OHS law in Australia obliges workers and those in control of a workplace to ensure the safety of people on their premises. Last week the Northern Territory government received a report into the security measures at the Royal Darwin Hospital. This hospital has undertaken fantastic medical work in the past, most noticeably, on a large scale following the bombings in Bali in October 2002. However it failed to prevent the rape of a five month old female infant on 30th March 2006, while the indigenous baby was an inpatient.

Carolyn Richards, the Health & Community Services Complaints Commissioner, said in her report: “As a result of a complaint reported to the Health & Community Services Complaints Commission an investigation was undertaken by the Director of Investigations, Mrs Julie Carlsen, who is employed as the Director of Investigations (DI) Health & Community Services Complaints Commission. This report highlights that the Department of Health & Community Services (DHCS) needs to implement effective risk control mechanisms to minimise the risk of an assault on a vulnerable inpatient in the Royal Darwin Hospital (RDH).

“The investigation has led to the conclusion that DHCS (DHF) and RDH have not complied with the applicable Australian Standard. It has also revealed that crucial information has been withheld from an expert engaged by RDH to review security arrangements and from the DHCS (DHF) Security Manager based at RDH. This report also details inadequacies and failings by those responsible for managing RDH who have failed for over two years to implement and maintain better security for patients in the Paediatric Ward. It is published with the hope that it will cause DHCS (DHF) and RDH to give higher priority to improving its risk management and security procedures.”

The Commissioner’s conclusions are worth including here so that OHS professionals and security officers can establish appropriate procedures for their workplaces.

“1. On 30th March 2006:
• There were no arrangements in place on the Paediatric Ward to ensure the safety and inviolability of vulnerable patients.
• No risk assessment had been conducted.
• The arrangements in place did not comply in any aspect with the Australian Standard which sets the benchmark for proper security.
• There was no control on access to the Ward or to the patients.
• The staff had not received adequate training and possibly none at all, about the risks arising from lack of security arrangements.
• In 2002 RDH had commissioned and received an expert consultant’s...
assessment and report on security arrangements at RDH. The Terms of Reference did not require SB to be assessed. By 30 March 2006 the recommendations in the report had not been implemented in Ward SB. This failure can only be described as shameful.

- Following the rape of the infant police were not notified for about 2 hours.

2. Action taken by RDH after the rape to improve security was: (a) slow (b) inadequate, and (c) has not been adequately evaluated or reviewed to determine its effectiveness

3. RDH has a Security Manager on site as well as an NT Police member stationed at the hospital. Neither has been asked to evaluate the security on the Paediatric Ward either before or after the rape of the infant.

4. Staff working on the Paediatric Ward have not been trained at their induction on the elements of security arrangements to reduce the risk to vulnerable patients nor has there been adequate ongoing training of staff before or after the 30th March 2006 incident.

5. In 2007 the same expert safety and security consultant, as in 2002, was engaged to assess security arrangements at RDH. He was not informed of the rape of the infant in March 2006 nor was he asked to report specifically on arrangements in the Paediatric Ward.

6. On 21 November 2007 two investigation officers from the Health and Community Services Complaints Commission visited the Paediatric Ward by prior arrangement. They were able to enter the Ward and wander around, have entry to every part of it and stand at the nurse’s station, for about 25 minutes without anyone asking who they were and why they were there.

7. Management’s lack of commitment to the proactive identification of risks and to taking appropriate action has not created a culture where each member of staff takes responsibility for identifying and reporting risks and developing safe practices.

8. A security review of RDH was carried out by an expert hospital safety and security consultant who issued a report in 2007. The Security Manager of DHCS (DHF) was not given a copy even though he requested it. HCSCC enquired of RDH management why he was not given a copy and RDH have offered no explanation. On 31 October after this report was published to RDH and DHF the CEO of DHF advised this Commission that he had finally been given a copy and that he had seen a draft copy.

9. RDH Maternal and Child Health Clinical Risk Management Committee considered security in the Paediatric Ward following the incident. The Committee met on 16th May 2006, 2.5 months after the rape of the infant. It met a further 4 times. It submitted an action plan to the General Manager of RDH in July 2006. At its last recorded meeting on 5 September 2006 there had been no response from the General Manager on the recommendations, particularly with respect to installing CCTV cameras with recording facilities on the Paediatric Ward. There were still no recording cameras on the Paediatric Ward as at June 2008 although a CCTV system had been installed in the kitchen area to deter the pilfering of food. Dr David Ashbridge on 31 October 2008 advised, when responding to a draft of this report, that CCTV cameras were installed in Paediatrics on 25 August 2008.

10. The surveys from the Australian Council of Health Standards which accredits RDH probably did not receive all relevant information about the incident of 30 March 2006 and what action RDH were taking. Those surveys on 13 October 2006 were informed by RDH that the patient information pamphlet and admission interview are being reworded to reflect the changes to ward access. There was no verification throughout the investigation that any action had
SafetyWeek PLUS

Please don’t forget there is a special members-only edition, SafetyWeek PLUS, available only as a download at the SIA website at http://sia.org.au/members/members-newsletter/member-safetyweekplus-bulletins.html

The latest edition includes article entitled

QLD Many near misses at crash crossing: train drivers
QLD QR confirms lights were working at level crossing accident
QLD Ash caused rash at school, tests reveal
FED Aust m says explosions did not initially worry him
NSW ‘Lung Bus’ to detect asbestos dangers earlier
QLD Man due to appear in court over harbour deaths
US Obama says too busy to think about his safety
FED Workplace flexibility on the rise: survey
NT Power and Water fined over man’s death
QLD Man accidentally shoots himself in foot at gun club
NSW Moonlight cops up 45 per cent in five years
NT No action in hospital after rape of baby, report finds

Continued from page 2

been taken by RDH to implement the recommendations of the review. Neither the report of ACHS nor records of information given to ACHS have been provided to the HCSCC. DHCS (DHF) was invited to provide me with those relevant documents in response to this draft. No response was received on this issue from DHF or RDH. According to the published information of ACHS the accreditation survey commences with a self assessment by the hospital concerned. This Commission specifically requested details and copies of the information provided to the ACHS surveyors but no response was received from either the CEO of the Department or the General Manager of RDH. 11. The governance arrangements at RDH do not promote adequate transparent accountability of the General Manager and the Department of Health and Families for the operation of the hospital. Control of all aspects of the day to day management of RDH rests in the hands of three individuals. This includes staff recruiting, training, security, nursing and medical services, procurement, record keeping, financial accountability and risk management. Such specialist management groups as exist are subordinate to the General Manager’s authority. The General Manager reports to the Director of Acute Services who reports to the CEO of the Department. I have been unable to find out what role the Royal Darwin Hospital Board has since its last annual report to 30 June 2006.”

It is well worth obtaining the complete report to understand how such an individual tragedy occurred. As one media commentator has posited

“One wonders what the reaction would have been if a non-indigenous infant was raped.”

This article original appeared in SafetyAtWorkBlog on 1 December 2008 (http://safetyatworkblog.wordpress.com/2008/12/01/how-management-failures-led-to-the-rape-of-a-five-month-old-baby/)

© Workplace Safety Services P/L

National Award Win For URS Health And Safety Program

1 December 2008

Engineering and environmental professional services firm URS, has been recognised nationally for its innovative safety program which has successfully changed staff behaviour resulting in the lowest recorded injury rate in the company’s history. The 4sight safe behaviour program won the Australian Consulting Engineers Association’s national award for Education and Training, presented for a project which demonstrates the strongest commitment to education and training and brings innovation and benefits to the firm, the industry, and the community in general.

Accepting the award on Friday, URS Asia Pacific Health and Safety Manager John Petersen said the Health, Safety and Environment team developed 4sight to provide employees with a simple and effective tool to help identify and control hazards at the worksite.

“I am very proud of 4sight as it was designed solely to empower our staff to look after themselves, and they have embraced it,” Mr Petersen said. “It doesn’t take enormous effort to change behaviour, but the outcomes, such as a safer working environment for our staff and a knowledge that URS supports them to question safety with our colleagues and subconsultants, are so beneficial and worthwhile. And that has been reflected in our improved safety record.”

This type of program is unprecedented in the engineering consulting industry, making it innovative in both the concept and development.

The major objective of the 4sight program is to keep safe behaviour ‘top of mind’ amongst the employees of URS, our subcontractors and where appropriate, our clients. The simple tool asks four questions to ensure that safe behaviour with any task is considered thoroughly and approached safely:
What am I about to do?
What could go wrong?
What could be done to make it safer?
What have I done to communicate the hazards?

“By just asking our staff to keep these four questions in mind, it has given them some very simple tools to put their safety and the safety of their colleagues and contractors to the fore,” Mr Petersen said. “Whether working in the field or in the office, 4sight has been developed so that it can be used by every URS employee every day for every task. It is the last minute safety assessment to help identify hazards before they become incidents.”

Source: URS

Minister for Transport Visits Rail Accident Site

28 November 2008

Transport Minister, John Mickel says people can be assured that proper arrangements are in place for a detailed investigation of yesterday’s Tilt Train accident South of Cardwell.

Mr Mickel, who travelled to the scene of the accident overnight said one of his priorities had been to ensure the accident was fully investigated.

“I have had extensive discussions with senior Queensland Transport and QR officials to make sure this happens and I am satisfied it will,” Mr Mickel said.

“It is important that people can have confidence in the integrity and calibre of the investigation that will occur.

“No effort will be spared in making sure this accident is investigated - fully, expertly and independently.”

Mr Mickel flew from Brisbane to Townsville late last night and travelled to the accident scene, 12km North of Ingham.

Together with QR CEO Lance Hockridge and Head of Passenger Services, Paul Scurrath, he arrived at 1:30am today and spent an hour being briefed on the situation. He was also accompanied by local state MP, Mr Andrew Cripps, the Member for Hinchinbrook.

Mr Mickel, senior rail and transport officials returned to the scene at 7:30am today for further briefings and discussions on the accident and the investigation.

Mr Mickel said a major focus of the inquiries would be the operation of the warning lights at the level crossing.

“There has been some speculation that the warning lights were not flashing at the time of the accident,” Mr Mickel said.

“At the same time it is clear that there is some confusion between these warning lights and those at another level crossing about 8km north at Conn Creek, which had been reportedly malfunctioned and had defaulted to constantly flashing.

“I have been informed by QR that the lights at the level crossing where...
the accident occurred were tested yesterday morning and were found to be in normal working order.”

Mr Mickel said the investigation would be independently chaired by the Australian Transport Safety Bureau. The investigation would be joined by a technical expert from South Australia focusing signals and the warning lights.

Investigators would also have access to other data captured by QR monitoring systems associated with the warning lights and signals, along with data from the trains data recording systems.

Source: Qld Minister for Transport, Trade, Employment and Industrial Relations

**Mining industry levy - a boost to mine safety** 28 November 2008

Mines and Energy Minister Geoff Wilson said the new mining industry safety and health levy which recently came into effect would boost the services provided by the state’s mine safety watchdog, the Mines Inspectorate.

Minister Wilson said the Inspectorate provides vital safety and health services that help save lives.

“Nothing is more important than that. The Bligh Government is asking for $26 million from an industry worth more than $26 billion to Queensland in 2006/2007,” Mr Wilson said.

“Taxpayers should not have to fit the bill for that,” he said.

“Queensland has the best mine safety legislation in Australia and it must continue to be enforced mine by mine, employer by employer, worker by worker.”

“That’s where the Mines Inspectorate steps in. This new levy will fund seven new specialist mines inspectors, two investigators, five scientific research staff, an occupational hygienist, a statistician and a manager of health surveillance.

“I am confident that the industry will see the logic in a safety and health levy.

“Queensland has one of the best mine safety and health records in the world. It is in everyone’s best interests to keep it that way,” he said.

Source: Qld Minister for Mines and Energy

**SafeWork SA Commits to NZ Exchange Visits** 28 November 2008

Three South Australian labour inspectors are heading to New Zealand to participate in an exchange programme designed to advance experience and knowledge between the two jurisdictions.

Today SafeWork SA Executive Director, Michele Patterson has also signed a Memorandum of Understanding to facilitate an ongoing programme of exchange visits over the next three years.

The exchange programme grew from discussions at the International Association of Labour Inspection Conference held in Adelaide during March. The idea was enthusiastically embraced, with New Zealand sending three inspectors to Adelaide in June for a two-week visit.

During their two weeks in New Zealand, the three senior SafeWork SA inspectors – Wayne Dodd, Ben Tugwell and Sandra Voumard - will visit Auckland, Queenstown and Invercargill. They will also meet staff at the NZ Department of Labour’s Wellington Head Office to learn about the Department’s approach to the administration and enforcement of OHS laws.

While in NZ, they will visit a number of workplaces across the country, including the Tiwai Point aluminium smelter and Auckland’s Eden Park, which is undergoing a major refurbishment to host the 2011 Rugby World Cup.

The inspectors arrive in New Zealand on Sunday 30 November and leave on Monday 15 December.

“South Australia’s labour inspection system places strong emphasis on training, and having a strategic framework and processes for dealing with workplace safety issues, while New Zealand takes more of a ‘hands-on’ approach to its issues, with more
specific industry hazard management,” Ms. Patterson said. “We firmly believe there is much to learn and much to gain from each other. “The New Zealand inspectors told us how their exchange visit helped energise their motivation and purpose. “We hope our inspectors gain the same benefits from their tour.”

Manufacturers Fined Over Hand Injuries 28 November 2008

The SA Industrial Relations Court has imposed fines totalling $51,000 on two manufacturers, whose workers suffered serious hand injuries in separate incidents. Today Bridgestone Australia Pty Ltd was fined $21,000 after pleading guilty to one count of breaching section 19(1) of the Occupational Health Safety and Welfare Act 1986 in failing to ensure the safety of an employee. In September 2005, as he tried to help a colleague resolve a problem, a 36-year-old male worker lost the tops of three fingers when his hand was caught in the die chamber of a rubber-extruding machine at Bridgestone’s Salisbury factory. The risk assessment had not factored in the possibility of two people working on the machine when one was usually required. A guard and an interlock device have since been fitted. Earlier this week, Artso Cores (SA) Pty Ltd was fined $30,000 for breaching the Act in the same manner. The company failed to answer to the court on the matter and was convicted in its absence. In August 2006, an employee was operating a core-making machine designed to produce dies. The die closed on his hand resulting in serious crush and burn injuries. The machine’s interlock system, designed to facilitate safe access, was not operating at the time. Industrial Magistrate Michael Ardlie said that while the risk of injury had been identified with the machine, that’s where the process had stopped. “We continue to see far too many of these types of injuries, which is why manufacturing remains a priority industry for all workplace safety authorities in Australia,” says SafeWork SA Executive Director, Michele Patterson. “During our Safe Work Month recently completed, our inspectors made many presentations on safety in manufacturing. “These two cases illustrate why we need to continually press home that message,” Ms. Patterson said.

Penalties Over Travelator Fatality 28 November 2008

Two companies have been fined a total of nearly $180,000 by an industrial magistrate today over the death of a worker in an incident involving a moving walkway or ‘travelator’ at Pasadena. On the 14th of December 2005, carpenter Stuart Munzberg was fatally injured when caught within a travelator, which had been activated for testing at a suburban shopping centre. Mr. Munzberg was not directly working on the device, but was engaged in general construction work around it. SafeWork SA’s investigation revealed he fell into a gap and was exposed to the travelator’s moving parts after a pallet or pallets were removed. Cox Constructions Pty Ltd pleaded guilty to one count of breaching section 19(1) of the Occupational Health, Safety and Welfare Act 1986 in failing to provide a safe working environment. SSL Lifs Pty Ltd failed to show for any of the legal proceedings and was convicted in its absence of two counts of breaching section 22(2) of the Act in failing to ensure that a person other than an employee was safe at a workplace under their control (i.e. Mr. Munzberg and others).
In announcing his decisions on penalty, Industrial Magistrate Michael Ardlie told the court that Cox Constructions as the first defendant should not have allowed its workers into the area when the travelator was being tested, and was not properly supervising the project at the time.

Magistrate Ardlie said that SSL Lifts as the second defendant, did not erect guarding or signage at the travelator entrance to prohibit entry, and should have taken steps to exclude other workers from the site. Magistrate Ardlie added that SSL’s employee could have used a manual control switch to inspect the travelator and deactivate it immediately, but did not.

He fined Cox Constructions Pty Ltd $59,500, having discounted the penalty by 15% to account for the early guilty plea and cooperation.

SSL Lifts Pty Ltd was fined a total of $120,000.

Compensation totalling $20,000 was awarded to Mr. Munzberg’s immediate family.

“This is a shocking and tragic example of the consequences of poor safety planning and poor communication,” says SafeWork SA Executive Director, Michele Patterson.

“It was easily avoidable, and we urge those engaged in multiple activities on any one worksite to factor each other’s activities into their safe work practices to make sure such an incident is never repeated.”

New CRC Guidelines Announced - Public Interest Research Reinstated

Senator Kim Carr, Minister for Innovation, Industry, Science and Research, today released the new guidelines for the Australian Government’s re-invigorated CRC Program and launched the 11th CRC selection round.

“The revitalisation of the CRC program was an election commitment, which I am very pleased to say we have delivered after a comprehensive review of the program, conducted by Professor Mary O’Kane.

“The re-instatement of public good as an assessment criterion and the inclusion of the humanities, arts and social sciences will broaden the base of the program.

“The new program responds to the recommendations of the O’Kane review and takes account of stakeholder feedback.

“The revised objectives mean that CRCs will deliver significant economic, environmental and social benefits.

“The CRC Program is a cornerstone of Australia’s national innovation system. In 2008, the Australian Government will provide more than $182 million to CRCs.

“I am expecting a strong field in this selection round. There are over 20 existing CRCs whose agreements finish in June 2010, and many of these have said they will reapply.

“I also expect that good applications from 2006, deemed uncompetitive at that time because of their focus on public good, will be resubmitted.

“Applications close on 20 March 2009, and I expect to announce the results of the selection process by the middle of next year.

“Information sessions will be conducted nationally and I urge participants to obtain a copy of the guidelines from the CRC Program website and to attend the information sessions (details attached). Further information about the guidelines, the information sessions and application materials can be found on the CRC Program website.

Source: Minister for Innovation, Industry, Science and Research

Asbestos investigation ordered at Collinsville Hospital site

Queensland Health has launched an investigation into concerns asbestos has been identified on the Collinsville Hospital site.
Last week the Deputy Prime Minister and Minister for Workplace Relations, Julia Gillard, delivered on some of the government’s promises by presenting the Fair Work Australia Bill into the Australian Parliament. This does not present a revolution but is a solid rollback of some of the excesses of the previous (conservative) government. The responses from employer groups and trade unions were in the tones and on the topics that were expected.

The National Review into Model OHS Laws rolls on towards its January 2009 deadline. The OHS law review was not something urgent for the government, even though it was an election pledge, and it does not indicate a commitment by the government to improving the level of safety in Australia. The aim is to provide an easier way of managing safety across state borders in Australia with the hope that this will flow to benefit the safety of workers.

It is important to remember that this review came after years of concern about the perception(?) that OHS was part of the red tape of managing businesses, and therefore an unacceptable cost burden. The danger in this review is that the recommendations will reduce the business costs with no discernible improvement in safety.

There are many OHS professionals and organisations who are hoping for some grand review of workplaces safety. It is a review of law and business bureaucracy, not safety. Those who will most benefit will be large companies that operate in multiple States. It will provide no change to small business. It will not increase safety in the vast majority of workplaces. It may improve the bottom line company results in 2009 when profit growth is declining but that just means that managerial bonuses are less than normal. It does not mean that the cost savings will be used to improve safety.

The Fair Work Australia Bill and the National OHS Law Review may change some of the ways in which corporations approach OHS but they will have little, if any, benefit to individual workers.

It is important to remember that any legal changes always benefit legal practitioners, as well. And OHS lawyers are almost always there after the incident in order to minimise company damage. Policies and procedures are largely determined without legal involvement. Machine guarding is not installed by lawyers. Abusive supervisors are not tempered by legal threats. Safety is the manager’s job in partnership with the employees, and it will always be so.

This article original appeared in SafetyAtWorkBlog on 1 December 2008 (http://safetyatworkblog.wordpress.com/2008/12/01/fair-work-and-ohs/)

© Workplace Safety Services P/L
Health Minister Stephen Robertson today told State Parliament asbestos had been found in samples of soil and broken pieces of fibrous cement wall sheeting taken from the hospital site.

"Indications are that the presence of asbestos is related to demolition work that was carried out many years ago and not connected with the work Watpac has carried out in the last 13 to 14 months to build the new hospital," he said.

"Occupational health and safety consultants have advised that there is negligible risk to staff and patients at the hospital."

Mr Robertson said to date no on-site soil sampling had identified asbestos.

"Upon being made aware of concerns Queensland Health acted quickly and immediately engaging environmental consultants, Parsons Brinckerhoff, to investigate and provide advice on how to best deal with the asbestos problem," Mr Robertson said.

"Further air monitoring and soil sampling is being carried out by Parsons Brinckerhoff and following testing and analysis of the results, they will report on the most appropriate means of dealing with the contamination," he said.

"The safety and health of our staff, contractors and the community is our number one priority.

"That's why as a precaution, the affected area has been watered down and access has been restricted until the investigation, sampling or remediation works are complete.

"It is important to remember that the mere presence of asbestos does not constitute a public health risk if people are not exposed to airborne fibres."

Mr Robertson said the investigation was expected to be completed next week.

Source: Qld Minister for Health