform industry as quickly as possible of steps they can take to prevent a similar incident from happening at their workplace. Most often these alerts raise awareness of mechanical or engineering faults with items of plant, but can also include unsafe work practices which may have become common within a particular industry.

The timeframe for issuing a safety alert varies depending on the complexity of the matter and the external consultation required. Often engineering tests are involved and industry stakeholders must be consulted to ensure any unintended consequences of issuing the alert are addressed. As a general guide, safety alerts are prepared within two weeks of an incident in readiness for consultation with stakeholders. For example, for a fatal incident in February 2016 when part of a broken disc from an angle grinder struck the worker's chest, the safety alert was issued within one month of the incident. Safety alerts for less complex matters are issued in much shorter timeframes. For instance, for a recent incident involving concrete wall panels at Eagle Farm Racecourse, a safety alert was issued within one week of the incident.

Once the alert is approved and endorsed, it is either sent directly to companies affected by the advice, sent to specific industry sectors, or sent to all of the subscription email database. Safety alerts are also published on WHSQ's website and, if still valid after two years, are incorporated into the main website content as permanent guidance.

Safety advisory (ESO only)

A safety advisory is an ESO-specific response, used to provide timely information and advice to the electrical industry and community on a range of electrical safety issues such as legislation and obligations, and emerging issues. Safety advisories operate on a similar premise as safety alerts.

Audit campaign

Where a number of incidents have occurred in a particular hazard area or where it may be prudent to assess the prevalence of a hazard in wider industry, an audit campaign is often progressed. An audit campaign seeks to assess the compliance of duty holders within a particular industry sector with regard to the identified hazard or risk and suggest, sometimes through statutory notices, work health and safety improvements. Audit campaigns comprised a considered response to the recent Dreamworld ride incident, where all amusement devices in all theme parks on the Gold and Sunshine Coasts were audited.

Product safety recall

Where an electrical product has a systematic failure and is likely to cause injury or damage property, the ESO works with the supplier, Queensland Office of Fair Trading, Australian Competition and Consumer Commission and other safety regulators to arrange a product safety recall. Once the supplier agrees to the recall, ESO staff communicate the product safety recall through social media (Twitter, Facebook), and via e-Alerts through the ESO email subscription database and on the ESO website. The product safety recalls are also provided to the Electrical Safety Board.

Successful Prosecutions and Enforceable Undertakings

Successful prosecution and accepted enforceable undertakings are published on the WHSQ website. Successful prosecutions are also published as eSAFE articles, which are delivered via email to subscribers.

Other incident-specific response

Other incident-specific responses are determined through the Organisational Response Governance Group (ORGG) process. ORGG is convened bi-monthly for management across all directorates of OIR to consider all coronial inquest findings and comments and coronial recommendations and develop an appropriate organisational response.

Once the organisational responses have been determined, ORGG provides this information to the Office of the State Coroner for consideration.

The progress of the responses are published on the Coroner's Court of Queensland website and monitored by ORGG until implemented. These responses are reported through a whole-of-government reporting process, the purpose of which is to ensure that the Queensland Government departments respond to each recommendation and that these responses are publicly accessible.

Recent examples of ORGG responses include:

- a guide by OIR and the Department of Natural Resources and Mines in relation to the prevention and management of heat injury in the heavy construction industry;
- an information sheet on carbon monoxide in breathing air during air compressor use which references exposure to hazardous substances, abrasive blasting and spray painting; and
- an information sheet entitled *Work health and safety at public events and in the natural environment*.

Findings

It is the view of the Review that, while there is understandable limitations on the advice WHSQ can provide immediately following an incident and a need to ensure information is accurate, this needs to be balanced with ensuring employers and workers have sufficient information to mitigate risks where incidents relate to common work practices or equipment. Additionally, industry reliance on the regulator as a source of reliable information, and the demand and desire from industry to learn from these incidents and ensure they are up to date on emerging issues, dictates that improvements to WHSQ's approach to providing an organisational response to stakeholders about notified fatalities is required.

The Review notes that the timeframes and information available are influenced by the number of jurisdictions involved in an investigation and whether external expert reports are required. For example, in the recent Dreamworld ride incident, a joint investigation between WHSQ and the QPS was undertaken and forensic testing undertaken and engineer reports required. Due to the extensive and multi-jurisdictional nature of these inquiries, information was not readily available for release until months into the investigation. In contrast, the recent Eagle Farm Racecourse incident allowed for a more timely release of information as WHSQ and the QPS conducted parallel investigations into the matter.

It is acknowledged that OIR is restricted in the scope of information available for release to stakeholders whilst an investigation, prosecution or enforceable undertaking is ongoing. The information that is released must comply with right to information and information privacy legislation and not compromise the integrity of the investigation, prosecution or enforceable undertaking. In an attempt to provide timely information for incident and safety alerts in consideration of these factors, OIR depersonalises the information as much as possible to remove any particulars identifying involved persons or entities. Limited information is also released in the early stages of a matter reflective of the known information at the time in relation to injuries sustained and incident causation.

In acknowledging these operating constraints, the Review focusses its findings in two key areas: detail of information communication, and reporting inconsistencies.

Detail of information communicated

The information that is communicated in incident alerts, safety alerts, safety advisories and product safety recalls is consistent with the principles and intended purpose of these communication mediums, for instance, to satisfy the purpose of an incident alert to advise that an incident has occurred and provide a reminder that it could have been you, minimal incident details are required. Minimal information is also included to ensure factual accuracy as the investigation may later discredit early information. It is pertinent that as a credible modern regulator, information that is provided is accurate and this can only be confirmed in time as an investigation achieves its milestones.

However, while the incident alert serves as a timely mechanism to inform stakeholders of a recent workplace fatality, the limited information communicated does not satisfy the public interest. In its current form, the incident alert does nothing more than to confirm to stakeholders that a fatality has occurred and provide links to existing documents that may or may not be relevant to the reasons for the incident, which cannot be confirmed at this time.

To more fully achieve its purpose to inform rather than simply alert as seems to be the current state, the incident alert should contain information that is more relevant to the public interest, such as what WHSQ is doing to investigate the matter generally and when and how the safety lessons learned from the incident are likely to be available. This could be as simple as stating that, where the incident has involved hazard or risk relating to equipment, a common work practice or work situation, the likely contributing factors and appropriate preventative action will be communicated via safety alert to eSAFE subscribers in the coming weeks. It is understood that safety alerts are not published for all fatalities, only those where there is a clear safety learning to communicate in terms of identifying the contributing factors and action required to prevent reoccurrence. In circumstances where a safety alert is unlikely to eventuate, readers should be directed to monitor their emails for the outcomes of the investigation in the eSAFE newsletter or for an incident update of contributing factors and prevention advice for similar incidents as more information becomes known. The same principles apply to safety advisories issued by the ESO.

Likewise, the current incident alert includes a statement that the alert is “a reminder for you and your organisation to consider the effectiveness of your safety management system in preventing an incident like this from occurring at a workplace”. There is scope to revise this content for the public interest, achieved by summarising similar incidents that have occurred and the safety learning that has been gleaned. It may also

be in the public interest to understand more about what is involved in a WHSQ investigation in terms of the process undertaken, and this could be explained in the incident alert to manage reader expectations about the timeliness and detail of information provided.

It may also be in the public interest for incident alerts to be issued for all matters required to be notified to the regulator under the WHS Act 2011 rather than limited to fatalities. The revised scope of the incident alerts may also warrant publication on the WHSQ and ESO website.

Reporting inconsistencies

The reporting undertaken for each organisational response varies within WHSQ and lacks a coordinated and consolidated effort. In support of this finding, it is interesting to note that product safety recalls, are provided to the Electrical Safety Board but safety alerts are not provided to the WHS Board or ISSCs unless members receive them through their individual eSAFE subscriptions. Similar inconsistencies exist for the publishing of prosecution summaries and accepted enforceable undertakings, and ORGG reporting. It is unclear why organisational responses developed through ORGG are reported externally to the Office of the State Coroner but not provided to the WHS Board or ISSCs nor published on the WHSQ website. Likewise, while both prosecution summaries and accepted enforceable undertakings are published on the WHSQ website to encourage compliance with work health and safety legislation through an increased awareness of the consequences of non-compliance, there are some missed opportunities with regard to enforceable undertakings. Enforceable undertakings are viewed as an alternative to prosecution but not promoted in the same vein as prosecution summaries with regard to inclusion in the eSAFE newsletter. In terms of the website, the information published on the website simply notes that the enforceable undertaking has been accepted, the total minimum expenditure associated with the undertaking and the requirements of undertaking. It is unclear from the information published whether the obligation holder actually delivered on the undertaking.

The WHS Board and ISSCs seem somewhat underused with regard to reporting and reviewing organisational responses to fatal incidents. Where responses are provided to members of these committees, they are provided for noting and only discussed upon a member's request. Provisions should be made for the WHS Board and ISSCs to adopt more of a review and advice function with future meetings embedding 'OIR response to notified incidents, events and fatalities' as a standing agenda item at which members are asked to review activity undertaken to date and suggest further responses.

For the WHS Board and ISSCs to adopt more of a review and advice function, a coordinated and consolidated approach to reporting organisational responses to notified fatalities is required. It has become apparent that while WHSQ undertakes a number of activities to advise stakeholders of its response to notified fatalities, responses are provided in various forms (e.g. incident alerts, safety alerts, responses determined through ORGG) but there is no central means to review the responses in their entirety. ORGG appears well-placed to adopt this coordination function and its terms of reference should be broadened to incorporate a role for the coordination and reporting of all WHSQ and ESO responses to notified fatalities and serious incidents on a six monthly basis to the WHS Board and ISSCs, and outcomes published on the WHSQ and ESO website.

Recommendation

57. In relation to WHSQ's response to, and notification to industry of, serious incidents:
 - a. WHSQ refocus the content of incident alerts to address the public interest and stakeholder desire for information by providing information about the investigation process, communicating how further information about incident causation and preventative action will be provided (i.e. incident updates, eSAFE articles, safety alerts) and providing information about previous incidents similar in scope that might offer a relevant safety learning;
 - b. WHSQ expand the scope of incident alerts to include all matters required to be notified to the regulator under the *Work Health and Safety Act 2011*;

- c. WHSQ publish the refocused incident alerts on its website;
- d. WHSQ, through the Organisational Response Governance Group process, apply a coordinated and consolidated approach to reporting organisational responses to notified fatalities in which all responses to notified fatalities and serious incidents in their entirety are reviewed at six monthly intervals and reported to the Work Health and Safety Board and Industry Sector Standing Committees and published on the WHSQ website;
- e. the Work Health and Safety Board and Industry Sector Standing Committees adopt, as a matter of routine business, a review and advice function with respect to WHSQ's response to notified fatalities and serious incidents in which they review the six monthly reports and provide further advice about additional activity to be pursued; and
- f. WHSQ regard enforceable undertakings in the same light at successful prosecutions and apply the same communication tactics to both.

6.3.6 Role of the new labour hire inspectorate

On 25 May 2017, the Minister for Employment and Industrial Relations introduced the *Labour Hire Licensing Bill 2017* (the Bill) into the Queensland Parliament.

The Bill responds to ongoing and serious allegations of exploitation of workers in labour hire arrangements and other practices to avoid legal obligations in respect to taxation, migration and workers' compensation. These issues were reported by the Queensland Parliamentary Finance and Administration Committee following its inquiry into the practice of the labour hire industry in Queensland. The findings of that Inquiry have been echoed in similar labour hire and relation Inquiries conducted in Victoria, South Australia and the Commonwealth.

The policy objectives of the Bill are to protect labour hire workers from exploitation and restore confidence in the labour hire industry through the regulation of providers of labour hire services in Queensland. The Bill achieve its policy objectives by:

- establishing a mandatory business licensing scheme for the labour hire industry in Queensland;
- requiring labour hire providers to be licensed;
- requiring persons who engage labour hire providers to only engage a licensed labour hire provider;
- requiring a labour hire licensee to satisfy a fit and proper person test to establish that they are capable of providing labour hire services in compliance with all relevant laws and that the business is financially viable;
- requiring a licence holder to report regularly, including timely notification of changes in circumstances;
- providing strong penalties for breaches of obligations; and
- providing an awareness, monitoring and enforcement function through a compliance unit.

The Bill is the first of its type in Australia.

Inspector powers and functions

Part 6 (Sections 47 – 89) of the Bill provides for the appointment, functions and powers of an inspector.

The inspector's functions are to monitor compliance with the WHS Act 2011, to investigate and, where necessary, take action to deal with alleged contraventions, and to inform providers and workers of their rights and obligations.

The inspector's power to enter, either with or without consent, or by warrant; to require information or attendance; and to seize evidence is similar to those of an inspector appointed under the IR Act or the WHS Act 2011.

As a consequence of Queensland having referred its private sector industrial relations jurisdictional powers to the Commonwealth in 2010, there are constitutional limitations upon participation in the employment relationship of private sector participants. This means that there is no scope for a State licensing scheme to impose industrial conditions on labour hire agents and hosts. Doing so would amount to a direct inconsistency with the *Fair Work Act 2009* which ‘covers the field’ for the purposes of industrial entitlements for private sector employers and for the purposes of applicable industrial instruments.

Similar limitations will apply for direct intervention in matters of harassment and discrimination, taxation and migration which are subject to Commonwealth jurisdiction.

The Bill does require a licence holder to “comply with all relevant laws applying to the licensee”.²²¹ Upon suspicion of breach of a relevant law, a person who is engaged in the administration of the WHS Act 2011, can disclose that information to another person “in connection with the administration of ... or the enforcement of a relevant law”.²²² It is a policy decision of the Government that the Labour Hire inspectorate will not duplicate the compliance and enforcement activities of other State or Commonwealth agencies which have appropriate jurisdiction.

The Bill also requires that a user of labour hire services only engage with a licensed provider. There are significant penalties for breach of this obligation. Leveraging the supply chain to promote compliance is a vital part of the licensing scheme. Users of labour hire services will be a significant focus of the compliance activities of inspectors.

Compliance Unit

Stakeholder feedback during consultation on the Bill has revealed a very high expectation for a strong presence to be established for the enforcement and monitoring of the labour hire licence scheme. In response, it is anticipated that a well-resourced compliance unit of inspectors and desktop auditors will be established to promote awareness of the scheme and ensure compliance.

While still in its formative stages, it is proposed that the Labour Hire inspectorate (Compliance Unit) will consist of:

- desk-top auditors (for application and reporting validation); and
- Inspectors (for conducting investigations, whether by complaint or by targeted programs).

The inspectorate will also coordinate an extensive awareness and education campaign. The inspectorate will be responsible for administering an extensive online presence through the Government’s labour hire website, to be used for the dissemination of information to providers, end users and workers(including people of non-English speaking background), and the publishing of the register of licensed labour hire providers and applicants.

The inspectorate will report to the Director, Industrial Relations Compliance and Regulation, within the OIR. Funding for the Inspectorate/compliance unit will be \$5 million in the first two years of operation, with recurrent funding of \$2 million per year thereafter. This funding is to be made available from revenue derived from the licensing fees.

Desk-top auditors will review and validate license applications and reporting. The license application and reporting function will be a digitalised online system requiring applicants to establish their fitness for holding a licence and their business’s financial viability by declaration made under oath. All applications will be vetted, with a proportion, including those that may trigger a need for further inquiry, subject to full desktop audit.

²²¹ Labour Hire Licensing Bill 2017, s 28.

²²² Ibid, s 104(3)(d).

Inspectors will undertake in-field compliance activities, working in cooperation with established investigation programs currently undertaken by the Fair Work Ombudsman (FWO) e.g. the annual Harvest Trail audit campaign; and with the Horticultural Workers Industry Group consisting of DJAG, the QPS, DTMR, the Department of Agriculture and Fisheries, SWA, the Department of Immigration and Border Protection and the FWO. These investigation activities will include 'on-complaint' and targeted compliance campaigns.

The Labour Hire inspectorate will establish these co-operative relationships, underpinned by MOUs, with those agencies for the exchange of information and the investigation of complaints or suspicious activity.

While the Labour Hire Inspectorate will be regionally based, a final decision on the location of the unit, or the distribution of inspectors is yet to be made.

Appointment

Under the Bill, the Chief Executive (the Under Treasurer or appropriately delegated officer) may, by instrument, appoint an appropriately qualified public service employee as an inspector.

While the Bill provides for a stand-alone inspectorate, there is no prohibition on an inspector holding a dual appointment under this and one or more other Acts. Inspectors under the IR Act also hold appointments under the *Trading (Allowable Hours) Act 1990*, the *Child Employment Act 2006*, the *Workers' Accommodation and Pastoral Workers' Accommodation Acts* and the *Anzac Day Act 1995*.

It is anticipated that an inspector appointed under the IR Act will also be appointed under the Bill following its enactment. This dual appointment is considered reasonable, having regard for core competencies of the inspector appointed under the IR Act and the capacity of those inspectorates to undertake the work required under the Bill without detracting from or diluting their core functions.

It may also be efficient for inspectors who are already qualified and trained in other disciplines, such as a Workplace Health and Safety inspector, or a Workers' Compensation auditor, to be authorised to exercise powers under the Bill. The Bill makes provision for the Chief Executive to issue the instrument of appointment with limits upon the inspector's powers. For example, a Workplace Health and Safety inspector may be authorised under the Bill for the purposes of monitoring compliance with license requirements among labour hire providers operating with an appropriate license, and among users of labour hire services engaging only licensed providers. Training and appropriate referral procedures in the event of a suspected breach has the potential to extend the reach of the Labour Hire inspectorate and also strengthen the compliance and enforcement regime.

Qualifications

It is anticipated that a labour hire inspector will, immediately upon appointment, complete an appropriately structured inspector induction program. Furthermore, it is anticipated that an inspector will hold, or will undertake, a Diploma of Government (Workplace Inspection) qualification.

The induction, training, and a competency framework will be developed to manage the core competencies of the labour hire inspectorate in performing its role.

Such an approach is used in WHSQ, and managed by the WCU. WCU is responsible for the:

- Inspector Induction Program - through the coordination and management of training content delivered by relevant OIR technical experts and advisors, collectively known as subject matter experts;
- RPL Program – which is an OIR program designed to assist inspectors to gain the diploma qualification, who undertook their induction training prior to the implementation of the diploma qualification; and

- Diploma of Government (Workplace Inspection) – through a partnership with Queensland TAFE. WCU develops and assesses relevant material for the diploma and Queensland TAFE moderates and issues the qualification.

It is envisaged that the enacted Bill be operative in the first half of 2018. On this timetable, it is proposed to commence recruitment of inspectors commencing in late November, with a view to undertaking training in January-February 2018. At this time it is anticipated that up to 12 employees will be recruited into the Labour Hire Inspectorate (inspectors, desk-top auditors and one administrative officer). Complementary training will also be provided to other inspectorate workforces, e.g. the Industrial Relations inspectorate.

Findings

Given the significant role this new inspectorate will have in protecting some of Queensland's most vulnerable workers, and the significant presence of labour hire in high risk industries and in unsafe workplaces, WHSQ should work collaboratively with the new inspectorate.

Recommendation:

58. That WHSQ and the new Labour Hire inspectorate develop a formal co-operation arrangement including the exchange of information and technical support. Over time, Inspectors under the Labour Hire Licensing system should be trained and appointed as work health and safety inspectors.
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Attachment 1: Terms of Reference

The Best Practice Review will consider Workplace Health and Safety Queensland's effectiveness in light of contemporary regulatory practice. The Review will focus on the appropriateness and effectiveness of Workplace Health and Safety Queensland's policies, procedures and activities that support its approach to ensuring that the *Work Health and Safety Act 2011* and the *Work Health and Safety Regulation 2011* are communicated, complied with, and enforced.

The scope of the Review includes all Workplace Health and Safety Queensland's functions: inspections, investigations, prosecutions, enforceable undertakings, research, strategy and policy development, information and education and awareness campaigns.

The Review and subsequent recommendations should specifically consider:

1. the appropriateness of Workplace Health and Safety Queensland's Compliance and Enforcement Policy;
2. the effectiveness of Workplace Health and Safety Queensland's compliance regime, enforcement activities, and dispute resolution processes.
3. Workplace Health and Safety Queensland's effectiveness in relation to providing compliance information and promoting work health and safety awareness and education;
4. the appropriateness and effectiveness of the administration of public safety matters by Workplace Health and Safety Queensland; and
5. any further measures that can be taken to discourage unsafe work practices, including the introduction a new offence of gross negligence causing death as well as increasing existing penalties for work-related deaths and serious injuries.

Attachment 2: List of consultations with key stakeholders

Organisation
Queensland Council of Unions & Affiliates
Building Trades Group of Unions (CFMEU, ETU, AMWU, Plumbers Union)
Australian Workers Union
Business Groups (CCIQ and National Retailers Association)
Agricultural Groups (GrowCom)
Queensland Tourism Industry Council
Construction Industry Associations (HIA, CCF, Master Plumbers, Master Electricians, NECA)
Asbestos Disease Support Society
Queensland Law Society
Bar Association of Queensland
Master Builders Queensland
Queensland Ombudsman
Electrical Safety Commissioner
Families Forum
AiGroup and Members
WorkCover Queensland
Richard Johnstone (QUT)
Queensland Farmers Federation
Director of Public Prosecutions
Queensland Trucking Association
Former Work Health and Safety Board Members
Construction inspectors
State Coroner and Deputy State Coroner
Safe Work Australia

Attachment 3: Schedule of persons and organisations who made written submissions to the review

Australian Industry Group

Australian Lawyers Alliance (With an additional submission concerning industrial manslaughter)

Australian Manufacturing Workers Union

Australian Sugar Milling Council

Australian Workers Union

Building Trades Group of Unions

Centre for Human Factors, University of the Sunshine Coast

Chamber of Commerce and Industry Queensland

Civil Contractors Federation (With an additional submission concerning industrial manslaughter)

Clubs Queensland

Department of Education

Department of Health

Dr Gunther Paul, James Cook University

Housing Industry Association

Master Builders Queensland (With an additional submission concerning industrial manslaughter)

Master Electricians Australia

Melissa Evans

Professor Robin Burgess-Limerick, University of Queensland

Queensland Nurses and Midwives Union

Queensland Council of Unions (With an additional submission concerning industrial manslaughter)

Queensland Fire and Emergency Services

Queensland Law Society

Queensland Tourism Industry Council

Sara Pazell, Viva Health Group

Warren Kelly, Health Safety and Wellbeing Team, Townsville City Council

WorkLaw Health and Safety Pty Ltd