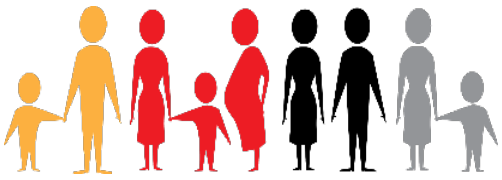
Submission of the Health Services Union

Recommendations of the 2018 Review of the Model Work Health and Safety Laws
In response to Safe Work Australia's Consultation Regulation Impact Statement

7 August 2019



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About the Health Services Union

The Health Services Union (**HSU**) is a growing member-based union with nearly 90,000 members working across the health and community services sectors in every state and territory.

Our members work in aged care, disability services, community health, mental health, emergency services, alcohol and other drug services, hospitals and private practices.

HSU members include social workers, paramedics, disability support workers, aged care workers, personal and community care workers, physiotherapists, occupational therapists, diagnosticians, nurses, scientists, technicians, clerical and administrative staff, doctors, medical librarians, wards-persons, cooks, cleaners, security officers, and administration staff.

We are committed to advancing and protecting the wages, conditions, rights and entitlements of our members through campaigning, education and workplace activism. The HSU also provides a range of services and support to assist members with many aspects of working and family life.

We are a driving force to make Australia a better place. We work to ensure the rights of not just our members, but all working Australians, are protected. Our work and advocacy are in recognition of the inextricable link between accessible, quality and safe healthcare and meaningful social and economic participation. A valued health workforce is central to delivery of outcomes.

While this submission has been prepared by HSU National, it is made on behalf of our branches and HSU members Australia-wide.[1]

HSU National is the trading name for the Health Services Union, a trade union registered under the *Fair Work (Registered Organisations) Act 2009*.

Introduction

The HSU and its members welcome the opportunity to further contribute to the 2018 Review of the Model Work Health and Safety Laws (**the Review**). The HSU's submission provides comment on the Recommendations outlined in the 'Consultation Regulation Impact Statement: Recommendations of the 2018 Review of the Model Work Health and Safety Laws' (**Consultation RIS)** that have the greatest relevance to our members and therefore, for which we can provide the most informed position. That said, as an organisation committed to improving the lives of all workers and the 'touch one, touch all' work health and safety philosophy, we call on the relevant Minister to accept all 34 Recommendations. We call on all harmonised jurisdictions to work closely, in a tripartite manner with employees and their representatives, namely trade unions, the Minister and SafeWork Australia to ensure changes are made in the most efficient and effective manner.

This submission is centred around the first-hand experiences of our members. The HSU warns that these accounts may be distressing for some readers.

Summary of positions

Recommendation 2: Make regulations dealing with psychological health. Strongly support.

Recommendation 8: Clarify workplace entry of union officials providing assistance to an HSR. Strongly support.

[1] The HSU has branches representing members in every state and territory. We acknowledge the decision in Victoria not to harmonise with the Model Laws and note the comprehensive work being undertaken in Western Australia in consideration of harmonisation.

Recommendation 9: Require inspectors to deal with safety issue when cancelling a PIN. Support.

Recommendation 10: HSR choice of training course. Strongly support.

Recommendation 13: Introduce referral of outstanding disputes to a court or tribunal after 48 hours. Strongly support.

Recommendation 15: Remove 24-hour notice period for entry permit holders. Strongly support.

Recommendation 17: Require production of documents and answers to questions after entry. Support.

Recommendation 23a: Enhance Category 1 offence to introduce fault element of gross negligence. Strongly support.

Recommendation 23b: Introduce an industrial manslaughter offence. Strongly support.

Recommendation 26: Prohibit insurance for WHS fines. Strongly support.

Recommendation 2: Make regulations dealing with psychological health

Psychosocial hazards in health care

As noted in the Review Report, the nature of work is changing to move away from standard models of employment.[2] These changes are marked by system redesign, including but not limited to, increasing use of casual, labour-hire and supply chain arrangements; and individualised and digitised procurement of labour. Such arrangements are giving rise to an increase in psychosocial hazards including job and wage insecurity, chronic workload pressures (inadequate staffing levels), lack of supervision and co-worker support, real or perceived lack of respect and recognition from management and society, poorly defined work roles and working outside scope, unsafe workforce planning practices (rostering) and fatigue.

HSU members repeatedly report concerns relating to the psychological impact of work arrangement and systemic hazards. Our members consistently, across the full breadth of health services they work in, advise of the adverse impact of such hazards on their emotional and mental wellbeing, physical wellbeing and the ability to ensure consistent, quality care.

Accounts from aged care workers highlight the lived experience of risk factors outlined above:

'I am an enrolled nurse,[3] but my job exceeds what I was hired to do. I am also dealing with the laundry, clearing tables, emptying the dishwasher, care work (showering, toileting, dressing, feeding, putting to bed, changing continence pads). At my work there are two separate buildings across the road from each other. We are constantly running back and forth to help the enrolled nurses over in the other building.'

Health and Community Services Union (**HACSU**)[4] member, Tasmania

[2] Boland, M 2018, 'Review of the model Work Health and Safety laws', final report, pp. 39-40.
[3] An enrolled nurse scope of practice typically includes undertaking clinical care, contributing to falls management and prevention plans, identifying changes in resident needs including deterioration, contributing to care plans and liaising with family, carers, other nurses and medical practitioners as to a residents care needs, administering specified medications, wound care (under the direction of a Registered Nurse).
[4] HACSU is a registered branch name of the Health Services Union.

'Having to control my own levels of stress, so I don't take it home and have it impact on my family life. It means I have to know when to keep quiet and say nothing [to management] about issues at work. Pick your battles, you know? We are taught that reporting incidents and issues can't happen without retribution.'

HSU member, Queensland
when asked 'What aspects of the job do you find difficult or stressful?'

If we had fixed rosters and more certainty of hours, it would really help everyone – us and what we can do for the residents. We definitely need both things.'

HSU member, Western Australia
when asked 'What things would make your job easier for you?'

Case study 1 - Medical scientist, aged early 30's

Andrew* was employed full-time on a rotating roster as a medical scientist in a 24-hour clinical laboratory servicing a major hospital, as well as other smaller medical services clients in South Australia. He had no pre-existing medical conditions of a psychological or physical nature and was in good health. The laboratory Andrew worked in was not situated within the hospital, therefore the workers were isolated from colleagues and referring doctors. For approximately 2-years, he had been working on a rotating roster, the majority of his shifts being nightshift. There were periods where Andrew was required to do batches of overnight shifts at random order, sometimes with fewer than 10 hours in between to recover and sleep. There was a feeling amongst the workers that the employer relied on the sense of duty felt by staff, and the perception there would be negative consequences if they spoke up.

Over recent months, there had been a number of cuts to staffing levels. This meant Andrew regularly worked on his own and did overtime, extending his rostered shifts to 12-14 hours in length. The lab was understaffed, and in particular there was a shortage of multi-skilled scientists, of which Andrew was one. The minimal number of staff created a culture where employees would stay behind so there would not be a build-up of incomplete tasks for the next person. Andrew's accommodating demeanour and diverse skillset made him a go-to for management when covering shifts because others were sick or refused to do additional unpaid hours.

On multiple occasions, Andrew raised concerns about the impact the work arrangements were having on his sleep and mental health, noting social isolation both at work and home, excessive nightshifts, prolonged shifts, erratic rostering, changes to rostering without consultation, minimal time between shifts for rest, and additional workload as the main concerns. There were no changes to his work arrangements or rostering practices. Eventually, Andrew took leave on workers' compensation to recover from insomnia and anxiety. He was admitted to hospital in an attempt to re-establish healthy sleeping patterns. On his return to work after 4 weeks of treatment, he was rostered on three rotations of 5 overnight shifts. He was required to do overtime on each shift as no extra staff had been rostered to assist. He had as little 8 hours rest time between some shifts.

Andrew was so fearful of losing his job if he spoke up again, that he pressed on. As a result, Andrew developed a subsequent addiction to sleeping aids and permanent disruption to his circadian rhythm, deemed a secondary physical injury. This time, there were substantial delays in accepting his workers' compensation claim. The insurer cited the absence of a single incident as a cause for the delay. Andrew has since required a prolonged in-stay at hospital and ongoing treatment by a team of professionals. Andrew remains off work on compensation. His colleagues report that there have been no changes to the work systems and arrangements.

Heightened risk of psychological injury

Healthcare workers[5] and workers in or interacting with healthcare settings, such as hospital emergency departments, are some of the most at-risk of suffering a workplace injury, physical or psychological. In

[5] For the purposes of this submission, a healthcare worker refers to anyone providing direct or indirect care, support or administration in a health setting. It includes but is not limited to: social workers, paramedics, disability support workers, aged care workers, personal and community care workers, physiotherapists, occupational therapists, diagnosticians, nurses,

healthcare, the nature of work is particularly emotionally and physically intensive, due to the heightened exposure to people handling[6] and this handling occurring at times of illness, incapacity, injury, stress, aggression, grief or trauma for the person(s) requiring care. For HSU members, the ageing population with increased rates of violent dementia, and the rise in alcohol and other substance abuse, as examples, are heightening exposure to physical and psychological hazards. Depression, anxiety and post-traumatic stress disorder are ever-present risks for healthcare workers.

Healthcare workers are more likely to experience repeated exposure to trauma and violence than other occupations.[7] HSU members report exposure to such circumstances as 'the norm', occurring in every shift at least once but most commonly in multiple incidents within a shift. HSU members have provided the following accounts of their day-to-day work:

'One nightshift I had a resident in a lifter. The resident collapsed and was 'clinically dead'. I performed CPR for a significant period. Only three staff were on duty. One staff member was in the dementia ward so could not leave. Two of us had to remain with the resident who eventually survived. It was extremely traumatic.'

HSU member, personal care work, New South Wales
When asked to describe the relationship between inadequate staffing and trauma

'I had to wash the [deceased] resident and change their clothes and bedding. The whole time I was doing it I kept thinking, "I just saw them the day before and they were fine". We'd had a conversation and a cup of tea and biscuits. They were happy and now they are gone. I thought about them the entire shift. At work and when I got home, I was sad. You can't help but get attached to these people and when they pass away it moves you. It's like you are losing a friend.'

HSU member, personal care worker, regional New South Wales
When asked to describe the emotionally intensive nature of personal care work

'The trauma for us [paramedics] is when you go to someone who has lost their loved one of 50 years. Or the 35-year-old with stage 4 melanoma and his wife is there and his two little kids are running around. You look at him and he is seizing. Not moving, but an absent seizure. I know he is going to start a tonic-clonic seizure and I know I am not going to be able to stop it and I know he is going to die. And there are kids, their two little kids. And you have to tell his wife, 'It doesn't look good; I'll do everything I can'.

I went to a job with a little 4-year-old, she was seizing. Posturing in a decorticate position, which is a pretty good sign her brain is incredibly irritated. She was really sick. I picked her up, and she looked like my daughter. I lost it. Gone. On the workers comp claim they asked me "what was it" and I said it was that job, but it wasn't just that job. My psychologist thinks that single incident… was just the straw that broke the camel's back…. It's not like if I fell over and broke my leg. A psychological injury doesn't just happen. It's an accumulation thing.'

HACSU member Tasmania, paramedic

Deterrents and deficiencies - reporting psychosocial hazards and psychological injury

Healthcare workers are either not reporting or underreporting single incident and/or cumulative exposure psychological injury(s). The reasons for non- and underreporting are myriad and interrelated. The current Regulations do not place sufficient onus of responsibility on duty holders to proactively prevent or remedy psychosocial hazards.

Normalisation and organisational culture

scientists, technicians, clerical and administrative staff, doctors, medical librarians, wards-persons, cooks, cleaners, security officers, and administration staff.

[6] Safe Work Australia, 2018, *Health and Community Services*, industry profile, Safe Work website.

[7] Way, KA 2012, 'OHS Body of Knowledge Psychosocial Hazards and Occupational Stress', Health and Safety Professionals Alliance, p. 23.

Healthcare workers can be deterred from reporting workplace stress, trauma and violence because there is a widely held view that it 'comes with the territory'.[8] Reports are often downplayed by management on this basis; being inaccurately reported as 'mild, near miss or no-harm' and subsequently receiving limited investigation and response,[9] despite their seriousness and potential for harm. HSU members also report fears of reprimand and being made to feel shame for not displaying stoicism and resilience at expected levels (see below). The culturally entrenched stigma that is associated with psychological injury and illness persists, and for HSU members, there is no place it is reinforced more than in the high-pressure environment of healthcare. Such views and responses reinforce the normalisation of workplace trauma and violence, as well as harmful organisational culture and systems.

Community and self-expectation

Health workers often note a commitment to public wellbeing and safety, and the desire to provide high levels of professionalism, care and empathy, as prime motivators for choosing their profession. Healthcare workers report that a fear of not providing quality care or not being able to provide quality care due to organisational arrangements, as outlined above under 'psychosocial hazards in health care' as primary stressors.[10] The recent Senate inquiry into first responder mental health outlined that for paramedics, 'individuals recruited often have high expectations of their own performance and a low tolerance for failure.'[11] This self-expectation is also driven by external community expectation, that healthcare workers will be, 'ready and available at all times day and night and in all circumstances'.[12]

Duty of care

Non- or underreporting of issues such as workplace violence often occurs because healthcare workers wish to protect the patient/client/resident under their care from repercussion, particularly where violent behaviour is directly related to an injury, illness or incapacity.[13] Workers identify this behaviour as without ill-intent and malice. The absence of ill-intent or malice, along with a strong sense of duty to the person in their care, in turn deters workers from reporting these risks and incidents.

Onerous reporting and compensation schemes

As the Review Report recognises, formal data collection mechanisms such as state-based compensation schemes do not capture all instances of work-related psychological injury.[14] Reporting through these structures is often avoided due to the above outlined deterrents, as well as perceptions that a claim will not be believed (persistent social stigma); will compound stress for, and result in discrimination against, the worker; and will not lead to meaningful change in the workplace. Where psychosocial hazards and psychological injury are reported, there is evidence that subsequent compensation responses, particularly where insurers reject or delay acceptance of a claim, can significantly aggravate injury and prolong recovery.[15]

Deficient incident reporting framework

The harmonisation process of the Model Laws has resulted in deficiencies within the incident reporting process, due to the removal of several notification triggers designed to capture psychosocial hazards. The previous inclusion of these triggers improved efficacy in handling reports relating to psychological

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[8] Mayhew, C & Chappell, D 2003, 'Workplace Violence in the Health Sector – A Case Study in Australia', *The Journal of Occupational Health and Safety – Australia and New Zealand,* vol. 19, no. 6, p. 36.

[9] Incidents routinely categorised in this way include attempted strangulation, kicking a pregnant worker in the stomach, sexually inappropriate conduct, and being kicked and punched.
Victorian Auditor-General's Office 2015, 'Occupational Violence Against Healthcare Workers', Report, pp. 11-12.

[10] Evesson, J & Oxenbridge, S 2017, 'The Psychosocial Health and Safety of Australian Home Care Workers: Risks and Solutions', Employment Research Australia, Report, p. 122.

[11] Commonwealth of Australia Senate 2019, *The people behind 000: mental health of our first responders*, Report, p. 7.

[12] Ibid, p. 85.

[13] Ibid 8, p. 30.

[14] Ibid 2, p. 34.

[15] Dean, A, Matthewson, M, Buultjens, M & Murphy, G 2018, 'Scoping review of claimants' experiences within Australian workers' compensation systems', *Australian Health Review*, vol. 42, no. 4, pp. 112-114.

injury and encouraged proactive management of these risks by duty holders. Currently, there is no explicit requirement within the WHS regulatory framework to report or respond to incidents involving psychosocial hazards. The impetus for duty holders and regulators to investigate and address psychological harm is severely restricted under the current WHS reporting requirements. For example, incidents of workplace violence are only notifiable where they result in a primary physical injury.

Preferred option

The HSU strongly supports *Option 2 – Include requirements for managing psychosocial risks in the model WHS Regulations. Option 1 – Status quo* is **not a valid option**.

NB: Recommendation 20 improves incident reporting and in conjunction with Recommendation 2, will help remedy some of the issues relating to psychosocial hazards and psychological injury.

While the Review Report notes perceived difficulty in 'designing out' psychosocial risks in the workplace, the HSU wholly rejects this position. The HSU is of the firm view that tangible action to address psychosocial hazards and psychological injury can be taken immediately, and well-designed Regulations will provide clear and achievable guidelines for duty holders. Amending the Regulations will ensure accountability is written into the legislative and regulatory framework. Noting that the health and community services industry is the largest employing industry for the Australian labour force[16] and is growing, it is essential that measures are undertaken now to protect the whole-of-person wellbeing of these particularly vulnerable workers. Improvements to the psychological wellbeing of healthcare workers will improve health outcomes for those under their care.

The HSU is of the view that any perceived difficulties or rejection of responsibility by employers or their representatives are a smokescreen to avoid having to recognise the increasingly interrelated nature of personal and professional life, and therefore to have to allocate expenditure to rectifying unsafe, systemic workplace practices that give rise to psychosocial hazards and psychological injury. *Case study 1* demonstrates the direct relationship between modern employment practices and arrangements as a causal factor to psychological risks and injury. The HSU and its member were cognisant of the fact that any admission of liability in his claim would have meant the duty holder had to address multiple, systemic issues within the workplace.

The HSU suggests that prescriptive psychosocial Regulations be drafted using repealed Regulation 9 of the *NSW Occupational Health and Safety Regulation 2001* under the pre-harmonised *NSW Occupational Health and Safety Act 2000, as a starting point*. Under this Regulation, employers had responsibility to 'take reasonable care to identify any foreseeable hazard that may arise from the conduct of the employer's undertaking', including:

> (b) work practices, work systems and shift working arrangements (including hazardous processes, psychological hazards and fatigue related hazards), and
>
> (g) the layout and condition of a place of work (including lighting conditions and workstation design), and
>
> (i) exposure to noise, heat, cold, vibration, radiation, static electricity or a contaminated atmosphere,
>
> (j) the potential for workplace violence.

Additionally, with respect to the design of a Regulation pertaining to safe systems of work and harm minimisation, the new global health and safety management systems ISO 45001, now directly adopted in Australia as AS/NZS ISO 45001:2018, provides an exemplary hazard identification clause. Namely, clause 6.1.2 of the Standard, 'Hazard identification and assessment of risks and opportunities', items:

> (a) how work is organized, social factors (including workload, work hours, victimization, harassment and bullying), leadership and the culture in the organisation; and

[16] Ibid 6.

(f) (1) the design of work areas, processes, installations, machinery/equipment, operating procedures and work organization, including their adaptation to the needs and capabilities of the workers involved'

should be referenced in any Regulation relating to psychosocial hazard management.

Health and Safety Representatives (HSRs), Provisional Improvement Notices (PINs), Disputes, Entry Rights

The HSU will deal with Recommendations 8, 9, 10, 13, 15 and 17 together.

The presence and operation of HSRs has been proven to improve WHS outcomes for individuals and organisations. The ability for HSRs to issue PINs and carry out inspections, as examples of their functions, provides for a direct worker influence on safety matters. Similarly, a direct correlation between improved safety outcomes and the ability of union officials to exercise right of entry and provide assistance to workers, also exists. Despite this, the rights of both HSRs and union official right of entry have been systematically minimised. It is the experience of HSU members in HSR positions, and HSU officials, that a tension exists between the Regulator and employees or their representatives. Limited rights and stymied working relationships are contributing to unnecessary delays in resolution of safety issues and disputes.

In line with the findings of the National OHS Panel, noting these gave rise to the Model Laws, optimal safety regimes and outcomes are only possible where duty holders proactively engage and work cooperatively alongside the workforce and its representatives.[17] There is a wealth of evidence from within Australia and internationally that support the joint approach and provide tangible evidence that it significantly lowers injury, illness and fatality rates for workplaces.[18] Yet, the experience of HSU members and union officials assisting them, is that duty holders resist engagement with the workers, HSRs and union officials. The effect is that safety concerns are downplayed, not addressed, or addressed only after a serious incident has occurred. The resistant and reactive approach by duty holders[19] is legitimised by wider hostile anti-union sentiment. The HSU is concerned that, particularly in light of the recent findings in Powell,[20] the right to fair representation and representation more broadly will be further restricted. In addition, the regulatory, resource and expenditure burdens on unions and their officials will continue to increase. It is therefore imperative that the Model Laws be amended to ensure that restrictions to an HSRs right to representation, including restrictions under other legislation,[21] are removed. Without securing the policy intention of the Model Laws, the precedent set by *Powell* and supported by broader anti-union sentiment may have unintended negative consequences.

The experience of HSU officials working on behalf of members to resolve health and safety disputes is that, as the Review Report reflects,[22] the process lacks efficiency. Delays in resolution can arise due to various factors. In part they are driven by the adversarial nature of duty holder views to joint safety management, limitations to inspector powers, and limited avenues for recourse when matters are escalated. Whatever the cause, delays in resolution exacerbate underlying issues and increase or prolong risks.[23] Amending the Model Laws to provide a system that enables the prompt and fair resolution of disputes, and empowers inspectors, HSRs and unions officials to aide this process, for

[17] Australian Government, Attorney-General's Department, 2009, 'National Review into Model Occupational Health and Safety Laws Second Report to the Workplace Relations Ministers' Council', Second Report, p. 133.
[18] O'Grady, J 2000, 'Joint Health and Safety Committees: Finding a Balance', in T Sullivan (ed.), *Injury and the New World of Work*, UBC Press, p. 175.
[19] Ibid, pp. 181-182.
[20] *Powell v Australian Building and Construction Commissioner & Anor; Victorian Workcover Authority v Australian Building and Construction Commissioner & Anor* [2017] HCATrans 239.
[21] Namely, the *Fair Work Act 2009* (Cth).
[22] Ibid 2, p. 78.
[23] Lyons, T 2017, 'Best Practice Review of Workplace Health and Safety Queensland', Final Report, pp. 86-88.

example by the ability to refer outstanding disputes to a relevant court or tribunal, will be an important step in improving workplace health and safety. Measures promoting the sharing of information and removal of time-restrictions in investigative and resolution processes must also be implemented in support of other regulatory and legislative changes.

Case study 2 – Ambulance Ramping – Employer and Regulatory response

Ambulance ramping occurs when paramedics are unable to complete a patient's transfer of care to a hospital emergency department (**ED**) within a clinically appropriate timeframe. When ramped, the patient must remain in the care of the paramedics until such time the hospital has the staff and/or beds available to admit the patient. The ambulance vehicle remains unavailable to any other jobs that arise, regardless of severity.

In a jurisdiction where an HSU branch has coverage of paramedics, HSRs and other paramedics regularly advise the union ramping is occurred. Worker and patient safety concerns arising from ramping are cited frequently. These include, but are not limited to, inability of vehicles to attend other jobs/significant delays to timely ambulance response; significantly reduced access to definitive assessment and care for persons waiting for an ambulance or waiting for treatment in ED; compromise of patient ambulance stretchers blocking hospital corridors; significantly reduced infection control; significantly reduced ability to provide acute care; required medical equipment and safe systems of work; and increased risks to worker psychological (e.g. stress, ethical dilemmas) and physical wellbeing (e.g. trip hazards, violent patients in confined treatment spaces).

In early-2018, in or around March, concerns worsen in line with increasing external, systemic pressure on the jurisdiction's public health services. The union encourages its members in HSR positions to continue following protocol for raising the serious safety concerns, including issuing of PINs. The HSRs, and other workers, repeatedly raise the issues and proposed solutions to the employer and state government Department of Health. Proposals from the HSRs include the immediate employment of additional ED staff dedicated to clearing ambulance crews. It is noted that this practice is in place in other jurisdictions. In the longer- term, additional hospital beds will be required.

A union official seeks to assist and provide representation. A meeting takes place on 20 March 2018 with all relevant parties, including an HSR, the union official, an employer representative and a Department representative. Nil additional action is taken by the employer or Department.

On 7 August 2018, the union official writes to the employer outlining the issues and requesting a formal response. A response is received on 13 August 2018, in which the union is advised the matter has been referred to the employers 'Patient Safety Officer' and Regional Managers. The union is asked to reassure its members that commitment to safety exists within the organisation. A second meeting is convened and takes place on 14 August 2018. A further series of commitments are given by the employer, namely that additional funding will be set aside for hospitals in the next Budget handed down by the state government. No additional ED staff are employed.

At a meeting on 16 October 2018, the union official and HSR are again reassured that additional state funding is on its way and the matter is being treated seriously. The HSR advises that the situation cannot wait for additional funding allocation. It is reiterated that the immediate employment of additional ED staff would assist in the meantime.

On 21 November 2018, the union official again writes to the employer to advise no progress has been made. The union advises that if no adequate response is received within 7 days, including responses to requests for updates on how the matter is being addressed by the employer, the union will refer the matter to the WHS regulator for investigation under the relevant section of the legislation.

On 27 November 2018, the employer responds and requests a further meeting. The meeting takes place 11 December 2018. Nil action is undertaken by the employer after the meeting.

On 1 April 2019, the union lodges a complaint with the WHS regulator, citing duty-holder non-compliance with following legislative obligations:
'A PCBU must ensure, so far as is reasonably practicable –
(a) the provision and maintenance of a work environment without risks to health and safety; and

(b) the provision and maintenance of safe plant and structures; and
(c) the provision and maintenance of safe systems of work; and
(d) the safe use, handling and storage of plant, structures and substances; and
(e) the provision of adequate facilities for the welfare at work of workers in carrying out work for the business or undertaking, including ensuring access to those facilities; and
(f) the provision of any information, training, instruction or supervision that is necessary to protect all persons from risks to their health and safety arising from work carried out as part of the conduct of the business or undertaking; and
(g) that the health of workers and the conditions at the workplace are monitored for the purpose of preventing illness or injury of workers arising from the conduct of the business or undertaking.'

The regulator responds by email on 10 April 2019 requesting additional information. The union provides all additional requested information by letter on 17 April 2019.

To date, no further action has been taken by the regulator or employer, despite repeated requests for an update and outcome from the union.

The HSU is supportive of the recommendations aimed at strengthening the rights of HSRs, union officials and safety inspectors, and for improving dispute resolution processes.

Preferred options

The HSU strongly supports *Recommendation 8 – Option 2 - Clarify workplace entry of union officials providing assistance to an HSR*.

The HSU supports *Recommendation 9 – Option 2 - Requiring inspectors to deal with safety issue when cancelling a PIN*.

The HSU strongly supports *Recommendation 10 – Option 2 - HSR choice of training course.*

The HSU strongly supports *Recommendation 13 – Option 2 - Introduce referral of outstanding disputes to a court or tribunal after 48 hours*.

The HSU strongly supports *Recommendation 15 – Option 2 - Remove 24-hour notice period for entry permit holders.*

The HSU supports *Recommendation 17 – Option 2 - Require production of documents and answers to questions after entry*.

NB: The HSU welcomes *Recommendation 18 - Clarify that WHS regulators can obtain information relevant to investigations of potential breaches of the model WHS laws outside of their jurisdiction*, particularly when introduced in conjunction with the above preferred Recommendation Options.

The Category 1 offence, industrial manslaughter and prohibited insurance

Background

Every week, four people are killed and thousands more are seriously injured in Australian workplaces. Each of these incidents is preventable. Workplace death and serious injury have a serious detrimental impact on individuals, families and communities, as well as causing wider social and economic harm. The most recent SafeWork Australia analysis reveals that the direct and indirect costs of injury, disease and death are felt by the worker (77 percent), the community (18 percent) and duty holders (5 percent).[24]

[24] Safe Work Australia, 'Costs of work-related injuries and diseases - Key WHS statistics Australia 2018', website, viewed 2019.

These statistics demonstrate that there is minimal cost to businesses responsible for workplace serious injury and death. Work and workplaces, despite their central role in the lives of working Australians, has been constructed to sit outside other social and economic structures, therefore making them exempt from the same penalties expected to be applied to other serious and criminal misconduct resulting in serious injury or death.

Serious injury and death at work occur because of interrelated, complex and systemic failures. These failures are often preventable, meaning that these incidences and loss of lives are preventable. As outlined under Recommendation 2, changes to employment arrangements and the nature of work are allowing employers to increasingly subvert their WHS (and other employment) responsibilities. The result for healthcare workers is increasingly pernicious work environments and growing rates of serious injury and death above the average for other industries.[25] Notably, healthcare workers are exposed to heightened risks at work of serious injury or death from vehicle accidents and violence or aggression from person(s) they are administering care to. It is the experience of our members or their families that responsibility is often shifted to external authorities or legislative frameworks, such as road authorities or criminal law. Where this happens, it is the feeling of our members or their families that the employer has 'got off scot free' or that 'nothing will change.' For families of deceased workers, there is little to no emotional or financial capacity to pursue a penalty against the employer. Where there is a decision to do so, feelings of hopelessness are exacerbated by the sentiment that it is futile.

The HSU believes that due to non- and under-reporting, and formal data collection mechanisms that rarely extend beyond the life of a formal compensation claim or following the end of employment, rates of serious injury and death are likely to be even higher for healthcare workers. There is overwhelming evidence regarding the prevalence of physical comorbidities where a psychological injury or condition is present, and vice versa.[26] As secondary conditions are rarely captured in compensation schemes and WHS processes, the rates and outcomes of comobordities, sometimes fatal, are not recorded and therefore, duty holders are not being adequately held to account. The Senate Inquiry into first responder mental health details the higher rates of comobordities and suicide amongst paramedics,[27] the issues in capturing accurate data, and the inadequate often non-existent institutional supports and responses.

Under the current laws (WHS and criminal), it is difficult to convict employers that are found to have failed to protect the safety and wellbeing of their workers. The penalties for employers are grossly insufficient and do not provide a genuine deterrence against negligent, unsafe workplace behaviour and systems. The inconsistency between the states and territories for penalties and enforcement exacerbates gaps and deficiencies. The current laws and schemes place an unfair burden of responsibility on individuals to protect their own health and safety. The ability to take out insurance against fines for breaches only compounds the climate of non-compliance and nil-deterrence.

Corporations are expected to meet their WHS obligations and comply with all relevant laws. Where a corporation or its officers are found to be non-compliant, they can be ordered to pay a financial penalty. Currently, there is nothing in the model WHS laws to prevent corporations taking out insurance to cover the cost liability of such penalties. The Review found that the deterrent effect is reduced where employers can take out insurance to protect the corporation and its officers from liability to pay fines. There is evidence from international case studies that strongly supports legislative provisions expressly prohibiting a corporation from having such insurance, leading to improved WHS compliance. The HSU promotes approaches to preventative work health and safety systems and processes.

One death at work, one serious injury at work, is one too many. It is imperative that the penalty and enforcement regime for duty holders responsible for such horrific incidents be greatly improved.

Preferred Options

[25] Safe Work Australia 2018, 'Health care and social assistance: Priority industry snapshots', fact sheet.

[26] KM Scott et al. 'Association of Mental Disorders with Subsequent Chronic Physical Conditions: World Mental Health Surveys From 17 Countries', *Psychiatry*, vol. 73, February 2016, pp. 150-158.

[27] Ibid 11, pp. 14-15, 20.

The HSU strongly supports Option 4 - *Recommendation 23a - Enhance Category 1 offence to introduce fault element of gross negligence* **and** *Recommendation 23b – Introduce an industrial manslaughter offence.*

The HSU strongly supports *Recommendation 26 – Option 2 - Prohibit insurance for WHS fines*.

Recommendation 27: Clarify the risk management process in the model WHS Act

The risk management process – in reality

Effective risk management processes are of the utmost importance to improving WHS outcomes. However, as noted in the Review Report, best practice is not always adhered to and in fact, some stakeholders claim there is ambiguity in the Model Laws about how to approach risk management and whether they should apply the regulatory framework to their undertakings.[28] The HSU is of the view that, as demonstrated under 'Recommendation 2', there is also an element of choice by employers to prioritise operational and business efficiencies, such as savings on workforce expenditure, over their responsibility to manage risks within the workplace(s).

The workforce and its representative, by way of Health and Safety Representatives (**HSRs**), Health and Safety Committees (**HSCs**) and union officials, under systems of work intricately, as they work within them on a regular basis. At present, the Model Laws do not sufficiently account for the invaluable voice of the workforce in risk management assessment and response. It is the common experience of HSU members, particularly those in HSR roles, to have suggestions ignored by duty holders. Genuine consultation and feedback mechanisms are critical to the success of risk management.

Risk management is developed on an elimination, or as far as reasonably practical to eliminate, basis. For healthcare workers sufficient staffing, as an example, is an immediate risk control measure that can prevent both physical and psychological injury. Despite this, HSU members consistently report being placed at risk of injury, or suffering injuries, as a result of insufficient staffing. Risks also arise, or are compounded, in instances where healthcare workers must also carry out their duties without access to equipment or access to adequate or well-maintained equipment. A risk management process as simple as the 4 questions posited in the Review Report[29], when applied to any number of healthcare settings, reveal the inherently dangerous nature of work and high stakes of risks gone unmanaged. Yet, as the Review Report suggests, duty holders struggle to identify such risks and, more importantly, manage them to eliminate, or reduce the potential for harm as far as reasonably practicable.

Case study 3 – Ambulance Tasmania

John* has been a full-time paramedic in Tasmania for over ten years. Since commencing in his role, John has witnessed what he describes as 'drastic' staff and budget cuts. These cuts have occurred despite the ageing of the local population, the rise of homelessness in the area, and the prevalence of illicit substance abuse including ice, which is commonly linked to violence, aggression and psychosis. John is stationed just north of Hobart in Glenorchy. His station often has just one ambulance vehicle available to it, including over peak periods such as weekends. On the weekend of 20-21 July, John is forced to work by himself without an ambulance available to him.

This occurs just two weeks after a colleague of John is rostered to work by them self on the weekend. John's colleague is called out to a critical incident. The patient cannot be left unattended in the back of the ambulance. There is a 90-minute wait for back-up, meaning it will be 90-minutes before someone is available to drive the ambulance to the emergency department. The patient's relative is an off-duty police officer and drives the ambulance to the hospital, so that John's colleague can continue administering care during transport.

[28] Ibid 2, p. 140.

[29] Ibid 2, p. 140. Questions: 1) Given what I do, what could go wrong? 2) How wrong can it go? 3) What are the consequences of it going wrong? 4) How can I stop it going wrong?

Preferred option
The HSU strongly supports *Option 2 - Clarify the risk management process in the model WHS Act*, with additional addition to the Regulations *Introduce a new section in the Regulations at Chapter 4 – Hazardous Work – Healthcare Work.*

NB: strengthened risk management processes may also assist in the resolution of referrals and disputes to relevant regulators.

Comprehensive and efficient risk management under the Model Laws must include robust hazard identification measures, genuine and 'looped' consultation processes, regular review mechanisms, and hierarchical control measures. Amendment to the Model Laws that aid duty holders to understand and enact improved risk management, bound by legislative obligation, is strongly supported by the HSU.

Introduce a legislative obligation for duty holders to apply industry standard and/or widely accepted controls

Amend the Model Laws at Section 18 to include a new subsection stipulating a breach of the Act where a duty holder refuses to apply an industry standard or HSC recommended risk control, or to conduct a risk assessment on health and safety practices, as proposed by an HSR, their nominated representative and/or a union official. In this process, Section 18 should be amended to reflect the Safe Work Australia Guide at 'Capacity to pay is not relevant.'[30]

Capacity to pay is not relevant
The question of what is reasonably practicable is determined objectively, not by reference to the particular person conducting business or undertaking's (PCBU) capacity to pay or other individual circumstances. A PCBU cannot expose people to a lower level of protection simply because it is in a lesser financial position than another PCBU facing the same hazard or risk in similar circumstances.

If a PCBU cannot afford to implement a control measure that should be implemented after following the weighing up process set out in this Section (s18 of the WHS Act), they should not engage in the activity that gives rise to that risk.

It is the experience of HSU members that duty holders will reflexively reject worker and/or union member raised work health and safety issues by citing alleged financial costs and pressures to the business associated with rectifying the risk(s). Insertion of the additional text to Section 18 would provide clarity and approve the efficacy of the Model Laws application regarding risk control and management.

Introduce a new section to Chapter 4 of Regulations
The experiences of HSU members working in paramedicine provide an excellent example of the need for improved risk management capturing the above-listed essential elements, as well as the introduction of a new section in the Regulations at 'Chapter 4 – Hazardous Work – Healthcare Work'. The introduction of specific Regulations will reduce ambiguity for employers, improve clear and continuous consultation, monitoring and evaluation, and lead to clearly defined safe systems of work for healthcare workers. Such a change to the Regulations would introduce clear and specified hierarchy of controls for application to specific healthcare duties. The benefits would be realised by workers, primary duty holders and the general public.

[30] Safe Work Australia 2013, '*How to determine what is reasonably practicable to meet a health and safety duty*', Guideline, p. 16.