NATIONAL RESEARCH CENTRE FOR
OCCUPATIONAL HEALTH AND SAFETY REGULATION

REGULATION AT WORK

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At the Centre

In this edition of *Regulation at Work* we present the regular updates on **Developments in regulation**, **Key research and reports** and **Key cases**. We also include a **Feature article** which presents a précis of Professor Michael Quinlan's report as the OHS expert assisting the special investigator into the Beaconsfield seismic event and rock fall on 25 April 2006, which led to the death of one mine worker and the entrapment of two others for 11 days. The article highlights some of the important findings in the Quinlan report about response to seismic activity in underground mines, consultation and communication with the workforce, assessment of risks and other matters of wider relevance to OHS management.

Inside this issue:

NRCOHSR symposium

In May, the Centre organised a symposium for OHS regulators and regulatory researchers on the National Review into Model OHS Laws. There were presentations on:

- *The primary duty of care of a person conducting a business or undertaking* – Professor Richard Johnstone, Griffith University and RegNet, ANU adjunct professor;
- *The duties of officers and due diligence* – Mr Neil Foster, University of Newcastle;
- *Offences relating to breaches of the duty of care, defences and related matters* – Professor Ron McCallum and Ms Belinda Reeve, University of Sydney;
- *The upstream and other 'specified classes' of duty holders, reasonably practicable and risk management, and access to OHS advice* – Ms Liz Bluff, RegNet, ANU;
- *Workplace consultation, participation, representation and protection* – Ms Andrea Shaw, Shaw Idea and Dr Deb Vallance, Australian Manufacturing Workers Union;
- *The role of the regulator and inspectors* – Mr Jim Carmichael, Workplace Health and Safety Queensland.

Presentations from the Symposium are online at: http://ohs.anu.edu.au/projects/events.php#past.

There are also links to working papers from three of these presentations (Centre working papers 66, 67 and 68) at: http://ohs.anu.edu.au/publications/index.php.

More information about the National Research Centre for OHS Regulation, its publications and activities, and about OHS regulation and OHS regulatory research more generally, can be found online at: http://ohs.anu.edu.au.

Developments in regulation

Australia – The first meeting of the new tripartite Safe Work Australia Council was held on June 10, 2009. The Council was established to drive national policy development on OHS and workers' compensation matters and replaces the Australian Safety and Compensation Council (ASCC). Among other matters, at its first meeting the Council agreed to establish a tripartite Strategic Issues Group on OHS matters which will have limited decision making power to progress the Council's work in relation to the development of the model OHS Act and model OHS regulations. This will include resolving policy issues arising from recommendations for the model Act. The Strategic Issues Group will also be able to establish advisory groups to progress specific OHS matters. Membership of these advisory groups may include technical experts from industry or the community. More information about the Safe Work Australia Council and Safe Work Australia, the independent body established to support the Council, is online at http://www.safeworkaustralia.gov.au.

Australia – The Workplace Relations Ministers Council (WRMC) endorsed the proposed structure and content of the model OHS Act and has asked the Safe Work Australia Council to develop the model OHS laws in accordance with its decisions. Subsequently, the Safe Work Australia Council agreed to recommend to WRMC a revised timeframe for the development of the model Act. This would involve release of an exposure draft of the model Act and Regulatory Impact Statement in September 2009, for a period of six weeks public comment, and submission of the draft model Act to WRMC by the end of 2009. The drafting of the model OHS Act is to be guided by and take account of the following areas:

- A primary duty of care will be owed by any person conducting a business or undertaking with the object of moving away from the traditional emphasis on the employment relationship and to provide greater protection for all persons involved in, or affected by, work activity. The scope of the duty is to be limited to OHS matters and not to extend further into areas of public safety that are not related to workplace activity.
- The model OHS Act will protect volunteers in their capacity as workers but should not have the unintended consequence of discouraging voluntary participation in community-based activities by placing inappropriate duties on volunteer directors and persons who undertake work in a voluntary capacity.
- To avoid unwarranted and irreconcilable conflicts with existing criminal and procedural laws in the jurisdictions, certain matters will be dealt with outside the model OHS laws.
- Some more prescriptive matters will be dealt with in subordinate OHS legislation rather than in the model OHS Act.

A Table identifying how WRMC responded to each recommendation in the two reports of the National OHS Review is online at: http://www.safeworkaustralia.gov.au (under 'Model Legislation).

Developments in regulation (continued)

Also in Australia – The Productivity Commission sought comment on its issues paper *Performance Benchmarking of Australian Business Regulation: Occupational Health and Safety*. The paper was issued in April with submissions requested by 15 May 2009. Comment was sought on 16 issues. Some relate to: perceived changes in the OHS regulatory burden over time; studies or sources of data for performance benchmarking; whether industry-specific or other legislation should also be benchmarked; outcomes or indicators of regulation effectiveness; usefulness of average workers' compensation premiums as an indicator. Others ask for information about regulations posing the most significant burden; the burden due to jurisdictional differences; different impacts within an industry (eg for large vs small business); codes posing the greatest burden; assistance provided by codes and guidance material; and promotion and enforcement of codes. There are also issues enquiring about the frequency, thoroughness and efficiency of inspection; non-enforcement or partial enforcement; the role of educative and punitive approaches in achieving change; and interactions with regulators that impose the greatest burden. Finally the issues paper asks about the ten top perceived burdens. The Productivity Commission is to develop a range of feasible quantitative and qualitative performance indicators and reporting framework options for ongoing assessment and comparison of regulatory regimes across all levels of government. The issues paper is online at: http://www.pc.gov.au.

ACT - An exposure draft of the *Work Safety Regulation* 2009 was released for consultation. The draft is available for comment until 20 July 2009. The exposure draft includes:

- Provisions of the *OHS (General) Regulation* 2007 remade in line with the terminology and concepts in the new ACT OHS Act;
- Further detailed provisions for workplace arrangements;
- Provisions implementing the *National Standard for Licensing Persons Performing High Risk Work*, and retaining those provisions in the *OHS (Certification of Plant Users and Operators) Regulation* which cover additional load shifting machinery;
- The *OHS (Manual Handling) Regula*tion 1997 remade in line with the terminology and concepts in the new ACT OHS Act and a new national standard; and
- A schedule of reviewable decisions for the Act and Regulations.

A discussion paper and the draft regulations are online at: http://www.cmd.act.gov.au/governance/public/wpsafety.

New South Wales – The NSW Government will cooperate with federal agencies to develop a mandatory reporting and labelling system for nanomaterials used in the workplace, and a national approach to nanotechnology legislation. The decision implements recommendations of a parliamentary Standing Committee on State Development inquiry concerning the safe use and further development of nanotechnology. The report, *Nanotechnology in New South Wales (Final Report)* and further information are online at: http://www.parliament.nsw.gov.au.

Queensland – The *Mines and Energy Legislation Amendment Bill* seeks to amend various Acts administered within the mines and energy portfolio. Of relevance to OHS are provisions to establish a commissioner for mine safety and health to, among other matters, report on the performance of the mines inspectorate. The Bill also creates an offence for a person causing detriment to another person providing information about a safety concern. The intention is to facilitate reporting of unsafe or illegal practices without fear of retribution or victimisation. The Bill also proposes amend-

Developments in regulation (continued)

ments that will offer greater protection to statutory officials from civil liability, extending current protection for an act done or omission made honestly and without negligence, to clarify that an 'act done' can refer to giving information and advice. More information is online at: http://www.parliament.qld.gov.au/.

South Australia – SafeWork SA has issued a draft *Code of Practice for Working Hours* and a revised draft code of practice for first aid, for public comment. For both drafts, public comment closes on 30 June, 2009. The draft codes and discussion papers are online at: http://www.safework.sa.gov.au.

Tasmania – The Beaconsfield Investigation Report prepared for the Tasmanian Coroner, concerning the death of Larry Knight and entrapment of Todd Russell and Brant Webb, was released. The report and supporting documents are online at: http://www.justice.tas.gov.au. (See also Feature Article in this edition of *Regulation at Work*).

Also in Tasmania - Workplace Standards released for public comment a draft *Code of Practice – Induction for Construction Work*. The code provides guidance to persons working in general and residential construction sectors on the types of induction training that may be needed to provide construction workers with an awareness and understanding of common hazards on construction sites and how they should be managed. Public comment closes on 17 July 2009. The draft code is online at: http://www.wst.tas.gov.au.

Victoria – WorkSafe published an industry standard for *Safe Erection of Structural Steel for Buildings*. The industry standard provides practical guidance for the design, fabrication, transportation and erection of steel members for buildings, to eliminate and reduce the risk to health and safety of employees and contractors involved in structural steel erection, and the public in the vicinity of this work. The standard is online at: http://www.worksafe.vic.gov.au.

Western Australia – The statutory review into mine safety conducted by Commissioner Stephen Kenner made 119 recommendations. The report recommended continuing implementation of the *National Mines Safety Framework* and extending the application of the provisions of the OSH Act that are the same as the *Mines Safety and Inspection Act* but continuing the MSI Act as complementary legislation (not replaced by the OSH Act). The report also recommended adoption of a three tiered risk management approach to accommodate mining operations of differing size, complexity, motivation and sophistication with a safety case regime available on an opt-in basis. Further recommendations supported substantially increasing the resourcing of the Resources Safety Division and implementing an infringement notice scheme. The report and full recommendations are online at: http://www.dmp.wa.gov.au.

Other developments

Safe design of agricultural machinery - The peak European trade union body ETUI has initiated a project to contribute workers' experience in using combine harvesters to inform and improve the EU harmonised standard - EN 632 *Combine harvesters and forage harvesters: Safety*. The project, named Agri-Project, will run from April to December 2009. The aim is to improve standard EN 632 by examining the gap between the designer's view of machinery operation and how it actually works in the field. The project will be carried out by relevant unions in Denmark, Germany, Italy, Sweden and the UK. Operators will be invited to participate in working groups and share and record their day-to-day experience in the use of harvesters. These ideas will then be compared with the design solutions in EN 632, with a view to identifying gaps and shortcomings that need to be resolved. More information is online at: http://hesa.etui-rehs.org/.

Fatalities in small construction firms - An analysis of fatalities in the UK construction industry conducted by the Centre for Corporate Accountability on behalf of the building workers union, UCATT, found that workers employed by smaller construction businesses (less than 50 employees), are at a higher risk of dying than those who work for large companies. While 34% of workers in the construction sector work for businesses with between 1-49 employees, 51% of the deaths were for this category of business. The report is online at: http://www.corporateaccountability.org/.

Key research and reports

Standards setting

Scott, *Standards-setting in regulatory regimes*, University College of Dublin Law Research Paper no 07/2009, School of Law, University College Dublin, 2009. This paper elaborates the meaning of standards within regulatory regimes in terms both of instrument types and the nature of standards. The paper then considers the variety of state and non-state actors who are involved in standard-setting and the processes through which standards are set and applied, at national and supranational levels, and including state and non-state organisations. The paper is online at: http://ssrn.com/abstract=1393647.

Enforcement

N Gunningham and D Sinclair, 'Regulation and the role of trust: reflections from the mining industry' (2009) *Journal of Law and Policy* 36(2): 167-194. This article reports research in the mining industry about interactions between inspectors and the industry and the centrality of trust to constructive relations. The research found that when trust breaks down, dialogue ceases, information is withheld, in-firm preventive action is inhibited and both sides retreat to adversarialism that undermines regulatory effectiveness. The article also discusses how trust may be regained.

D Weil, 'A strategic approach to labour inspection' (2008) *International Labour Review* 147(4): 350-375. This article discusses the need for inspectorates to go beyond calls for more resources and adopt a clear, strategic framework for responding to incoming complaints and targeting programmed

Key research and reports (continued)

investigations in order to maximise effectiveness. The article suggests inspectorates should be guided by principles of prioritisation, based on probable severity of problems facing an industry or workplace; deterrence or the threat of inspection spurring on changes in compliance or practices prospectively; sustainability, a measure of whether past interventions produce continuing compliance; and achieving systemic effects, taking into account geographic, industry or product/market effects.

P Katsakiori et al, 'A method of investigation by labour inspectors – design and preliminary evaluation' (2009) *Policy and Practice in Health and Safety* 7(1): 53-68. This paper proposes a structured method for incident investigation which starts with active failures, then searches for immediate and underlying factors, and then finds root and legal factors. The method has been evaluated by inspectors in Greece.

B Barrett, 'The Health and Safety (Offences) Act 2008' (2009) *Industrial Law Journal* 38(1): 73-79. The article discusses this UK Act which addresses the penalties that courts may impose for breach of duties of the *Health and Safety at Work Act* 1974. The Act sets out a schedule identifying the offence, the mode of trial, the penalty on summary conviction and the penalty on conviction on indictment.

OHS culture, OHS management and OHS performance

E Wadsworth and J Smith, 'Safety culture, advice and performance' (2009) *Policy and Practice in Health and Safety* 7(1): 5-31. This article reports on a study of the associations between corporate OHS performance, culture and OHS practitioner advice. UK organisations from various industry sectors took part in three questionnaire surveys measuring safety climate, OHS practitioners' experiences and OHS performance. The study found that the perception of organisational safety culture was consistently and independently associated with corporate OHS performance. There were also independent associations between OHS performance and both the level of OHS practitioners' training and qualifications, and organisational receptiveness to advice.

B Fernández-Muñiz, J Montes-Peón and C Vázquez-Ordás, 'Relation between occupational safety management and firm performance' (2009) *Safety Science* 47: 980-991. This article presents research examining the relationship between OHS management, OHS performance, competitiveness and financial performance. The research was based on a survey questionnaire completed by the OHS officer or coordinator in 455 Spanish firms. The findings suggest OHS management had a positive influence on OHS performance, competitiveness and financial performance.

Performance indicators

A series of articles in *Safety Science* 47(6) 2009 discuss the development and application of performance indicators. The discussions focus on process indicators for major hazards facilities but are also relevant to other industries.

Key research and reports (continued)

Health and safety representation and participation

M Menendez, J Benach and L Vogel, The impact of safety representatives on occupational health - a European perspective, ETUI-REHS, Belgium, 2009. This report reviews European studies relating to the presence of union officials in a workplace and OHS protection. The report concludes that having union representation can lead to better observance of rules, lower accident rates and fewer work-related health problems. The report also analyses the conditions and factors for effective representation. More information is online at: http://hesa.etui-rehs.org/uk/publications/pub46.htm.

J Popma, 'Does worker participation improve health and safety? Findings from the Netherlands' (2009) *Policy and Practice in Health and Safety* 7(1): 33-51. This article examines recent empirical findings concerning the effect on OSH performance of worker participation in the Netherlands. Worker participation through formal consultation via works councils was found to be only marginally associated with better OSH performance in organisations. Increased worker participation correlated with better quality risk assessments and preventive measures, especially concerning psychosocial risks, although the effect was not strong. The strength of workers' roles in OSH was influenced by whether works councils took an activist stance in their dealings with management and the organisation's management style.

Biomechanical risks

ETUI, *Risk assessment of biomechanical damage risks in small and medium-sized enterprises*, ETUI-REHS, Belgium, 2009. This report reviews the musculoskeletal disorders faced by workers in small and medium enterprises. It presents a holistic, participatory and multidisciplinary approach to assessing biomechanical risks and work situations to produce practical solutions to problems. Options derived from daily experience of working in smaller firms are also presented. More information is online at: http://hesa.etui-rehs.org/.

Hazardous substances

J Killey, J Temperley and L Fragar, 'In Australia, can a user know whether a pesticide is a hazardous substance?' (2009) *Journal of Occupational Health and Safety – Australia and New Zealand* 25(2): 123-128. This article reports on a study in which 300 pesticides registered for use in agricultural production were classified to determine if they were hazardous substances according to Australian OHS regulations. The researchers describe the considerable practical difficulties encountered in determining whether particular pesticides were 'hazardous'. They suggest their findings make a strong case for mandatory inclusion on pesticide labels of hazardous substance statement for those products that meet the classification criteria and further that the Australian Pesticides and Veterinary Medicines Authority should be provided with all relevant information to ensure the statement is accurate.

European Risk Observatory, *Expert forecast on emerging chemical risks related to occupational safety and health*, European Agency for Safety and Health at Work, Belgium, 2009. This report presents the results of a forecast on emerging chemical risks for OHS. It is based on an expert survey and literature review. In the top ten emerging risks are nanoparticles and ultrafine particles, diesel exhaust and man-made mineral fibres. Others are epoxy resions, isocyanates and dermal exposure. Sector specific risks are hazardous substances in waste treatment and construction, and substance use in SMEs. The report is online at: http://osha.europa.eu/en/publications/reports/. See also the article in 'International news' in this edition about the European Trade Union Confederation (ETUC) list of priority chemical substances.

Key research and reports (continued)

Mesothelioma

Safe Work Australia, *Mesothelioma in Australia*, Safe Work Australia, Canberra, 2009. This publication reports on the number of new cases and the number of deaths from mesothelioma over time. The report is based on data collected by the National Cancer Statistics Clearing House and the National Morbidity Database, provided to Safe Work Australia by the Australian Institute of Health and Welfare. The report is online at: http://www.safeworkaustralia.gov.au.

Safety and engineering

J Downer, *When failure is an option: redundancy, reliability and regulation in complex technical systems*, Centre for Analysis of Risk and Regulation Discussion Paper 53, The London School of Economics and Political Science, London, May 2009. This paper examines redundancy in engineering, arguing that it should be understood as a design paradigm that frames regulatory assessments and interpretations of all complex technical systems. Further, the redundancy paradigm contains ambiguities that lead to imperfect predictions about the effects of redundancy in practice. Using aviation regulation as an example, the paper illuminates wider issues about technology governance. The paper in online at: http://www.lse.ac.uk.

N Stacey, K Simpson and G Schleyer, *Integrating risk concepts into undergraduate engineering courses*, Health and Safety Executive Research Report RR 701, HMSO, Norwich, 2009. This report describes a joint project conducted by the Health and Safety Laboratory and the University of Liverpool Engineering Department to integrate risk concepts into the university's undergraduate engineering course. The project included definition of risk education learning outcomes, implementing them through real accident case studies into core engineering modules and evaluation of the project. The report is online at: http://www.hse.gov.uk.

Migrant workers

M Sargeant and E Tucker, *Layers of vulnerability in occupational health and saftey for migrant workers: case studies from Canada and the United Kingdom*, Comparative Research in Law and Political Economy (CLPE) Research Paper no 8/2009, Social Science Research Network, 2009. This paper is concerned with the implications of increases in migrant workers for protective labour laws generally and OHS regulation in particular. The authors identify a framework for assessing the OHS vulnerabilities of migrant workers and to identify risk factors. They compare the situation of migrant workers in Canada and the UK. The paper is online at: http://ssrn.com/abstract=1415371.

OHS regulation and globalisation

V Heyvaert, 'Globalising regulation: reaching beyond the borders of chemical safety' (2009) *Journal of Law and Society* 36(1):110-128. With reference to the EU regulation on the Registration, Evaluation, Authorisation and Restriction of Chemicals (REACH), this article discusses the normative, social, economic and strategic reasons behind the push to promote the global adoption of REACH, and the potential disadvantages. While harmonisation may foster trade through mutual recognition and the development of transnational regulatory frameworks, it also reduces regulatory diversity, amplifies both the strengths and weaknesses of a regulatory regime and increases the potential for conflict and trade flow disequilibria.

Key research and reports (continued)

M Baram, 'Globalisation and workplace hazards in developing nations' (2009) *Safety Science* 47: 756-766. This article discusses the problem of multinational corporations introducing hazardous technologies into developing countries which lack the safeguards, expertise and public pressure to prevent harm to workers. The article evaluates current approaches taken by international and industrial organisations to address hazards in legislation, codes of conduct and through voluntary self-regulation. A new approach is suggested, the key features of which are defining a standard of care and establishing contractual relationships between multinational corporations and host countries to implement the standard and transfer practices for using the transferred technology safely. Such a commitment would require the multinational corporation to follow standards and practices equivalent

Workers compensation

International Social Security and Workers Compensation Journal. The first edition of this new online journal contains articles on occupational diseases, work-relatedness of myocardial infarctions, stress minimisation and protecting dependants from the effects of occupational hazards. The journal is online at: http://www.business.curtin.edu.au/business/research/journals/.

International News

Priority chemicals - In March, the European Trade Union Confederation presented the European Parliament with its list of priority chemical substances for authorisation under the new European law on trade in chemicals - Registration, Evaluation, Authorisation and Restriction of Chemicals (REACH). The list classifies 306 substances in order of priority, with 191 of these being substances that cause recognised industrial diseases. The aim of the list is to contribute to authorisation procedures under REACH which will identify the most hazardous chemicals currently on the European market, control risks arising from their use and replace them with safer alternatives. The report, *Trade Union Priority List for REACH Authorisation*, explains how the list was developed and incorporates the list. It is online at: http://hesa.etui-rehs.org.

Key cases

***R v H Waterhouse & Son Pty Ltd*, Supreme Court of Victoria — Court of Appeal (Warren CJ, Vincent and Nettle JJA), 9 June 2009**

H Waterhouse & Son Pty Ltd (the applicant) sought leave to appeal against convictions for two counts of contravening the employer's general duty in sections 21(1) and 21(2)(a) and 21(1) and 21(2)(e) of the *Occupational Health and Safety Act* 1985 (Vic). Much of the appeal was directed at the Trial Judge's direction to the jury. The Court of Appeal refused leave to appeal. In so doing, the Court made some interesting observations.

First, it found that the applicant was incorrect in arguing that the Trial Judge's directions in relation to the issue of control in section 21(3) of the Act were inadequate. Section 21(3) provides that for the purposes of the employer's general duty in section 21:

a) "employee" includes an independent contractor engaged by an employer and any employees of the independent contractor; and

b) the duties of an employer under those sub-sections extend to such an independent contractor and the independent contractor's employees, in relation to matters over which the employer—

(i) has control; or

(ii) would have had control but for any agreement between the employer and the independent contractor to the contrary.

The Court of Appeal found that the Trial Judge had properly instructed the jury that the question of 'control' related to the particular risk of welding inside the tank.

Further, in para [24] the Court of Appeal noted that:

> [T]he judge did not equate control over the workplace to control over the risk or fail to emphasise the matters set out in s 21(3)(b) of the Act. So far as control is concerned, her Honour listed and expatiated upon no less than eight matters which she directed the jury could be taken into account in determining whether Waterhouse had control over the welding of the two tanks together. They were (1) that Mr Rowe and Mr Williams were on Waterhouse's premises doing work for Waterhouse; (2) that practical control may be important; (3) that K & T was engaged as an expert or specialist in a field and that Mr Rowe and Mr Williams were themselves specialists in that field; (4) that there was a dispute on the evidence, which needed to be determined, as to whether K &T were engaged by Waterhouse to provide contract labour to work at Mr Spence's direction; (5) that control need not be exclusive; (6) whether under the arrangements which obtained, Waterhouse had the right or Mr Rowe and Mr Williams accepted that Waterhouse had the right to give directions not to perform work in a particular way; (7) whether Waterhouse had effective control of that part of the premises in which was done the work of welding together the two tanks; and (8) whether Mr Rowe and Mr Williams were brought onto the premises for the purposes of Waterhouse's enterprise. There was no suggestion of equating control of the premises to control of the risk. Her Honour simply made the point, correctly that one of the factors to be taken into account in determining whether there was control of the welding operation was whether there was control of that part of the premises in which it was being conducted.

A second appeal point was in relation to the privilege against self incrimination. Section 39 of the Act provided that:

Key cases (continued)

> An inspector may for the purposes of the execution of this Act or the regulations— … (i) require the production of examine and take copies of any document or part of any document …

Section 42(1)(c) provided that:

> Any person who — … (c) fails to produce any document required under this Act or the regulations by an inspector, shall be guilty of an offence.

Section 40(8) of the Act provided that:

> No person shall be required under section 39 to answer any question or give any evidence tending to self incrimination.

The applicant argued that it could not be asked to produce certain documents because the documents were the subject of privilege against self-incrimination and thus should not be tendered in evidence.

The Court of Appeal rejected this argument:

> **[51]** If the applicant had been a natural person, it might have resisted production of the documents on the ground of the common law privilege against self-incrimination. But the common law privilege against self-incrimination does not and never did apply to corporations in this country, even though for some time it was widely assumed that it did. Consequently, if the applicant had sought to resist production of the documents on the basis of the common law privilege against self-incrimination, the claim would have failed.
>
> **[52]** Despite that, however, counsel submitted that, because s 38 of the Interpretation of Legislation Act 1958 provides that, unless the contrary intention appears, "person" includes a body politic or corporate as well as an individual, s 38 should be taken to have extended the privilege to corporations like the applicant.
>
> **[53]** We do not accept that submission. It is highly improbable that Parliament intended to expand the scope of the privilege in that fashion. But even if s 40(8) did apply to corporations in the manner contended, it did not provide that the persons to whom it referred should have the benefit of the privilege against self-incrimination, but only that they should not be required to answer any question or give any evidence tending to self incrimination. The notice under s 39(i) did not require the applicant to answer any question or give any evidence; simply to produce documents, and that was all it did.

Finally, the applicant argued that (para [55]) 'the judge erred in treating the regulations made under the Act as applicable to the applicant and thus in directing the jury that one of the considerations to which they might have regard when determining whether the applicant had done what was reasonably practicable for the purposes of section 21(2)(a) of the Act was the obligations imposed on employers by the *Occupational Health and Safety (Confined Spaces) Regulations 1996.*' In effect, the applicant was arguing that as the term 'employer' was not defined in the regulations, it had the same meaning as the definition of 'employer' in the Act in section 4, and therefore was not applicable to the situation before the Court. The Court of Appeal rejected this argument:

Key cases (continued)

> **[57]** … As has been seen, s 21(2) imposed upon an employer an obligation to provide and maintain so far as is practicable for employees a working environment that is safe and without risks to health. One of the matters to which one might properly have had regard in determining whether an employer had discharged that obligation was whether it had complied with the Regulations. Regulation 14 provided that an employer must ensure that all hazards associated with work in a confined space are identified, having regard to the state of knowledge about hazards. "Work in a confined space" was defined in reg 4(2)(a) to mean work in the space by an employee and as including the entry to and exit from the space by the employee. Consequently, in determining whether an employer had complied with the obligation under s 21(2) to provide and maintain so far as is practicable for employees a working environment that was safe and without risk to the health of the employees, one of the matters to which one might properly have had regard was whether with respect to an employee working in a confined space the employer had ensured that all hazards associated within the confined space were identified having regard to the state of knowledge about hazards.

***Smith v Northamptonshire County Council* [2009] UKHL 27 (20 May 2009)**

(Adapted from a note provided by Neil Foster, University of Newcastle, NSW).

In this case, the UK House of Lords examined the scope of the *Provision and Use of Work Equipment Regulations* 1998 in an action for breach of statutory duty. The claimant, Mrs Smith, an employee of the Council, was injured while wheeling an elderly client out of her house to take her on a bus to a day centre. The client's wheelchair needed a ramp to leave the house. A defect in a ramp (provided by the National Health Service, not the Council, some years previously) caused Mrs Smith's injury. There was no negligence by the Council but there was a civil action for breach of regulation 5 which required 'work equipment' to be 'in good repair', if the circumstances of the incident fell within regulation 3(2). This came down to two questions discussed in the lower courts: (1) was the ramp 'work equipment'? (2) was it 'provided for use or used by an employee at his work'?

In relation to (1), there was general agreement that the ramp was indeed 'work equipment'. (See the comments of Lord Hope at [21]-[22] that the object must be intended to be used by workers and not just by family members.) The second question involved examining whether the ramp was covered by the regulations, given that it was not 'provided' by the Council? (It was, however, inspected by Council employees and tested by them occasionally.) All members of the House accepted that the words 'used by' the employee would, if read literally, have meant that the ramp was included since every time Mrs Smith fetched the client she in fact used the ramp. However, each said that there needed to be some limitation on the full breadth of these words, as otherwise an employer could be held responsible for the condition of some item which an employee, sent off-site, in fact used despite the employer not even being aware of its existence and having no influence over its condition.

At para [65] Lord Mance (speaking for the majority, Lords Carswell and Neuberger) held that the equipment must have been somehow 'incorporated into and adopted as part of the employer's business or other undertaking', either being supplied by the employer or 'provided by anyone else and being used by the employee in it with the employer's consent and endorsement'. In using this language his Lordship was it seems adopting the terminology of the European Directive 89/655/EEC at 3(1), which the regulations were said to have been implementing – see para [62]. In this case the ramp was not part of the Council's undertaking - they did not own it, had no right to repair it without more, and the mere fact that they inspected it only meant that they were careful (see paras [67]-[70]).

Key cases (continued)

Lord Hope, on the other hand (supported by Baroness Hale), preferred a different test. His Lordship argued that the 'limiting' factor on 'mere use' should be related to the question of 'control' exercised by the employer over the item. In adopting this term he referred to the test of 'control' to be found in regulation 3(3), which applied to persons other than employers, but said that the concept was a helpful one for the whole regulation (see para [27]). In this case the Council had 'control' in that they knew the ramp was being used, their officers had tested it occasionally and they knew that it was needed for the job to be done. Hence the Council should have been held liable for defects (see para [30]).

Lord Neuberger noted that the difference between the two tests comes down to Lord Hope's focussing on control over the employee, whereas Lord Mances' emphasises control over the equipment (see para [83]).

Clearly equipment about which the employer has no knowledge, nor could be expected to know, will not fall within the scope of the legislation - see for example paragraph [23]. However, determining where the line should be drawn in other situations will require consideration of the extent of 'incorporation' or 'control'.

***Edwards v Woolworths Ltd* (2009) 178 IR 239**

Master Harper in the Supreme Court of the Australian Capital Territory found that section 223 in the *Occupational Health and Safety Act* 1989 (ACT), which provides that nothing in the Act be taken to affect civil liability, applied to the regulations made under the Act, so that a breach of the regulations could not found an action for breach of statutory duty.

***Telstra Corporation Ltd v Smith* (2009) 178 IR 430**

Comcare conducted an inspection under the *Occupational Health and Safety Act 1991* (Cth) into an incident in which a pedestrian fell over a Telstra pit lid on a public footpath. Telstra argued that there had been a denial of procedural fairness because Comcare did not give Telstra a draft of the investigation report, nor notice of the conclusions contained in the report prior to the report being published. Telstra also argued that the investigator was not empowered to make a finding or conclusion that Telstra had breached the Act, because of the principal that 'the statutory power to inquire and report is not in the absence of clear words to be read as extending the power to make a finding of criminal guilt or other improper conduct' (*Brinsmead v Commissioner Tweed Shire Council Public Inquiry* (2007) 69 NSWLR 438 at 443).

Middleton J in the Federal Court of Australia found that the pit and lid was a 'workplace' at the time of the incident even though no employees or contractors of Telstra were working at or near there at the time. Middleton J also found that there was no denial of procedural fairness to Telstra. Middleton J also held that the investigator could make a finding that Telstra had breached the Act (ie 'improper conduct') because (at 448):

Key cases (continued)

> S 41 of the Act empowers an investigator to conduct an investigation concerning a breach or possible breach of the Act, and the report of that investigation (in the case where the investigator considers there to be a breach) must necessarily include his conclusion from conducting the investigation. This seems to me to be the clearest indication … that an investigator is not only empowered so to conclude, but is under a duty to include in his or her report any conclusion reached as to the breach, or possible breach, of the Act.

Middleton J further held that there was material available to the investigator capable of satisfying him that there was a breach of the employer's general duty in the Act, and held that the investigator examined each of the components of section 17 and the relevant evidence.

Michael Dalzell v Andrew James Ferguson **[2009] NSWIRComm 81**

A manager appealed against a conviction by a magistrate for an offence under section 136 of the *Occupational Health and Safety Act* 2000 (NSW) which provides that:

> (1) A person must not:
>
> (i) obstruct, hinder or impede any authorised official in the exercise of the officer's functions under this Act …

Two officers of the Construction, Forestry, Mining and Energy Union (the CFMEU) had entered the site at which the manager worked in order to conduct a site safety audit. The two officers were authorised representatives of the union for the purposes of section 76 of the Act, which permits authorised union representatives to enter workplaces for OHS purposes. The manager obstructed them, because, as he argued, he did not believe that the two men were at the site for the *bona fide* purpose of conducting a site safety inspection. Rather he claimed that the officials attended the site to cause harm and damage; they intended to unlawfully solicit bribes; and that there were no safety problems on the site.

At first instance the magistrate found that the manager had obstructed the two officials and had sprayed them with water. He found that the manager's conduct was motivated by 'a determination to stop a legitimate and duly authorised site safety inspection from taking place'.

On appeal, the manager argued that he was acting under an honest and reasonable mistake of fact at the time of the offence.

The Full Bench held that section 136 established a strict liability offence, in the sense that '*mens rea* will be presumed to be present unless and until material is advanced by the defence of the existence of honest and reasonable belief that the conduct in question is not criminal in which case the prosecution must undertake the burden of negativing such belief beyond reasonable doubt (see para [34]). It held (para [45]) that 's 136 requires some form of mental element, such as the holding of an honest and reasonable but mistaken belief, that the person entering the premises is either not properly authorised or not entering for an official purpose under the Act.' The Full Bench determined that the defences in section 28 of the Act did not apply to section 136. The Full Bench agreed with the magistrate's finding that the manager did not act under a 'reasonable and honest mistake of fact.'

Key cases (continued)

Police Federation of Australia v Victoria Police Force **[C2009/2227] [9 April 2009]**

A Full Bench of the Australian Industrial Relations Commission (Vice President Ian Watson, Senior Deputy President Brian Lacy and Commissioner Wayne Blair) held that Victoria Police Force had the right to terminate an agreement with the Police Federation of Australia which allowed termination if 'there was a bona fide health and safety issue', in relation to a trial of a 12 hour variable roster at the Hastings Police Station in Victoria.

The Full Bench noted that English academic research found that there were significant risks associated with fatigue inherent in 12-hour rosters for policing justifying a refusal by police and the police federation in a county in north-west England refusing to accept 12-hour shifts on OHS grounds. Further, evidence from officers at the Hastings Police Station suggested that the roster gave rise to significant health and safety issues. The Full Bench concluded that a bona fide health and safety issue arose from the operation of the variable roster.

OHS Management at the Beaconsfield Joint Venture Gold Mine in Tasmania

Background

On the evening of 25 April 2006, a rock fall incident at the Beaconsfield Joint Venture Gold Mine in Tasmania resulted in the death of Larry Knight and the entrapment, for 11 days, of Todd Russell and Brant Webb. At the time of the incident the three miners were in the 925 west level of the mine near the stope brow constructing a barricade to minimise backfill in the void between the 915 and 925 level created by the removal of gold-bearing ore. Following the mine's procedures, Todd Russell and Brant Webb had checked for evidence of seismic activity before entering the area. After creating a two metre high bund of waste rock near the stope brow, these two workers were in the basket of the Telehandler (a versatile service vehicle with an extendable boom and lifting tynes) driven by Larry Knight, undertaking the task of installing eye pins into previously bored holes and then installing the mesh and rope wall.

At 9.23pm a seismic event occurred, causing a series of rock falls that trapped Todd Russell and Brant Webb and caused the death of Larry Knight. A slight difference in timing could have had even more severe consequences, with other miners also killed or injured, or it could have resulted in no injuries at all, as had occurred several times in the past. In this regard, in the six months prior to the fatal rock fall on 25 April 2006 there were three significant falls of ground (two in October 2005 and one in March 2006) in relatively close proximity in the 915 and 925 levels. These falls all occurred at times when the affected areas were designated 'no-entry' and so, fortuitously, they did not result in injuries.

Following the 25 April 2006 incident a full investigation into the causes of the incident was conducted and a report was prepared for the Coroner, at the request of the Tasmanian government. Professor Michael Quinlan of the School of Organisation and Management, University of New South Wales was appointed as the OHS expert to assist Special Investigator Greg Melick. Professor Quinlan's report on OHS management at the Beaconsfield mine was recently made available. The report presents impor-

OHS Management at the Beaconsfield Mine (continued)

tant findings about response to seismic activity, communication with the workforce, assessment of risks and various other matters which are of wider interest to OHS management.

In this Feature Article we provide a précis of key findings of the Quinlan report. For full details readers should refer to the report which has been published online, together with the Melick report, the report of geotechnical expert Scott Marisett which makes recommendations about future operations in mines with significant levels of seismicity, and the Coroner's findings and recommendations. These can all be accessed online at: http://www.justice.tas.gov.au.

The Quinlan report was drawn from analysis and examination of information from a wide range of sources. These included interviews with, and statements and documentation from Beaconsfield mine management, supervisors and workers; Workplace Standards Tasmania (WST); unions with members at the mine; and other persons with relevant knowledge. Information was also obtained from coronial and other government inquiries into safety in mining; and reports and statistical data relating to mining safety, major hazard events, risk management and related matters in Australian and overseas jurisdictions. The report on the Beaconsfield mine prepared by the geotechnical expert Scott Marisett was also a key source.

Seismic activity and rock falls

Over a number of years the mine had engaged various expert consultants to help it track and manage seismicity and advise on ground control measures to address safety risks. The recommendations of these consultants were largely adopted by the mine, with a number implemented at the time of the April 2006 incident. However, Scott Marisett, the geotechnical expert engaged to assist the investigation, identified a number of deficiencies in mine design or mining methods, ground support and the monitoring and assessment of seismic risk (including rock falls) in the period prior to the Anzac Day 2006 incident, notwithstanding a significant upgrade of seismic assessment in 2005. According to the Marisett report, based on analysis of seismic data supplied by the mine, there was a significant increase in micro-seismic activity in the mine and in the 940 mining block in particular in the week prior to 25 April 2006. In Mr Marisett's view this represented a significant increase in seismic activity and was abnormal compared to previous oscillations in seismic activity at the mine. From an OHS perspective there was an issue of concern that there did not appear to be protocols in place that when seismic events in particular areas increased beyond those levels normally associated with firing this would result in the extended withdrawal of mineworkers from these areas and/or an urgent meeting of appropriate managers to consider if any action was warranted.

In addition to trends in seismicity there was also an ongoing pattern and problem with rock falls at the mine. From January 2004 and up to and including the fatal fall on the evening of Anzac Day 2006, there had been at least 24 recorded rock falls (or one fall of 50 tonnes or more every ten weeks) with no drop in frequency. A significant number of falls at the Beaconsfield mine prior to 25 April were of a size that could be expected to entail serious injuries or fatalities were workers to be in the area at the time. The frequency of falls was indicative of problems with mining methods or ground support. This should have alerted management to serious issues prior to the October 2005 falls and should have indicated that the measures adopted after October were insufficient.

OHS Management at the Beaconsfield Mine (continued)

The Marisett geotechnical report identified three factors believed to have contributed to the seismic event and rock fall(s) that caused the death of Larry Knight and trapped Todd Russell and Brant Webb. In order of significance these were inadequate mine design for the ground conditions; less than adequate ground support for the changing ground conditions; and inappropriate procedures to manage the ground conditions (hazard assessment, re-entry inspections and training). There is further discussion of these issues in the Marisett report.

Consultation and communication

The investigation revealed that there was a widespread view amongst workers and others that seismicity had been increasing at the mine for 12 to 18 months (or longer) leading up to the incident of 25 April 2006. A significant number of mineworkers, especially experienced ones, and the majority of shift supervisors, held concerns about mining and ground control methods, especially the removal of supporting pillars. The mine's management argued that evidence from toolbox meetings; shift supervisor notes; weekly shift supervisor meetings; Zero Committee meetings; crew talks and other meetings; ABFA hazard report cards; incident, accident or near-miss reports; complaints to other staff, the AWU or WST did not indicate that seismicity was a significant issue for workers prior to the Anzac Day incident.

Professor Quinlan found that while there were few references to such concerns in written records of meetings, there was convincing evidence (from statements made to the investigation) that mineworkers held concerns about seismicity and mining methods prior to the Anzac Day incident. These concerns were not confined to union members or others with grievances against management, and were shared by direct employees of the mine as well as contractors. Most shift supervisors were also aware of these issues and some also held concerns about the safety of mining methods.

The Quinlan report concluded that there was clear evidence of a significant communication problem at the mine, and that the limited documentation of worker concerns needed to be seen in the context of considerable evidence of inadequate consultation and participatory practice. This was particularly the case in relation to the ability of workers to feed back some of their more serious safety concerns (such as seismicity and ground support) to management and have these treated with due regard. There was little evidence of genuine consultation in the sense of two-way exchange of views, where the views of mineworkers were given serious consideration. Apart from a brief period (in 2005) the mine lacked a site-wide OHS committee and health and safety representatives to represent the workforce on OHS matters. The 'Zero Committee' that operated for 8-9 months in 2005 had representatives of underground mine workers (but not contractors or above-ground workers) and was not successful. Professor Quinlan found that the reasons for the communication problem or disconnect were predominantly structural, notably the flat management structure, the absence of effective forms of worker representation on OHS at the mine, and a level of mistrust between many workers and management that resulted from the poor industrial relations climate at the mine.

Also, consultants who visited the mine did not speak to workers to gain the views even of more experienced mine workers, and the short-time frame and infrequency of their visits gave them limited opportunities to interact. Management provided workers with limited information from consultants' reports, and the information that was passed on did not include matters of concern such as pillar thickness, the magnitude of seismic events and likelihood of further large seismic events. There was also little evidence that management sought workers' views and ideas about control measures.

OHS Management at the Beaconsfield Mine (continued)

Assessment of mining methods and ground support

There was no evidence that a thorough and independent assessment of mining methods and ground support was undertaken following the serious incident in October 2005. The mine safety management plan had a strong focus on routine injury risks (as measured through lost time and medically treated injuries) and behaviour modification (of both managers and workers), with arguably less attention being given to less routine or catastrophic risks. As Professor Quinlan observes, a deficiency with regard to balancing routine and catastrophic risks has been identified in connection to mine management safety regimes and OHS management systems more generally in high hazard workplaces.

In the case of the Beaconsfield mine, catastrophic risk was not ignored. In 2004 the mine engaged a consultant to facilitate a catastrophic risk review (based on Australian Standard 4360). The risk of fire in the timber-lined shaft was ranked highest and ground control was ranked fifth. The mine contended that this ranking was the outcome of a thoughtful process by experienced people, but managers appeared to be unaware that rock falls had been the single most significant cause of death amongst underground mineworkers in Tasmania over many years. There was no systematic risk assessment following the October 2005 seismic event and rock fall, and the risk ranking of ground control in the original catastrophic risk assessment was not reassessed or revised after this event.

The Quinlan report provides a detailed discussion of a series of pitfalls in risk assessment and how each of these was manifest in the practices at the Beaconsfield mine. The pitfalls were: dividing the time spent on hazardous activity between several individuals (so that risk is perceived to be lower); not involving a team of people in estimation of risk or not involving workers with practical knowledge of the process of activity assessed; ineffective use of consultants; failure to identify hazards associated with a particular activity; not acting on the results of assessment; and not linking hazards with controls. (For further discussion of assessment and these pitfalls see paragaphs 646-728 of the Quinlan report).

Foreseeability

With regard to the question of foreseeability, mine management was aware that rock falls represented a serious hazard. The mine had experienced a number of significant rock falls in the same levels as, and in relatively close proximity to, the 25 April 2006 falls. Also, rock falls were experienced on a relatively regular basis with no apparent drop off in frequency when changes to mining methods were implemented after October 2005. Several expert consultants had informed mine management that further significant seismic events could occur, notwithstanding the changes to mining methods. While the specific seismic event, rock falls and location of these on 25 April 2006 may not have been foreseeable, the evidence indicated that further significant seismic events in the mine in the 915 and 925 metre levels were foreseeable.

Reasonably practicable preventive action

The mine recorded both rock fall and seismic activity and undertook detailed investigation into a number of rock falls. There was a rock noise reporting system and in 2005 seismic measurement was significantly upgraded to provide more accurate and real-time information that could be used by both senior management and shift supervisors to minimise the risk of exposure of mine workers to falls of ground. The mine had also developed a Ground Control Management Plan that was upgraded progressively and expert consultants were engaged to provide advice on mining methods and ground support. Following the serious seismic events and rock falls in October 2005, the mine closed a number of stopes, engaged various consultants

OHS Management at the Beaconsfield Mine (continued)

to review seismicity and provide further input on extraction sequences and ground support, and modified extraction sequencing and ground support before re-opening the affected areas.

However, the response to events in October 2005 did not entail a thorough or systematic risk assessment that was duly documented for review, monitoring implementation of control measures and revision. The risk ranking of ground control in the Catastrophic Risk Assessment was not reassessed or revised in the light of this event, the Ground Control Management Plan was not subject to an independent audit, re-entry protocols were not assessed and a set of formal protocols for determining 'red flags' for worker withdrawal, suspension of firing/stopping or urgent consideration in relation to seismic activity were not developed. Nor was there evidence that the history of rock fall activity at the mine had been reviewed since seismicity emerged as an issue, in order to determine whether the frequency or location of falls indicated the need for additional measures (or should be used to determine 'red flag' action points in the future). Also, as discussed above, the weight of evidence indicated that workers were not genuinely consulted as part of a risk assessment process following the October 2005 events.

Professor Quinlan argues that all the above measures were reasonably practicable and some were specifically required under the *Workplace Health and Safety Act*, 1995 and *Workplace Health and Safety Regulations*, 1998; such as the requirement to undertake a systematic risk assessment following the incident and to consult with the mine workforce with regard to this. While the evidence available was not sufficient to state with confidence that the measures identified, either individually or in combination, would have prevented the seismic event and rock falls on 25 April 2006, or at least prevented workers being in the affected areas at the time, undertaking these measures would have constituted steps towards minimising the likelihood of the event and its consequences.

Recommendations

The Quinlan report makes a number of recommendations based on its findings, to address problems identified in relation to the management of OHS at the Beaconsfield mine and to improve OHS in the Tasmanian mining industry. These include:

- An on-site OHS Committee and implementing of other measures to enhance genuine two-way communication on OHS at the Beaconsfield mine;
- Provision of information to mine workers on trends in rock noise, seismic activity and rock falls and the opportunity to express views in relation to deliberations on changing mining methods;
- Using other OHS performance indicators, including compiling, analysing and reporting all rock fall incidents/trends;
- Taking explicit account of changes to work processes including mining methods as an integral part of mine safety management plans, including documenting the risk assessment and consultation process undertaken;
- The Tasmanian mining industry examining the adequacy of ground awareness training;
- Urgent consideration to developing a 'red flag' protocol in relation to seismic activity and rockfalls; and
- Reviewing the application of the bonus systems with a view to eliminating any adverse effects on safe work practices.

OHS Management at the Beaconsfield Mine (continued)

With regard to current legislative arrangements, the role of government and the inspectorate (WST), the report recommends:

- Introducing a safety case regime for larger mines, OHS management for smaller ones, and independent audit of these;
- Review of regulations and guidance material to identify gaps or areas needing revision;
- Increased resources for mining inspection, investigation and prosecution, and access to geotechnical expertise;
- Amendment of inspection protocols to require contact with OHS representatives or a member(s) of the OHS committee, and regular review of the existence of these arrangements;
- Establishment of a tripartite mining industry advisory council;
- Amendment of the WHS Act so that only one responsible officer, the person with overarching responsibility/managerial control, is appointed for a workplace;
- A new procedure requiring mines to notify WST of all uncontrolled or unplanned falls of ground;
- Retention of the current legislative requirement for designated workplaces to keep a record book, which inspectors can make entries into and for copies to be accessible to the workforce, and an amendment to allow OHS representatives to make entries into the record book;
- Strengthening of the WHS Act relating to the establishment of OHS committees and the appointment, role and training of OHS representatives and committee members;
- Strengthening of consultation provisions in the WHS Act;
- Giving consideration to moving requirements for hazard identification, risk assessment and control from regulations to the WHS Act;
- Making the trial scheme of union appointed OHS representatives in the Tasmanian mining industry permanent;
- Prohibiting the practice of imposing bonus penalties in relation to authorised or sickness related absence from work;
- Reviewing the application and OHS implications of the use of production bonus schemes in Tasmanian mines;
- Preparing a guidance note on the use and responsibilities of consultants under the WHS Act; and
- Clarification of any ambiguity under the WHS Act regarding the status and responsibilities of administrators and major creditors when a workplace is under administration.

Readers are encouraged to review the full Quinlan report for further details of the findings of the Beaconsfield mine investigation and associated recommendations, as well as the other reports associated with the investigation. These can all be accessed online at: http://www.justice.tas.gov.au.