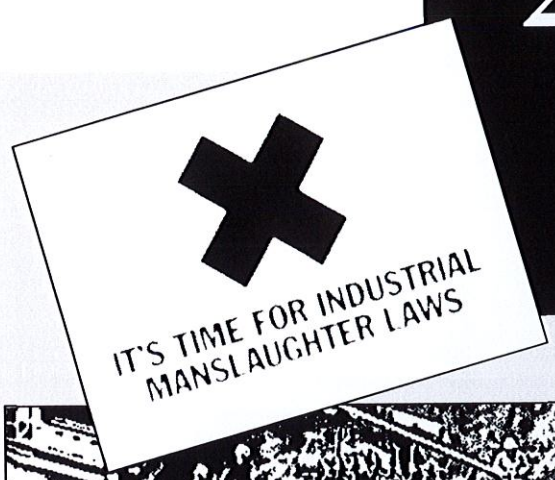
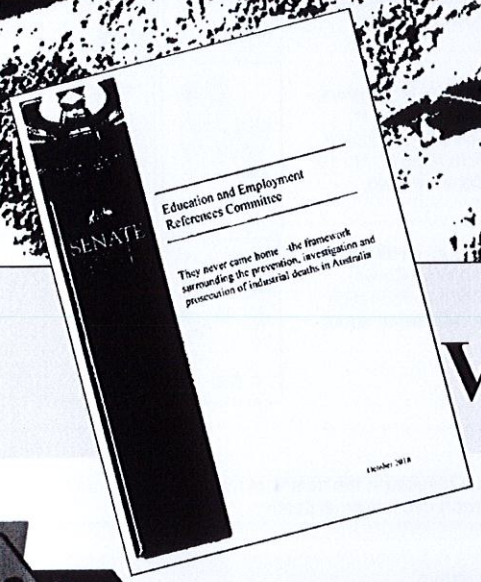
23 Deaths at work





Victoria 2018

FOREWORD by Dr Lana Cormie

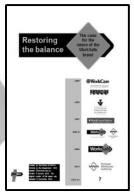
OHSIntros

A paper on the death toll at work in Victoria during 2018 by the OHS blog OHSIntros
Version 1: November 2019

23
Deaths at work in Victoria 2018

DEDICATION: This paper is dedicated to the memory of Charlie Howkins, Jack Brownlee and Anthony Carrick.

Contents



About this paper:
This paper (No.11 of a series) has been prepared by OHSIntros for the information of the OHS community and others who might be interested in the performance of the OHS system in Victoria during 2018 and its influence on other jurisdictions and the development of harmonisation. The paper also puts the year into an historical context and discusses the effects of related political actions.

Earlier papers are available on request:
(No.1, *Restoring the balance;* No. 2, *23. Deaths in Victoria 2014*; No. 3, *30 years of OHS in Victoria;* No. 4, *State of OHS in Victoria 2015;* No. 5, *20. Deaths in Victoria 2015;* No. 6, *State of OHS in Victoria 2016;* No. 7, *26. Deaths in Victoria 2016*; No. 8, *State of OHS in Victoria 2017*; No. 9, *Deaths in Victoria 2017;* No.10, *State of OHS in Victoria 2018* . (See covers right and contact details below).

About the author:
Barry Naismith is an OHS consultant, analyst and blogger trading as OHSIntros. A former journalist, Barry spent 15 years working with the Victorian WorkCover Authority, which is known as WorkSafe Victoria. He believes sharing information and knowledge within the OHS community is essential to foster discussion about how to be more effective in eradicating work-related harm.

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COVER: The site of the Delacombe incident in March, 2018, that resulted in the deaths of Charlie Howkins and Jack Brownlee. Inset: Industrial manslaughter flyer in Victoria and the senate report into industrial death.

Acknowledgement:
Thank you to Christopher Chong for proof-reading and editing.
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FOREWORD

By Dr Lana Cormie

LANA CORMIE is a doctor of veterinary science and advocate for change based in the Ballarat region. The mother of two was married to Charlie Howkins, a registered building practitioner. Charlie went to work one day and never came home. Through the experience of losing her husband, as one of two men killed while pipelaying at a civil construction project in 2018, Lana has learnt much about the operation of Victoria's workplace safety regime. She has joined other families to advocate for change in the OHS framework in Victoria and nationally.

Barry Naismith's 11th paper provides a powerful and thought-provoking account of 2018 from an OHS perspective. It is important not only as a useful analytical tool, but also as an historical record. Naismith is well-qualified to provide such commentary, with both formal qualification and professional and personal experience in this field. Once again he delivers the attention to detail and balanced analysis ubiquitous to his reports.

My own foray into the world of OHS began with personal tragedy, when on March 21, 2018 my husband Charles Howkins (along with workmate Jack Brownlee) was killed in a workplace incident while working on a Pipecon trench in Delacombe. I refrain from the use of the word 'accident', as this belies the true nature of such events, which are rarely a true accident and most often a failure of a system of procedures, with disastrous consequences. With the appropriate attention to management of hazards (as required by OHS law) the majority of workplace fatalities are indeed avoidable. Therein lies the frustration, injustice and deep rage which remains. Such events should never occur. Unlike many other sudden death events, workplace deaths are both foreseeable and avoidable.

My own frustration is not dissimilar to that felt by many who are savvy to the failings of OHS in this country. Fuelled by personal experience and a wealth of knowledge, Barry Naismith is one such person. This paper, simply entitled 'Death at Work', shines the spotlight on selected individual cases of workplace death – putting the focus right where it should be: The Death and Devastation – The Harm. This emphasises why the time has come for OHS law (and its interpretation by the courts) to address Harm, not just a risk-based breach of the law.

The paper highlights what should be learnt from the past year, not shying from the reality that these learnings have been written in the blood of dead and injured Victorians, as is often the case with other more sterile reports. In doing this, Naismith honours the lives lost by drawing knowledge and raising questions in relation to each.

I strongly urge all stakeholders, interested parties and industry as a whole to take heed of this independent report. Discussion should be stimulated and policy formed based on such analysis. This meticulously written paper, along with Naismith's other works, should be regarded as a valuable resource and tool for all those interested in improving OHS in Victoria and indeed Australia. This includes regulators, government, the judiciary, OHS professionals and all those interested in workplace safety. It provides a comprehensive record and commentary of 2018, tackling a breadth of issues unparalleled in any other annual publication. No doubt those with vision and aspiration will take this paper and apply the documented learnings of 2018 to create positive change.

November 2019

BOOK ONE

The legacy of Delacombe
The Senate Inquiry into industrial death
The Victorian Industrial Manslaughter campaign

1. Introduction

This paper features the story of one of the most extraordinary periods in the history of occupational health and safety in Victoria: the Delacombe incident. It resulted in the death of Charlie Howkins and Jack Brownlee. There had been many incidents in the modern history of OHS in Victoria that began in 1985, but nothing of the dimension and scope of this. It was unprecedented in its impact and the questions it raised.

'From then on, everything said about OHS fundamentals had to have the "Delacombe context" or it lacked substance and meaning …'

These questions were about the very existence and purpose of the workplace safety system; its commitment to preventing harm; and its capacity to deter, enforce and compensate when breaches of law result in death at work and consequent harm to the community. These key questions about community harm were already being asked long before Delacombe[1]. This made them real.

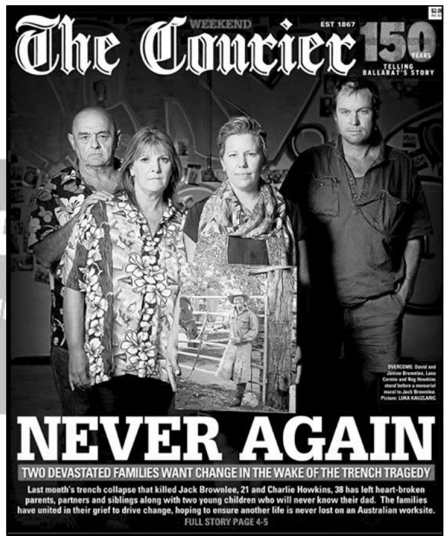
The industrial manslaughter campaign was heating up in Victoria, and a senate inquiry on industrial death was underway, when the incident happened in March 2018. Delacombe connected them and became their case study. It brought the spotlight, greater momentum, determination and a sharper focus to these initiatives. From then on, everything said about OHS fundamentals during 2018 needed placement with the 'Delacombe context' or it lacked substance and meaning, or seemed heartless and astonishingly ignorant about the effects of harm.

The story told in this paper is only up to the end of 2018. The ripple effect continues during 2019 … and beyond.

WARNING: The accounts of Delacombe and other incidents in this section may contain some content and comments that may be distressing.

Context for this paper:

This paper records and reviews reportable deaths at work in the Victorian state OHS jurisdiction for the 2018 calendar year, death claims for the 2017-18 financial year, other deaths at work not recorded formally, and prosecutions during the 2017-18 financial year involving a death at work. The paper also puts these topics in an historical perspective. The content is limited by official OHS information that is available publicly and from some related supplementary information from other sources. Content and comment in this paper is based on that information. It is assumed to be correct at the time of writing.



Top: OHS on the front page. Above: Victorian premier, Dan Andrews, with the Delacombe bereaved (from left, Dr Lana Cormie, widow of Charlie Howkins, with baby George, and Janine and Dave Brownlee, parents of Jack) at Ballarat after the announcement of the industrial manslaughter policy being adopted as ALP policy for the November 2018 election *Source: media reports*

[1] *State of OHS in Victoria 2018: Recognising the harm*, OHSIntros, June 2019.

2. The legacy of Delacombe

On Wednesday, March 21, 2018, workplace health and safety in Victoria changed forever. On that fateful working day, on a civil construction site in Delacombe, near Ballarat, a trench was being dug in a paddock near the Glenelg Highway to lay sewer pipes.

Working on the trench late-morning were Charlie Howkins, a 34-year-old father of two young children and Jack Brownlee, a lively 20-year-old on his eighth week at his new job, and with his life ahead of him. Long before the working day ended Howkins was dead and Brownlee was in hospital with serious injuries that proved fatal.

Top: Victims of the Delacombe incident in March 2018: Charlie Howkins, left, and Jack Brownlee. Above and below: The site of the trench collapse showing excavation during the rescue to allow emergency workers to safely enter the trench and gain access to the trapped workers. *Source: media reports.*

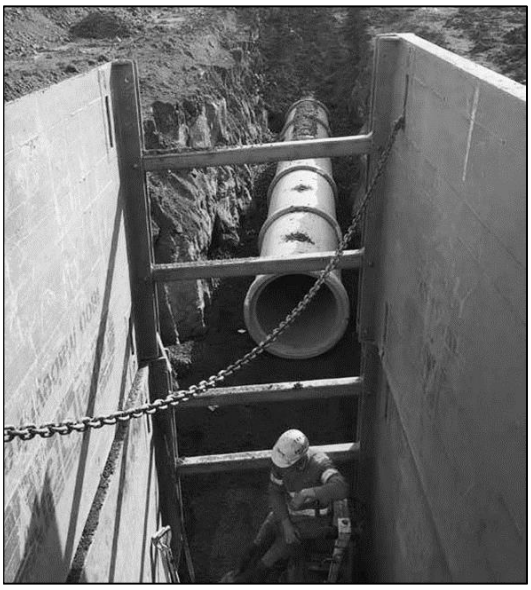
The deaths were caused by the collapse of trench walls that engulfed the two work mates.

Media footage of the site showed a deep trench that appeared to be recently dug or still being worked on. There was no sign of battering, benching, trench guards, safe entry or barriers to prevent access and falls (although some temporary site fencing could be seen). Those are the usual risk control measures for such high risk construction work. They were either not present when the collapse happened or removed during the rescue work.

This scenario, and why work was being conducted on an apparently 'incomplete' and potentially unsafe trench, would be one of the matters WorkSafe Victoria investigators had to determine.

Trenching is defined as 'high risk construction work' and covered in the hazard-specific OHS regulations and in WorkSafe Victoria's Compliance Code for

Excavation (2018) that specifies industry best practice. It is what the regulator expects to see as a minimum in this work when its inspectors visit such worksites. The code, which deals with trenching in detail throughout the document, was drafted and available to the industry, but not approved until May 2018. It thus had no legal 'status' at the time of the incident. However it 'codified' the existing state of knowledge (ie what employers would be reasonably expected to know). It was the result of a consultation process with industry leaders and subjected to a public comment process before being signed off by the then responsible Minister, Robin Scott. It isn't known if Pipecon participated in that process, and provided advice about their safety practices. The company may have done so as part of participation in the process by the Victorian branch of the Civil Contractors Federation that represents many employers during engagement with government.[2]



Charlie Howkins at work on an earlier pipelaying project where trench guards and benching are used as risk control measures. Below: Worksafe Victoria's Compliance Code on Excavation released in May 2018 codified best practice for safer trenching. *Source: media report/WorkSafe.*

One matter that was covered in the code, and came to light later as a consequence of the incident, was the increased risk from the position and posture of workers doing trenching eg working on knees or crouching in a trench as opposed to being upright. It was one of the few instances where discussions around an active investigation may have actually informed and improved development of statutory guidance.

It isn't known whether WorkSafe inspectors had visited this site previously during its construction compliance program for the 2017-18 financial year, and what, if anything, they observed. Such inspections would have been conducted regularly out of WorkSafe's Ballarat regional office. The reason this was raised is there was a report of a collapse in that trench two weeks earlier and just 2m away from where Howkins and Brownlee were working on the day of the incident.

In the following months, the Delacombe incident became one of the most publicised and significant events in Victorian OHS history. In January 2019, WorkSafe Victoria charged employer Pipecon P/L over the fatal incident. At the time of writing the case had not been finalised[3].

NOTE: The full details of the incident are not known at the time of writing and no further details were released because of restrictions due to privacy and legal protocols. The account beginning on page 9 is based on information in the public domain prior to the prosecution beginning.

[2] Pipecon is a member of the Victorian branch of the CCF. Pipecon managing director, Andrew Mahar, was president and a broad member of the Victorian branch at the time of the incident. He stepped down in December 2018, just before WorkSafe laid charges against Pipecon.
[3] The case was scheduled for a contested hearing on December 3, 2019.

Postscript
In February 2019, WorkSafe Victoria issued a safety alert titled: *Workers engulfed in trench collapse*. This non-statutory advice document referenced its other guidance including the relatively new compliance code on excavation (see previous page).

The document warned employers and workers to take trench safety seriously, after two plumbers were engulfed in a trench collapse. It also referred to three fatalities involving trenches that occurred in 2018 (Delacombe and Wallan incidents). The document stated: "All of these incidents are a reminder of why it is important to ensure all necessary safety measures are in place to control the risks of working in and around trenches."

The alert specifically referred to trench shield and soil conditions:

- Trench shields are not intended to provide ground support, they provide engulfment protection to workers within the shield. Workers need to stay within the confines of the shield at all times when working in a trench.
- Soil conditions can create a higher risk of ground slippage and engulfment. Soil conditions always need to be taken into account when undertaking trenching work.

The alert said: "All trenches can pose a significant risk to the health and safety of workers, especially those who are bending down to work on pipes or other services. Risks of engulfment and serious or fatal injuries increase with trench depth."

It is assumed the advice and the 'state of knowledge' (SOK) in these documents, and related statutory and non-statutory guidance, would be central to the Delacombe prosecution.

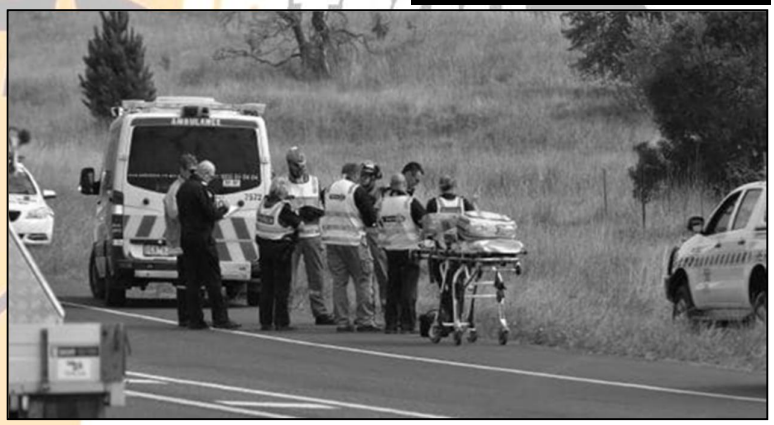
The incident

According to WorkSafe Victoria and police, the two trench diggers (Howkins and Brownlee) were working on a sewer trench (approx. 4m deep) for the laying of sewer pipes at the Winterfield housing estate development on the Glenelg Highway, Delacombe, near Ballarat. This was part of the works being done at the site by their employer, Pipecon P/L, which is a prominent local business, based at Delacombe.

It isn't known with certainty when the incident happened because no other workers were in the area for several hours. First responders said it may have happened around 11 am, but this was when concreting contractors, not connected to the pilelaying, passed through the area to conduct their own work. It is believed that other workers at the large site had last seen Howkins and Brownlee around 9.30 am. However the pair were not at the morning 'smoko' break, some distance from the trench. Presumably site supervisors did not notice they were absent during the usual rest break and the site was too distant from amenities to have seen or heard anything.

> "I looked up to see a helicopter in the sky and I knew something was happening," Dr Cormie recalled. "I found out via a friend that there had been an incident in the area and had to go to the roadblock … to await … news that my husband had been killed …"

When the concreters were confronted by the collapsed trench, and raised the alarm with Pipecon, they tried frantically to dig out the trapped pair. It was originally reported by the media that Howkins may have been totally buried in a prone position. It later emerged he was engulfed up to his waist, but still fatally injured while Brownlee was buried up the neck and rapidly weakening from the crush injuries. As workers dug with their hands to free Brownlee's upper body, a distressed Jack must have known his work mate's body was beside him.



Police and WorkSafe Victoria inspectors gather on the Glenelg Highway police cordon to determine what happened and what action needs to be taken. *Source: media report*.

Emergency services in charge of the rescue scene worked for more than two hours to widen the trench so the surviving worker could be dug out and the body of Howkins recovered. It was reported that the owner of the business had got to the site and was operating one of the pieces of plant to help with the rescue. While he was undoubtedly an operator of experience and expertise, the families of the deceased workers were aghast that a heavy excavator was used so close to the injured workers. In this situation a judgement must have been made that the urgency of digging them out was greater than the risk of striking them or adding significant pressure to the crush injuries.

Meanwhile, members of the families of the two victims, Dr Lana Cormie, from Broomfield, outside of Ballarat, and the parents of Jack Brownlee (Dave and Janine Brownlee), of Ballarat, were oblivious to what was transpiring that morning.

"I looked up to see a helicopter in the sky and I knew something was happening," Dr Cormie recalled. "I found out via a friend that there had been an incident in the area and had to go to the roadblock and stand by the side of the road to await the news that my husband had been killed hours earlier."

'Brownlee was … sedated and flown to the Royal Melbourne for surgery. After four separate operations, he was placed in an induced coma, but died the following day.'

Dr Cormie, a local veterinarian, had been working in the general area. Dave Brownlee had been attending to his wife who was in a Ballarat hospital for a minor medical condition. He had been contacted by a friend working in Geelong who had then seen the news of the incident shared on social media and thought Jack might have been involved. On hearing this, Dave Brownlee went to the site too for news of his son, and was also stopped at the police cordon across the highway. The Brownlees eventually found out that Jack was alive and conscious but seriously injured.

The officer in charge of the scene, Ballarat Senior Sgt David Hermit, told the media at the site that it had been "traumatic" for the injured worker who was conscious throughout the long rescue. There were no witnesses to the incident so emergency services were not able to determine what happened, other than what they could see of the aftermath. Such information may have helped expedite the rescue, and reduce risk to the lives of emergency workers who were wary of a further cave-in as they worked.

Sen-Sgt Hermit praised the efforts of those who helped in the rescue. "They, first of all, just used hands, then they used hand tools and then he's (Brownlee) been removed by the CFA and MFB specialists," he said. "It (the rescue work and stabilising the trench) is quite delicate and quite dangerous."

The injured Brownlee and the body of Howkins were removed from the trench at around 2.30 pm. Brownlee was assessed as having serious injuries to his lower body. He was sedated and airlifted to the Royal Melbourne Hospital for surgery. After four separate operations, he was placed in an induced coma, but died the following day.

"On behalf of Dave, Janine, Mitch, family and friends, we have the unfortunate task of announcing our son, brother and best mate 'Jackie Boy' has passed away," the Brownlee family said in a statement. "We would like to thank the efforts of the amazing team at the Royal Melbourne Hospital for their care, compassion and efforts over the past 24 hours. We, the family, know that what could be done was done to get our boy back up and running."

It was left to local police and a team of WorkSafe inspectors and investigators to prepare a report for the coroner[4]. WorkSafe inspectors would have taken compliance action against the employer, Pipecon, to secure the site for initial investigation, possibly by issuing an 'non-disturbance notice', then required actions by Pipecon to make the site safe before work could continue in the area. This involved filling in the trench so that work in the area could resume as required the following day. In media reports the families of the deceased workers asked why the trench was filled in so quickly without technical experts, such as a geotechnical engineer, examining it.

While police and WorkSafe continued their investigations, the picture became a little clearer as to what did or did not happened at the site that day and which may or may not be germane to the strictly risk-based character of OHS investigations. Much of this information came to light later in the

[4] At the time of writing, no coronial inquest had yet been held.

proceedings of the senate education and employment reference inquiry that was coincidentally running in Canberra to look into the *Framework Surrounding the Prevention, Investigation and Prosecution of Industrial Deaths in Australia* [5].

'The inquiry was about broader issues … but Delacombe and its impact was so raw in the public consciousness that it was a dominant theme during the national probe … '

Coincidentally, the inquiry called for public submissions in March 2018 (the month when the Delacombe incident happened), ahead of its hearings in the each state capital. It meant that Victorian submissions would be loaded with the matters related to Delacombe. Those involved in the Victorian industrial manslaughter campaign (see page 17), notably the Delacombe bereaved, made submissions to the inquiry[6] and were invited to speak to those submissions at the public hearing in Melbourne on August 28. The proceedings were protected by parliamentary privilege and recorded in Hansard (see picture). The comments were therefore blunt and unfiltered.


COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

SENATE

EDUCATION AND EMPLOYMENT REFERENCES COMMITTEE

Industrial deaths in Australia

(Public)

TUESDAY, 28 AUGUST 2018

MELBOURNE

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BY AUTHORITY OF THE SENATE

[PROOF COPY]

The inquiry was about broader issues than just Delacombe-related matters (see details, page 34), but Delacombe and its impact was so raw in the public consciousness that it was a dominant theme during the national probe and its subsequent deliberations.

The many uncertainties drove the bereaved to seek answers about what had occurred that tragic March morning. In their submission to the senate inquiry they were angered that it was up to two hours before the two men were discovered. Brownlee had been buried up to his neck, with just one arm free. He couldn't move, yet conscious enough to realise his predicament and be seriously distressed. It took a further two hours to secure suitable trench rescue equipment for the arduous task of digging the men out. The Brownlees asserted that had there been workers nearby to raise the alarm, and an appropriate emergency plan in place to secure trench rescue equipment from nearby Ballarat, Jack Brownlee may not have died. Instead, the use of an excavator in their view added risk to the rescue and may have caused further harm to their injured son.

In their evidence before the senate committee, the Brownlees said: "In the first two hours, Jack would have had the most horrific time. His mate, Lana's husband, was dead beside him, metres away. Jack would have been screaming for help, and the other boys were at smoko. They were left on their own. There was no supervision of these boys. There was nothing."

Dave Brownlee was critical of the cold, matter-of-fact way a workplace death is handled. This was a 'notifiable incident' under OHS law but there is no requirement for the regulator to notify next of kin

[5] https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Education_and_Employment/IndustrialdeathsinAus

[6] https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Education_and_Employment/IndustrialdeathsinAus/Submissions

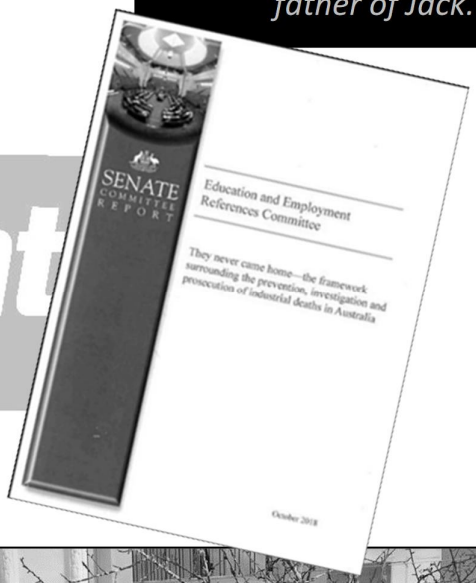
promptly. Janine Brownlee got a phone message from her son's boss about 5.30 pm when she and Dave were already in Melbourne to be with their son in hospital.

"The company has not been near us, no flowers, card or even a phone call when our son died. We received in the mail our son's payslip and they docked him two days' pay … only paid him up to the day he died," Mrs Brownlee told the committee.

Dr Cormie felt the same. " … in my case, I've just seen a helicopter hovering above my work, because my husband was dead underneath it, and no-one bothered to call me. I'm not feeling particularly good … yet the first thing is that I have lost my husband and I have had to stand there and see a helicopter and then go to a roadblock and, on the side of the road, find out about the most important person in my life, bar my children."

> "It was only that Jack was a young, fit, strong man and he fought and fought and fought, until the next day when he couldn't fight any more."
>
> *- Dave Brownlee, father of Jack.*

Although it seems improbably disrespectful, it is common for companies who are aware of the clout of OHS law to avoid any possible perception of liability and the potentially severe compliance and enforcement action that comes with it. It is a cautious approach until the facts of the incident can be known and blame determined. Will that ever change? The right of families to be told about incidents involving their loved ones was one of the first matters families felt should be addressed.



In further testimony to the senate committee[7], Dave Brownlee said he was eventually told that his son had been put in an induced coma and evacuated by ambulance to Melbourne. "I was informed by the police that the best thing to do was to hightail down to Melbourne and meet him at the hospital." He picked up his wife at hospital in Ballarat and his other son Mitchell, only to be delayed in Melbourne's peak hour traffic. While they crawled to the Royal Melbourne the family was getting updates from the hospital, and the 'hurry, up, your son might not make it'.

The Delacombe bereaved (Dr Cormie and the Brownlees) at the end of the Senate hearing in Melbourne with Senators Marshall (chair) and Bilyk and O'Neill. Also pictured are witnesses (Bette Campbell-Phillips) and Canberra witness, Kay Catazani.

"When we arrived at the hospital, Jack had already had his third operation,"

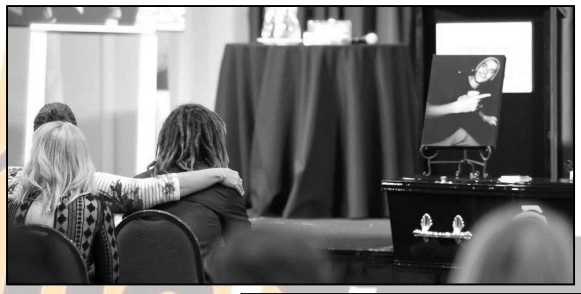
[7] The senate committee members at the Melbourne hearing were Senators Marshall (chair), O'Neill and Bilyk plus Senator Gichuhi (by teleconference).

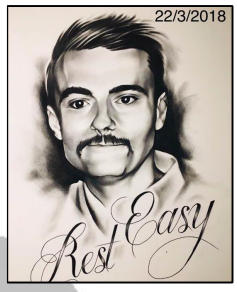
Mr Brownlee said. “Every organ in his body was damaged. He was bleeding profusely. They could not stabilise Jack. He was operated on and operated on … his stomach was left open while they tried to stabilise the body. They couldn't stabilise him. He was getting worse by the minute. He was described by the nurse as the sickest boy in the state. They pumped every drop of blood of his type through his body and it just came out as quickly as it went in …”

The hospital eventually pumped in 63 litres of blood to keep him alive while they worked on him, he said. “It was only that Jack was a young, fit, strong man and he fought and fought and fought, until the next day when he couldn't fight any more.”

‘Tributes were peppered with jokes and anecdotes about a much loved young man (Jack) who was the life of the party.’

Jack Brownlee died at 12.30 pm the following day. “The hardest thing was to drive home the next day, leaving our boy at the hospital,” Mrs Brownlee said: That was one of the hardest things I've ever had to do: knowing he was there on his own; leaving my baby there.”





The social harm

Charlie Howkins and Jack Brownlee were laid to rest locally, Brownlee after a big service in Ballarat and Howkins at a memorial near the family home in Broomfield.

More than 650 people said goodbye to the ‘King of the Jungle’, ‘Jacky Boy’ Brownlee, the youngest son of Ballarat’s Dave and Janine Brownlee (see pictures, right). This young man was described as “socially charismatic” and “filled with life and laughter” who had a deep love of the Carlton AFL club.

Top: Farewell to Jack in Ballarat. Above: Brownleeôs parents, Janine and Dave and brother Matt with a mural done in Ballarat in memory of their ôJacky Boyô *Source: media reports.*

Tributes were peppered with jokes and anecdotes about a much loved young man who was the life of the party. His mother said: “You could never watch a funny video with `Jacko’ because he would laugh out loud, you would end up laughing

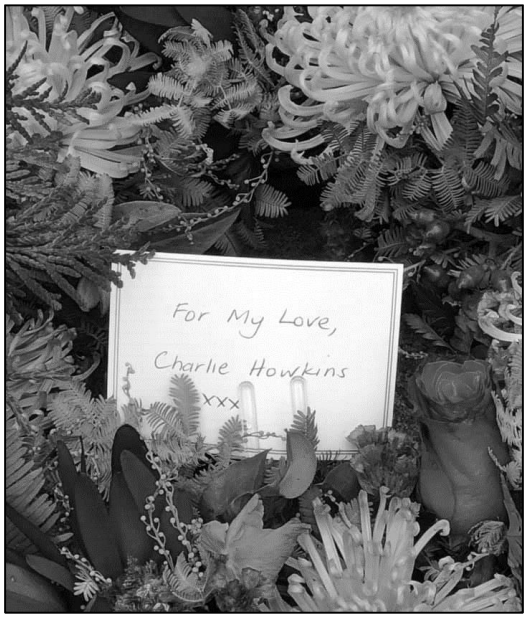
at him, he was so loud with that infectious laugh of his," she said. "He had such a soft side to him, he loved his family, he was so protective, but on the same side he was a frustrating little bugger ... but he'd look at you with his big, bloody brown eyes and all would be forgiven."

Friend Kelly said Jack had got the last laugh. "Me and Jack would take it out on each other, because he loved Carlton and I was North Melbourne. I reckon he'll be laughing right now because he's pulled a bigger crowd here than half the games I go to."

At Broomfield, family and friends celebrated the life of Charlie Howkins, husband of local vet, Dr Lana Cormie, and father to Sophie, three, and one-year-old George. Mourners were asked to wear colour to the memorial where a garden was planted in his honour.

Top: Charlie Howkinsôwidow Lana and Charlieôs brother Reg. In the family photo, Lana and Charlie with, one-year-old George and Sophie 3. Above: Charlie Howkins, the stockman and tradie. He and Lana moved from Queensland to Victoria to settle and start a family. *Source: media reports.*

Originally from Queensland, Charlie Howkins was said to be a true all-rounder. A tradie and a stockman who could master just about anything practical, he met Lana while working on a northern cattle station. She hailed from Victoria and the couple made the decision to head south to start a family. "The kids were a massive part of Charlie's life, he adored them and he was very involved," Dr Cormie said.



A few weeks later, in an interview with the local newspaper, Dr Cormie said she was being guided by a need to stay strong for her children in the daunting task of raising a family alone in a regional centre of Victoria where support services can be limited. At the same time she believed she needed to speak up about what she saw as failings that led up to the incident and the stressful, drawn-out and perplexing legal processes that followed

With her academic and medical background, Dr Cormie was equipped to take on an advocacy role

on behalf of all families placed in similar situations. She did so with tenacity and forensic attention to detail. But even she admitted to struggling to grasp the working of the 'unique' OHS system. It resulted in some pointed and awkward questions for the regulator. This occurred in the midst of a heated industrial campaign and a state election at the end of 2018 when such questions had never held such currency.

> "I will somehow, out of this, create the life for my children that we had planned, obviously with a big hole in it, but I will do this as best I can."
>
> - *Dr Lana Cormie, widow of Charlie Howkins*

Dr Cormie brought the discussion to the media and in various forums. There was a "minefield of issues" that needed to be addressed but chief among them was strengthening safe work cultures and more effective penalties for employers, and that meant introducing industrial manslaughter. "Laws need to be brought in line so that penalties match the crime as they do in other areas of society," Dr Cormie said.

Until the March incident, Dr Cormie said she had "no idea" how OHS safety laws worked. "There isn't a lot of awareness," she said. "We assume in our society that the system is looking after us and if the worst happens it will compensate families effectively and investigation and prosecutions will be completed efficiently. I made that assumption. The reality is very different and unless you come face-to-face, you don't understand how deficient it is."

The campaign begins. Delacombe bereaved Dr Lana Cormie and Dave Brownlee take the role of safety advocates. *Source: media report*

She said the whole process following a death, was difficult to navigate; "WorkSafe, WorkCover, the police investigation, the whole gamut of complexities and no-one is given a guide to the process."

People dying in the workplace often suffered some of the most painful and horrific deaths possible, Dr Cormie said. "We are talking about people being crushed to death, electrocuted, impaled or macerated. These people are not going to war, they are going to work. And you do not expect that you or any of your loved ones are going to go to work and suffer any death, let alone that type of traumatic, painful, horrific death. It is just unacceptable in a first-world country."

Dr Cormie said she was driven by a determination to be resilient for her children and to fight for change. "I remember thinking when this first happened, we will not become victims," she said. "I will somehow, out of this, create the life for my children that we had planned, obviously with a big hole in it, but I will do this as best I can."

The Brownlees told the local media they were just as determined to "see change". Everyone has a right to come home, Mrs Brownlee said. "It's not about sending bosses to jail, we don't want people to go to jail, we want safety and more change in the workplace. People need to be more accountable for their actions."

It's not the fight we wanted to fight, Dr Cormie added. "We have realised how little we knew about the deficiencies in the area before our men died and now we feel it is up to us to tell everyone else before it happens to someone else. "I think it's a real shame that something like this has become politicised because I think it is a human rights issue which should have bipartisan support."

Dr Cormie said she was determined to speak out about workplace safety in hope that no other families have to suffer. "I just think if I sat back and didn't say anything, for me personally, I would feel like I'm part of the problem," she said. "The only thing that I can hope that can come from Charlie's death, and Jack's, is that there will be change and in the future people will be safer and less families will have to go through what we are."

> "It (safety) is not a priority, across all industries. The only way to change that culture to where it becomes the most important aspect is to make people personally accountable."
>
> - *Dr Lana Cormie, widow of Charlie Howkins*

Her growing concern as the months rolled on after the tragedy, and she became more exposed to the process that followed such tragedies, was that there was a serious cultural issue in workplace safety prevention and compliance.

"It's not a priority, across all industries," she said. "The only way to change that culture to where it becomes the most important aspect is to make people personally accountable. "This isn't about sending anyone to jail. This is about sending a really clear message which will say you are personally accountable."

As the IM campaign steps up in the aftermath of Delacombe, more died at work. The Wu family mourn the death of Dillon Wu in October. Relatives came out from China for the funeral. *Source: media report*.

It had to be remembered that while the Delacombe families had a powerful story of their own grief to tell, and what that meant for the OHS and compensation system, they were effectively speaking on behalf of families whose loved ones continued to die at work in Victoria, as the IM manslaughter campaign rolled on. Many more people died to the end of 2018, bring the toll to 23 for the year (see part 5). Their stories, eg the death of apprentice Dillon Wu, did not attract as much attention but no less harrowing (see picture and page 75 for more details).

Postscript:

On May 26, 2018, the campaign for justice for the victims of industrial death, entered a new phase when the Premier, Daniel Andrews, signalled a change in the law, if the government was re-elected in November. It was the first time an OHS matter had received such prominence in state politics for many years.

"It couldn't be more simple … no one should die at work. These laws will help make sure that every Victorian makes it home to their loved ones," the Premier said. "Families who have lost a loved one at work deserve justice - and that means jail, not a slap on the wrist." See Appendix 5 for the statement.

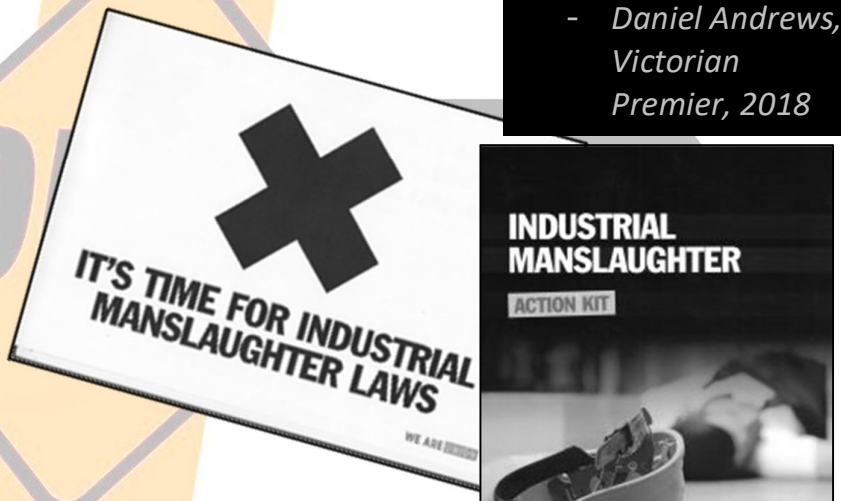
3. Industrial manslaughter

The Brownlees and Dr Cormie's family were not known to each before the tragedy of Delacombe took their loved ones from them. In the weeks that followed they were united in their grief. It quickly grew into an unyielding alliance that spoke out at every opportunity about the circumstances of the incident and unacceptable number of work-related deaths in Victoria.

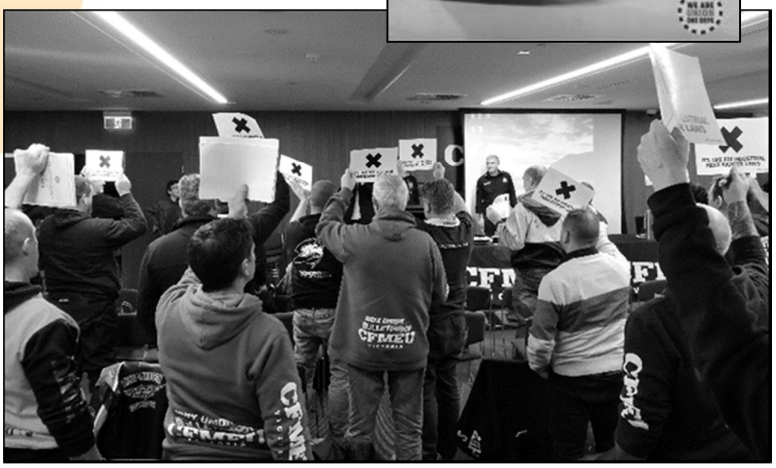
While WorkSafe's investigations continued over the Delacombe incident, always a slow and often agonising process for families, the Delacombe bereaved began to question what had happened and what was deficient in the lead up to the incident, and how justice was to be delivered through the court system that had a record of weak sentencing on OHS matters.

> "No-one should ever die at work. It's why it's our sincere hope that that these new laws need never be used - that instead they'll change our workplaces and change our culture."
>
> - *Daniel Andrews, Victorian Premier, 2018*

In the weeks following they broadly challenged the way WorkSafe was conducting the investigation, its compliance and enforcement strategies under the OHS Act, the tardiness of prosecution processes, the effectiveness of its prevention initiatives and the uncaring nature of employers who did harm and then rationalised it.



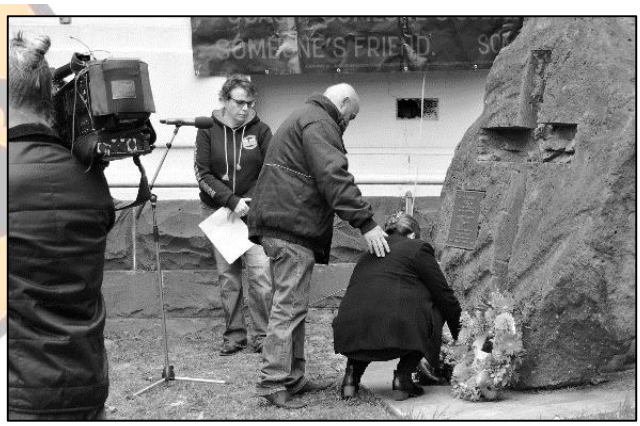
Below: The industrial manslaughter campaign rolls on - IM campaign pledge at the CFMEU reps meeting in July, 2018.



They were supported in their concerns by the union movement. This was not just by the awful circumstances of the case but because the incident happened at the beginning of the year when the Victorian Trades Hall Council (VTHC) was scaling up the second and final year of its industrial manslaughter (IM) campaign, ahead of the state election in November 2018. The two campaigns aligned and the families were adopted as the high profile face of the IM campaign throughout the year when 21 others died at work (see part 5). They became passionate advocates for

change with Dave Brownlee having first-hand knowledge of high risk work from his experience as a miner and Dr Cormie, in her emblematic ‘red coat of remembrance’, bringing an academic discipline to analysing OHS and legal processes.

Workerôs memorial day 2018. Lanaôs story of loss is read out on her behalf by grief counsellor, Bette Phillips-Campbell, from Uniting Victoria. Below: The Brownlees lay a wreath to the memory of son Jack who died in hospital the day after the incident. Bottom: The Delacombe bereaved with symbols of loss of their loved one.



Five weeks after the incident, on April 28, the Delacombe bereaved were special guests at the 2018 Workers Memorial Day ceremony help beside trades hall in Melbourne. The Delacombe incident was still the dominant topic in the working community. It brought the reality, relevance and a new urgency to the campaign. As VIPs on the day, the Brownlees and Dr Cormie shared the limelight with WorkSafe Victoria’s senior executives and union leaders and others, including former attorney-general Rob Hulls (head of RMIT’s Centre for Innovative Justice) who were paying their tributes to those who had died at work over the last 12 months. At the service, boots were laid out for the 26 Victorians who were killed at work since the last ceremony, including work boots representing the deaths of Charlie and Jack (see picture, right).

“It was incredibly moving and tragic to see so many pairs of empty boots at the workers memorial service”, Dr Cormie said. “There are far too many,” she said about the symbolic depiction of workplace fatalities in Victoria. “Something needs to change and it should start with the laws being strengthened to include industrial manslaughter in Victoria.”

After the ceremony, they were granted an audience with keynote speaker Finance Minister Robin Scott, the then minister responsible for WorkSafe Victoria. This was an important first step by them in directly convincing government to change the law to make industrial manslaughter a crime that would see individual employers sent to jail for lengthy periods and companies fined up to $20 mill.

The objective of the campaign was to change ALP policy so that industrial manslaughter would be an issue in the election campaign and part of a platform voters could endorse. The preference was for

the policy to be non-partisan in the event the Andrew Labour Government did not win a second term. This issue was whether it would be effective as a deterrent when employers could already be heavily fined over a death at work and jailed for reckless endangerment. By introducing the new penalty it would create a scale of penalties that could be brought against employers for a workplace incident resulting in death (see Table 1 for details):

- s21 offence by employer, under the "duty of care"
- s26 offence by person in control
- s32 offence of 'reckless endangerment'
- s144-45 offence of not taking reasonable care
- TBN – industrial manslaughter.

Dave Brownlee, left, and Dr Lana Cormie (obscured) are introduced to the then ñWorkCover minister, Robin Scott, and trades hall secretary, Luke Hilakari, at the workers memorial service 2018.

Table 1: Prosecution pathways in the event of a work-related death In Victoria under the Victorian OHS Act 2004

Section of the Act	*What the law requires of an employer*	*The breach of the law*	*Penalty (maximum)**
s21 - duties of an employer	Provide and maintain a working environment that is safe and without risk to health (so far as is reasonably practicable).	Failure is any contravention listed under s22	• $290,142 fine (a person) • $1,450,710 (corporate entity).
s26 - duties of person in management or control of a workplace	Ensure the means of entering and leaving a workplace is safe and without risks to health (so far as is reasonably practicable).	Failure of specific duty	• $290,142 fine (a person) • $1,450,710 fine (corporate entity).
s32 - duty not to recklessly endanger	Not to place another person in danger of serious injury.	Failure of specific duty	• Five years imprisonment or $290,142 fine (a person) • $1,450,710 (corporate entity).
s144 and s145 - offences by officers	Not taking reasonable care.	Failure is any contravention of the Act with regard to four matters	• $290,142 fine
TBN: Industrial Manslaughter	Not to conduct work in a grossly negligent manner that causes death.	Failure of specific duty	• 20 years imprisonment or $16 mill. fine (person) • $16 mill. fine (corporate entity).

*according to current value of penalty units set at March 2018.
Note 1: Almost all prosecutions over a death are made under s21.
Note 2: Also upstream duties for safe use by designers, manufacturers, suppliers and *installers with same order of fines.
Under s131, any person can require the regulator to investigate a breach when WorkSafe does not take action on any matter eg a work-related death.
Source: Victorian Law Today, Victorian Government, online, accessed 2019

In a way, 'industrial manslaughter' was a misnomer. The original term of 'corporate manslaughter' (see page 22) was probably a more accurate term, and explained the reason why IM was necessary and why the offence of 'reckless endangerment' was not the answer for many offences resulting death.

While trades hall in Victoria was running its local campaign, the ACTU as a national body wanted a national law inserted into the model WHS legislation, and called up uniformly in all jurisdictions. Having it adopted in Victoria would make that easier to achieve. This had already been inserted in Queensland's version of its form of harmonised legislation so was possible. The senate inquiry made it possible to achieve while the WHS legislation was going through its five-year review, to which the ACTU was also feeding in its suggested amendments.

In summary 'reckless endangerment' requires a higher level of wrong-doing and proof of it than IM for category 1 offences (the most serious offences, under harmonised law[8]). IM was more suited to taking on corporates than to rely on 'recklessness' as the measure of a serious breach.

During the senate hearing in Melbourne, the ACTU's legal an industrial officer, Sophie Ismail, explained it this way: "It (recklessness) requires someone to have known about a risk and turned a blind eye to it. What that has meant in practice is that it's very, very difficult for the prosecution to jump over that hurdle, and there have been few prosecutions as a result." It is therefore "not appropriate" for an IM legal regime …

"The problem arises in relation to medium and larger corporations," Ismail stated. "If you look at the prosecutions that are successful, they're often in relation to smaller businesses with one or two directors where those people have been actively involved in the WHS culture in the workplace. When it becomes extremely difficult, if not impossible, is where you've got organisations with larger and more complex corporate structures … the way the criminal law works is that you have to prove that there's a 'guiding mind' involved and that requires individuals to be identified as to who's taken responsibility for certain actions.

"It's effectively impossible to hold a medium or large corporation responsible for a negligent act or an omission that leads to the death of a worker. We think that's an unacceptable gap. Why should it be that smaller corporations or individuals can be held accountable but medium and large corporations, simply because of their complex structures, can avoid consequence? So we think that needs to change."

> "Why should it be that smaller corporations or individuals can be held accountable but medium and large corporations, simply because of their complex structures, can avoid consequence?"
>
> - *Sophie Ismail, ACTU, August 2018.*

In addition to Queensland, similar IM laws to that proposed in Victoria have been long established in the United Kingdom (in a limited form) and Canada, and most notably in the ACT (2004). IM was proposed by the NSW Labor opposition in that state's election in earlier 2019, but they failed to win power.

Postscript:

The IM campaign effectively ended when the Andrew Labor Government was returned to power in Victoria in November 2018, with an increased majority. However, it failed to win a majority in the upper house which meant all new legislation, such as IM laws, would be challenged. The new Government's plan for introduction didn't begin until early 2019 - this is beyond the scope and timing of this paper.

[8] Category 1 under model WHS law ï a duty holder, without reasonable excuse, engages in conduct that recklessly exposes a person to a risk of death or serious injury or illness. Model penalty: $300,000 or five years imprisonment for an individual, $600,000 or five years imprisonment for an individual as a person or officer conducting a business or undertaking, $3 mill for a body corporate.

The first campaign

This, of course, was not the first attempt to introduce a form of IM in Victoria. The first public campaign reached the stage of drafting the bill in 2001 (see picture) referring to 'corporate manslaughter' (defined as a body corporate causing death or serious injury through gross negligence). The Bill could not attract enough support in the upper house and was shelved as unachievable. The focus shifted to the updating of the 15 year-old OHS Act for 2004.

Crimes (Workplace Deaths and Serious Injuries) Bill

As Sent Print

EXPLANATORY MEMORANDUM

PART 1—PRELIMINARY

Clause 1 states that the purposes of the Act are—

- to create new criminal offences of corporate manslaughter and negligently causing serious injury by a body corporate in certain circumstances; and
- to impose criminal liability on senior officers of a body corporate in certain circumstances; and
- to increase penalties in health and safety legislation; and
- to make other miscellaneous amendments to health and safety legislation.

Clause 2 provides that the Act will come into operation on the day after the day on which it receives Royal Assent.

PART 2—AMENDMENT OF CRIMES ACT 1958

Clause 3 inserts new Subdivision (3) into Division 1 of Part 1 of the **Crimes Act 1958** (new sections 11–14F).

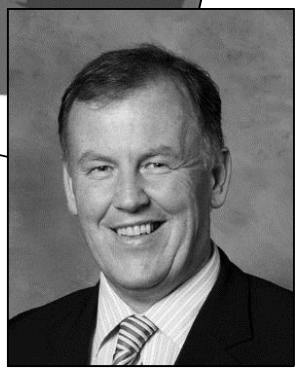
New section 11

New section 11(1) defines the terms "agent", "conduct", "employee", "industry", "outworker", "senior officer", "serious injury" and "worker" used in the Subdivision.

This first attempt, pioneered by the then Bracks Labor Government, involved the Crimes (Workplace Deaths and Serious Injuries) Bill 2001, under the Crimes Act 1958. The Bill intended to make corporations criminally liable for serious injury and death in the workplace. This was a separate Act that was aimed at significantly lifting the consequences of harm in a breach of the OHS Act ie death and injury caused by unsafe work. It was different from the risk-based action under the OHS Act. To ensure the increasing number of public corporations would also be captured by the proposed law, the government sought advice from the Victorian Law Commission on how that could be done (see picture of report, right).

The then Attorney-General, Rob Hulls[9] (see picture), accepted a model proposed in the commission report of early May 2002 that included an amendment to capture public sector entities. The maximum penalty for the offence of corporate manslaughter was proposed as $5 mill. (far exceeding the maximum fine under the OHS Act) and imprisonment of five years.

During the debate on the Bill government members had to deal with some "unease" in the community about such "severe" penalties being imposed on employers. In his address to parliament on November 20, 2001, Hulls stressed the number of deaths at work in recent years, noting that 31 Victorians (actually 30) killed in the previous year and 25 to date for 2001 (ended up being 36 for 2002).



As Attorney-General in 2001, Rob Hulls led the program to introduce a corporate manslaughter law. It was defeated in the upper house at the end of 2002.

"When Victorians go to work, their loved ones and their families expect them to come home," he said. He said the new legislation meet community expectations and sent a clear message to those who do not take workplace safety seriously. "The message is that they will face the

[9] Rob Hulls is now director of the Centre for Innovative Justice at RMIT University.

full force of the law. We want the safest workplaces in the country. For those who take safety seriously the legislation will impose no additional burden."

The Bill was ahead of its time by aiming to chase down owners and company directors even if they "liquidate" or close down their companies in a bid to avoid being charged for a breach of the OHS Act. It also treated "serious injury" under this same offence for an action or inaction that caused injury that could have resulted in death.

Details of the offences sought were:

- A body corporate was negligent of causing death or serious injury by failing to:
    - adequately manage, control or supervise
    - engage a person reasonably capable of providing the services
    - provide adequate systems for conveying relevant information to relevant persons
    - take reasonable action to remedy a dangerous situation that was known
    - take reasonable action to remedy a dangerous situation that was indentified and served in writing.

Penalty was to be set at $5 mill over death and $2 mill for serious injury.

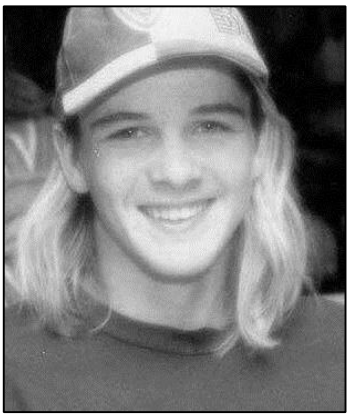
- If a body corporate has committed the offence a senior officer (in position of decision-making and management responsibility for the corporate body) is also negligent of causing death or serious injury by:
    - being organisationally responsible for the conduct
    - perform or not perform their organisational responsibilities
    - knew that the the body corporate was engaging in unjustifiable conduct that involved a risk of death.

Penalty was five years jail over a death; two years over serious injury plus a significant fine.

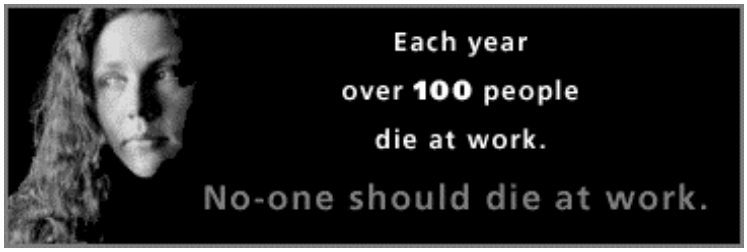
The amended bill was voted down in the legislative council in June 2002 by the Liberal and National parties who had a majority in the house and were ideologically opposed to it. It would have only succeeded if there were sufficient bipartisan support or a crossbench existed to 'horse trade' over its passing, a necessary but unedifying tactic that is disrespectful for the intent of the legislation.

'The only benefit of the "failed" corporate manslaughter campaign, was that change was already underway, even without any action against those employers who might have subsequently been "grossly negligent".'

The first campaign in industrial manslaughter hits the streets in Melbourne circa 2001. Below: The ϕoster boyôfor the first industrial manslaughter campaign in Victoria. Eighteen-year-old Anthony Carrick was killed on his first day at work in 1998. The company was fined $50,000. The fine was never paid. *Source: media reports*



In 2003, the Bracks Labor Government said it would not resubmit that Bill to Parliament and abandoned the idea of an offence of IM. The government stated that other means for improving corporate accountability and the accountability of senior officers for serious breaches of health and safety would be considered.



The first cohesive WorkSafe campaign on prevention of death (2002) depicting bereaved families. It coincided with the first attempt to introduce an offence of industrial manslaughter. *Source: VWA website 2002.*

At the time it was not clear what these would be. Soon after prominent jurist Chris Maxwell was retained to review the OHS Act. This then led to recognition of the role of 'company officers' but far short of what was envisaged by the first IM campaign. See postscript, page 25, for more details.

In the first campaign, the fatal Drybulk incident of November 1998 was key to raising public awareness of the need for corporate manslaughter. The 'face' of the first IM campaign became the victim of the incident - Anthony Carrick (see picture, previous page). The 18-year-old Drybulk apprentice was killed when a concrete slab wall fell on him as he swept the floor at the company's Footscray premises - on his first day at work. In 2001. At the height of the corporate manslaughter campaign, the company was fined $50,000, the owner $10,000 and the foreman $5,000. It is believed the fines went unpaid.

At that time the number of industrial deaths had spiked (see part 6, page 61, for details), particularly in the construction industry, after the rates had started to trend down. The year of the Drybulk incident, 37 were killed at work. The following year 39 died. In the year the draft bill was presented – 2001 - the death toll was 38, and there was a real concern that compliance and enforcement in high risk work was no longer tough enough.

The low fine for the Drybulk incident, within the scope of what the court could have theoretically imposed, helped stir up the campaign by the unions. This penalty over death was typical. In the five years to the end of 2001 the average fine over a death at work was little more than $20,000 (see Table 12, page 65).

The only benefit of the 'failed' corporate manslaughter campaign, was that change was already underway, even without any action against those employers who might have subsequently been 'grossly negligent' in causing harm. It may have been a catalyst, just as the second campaign hoped to be through the 'deterrent' effect.

Five months before the Bill was voted down in parliament, the VWA, under its relatively new 'WorkSafe Victoria' banner, had launched its first fatality prevention campaign ('Nobody should die at work', see picture, above). This was part of its strategy to raise the profile of OHS as a community issue and reflect community disgust about the low level of fines over serious cases it prosecuted. The VWA rightly expected higher penalties on behalf of the community, but this issue was out of its hands. Launched on January 27, 2002, the 'public education campaign' told four stories of Victorians forced to cope with a death at work of a colleague, son, brother and staff member. The VWA campaign was significant because it used the actual stories of the bereaved in its campaign. At the launch, the then Minister for WorkCover, Bob Cameron, said: "It is impossible to hear these stories without being motivated to do more to prevent workplace fatalities in this state."

The 'No-one should die at work campaign' was the precursor of WorkSafe award-winning 'Homecomings' advertising campaign and prevention themes beginning in 2007, and that still resonates today. Some of the messaging featured in the industrial manslaughter campaign in 2017, was that of the 2007.

The campaign was the product of some progressive OHS thinking at the time. It drew on and paid homage to the memory of Anthony Carrick, and the many other workers since 1998 who died in tragic circumstances that may have met the definition of 'gross negligence' under manslaughter in some cases. For many of the bereaved, the new campaign brought back memories of the old campaign, and how justice "should" have been served better, and many lives potentially "saved" by the original law being passed in 2001.

Anthony's mother, Jan Carrick, became involved in that 2001 campaign. Almost 20 years later she recalled that even though the corporate manslaughter law wasn't adopted, some good things were achieved at the time[10]. "Workplace death is like no other death. It is hidden away. Until Anthony's I did not take any notice of it; unlike car accidents where it is on the news and in the papers and talked about everywhere. This has now changed, and I hope in some small way I had something to do with this change."

> "Workplace death is like no other death. It is hidden away … unlike car accidents where it is … talked about everywhere. This has now changed, and I hope in some small way I had something to do with this."
>
> - *Jan Carrick, mother of Anthony who was killed at work in 1998*

It was the need to get the word out that motivated involvement in the first campaign. The second campaign was more about 'it is about time!'. With the benefit of hindsight, Jan Carrick is more circumspect. "I don't think the Industrial Manslaughter laws will have much effect. It will have to be a very blatant disregard for workplace safety to be enforced and unless the courts get serious these different penalties will not be handed down. Judges do not want to set a precedent."

Postscript:

Soon after the first IM campaign was abandoned, prominent jurist Chris Maxwell QC (see picture, next page) began his work that framed the 2004 Act[11]. The issues of the first IM campaign were aired again as Maxwell engaged in an extensive period of consultation before presenting a review report in 2004 that would father the new Act.

The spirit of the first campaign lived on in the proposals for revisions of the OHS Act. In its preliminary paper to its submission for the review[12] the VTHC pushed again for the introduction of amendments to the Crimes Act to create new offences of 'corporate manslaughter' and 'gross negligence' by a corporation causing "serious injury" as the "pinnacle" of the "pyramid compliance" model. "We recognise that, at common law, there continues to be difficulties in attributing the conduct of individuals to a corporation given the current state of the common law …"

It was for this reason that trades hall strongly support the introduction of the Crimes (Workplace Deaths and Serious Injuries) Bill 2001. "We note that there are significant obstacles in the path

[10] Source: safetyatworkblog, *"They don't know what to say, so they don't say anything"*, accessed July 2019.
[11] Occupational Health and Safety Act Review, Chris Maxwell, March 2004
[12] Review of the OHS Act and discussion paper, *Corporate Accountability and Occupational Health and Safety under Victorian Legislation*, Victorian Trades Hall Council, 2003.

towards making corporations and their senior officers properly accountable, particularly when their conduct leads to the death or serious injury of their employees and/or members of the public."

Trades hall said that a view could be formed that the courts in Victoria regarded workplace deaths and serious injuries as being of "lesser importance" when compared to deaths and serious injuries occurring outside the workplace. "To shift this apparent attitude will require a stronger legislative and Government approach."

It proposed appropriate training for court staff likely to be responsible for hearing OHS prosecutions to ensure they understand the Act, its objectives, and that these are criminal offences. It further proposed they be trained on the impact workplace deaths and serious injuries have on the victims.

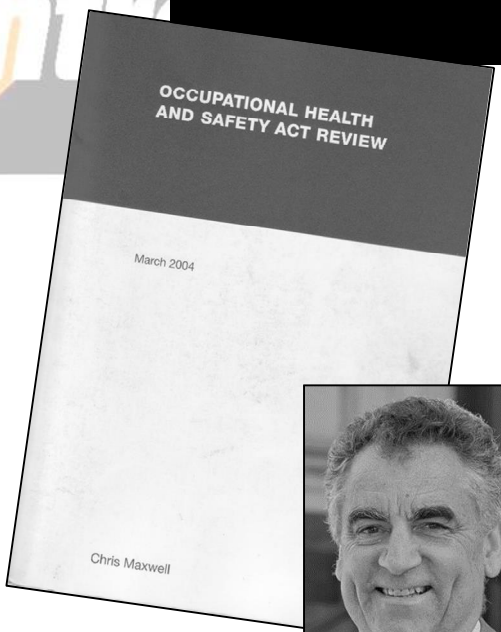
Maxwell did address the matter of the obligation of 'company officers' but this fell well short of what was intended in the campaign of 2001-02. It set the scene for the next campaign. He did recommend extending custodial sentences in matters involving "high-level" culpability but not specific to "company officers". He did refer to "negligence" but only in context of the civil law of negligence on which OHS is based where remedies are about compensation for "loss and damage".

'OHS is a "quite different creature" … because it gives rise to no civil remedy for negligence … OHS is a criminal offence but a prosecution for a breach of the OHS duty is "quite unlike" a criminal prosecution.'

- *Chris Maxwell QC, 2004*

OHS is a "quite different creature", he wrote because it gives rise to no civil remedy for negligence. That is left to a breach of an OHS duty that is "quite unlike" a criminal prosecution.

Maxwell stressed the legal point that offence is committed whether or not harm was caused. "Though prosecution typically follows workplace accidents (sic), the dutyholder is not charged with 'conduct causing death or serious injury'. Nor is the seriousness of the breach of duty measured by the seriousness of the consequences, if any, of the breach."



The father of the 2004 OHS Act - Chris Maxwell. The then eminent QC went on to join the bench.

Maxwell went on to categorically state that there can be "no question of the manslaughter" for breaches under the OHS law of that time. The main reason is "causation" does not arise. Whether someone is injured or dies is only relevant in evidence as the existence of the risk, the severity of that risk and the failure to take measures to prevent the risk being realised.

This is why the avenue for industrial manslaughter is through the Crimes Act, where harm is the subject not the incidental outcome.

The aftermath of Delacombe

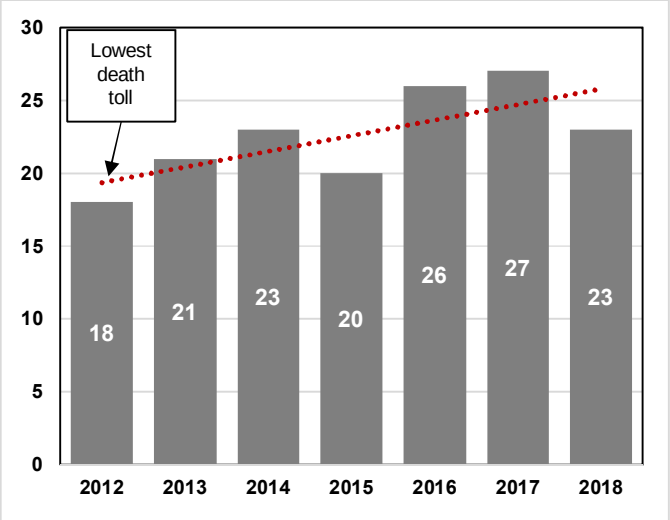
What followed Delacombe was unprecedented in the state's OHS history. There have been multiple deaths at work before (see Table 2, over page) and there have been more than 10 deaths in Victoria over the years involving similar work to that of Delacombe[13]. But it was the timing of the incident - in the midst of an IM campaign - and what it said about the effectiveness of WorkSafe's current compliance and enforcement processes and action. It sent a message to the working community and public at large about the extent of harm and delivery of justice.

At the time of the incident, the VTHC was well into its high profile campaign to introduce IM. The second attempt following the failed 2001 bid, this revival was inspired by the introduction of this ultimate penalty in sister jurisdictions of the Australian Capital Territory (2004) and Queensland (2007). The tone was that since 2001, some Victorian employers, and particularly large corporates were effectively getting away with little short of 'murder' at a workplace.

The revival came when Victoria's work-related death toll began to climb after reaching a record-equalling low of 18 deaths in 2012 (see Graph 1). The toll reached 27, the highest since the 29 deaths of 2009. The campaign effectively kicked off when trades hall signalled in 2015 that the law needed more teeth to make employers accountable.

A makeshift shrine at the Delacombe site after the pipework was completed and the deadly trench covered. Below: The idyllic and exclusive Winterfield housing estate proposed at a prime location on the Glenelg Highway, Delacombe, near Ballarat. The price of progress - residents are unlikely to know that two workers died during groundworks in early 2018. *Source: media reports*

Graph 1. Reported fatalities in Victoria – since record low
Totals for calendar years 2013-2017 (117 deaths) exclude some traumatic deaths that may be considered work-related under other definitions. *Source: VWA/interpreted by OHSIntros*



[13] The Death book, OHSIntros 2018

The aim was to change ALP policy ahead of the 2018 state election, and argue for non-partisan support, to ensure the policy would survive a change of government. In early 2018, the trades hall campaign was clicking up a gear up for election year (the election was called for November 24) when Delacombe happened. It was no longer just politics. The double fatality at Delacombe made the campaign hyper-real, urgent and raw.

Table 2. The Delacombe agenda: changes called for by the bereaved 2018
Areas of improvement in the Victorian OHS and compensation system related to death at work. Supports, but not necessary dependent on the introduction of IM, but necessary to improve prevention, enforcement and death compensation.

Issue of concern	*Activities requiring review and changes*
Operation of the regulators	• investigation resources and competency • notification and communication with families • compliance and enforcement • incident response • prevention/learnings.
Compensation	• fair death compensation • family services and support.
Community engagement	• creating a legislated consultative group, with ongoing role in advising government/regulator on improving the system • providing a voice for the bereaved.
Penalties	• more appropriate penalties eg industrial manslaughter • employers insuring against penalties.
Legislation	The lack of effectiveness of self-regulation in high risk work.
Role of employees	Greater use of influence and expertise of unions and HSRs to raise safety matters
Police involvement	Involvement and interaction with police at incident scenes/collecting evidence
Zero fatality program	Similar to road toll programs.
Matters related to industrial manslaughter	• eliminate ñphoenixingò by taking action against directors registered under corporations law • proportionality of fine to size of company • update sentencing guidelines • set minimum penalties • publicity/release of all charges and sentencing details to working community and public to increase deterrent effect • inclusion of delayed death (eg. work-related illness).

Source: Comments by the Delacombe bereaved, 2018.

A month following the incident, the Delacombe bereaved joined the trades hall campaign. It gave the campaign a significant boost. As a team the Brownlees and Dr Cormie became the face of the campaign and powerful advocates for the new law. The incident itself was also the kind of situation where such a law may apply. It was a view of the Delacombe bereaved that is also exposed deficiencies in the regulator's investigation and prosecution processes. It was not just about IM, but a shift from a risk-based approach under s21 to more extensive action that would require a prosecution over a loss of life. Such an incident should therefore be treated similarly to criminal manslaughter which hinged on the legal concept of 'negligence' and required a more forensic approach.

In the corridors of power and getting political: Left, Janine Brownlee and Dr Lana Cormie, join the election campaign, and below, Dr Cormie elicits support from cross-bench MP, Fiona Patton (Reason Party).
Source: media reports

The campaign confronted cynics who said that even if IM was adopted in Victoria it would be ignored by the regulator and never used, so what's the point? The point was that it would raise the bar on deterrence, but more than that it would be a catalyst for a raft of changes in safety and compensation over death, and serious injury at work. This was the

essence and value of the campaign the Delacombe bereaved were relentlessly waging within the IM campaign. This soon became referred to as the "implementation package" that would take shape throughout 2019 and support the final assent of the new law. It was not just about tacking on a new part to OHS Act, but integrating it within a broader compliance, enforcement and compensation package. The result would be a more capable and effective regulator.

What might an ôindustrial manslaughterôcase look like? The deadliest incident in modern OHS history was the collapse of a perimeter wall at a Carlton construction site in 2013, on the eve of before Easter 2013, killing three pedestrians. See Table 3, below for more detail. *Source: media report*

Table 3. What does industrial manslaughter look like? Major prosecutions over a death in Victoria to date
Examples of major prosecutions in Victoria that in retrospect might have been subject of an industrial manslaughter action.

Year of incident	Employer	Incident	Victim/s	Prosecution
2014	Redback Tree Services	Electrocuted while trimming trees near live powerlines. (No attempt to isolate power.)	Scott Gamble, 22.	Convicted and fined $150,000 (2017)
2013	Grocon (Victoria Street) P/L	Brick wall and attached hoarding at site perimeter in inner Melbourne collapsed on footpath. (No structural assessment of 80-year-old wall, no assessment of structural integrity of wall for attaching hoarding by contractor, no council or design approval.)	*Bridget Jones, 17 *Alexander Jones, 19 *Dr Marie-Faith Fiawoo, 33.	Fined $250,000+ (2014)
2011	Melbourne Water Corporation	Drowned after falling through unsecured grate over sewer channel at treatment plant while taking water samples. (The organisation was aware of the risk from loose and missing grates.)	Tim Bakerov, 53.	Convicted and fined $400,000 (2014)
2003	Paper Australia/ Amcor Fibre Packaging	Died from head injuries after being dragged into unguarded rollers on paper drying machine during electrical maintenance work. (The organisation was aware of the risk from lack of guarding.)[14]	Darren Moon, 29.	Fined $360,000 (aggregate) (2005)
2001	Bendigo Mining	Helping a colleague jump-start a heavy mining dump truck while underground when the vehicle rolled forward, killing him.	Patrick Stevens, 19	*Compliance action under Mine safety law*.
1998	Drybulk	Eighteen-year-old casual in first week at work crushed to death when a freestanding concrete slab fell. Another 18-year-old sustained serious injuries to back and legs.	Anthony Carrick, 18	Fined $50,000 (2001). Managers fined $10,000 and $5000.
1991	Denbro	Worker killed when lost control of an unsafe truck down a slope on a construction site as a result of defective brakes. Putting the trucks into work was given a higher priority than the safety of workers. Company and responsible officer had been criminally negligent.	Anthony Krog	Fined $120,000 (1994). Officer of company fined $10,000.

Sources: Dr Gerard Ayers, CFMEU Victoria presentation, SIA OHS construction forum 2018 and VTHC discussion paper 2001/ interpreted by OHSIntros.
**pedestrian*
+Aussie Signs P/L also fined $250,000 by WorkSafe plus separate $7000 action over lack of permit.

[14] The Darren Moon incident was one of the five case studies included in a government report on the status of industrial death in Australia: *Workplace death and serious injury: a snapshot of legislative developments in Australia and overseas*, Nov. 2004, Department of Parliamentary Services.

Later in 2018, the 'high profile' of the bereaved saw them connect with the corridors of power: audiences with government and meetings with WorkSafe's senior management to state their case. Such high level consultation over a workplace incident hadn't happened before. And this occurred at a sensitive time - while WorkSafe lawyers where working methodically behind closed doors on the making a case against Pipecon.

The Delacombe bereaved list for overhauling Victoria's OHS regime in its response to death at work was echoed in their senate inquiry submissions (see part 4). The 'Delacombe agenda' saw the OHS/comp system as disconnected and flawed and not as integrated as it is supposed to be. This was based on the experience of their early engagement with a supposed logical and seamless system. So system wide changes were needed as a whole whether IM was introduced or not (see Table 2, page 28):

> "It would seem clearly beyond dispute that … employees were so accustomed to performing their duties in an unsafe environment, that they, and … their employer, barely saw the danger …"
>
> - *Court of Appeal, Amcor case 2005, over death of Darren Moon*

Part of the challenge of the campaign was to explain what 'industrial manslaughter' would look like? What horrendous incidents might have been subject to such an offence had it been introduced at first try in Victoria in 2001? And would a 'Delacombe' be a candidate as a case? If the death of two workers was not serious enough, what might 'negligence' mean for the general public?

This was touched on in a few forums, including one hosted by the Safety Institute of Australia during WorkSafe health and month in October (see picture), just before the caretaker period switched government from policy development to election mode. The selection of notorious incidents offered by the CFMEU's Dr Gerry Ayers at this forum (see Table 3, previous page) included the Grocon incident of 2013 when a perimeter site wall collapsed, killing three pedestrians (see picture, previous page).

Dr Lana Cormie takes the limelight on the OHS policy and legal panel at the SIA's industrial manslaughter forum during WorkSafe month 2018. Left is Dr Gerry Ayers who listed some of the worst OHS cases as examples of where corporate manslaughter may have applied.

In his presentation Dr Ayers listed the Melbourne Water Corporation (2014) and the Amcor (2005) cases effectively as "corporate manslaughter" cases. In the Amcor case, just a few years after the first corporate manslaughter proposal was blocked in the upper house, the DPP appealed against what was claimed to be manifestly inadequate sentencing in the original case in October 2004. The sentence in the magistrate court was just $60,000 on each of two counts.

Court of Appeal, judges Vincent, Eames and Nettle, said of the original Amcor fine given in the magistrates court[15]: "It would seem clearly beyond dispute that Mr Moon (deceased worker Darren Moon) and his fellow employees were so accustomed to performing their duties in an unsafe environment, that they, and presumably their employer, barely saw the danger to which they were exposed. No effective action was taken in response to the limited warning given by the risk

[15] https://www.austlii.edu.au/cgi-bin/viewdoc/au/cases/vic/VSCA/2005/219.html

assessment report, which in turn was prepared without the engagement of independent, properly qualified persons, nor was it regarded as necessary to undertake preventative action as a consequence of earlier incidents. It is equally clear that there was no adequate instruction or supervision of the deceased concerning the performance of the task that he was undertaking at the time that he was drawn against the rollers."

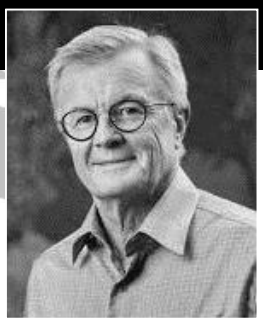
The judges commented that despite Amcor's assertions about its concern for the safety of its workforce, and despite the claimed difficulties in fitting a guard, the fact was that a guard was able to be fitted within a very short time after the incident.

"Furthermore, while the cost of installation was plainly substantial ($700,000), the factor which seems to have been of greatest importance to the respondent was that installation of the guard and the adoption of safe working practices significantly increased the costs of operating the machine and otherwise conducting the respondent's operations.

"In our opinion, the inference is irresistible that the respondent approached the situation from the viewpoint that as little untoward had happened over a long period of operation, it could be assumed that nothing ever would and therefore that the substantial expenditure and increased operating costs
involved in the removal of the danger were not regarded as justified. A degree of complacency based upon the acceptance of that assumption can be seen to have contributed to the death of one of its employees."

"I accept without reservation the deep grief and loss she (Mrs Bakerov) and her family feel. It is likely this will continue for the rest of their lives."

- *Judge Christopher O'Neill, sentencing over the 2011 death of Tim Bakerov*



Judge Christopher O'Neill

The Amcor case became an important for case law, as was shown when it was quoted among some other terrible fatality cases (Nationwide Towing & Transport 2011 and Coates Hire Operations 2010) during the Melbourne Water judgement.

In sentencing Melbourne Water, County Court Judge Christopher O'Neill in 2014[16] said there were two aspects of the failure: "The first is that there were a number of incidents going back three years where there were clear reports of missing or displaced grates on the walkways … despite the evidence of reports of these prior occasions no steps were taken to investigate the risk of slatted grates becoming dislodged and no consequent steps taken to secure them. In my view this was a clear and substantial failure, in particular in a workplace where there were considerable hazards and occupational health and safety matters were said to be important. The second significant issue in my view is that the potential consequence of the failure to take adequate steps to properly secure the grates was dire. A missing or displaced grate in this plant with hazards such as water courses and channels would likely result, to anyone who gave the matter a moment's thought, in the death of a worker by drowning, if he stood upon an uncovered hole or attempted to lift the heavy grate back into place. Tragically in this case that indeed occurred."

The corporation pleaded guilty but it is unlikely that it would have lessened the grief felt by the Victim's family. Judge O'Neill said in handing down the sentence that, "whatever penalty I impose, little of what was said in the course of the plea hearing and of what I have to say today will give much

[16] https://www.austlii.edu.au/cgi-bin/viewdoc/au/cases/vic/VCC/2014/184.html?context=1;query=Melbourne%20Water;mask_path=au/cases/vic/VCC

solace or comfort to Mrs Bakerov and her daughters, given the tragic circumstances of the death of their husband and father."

He said there was a clear and comprehensive impact statement by Mrs Bakerov about the tragic affect upon her and her daughters. "I accept without reservation the deep grief and loss she and her family feel. It is likely this will continue for the rest of their lives."

He also accepted that the management and workers at the corporation's treatment works were shocked by and deeply regret his death in the course of his work duties.

Victorian Premier, Dan Andrews, launches the IM program in Ballarat in March 2019 with the Delacombe bereaved and local MPs. On his left is newly appointed workplace safety minister, Jill Hennessy. *Source: media report*

These are two of many more Victorian cases of recent years that could have been listed here. These two most clearly illustrate a serious degree of lack of 'duty of care' that could be argued are akin to coporate manslaughter.

At the same time as IM was being debated during WorkSafe health and safety month 2018, the senate inquiry had wound up. The secretariat was completing the committee report which was due to be tabled in the chamber in Canberra.

The content for the report consisted of initial submissions from stakeholders, regulators, Safe Work Australia, supporting bodies, a large number of bereaved families, interested individuals and supplementary testimony from the hearings held around the state[17]. Many of the regulators stated existing positions. They saw no need or compelling reason to change policy and operations related to compliance and enforcement on potentially fatal hazards and risks in their jurisdictions.

The coincidental release of the report during WorkSafe health and safety month gave a national dimension to the Victorian campaign, and offered a cogent argument to include IM in national model legislation. It was already in the harmonised versions called up in Queensland and the ACT, so didn't seem a step too far.

Less than two months after the Senate report was tabled in Canberra, the Andrews Labor Government in Victoria was re-elected and announced that it would implement its IM policy, as a key part of a raft of related OHS changes. This would be the responsibility of then new Attorney-General (and also Victoria' first 'Workplace Safety' minister) Jill Hennessy, the former health and human services minister.

This was delivering on the commitment made in Ballarat in May 2018 when Premier Andrews and met the Delacombe bereaved (see picture) for the first time. This was officially recorded at the end of May in a government statement (see Appendix 5).

[17] Those giving evidence at the the Melbourne hearing of the senate committee included WorkSafe Victoria (on behalf of the Victorian Government), the Victorian Trades Hall Council, the ACTU and a panel of the bereaved.

On the first anniversary of the Delacombe incident (March 2019), the government stated it was delivering on its promise to make industrial manslaughter a criminal offence, with work kicking off on the development of the tough new laws. “We promised we’d make workplace manslaughter a criminal offence and we’re not wasting a minute,” Andrews said.

‘ … for the first time in OHS history victims’ families would be asked for their views on OHS law by being invited to be part of the taskforce.’

Under the proposed new laws employers would face fines of almost $16 mill. and individuals responsible for negligently causing death could be jailed for to up 20 years. The program to develop the new offence, and harmonise with Queensland and the ACT, was to be led by an “implementation taskforce” headed by the former Minister for Industrial Relations Natalie Hutchins, see picture, in her new role and assistant to the workplace safety minister. It would guide the advisory group of legal stakeholders that would propose the model for the new law, under the direction of the Department of Justice and Community Safety. This was a different process than developing safety laws. This may have been necessary because of complex legal opinion around the concept of ‘manslaughter’, a crime of violence, and the level of ‘gross negligence’ as the measure being introduced to an industrial environment, and what level of evidence would be required.

The IM implementation taskforce was to be led by the former Minister for Industrial Relations Natalie Hutchins. She became assistant to the workplace safety minister.

The taskforce was to be made up of the usual union and business representatives and legal specialists. But for the first time in OHS history victims’ families would be asked for their views. Taskforce chair, Hutchins, said: “The families of people killed at work deserve a voice and will provide vital input in the drafting of these laws.”

They were to be part of a supporting Workplace Fatalities and Serious Incidents Reference Group specifically to represent the community cohort of bereaved families. This was to “ensure that those who have lost loved ones in workplace accidents (sic) can contribute to the reforms,” the government said.

The government planned to have the law in power by the end of 2019[18], assuming it passed the legislative council, the stumbling block at the first attempt so many years before. The roll-out of the law, the government said, would see WorkSafe Victoria given the powers and resources needed to ensure employers who “do the wrong thing” will be prosecuted. This was a broad statement, and there was an indication that there would be an “implementation plan” that would mean the new law would not just sit on the shelf as some sort of theoretical deterrent, as seemed to be indicated in the premier’s comment about this process: “No-one should ever die at work,” the premier summed up. “It’s why it’s our sincere hope that these new laws need never be used - that instead they’ll change our workplaces and change our culture.”

[18] At the time of writing, the implementation taskforce and reference committee had completed deliberations on the new law. The membership, details of deliberations and supporting documents of both committees were not made public.

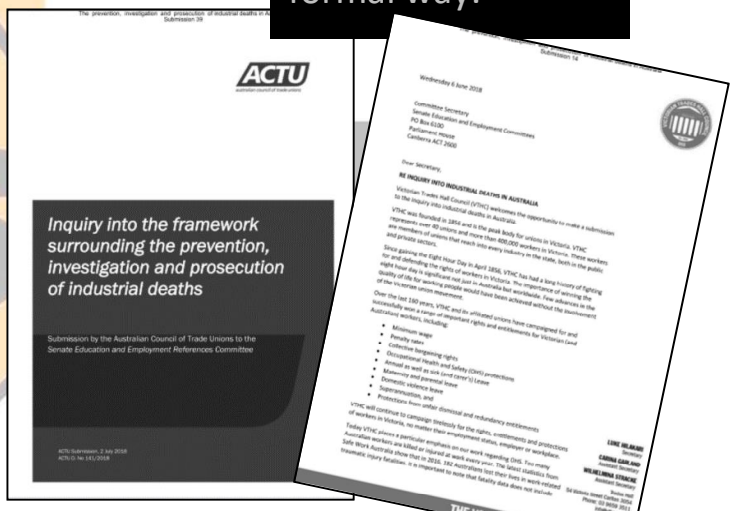
4. The Senate inquiry

The terms of reference for the 2018 Senate inquiry into industrial death in Australia was expansive:

1. The effectiveness and extent of the harmonisation of workplace safety legislation between the states, territories and Commonwealth;
2. Jurisdictional issues surrounding workplace investigations which cross state and territory boundaries;
3. Issues relating to reporting, monitoring and chains of responsibility between states, territories and the Commonwealth;
4. Safety implications relating to the increased use of temporary and labour hire workers;
5. The role of employers and unions in creating a safe-work culture;
6. The effectiveness of penalties in situations where an employer has been convicted of an offence relating to a serious accident or death;
7. Any other related matters.

Chaired by ALP senator, Gavin Marshall, in his parliamentary swansong, the inquiry had a harmonisation agenda that was mostly irrelevant to Victoria's standalone system. Only the last two terms gave wriggle room for Victorian matters of the moment eg the IM campaign. These matters could be expressed during the submissions and hearings where the voices of the bereaved were welcomed. They had not been so prominent, dominant and respectfully regarded in such a formal way.

'… during the submissions and hearings … the voices of the bereaved had never been so prominent, dominant and respectfully regarded in such a formal way.'



Submissions to the Senate inquiry by the ACTU and trades hall. Both worker bodies gave evidence at the Melbourne hearing. Right: Inquiry chair, Victorian Senator Gavin Marshall.

The submissions were made in May 2018. The issues raised by the Brownlees and Dr Cormie in their submissions were based on the incident that was fresh in their memories. There had been little time to reflect on the total impact of the incident but they were determined to speak up and speak boldly. It was based on their early and incomplete experience dealing with the investigations process and compensation system. They were not fully able to reflect on the total experience with the safety and compensation system that by its nature is complex, detailed and time-consuming eg they had yet to be engaged in the coronial process or see prosecution outcomes and possibly civil actions unfold.

The submission format allowed expansion on the terms of reference and gave some guidance on what they could provide that would assist the inquiry. Many questions were about the full scope of experience by the bereaved. Some of these questions and the response by the Delacombe bereaved are set out in Table 4, see next page:

Table 4.1 Comments by the bereaved to the 2018 Senate inquiry into industrial death

Matters for submission related to inquiryôs terms of reference (TOR). Comments are from submissions made to the inquiry and evidence given by the Victorian panel of the bereaved related to the Delacombe incident of March 2018. Note: questions and responses have been edited for clarity and brevity. They refer to submissions (May) and the Melbourne hearing (August).

Issues related to TORs	*Comments by bereaved, where applicable.*
Operations of the harmonised model of safety relating to investigations across different states, reporting, monitoring and chains of responsibility.	• The federal and state laws around workplace safety are not cohesive, regardless of the implementation of the model laws. Should represent a minimum standard of compliance that the states must meet or exceed. • The phoenixing option must be closed off nationally to ensure accountability.
The role of those impacted by a workplace death eg some families taking their stories into workplaces to help raise awareness. *(Note: includes role of unions, under TOR No. 5)*	• Without unions entering sites and representation, workers donôt know their rights and donôt ask in case they lose their jobs. • Unions help ensure workers are educated when safety measures are not up to standard. Employers are not providing training. • There is too much reliance on self-regulation; employers do not consider safety a priority; it slows down the job and reduces profit. • Incidents are not reported to protect an artificial ósafety recordô Lack of reporting means that safety protocols are not reviewed. • Laws needs to be followed up with education and policing to maximise change. • The messages of safety are not being heard. More resources are required to ensure regulators can do this uniformly. It is left up to the families to speak up and help raise awareness of the consequences of incidents.
The role the fines handed out by the courts have on prevention.	*Note: comments provided before Victorian government endorsed IM laws.* • Penalties for offences in Victoria are insufficient. Employers must take OHS seriously and have it a priority, rather than an after-thought. • Director of companies need to be accountable for the safety of their workers. Until they see themselves responsible for safety outcomes, they will fail to consider OHS a priority. • The laws and penalties should be brought into line with what the public expects. We have a right to expect that our laws will uphold the values of our people. • An increase in penalties to include jail and serious fines needs to be part of a holistic approach to OHS reform. • The argument against IM is unsound. These laws only change the penalty, not the rules. It forms part of the picture by motivating change from the top.
Notification about death and how it could be handled better.	There should be a legal requirement for employers to notify the next of kin at the earliest opportunity. It is too slow in todayôs age of social media.
Level of support: sufficient information to move forward and understand the legal issues. How could it be improved?	• The processes are difficult to navigate, even those who believe they are capable and ówell educatedô • A ócaseworkerôfor each family would aid in the process and reduce the distress experienced.
Satisfaction with the length and inclusion in the legal process.	• The focus appears to be around the incident. A broader approach may undercover the root cause of the safety issue. • Inadequate resources for investigations. This is a concern, given that prosecutions are required to act as a deterrent. • The legal process is too long and secretive, and contributes to the impact on the bereaved.
If a prosecution: satisfaction with the outcome, understanding what happened to the victim and was justice served?	• There are limited avenues for prosecution in cases of a workplace death. There should be avenues for families, unions or other parties to press charges. • In the case of an employer being found guilty, there should be additional options available for actions and adequate compensation.
Operation and adequacy of the compensation system.	• The compensation system is too complex to navigate. It should involve a direct application to reduce the costs, legal fees and streamline the process. • Entitlements are not adequate, too slow in being provided, and not related to the whole process eg a ñpensionòcould be provided to families who have lost a breadwinner to help care for children while awaiting approvals and to the end of the process. • There should be category of entitlement to any parent/family that has lost of child who was a vulnerable worker eg apprentice worker exposed to high risk. • Death claims should be proportional - higher level of claims should be made for the death of a young worker and any victim with young children. • The cap should be raised on payments made under common law. This is fair when an employer has been found guilty of an OHS breach. • The system creates a conflict of interest. The insurer aims to minimise the payout when the function should be rightful compensation.
Other issues	See Table 4.2

Source: Submissions to the senate reference committee inquiry into the *Framework Surrounding the Prevention, Investigation and Prosecution of Industrial Deaths in Australia, 2018*

Table 4.2 Comments by bereaved in submissions to the 2018 Senate inquiry into industrial death Matters for submission related to inquiry's terms of reference (TOR). Comments are from submissions made to the inquiry and evidence given by the Victorian panel of the bereaved related to the Delacombe incident of March 2018. Note: questions and responses have been edited for clarity and brevity. They refer to submissions (May) and the Melbourne hearing (August).	
Other matters	*Comments by bereaved, where applicable.*
Level of fines	A component of sentencing should be restitution due to loss of income and cost to family left in financial difficulty eg young children, whether they were dependent or not should have regard to the circumstances eg mental and physical health and welfare and their future needs.
Trench rescue procedures	• delay in emergency response that may have contributed to death of Jack Brownlee includes two hours to discover there had been an incident at a high risk work site and a similar period to transport rescue equipment to the site. • resourcing emergency services is required to ensure they are equipped and trained for such incidents especially in developing regions where high risk work is being conducted eg mine safety rescue equipment is available in the Ballarat area, and in other active regional areas with limited resources and where communication may be difficult.
Prevention	• WorkSafe Victoria is not sufficiently resourced to conduct the necessary amount of compliance and enforcement in regional areas eg developing areas. • WorkSafe needs to invest more in prevention and do more monitoring of high risk work. This should be the work of a special arm of WorkSafe.
Training and education	• increase the training and education for safe trenching eg a form of certification so workers know the risks, what a risk looks like in this type of high risk work and how to speak up about unsafe work. • The same should apply to all high risk construction work.
Review guidance information	• Such incidents should trigger a review of the adequacy of statutory guides, their impact and take up and the interpretation of the regulations to which they related. Reviews should be conducted by safety experts and compared with state of knowledge and best practice eg shoring a trench deeper than 1.5 m inadequate as a collapse may still engulf a worker up to the neck, and bury them if the working posture requires bending or crouching as in pipe laying tasks.
OHS reform	• OHS law lacks an holistic approach to compliance that is needed to integrate education and prevention.
Source: Submissions to the senate reference committee inquiry into the *Framework Surrounding the Prevention, Investigation and Prosecution of Industrial Deaths in Australia, July 2018*	

The most pertinent submission to the senate inquiry from a broader Victorian perspective came from the VTHC, the driver of the Victorian industrial manslaughter campaign. This was further articulated in the Melbourne hearing by its OHS lead organiser, Dr Paul Sutton.

Trades hall was running hard with its IM campaign at the time of the senate hearings. This was the undercurrent of the submission and even blunter in the evidence and the responses to the senators' questions Dr Sutton gave to the Melbourne hearing. Trades hall first took aim at harmonisation to provide perspective to its campaign. While generally supporting the principle, it like many bodies and observers endorsed the Victorian decision to stay outside the model regime. It did not believe harmonisation was "based on best practice and to harmonise would have taken Victoria backwards".

On specific matters trades hall raised concerns were about temporary work and the risk in labour hire that was subject of then recent Victorian Government Inquiry into Labour Hire and Insecure Work. The increasing use of flexible work may have helped businesses' bottom line, and IR enforcement measures policed by the Australian Building and Construction Commission might have reduced disputes on building sites involving unions but was not contributing to improved OHS outcomes in high risk where fatalities are always a fear. Trades hall also took aim at the "behavioural-based safety" proposition that blames the behaviour of individual workers for most work-related injuries and illnesses. This continues to ignore the accepted methodology of managing risk by applying the fairly basic hierarchy of control and the fact that higher order controls are often more cost effective than "telling someone to be careful" especially when an employer ends up in court over a serious incident that could be easily prevented.

"For many years the number of serious injuries and workplace fatalities was dropping. This is no longer the case," trades hall stated in its submission, "… this is because our workplace laws continue

to have a gap and they fail to provide justice when a person is killed. The message sent by our laws is not serious enough when a person is killed by corporate negligence."

In making the case for implementing IM, the submission went on to say: "In all other areas of life if you negligently kill someone you go to jail. That sends the right message to the community about the dangers and harm that your actions can cause."

Its Melbourne senate hearing, evidence presented by Dr Paul Sutton, reaffirmed the importance of IM being adopted in Victoria.

Dr Sutton noted that IM shifts the focus to the harm: "The death of a person is merely a factor in a court's consideration of whether the employer controlled the risk or not. In a way this devalues the way that death is treated during the court case. It just becomes a factor among many other factors that the court juggles and lawyers argue over. The importance of industrial manslaughter laws lies in part in that the death becomes a central element. It has to be recognised by the court; the court has to find that the death occurred; and it becomes part of that justice that currently is really not happening for families. If we can get these laws through, they'll be able to hear in a court of law, 'We are recognising the fact that you have lost a family member and we are here to get justice for that.' It is the focus away from the uncontrolled risk to the fact that someone died."

"...if we can get these laws through, they'll be able to hear in a court of law, 'We are recognising the fact that you have lost a family member and we are here to get justice for that.' It is the focus away from the uncontrolled risk to the fact that someone died."

- *Dr Paul Sutton, OHS lead, VTHC, August 2018*

Dr Sutton challenged the notion that industrial death is only about a traumatic death. He said the discussion around industrial death invariably focusses upon those horrific incidents that take a life immediately: "We need to not lose sight of those thousands of deaths that are actually occurring through occupational exposures to various substances that can result in cancers, black lung, silicosis, and those kinds of conditions that are occupational diseases that will kill people. Not enough is known about that or done about that."

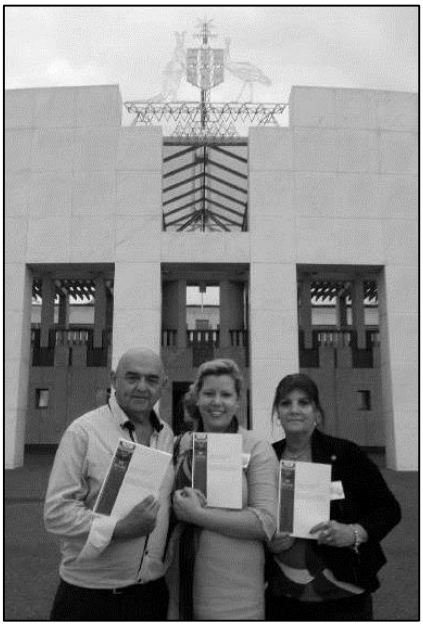
Dr Sutton's view was that if there was a case of asbestos-exposure by a corporate entity, such as in the James Hardie scenario, the board of directors of such a company could be prosecuted under IM laws. "One of the problems we face is that statistics in these areas are essentially based on best guesses and estimates. There is a lack of hard data." he said.

There are a number of reasons for this, he said. First was long latency in disease development making them low profile. The second was "strategic" decision-making in workers compensation claims. "I can tell you right now that they don't get 3000 occupational disease claims. That is not happening. People are not putting in the WorkCover claims. With some diseases they will, because it's so well known."

This situation applied to some extent with asbestosis and mesothelioma where claims are often made after many years. "But with a lot of diseases people don't necessarily understand or know about it. The occupational physicians don't necessarily know about it, so there are a lot of WorkCover claims not being made. Therefore, the agencies aren't seeing the problem in a way that would force them to act on it."

The senate report

The senate inquiry report was tabled in Canberra in October 2018. It was rich in many of the matters raised by the panel of bereaved, and their supporters, at the various hearings. These matters were reflected in the comments by the committee in the report and its 34 recommendations to government (see Appendix 6 for details).



The Delacombe bereaved in Canberra for the release of the senate report in October 2018. They made submissions to the inquiry and were witnesses at the Melbourne hearing. Below: in parliament house - the delegation of the panels of the bereaved from the senate hearings around the nation, hosted by the ACTUôs then assistant secretary, Michael Borowick (who led the ACTUôs submission), met with several political leaders to put their case for reform, including the Minister for Jobs and Industrial Relations, Kelly OôDwyer. Bottom. ACTU president Michelle OôNeil, speaks at the release of the report, flanked by the bereaved. *Source: media reports*

In summary the most relevant recommendations were:

- expand the traumatic injury fatalities dataset to capture death resulting from industrial diseases.
- publish a dataset on the prosecution of industrial deaths eg used to ban organisations with poor safety records from bidding for government tenders
- extend the WHS framework to cover precarious and non-standard working arrangements
- regulators are adequately funded and resourced to allow them to complete investigations in a timely, thorough and effective manner
- develop and deliver standardised training modules to ensure that all investigators have the appropriate skills, experience and attitude to carry out high quality investigations
- regulators formalise collaboration and evidence-sharing between themselves and with other law enforcement agencies during investigations following an industrial death
- regulators have adequate resources to allow for increased and more effective preventative activities
- introduce a nationally consistent industrial manslaughter law
- regulators publish a justification for why it chose not to prosecute following an industrial death
- unions, injured workers and their families able to bring prosecutions
- develop national sentencing guidelines and review levels of monetary penalties
- implement national reforms to combat phoenixing.

Several other recommendations specifically related to the plight of bereaved families and what should be done to give them a voice and provide further assistance. These included:

- develop clear guidelines for the notification of families after an industrial death
- make the investigation processes as transparent as possible
- provide a forum and advisory body for bereaved families
- fund support services and legal assistance
- ensure that all regulator staff with contact to impacted families have adequate training
- review adequacy of workers compensation legislation.

Judging by the topic of the recommendations, the reference committee heard the voice of the bereaved and those supporting their calls for more effort by regulators to prevent death and serious injury from high risk work. This was noted by the committee in its acknowledgements.

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

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

- *Senate committee report, October 2018*

Chapter two of the report proper began with a homage to the panels of bereaved who had been united in the need for reforms so that other families were not put in their situation. The chapter content was devoted to stories and impassioned pleas of bereaved families, to help explain the impact of harm, starting with the statements of the Delacombe bereaved. "The human impact of an industrial death is catastrophic and far-reaching", the report stated at the opening of chapter two, simply titled, family voice: "The human impact of an industrial death is catastrophic and far-reaching. For the families and friends of those individuals killed at work, the terrible and profound human cost and associated consequences they must suffer is lifelong."

The testimony of the bereaved and those who support them was seen elsewhere in the report eg in the pivotal chapter 4 ('investigations of incidents'): **"**Families were also concerned that they were not seen as valid stakeholders in the investigation and as a result were not kept up to date with the process." Then further on in this searching chapter: "The committee acknowledges the frustration of families when investigations take lengthy periods of time. The committee also acknowledges that it is difficult for families to find closure and deal with their grief when they do not have confidence in the investigative process that follows the death of the loved one."

For more information on the senate report: see the recommendations in the Appendix 6 and matrix in the senate report on maximum penalties by jurisdictions as at October 2018.

In a minority 'report' coalition senators acknowledged the findings as important. While they supported many of the recommendations, they also believed that several recommendations were not the most effective policy responses in achieving the best possible health and safety outcomes for every workplace across the country[19]. This was a reflection of federal government policy.

[19] Comments made by Senators Slade Brockman (deputy chair) and James Paterson (Liberal Party). They were not present at the Melbourne hearing.

Their criticism was mostly about industrial manslaughter laws. Their view was IM introduces potentially overlapping offences (see Table 1, page 19, in a Victorian context) and are likely to "complicate rather than support accountability". They also believed it promotes an adversarial legal approach based on a "blame" culture.

"It is punitive rather than preventative, which can ultimately distract from the core object of WHS laws in Australia. It is better to focus on the processes in preventing injury and death in the first place - rather than focus on the punishment and what to do after an injury or death has happened."

A further concern was managers being responsible for poor safety behaviour of workers. They thought it could have the opposite effect to what is intended … "making companies and managers less likely to disclose and address risks".

They quoted the long term success of existing laws in reducing the rate of death across Australia. "We believe the focus on holding companies and managers accountable for breaches in their WHS duties regardless of outcome, as is inherent in the existing model laws, is the appropriate approach to continue to drive a reduction in fatalities and injuries in the workplace."

The coalition senators dismissed the suggested pathway for implementing the recommendations. The coalition senators said that to ensure relevant recommendations are taken forward, they must be dealt with by the agencies and authorities that are most appropriate to do so. Safe Work Australia (SWA) had no role in that, as nominated in the majority report.

"We believe the focus on holding companies and managers accountable for breaches in their WHS duties regardless of outcome, as is inherent in the existing model laws, is the appropriate approach to continue to drive a reduction in fatalities and injuries … "

- *Minority report, Coalition senators, October 2018*

They were concerned that recommendations may not properly take into account the role of SWA and the purpose for which it was established. Its role, they said, was to drive national policy in work health and safety and workers' compensation. It is not responsible for whether jurisdictions act in accordance with SWA policy eg whether a state implements the model WHS laws. This was further emphasised in the government response to the report (see next page).

They felt that many of the recommended actions should have been directed at the established Heads of Workplace Safety Authorities (HWSA) and Heads of Workers' Compensation peak bodies. HWSA is the accepted body where jurisdictions discuss and co-operatively deal with matters that are within their remit and where they can exercise their regulatory powers.

At the launch of the report, inquiry chair, Senator Marshall, put the findings in the stark reality of the times. He passed the baton to government for its response and action, saying: "A rise in precarious employment practices and the pursuit by many companies of profit at all costs has led to a reckless disregard for the welfare of workers."

Response to the Senate Report

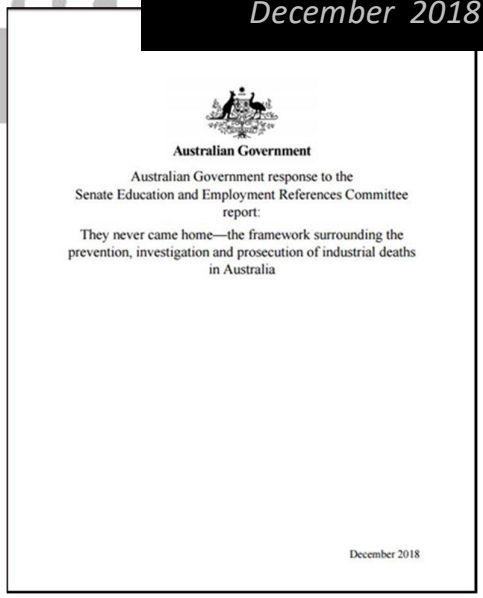
The Federal Government response to the senate report came in December (see picture). The report was curiously unsigned and not formally acknowledged by any department or minister but did mention in the content the then Minister for Jobs and Industrial Relations and Minister for Women, Kelly O'Dwyer[20].

Regardless of the uncertainty about government accountability for such matters, the government response was highly supportive of the senate committee's work. Twenty-one of the 34 recommendations were either "supported", "supported in principle" or "strongly supported" in equal proportion. Only one was rejected; the remainder were "noted" and comments made.[21]

However, there was the usual qualifier: "The Government recognises, respects and agrees with the intent of the recommendations. However, it is concerned that some of the actual measures and the mechanism identified will not achieve the intended outcome. It is particularly concerned that the people most affected, workers and their families, will not get what they are seeking which is justice."

It related that on the day the senate report was tabled, Minister O'Dwyer, and other ministers met with some of the families: "The minister is committed to seeing that lessons learnt from their traumatic experiences result in improvements to the framework surrounding the prevention, investigations and prosecution of industrial deaths in Australia," the report said.

> "The minister is committed to seeing that lessons learnt from their (families) traumatic experiences result in improvements to the framework surrounding the prevention, investigations and prosecution …"
>
> - *Government response to Senate report, December 2018*



Australian Government

Australian Government response to the Senate Education and Employment References Committee report:

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

December 2018

The government report was just as appreciative as the committee about the role the bereaved took in the inquiry and for the "courage and poise" they showed in retelling their stories. The mostly strongly supported recommendations were in fact those related to support and entitlement for the bereaved, and assistance with navigating the "system" which together made up a third of them.

Apart from responses to the recommendations, there were few concrete actions proposed. This is not a criticism of the response because many of the recommendations were directed at SWA and their influence on the local jurisdictions. So commitment of the government had to follow the mechanics and process to:

- drive improvements in the support for families bereaved by a workplace death by proposing that SWA establish a best practice model for centralised services.[22]
- work with all jurisdictions to improve current practice to ensure duty holders are diligent about workplace safety and improve the quality of investigations and prosecution outcomes

[20] O'Dwyer retired from politics at the May, 2019, Federal Election.
[21] The government responses are included in Appendix 6.
[22] Only Victoria has such a service, funded by the regulator and delivered by a specialist service provider.

- consider the application of existing Commonwealth work to WHS and criminal laws, and call on states and territories to do the same, to identify how best to achieve both justice for families and appropriate penalties for those who should be held accountable.
- advocate for a mechanism to enable families to provide information about their needs, and what is and what is not working in their jurisdiction.

Action on the third point was for Minister O'Dwyer, who had responsibility for SWA in her portfolio, to write to WHS ministers seeking their support for this initiative and the involvement of SWA in accordance with the committee's recommendations.

The introduction to the response gave further details on the matters of most concern and what action it may take, specifically:

- work with states and territories, who have a crucial role in the implementation of the enforcement, investigation and prosecution of WHS laws in driving improvements in their applications
- call on SWA to address critical issues identified with the framework of prevention, investigation and prosecution
- write to states and territories to take the recommendations through the relevant intergovernmental forums to ensure all governments are fully involved and accountable for these important issues.

"Many of their (families) requests and expectations are very reasonable and could be met through governments simply sharing information and joining up their own services. Others will require additional effort, training and resourcing …"

- *Government response to Senate report, December 2018*

The response cautioned that such improvements would take time. They required addressing failures across many local jurisdictions, and co-operation and implementation within a harmonised framework to achieve national consistency to ensure that the "loss of a life in one jurisdiction is treated and valued in the same way as in other jurisdictions".

The response indicated that the bereaved still had a role in advising on progress of the changes. "Many of their requests and expectations are very reasonable and could be met through governments simply sharing information and joining up their own services. Others will require additional effort, training and resourcing and the Government again calls on states and territories to consider, as it will, the recommendations."

The senate inquiry report and the government response was issued in the time of Kelly O'Dwyer, (Minister for Jobs and Industrial Relations), and also the minister responsible for Safe Work Australia. On her retirement from politics in May 2019, the portfolio was split between Senator Michaela Cash and Attorney General Christian Porter, both former Western Australian lawyers with experience in industrial law.

The response only departed from the recommendations related to IM. While noting the recommendation calling for the offence to be adopted nationally, the Government was concerned that this would not address the underlying issues identified by families impacted by workplace fatalities, which were poor investigations by jurisdictions leading to poor outcomes.

"A separate IM offence in the model WHS laws is unlikely to achieve justice for families who have lost a loved one in the workplace. While justice is seen to be available under laws that apply tough

penalties to the death of a worker, justice is unlikely to be achieved where, based on the evidence presented to the inquiry, the enforcement of laws is an issue. To suggest that the introduction of an industrial manslaughter offence is the solution to the issue of workplace deaths in this context would be to create an unrealistic expectation."

"The Government believes that a more effective approach, that would be more likely to achieve better outcomes, is to focus on addressing the critical issues that have been identified in relation to the enforcement of existing laws, in particular, the way in which investigations into workplace deaths are conducted. This is because the investigation of workplace deaths clearly impacts significantly on the likelihood (or otherwise) of a successful prosecution, whether that be for an offence under WHS laws or a criminal manslaughter offence."

"The Government believes that a more effective approach … is to focus on addressing the critical issues that have been identified in … enforcement of existing laws …"
- *Government response to Senate report, December 2018*

In taking this view, the government referred to the absence of IM cases so far brought in Queensland. It quoted the evidence given by the Law Council of Australia to the inquiry which stated in part … "the offences in Queensland, do not account for circumstances of accident, involuntariness, reasonable excuse or acts independent of the will of a defendant … the absence of such defences, combined with the low standard of proof of negligence and the high maximum penalties … has the potential to result in unjust, unintended consequences."

The Coalition Government stated further that the current offences in the model WHS laws, together with current criminal manslaughter laws, are able to address workplace deaths provided they are applied appropriately.

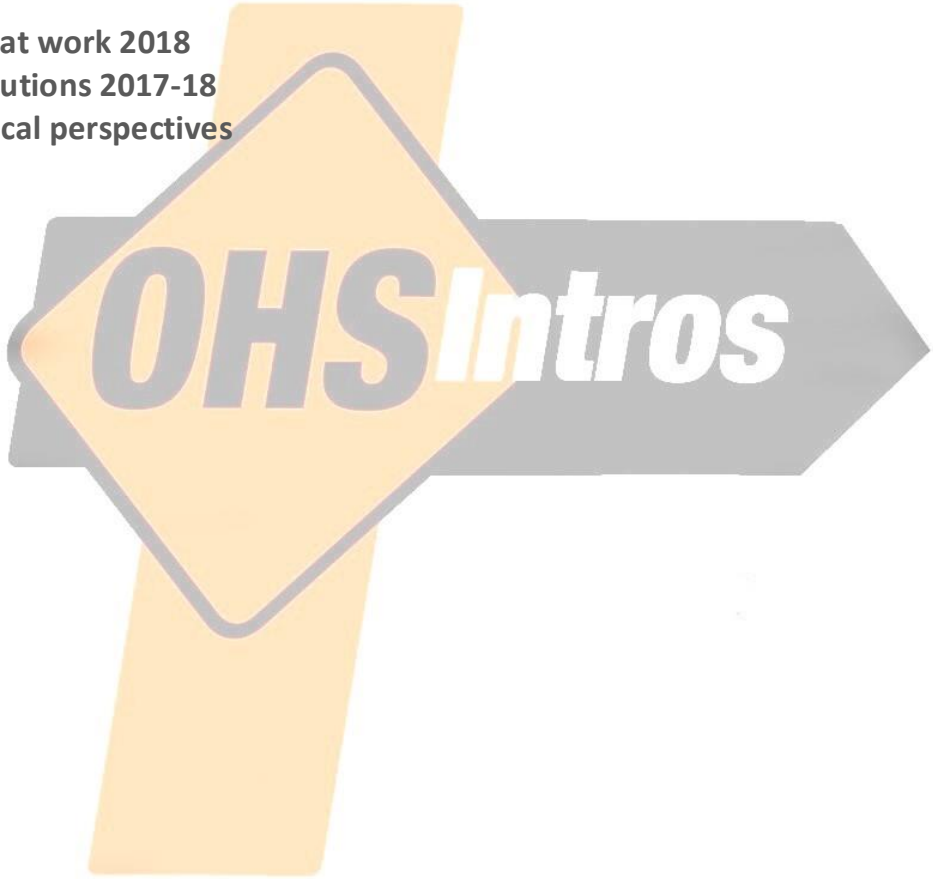
The government's response was made before the federal election in May, 2019, when it was returned to power. The responsible minister changed in a cabinet reshuffle for the third term of government and a split in the portfolio. It is not known if the commitments made by the government in the response report are to be pursued to a timetable, or as was suggested, actions are to be considered over the longer term. At the time of writing, there was had been no federal government action on the senate inquiry's report.

It is a shame that the senate inquiry had to have a national filter, where OHS is a responsibility of the states and territories, as is many "local" matters, under the federal system. It meant the deliberations had to have the broader scope and had to be referred to the only 'relevant' national body, the SWA. It spoke in the lingo of the model WHS legislation that was not nationally and uniformly adopted after five years in 'operation'.

Without clout SWA could only work within its tripartite national forums and refer policy to the department to which it reports. The risk was that under a coalition government, OHS tends to be tangled up and lost in the bigger picture of employment programs, industrial relations, socio-economic policy and budget cost reductions. The pathway for change was therefore unclear and had no urgency at a national level. After the re-election of the coalition government reform of industrial relations appeared to be the chief workplace matter on the agenda and was being driven by the attorney general's department.

BOOK TWO

Death at work 2018
Prosecutions 2017-18
Historical perspectives



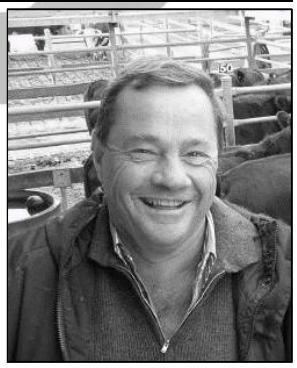
5. Reported fatalities 2018

> "Twenty-three families last year suffered the heartbreak of losing a loved one in a workplace incident that should never have happened."
>
> - *Julie Nielson, Executive Director, Health and Safety, WorkSafe Victoria, February 2019*

In the year when the incident at Delacombe claimed two lives, the death toll actually went down. This puts the toll in perspective - a lower toll in one year could easily be much higher the following year. So the impact of harm done in any year can never be denied. The underlying level of risk continues to exist from year to year while workplaces fail to manage potentially fatal hazards in a systematic way. Every year reminds us of that terrible safety truism and that the effort to adopt effective prevention measures in high risk work must be unrelenting.

For the record, 23 Victorians died as a result of work during 2018 compared with 27 in the previous year. Each death was caused by the same failings repeated over so many years (see part 6) and mostly in the high risks occupations of construction and agriculture. The sad statistics of the 2018 toll were:

- continued over-representation of deaths in construction trades (10, compared to five in 2017)
- over-representation of deaths in regional and rural workplaces (16 compared to 20)
- death of two females for the second year in a row - a 17-year-old stable hand and 49 year-old in civil work. This was the second stablehand to die in two years
- vulnerable workers[23], both young and older workers, made up a majority of the deaths (16, compared to 23), see Graph 2, over page for more details
- biggest killer was working with or near dangerous plant, particularly mobile plant (11, the same number as the previous year but greater in proportion) mostly associated with farming and construction, followed by falls (four compared to eight). Two further plant-related deaths involved dangerous conveyors at manufacturing workplaces
- three deaths were while doing electrical work, and of course there were the two deaths at Delacombe that were engulfment but also technically defined as 'structural' collapse. There were actually three deaths related to trench work but the third was a fall into a trench while shields were being lowered into place using an excavator
- 19 of the deaths involved four of the five known causes of death - falls, structural collapse, plant, electricity[24]
- 16 of the deaths involved work that was classified as regulated hazards (plant, falls, and working in an enclosed space). Most of the 23 were also classified as high risk work or high risk construction work that is also regulated. All are known hazards and risks with straightforward risk control solutions
- The oldest worker killed was 77 and the youngest was 12, both on farms.



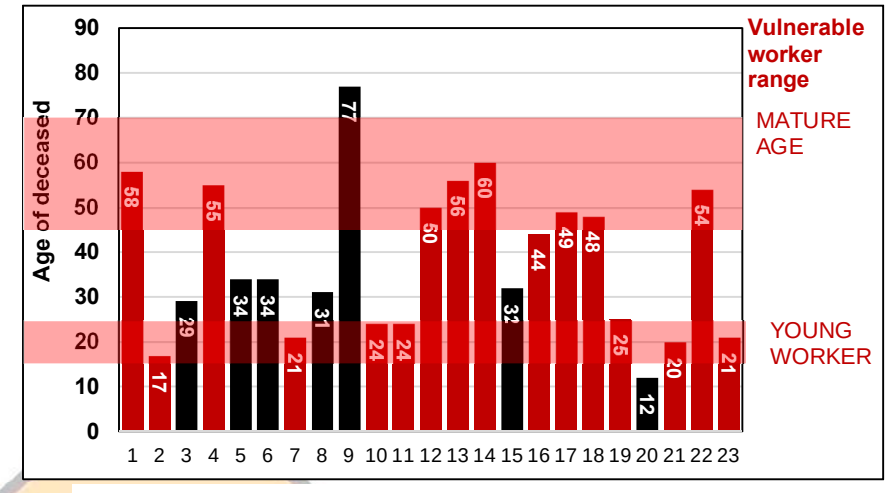
First official death at work 2018 (January) was stock agent Nick McKimmie, 58, who was crushed by cattle at a property in northern Victoria. *Source: media report.*

See Graph 3, over page, for fatal hazards for 2018.

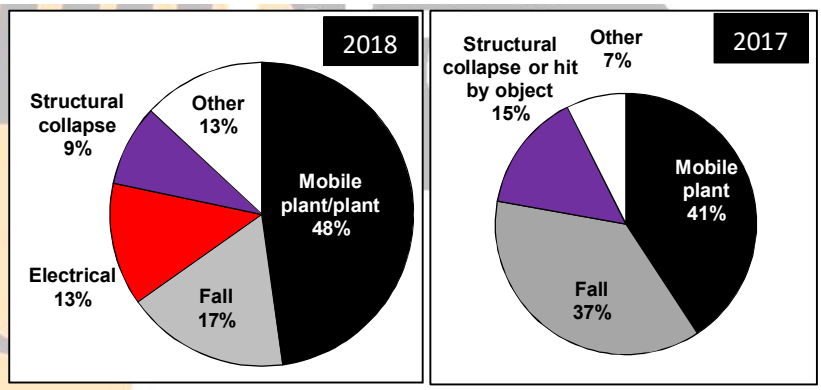
[23] Young and mature workers who may be at greater risk due to lack of experience or have work limitations.
[24] The fifth hazard is roadside work.

One of the major worries of the ongoing annual death toll has been the high average age of the victims, a reflection of the ageing working demographic, and delayed retirement for various reasons, particularly in agriculture. Only five of the victims of incidents on farms in 2018 were in the older worker category (>45 years), that is, statistically at greater risk of harm. The oldest farm worker killed in 2018 was a 77-year-old at an Ouyen sheep farm in May. At the other end of the scale of vulnerable workers – seven younger workers (<25) were killed, an awful statistic, given the work being done to raise awareness of the risk to this cohort and the death-free record in 2017. In summary, there were 16 vulnerable-aged persons killed at work in 2018, compared to 24 in 2017. Hopefully this is a positive trend, not a statistical anomaly over the 12-month period (see part 6)

Graph 2. Deaths at work in Victoria by age and vulnerable worker status 2018
Vulnerable workers may be at greater risk due to age or inexperience. Working age assumed to be 15 to 70 years.



Graph 3. Causes of traumatic work deaths in Victoria 2017 v 2018
Officially reported and investigated traumatic deaths in calendar years under s38 of the OHS Act. *Source: WorkSafe/interpreted by OHSIntros*



WorkSafe Victoria inspectors and police attend the site of the death of man in his 60s at family farm in Beaufort in May. He was killed while operating a backhoe attachment on a tractor. *Source: media report.*

The other statistic note was the average age of workers killed in 2018 was 38 compared with 57 during 2017. The 2018 average age for deaths was the lowest for a working year this century, a confounding number. It is outside the usual 'vulnerable' age spectrum that is supposed to help lower risk. It does not explain why, experienced '38-year-old' workers were just as exposed to fatal risk in 2018. However, this is likely to be aberration in the short term as the average of Victorian workers in an aging population remains high.

Details of death toll

Electrical hazards cost three lives in 2018, including those of Ryan de Wit, (electrocuted), top left, at Dandenong in January, Graeme Edwards (electrical flash), right, at Yallourn in November, right, and below, the rural property where a truck driver died in February (contact with powerlines). *Source: media reports.*

The names of workers or others killed at work (officially reported deaths) are still rarely released, even if the families give their permission. This may not help the community understand the harm caused by a preventable death. This list below of those 2018 victims made public by the media, police, courts or other sources with the permission of families[25], and their stories, may help raise that awareness. Those who tragically died from known hazards and risks, and in potentially preventable circumstances, were:

The scene of the death of Leonie Peacock at Donvale, involving the unloading of an excavator. She was one of two females killed at work in 2018. *Source: media report.*

- 58-year-old stock agent **Nick McKimmie** (see picture, page 70) was trampled by cattle at a Georges Creek farm, near Tallangatta
- 29-year-old **Ryan de Witt** (see picture above) was electrocuted while working on a switchboard at a Dandenong factory
- 34-year-old **Charlie Howkins** (see picture page 6) died when a trench collapsed on him at a Delacombe worksite in Ballarat
- 21-year-old **Jack Brownlee** (see picture page 6) died in hospital from injuries sustained in a trench collapse at a Delacombe worksite in Ballarat
- 44-year-old **David Klingberg** died in hospital after falling through a stair void at a Rosebud housing construction site
- 35-year-old **Andrew Wahlert** (see picture, page 73) fell into a trench at a Wallan housing construction while detaching shields from an excavator
- 49-year-old **Leonie Peacock** was run over by a truck carrying an excavator during unloading at a Donvale property
- 48-year-old man **Shaun Burns** (see picture, next page) was struck by a kibble of concrete that fell from a crane into a pit at a Box Hill construction site
- 20-year-old **Dillon Wu** (see picture, page 75) was suffocated while welding inside a tanker at a Cranbourne West manufacturer
- 54-year-old **Graeme Edwards** (see picture, above) died in hospital from serious burns after a high voltage circuit breaker he was working on exploded at the Yallourn power station (see page 79).

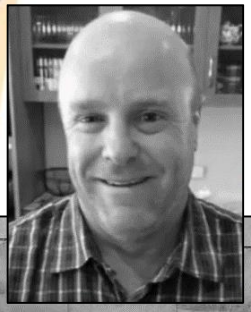
[25] Releasing the names of the deceased is important so that their stories of life cut short can be told and the true impact of work-related death on the community is understood.

As has been noted is previous papers, risk in rural and regional areas dominate while the regional centres grow and do so as a priority of both state and federal government. This increases exposure to risk in those populations. The death of the Delacombe pair is an example of that.

These families lived in small communities where deaths were often more heavily felt and there was more openness and will about sharing the grief with the public in the interest of preventing more deaths.

The heightened awareness following Delacombe may be part of the reason why there was greater coverage given to subsequent deaths during 2018.

See BOOK THREE for some of the stories of lives tragically cut short during 2018.



The incident at a Box Hill construction site in September where Shaun Burns, 48, (left) was struck and killed by a kibble that fell from a crane. Above, rescue attempt by emergency services and below, the body of Burns is prepared for removal from the site. *Source: media reports.*

The real death toll in 2018

Twenty-seven was the official death toll according to the strict definition set by the regulator (see Appendix 4 for official definitions and inclusions/exclusions). There were others who also died at work but for various reasons were not included in the total.

The estimates are that the number was at least seven more, although reports of these deaths are only known if reported in the news media and social media - see pictures right and see Appendix 1 for the full list. This brought the 'true' total to 30, as far as is known.

Not included in the death toll: pedestrian struck and killed by an ambulance on an emergency call. This was treated as a road accident. *Source: media report*.

Not included in the death toll: worker struck and killed by a mobile crane while he and a colleague were stopped on the side of the road securing the load on their truck. This was treated as a road accident, as are all incidents on the road involving work vehicles. *Source: media report*.

The work-related aspects of the additional deaths have not been verified so it can only be assumed that they were connected to a work activity.

These deaths are usually related to occupational driving or at premises where the activity is not considered work or the location not seen as a 'workplace'. In the situation of incidents on the road involving work vehicles engaged in work, the victims and their dependent families fall into a prevention 'black hole'. These incidents are left to entitlements under the compensation system where work factors are assessed and compensation may be available, regardless of any OHS actions, or lack of them. Deaths involving truck drivers and other occupational drivers are added to the road toll without more explanation of the circumstances, or any referral to WorkSafe for prevention and enforcement purposes. It is believed the Transport Accident Commission has those details but does not release them.

The 'excluded' deaths 'reported' during 2018 were:

- member of the public died after a logging truck crashed into cars stopped at roadworks
- while operating mobile plant on a 'family farm'
- fatal head injuries after a fall from a ladder at a factory
- a man who died on the roadside when hit by a work vehicle while helping to secure a load on a work truck (see picture above)
- a fatal motorcycle crash at a farm
- pedestrian hit by ambulance on an emergency call (see picture above).

Always excluded are the many who died during 2018 as a result of occupational illness and disease. They are not counted in any official toll.

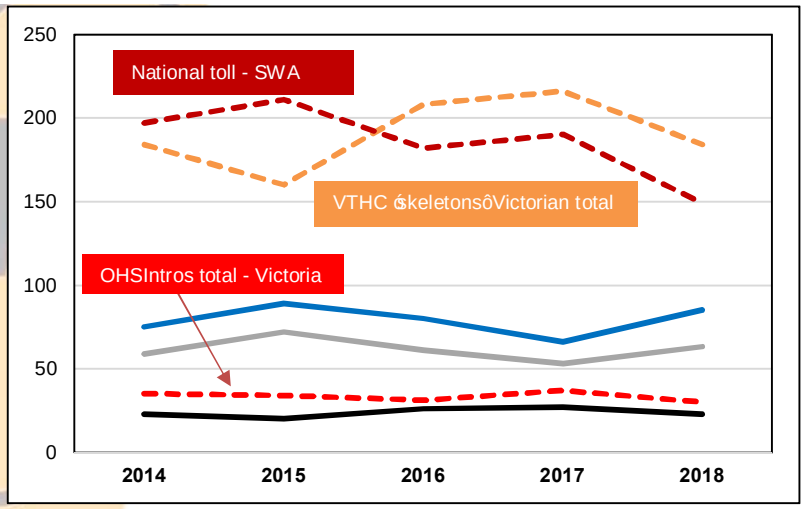
The only way to gain a better appreciation of the full extent of fatal harms at this time is to combine official measures, unofficial counts and other estimates to 'fill' the gaps. These tallies are:

- officially reported and investigated death toll - Victoria
- official death claims, excluding traumatics recorded above
- unofficial traumatic toll - Victoria (eg OHSIntros estimate)
- the “skeletons in the closet toll” measures develop by the VTHC
- the national traumatic toll of Safe Work Australia, including a Victorian toll that is different from the official toll.

Combining these tallies (See Graph 4) is no substitute for an official dataset. The call for such a crucial initiative has been made over many years and has been canvassed in previous papers. There seems to be no urgency to attend to this, in spite of the obvious need to fully understand the extent of work harms.

Graph 4. Victoria’s official work-related death total vs other measures – five year trend

Comparison of different datasets measuring work-related death against the official Victorian reported and investigated total (BLACK), death claims total (GREY) and aggregate of official reported deaths and traumatic death claims in Victoria (BLUE), against other measures. *Source: VWA/Safe Work Australia/VTHC - interpreted by OHSIntros*



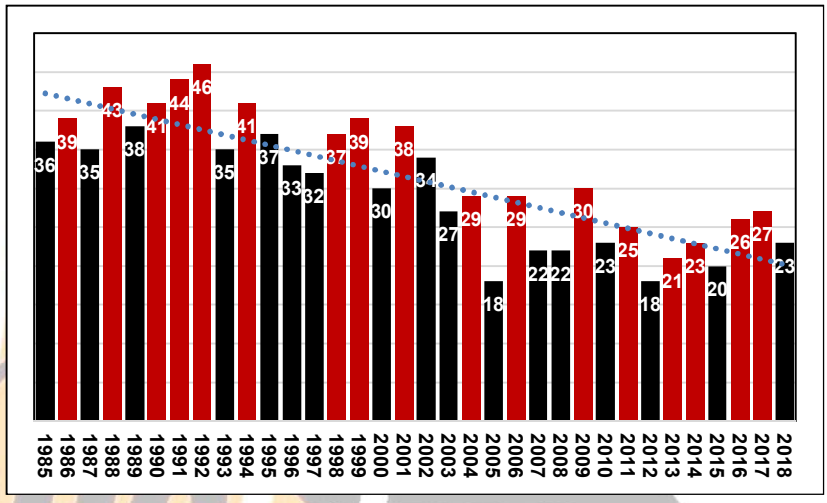
6. Reported fatalities since 1985

The 23 deaths in 2018 bring the official toll of reported and investigated traumatic deaths in Victoria by calendar year since 1985 to around 1061, including 485 deaths this century. The reduction during 2018 was a relatively low total after a total of 53 people died from work in 2016 and 2017.

Reported deaths is the 'meaningful' measure used in OHS for fatal trauma. The historical trend is to fewer deaths over the 30 plus years (see Graph 5). However the spike in traumatic deaths in recent years has now slowed the overall trend to fewer deaths. In fact the five-trend to 2018 has seen the trend reverse - an alarming irony (see Graph 6). This has raised many questions about management of high risk in modern, changing workplaces as the state's working population grows.

This concern over recent years sparked the IM campaign in Victoria and brought it to its conclusion. This campaign challenged the view that a significant number of reported deaths over many years has been one of the great achievements of the Victorian OHS system. There is clear evidence that the improvement in the capability of the Victorian WorkCover Authority since it took charge of the OHS system in a merger with Victoria's prevention agency in 1996 has created an entity with more resources and clout. The point has been reached where this reputation is being challenged.

Graph 5. Reported fatalities in Victoria since 1985
Totals for calendar years exclude some deaths that may be considered work-related under other definitions eg work-related driving deaths. Traumatic deaths only - excludes deaths from occupational disease and illness. *Source: VWA/interpreted by OHSIntros*



Graph 6. Reported fatalities in Victoria – five year trend
Totals for calendar years exclude some deaths that may be considered work-related under other definitions eg work-related driving deaths. Traumatic deaths only - excludes deaths from occupational disease and illness. *Source: VWA/interpreted by OHSIntros*

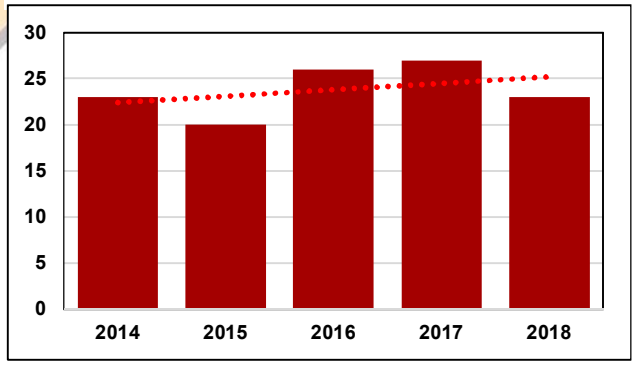


Table 5: Totals and average of work-related death, Victoria 1985-2018
Official reported and investigated fatalities.
Source: VWA/interpreted by OHSIntros

Calendar years	Number of deaths	Ave. per year
1985-1989	191	38.2
1990-1999	385	38.5
2000-2009	279	27.9
2010-2018	183	20.3
Total/Average: 1985-2018	**1061**	**31.2**

The toll dropped from an annual average of 38.5 reported deaths in the first full decade of the current OHS regime - 1990s to an average of 20.3 so far this decade (see Table 5, above). The view of the IM campaign was that this level of 'progress' is not acceptable and employers must be held more accountable by implementing a law that is specifically about a death at work.

The rationale is simply that industrial death should no longer be tolerated for these most basic of reasons:

- The working community well knows the hazards that kill at work (see Graph 9, page 54).
- There is sufficient SOK about risk of these hazards causing death.
- The working community well knows effective ways to manage these risks.
- Effective controls are readily accessible and reasonable.
- Application of technology is helping to reduce exposure to high risk work.
- This is the way work is done in professional and productive workplaces.
- Community expectations have risen. Employers are now expected to be more accountable and be socially responsible in an ever more visual and connected society.

Table 6: Multiple deaths from work incidents in Victoria since 1985

Year of incident	*Incident and harm*	*Penalty under OHS Act*
2018	***Two deaths*: Trench collapsed during pipe-laying work killing one worker. Co-worker died in hospital the following day.**	**Action commenced 2019**
2016	*Two deaths*: A scuba-diving instructor drowned in heavy seas trying to save the life of another diver, who also died.	$20,000 fine
2014	*Three deaths*: Two motorists and a passenger struck by a trailer that broke loose from a prime mover and into the path of traffic.	No action
2013	*Three deaths*: Perimeter wall at building site collapsed onto footpath killing three pedestrians.	$500,000 fines (aggregate)
2013	*Two deaths:* Tree fell on DSE vehicle during firefighting killing two workers.	No action
2012	*Two deaths*: Two workers hit and killed by broken part of drill during drilling operations in Bass Strait.	$300,000 fine (Federal case)
2010	*Two deaths*: father and son electrocuted when the windmill they were transporting with a tractor struck powerlines.	$80,000 fine
2004	Two deaths: Ambulance ran off road and hit tree on the way to attend road accident.	No action
2001	*Four deaths*: four members of the public killed when unsafe truck driven by fatigued driver crashed into cars been stopped at roadworks.	No action
1998	*Five deaths*: CFA crew of five trapped and died in truck during bushfire.	No action
1998	*Two deaths*: explosion and fire at Esso's Longford gas plant killed two workers.	$2 mill fine
1991	*Two deaths*: workers fell from concrete hopper into a trench.	No action
1986	*Four deaths:* Fatal burns to four workers from an explosion at a manufacturing plant.	No action

Source: VWA/ death book.

The Delacombe incident, in the midst of the IM campaign, reinforced the strength of these immutable facts. There have been eight multiple deaths from incidents in the 'modern age' since 2000 (see Table 6) including three pedestrians killed in the perimeter wall collapse in 2014. These are the kinds of inexcusable tragedies under a modern OHS system that do not need to happen.

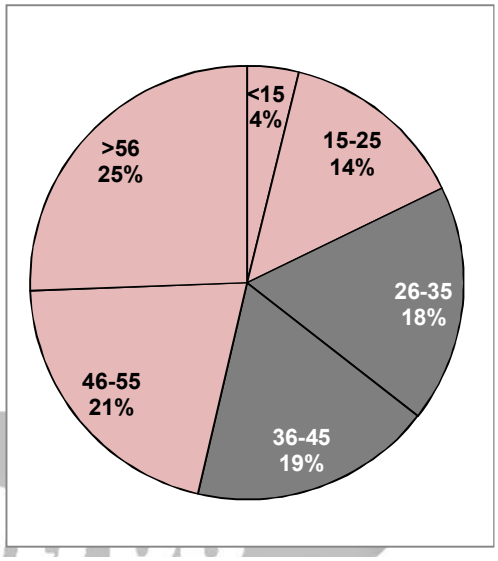
The level of harm perpetrated on the Victorian community in the last 33 plus years by failing to follow acceptable minimum safety practices is shown in these awful 'lowlights':

- the death toll climbed to 43 in 1988 and peaked at 46 in 1992. The toll was above 40 for four of the six years between 1988 and 1994. The rise was during the implementation of the first OHS Act introduced in late 1985

Victoria's worst workplace incident remains the collapse of a span of the West Gate Bridge during construction in 1970. It predated the modern OHS system, but its legacy and lessons helped shape it. Below: In September 2018, the then federal opposition leader Bill Shorten with Longford incident survivor, Jim Ward, mark the 20 anniversary of the Longford gas plant incident that killed two workers. *Source: Public Records Office and media report.*

- during the peak toll year of 1992, the WorkCover compensation system replaced WorkCare and among other things promised more focus on safety
- the death toll began to fall sharply during implementation of fresh initiatives that began with the WorkSafe brand in the early 2000s
- the toll reached record lows of 18 in two years under the WorkSafe brand. The results of the intervening years have been patchy to a point where the rate of reduction has not kept pace with the trend to lower annual injury rates.

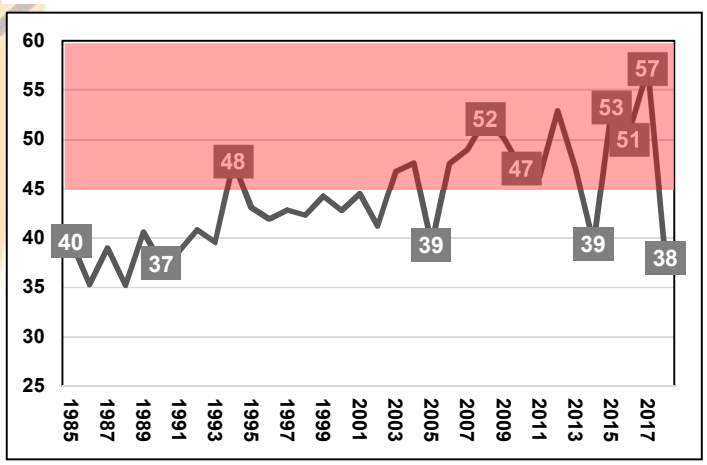
Graph 7. Age groups for those killed at work in Victoria since 1985
The older worker cohort up to the end of 2018 still dominates employment and this is reflected in death at work. Note - pink refers to workers who were in the óvulnerableô age groups that accounts for almost two-thirds of deaths. *Source: VWA/interpreted by OHSIntros*



Facts about the death toll include:

- average age of those killed at work persists at 44, on the cusp of the 'vulnerable' worker range (<25 and >45). This is an argument to continue focusing on safety in that group to reduce the risk of harm while the population is aging
- death toll since 1985 has had an impact on the productivity of the Victorian economy. Assuming most workers retire at 65, thousands of working years have been lost from the state economy as a result of work-related deaths, plus another 636 potential working years as a result of 23 more deaths in 2018
- another measure of cost to the economy is the 'value' of a 'productive life' ($4.3 mill. per person[26]). A conservative figure that neglects many life factors, it estimates deaths at work to cost Victoria more than $4.5 bill. in lost human resource to the community since 1985
- first female to die at work was in 1988 when a mature age factory worker was caught in machinery. More than 41 women have been killed at work in Victoria since 1985

Graph 8. Average age of those killed at work in Victoria
The workforce has greyed to the point that the average age of a worker (and victims of unsafe work) is well above the óvulnerableô range. The sudden reduction in 2018 may be an aberration. Note - pink shading refers to mature worker óvulnerableô age groups.
Source: VWA/interpreted by OHSIntros



- Victoria's and Australia's worst workplace incident remains the collapse of a span of the West Gate Bridge during construction in October 1970 (see picture page 61), before the current OHS system was introduced. It cost the lives of 35 workers. The incident is remembered each year by a gathering at the memorial park near where the span collapsed on the Spotswood side of the river. A Royal Commission over the incident spurred the development of the current safety system in Victoria

[26] *Victorian Government guidance on the value of a statistical life, Economic Evaluation for Business Cases*, Department of Treasury and Finance, Melbourne 2013.

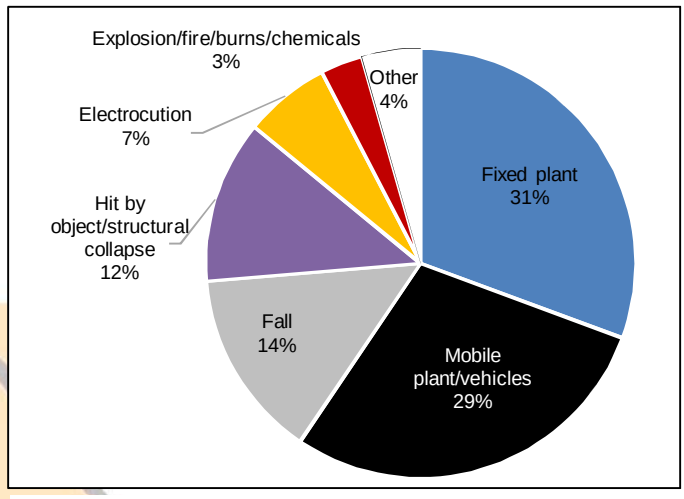
- highest death toll in a single incident under the current safety regime and definition of work-related death was that of three pedestrians in the collapse of a brick wall on the perimeter of an excavation site in Carlton during March 2013
- death of two workers in an explosion and fire at Esso's Longford gas plant in September 1998 inflicted the most harm on the community of any safety incident by affecting the state energy supply. The outcome of a Royal Commission, the second in Victoria over a workplace incident, was the development of a strict new safety regime for Victoria's hazardous facilities
- oldest to be killed as a result of a work-related incident was a 98-year-old nursing home resident who fell while he was being transferred from a bed during 2017. The youngest was a four-month-old boy who was hit by a forklift at an automotive repair shop during 2014

Causes of death

Nothing has changed about the causes of death (see Graph 9) and where workers and bystanders die (see Graph 10). How these incidents happen during hazardous work are due to the same systematic failures to manage OHS risks in Victorian workplaces:

- employer in control is ignorant of, indifferent too, or has little regard for what 'duty of care' really means
- employer is negligent or even reckless when it comes to known hazards and risks
- the hazard and risk is unforeseeable (see first point)
- reasonable means of controlling risk is no longer effective due to changing conditions (see first point)
- employee does not follow safety procedures (see first point).

Graph 9. Causes of reported deaths in Victoria since 1985
Includes all traumatic deaths required to be reported by employers to WorkSafe under OHS law. Note: The composition of the graph has not changed significantly in recent years. *Source: VWA/interpreted by OHSIntros*



Graph 10. The most deadly industries in Victoria since 1985
Includes all traumatic deaths required to be reported by employers to WorkSafe under OHS laws. Agriculture and construction account for more than half of all deaths. The relative proportion of deaths in these industries has not changed in recent years.
Source: VWA/interpreted by OHSIntros

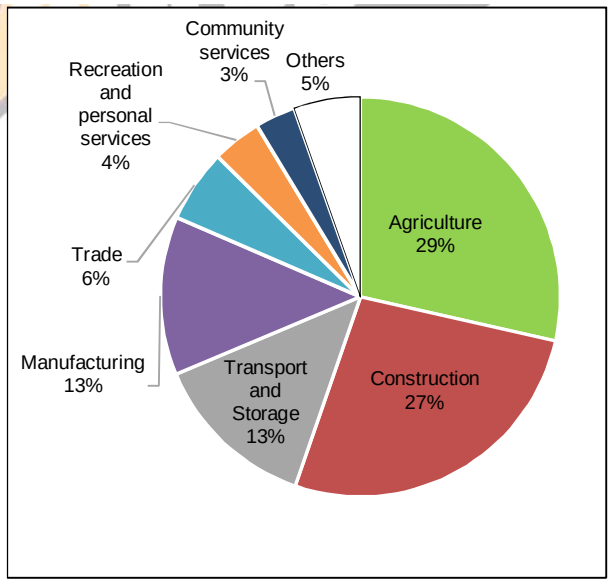


Table 7: Killing machines in Victorian workplaces since 1985
Proportion of these items or plant in plant-related reported and investigated death. *Source: VWA/interpreted by OHSIntros*

Tractors	39 per cent
Trucks and other motor vehicles	27 per cent
Stationary plant	16 per cent
Forklifts	10 per cent
ATV/motorcycle	Six per cent
Trains	Two per cent

The Victorian regulator has been drawing a line in the sand on compliance, and advancing it progressively, over more than 32 years. This is about what its inspectors expect to see employers doing to stop workers being seriously hurt. The list associated with dangerous work that may result in traumatic death and fatal injury is obvious:

- related to falling more than 2 m from a height or into a depth eg an excavation (or working under structures from which objects could fall)
- working with or near mobile plant that can result in being struck, run-over or entangled
- working with machinery that can result in being struck by or caught in moving parts
- working on or near unsafe structures (this includes the collapse of an excavation causing a fall and or engulfment, as in the Delacombe incident)
- electrical work, including an electrical explosion as in the Yallourn incident
- working near roads - hit by motor vehicles or work vehicles.

Since 1985 mobile and stationary plant of various types caused around 60 per cent of all fatalities (see Graph 9, previous page). Tractors are the being single killers (see Table 7, previous page), having been involved in the work-related deaths of at least 159 Victorians (plus two more in 2018). Tractors kill more workers than ubiquitous forklifts and more than stationary and mobile vehicles combined.

Most deaths continue to occur in construction and farming, both very different industries. They have their own challenging hazard profiles that required a level of constant safety planning and oversight that is more challenging than many other industries.

7. Death claims

Since 1985 the death compensation process under Victoria's hybrid OHS and workers compensation system has paid out almost $765 mill. in compensation to families over the death of a provider at work.

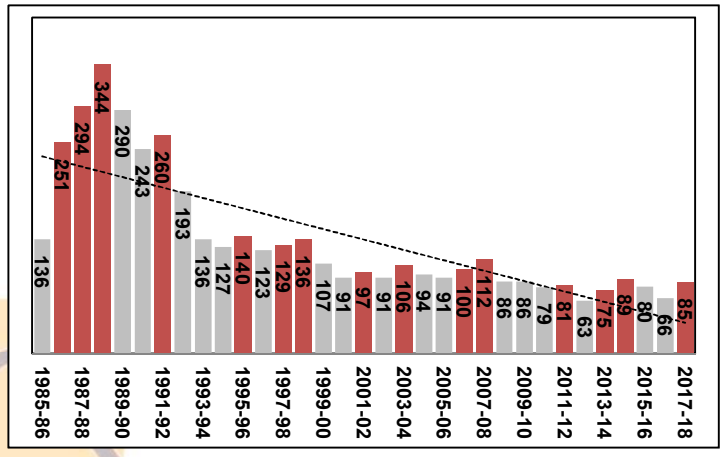
In that period, the system has provided compensation to 4468 dependents ie spouse and/or young children at an average of $167,467 per claim (more than one claim may be made for dependency, as in the case of a large family).

During the most recent financial year 2017-18 claims increased to 85 (see Graph 10), the highest in four years. These claims were similar in causes and proportion of the previous period. This was apart from a higher percentage of traumatic deaths (a consequence of a recent high fatality rate) and fewer heart-related illness (a possible younger worker cohort and/or the impact of the blanket awareness raising of health and wellbeing at work). See Graph 13 over page for details.

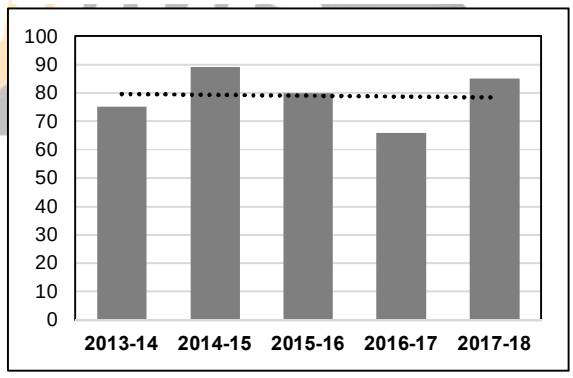
Cost of the claims granted in 2017-18 was $27.6 mill. (ave. of $324,705 per claim). This was the lowest total claims payment since the peak of $37.6 mill. three years ago. See Graph 12 for cost of claims over time.

The latest figure of 85 claims may not be statistically relevant because unlike reported and investigated traumatic deaths over a calendar year under OHS law, many claims happen over a longer period, as in the case of a lingering occupational disease that is ultimately fatal eg exposure to asbestos. The number of claims has been declining, along with the cost of claims, but the 'rate of reduction' in the number of claims is slowing in recent years (see Graph 11). It is not clear why this is happening. That answer may be in

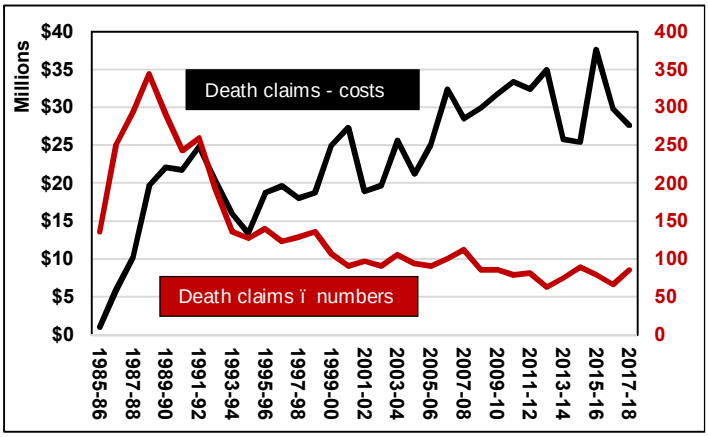
Graph 10. Compensated deaths in Victoria 1985-2018
Number of death claims for compensation granted by financial year. Claims payouts can only be granted to dependent spouse/and or children. Trendline shows decline in claims over time. *Source: VWA/interpreted by OHSIntros*



Graph 11. Compensated deaths in Victoria - five-year trend to 2017-18
Number of death claims for compensation granted by financial year. Claims payouts can only be granted to dependent spouse/and or children. Trendline shows a slowing in the decline in claims in recent times. *Source: VWA/interpreted by OHSIntros*



Graph 12. Cost of death claims Victoria 1985-2018
Cost of death claims per financial year and number of claims per year. Claims costs have been increasing while claims have been reducing. Note maximum payment has increased and workforce has grown over time. *Source: VWA/interpreted by OHSIntros*



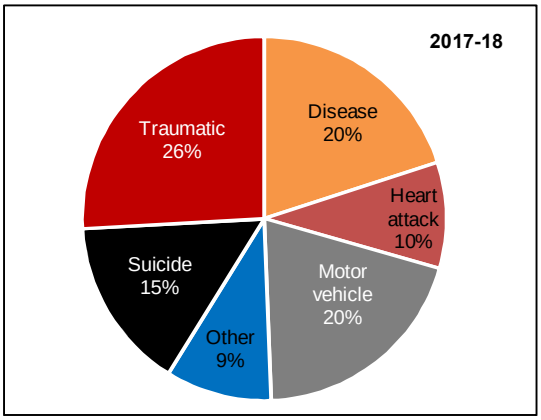
the details of the claims but this causality data is not available because this is not the purpose of the claim process. It is possible that more families are lodging claims, as might be the case with fatal asbestos exposure. But with fewer families being dependent on a single breadwinner, and smaller families being the norm, the number of eligible claimants should be reducing. It is possible that the type of deaths that are the subject of claims are persisting as the state's economy and workforce grows, despite prevention initiatives.

The picture in historic terms over 30 plus years (see Table 8) shows that occupational disease and illness is the biggest 'killer' under this regime. Occupational driving (eg truck crashes), then traumatic injury resulting in death, are the top three reasons for compensation.

The fact that almost 30 per cent of death claims are people who have died while driving for work (ie the death of approximately 1285 people), and that cannot not be dealt with as an OHS matter, is an increasing issue. Expansion in the industry, greater driving risks and competitive and cost pressure can come with more risk. That increased risk applies for work-related suicide but in a different way. While this sad scourge of society accounts for just four per cent of claims, the impact on the community and its connection with the risk in mental injury makes it a serious concern in an OHS perspective where mental injury it is up to around 12 per cent of injury claims. It is the only cause of death claims that is growing.

For more information on the trend in work-related driving and suicide causes, see Graph 14. It shows that the work-related suicides numbers in recent years have caught up to the recent rise in work-related driving deaths, an extraordinary and shameful reflection on working life when looked from any angle.

Graph 13. Compensated deaths Victoria: 2018 vs 2017
Totals for financial years by cause of death. Claims payouts can only be granted to dependent spouse/and or children.
Source: VWA/interpreted by OHSIntros



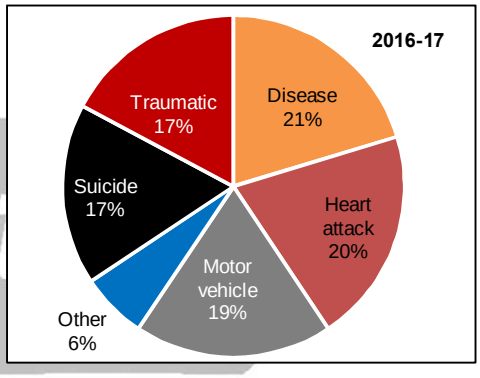
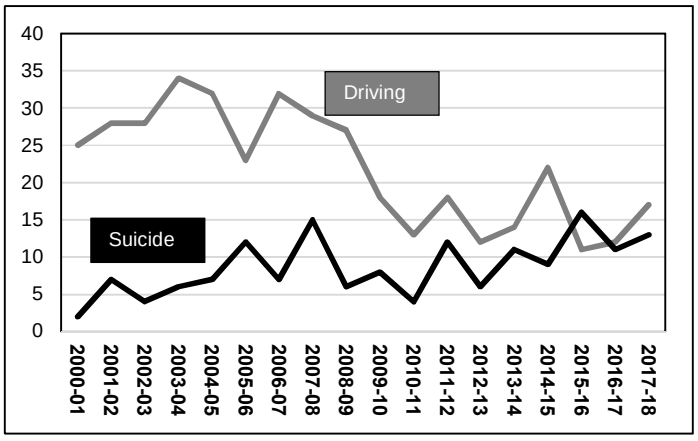


Table 8: Totals compensation claims in Victoria by type 1985-2018 (financial years)
Source: VWA/interpreted by OHSIntros

Type of claims	*Numbers*	*Proportion*
Disease/illness	1616	36%
Motor vehicle	1284	29%
Traumatic	1008	23%
Heart attack/stroke	282	6%
Suicide	190	4%
Other	88	2%
Total (number)	4468	

Graph 14. Compensated deaths Victoria: suicide and driving
Totals for the financial years by cause of death - work-related suicide and occupational driving since 2000. *Source: VWA/interpreted by OHSIntros*



Anomalies and anachronisms

The simplest way to explain Victoria's hybrid OHS/compensation system is the OHS regime is focused on risk, while the compensation regime is concerned with any harm caused. One is about blame, the other isn't.

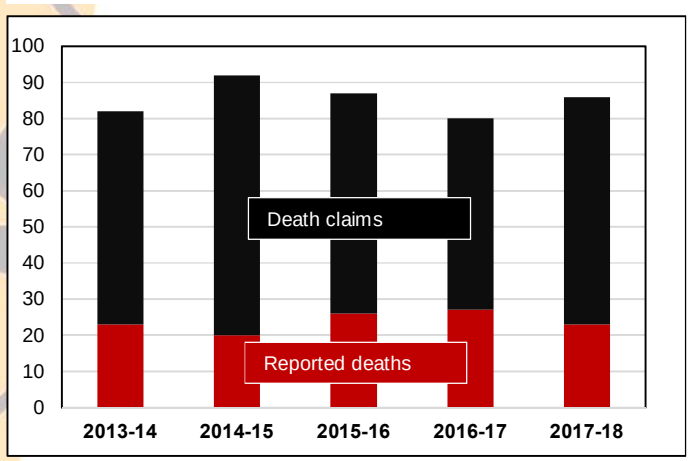
It is meant to be a cycle of continuous improvement that reduces risk and harm in the working community. The problem is risk causing death under OHS law does not directly relate to the way death is defined under the compensation system. The result is a compliance and enforcement system that mostly reacts to traumatic injury and death is about 25 per cent of the OHS death toll in a 12-month period (see Table 9 for 2018 figure). Given that many traumatic deaths also result in a death claim, the real death toll is about three times the traumatic toll (see Graph 15). Yet there is no way to be certain of this because of incompatible data sets that have been devised for different but still legitimate purposes under a conventional regulatory scheme.

Table 9: Reported fatalities 2018 vs death claims 2017-18
Source: VWA/interpreted by OHSIntros

Reported and investigated fatalities under s38 of the OHS Act		Death claims compensated under the division 8 of the WIRC Act	
Hazards	***Number***	***Hazards***	***Number***
Plant-related	13	Traumatic incident (various hazards)*	22
Falls	4	Occupational illness **	17
Electrical	3	Vehicle crash (ie truck crash)**	17
Structural collapse	2	Suicide **	13
Other	1	Heat attack **	8
		Other (not specified)	8
Total	*23*		*85*

**may also be counted as a reported fatality.*
*** specifically excluded from reported fatality count*

Graph 15. Total death toll: reported death and death claims
Five year trend in Victoria - combined datasets and different 12-month periods. Red donates reported and investigated totals under OHS regime, black denotes death claims (excluding traumatic injury resulting in death - est.). *Source: VWA/interpreted by OHSIntros*



This creates many anomalies and anachronisms that distort the true picture of the state of OHS in the community at any point in a working day, and reduces the capacity of the OHS system to be as effective as it could be in managing risk in the Victorian working community (see Table 10 at the end of this part, for a list of anomalies and anachronisms).

However, redefining and blending the data to create a clearer picture of what total work-related harm looks like in Victoria will still not be accurate a because death claim application through the compensation system is not compelled. It is an entitlement that is even readily known as available and when an application is made it is 'means-tested', in the sense that the families must be dependent on the deceased worker to be granted a claim.

'Dependency' is an anachronism based on old social, and paternalistic assumptions that need a rethink. By persisting with an outdated definition of what a family unit is in the modern age misunderstand the real affect and impact death has on today's more flexible and rapidly changing 'family'. It also does not meet the ideal of compensation and wastes valuable data for vital prevention analysis purposes. The impact may be different for every family. But whatever the need, it is unfair to assume that 'harm' a family perceives is less if that family is not financial dependent on the deceased. It's improper to assume those who are monetarily independent are any less vulnerable to the trauma of such an awful life event.

It is therefore important for the term 'dependency', with its narrow 'financial' interpretation, to be replaced by a term such as 'inter-dependency' that better fits with the complexity of modern relationships and child-rearing. It is a term that better encapsulates the more socially inter-connected mode of modern life and its overlap with working life. This proposition has been embraced by wellbeing initiatives allied to today's evolving model of health, safety and wellbeing and community welfare.

'The challenge will be to determine the form and degree of "inter-dependability" or "connectiveness" between the family unit and the deceased, and what detrimental effects there have been.'

The challenge will be to determine the form and degree of 'inter-dependability' or connectiveness between the family unit and the deceased, and what detrimental effects there have been. If it is not to be a purely financial measure what might be a suitable way to 'compensate' for those harmful effects? Could it be some sort of support or advice to help maintain the wellbeing of the remaining family unit for an appropriate period of time? Whatever that compensation might be it recognises that harm has been done as a consequence of the death. It officially records the circumstances of a death that is currently 'hidden'.

The counter argument may be the cost of recognising the value of 'inter-dependability' in a system that has to be sustainable and is under pressure from increasing costs. Even provision of services as opposed to a payment, has associated costs. But what about the upside? It is a contribution to community by raising awareness of the need to tackle serious harm by providing a suitable for of restitution for a crime.

The Victorian OHS/compensation scheme is supposedly more engaged with the community than ever before. "Community" is the new catchcry and this adds another facet to it. Yet there hasn't been a needs-based analysis and longitudinal research on the application of monetary compensation in instances of death compensation dependency. Is it working, and if not, is inter-dependability now the issue? What are the family inter-connections and needs that are different from the 1950s model of a typical family? What does the death of a spouse, a parent, a child or a sibling at work now have on more diversely composed modern families? What might be the cost-benefits in short and long term if compensation modes charged? Or is it simply easier to administer a shallow, means-tested monetary payment?

The table on the next page is a starting point (Table 10). It poses the strengths and weaknesses of the current death compensation system.

Table 10. Victorian death claims compensation and entitlements: strengths and weaknesses Related to claims for death compensation

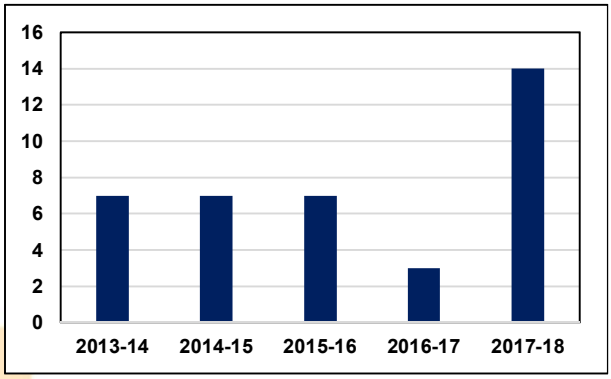
Provided under the *Workplace Injury Rehabilitation and Compensation Act 2013*

Source: WIRC Act provisions and claims book/interpreted by OHSIntros.

Strengths	*Weaknesses*
Addresses work-related harm under a óno blameô insurance model, not the OHS risk that led to harm.	• Low premium environment limits development and expansion of benefits. Cost increases put pressure on providing sustainable level of benefits. • Claims may be investigated to determine eligibility but not for any breach of OHS law. • Confusion over different definitions of work-related harm between OHS and compensation systems. • ôNo blameômay lead to perceptions of óno justiceôfor those who are not dependent.
Provides some initial entitlements and clinical support for affected families regardless of dependency.	• The compensation process can be complex and difficult to navigate. • Families may be unaware of entitlements and may need assistance in making a valid application. • Issues around the efficacy of immediate support and longer term support • One-size-fits all - ignores individual needs of families. • City-centric - communication issues for regional and rural families.
Pays a death claim up to $600,000 for dependent spouses and dependent children.	• Requires an application through a formal legal process. • Families may be unaware of this entitlement. • Total cap of grant denies specific and difference of families, especially large families. This may be discriminatory or unfair. • The compensation process can be complex to navigate without assistance and potentially requires expensive legal assistance. • Requires evidence of dependency by spouse and dependent children of deceased person in accordance with conventional and legally defined relationships and kinship. • Denies the importance and value of óinterdependency of modern, more flexible relationships that are not based on financial dependency but no less valid as a ôfamilyô situation recognised in the community. • Claims may be disputed in complex relationships. • Lack of financial literacy and independent advice may lead to payments not being used for purposes as intended ie not to sustain welfare of the family. Unwise, improper or illicit use that may result in harm being done. Lack of accountability and auditing of use of funds for legitimate purposes.
Entitlement and claims can be granted regardless of compliance and enforcement outcomes under OHS processes.	• Denial of claim due to dependency creates confusion and dissatisfaction about the compensation process. • Lack of OHS response over the subject of a claim creates confusion and dissatisfaction about the compensation process and leads to perceptions of injustice. • Confusion over different definitions of work-related harm between OHS and compensation system
Provides compensation on work-related death not subject to OHS compliance and enforcement eg long onset illness of disease	• Confusion and dissatisfaction about the timelines for long latency illness/disease claims. • Complexity and long latency of claims may require extensive and costly legal support. • Definition of work-related death claim is incompatible with OHS definitions. • Lack of OHS response over the subject of a claim creates confusion and dissatisfaction about the compensation process and leads to perceptions of injustice. • Confusion over different definitions of work-related harm between OHS and compensation system.
A significant number of claims have been granted since 1985.	• Details of granted claims are not made public eg in conflated form for OHS purposes. • It isnôt known how many claims are made and how many are rejected and reasons for rejection eg lack of dependency, issue of work-related cause, late claims. • It isnôt known how many families may be eligible for a claim but do not make a claim, and why eg lack of awareness, an illness or disease that may be work-related • it isnôt known if there is, or could be, any process over a claim that could or should trigger compliance or enforcement action over the hazard and risk in the interest of prevention.

8. In the courts 2017-18

Graph 16. Cases finalised in Victoria involving death
Five-year trend in Victoria (financial years) - for cases prosecuted under the OHS Act and finalised in the period.
Source: VWA/interpreted by OHSIntros



In the background of the IM campaign that rolled on during the financial year of 2017-18 was the justification of the campaign: WorkSafe concluded 14 cases against employers that had been responsible for causing the death of 15 Victorian workers. This included an incident that resulted in a double-fatality in the recreation industry (see Table 11, at the end of this part for all prosecution details).

These cases were part of a record year of cases finalised by WorkSafe Victoria's enforcement department following a considerable boost in compliance and enforcement resources after several years of lacklustre delivery in this critical area of the regulator's work. Cases involving a fatality are the top priority for the regulator and are pursued relentlessly and aggressively by the regulator where clear evidence of the breach can be found by its investigators. The 14 cases successfully completed compared with just three in the previous financial year, the lowest in many years (see Graph 16). This low total seemed to be created by a backlog of priority cases after a spike in reported deaths in recent years.

While the numbers can vary from year to year because of many factors, the regulator has to send the right message about the deterrence and the ultimate penalty for committing a safety crime, and do that consistently. This is fundamental to its compliance and enforcement policy. Maintaining a high clearance rate was a must during the politically-charged 2017-18 financial year. The year of 2016-17 failed to deliver; the year 2017-18 did. It potentially placed the regulator well for 2019 and beyond if the bar is raised in the event of IM manslaughter being added to enforcement tools.

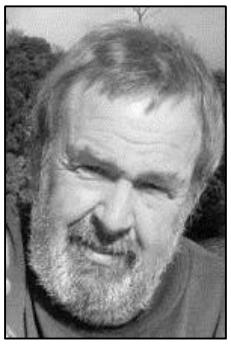
Some of those completed 2017-18 cases may just have been subjects for an IM case, had that tool been available. In fact, one of the cases - the prosecution of Redback Tree Services over the 2014 death of young arborist Scott Gamble from electrocution during tree trimming near power lines - was seen as fulfilling the criteria for a gross negligence action under an IM charge (Table 3, page 29), at least in theory (see case study, page 106).

The size of the fines in 2017-18 was also significant as were the types of incidents. Fines totalled around $5.8 mill. This included a fine to a leading public company and another, involved in the same incident being one of WorkSafe's fellow regulators in VicRoads. The 2017-18 aggregate valued the death of each person at an average of just $387,835 (around $500,000 excluding the small fine over the diving incident in Mornington in 2016). This remains an 'academic' figure because as usual monetary terms never represent true justice, or anything approaching the full extent of a penalty available to the courts under the OHS law. It once again raises questions about the capacity of the judiciary and whether too much weight is given to mitigation when the breach of the law seems clear.

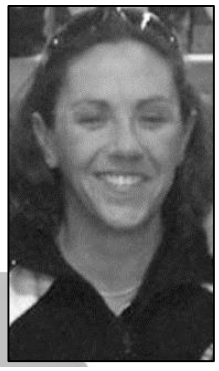
Some of the fatality cases were also historically significant and therefore additionally shameful:

- The $1.3 mill. fine to Downer EDI Works P/L was the biggest in the construction sector and the third biggest in Victorian OHS history.
- The $1.137 mill. to CK Crouch P/L was the biggest fine in the agriculture sector and precipitated the liquidation of the company.
- The $400,000 fine to Ambulance Victoria is the biggest fine to a government agency.

- The $250,000 fine to VicRoads, related to the Downer case, is the first time the agency has been fined over its project work.
- The $180,000 fine to David Shane Fergusson, over the death of an apprentice, in a structural collapse in August 2013, was the biggest fine to an officer of a company.



At another level the $20,000 fine to Nautical Training Australia P/L over a double-fatality - the death of an instructor and her pupil - seemed inexplicable. The specialist training firm was only charged over inadequate safety documentation, a minor administrative breach, and not for the consequences of it[27].



Most prosecutions involving death are indictable offences. Breaches over the death of paramedic, Clive Hawkes (top), 65, in January 2015 at Heywood ambulance station and diving instructor, Leonie Hanson, 39, (above right) at Mornington in 2016, were heard summarily. Above left, emergency services at the scene of the drowning of Hanson and a student. The breaches in both cases were over inadequate safety systems related to the deaths. *Source: media reports*

The cases finalised by WorkSafe in the courts during 2017-18 were over the needless deaths of these workers, and others, as a result of unsafe working conditions:

- Harry Zagaretos, a 49-year-old traffic controller, was struck by mobile plant during night work on a highway resurfacing project in Bayswater in December 2011 (see case study, page 85).
- Troy Baker, a 41-year-old farm worker, was struck and killed by a forklift during chicken collecting in low light conditions in November 2015 (see case study, page 91).

The awful reality of a safety crime at work that ends in tragedy - WorkSafe inspectors and police investigate a death of a worker at a Geelong recycling depot in May 2016. The 29-year-old worker was runover by a bobcat while sorting rubbish. The employer was prosecuted and fined $175,000 in October 2017. *Source: media reports*

- Nicholas Mackenzie, a 20-year-old apprentice, was killed when an overloaded floor collapsed on him at a Caulfield South residential construction site in August 2013 (see case study, page 94).
- Clive Hawkes (see picture above), a 65-year-old ambulance officer died in January 2015 from the effects of a dangerous drug that was not secured at the Heywood ambulance station.
- Carlos Araujo, a 28-year-old labourer, was hit by a load that fell from a forklift at a storage yard in Keysborough in November 2015 (see case study, page 98).

[27] This was not the first death of this type. In 2007 Melbourne Diving Services P/L was fined $200,000 over the death of 32-year-old trainee, David Grant, at Portsea in 2004.

- Chris McCann, a 53-year-old maintenance worker, entangled in a grain auger while working on a silo at Tongala in September 2014 (see case study, page 101).
- Greg McRae, a 53-old-old truck driver, died from fatal injuries after being hit by a car while loading plant onto a low loader at the roadside in August 2015.
- Agron Tahiri, a 34-year-old recycling worker, died from blood loss after being caught in an unguarded baler in March 2016.
- Leonie Hanson (see picture, previous page), a 39-year-old diving instructor, drowned during a lesson with a trainee in heavy seas at Mornington in June 2016 (see picture, previous page).
- Name not made public - a 40-year-old diving trainee, drowned during a lesson in heavy seas at Mornington in June 2016.
- Julian Fava, a 37-year-old man found fatally injured at the controls of an unsafe skid steer loader during landscaping works at the residence of his parents in June 2015 (see case study, page 104)
- Scott Gamble - a 22-year-old arborist, electrocuted while trimming branches near power lines in Highett in May 2014 (see case study, page 106).
- Not made public - 29-year-old yard hand died after being run-over by a skid steer loader in May 2016. See incident scene, previous page.

Table 11: Prosecutions finalised by WorkSafe during 2017-18 - fatalities

Fine	*Defendant*	*Incident*
$1,300,000	**Downer EDI Works P/L***	Traffic management worker struck and killed by a sweeper truck when it reversed into an exclusion zone. See also VicRoads below.
$1,137,525	**CK Crouch P/L (in liquidation)***	Worker hit and killed by a forklift during catching and loading chickens into cages in a darkened shed.
$700,000	**Jacbe Builders P/L***	Floors collapsed under weight of trusses during construction, killing an apprentice working below. See also David Shane Fergusson case.
$500,000	**Specialised Concrete Pumping Victoria P/L***	Worker crushed to death by load being lifted unsafely by a forklift in the storage yard.
$400,000	**Ambulance Victoria***	Employee found dead at ambulance station. Dangerous drugs could be accessed due to inadequate system for recording and securing storage.
$350,000	**Phelpsys Constructions P/L***	Son of a resident found dead at controls of an unsafe skid steer loader left unsecured at the property during landscaping works.
$275,000	**The JMAL Group P/L**	Vehicle collided with a crane being loaded onto a low loader at the roadside for transportation, killing operator.
$260,000	**Ricegrowers Ltd**	Worker fatally injured when screw conveyor operated inside surge bin during maintenance.
$250,000	**VicRoads***	Traffic management worker has struck and killed by sweeper vehicle when it reversed into exclusion zone.
$180,000	**David Shane Fergusson**	Floors collapsed under weight of trusses stored during construction, killing an apprentice working below. Sole director of Jacbe Builders P/L.
$175,000	**Retmar P/L**	Yard hand fatally injured when he was run-over by a skidsteer loader.
$150,000	**Redback Tree Services P/L**	Arborist electrocuted when a branch he was cutting touched powerlines.
$120,000	**AAD Services Australia P/L**	Forklift operator caught in baler. Died from blood loss as a result of traumatic injuries to lower limbs.
$20,000	**Nautical Training Australia P/L**	Instructor and trainee drowned during diving lesson. Fined over breach of safety documentation.

Source: VWA/interpreted by OHSIntros
**highlighted in WorkSafe's annual report 2017-18*

See BOOK THREE for some of the stories of prosecutions over the incidents mentioned above.

9. In the courts since 1985

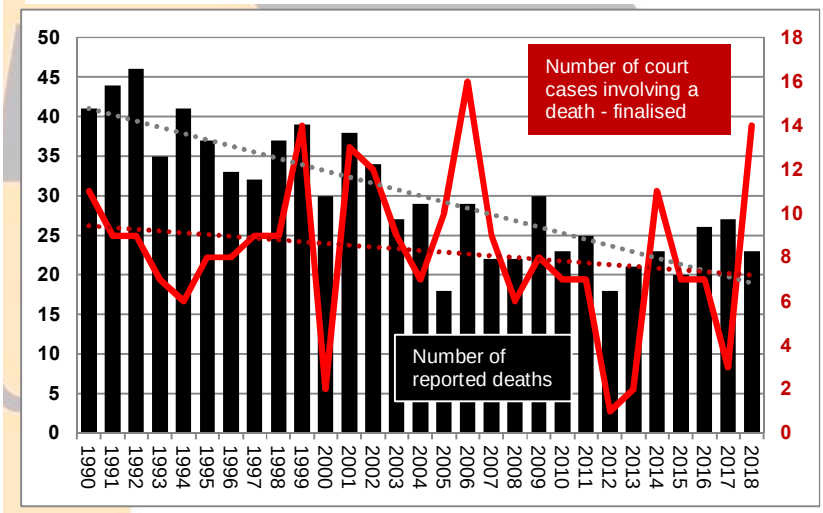
Since the current OHS system began in Victoria in late 1985, the regulator has successfully prosecuted around 270 cases involving a traumatic incident at a workplace that resulted in death. Another 14 were added to that total in 2017-18.

The regulator has always given top priority to investigating and prosecuting these incidents. It is the core part of its compliance and enforcement framework which must, among other things, send a strong message to employers that such incidents should have been prevented and that a loss of life at a workplace is intolerable in a modern society. If deterrence is so important, then 2017-18 was an exceptional 12-month period. It would have delivered that message loudly and clearly.

'If deterrence is so important, then 2017-18 was an exceptional 12-month period and would have delivered that message loudly and clearly.'

But it has to be remembered there are many other cases WorkSafe Victoria prosecutes over potential fatal practices that don't end up in death or even serious injury. Only about 12 per cent of all OHS cases are over a death. These figures has not changed over the span of recent years.

Graph 17 Reported fatalities vs prosecutions - 1990-2018
Red line shows number of prosecutions brought by VWA/WorkSafe, by financial years, involving a fatality compared with reported fatalities that calendar year. Trend lines (dotted) show consistent priority prosecutions over fatalities despite long term reduction in total number of deaths at work each year. Note there can be a two-year lag between incident and prosecution. *Source: VWA/interpreted by OHSIntros*



The total fines from prosecuting employers over all fatality cases on public record in Victoria amounts to around $38 mill. up to 2017-18[28], or around 44 per cent of fines for any offences, another proportion that has not changed over time.

Fines over almost 30 years have ranged from $2 mill. in the Esso Longford incident that caused the death of two workers in 1998 (see picture) to good behaviour bonds in cases where the circumstances of the death and who was responsible were less clear for the courts.

The latest cases added four cases to the list of the 20 largest fines in Victorian OHS history

Esso was fined $2 mill. in 2001 over the Longford gas plant explosion of 1998. Two workers were killed in the incident and considerable harm and economic loss was caused across the state for some. It still remains the heaviest fine in Victorian OHS history. *Source: media report*.

[28] From 1990-91. Information on early OHS cases n/a.

including two of more than a mill. (EDI Downer and CK Crouch, see part 8), but only six fines in history have been more than $1 mill. (see Graph 18). That's well short of what judges could hand down to increase the deterrence level and encourage the regulator to a more aggressive enforcement approach that is more in the interest of the community.

Mitigation available to judges under the Sentencing Act seems to be the issue. They often state in court that they are prevented from taking the harm into account because of limitations of risk-based OHS law. They keep raising it, almost as an apology, then in an off-handed way that seems callous, and even insulting to the bereaved, dismiss it when handing down the sentence. It is an anomaly when OHS breaches are actually criminal law. This is not received well in the bereaved community and their supporters, especially in the unions, and even more so when the maximum fines are never handed down. This is another factor in the understating of the impact of an OHS breach. It is an issue needs to be addressed in the future.

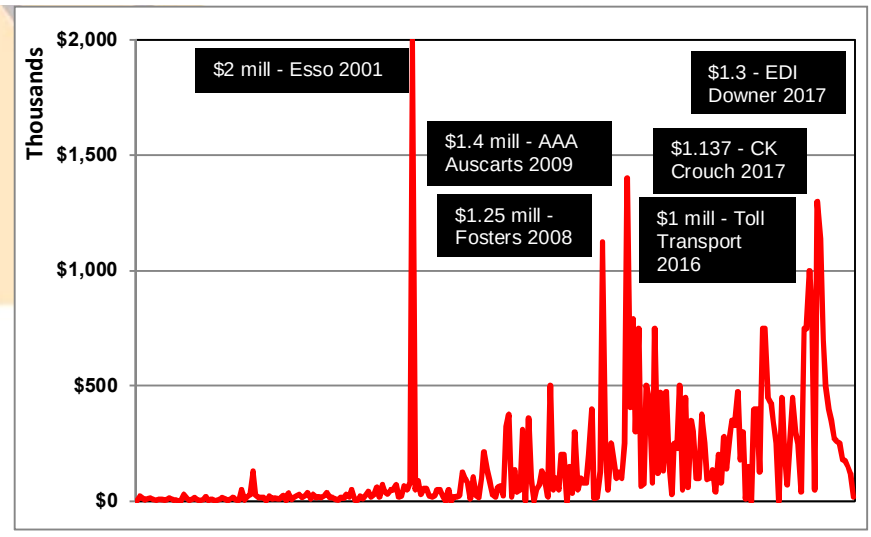
'Judges often state … they are prevented from taking the harm into account … then in an off-handed way … dismiss it when handing down the sentence. It is an anomaly under criminal law.'

For the record, when all the mitigation is taken into account, which often reduces cases to one charge in hope of a guilty plea and quick conclusion to court time, the average fine over a case involving a traumatic death is $158,000 since 1990. That total has crept up in recent years but so has the level of penalties and increases in penalty units set by government. See Table 12 for more information.

Table 12: Increase in court fines (ave.) handed down to employers for OHS offences involving a fatality
Source: VWA/interpreted by OHSIntros

Financial years	*Ave. fine*	*Maximum penalty allowed under the OHS Act*
1990-1994	$13,290	$40,000
1995-1999	$21,864	$250,000 (1997 on)
2000-2004	$109,745	$250,000
2005-2009	$181,794	$1 mill.
2010-2015	$257,259	$1.3 - $1.5 mill.
2016-to date	$462,160	$1.5 mill.

Graph 18. Court fines for individual OHS fatality prosecutions in Victoria 1990-2018
Shown over time. For more information see Appendix 3.
Source: VWA/interpreted by OHSIntros



In the early years, the average fine given by the courts for all offences, including those involving a fatality, was just $1500 whereas 25 years later it is closer to $50,000. The state government eventually took matters into its own hands by raising the maximum fine for a single offence to $250,000 in 1997 after five years at just $40,000. The maximum increased from $250,000 to $1 mill. as part of the overhaul of the original OHS Act in 2004 and now sits at approx. $1.5 mill. (9000 penalty units x $165.226 at current indexed value for a single offence). As it stands the maximum penalty for a charge under general provisions over a breach, whether there has been a death or not, is currently at $1.5 mill. for

a company and $297,396 for a person (based on penalty units set in the OHS Act and value set by government[29]).

A perspective that has to be added here is that only about one-in - four reported fatalities under the OHS Act are prosecuted (see Graph 17). This is at a low level because of a lack of a legal entity, insufficient evidence, or other legal reasons not always made public (eg self-employed, family farm, worker not working safely as directed). The fact that fatalities are taken seriously by the regulator, when action is possible, can be seen by looking at its total prosecution success (total prosecutions include those brought over injury, pure risk and breaches of administrative provisions). The 267 approx. recorded 'fatal' prosecutions are out of the more than 2145 cases of all OHS breaches (regardless of level of harm/risk) mounted by the regulator since 1990. While death cases were only 12 per cent of the total cases concluded, 44 per cent of total fines of all cases (more than $86 mill.), were death cases, as would be expected (see Table 13). Fines for cases involving fatalities are of course higher, but not always.

'Just because the evidence does not support a winnable prosecution, does not mean that the employer did all that was necessary to prevent a death.'

Table 13: Total prosecutions vs prosecutions over deaths (since 1990)
Source: VWA/interpreted by OHSIntros

All prosecutions	2145 approx.
Prosecutions over death	**267 (12%)**
Total fines ï all prosecutions	$86,372,067
Fines - prosecutions over deaths	**$37,923,525 (44%)**

The 25 per cent strike may not seem a bad effort over deaths, given WorkSafe's limited resources and challenges in mounting some cases. Fatalities are a priority for the regulator and it has an impressive record in the 90 per cent plus range for succeeding in cases it feels it is able to pursue confidently. It has rarely lost a case involving a fatality.

While there is usually a valid legal reason not to pursue the other 75 per cent of fatalities, there will always be an instance, on the face of it, of duty of care. Just because the evidence does not support a winnable prosecution, does not mean that the employer did all that was necessary to prevent a death.

Those affected by it ie the bereaved, and the community impacted by it, and even the deceased's colleagues who may also have been at similar risk, need clarity from the regulator on why they did not take a breach of the law to prosecution. Why was 'softer' compliance appropriate when someone has died?

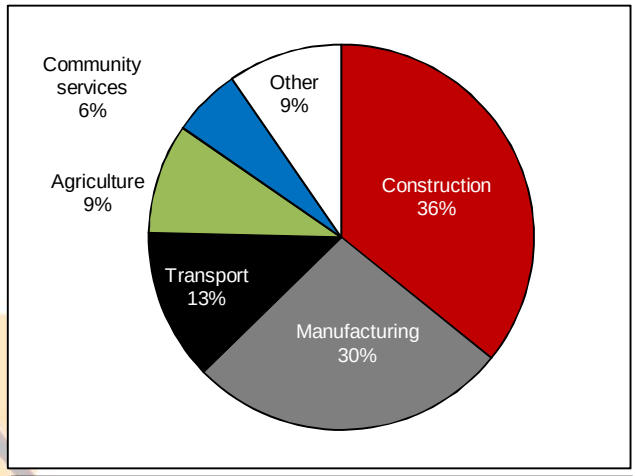
Further to that, there was a death that needs some response in OHS prevention terms, especially if it happened in high risk industry and involves high risk work. Affected parties need to at least be assured that the findings of the investigation would contribute to the SOK on preventing such incidents from happening again. This could include issuing or updating of prevention information to the OHS community or some other form of compliance response by the inspectorate such as a blitz on that issue. This happens in some instances where there is a real likelihood of non-compliance other workplaces. The sound assumption around this is that the hazard behind any a type of incident isn't isolated to that workplace.

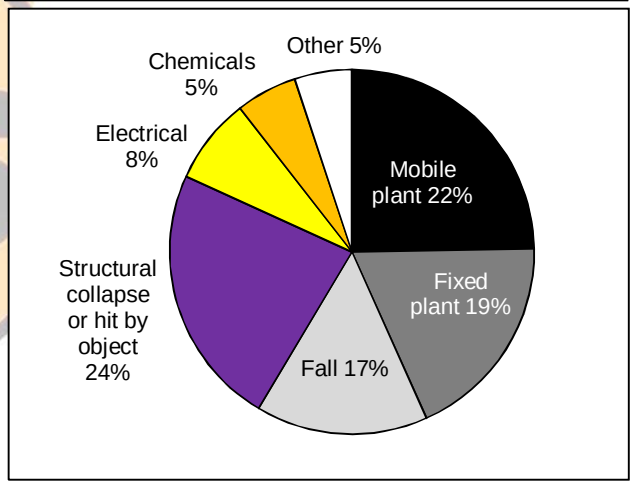
A review of the list of prosecutions over the last 28 years continues to show that construction and manufacturing are the most deadly workplaces, as would be expected.

[29] https://www.justice.vic.gov.au/justice-system/fines-and-penalties/penalties-and-values

Mobile plant found in the building industry and fixed static machinery used in manufacturing surprisingly create the most deadly hazards and risks. See Graph 19, for details. But there is a mismatch between the most serious hazards/risks of reported fatalities and the priority for prosecutions. An example is that mobile plant/vehicle has caused around 40 per cent of deaths at work while it is the subject of 22 per cent of finalised prosecutions over a death related to that hazard. Another example is fixed plant accounts for four per cent of deaths but 19 percent of successful prosecutions over this hazard. There are reasons for this related to the aforementioned legal and evidential matters. However in the case of a fatal fall it's a perfect match of around 20 per cent each.

Graph 19. Industry of employers prosecuted in Victoria over a workplace fatality and the hazards causing the prosecution – 1990-2018
Source: VWA/interpreted by OHSIntros





When the lists of all death-related hazards and prosecutions is all tallied up, at the 'bottom of the barrel' are prosecutions related to the agencies of illness and disease. These are almost impossible to get up mostly because the passing of time and uncertainty of work-related causes. That is no reason for the regulator to ignore the ultimate sanction if it is serious about a deterrent for all fatal hazards and risks. The obvious examples are fatal exposures to a known hazard such as asbestos and emergency ones such as silicosis and glyphosate. Legislated time limits for bringing charges (nominally six months) after an investigation and WorkSafe's own two-year investigation-to-prosecution timetable adds another level of difficulty in such cases when resources are limited and there are KPIs for utilising resources effectively for the short term. It continues to be an area of injustice that has no resolution under OHS law.

The other aspect of the history of fatalities is the large number of vulnerable working people killed - both young workers and the number of 'older' workers that may be at risk. The average age of dead workers in prosecution cases is around 44.

Since 1985 many young workers have been killed in preventable incidents, and employers have paid the penalty in the courts. Surprisingly only one employer has been fined over the death of an apprentice - the Jacbe Builders case completed in 2017-18. However, there have been more than 50 successful cases against employers over injury to an apprentice. Many of those related to fatal hazards. Many other younger workers have not been so fortunate. Examples are:

- 15-year-old casual labour hire worker was killed in 2012 when the forklift he was driving at a farm tipped over. Lilford Farms was fined $450,000 in 2016.

- 17-year-old worker was shovelling fertiliser into the bucket of a front end loader when he was crushed by a container that fell from a wall. He was working alone in a Maffra transport depot in 1998 when the incident happened. His body was later found by his mother. John Vardy Transport was fined $40,000.
- 18-year-old working alone at night in a Bendigo food processing plant in 1997 when his head and chest were caught in a pasta-making machine because of an inoperable safety device on the guarding. He died from the injuries. The Pasta Master was fined $30,000.
- 18-year-old casual was crushed when a concrete slab wall fell at a storage site in Footscray in 1998. Drybulk was fined $50,000 and its managers were fined an additional total of $15,000.
- 19-year-old runner for a recycling truck in 1998 slipped on a step of the truck as it was reversing. He was run over and fatally crushed. Labour Hire (Victoria) was fined $50,000 (after an appeal by the DPP).

'The vulnerability of these workers, whether younger of older, is one of the factors that is not specifically noted in prosecutions.'

At the other end of the vulnerable scale, several cases since 1990 involved workers who were more than 65 years old. This included the prosecution over the death of the oldest vulnerable worker. It was the result of a 1999 explosion in the dry cleaning area of a Benalla tannery where chemicals were used to clean skins. The 74-year-old worker died in hospital from burns. The employer and supplier of the flammable chemicals were fined a total of $55,000.

The vulnerability of these workers, whether younger of older, is one of the factors that is not specifically noted in prosecutions. This is another element of harm not given the emphasis it should receive in risk-based prosecutions. Judges mention it, particularly where the victim was young, and refer to that impact if they choose to note victim impact statements, but put it aside in sentencing, along with other aspects of harm to families and the community caused by a death at work. Is it time for a fundamental change in the legal process so that harm is given as much weight in sentencing as the risk-based breach?

For a list of all major prosecutions in Victoria over fatalities, see Appendix 3. For a list of all offenders, see Appendix 2.

BOOK THREE

THE HARM DONE
Case studies (five) over deaths at work 2018

THE HARM DONE
Case studies (seven) of 2017-18 prosecutions over deaths

THE HARM DONE
Summary and comments

WARNING:

The following accounts of deaths at work, and court proceedings over death, are based on publicly available information. They contain some graphic descriptions, comments and pictures that may be distressing.

Note: comments about incidents in 2018 are made when investigations may not have been completed and when charges may not have been laid (and may not be). It is nominally a two-year process between an investigation commencing and a prosecution being finalised. This means the full facts of incidents may be unknown or unclear at the time of writing.

10. Case studies - deaths at work 2018

1. The death of Nick McKimmie - January 2019

Nick McKimmie was a stock agent, well known in Victoria's north-east. He had been around cattle all his life.

On the early morning of January 4, 2018, that working life ended when he was trampled while drafting cattle at a Georges Creek Road property.

He was remembered as a respected stockman, devoted husband and father of three. Born in Corryong, he moved to the border region and was living in Tallangatta.

McKimmie was believed to be acting for stock and station agent, Paull and Scollard, at the farm when the incident happened in the farm yard. He has been associated with the company for more than 30 years and was well known for his work in the region.

WorkSafe and police investigate the incident at a Georges Creek cattle property in January where Nick McKimmie (right) died. Below: a farewell to a fine stockman at Yabba cemetery in Tallangatta South, overlooking a Mitta Mitta farm McKimmie once owned. *Source: media reports.*

Paull and Scollard managing director, Stephen Paull, told the media that his thoughts were with his family and friends. "It is with great sadness that we learned of the passing of a fine stockman, husband and father," he said. "Nick was a close friend to many of us and was highly respected in the industry for his professionalism and integrity."

More than 1000 people were at McKimmie's funeral in Tallangatta South, overlooking a Mitta Valley farm he had once owned. He was remembered at this farewell for his sense of humour, and love of practical jokes. The 58-year-old was a keen fisherman - believing fishing trips were a cure for all problems. He loved music and dancing and was an avid tennis player and coach who had been pulled out of retirement to make up the numbers for a match.

A colleague of nearly 14 years remembered him as a mentor and an innovator in the cattle industry. "He was a highly regarded, professional stock agent in the north-east of Victoria. Nick's knowledge of livestock was second to none." It was a life "well-lived", he said. "Family came first and he was extremely proud of his children's achievements and the adults that they've become."

One of McKimmie's sons, Tom, said he'd had a "deep, burning ambition" to make his dad proud. "I haven't just lost my dad, I've lost my mentor, my hero and my best mate," he said. "I've still got so many, many questions to ask him and things to learn, and there was so much for him to see me do and so many more things to make him proud."

2. The death of Ryan de Wit - January 2018

Twenty-nine-year-old electrician Ryan de Wit started his working year in 2018 looking forward to becoming a dad in just a few weeks. On January 29, 2018, he was working near a live switchboard at a Dandenong factory. He never came home. His death, by electrocution, was the third work-related death of the year in Victoria for 2018, a tragic start to the year.

In a facebook tribute, Ryan's wife of two years, Emma, remembered him as beautiful, fun and loving. "My heart is so broken", she posted. "There will never be anyone like him and we were all so lucky to have him in our lives. I will miss him forever. He was my best friend and soulmate. Rest In Peace you beautiful soul. "I love you so-so much and always will. I hope that our baby will grow up to be just like you."

Ryan and Emma de Wit. They were expecting their first child when Ryan was electrocuted. Below. Ryan plays his role in Narre Warren's win in the 2014 reserves grand final *Source: media reports*.

They had married in 2016. In recent months, the couple had been putting their lives in place and had bought a house in preparation for starting a family.

A contractor for a Dandenong-based electrical services firm, de Wit was remembered as a "big hearted", gem of a bloke who was everyone's mate. He was always making people laugh and smile. He had a long list of friends who said he "lightened up" the lives of everyone he met.

He was also a noted local footballer, playing for the Narre Warren Magpies in the VSFL competition, ironically sponsored by WorkSafe Victoria as part of its strategy to raise awareness about workplace safety with local communities where many tradies live and work.

He was described as the club's "social glue". An accomplished DJ, he performed at numerous birthdays, engagements and celebrations at the club. One of his lasting legacies was bringing the club's footballers and netballers together for social events known as the 'Narre Nights'. About 150 devastated players, parents and members – young and old – gathered at a Beaconsfield pub on 31 January for an impromptu wake.

Narre Warren Football and Netball Club president Stuart Stephenson said it was rare for a young man to befriend so many across the generations. He was a "massive part of our club", bringing the teams together on the field and off the field. He was widely known and well loved," Stephenson said. "He always had a smile on his face, always welcoming to all the new people in the club."

His footballing record spanned a decade during which time he displayed leadership and loyalty. He was a best-and-fairest winner, vice-captain and captain of the reserves side; a premiership player in

2010 to 2014. The club was planning a lasting tribute in some form that would be part of the opening of its new social rooms in April, 2018

His sister-in law, Leah, said Ryan would never be forgotten. “Thank you for bringing so much joy, laughter and love into our family and making my beautiful sister so happy. Baby de Wit will be so loved. Will miss you always and remember you forever.”

Wedding day 2016 for Emma and Ryan: the Cover photo of the GoFundMe page to raise money for Emma and their unborn child.

De Wit had often described Emma as his “better half”. His father-in-law wrote that Ryan was his daughter's "perfect match and soulmate". Fathers always worry about their daughters, but not with Ryan, he wrote. "The love they shared together was amazing to watch. He was the most caring guy in the world and I'm so glad we had him in our lives, he has touched our hearts in so many ways."

His sudden, tragic death left his family and friends concerned over his wife and unborn child. De Wit’s sister Dani set up A GoFundMe Me page to provide for his widow and his child. It raised $13,000 in the first day.

3. The death of Andrew Wahlert - August 2018

There were three deaths in 2018 related to trenching work. Less than six months after the double fatality at Delacombe, 35-year Andrew Wahlert died in a trench during pipelaying work at a Wallan construction site.

This incident in August involved a fall into a trench while shields were being lowered in position, using an excavator as a crane.

Wahlert was reported to be directing the shield placement by the excavator when he fell into the deep trench. He was working out of sight of the plant operator, so there was no clear witness to the incident.

Top: The site of the incident at a Wallan construction site in August where Andrew Wahlert, 35 (right), died in a fall during trenching work. Above: Emergency services (foreground) at the site and WorkSafe inspectors (right) investigate. *Source media reports.*

Whatever the cause that will be an outcome of the investigation, trenching is high risk work often involving high risk plant and requiring some expertise. It is one of the many risks associated with excavation and trenching, that was subject to the release of a new compliance code by WorkSafe (see page 7) on the subject.

Initially it was feared the incident might have had some similarities with Delacombe, but this discounted by emergency services when they accessed the site to remove De Wit's body. "There's been no actual physical collapse of the trench," the local CFA's Mark Owen reported. "It's believed that the gentleman may have just stepped off the edge by mistake."

Andrew Wahlert in happy times - devoted dad of two and experienced trench worker. *Source: media report.*

Reports from the site were that Wahlert was with a construction team from Kilmore-based excavation firm, Crowley Excavation. They were building a drainage system at the site of a new housing estate development for the booming outer suburbs of northern Melbourne.

The incident shocked his work mates as well as nearby residents who had seen the works unfold from their front yards, and were drawn to the scene to see what had happened in their new neighbourhood. “It just was a big shock that someone has actually passed away,” one local said. “I feel for their family and their work mates that work with him every day.”

Walhert’s boss, Rory Crowley, managing director of Crowley Excavation, said he was “shattered for his family.” Crowley was a growing excavation and pipelaying contractor with a “commitment” to safe and quality work. Wahlert was said to be one of its experienced workers.

On its website Crowley Excavation stated it is an accredited sewer and water contractor. It held an internationally recognised certified status with QMS Certification Services for the nominated Quality, Occupational Health & Safety and Environmental standards ie AS/NZ 4801 for a safety management system specific to their work. This status had been maintained since June 2011 and accreditation updated on June 2018, two months before the incident. Other than that nothing on the business’ website directly related to OHS. However after the incident, it posted its ‘Health and safety policy’ on its website. Dated February 2019, such a policy is one of the elements of AS4801 accreditation. It stated: “Crowley excavation recognises the inherent risks associated with civil construction and are committed to ensuring the safety and welfare of employees, interested parties and those the organisation may influence. CE believes that providing a safe and healthy work environment contributes in a significant way to the quality of our work and the sustainability of our business.”

In summary, if the site was safe and Crowley employees were following safe systems or work, what happened? Were the systems inadequate for this particular task or not followed by the crew, which increased the risk, or a bit of both? That will be the core of the WorkSafe investigation.

HEALTH & SAFETY POLICY

The Crowley Excavation recognise the inherent risks associated with civil construction and are committed to ensuring the safety and welfare of all employees, interested parties and those the organisation may influence. Crowley Excavation believes that providing a safe and healthy work environment contributes in a significant way to the quality of our work and the sustainability of our business.

To maintain a safe and healthy workplace for all those associated with the company, we will:

- Comply with all relevant OH&S legislation and regulations, and other requirements that are placed on us, or to which we subscribe;
- Understand the needs and expectations of interested parties;
- Develop, implement and maintain procedures for hazard identification, assessment and control covering all of our activities, and of those who we may influence;
- Establish and pursue Health and Safety objectives and targets that focus on improving management performance by eliminating or minimising risks of workplace illness or injury;
- Identify competencies required for the establishment and management of a safe and healthy workplace, and ensure such competencies are always retained within our workforce;
- Endeavour to ensure that workplace bullying and harassment does not occur;
- Identify potential emergency situations and establish procedures for their prevention and response;
- Consult with our staff and engage with other stakeholders to reduce workplace risks and improve health conditions;
- Ensure occupational rehabilitation for injured/ill employees without them being prejudiced or disadvantaged, and to guarantee that effective return to work plans are developed and implemented;
- Maintain a certified Occupational Health & Safety Management System in accordance with the requirements of AS/NZS 4801:2001.

Rory Crowley
Managing Director
11/02/2019

Crowley’s health and safety policy of February 2019. The company’s AS4801 accreditation was updated in June 2018.

Tooburac Hotel in August 2019, in memory of popular patron Andrew Wahlert, at a community gathering 12 months after his death. Below: partner Katie and son William. *Source: Uniting Victoria.*

Postscript

Andrew Wahlert was said to be a devoted dad to William and Charlee, and partner to Katie. On the 12-month anniversary of Wahlert’s death, a large crowd of family, friends and colleagues, gathered at the Tooburac Hotel, in memory of a favoured patron. The family unveiled a bench seat in the pub’s garden dedicated to the memory of the husband, father and hard worker.

4. The death of Dillon Wu - October 2018

Apprentice, Dillon Wu, died in his second week of a new job. Below: grieving father Xiancong Wu and mother Guojuan Hu. S*ource: media reports*.

Dillon Wu was a fun-loving, 20-year- from a Chinese family making its way in Australia. He told his family and friends he was excited about his future after getting a job as an apprentice in metal engineering.

"At the start of this job he was like, 'I'm going to do at least two years until I have enough money to buy my own house and everything, so my life can go a better way,'" Dillon's sister, Xinlei Wu, recounted after his death.

He was in his second week of that much-sought after apprenticeship with the prestigious Ai Group Apprentice and Trainee Centre placement scheme run by the Australian Industry Group, one of the country's most influential business groups.

He had been placed at Marshall Lethlean, a manufacturer of tankers for heavy haulage transport at Cranbourne, not far from his home. The 40-year-old manufacturer made heavy haulage tanker trailers for transporting petrol, milk, chemicals and gas. Its customers are some of the biggest names in road transport such as Toll Transport, Linfox and K&S Freighters. The company had has only recently moved from its old Laverton base to new factory in a new industrial estate in Cranbourne West.

Wu started off his apprenticeship with practical work as a boilermaker. His job was to weld plates and tubes inside the tanker shell to form the steel fabrications, then finish off by grinding the welds.

On the morning of October 10, 2018, Wu was using the argon welder on the factory floor. While he worked alone on the tanker fabrication there was WorkSafe Victoria inspector coincidentally visiting the company over a complaint (see picture of inspector's notice, next page). About 15 minutes after the inspector departed, Dillon Wu was found unconscious in the tanker. He had apparently been overcome by welding fumes that must have collected in his 'breathing zone'.

It is was later found that Wu had probably suffocated, not by fumes, but from the argon gas that leaked through a faulty gas line supplying his welding unit. A colourless, odourless and dense gas, a high volume of argon could have escaped to leak out undetected and quickly displaced the air in Wu's breathing zone, causing him to lose consciousness and suffocate.

A copy of the inspector's report, acquired by the media, showed the inspector was responding to a complaint about traffic management and related matters raised during a safety meeting at the factory. The inspector sought assurances from management that the safety issues would be resolved, and would return to the factory at a later date to check for compliance

WorkSafe VICTORIA

ENTRY REPORT

State Government Victoria

Visit Number: V01027201358L

Entry Date and Time : 04/10/2018 08:00 AM Departure Date and Time: 04/10/2018 09:45 AM

PLACE ENTERED

MARSHALL LETHLEAN INDUSTRIES PTY LTD

ABN: 42124965582 ACN: 124965582

Phone Number: [redacted]

Service Method: Delivered electronically

THIS REPORT GIVEN TO

Name:	Person's Position:	Email Address:
[redacted]	Employer Representative	[redacted]
Name of person copy given to: [redacted]	Person's Position: Health and Safety Representative	Email Address: N/A

The visit was specifically about the subject of the service request. However, during the course of the inspection it was reported that the inspector also viewed a copy of a risk assessment 'audit' report done for the company in August by AiGroup, presumably to verify the current safety of the workplace for a labour hire placement.

The report done for AiGroup was said to have listed 11 "serious" hazards to address, including lack of procedures for staff working in confined spaces, which it categorised under "High/Significant Risk, Almost Certain likelihood, Serious consequence". The report also raised concerns about a lack of equipment maintenance, unsafe handling of dangerous goods and chemicals, and observed that part of the factory's machinery was not secured to the ground.

The Marshall Lethlean workshop in Cranbourne where apprentice Dillon Wu was suffocated while welding. Below: Wu's tools- left behind inside the road tanker where he was welding. *Source: Media reports.*

It recommended the company carry out a complete overhaul of its safety procedures "in order to meet legislative requirements and reduce the risk of injury to workers".

It is not known if the company addressed those safety concerns. Whatever the outcome of the audit report, AiGroup placed Dillon with Marshall Lethlean for his training in September, starting as a boiler-maker. The AiGroup claimed that the safety issues outlined in the report were not insurmountable. AiGroup's CEO Innes Willox said in response to Wu's death: "All our indications were and continue to be that it was a safe place of work, but what occurred was a terrible tragedy, the details of which we don't know."

Willox said they had been placing apprentices with Marshall Lethlean for 17 years and the program had been successful. "This is the first death of an apprentice that we've had," he said.

The union with coverage at Marshall Lethlean was scathing. The Australian Manufacturing Workers' Union, Tony Mavromatis, claimed there had been “no changes” to its safety procedures after the Ai Group audit report. "It's quite disturbing to know that not only the host employer knew about it, but that the direct employer knew about it," he said. “The system failed Dillon at almost every step.”

The union said there were in sufficient safety measures in place at the factory for Wu’s task. This included no supervision for a new apprentice learning the job, lack of ventilation, no air test before the work start and no gas monitor with the equipment to alert to high levels of fume or a gas leak.

It was ironic that the peak employer body was caught up in such an incident. Such a body prides itself on representing best practice. On its website the training arm and apprentice arm says: “We are passionate about helping good businesses become great through the delivery of cost effective, customised apprentice management solutions with a focus on the productivity of your workplace. It starts with the quality of our apprentices …”

> “We can confirm that WorkSafe visited the site on the morning of the fatality in response to a service request about specific health and safety matters. As our investigation is continuing, it would be inappropriate to comment further.”
>
> - *WorkSafe statement*

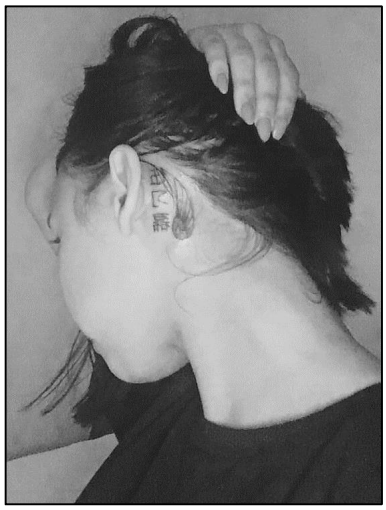
A poorly maintained welding gas supply gas line that may have leaked and caused Wu’s death. *Source: Media report.*

But why didn’t the WorkSafe inspector view the welding work during the response visit, as a matter of course? The inspector was at the workplace on that fateful day for a specific reason that was dealt with, which is normal practice, and probably had another visit pending. It was reasonable for the inspector to accept the assurances of Marshall Lethlean that it had resolved the issues raised in the risk assessment report, including the confined spaces matter. The inspector did not need to view the welding work that particular morning and could not be expected to be aware that risk remained.

Could the incident have been prevented? It was possible but the legal duty that day had nothing to do with the inspector visit. The responsibility rested with the employer. WorkSafe’s response to the inspection was: "We can confirm that WorkSafe visited the site on the morning of the fatality in response to a service request about specific health and safety matters. As our investigation into Mr Wu's death is continuing, it would be inappropriate to comment further."

A few hours later inspectors and investigators were back to investigate Wu’s death. Part of the response was a prohibition of welding inside the tankers until the task was made safe.

According to a media report, another WorkSafe inspector visited the factory at a later date - October 25 - after a complaint that staff had been told to resume working inside tankers even through safety procedures have not 'improved' since the incident. This was denied by Marshall Lethlean management. However, several Marshall Lethlean workers continued to complain to the media that procedures had not improved since the incident.



Despite its 'anglo' brand, the long-established Australian-owned firm was believed to have been taken over by Chinese interests. It was claimed to be the same in branding only. Not previously known for major OHS concerns, Marshall Lethlean had now come under fire from unions. It was claimed the 'new' company had adopted lax work practices. Its workforce was said to be made up of many Chinese workers, possibly on working visas, and some young and vulnerable workers such as Dillon Wu, under labour hire arrangements, who were exposed to high risk. As a result, the Marshall Lethlean workplace of 2018 was referred to as "troubled" when it came to its relationship with its workers.

A very millennial type tribute? Dillon Wuôs friends Claudia top and Steve above got tattoos of his name in Chinese characters. *Source: media reports.*

In its statement to a media request, Marshall Lethlean's John Zhang said Dillon's death on its worksite had left its directors and employees "shocked and deeply saddened".

"There is an ongoing investigation into this matter by WorkSafe Victoria. The company is fully cooperating with this process and will continue to do so. It is also conducting its own enquiries into the circumstances surrounding the accident as part of its ongoing safety management process. As such, it is not in a position to comment on the causes of the accident at this stage."

The timing of Dillon Wu's death and the circumstances that led to the incident was also caught up in the Victoria union movement's public campaign on industrial manslaughter campaign. IM was one of the themes of WorkSafe Health and Safety month that was in its second week when the incident happened. The incident led to renewed calls to make IM a criminal offence. This was not surprising as Wu's 'co-employer AiGroup had been among the most vocal opponents of the proposed changes to the law, describing the model as used in Queensland legislation as "poorly conceived and unnecessary".

Innes Willox said it was inappropriate at the time to comment further about changes to the law, when a worker has just died in an incident that was still being investigated by WorkSafe Victoria. "This is a terrible tragedy and I wouldn't like anyone - unions or anyone else - seeking to make some political capital out of this," he said. "Let's just deal with this issue as it stands."

The response by AMWU's Mavromatis to that was: "That should wake employers up and really take notice about employees' safety and making sure that they actually take that duty of care that they need to. We have these rules and regulations for a reason, and it's just shameful what has happened here," he said. "The AiGroup and Marshall Lethlean need to be held to account. We will be watching the outcomes of the investigation closely."

Wu's death resonated through the community. Even the then Federal Minister for Jobs and Industrial Relations, Kelly O'Dwyer, noted Wu's passing, saying his death was tragic. It had an impact beyond Australia with the Wu family planning to honour his passing in a culturally appropriate way by bringing relatives from China for the funeral at considerable cost.

'It had an impact beyond Australia with the Wu family planning to honour his passing in a culturally appropriate way by bringing relatives from China for the funeral at considerable cost.'

Wu's friend from his school days, Claudia, told the media that she hoped his family got the justice they were still desperately searching for. She had received a phone call from Wu the week before he died, asking to catch-up and saying he was "excited" to be starting his apprenticeship. They had been at Dandenong High School together until Wu dropped out in Year 11. "He didn't know what he was doing with his life," Claudia said, "So when he was offered this apprenticeship we thought it was a great opportunity for him."

Wu was older than her, but Claudia's regarded him as little brother. She described him as a "bubbly, fun-loving person who had always filled a room with laughter". She couldn't believe it when she received the phone call to tell her that her fun-loving friend had died while working on the apprenticeship he had been so excited about just a week before.

Claudia said Dillon's family and friends, were searching for answers and wanted his employers to be brought to justice. She said there was not enough money in the world to compensate Dillon Wu's devastated family for the loss of their son. "People go to jail for way less," she said. "There is no price for a life."

Postscript:

WorkSafe Victoria was in the midst of investigating the incident, prior to determining whether to prosecute AiGroup and/or Marshall Lethlean over Wu's death when in March 2019 it issued an Alert titled: *Safety when working in confined spaces*. This non-statutory guidance document was not specific to the Wu case. In its safety recommendations it drew on WorkSafe Victoria's relatively new Compliance Code on Confined Spaces, and the prescription in the hazard-specific chapter in the OHS Regulations.

But in its introduction the alert said: "In October 2018, an apprentice died while working in an open-ended tanker. WorkSafe is still investigating the causes of this incident, including whether the apprentice was in fact and at law working in a confined space but … we remind you of the dangers of working in confined spaces."

Alerts only tend to be issued by the regulator when there is immediate risk in workplaces of a repeat incident that needs to be brought to the attention to the working public[30]. The Alert referred to the known risks and appropriate controls measures necessary to control the risk when working in a 'confined space' which would be central to investigating the Wu incident. Without specifically mentioning this incident, the Alert defined the term "partially enclosed structure" which was the type of work space in the Wu fatality. "A space is considered a 'confined space' not just because work is done in an enclosed small space," the alert said.

[30] It has been estimated that there are approx. 250,000 Victorian workers potentially exposed to a confined/enclosed risk during a working year. Approx. 1300 entry permits are issued for such work each year. This risk is considered ñowò Source: *Regulatory Impact Statement for proposed Occupational Health and Safety Regulations 2017*, June 2016.

5. The death of Graeme Edwards - November 2018

Graeme Edwards had just celebrated his 54th birthday when he was badly burnt in an electrical short circuit explosion while performing a routine task at the Yallourn power station on November 12, 2018. He was taken to Alfred Hospital in Melbourne for treatment to serious burns to a large proportion of his body. He died the following day in the presence of his family.

> "Everyone loved him (Graeme Edwards), he got on with everyone. He was Mr Nice Guy, an absolute gentleman. It's such a shame it happened."

The much-loved, experienced and meticulous unit controller was remembered by friends as someone who always put others first. Known as a hard worker it is believed he was helping a colleague reinstall an HV circuit breaker to a switchboard according to a procedure called 'racking'. He and his colleagues had done this procedure for many years. This time the unit switched on and exploded.

It was a routine operation involving winding the circuit into place but a potentially hazardous one. It was done during a major maintenance 'outage' and was only performed by trained and authorised staff.

This work was part of a 70-day maintenance program on the generation unit, one of four at the station operated and now owned by Energy Australia following the privatisation of the state's energy system in the 1980s[31].

Yallourn power station worker Graeme Edwards, left, celebrates his 54th birthday in November 2018 with friend and former plant co-worker, Brad Williamson. A few days later Edwards died in hospital from fatal injuries caused by a preventable electrical incident. Below: The Yallourn power station where Edwards worked. *Source: media reports/Energy Australia.*

Old friend and former colleague Brad Williamson said Edwards was "one of the loveliest people you could meet". Everyone loved him, he got on with everyone. He was Mr Nice Guy, an absolute gentleman. It's such a shame." Mr Williamson's wife Janine Bodley described Edwards as the most kindhearted man she'd ever known. "I've honestly never met anyone quite like him. He always put others first. That was the kind of guy he was."

[31] The Yallourn Power Station was built in 1941. It was the first power station to be privatised in Victoria and one of three brown coal-fired plants in the Latrobe Valley, 150 kilometres east of Melbourne. It has a licence to continue operating until 2026, but this has been extended to 2032 by the Victorian government as part of a long term energy plan for the state.

She said what happened to him was a tragedy and “I think I speak for everyone who knew him, he will leave a hole in our hearts. We loved him dearly," she said. "A good, honest man gone too soon."

Edwards, who was single and had no children, had moved from Melbourne to further his career in the energy industry. He was living with his nephew at the time of his death and had just bought a home in Warragul.

Energy Australia’s managing director Catherine Tanna said: “No words can express the distress being felt by those who knew Graeme and worked with him during his long career in the energy industry.”

Head of Yallourn power station, Mark Pearson, added that Edwards was a popular, hardworking member of staff. “Graeme has been with us for around 33 years, established a lot of friendships and relationships over that period of time, so he will be sadly missed.” He did not answer questions from local media about workplace safety, saying it was inappropriate to discuss anything but concern and support for Mr Edwards’ family.

> “Safety is integral to everything we do, and the safety and good health of our employees, contractors and local community are key priorities. We aim for zero injuries and nurture a culture of vigilance and care.”
>
> - *Yallourn safety commitment, Energy Australia*

His fellow workers, who have been left traumatised by Edwards' death, claimed Energy Australia had refused to implement safety provisions in response to the incident, including in unit four, which houses an identical circuit breaker. However, the company says it was reviewing the safety controls of circuit breakers and had not instructed workers to perform racking since Edwards' death.

Unit three had been shut down so that WorkSafe and its specialist co-regulator, EnergySafe Victoria, could investigate the cause of the explosion. Pearson said no workers had been instructed to perform racking of live circuit breakers at the plant since the death. "We are performing risk assessments and reviewing all safety controls before restarting these activities on site," he said.

Workers said the incident was the third time in 18 months that a circuit breaker had exploded, the previous one just weeks before Edwards’ death. While no one was hurt in the first two blasts, they said this was only due to luck.

In Brad Williamson’s view, having worked with Edwards at the plant for decades, it was "extremely abnormal" to have three circuit breaker explosions in 18 months. "Everyone is very, very concerned with the events, for their own safety and for the safety of everyone there, because they work there every day," he said. "Everyone's extremely upset. It would be very unnerving to work there at the moment until they work out what went wrong. Until they know, they don't know if it could happen again."

CFMEU secretary Geoff Dyke called for the investigation to go beyond the technical cause of the explosion and into the wider safety culture at the plant. "Yallourn has a history of significant electrical equipment failures." He said the combination of an aging plant, poor maintenance and a "disregard" for safety had led to a significantly higher rate of failures, including electrical fires and transformer explosions. He said workers should have been provided with the most up-to-date protective gear, including arc flash suits, similar to what bomb disposal workers use.

Dyke said workers were refusing to operate the circuit breaker in unit four until their safety could be ensured. "Of course workers are very worried after seeing a workmate killed," he said.

Energy Australia managing director, Catherine Tanna: ñWe failed Graeme, his family and his workmates. Weôre sorry.ò *Source: media report.*

Companies rarely make public statements over an incident. In this case a provider of essential services cannot afford to hide behind a corporate veil. This is because of community concern over supply safety and the licensing agreements with government to provide a safe and stable supply of power to the state's energy grid. Many corporates, even those operating privatised but essential public assets prefer to leave it to the lawyers. They await the results of compliance and investigation, and any punitive action that might be imposed by various regulations, which may have to be defended to protect the corporate image.

Abiding by the playbook, Energy Australia managing director, Catherine Tanna, vowed to find out the cause of the incident but would not be drawn on whether there was a wider safety issue at the plant. Tanna also refrained from commenting on whether there had been previous circuit breaker explosions, saying she didn't want to speculate on the outcome of the investigation.

Like all large corporations, they set the bar high. About Yallourn, the company says: "At Energy Australia, we aim to make sure that all our stakeholders - customers, shareholders, employees, wider community, and the environment - are better off for our presence. This means doing the right thing and being accountable, particularly when it comes to safety."

Its corporate commitment said: "Safety is integral to everything we do, and the safety and good health of our employees, contractors and local community are key priorities. We aim for zero injuries and nurture a culture of vigilance and care. While we have comprehensive safety procedures and processes in place, in 2019 a key focus will be how to do safety differently - and better. We will be reviewing our safety systems and processes as well as methodologies, to ensure the wellbeing of our most important asset: our people."[32]

A large company of capacity and 'commitment' has well-developed OHS procedures. It does its own investigation, for prevention and improvement purposes. That content may be used in the form of an explanation, defence or contrition that will shape the course of a prosecution. Normally this is behind closed doors. In a welcome departure from this risk-averse practice, Energy Australia actually made its investigation public in good time (see below). It may be a stretch to say this is what OHS should be about in the corporate world where accountability seems to have long ago lost its meaning. But it was certainly a rare demonstration in corporate transparency and image management. Could it have set a precedent in corporate responsibility? If it is, it is to be applauded. It may just show that recognising 'harms' in a community context must be done, and is the right thing to do. It has nothing to do with legal processes and on the face of it was the minimum response that should be expected from every large corporate in such tragic circumstances.

The details of the Energy Australia investigation were publicly released on June 14, 2019[33] and even picked up in some of the general media, another rare occurrence. In that report, Tanna admitted fault and said "sorry". "To be clear, the investigation found that Graeme performed the racking procedure as he had been trained to do," she said.

[32] Energy Australia website, accessed August 2019

[33] https://www.energyaustralia.com.au/about-us/media/news/statement-yallourn-investigation-findings

The investigation report exonerated Edwards of making an error. The circuit breaker was in its correct operating position, and had not been reactivated, and the procedure followed. The question was therefore, how did the unit become activated, and fatally so during a maintenance outage?

> "In this instance we clearly got it wrong. There was a hazard on our site that we were unaware of and Graeme paid the ultimate price as a result of that."
>
> - *Energy Australia's Chan Sinnadurai*

The in-house investigation found:

1. A protective fibreglass panel over the frame of the circuit breaker cabinet had not been properly secured. This was not detected prior to the maintenance outage.
2. The panel was dislodged during the racking procedure by Edwards and his co-worker. Apparently this could not be detected during the procedure.
3. This left a gap for an unnecessarily long heavy duty metallic communications cable (indicating status to the control room) to sag into the cabinet and touch live parts of the frame.
4. The short circuit to earth resulted in a sudden and intense 'arc flash'.
5. The protective cover was not substantial enough to prevent the arc flash venting through the front of the circuit breaker cabinet where Edwards was working.

Energy Australia Manager of health, safety, security and environment, Chan Sinnadurai, presents the findings of the investigation of the November 2018 incident that killed Graeme Edwards. *Source: media report.*

In the public briefing on the report's finding the release Energy Australia's manager of health, safety, security and environment, Chan Sinnadurai, acknowledged that the protective barrier was a movable type and had not been fixed in place: "There were two key findings. The first one was that Graeme did his job and did it in a professional manner, the second finding was that the barrier in place to prevent access to the circuit breaker was inadequate and allowed for inadvertent contact with the live component."

He explained that the panel barrier was hinged and unique to that particular cabinet. "We've shared the findings of our investigation with the wider industry so they can take action if their sites are similar and we've completed specialist studies using external experts to ensure this kind of event can never occur again," Sinnadurai said.

The question was, why hadn't the risk been determined before, given the age of the coal-fired plant, its extended service life and its critical role in providing an essential service to the public under a government contract? The risk here was that the cost of maintenance on an old plant near the end of its operational life may not justify long term capital investment on its electrical systems.

Sinnadurai said the company worked hard to manage hazards at the power station, but had failed in this case. "In this instance we clearly got it wrong. There was a hazard on our site that we were unaware of and Graeme paid the ultimate price as a result of that."

Energy Australia said it has shared these findings with WorkSafe Victoria and Energy Safe Victoria. It was updating its other power station operators in the region and would share the main findings with other operators of large power plants. The report explained a range of improvement measures to prevent this basic fault happening again. The most necessary being installing fixed steel covers on top of each circuit breaker cabinet.

In the meantime Tanna said the company had upgraded protective equipment and technology had stopped employees reinstall circuit breakers on live switchboards. "We are determined to make sure no other family goes through what the Edwards' have experienced."

> "We are determined to make sure no other family goes through what the Edwards' have experienced."
>
> - *Energy Australia managing director, Catherine Tanna*

Postscript:

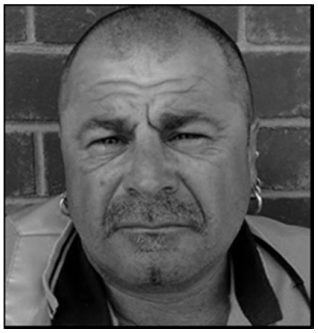
WorkSafe Victoria has only just started investigating the incident when in November it issued an Alert titled, *Employee fatally injured while reinstating 6600V circuit breaker*. In the introduction to this urgently issued non-statutory guidance document, WorkSafe stated: "An employee has died while racking in a 6600V (6.6KV) circuit breaker at a power station. The causes of the incident are still being established but it appears to have occurred when the 6.6KV circuit breaker was being placed back into service. The employee was exposed to an arc flash, electrical explosion, molten debris and super-heated gasses. WorkSafe is currently investigating the incident."

The document went on to state what actions should be taken in the event of any electrical arc flash or explosion (the scenario at Yallourn). "If there is a requirement for tasks to continue, including racking in/out 6.6 KV circuit breakers, all HV electrical energy should be isolated/de-energised before starting the task, or other controls should be implemented to prevent employees being exposed to electrical risks …"

11. Case studies - prosecutions 2017-18 over death

Case study 1*: The prosecution over the death of Harry Zagaretos*

The death of 49-year-old Harry Zagaretos (see picture) at a VicRoads project in Bayswater in 2011 led to a complex and drawn out case over six years - an intolerable delay for those affected by his death. It was however tenaciously pursued by WorkSafe against defiant defendants of significant legal resources to the point that it generated a major case study for students of OHS law. It later featured in a presentation by WorkSafe's enforcement department during Victoria's Health and Safety month in October 2018 (see picture next page).



Traffic controller Harry Zagaretos was struck and killed by a road sweeper at a VicRoads project in 2011. *Source: media report:*

The case brought by WorkSafe was against project owner, VicRoads, the principal contractor, Downer EDI Works P/L, and the driver of the road sweeper - Wayne Pollard - on an ill-fated night shift near the corner of Canterbury Road and Bayswater Road, Bayswater, in late spring. Both Zagaretos and the road sweeper driver were employed by different sub-contractors to Downer for their work so were owed a duty of care by those managing and controlling the site. It is believed that Zagaretos and others raised some concerns with those in authority about unsafe operation of the road sweeping near workers on foot. This was either ignored or not acted upon.

The scene of the crime at the night of the death of Harry Zagaretos on Canterbury Road, Bayswater. Below: the road sweeper that ran over him. *Source: VWA.*

On the night of the incident, Zagaretos was re-positioning bollards to delineate road traffic for the resurfacing works that had reached profiling stage. Re-positioning was a regular task as work progressed and also because bollards were often 'nudged' out of position by motor vehicles and site plant. He was doing this task when the street sweeper reversed over him about 11pm. A fellow worker who saw the incident called out immediately for help but Zagaretos was dead before paramedics arrived. It is likely he was killed instantly.

The main contractor did have spotters at the site but for some reason none were allocated when profiling work began that night.

The case was marred by the refusal by the accused to deny responsibility under workplace safety law. The matter had already dragged on for four years when in a last ditch effort, Downer and Victoria tried to stop it, saying they should not have been charged.

They argued that the OHS Act did not apply to road management work such as resurfacing because VicRoads operates under a different set of laws, including the Road Management Act, and the Road Safety Act and this legal regime should apply instead. This would have had the effect of striking out OHS charges and reducing the matter to a "minor breach".

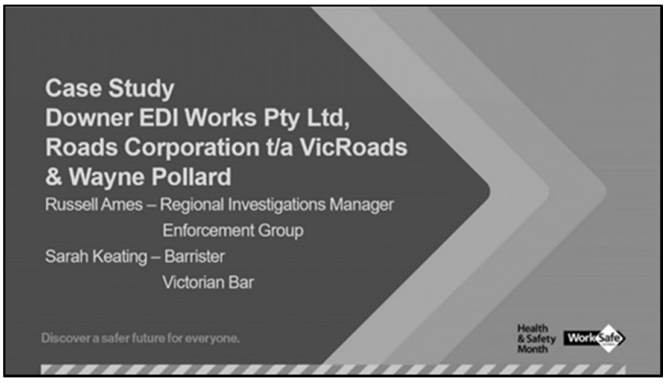
They wanted the trial to be conducted under a provision of the Road Safety Act that states a person doing works on a highway must ensure they are done "in a manner that is safe for road users and persons engaged in carrying out the works". The maximum penalty was just $7328.40, instead of more than a $1mill per charge under the OHS Act.

This in effect sought to overturn the custom and practice established several years earlier when WorkSafe, concerned by the number of road workers killed during roadside work, led a partnership with VicRoads, councils, employer stakeholder bodies and the representative union (the AWU, then led by Bill Shorten before his parliamentary career). This tackled the view that if you are working on public roads this is technically not a 'workplace'. Running a case that set out in the begging to minimise the risk of the offence made a mockery of the advances in WorkSafe policy on death at work.

> "That the legislature would intentionally have singled out VicRoads … by conferring … immunity from … offences of this grave nature seems … inexplicable and utterly improbable."
>
> - *Justice Mark Weinberg, Victorian Court of Appeal, 2015*

Judge Mark Weinberg

It was also nonsensical. VicRoads manages safety at its road projects in accordance with the OHS Act and its own governing laws. It expects its leading contractors to show how they would manage projects safely in accordance with strict OHS principles. As a result it had a good safety record on the sites it oversaw, until now.



The Downer/VicRoads matter became an OHS case study. It was presented at the WorkSafe Health and Safety month seminar in 2018.

It was also at odds with ED Downer's own commitment to workplace safety. Downer has form in various jurisdictions in which it operates. In its 2012 sustainability report the company stated: "A profoundly disappointing aspect of Downer's performance during the year was that we suffered three workplace fatalities." It referred to two incidents involving reversing vehicles on road maintenance sites, one in Victoria (the death of Zagaretos) and the other in New Zealand.

"Extensive investigations have been undertaken by senior safety professionals, managers and technical specialists into all aspects of these incidents. Following these tragic events, we have

undertaken an extensive review of work systems and practices and a number of initiatives have been implemented to address the hazards of involved with reversing vehicles …"

‘Regardless of the existence of unacceptable risk at this site, the main contractor refused to accept guilt going into the 2017 trial while VicRoads finally “broke ranks” by pleading guilty to a single change.’

It seemed appropriate then that the Downer/Vic Roads 2015 application heard before Justices Maxwell, Weinberg and McLeish in the Victorian Court of Appeal[34] was tossed out in a very dismissive manner. It was sent back to the County Court where it had originated in February 2015 and where it was to resume before a jury. Judge Mark Weinberg said that there was nothing in the provisions of the state's road management or road safety laws that demonstrated an intention to exempt “on-road workplaces” from the laws governing safety in all other workplaces.

"That the legislature would intentionally have singled out VicRoads, from all other corporate entities, by conferring upon it an immunity from prosecution for offences of this grave nature seems to me to be both inexplicable and utterly improbable," he said. "So much so that it would require a clear expression of legislative intent in order to warrant that conclusion. I do not consider that any reading of the relevant statutory provisions exhibits any such expression of legislative intent."

The case would have been simpler for the accused had there not been several OHS issues already in play at the site. On the night before the incident, a co-worker of Zagaretos was almost struck by a road sweeper. Later that night the same truck narrowly missed hitting a motor vehicle. Even an hour before the actual fatality, a Vic Roads surveillance officer was also repositioning some bollards while he was checking the site. He had to jump out of way of a road sweeper that reversed into his path. It bumped his shoulder but without serious injury. In the 2017 court case the surveillance officer stated that the driver had not seen him and continued on. It was usual for the sweepers to reverse some distance to fully clean debris created in the wake of the profiler. In this case the officer stated that the sweeper continued to reverse for 300m and was sometimes encroaching on the exclusion zone, marked by bollards, and where workers were close by.

Once the final unedifying legal obfuscations, and the obligatory process delays, were exhausted, the matter came down to a classic disconnection between a straightforward safe system of work that is well within the capabilities of a large public company and a government agency, and actual practice on the ground where there was a likelihood of a serious incident. Regardless of the existence of unacceptable risk at this site, the main contractor refused to accept guilt going into the 2017 trial while VicRoads finally ‘broke ranks’ by pleading guilty to a single charge.

The WorkSafe brief for the DPP was very clear about the breach by the two parties. In the part of the case relating to VicRoads, the prosecution led that the agency:

- had the authority to stop works at the workplace if there was imminent danger to safety but had not
- failed to ensure that a risk assessment was undertaken as part of the traffic management plan approval process, related to this part of the work

[34] https://www.austlii.edu.au/cgi-bin/viewdoc/au/cases/vic/VSCA/2015/287.html?context=1;query=Downer;mask_path=au/cases/vic/VSCA

- failed to ensure that their representative (the surveillance officer) had the authority to shut down works on the site by immediate communication with representatives from Downer when there was an immediate danger to health or safety of employees on site.

The WorkSafe case against EDI Downer was that:

- site induction did not address the dangers posed by the sweeper reversing on a busy site
- was no safe work method statements (SWMS) for setting out procedures for moving or setting up bollards
- there was a failure to supervise the operation of the sweeper and the movements of workers on foot in the vicinity.

In his sentencing in the final case in 2017[35], Judge James Parrish, said VicRoads would have been given a fine of $400,000 instead of $250,000 had it not pleaded guilty. VicRoads had told the court it had made its plea at the earliest opportunity. In making that determination the judge was critical of the timing: "Although the facts leading up to the plea of guilty were not disputed by those for the prosecution, it was submitted that in all the circumstances, bearing in mind the long history of this case prior to the plea of guilty, it was inappropriate to consider that the plea of guilty was at the earliest reasonable opportunity. I do not accept such submission."

> "… it is only a natural response to focus primarily on the death of a loved one. Hopefully, throughout the course of the trial … it became clear that … offences created by the legislation are concerned with risk …"
>
> - *Justice Parrish, County Court, December 2017*

Judge Parrish referred to the "impeccable" record of VicRoads in managing a large number of large of road infrastructure and maintenance projects conducted by "pre-qualified" and approved contractors. He noted that the chief executive, on behalf of the organisation, expressed his remorse for the failures in this project and the resulting death of Zagaretos.

"Although accepting that general deterrence is clearly a significant sentencing consideration, it was submitted that, in the circumstances, specific deterrence is of little or any relevance in this case, with respect to VicRoads," Judge Parrish stated. "As noted, VicRoads has a statutory mandate to improve the safety of the road system for all road users and it is focused on safety across the organisation. It is submitted that it is not necessary for the court to impose a penalty which includes an allowance for specific deterrence."

In making that comment, Judge Parrish, also noted the changes and improvements VicRoads had made to the processes and procedures for conducting any further work of this nature.

EDI Downer's belligerent and graceless defence in the face of the evidence did not impress the jury. In his sentencing, Judge Parrish, said the evidence was "in some respects overwhelming". And he did not believe the offender was remorseful.

During the lengthy proceeding, Judge Parrish did acknowledge the harm done and noted the victim impact statements of the Zagaretos family. But in keeping with the common interpretation under a breach of OHS law, did not give them any bearing.

[35] https://www.austlii.edu.au/cgi-bin/viewdoc/au/cases/vic/VCC/2017/2021.html

"I echo the words of the Court of Appeal that it is only a natural response to focus primarily on the death of a loved one. Hopefully, throughout the course of the trial hearing, in which comments were made as to the approach that must be taken, it became clear that legal principle requires that the offences created by the legislation are concerned with risk, rather than outcome," he said.

Harry Zagaretos and partner Nora Marshall. They were planning to marry; then he was killed at work. *Source: media report.*

Harry Zagaretos left behind a partner, Nora Marshall, a 25-year-old stepson who "adored" his stepfather, mother Ketena and brother Jim.

Quoting from the statement of Nora Marshall, Judge Parrish said Harry was someone who was "strong, committed, cheeky and unique". He was a hard worker and plans had been made for their future, including holidays and ultimately getting married. In particular, she described life without Harry as a struggle, with the loss of his love and protection.

His mother Ketena Zagaretos described her life as "stopping" after hearing of her son's death. Her heart "aches all day long, from the time I wake up to the time I go to sleep" and that a day does not go by without her crying, missing him at every moment of her waking life. She visits the grave every day, sitting alone for hours, wondering why her son is there and not out in the world enjoying himself.

The family's memorial was funded by his brother who had a "very close bond" with Harry. Jim Zagaretos paid for the family's memorial by increasing his mortgage. From the night of his brother's death, he felt his life has "stopped", in the sense of something "missing and broken inside of me that cannot be fixed to work properly". He had socially withdrawn from friends and from attending celebrations. Festive days, Christmas and Easter, had been enjoyable, but were now sorrowful.

At the end of the trial, Judge Parrish said: "It had no doubt been very trying for everyone and particularly for the members of the family, which I hope this brings some closure to this issue, but time will tell."

Following the case, Nora Marshall said she had been left devastated by the fight for justice. "VicRoads and EDI Downer have displayed no humanity nor compassion for our loss of Harry - they never once said 'sorry'." She said the workers' safety concerns and several near misses were repeatedly reported to Harry's employers over many weeks. "Workers' concerns were witnessed frequently, ignored and later denied."

WorkSafe Victoria supported the family's sentiment in responding to the finalising of the case. The then Executive Director of Health and Safety, Marnie Williams, said the penalties for VicRoads and Downer EDI reflected the seriousness of the offence.

"Any work that involves the need for pedestrian employees to be around traffic is high risk, and safety needs to be considered above everything at all times," Williams said. "There is little doubt that had Mr Zagaretos' concerns been listened to, and the risks at the site been addressed, this tragedy would not have happened."

In practical terms the five-year long case hinged on the driving of the sweeper driver, Wayne Pollard. His driving was not the subject of this case. It was dealt with in a separate case (see below) but he was considered responsible for his actions.

According to the evidence in the EDI Downer/VicRoads case witnesses claimed the operation of the sweeper by Pollard near workers had led to various complaints that were not acted on. His driving was described as "inconsistent" and "wayward". The problem with addressing such instances seemed to be a lack of communication in the poor visibility and noise of this type of busy night work. In one point of the trial it was said by a witness that the only way of getting the attention of a sweeper was to "throw stones" at the driver.

WorkSafe charged Pollard over the incident as a consequence of what was described as "unsafe" driving on the night of the fatality. In early 2014, a year before the case was concluded against EDI Downer/VicRoads, he pleaded guilty to a breach of a duty of an employee related to taking reasonable care of "others" at a workplace. He was sentenced to a corrections order involving two years of community work, and to undergo mental health assessment and treatment courses.

According to WorkSafe, Pollard's employer U-Sweep was not charged due to insufficient evidence of any OHS breach.

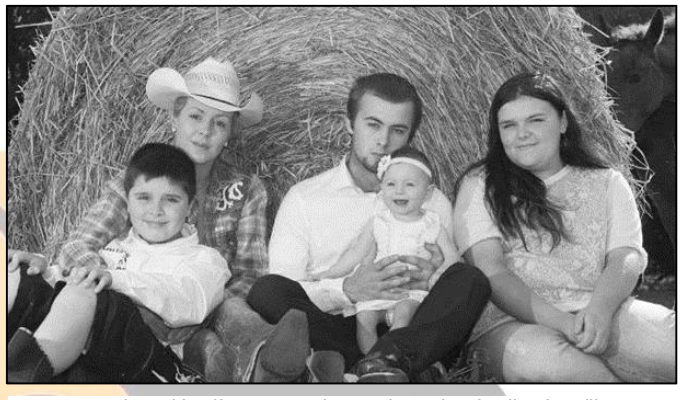
"There is little doubt that had Mr Zagaretos' concerns been listened to, and the risks at the site been addressed, this tragedy would not have happened."

- *Marnie Williams, Executive Director, Health and Safety, WorkSafe Victoria, 2017*

Case study 2:

The prosecution over of the death of Troy Baker

It was described in court as a case of "penny-pinching" by a Lethbridge chicken farm that resulted in the death of a worker. And when it came to paying a fine of $1.1 mill. over the safety failing that caused the death of 41-year-old Troy Baker, the company, which was an 'authorised' contractor of poultry giant Baiada Poultry, shut the farm gates and went into liquidation.



Top: Troy Baker with wife Tamar. Above: The Baker family of Wallington near Geelong left behind. From left, Tamar, Kade 9, Preston 16 (who was working with his father at the poultry farm), Kalya and Tamar's granddaughter Felicity. *Source: Media reports.*

Baker was herding chickens in the sheds of CK Crouch P/L with his teenage son, Preston, around 11 pm on November 30, 2015 when he was hit and fatally injured by a forklift. The Bakers were part of a team of people hired to do this work in near darkness to minimise "stress" to the chickens.

The task required herding the chickens to the sides of a shed, before the lights were dimming for catching and then loading into cage modules. The modules were brought in by forklift then picked up and placed on trucks to be taken straight to slaughter at Baiada. The forklift operated in the shed with red lights but did not have a reversing beeper.

The WorkSafe investigation found that the farm had safe work procedures for this task but there were no records of safety training given to its staff. In fact the workers were not aware of these procedures, though it involved working near high risk plant in low visibility. Even the forklift driver - the work supervisor - had not been inducted into these safety procedures.

On that night, Troy Baker and fellow workers were not issued with reflective clothing as would seem to be customary for working in low light, and had not otherwise been made aware of the risk. The work supervisor operating the forklift reported that he felt a thud, as though he had hit something. He had hit Troy Baker. It is thought Baker did not see the forklift and may have walked into its path.

Baker sustained severe chest, spinal and pelvic injuries and could not be saved by paramedics. The police reported that he was conscious and breathing but by the time the paramedics began attending to him his condition has worsened.

One the day of the incident Baker's wife, Tamar Baker, recalled getting an "I love you" text from her husband. "When the accident happened, nobody rang me but I knew," she recalled. "I had a massive anxiety attack and, when the police came to my door, I already knew he was gone."

Troy Baker was remembered as someone who would do anything for anybody. He was not a "things or stuff guy" and a "little rough around the edges", but "lived for his family" and was always ready to go out of his way to help others.

"Family, that's what it was all about for Troy. He had a pretty rough upbringing, but we were his everything," Tamar Baker said. "He's left a big hole. Our love was the grow-old-together kind of love, irreplaceable. We'll talk about him every day, we'll never let him be forgotten."

In the lead up to the incident the Baker family was essentially homeless and struggling to makes ends meet after job losses and taking on the custody of their then five-week-old grandchild. Things had started getting back on track when Troy was put on the full-time roster at the poultry farm and Tamar was able to go back to work as a horse trainer. The pair had found a new property that for Tamar to set up a horse training business.

"What's happened in the last 12 months would tear most families apart, but it just made us stronger," Ms Baker said of the situation after her husband's death. "It was a nightmare, just awful, but we got it together, found somewhere to live and have been moving forward from that point. We were looking forward and planning for things being a bit easier again, good again."

Christmas was just around the corner when the death happened. A family friend had set up a crowd-funding page to help the family afford to pay for rent, food and bills.

"It's the worst case since I've been on the bench, all for few dollars. I find it hard to believe the working environment here ... the welfare of the chickens was treated more seriously than the safety of the workers,"

- *Magistrate Frank Jones, Geelong Court, Nov. 2017*

When the case was heard in the Geelong Magistrates Court in November 2017, WorkSafe prosecutors told Magistrate Frank Jones that there was a risk of serious injury or death to employees working near a moving forklift in near dark conditions.

While the farm responded to the WorkSafe intervention by producing revised safety procedures, the owner had 'phoenixed' the company by the time the case got to court. The fine of $1,137,525 was the biggest given to an employer in the agriculture sector and fourth biggest in Victorian OHS history. It was not paid.

"It's the worst case since I've been on the bench, all for few dollars," Magistrate Jones said. "I find it hard to believe the working environment here ... the welfare of the chickens was treated more seriously than the safety of the workers. It seems amazing to say the chickens shouldn't be upset only within a couple of hours of being slaughtered, and in this case, it cost a life." Magistrate Jones said.

In its response to the case WorkSafe's then Executive Director of Health and Safety, Marnie Williams said the tragedy was easily preventable. She described the company's methods as a "recipe for disaster".

"This company had safety procedures written down and even illustrated in a diagram, but they weren't worth the paper they were on because they'd provided none of the information or training to their employees," Williams said. "To be operating a forklift late at night with the shed illuminated by a single row of dim lights during the catching and loading process, and with no requirement for workers to wear hi-vis vests is just a staggering departure from safe working practices."

Magistrate Jones told Mr Baker's widow, Tamar, he hoped the fine would "send a message to employers".

“I don’t carry anger about the accident,” Tamar Baker responded after the case. “It should never have happened, but I don’t blame them. That’s up to them (the company), they know what they should have done and where blame lies.

“I hope it (the sentence) sets a precedent and example so that any other employer that is lax or takes shortcuts and puts its workers at risk wakes up. They need to realise if you do the wrong thing someone can die or be badly injured, and it will also cost you financially. In this case shortcuts were taken, and for a long time they got away with it, but then there was a tragedy.”

Case study 3:

The prosecution over the death of Nicholas Mackenzie

This was a typical scenario of a small builder taking a risk and making a poor decision that resulted in the death of an apprentice. The builder, Jacbe Builders P/L, faced in court in September 2017 on a serious indictable charge. The County Court fined the company $700,000 over the August 2013 collapse at a residential construction project in Caulfield. As is often the case, the company went into liquidation.

During sentencing, Judge Garbriele Cannon, touched on several fundamental matters such as the overlapping duties of principals and contractors, management control, specialist expertise about what "ought" to be known about serious risk, the ready availability of safety information on this hazard and the ongoing issue of admitting guilt related to the degree of harm.

The apprentice builder with the ñnfectiousòsmile. Nicholas Mackenzie was crushed to death at a Caulfield building site in 2013 when an overloaded floor collapse on him (see incident site, below). Bottom: Just before the collapse - lifting floor panels onto the top floor. *Source: media reports.*

The difference in this case was that the company owner, David Shane Fergusson, put his own safety at risk too. He was seriously injured in the incident and carries those 'scars' forever, in the form of limited movement of his left shoulder and arm, and as a reminder what had happened. Recovery from his injuries stopped him working for seven months and, according to further evidence given in the case, he developed a depressive disorder. However he was eventually able to set up a new building company to operate as a sub-contractor. He was helped in re-establishing the new business by employing his son as an apprentice. Meanwhile, the family of his former employee, Nicholas McKenzie, grieved over the loss of a son and brother.

Nicholas McKenzie was 21 when he died, just two weeks short of completing his apprenticeship. He and his 52-year-old boss, David Fergusson were doing carpentry work on the second floor of the Caulfield apartment project where floor trusses had been installed, in preparation for laying the floor panels.

The court heard that on the day of the incident, Fergusson supervised the craning of three packs of floor panels onto the second floor trusses. Fergusson had been retained by the principal builder, Yuri Chiorny, to do the carpentry work. They were at the site that day with other sub-contractors and Chiorny. Chiorny organised the supply of the building materials for Jacbe but it is assumed as a builder of many years expertise, Fergusson would have been aware of the specified design live load for the trusses. The evidence was that he had adopted what the judge described as an insouciant "she'll be right" attitude.

The court heard that under Fergusson's direction, the crane driver placed two packs of floor panels on top of each other at the rear of the second floor trusses, leaving an overhang of almost a metre. The third pack was placed beside the first stack. The evidence was that shortly after the delivery had been completed, Fergusson told Mackenzie to get a nailgun from the first floor. It was while the apprentice was on the first floor that the trusses collapsed under the weight and crashed through the floor near where Mackenzie and through to the ground floor. Fergusson fell to the ground floor and onto the debris, and was then struck by more falling materials. Under him was Mackenzie who was trapped by the full weight of fallen building materials.

Mackenzie and Ferguson were found in the debris by Chiorny and other contractors who were fortunate to have been clear of the flooring work. Helped by passers-by, and then emergency workers, they rescued Fergusson who had a broken arm and collar bone and fractured ribs. They tried to free Mackenzie from under the mess of broken trusses and flooring but he was already dead.

"You (Fergusson) may have been lucky on a past occasion where this did not occur, which may well have emboldened you on this occasion, but the significant risk was always there …"

- *Judge Cannon County Court Nov. 2017*

The investigation by WorkSafe that led to the prosecution of both Jacbe and Ferguson in September 2017 claimed there was no safe system of work to determine whether those trusses were capable of bearing the load. Fergusson had earlier changed his plea to not guilty on the basis that he had not been given the truss drawings by the principal builder and presumably was not aware of the load limit.

Judge Gabriele Cannon

Judge Cannon said she understood that Jacbe was not the principal builder for this job, and was not given the structural drawings, but Fergusson was "not precluded" from asking for these in circumstances where it was his role to direct the delivery of the flooring. "I accept that this was not a case of you being aware that there was a significant risk involved in what you did, but ignoring it. If this had been the case, your moral culpability and that attributed to the company would have been even higher than it already is."

Although the plea was changed back to guilty for the trial, Judge Cannon was not impressed, saying that had Jacbe not eventually pleaded guilty, she would have fined the company $1 mill, making it one of the largest fines in Victorian OHS history, and second only to the EDI Downer penalty (see case study, page 77) which would have further underlined the seriousness of the safety failure.

In her sentencing to a packed court, with Fergusson in attendance, Judge Cannon regarded the offending as "objectively" most serious. "You and your company's conduct was a significant departure from acceptable safety standards. It is fairly obvious, I would have thought, that if you place a significant weight on trusses without any regard to the load the trusses can withstand, you are taking a most significant risk that the trusses will collapse."

"You may have been lucky on a past occasion where this did not occur, which may well have emboldened you on this occasion, but the significant risk was always there by such a dangerous practice."

She said there was "a good deal" of material available about safety standards associated with this work. While this information was more accessible to large builders, she saw no reason why smaller companies would not be familiar with best practice, and comply with it. She said it was reasonably practicable for Jacbe to have its employees spread materials, such as floorboards, across the trusses as they were unloaded. It would have added nothing to project costs.

"Unfortunately, you did not have any appreciation of the risk associated with placing the flooring bundles on the trusses in the way that you did. Obviously, as a registered builder, this is something that you should have been aware of, and taken appropriate steps to deal with, so as to maximise the safety of your employees."

WorkSafe Victoria went further on these issues. After the trial its Head of Hazardous Industries, Michael Coffey, said understanding the load bearing capacity of floors under construction was a "basic" skill. "He (Nicholas) put his trust in his boss, and his boss failed him in the worst possible way. And this young man's family has been left to grieve for a lifetime," he said.

> "He put his trust in his boss, and his boss failed him in the worst possible way. And this young man's family has been left to grieve for a lifetime,"
>
> - *Michael Coffey, Head - hazardous industries, WorkSafe Victoria, Nov. 2017*

Unlike some judges, Cannon spent some time in the judgement reading out the victim impact statements to the court.

Emergency services at the site of the incident in Caulfield in 2015 that cost the life of Nicholas Mackenzie. *Source: media report.*

Nicholas' mother, Debra Mackenzie, said her son had been excited to obtain an apprenticeship. From an early age, all he wanted to be was a builder. She said her son lived by good values and was extremely loyal to his family and friends. He lit up the room and was able to engage with people of all ages.

In her statement Debra Mackenzie spoke of her feelings of depression and anxiety since Nicholas' death. She spoke of her emotional turmoil and ruminations over what might have been, having lost the chance to share in her son's success and future happiness.

His father Alan Mackenzie described the devastating impact of his son's death. He had to identify Nicholas' body and also endured the pain of carrying his son to his final resting place. He said that time had not healed the immense grief that he continues to feel, made all the worse by milestone events such as birthdays and family gatherings. He really misses the way that with his infectious smile "Nick" would bounce into a room, and the fondly remembered weekly get-togethers for a counter meal.

Nicholas' older sister Kylie said Nick was a warm, charismatic and patient soul, who everyone adored. The death of "Uncle Nick" had a devastating impact on her eldest boy. She was sad that her two younger children would never get to know their uncle. Her youngest brother was her biggest inspiration, as he had always set goals for himself, which he achieved through hard work and determination.

She said that words could not adequately express how Nick's death has affected her. She said, "You needed to know him, everyone needed to know him. He was just that amazing."

Nicholas's electrician friend, Benjamin, referred to Mackenzie as his "brother". Benjamin said he had changed profoundly as a person, after the death and had distanced himself from other friends in the tight friendship group that he and Mackenzie had previously enjoyed. After the loss of his friend he had become "super cautious" at work which had slowed him down.

Mackenzie was going to be part of his future. He planned to have him as groomsmen at his wedding, and would have been a godparent of his children, as well as a confidante.

> 'She said words could not adequately express how Nick's death has affected her … "You needed to know him … He was just that amazing."'
>
> - *Kylie Mackenzie, sister of the late Nicholas Mackenzie.*

After the court case, Debra Mackenzie said no sum of money would make up for her son's death. "Nothing is ever going to be enough … how many more deaths do we have to have?"

She told the media that there was too much complacency about "accidents" at work. She didn't want her son's death to be in vain and prayed no other family would have to go through the trauma of losing a loved one in a workplace accident. "When he died, a part of me died too," she said.

In handing down her judgement, Judge Cannon said she had taken into account Fergusson's own injuries sustained during the accident and the regret he had expressed for what had happened to his young apprentice, but the legal course he had taken had "not painted a clear picture of insightful remorse". It is also unclear what impact such harm had on an employer and how they might conduct their business in the future. In the case of Fergusson, Judge Cannon described him as having a good working record and of good character, which makes such preventative incidents even more inexplicable.

Judge Cannon noted that in many years in the industry since coming to Australia from New Zealand Fergusson had employed and trained 11 apprentices over that time, "hence contributing to the community in that way". After the tragedy and Fergusson's recovery, his new business employed two apprentices including his eldest son who had given up his teacher training to assist his father. "Therefore, you and the company have made positive contributions to the community …"

This, like many others, showed the maddening disconnection between the realities of working life for employers trying to make a living in a highly competitive modern economy and expectation and exasperation of the community about employers who flout their legal duty of care and cause serious harm as a result. It was also concerned with the concepts of deterrence and remorse when wrong had been done to others. The risk of causing harm was seen as an acceptable sacrifice to the economy and just a setback in the long term prosperity of a business when things go wrong.

Case study 4:

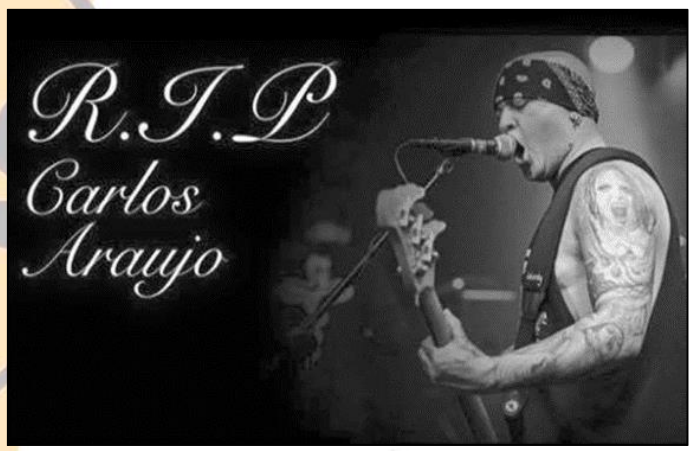
The prosecution over the death of Carlos Araujo

During the day he was a labourer for Specialised Concrete Pumping Services Victoria in its Keysborough yard. At night he was the energetic bassist of rising Melbourne heavy metal outfit, 'Crowned Kings'.

On November 12, 2015, 29-year-old Carlos Araujo was dead from fatal injuries in an incident at the Keysborough workplace. A year later when the WorkSafe prosecution was being brought to court, his employer was 'dead' too. It was therefore purely for the record that a fine of $500,000 was handed down in the County Court in early June 2018 over the safety breach that resulted in Araujo's death.

'The court was told the day after WorkSafe inspectors attended the incident the company told the regulator that it had developed an SWMS for that task.'

On the day of the 2015 incident, Araujo, two other workers and the company's operations manager were dismantling a 15m concrete pumping tower tube in preparation for loading onto a truck for transporting interstate. A forklift was lifting the tube at one end so that workers had access for unbolting the sections. As the tube was being raised, it slid off the tynes. It struck Araujo heavily in the side, crushing his ribs, and pinning him against a brick wall.



The late Carlos Araujo, playing with the Crowded Kings, and below in full flight during in a 2015 Melbourne performance before his death at work late that year. *Source media reports.*

In addressing her remarks to the sole director of the former company[36] who was in the County Court for the sentencing in February 2018, Judge Claire Quin noted that the manager operating the forklift did not wait until the workers were clear before lifting the tube.

"The gravamen of your breaches was that you allowed your employees to be left to improvise, using the forklift, making the lifting exercise of the tubing an inherently dangerous task. There were no written instructions or supervision provided relating to this task being carried out or as to the use or otherwise of the forklift with materials of this weight," the judge said.

It appeared that the company was well aware of the risk and did nothing about it, despite it being within its capability, as is

[36] Not identified in court documents but named as Ian Olifent in administration records at cessation of trading.

often the case with small/medium employer. The court was told the day after WorkSafe inspectors attended the incident the company told the regulator that it had developed an SWMS for that task. It stated that when tower tubes were unloaded off trucks they should be placed directly onto timbers so that they were already elevated. If a forklift was then required to further elevate the tower tube it would be done inside an exclusion zone and spotters oversee the task. A crane would be used to load tower tube sections onto a truck. This lack of an SWMS formed the basis of the WorkSafe prosecution.

> " … you took no steps to ensure this did not occur or to inform them of the dangerous manner in which they were undertaking the task."
>
> - *Judge Claire Quin, County Court February 2018*

WorkSafe's brief stated the use of a forklift for the particular task was inherently dangerous given the nature of the load being lifted, and that a crane should have been used instead. The company had allowed its employees to improvise a system where it should have provided a system of work for splitting the tower tube. Specialised also failed to provide instruction in that safe system of work and supervise its employees to ensure that a forklift was not used for the task.

"You have clearly fallen short of your duty to ensure the safety of your employees," Judge Quin told the director. "Although the men were not specifically directed to use the forklift in the manner in which they did or specifically directed to undertake the work in an inherently and obviously unsafe manner, you took no steps to ensure this did not occur or to inform them of the dangerous manner in which they were undertaking the task.

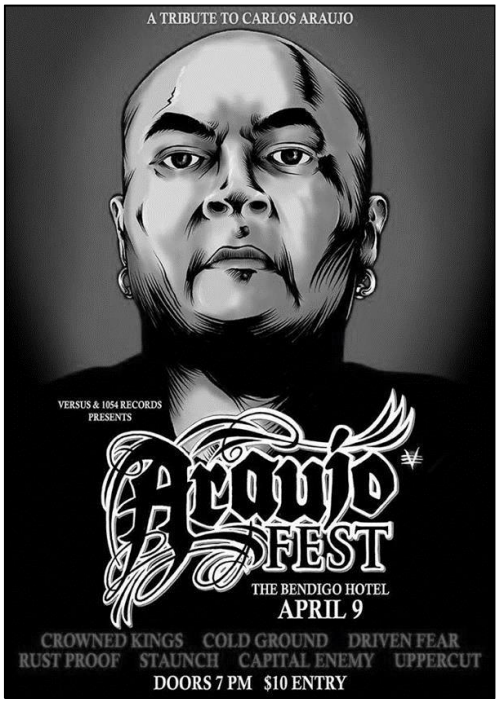
Judge Claire Quin

"The steps you should have taken to avoid the significant risk of death or serious injury was simple and available at the time of the incident," she said.

Judge Quinn said it was not suggested that unsafe practices were regularly adopted by the company. However, the risk of this tragic incident occurring was objectively high and the potential outcome grave.

"However, given that the workers were effectively left to their own devices to undertake the work in this manner, the prospect of them doing so was very real, as were the tragic consequences. It was a risk that needed to be managed."

Judge Quin treated the guilty plea as evidence of remorse but did not see any other evidence of remorse, other than full cooperation with WorkSafe investigators. She noted that the sole director had previously expressed regret to Araujo's family.



Farewell concert to Araujo in Bendigo 2016.

The grief over the death of Carlos Araujo said one very important thing about death at work in the modern age. A person's contribution, commitment and value to the community is not redefined just by what they do at work. The community is genuinely damaged and diminished when a person who has a role in the real 'work of life' is lost to the wider community where they had an impact.

Melbourne heavy metal crashers, Crowned Kings, on the rise in 2015. The band toured overseas and continued after the death Carlos Araujo (second from left). *Source: media report*

Postscript:

"Our community has lost a golden heart and we are feeling for all the bands, friends and family hurting today. To know Carlos was to feel comfort, encouragement and laughter in his presence. Though this horrible tragedy was caused by an accident, his kindness was a deliberate and natural action every day of his life. RIP sweet friend." - *Crowned Kings, 2015*

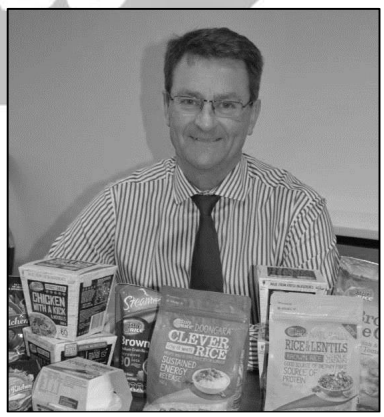
A farewell concert for Carlos Araujo was held in Bendigo on April 9, 2016 (see picture, previous page).

Case study 5: *The prosecution over the death of Chris McCann*

Ricegrowers Ltd is the public company behind the household brand, 'SunRice'. It is one of the largest rice food companies in the world and one of Australia's leading 'branded' food exporters. In September 2014, 53-year-old maintenance contractor, Chris McCann, was killed in a horror incident at the Tongala plant of its CopRice division while working on a surge bin. He died when the auger activated.

The scene of the crime: SunRice's Tongala rice mill where Chris McCann (below) was killed in 2014. Bottom, SunRice CEO, Rob Gordon: deeply saddened by the death. Health and safety was his "number one" priority. *Source: Media reports.*

SunRice was said to be a 'powerhouse' of marketing. It professed to a strong commitment to the safety of its staff and contactors across its operations. In its code of conduct it stated: "Health and safety … (is) fundamental to the way we do business. We are guided by the principle that all accidents (sic) and workplace illnesses and injuries are preventable. We are committed to being at the forefront of good work health and safety management practices and we aim to meet or exceed our obligations under work health and safety legislation and regulations wherever we operate. Our overarching measure of success is that you go home safely to your families at the end of every day."



At the time the company was being investigated by WorkSafe over the incident (2015), its CEO, Rob Gordon (see picture) said he was deeply saddened by the death and that the company had invested in safety upgrades over the past three years. He emphasised safety was his "number one" priority.

This was not some 'cowboy' operation with little understanding of or scant interest in duty of care for its employees. So what happened? In a large company it may be lip service to health and safety and as a result procedures are not followed. After a contested hearing that did little to enhance the company's corporate reputation and was scurrilous in two aspects of its defence (the defence suggested McCann had intended his own death and that WorkSafe had used improper means to gather evidence), the company pleaded guilty over the death and was fined $260,000 in April 2018. There was no mention of the death in its annual report or other corporate documents.

The case boiled down to one matter. In her sentencing remarks County Court Judge Susan Cohen said the company had breached safety standards by not installing an emergency stop button inside the surge bin. While this was not mandated or commonly used in the industry, it was ''clearly reasonably practicable as a measure to significantly reduce that risk''.

The court heard that the day before McCann died, he attended a safety meeting at the mill where he said he would work on the next day (Saturday) to fix the gate to a troublesome surge bin. The bin was classified as a confined space and could only be entered by removing an access plate at the top of the

bin. McCann was familiar with the workings of the mill, the safety procedures and other requirements. He had in fact delivered LOTO training at the mill for the company. This was part of the work procedure for the surge bin. Only weeks before he had entered the bin in accordance with a confined space entry to work on it. At that time his son Gerrin, a fitter by trade, was with him to act as the confined space observer.

On the day of the incident, Gerrin was on holidays. The court was told that the plant manager may have assumed the son would be observing that day. Chris McCann entered the bin alone, did not advise the plant manager of this, had not lodged a confined space entry permit and failed to isolate the power to the auger. One switch was near the bin, the other in the plant control room. It was known that the auger activated automatically when 'product' fed into the bin touched a sensor plate.

After the incident, parts of a timber pallet were found in the bin. According to WorkSafe, McCann had made a makeshift working platform on the beams above the auger to work on the gate. The platform had collapsed and McCann had triggered the sensor plate in his fall onto the auger.

> "… some procedures were not as assiduously followed or enforced as the policies of the company suggest, or that some complacency may have crept into the methods of those familiar with this … mill."
>
> - *Judge Cohen, County Court, April 2018*

Judge Cohen said that taking into account all the safety principles, she couldn't be satisfied beyond reasonable doubt that the breach of duty in this case did in fact cause or contribute to the death of McCann. She noted all the safety procedures, training and the fact that there was a safety meeting before the work to ensure the work was done safely.

"That very meeting suggests that subjectively some procedures were not as assiduously followed or enforced as the policies of the company suggest, or that some complacency may have crept into the methods of those familiar with this part of the workings of the mill. However, I have insufficient information to make any finding to that effect."

In then came down to the lack of an emergency stop button at the bin that would have been within reach of an observer, had there been an observer, as company procedures required. If fitted such as device may have been accessible to McCann on the day of the incident.

Judge Cohen said that although maintenance was infrequent, the configuration inside the bin held no protection for a person who was working there: "If the power was functioning to the sensor plate auger, the risk of coming into contact with the moving auger was high, and that meant the risk of extremely serious injury or death for any person coming into contact with the moving auger was very high. The need to eliminate the risk of power remaining on to the auger while a person was inside the bin was therefore critical. Even though an emergency stop button was not mandated by any regulations or industry standards, and … not commonly used in the industry, installation of an emergency stop button within reach of the access plate was clearly reasonably practicable as a measure to significantly reduce that risk."

In determining the sentence, the judge took into account the guilty plea but to lesser charges. This did not attract much leniency because of the company's late decision to change its plea. Judge Cohen also noted the defence's application to prevent victim impact statements to be heard.

"While the company was entitled to take all legal points available to it … the points it took through the committal and pre-trial stage significantly reduced the utilitarian value of the plea. These were disputed hearings lasting some days. Further, those points and the objection to victim impact statements being received, have, in my view, greatly diluted what remorse might have been inferred from the fact of the plea of guilty."

"… the objection to victim impact statements being received, have … greatly diluted what remorse might have been inferred from the … plea of guilty."

- *Judge Cohen, County Court, April 2018*

In changing its plea, the defence stated that a trial would contribute to ongoing stress to personnel at the Tongala plant. Judge Cohen had a different view. She said the company was exercising its rights on legal grounds … "However, I consider it inconsistent with genuine remorse or empathy for those close to Mr McCann. I reject the defence submission that the taking of a legitimate legal point does not affect remorse. Remorse is not a concept or state of mind based on the strict letter of the law."

That was balanced against the descriptions of the company both nationally and at the Tongala mill, taking safety seriously. "I accept that measures were taken after the incident, some of which were commenced before the prosecution began, to improve processes for risk assessments, to remind and retrain staff in such measures as well as in already existing safety requirements, and that there was a focus on the application of its safety policies and procedures to independent contractors."

Case study 6: *The prosecution over the death of Julian Fava*

The Phelpsys Constructions prosecution over a 2015 fatality that resulted in a fine of $350, 000 was an unusual case. It was not over the death of a worker and the company was not working at the location at the time.

The case was about management and control over a workplace and owning a poorly maintained and clearly unsafe item of plant that caused the death of the son of their clients. The consequence may also have been the eventual death of one of its clients, Godwin Fava, whose health, it was claimed, was affected by the loss of the son in tragic circumstances.

Julian Fava was 37 years old when he died tragically at his parents' Carrum Downs residence in June 2015. Godwin and Eugenia Fava had engaged local contactors Phelpsys Constructions to do landscaping and excavation at their property. The works did not include the nature strip, where the incident happened because it required a council permit.

On finishing work on June 9, the Phelpsys supervisor parked the company's skidsteer loader in the client's garage, intending to pick it up when they returned to complete the work a few days later. The keys were left in the ignition.

> "It is no answer at all to raise questions as to why Julian Fava was on the equipment. He was, but anyone could have met the same fate and that would include even an experienced operator employed by the company."
>
> - *Judge Tinney, County Court, February, 2018*

In the case heard before Judge Michael Tinney, in the Melbourne County Court, in February 2018, the court was told that on June 11 Julian was visiting his parents. He told his father he would help him out by borrowing the contractor's skidsteer loader to level the nature strip.

His father found him some time later at the controls of the skidsteer. He was slumped over, unconscious and bleeding from an impact to the head. The plant was bogged in the nature strip, wheels spinning still spinning, and the bucket elevated even though the safety bar had been raised. There was nothing his father could do. Paramedics pronounced his son dead at the scene.

The company had acquired the skidsteer loader the year before and had been using it despite the machine being unsafe. The investigation by WorkSafe showed the equipment had never been professionally inspected or serviced. There was no operator's manual with the machine to point out the safety features and the maintenance schedule. The company made no attempt to get one. A repair manual that was later obtained by Phelpsys did not cover the safety features or the nature of the periodic checks required. The owner's manual specified daily pre-start checks and regular weekly checks for a machine that was in regular use.

Examination of the machine by WorkSafe and the manufacturer revealed that it had numerous defects. Critical safety features were inoperative or disabled and may have been in that condition when the machine was acquired by Phelpsys. In particular the cable to the pedal lock system was broken and the seat bar switch had been bypassed. The operator didn't have to be belted in the seat or lower the safety seat bar to start the machine. This meant the machine could be started and operate by anyone with the key.

"Any competent service provider would upon examination have found these serious defects," Judge Tinney said. "They could have been easily detected and rectified. It is no answer at all to raise

questions as to why Julian Fava was on the equipment. He was, but anyone could have met the same fate and that would include even an experienced operator employed by the company."

Judge Tinney went on to say that the standards applicable to the machine were clear enough and "understandably they dictated that the controls should be arranged, de-activated or guarded so that they could not be operated unintentionally, in particular when getting in and out of the plant".

"It is common ground that these defects would have been obvious to any experienced service operator in the industry. It had never been serviced. Had the safety features been working this tragedy would not and could not have occurred."

In his judgement, the judge determined that the company "failed dismally" in engaging practicable measures to eliminate this risk. "They should have been discovered with a simple professional inspection or service and the faults were easily discovered and eliminated, if only the company had complied. Had there been any such prudent inspection or maintenance of this plant, quite simply we would not be here in court discussing this sad and tragic event."

"I expect that these tragic events would have driven home to the directors the critical nature of periodic inspections and maintenance of … equipment. Cutting corners may seem the cheap and easy way to go but it is a false economy and can produce real tragedies … "

- *Judge Tinney, County Court, February 2018*

The company was operated by brothers Brian and Eric Krepps. Judge Tinney stated the brothers, particularly Brian who was supervising the work, were deeply upset by the incident. "They would and do recognise the way in which the Fava family's life has changed forever and for the worse." He noted that Brian Krepps even attended the funeral …"They were not adopting some flippant or uncaring attitude. Quite the opposite. It was a tragedy and they know it. They feel also a sense of responsibility …"

Judge Tinney said the brothers had high hopes for what was a new business venture with good early feedback from clients and aspiration to set up a similar business in Queensland. These hopes "were dashed on June 11, 2015 and thereafter. He said the business income "plummeted", but it was it was more than that; it was also "the morale that was sapped by this awful event".

"I expect that these tragic events would have driven home to the directors the critical nature of periodic inspections and maintenance of this style of equipment. Cutting corners may seem the cheap and easy way to go but it is a false economy and can produce real tragedies such as this one. Specialist equipment requires specialist knowledge and servicing and maintenance. I would hope and trust that they never engage in such conduct again."

Judge Tinney concluded that he could not know if the company would cease to exist. "But even if it does, the directors will continue on in life as individuals. Will they operate in this area again? Will there be a corporate structure again? Whether there is or not, will they employ others? Will they manage or have any control over workplaces?"

Case study 7:

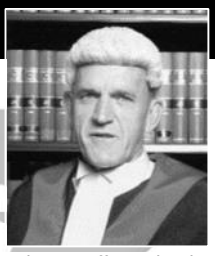
The prosecution over the death of Scott Gamble

In 2014 an employee of Redback Tree Services went to a Highett premises to quote on removing two trees. It was noted that the work would be done near powerlines.

The Moorabbin-based company had been trading successfully for more than five years and had a turnover of more than $1 mill. Sole director, Liam Peterson, (see picture, below) had 11 employees working for him by 2014, including 22-year-old arborist Scott Gamble who worked for the company for four years. Hailing from Western Australia, Gamble had recently become engaged.

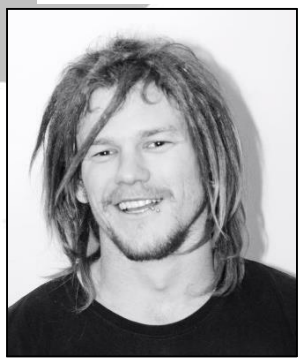
> "It appears to me that virtually nothing was done to reduce or eliminate that risk … the company relied upon the skill of Mr Gamble …"
>
> - *Judge Chettle, County Court, Nov. 2017*

Redback claimed to have an impeccable safety record in its working history in what is a potentially high risk industry where dangerous plant and fatality risks such as falls and working near powerlines, have to be constantly and carefully managed each day. That all changed on May 1, 2014, when Gamble and three other Redback arborists went to the Highett premises to do the removal work. Gamble had climbed one of the trees and was trimming branches near the powerlines when one of the branches touched them. He died from electrocution.

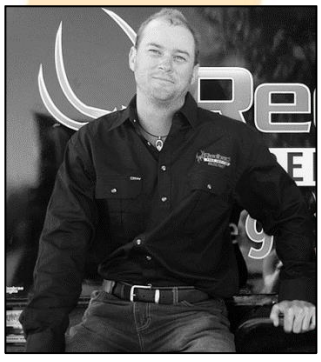


Judge Geoffrey Chettle

The County Court was told that existence of live powerlines had been clearly identified by Redback, but no "real" steps were taken to deal with that risk. Judge Geoffrey Chettle said the risk was obvious and the failure to deal with it serious: "It appears to me that virtually nothing was done to reduce or eliminate that risk. It would appear that the company relied upon the skill of Mr Gamble to avoid having branches coming in touch with the electric wires. Obviously that failed."



Gamble's WA-based parents were in court for the sentencing. They had been supported by the company and did not appear to blame the employer for the death. Following "Scottie's" death the company implemented further training and ceased work near live powerlines.



Top: the late arborist Scott Gamble and above, below emergency service workers at the scene of the Highett incident in 2014. Left: Redback's director Liam Peterson. He introduced new training after the incident. *Source: media reports.*

12. Summary and comments

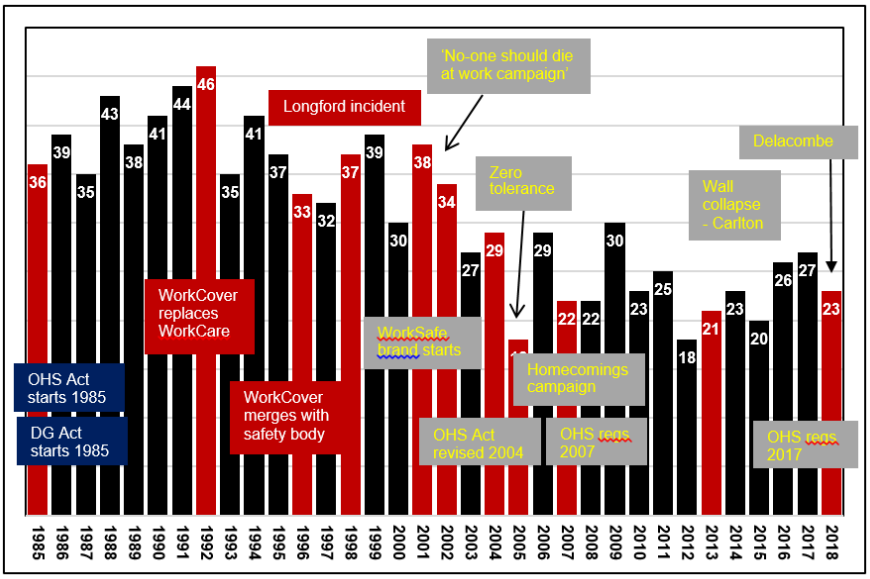
In the year of Delacombe the story of death at work became tragically and starkly simple. Too many people with the legal duty to protect those who work for them still take a risk with life. Dangerous machines killed people horribly; some fell to their death; others were electrocuted; another was suffocated while welding; yet another was trampled by cattle, and of course, the death toll was symbolised early in the year when two workers were engulfed by soil.

'It is now to the point where that final legal 'get out' clause, "so far as is reasonable practicable" no longer has any place in OHS law, nor has the concept of "foreseeability"'.

The difference in modern times is there is no excuse. Each year this behaviour becomes increasingly reprehensible in a civil society when the rule of law is supposed to bind us by delivering justice. Even the long term downward trend in fatality rate is no longer an acceptable rationalisation of any death in a state that professes to be most socially progressive and responsible in the nation.

Graph 20. Traumatic work deaths in Victoria since 1985 – historical perspectives

Note - these totals do not take into account the increase in employment levels as the Victorian economy grew and industry changes. Red text boxes denotes WorkCover and earlier bodies. Yellow text denotes WorkSafe trading brand. *Source: VWA/interpreted by OHSIntros*



It now comes down to the basic principle of applying what we know about work. We know what kills people, we know how, we know where, we know when and we know the type of employer who kills. We know how to prevent it and it has never been so easy to do this. To use a legal term, it has never been so reasonable to do this, and in a business sense it has never been so cost effective. Today there is no lack of information and assistance to make this happen. What we do know from the large number of prosecutions finalised during the year of Delacombe is that the courts are increasingly taking aim at the ignorance, wanton risk-taking and cost-cutting of offenders in determining the level of the breach and the appropriate sentence. It is just that the punishment doesn't seem to 'fit the crime', and that is an issue for prevention and deterrence. In 2018 this was never so hotly argued in public.

It is to the point where the legal 'get out' clause, "so far as is reasonable practicable" no longer has any place in OHS law, nor has the concept of "foreseeability". Prevention has become absolute because every serious high risk incident is foreseeable and the control of that risk is reasonable. Every 'reasonable' person should see this.

There is another reason to do this. In the year of the Delacombe, the community seemed increasingly intolerant of the harm that is done at work. A breach of a law that ignores the level of harm because of a fixation on arcane technical interpretations does not serve society well. It may have been OK when Victorian OHS law was first conceived in 1985, and arguably when renewed in 2004, but not anymore.

This is a time when the death rate is persistently high in Victoria, Australia's "safest" state, lauded over by the one of the "world's leading OHS regulators". There is now a rising expectation in Victoria, expressed throughout this paper about making employers more accountable. That is the business of the regulator. The message was clear in the heat-breaking grief of Delacombe, and in the noise of the industrial manslaughter campaign, and in the gravity of senate inquiry into industrial death.

'These are institutions that … have never been more challenged over their ethics, morals and values. IM raises the bar on deterrence to the highest it has been so far and it seems an appropriate sanction for such tarnished entities ...'

It eventually led to a change in Victorian government policy and a potential change in OHS law. The importance of IM is that it recognises the harm and captures negligent corporates who seem untouchable legal entities. These are institutions that conventional society has looked to for leadership but in this more complex and demanding modern age have never been more challenged over their ethics, morals and values. IM raises the bar on deterrence to the highest it has been so far and it seems an appropriate sanction for such tarnished entities, and the individuals who control them.

Should IM gain assent in 2020, the prediction is that the regulator may never have to use it. The question then becomes: should it be used if the death toll in Victoria continues to be high, as it was in 2018? In the opening phase of application of OHS law under the first OHS Act, 734 people died at work or as the result of work in Victoria (over 20 years). In the second phase under the second OHS Act introduced in 2004 the death toll has been much lower but still up to 327 (over 16 years), see Graph 20, previous page. Victoria is now effectively in a "third era" being influenced by an unprecedented reshaping of workplaces and working arrangements that will affect OHS risk management. The expectation is that the toll must be returned to a downward trend after too many shocking years, and shocking incidents. If that pattern does not markedly change, the calls will raise for IM to come into play as a prosecution option.

Ends/Appendix

Appendix 1

Official death toll 2018

Deaths at a workplace reported to WorkSafe Victoria and accepted as work-related and other fatalities related to a work situation not recognised/accepted by WorkSafe as work-related.

Death at work in Victoria 2018		
Reported fatalities at work in Victoria. Official total (provisional as at January 2019).		**Other fatalities not included in official toll (where known).**
January (3)	• 58-year-old stock agent died after he was trampled by cattle at a Georges Creek farm, near Tallangatta • 17-year-old female stable hand died after falling from a horse at a Tyaak property near Broadford • 29-year-old worker was electrocuted while working on a live switchboard at a Dandenong factory.	Nil
February (2)	• 55-year-old truck driver died after his trailer contacted overhead powerlines while unloading at a Kergunyah dairy farm, near Albury • 34-year-old groundskeeper died when struck by a branch while cutting trees at a school in Berwick.	Nil
March (3)	• 34-year-old worker died when a trench collapsed on him at a Delacombe worksite near Ballarat • 21-year-old worker died in hospital from injuries sustained in a trench collapse at a Delacombe worksite near Ballarat • 31-year-old man died after his fertiliser spreader truck rolled on an incline near Warragul.	Female member of the public killed when a logging truck collided with vehicles stopped at a roadworks in Portland.
April (1)	A 24-year-old man died after he was struck by a tractor attachment at a Carwarp orchard near Mildura.	Nil
May (2)	• 77-year-old man died after he was run over by a trailer while feeding stock at an Ouyen property • 24-year-old man died after he was entangled in a conveyor at a Benalla timber mill.	A 60-year-old man was killed while operating a backhoe attachment on a tractor at a family farm near Beaufort.
June (1)	A 50-year-old engineer died in hospital from head injuries after being struck by a piling rig at the West Gate Tunnel project site.	• man died in hospital from head injuries after a fall from a ladder at a factory. • 69-year-old pedestrian hit by tram after he fell on tracks in South Melbourne.
July (1)	A 56-year-old man died in an incident involving a tractor near a farm dam at Barjarg, near Mansfield.	Nil
August (3)	• 60-year-old DELWP employee working alone died during feral animal control work after his vehicle rolled on steep terrain at a Cheshunt property, near Mansfield • 32-year-old worker died after falling into a trench at a Wallan housing development site while detaching trench shields from an excavator • 44-year-old worker died in hospital after falling through a stair void at a Rosebud housing construction site.	A 34-year passenger in a work truck stopped in the emergency lane of ring road at Deer Park to secure a falling load and was struck and killed by a mobile crane.
September (4)	• 49-year-old female worker died when run over by a truck carrying an excavator during unloading at a Donvale property • 48-year-old man died after he was struck by a kibble of concrete that fell from a crane into a pit at a Box Hill construction site • 25-year-old worker died after he was caught in a conveyor belt at a concrete pipe manufacturer in Shepparton • 12-year-old boy died after he was run over by a tractor towing a spreader at a property near Leitchville.	A 39-year-old man died when his motorcycle crashed at a Bunnaloo farm.
October (1)	A 20-year-old welder died from suffocation while welding inside a road tanker at a Cranbourne West manufacturer.	Nil
November (2)	• 54-year-old Yallourn power station worker died in hospital from serious burns after a high voltage circuit breaker he was working on exploded • 21-year-old man died in hospital after falling from a ladder at a residential property in Bendigo while installing solar panels.	Nil
December	Nil	Male pedestrian hit and killed by an ambulance on an emergency call.
Totals	**Official total - 23**	**Unofficial total - 7**
Grand total		**30**
Source: VWA/interpreted by OHSIntros (official) and media/social media reports (unofficial)		

Appendix 2

List of offenders prosecuted 1990* to 2018 over a fatality

These are the employers, and some individuals, that have been successfully prosecuted by the Victorian WorkCover Authority (trading as WorkSafe Victoria since 2001) under the OHS Act (1985 and 2004) over a death at work. Note: includes 'OHS' risk prosecuted under the DG Act. Bold denotes prosecutions in 2017-18. Alphabetical order:

AAA Auscarts P/L
AAD Services Australia P/L
A. B. Oxford Cold Storage
A.C. Hatrick Chemicals P/L
ACN 107 424 788 P/L (formerly Haulmaster Equipment Co P/L)/Landfill Reduction
ACR Reconstruction Co P/L
ACR Roofing P/L
AGL Electricity
A.M. & P. Zanghi P/L
A.R.G. P/L
Abcor P/L
AirRoad P/L
Alex Del Brocco (director of Del Brocco Laundry and Linen Services)
Alitalia P/L
Alkay Nominees P/L
All Car Motor Wrecking P/L
Allbulk Landscaping Supplies P/L
Allseps P/L
Ambulance Victoria
Amcor Packaging (Australia) P/L (trading as Amcor Fibre Packing Australasia)
Andys Engineering P/L
A P Facilities P/L
Arnott's Biscuits P/L
Aussie Signs P/L
Australand Industrial Construction P/L
Australian Aluminium Shopfitters P/L
Australian Marble Company P/L
Australian Box Recycling P/L
Australian Steel Company (Operations) P/L (trading as Smorgon Steel)
B & P Caelli Constructions
B and B Gathercole P/L
B&D Australia P/L
BHP Steel (JLA) P/L
Bannockburn Excavations P/L
Barro Group P/L/Extec Sales and Distribution Australia P/L
Baulderstone Hornibrook P/L
Baxters Concrete P/L
Beez Neez P/L
Bendigo Gold Associates P/L
Bertocchi Smallgoods P/L
Bestaburgh P/L
Bilic Homes P/L
Blaxland Pacific P/L
Blockey Sim Tec P/L
Blue Lion Moving and Storage P/L
Bunge Meat Industries P/L
Caldwell & Pither P/L
Camden Neon P/L
Campbell Homes P/L
Candlefield P/L
Carter Holt Harvey Woodproducts Australia P/L
Charles Caughi (company director) Orbit Drilling P/L
Chien Wah Mfg P/L
Chubb Security (Australia) P/L
City Circle Recycling P/L
City Wide Services Solutions
Civil and Civic P/L
Keith Kelton
Keith William Chirnside (owner of Kerfab Industries)
Kone Elevators P/L
Kreuger Shopfitters
L. Arthur P/L
Labour Hire (Victoria) P/L
Lance Jobling
Lanore P/L (trading as Superior Reblocking and Underpinning)
Lasting Dimensions P/L/Wolfstep Projects
Leighton Contractors
Lewmarine P/L
Lilford Farms P/L
Linfox Transport Australia P/L
MA & J Tripodi P/L/Tornado Pumps and Sprayers P/L
M&M Binders P/L
Macquarie Textiles Group Ltd
Malcolm Rankin P/L
Manumatic Industries P/L
Martin & Company P/L
Martin John Smith (director of Orbit Drilling)
Marubeni Construction and Mining Equipment P/L
Mathews Timber P/L
Mawson Constructions P/L
Max Miller Carpets P/L
McCutcheon Builders P/L
McIntyre Steel Industries (Vic) P/L
Melbourne City Council
Melbourne Diving Services P/L
Melbourne Excavations and Demolitions P/L/Ecrorama
Melbourne Transit P/L
Melbourne Water Corporation
Melcann Ltd
Mildura Co-operative Fruit Company Ltd
Moama Refinery P/L
Monst P/L (formerly Lloyd Brewer Marine P/L)
Mulcany Pastoral Holdings P/L
Multigroup Distribution Services P/L (trading as Star Track Express P/L)
Multiplex Constructions (Vic) P/L
National Forge (Trading as West Footscray Engineering)
National Pile P/L/Obayashi//Transfield P/L
Nationwide Towing & Transport P/L
Nautical Training Australia P/L
New Home Caravans
Nibur Nominees P/L
Nikolic P/L
Northgate Ridge P/L/Abcor P/L
Nufarm Australia Ltd
Obayashi
One Step Concrete & Pumping P/L
Orbit Drilling P/L
P&O Ports Ltd
P and K Maher P/L/Unique Excavations P/L
Pacific Dunlop Ltd
Pacific National (ACT) P/L
Pacific Waste Management P/L
Page Data P/L/Toll Ipec
Paper Australia P/L
Patrick Stevedores No. 1 P/L
Paul Alan Francis (trading as Able Tree Services)

CLM Infrastructure P/L
Coates Hire Operations P/L
Combined Concrete Pumping P/L
Concorp (Melbourne) P/L
Concrete Constructions (trading as Lewis Construction Company)
Cook's Construction P/L
Cool Dynamics Refrigeration P/L
Corio Bay Plumbing P/L
CK Crouch P/L
Crystal Transport P/L
Dandenong Heavy Haulage P/L
Davey Products P/L
David Shane Fergusson
Dechi P/L
Denbro P/L
Deistra
DJA Homes
Depot Vic P/L (formerly Hyde Park Tank Depot P/L)
DMP Poultech P/L
Downer EDI Works P/L
Drybulk P/L
Dynamic Demolitions P/L
E Brockman and Sons P/L
East End Hire P/L
Eclipse Rural P/L
Ecrorama
Elliott Engineering P/L
Emack Riggers P/L
Energy Brix
Enetech P/L
Enfield Forge
Esso Australia
Evans Brothers (Bricks) P/L
Evans Deakin Industries
Evison Grain
Exopest Australia P/L
Extec Sales and Distribution Australia P/L
F. Alves Constructions
FRH Victoria P/L
Frewstal P/L
Fletcher Construction Australia Ltd
Flickers (Australia) P/L
Foamex Manufacturing P/L
Fonterra Australia P/L
Foscor P/L
Fosters Australia P/L
Frankipile Australia P/L
Fraser Enterprises (trading as Northern Fertilisers)
Gardner Smith P/L
Garrick and Dind P/L/Esso Australia
Garry Lakey Refrigeration Services P/L
Gary Charles Reid (trading as Advance Cartons)
Geelong Commercial Cleaners P/L
Gippsland Field Days
Goodyear Australia Ltd
Goudco P/L
GrainCorp Operations Ltd
Grayling Electrical P/L
Grocon (Victoria Street) P/L
GTS Freight Management
Gunther Mayr
H&H Contracting
HL & T & DL P/L
Hajel P/L
Hanson Yuncken
Hillcrest Private Nursing Home P/L
Hillcrest Tyrepower (Lilydale) P/L
Hindmarsh Waterboard
Huntingdale Mobile Cranes
ICI Australia Operations P/L
Ingham's Enterprises
Paul Greenway Hoffman (director of Keswick Willows P/L)
Permanent Erection Constructions P/L
Petroleum Refineries (Australia) P/L
Petra Simic
Phelpsys Constructions P/L
Pilkington (Australia) Ltd
Pilkington (Australia) Operations Ltd
Pivot Ltd
Polmere P/L (trading as Outback Trenching Services)/Rowland's
Underground Technology P/L
Polycell Australia P/L
Portland Pine Products P/L
Pressfast Industries P/L
Public Transport Corporation
R and D Roofing P/L
R&M Mascitti Developments P/L
R&T Tree Services
RJ & V Stracey P/L
RJ Lee Construction P/L
Race Industries P/L
Ricegrowers Limited
Rail Technical Support Group
Rapid Roller Co P/L
Redback Tree Services P/L
Redline Towing and Salvage P/L
Resources Recovery Victoria P/L
Retmar P/L
Roads Corporation T/A VicRoads
Robert Mascitti
Robert Thorne
Rodney James Damon (proprietor of Allabout Restumping)
Ronald Wilson Rafferty
Rossco Sunraysia Irrigation Contractors P/L
S.C.I. Steel Mill P/L
SCI Steel Mill P/L
SDS Beverages P/L
SPI Powernet P/L
Sebastian Ferraro
Seddon Cycles
Shell Company of Australia Ltd
Shell Refining (Australia) P/L
Shepparton Brick and Paving P/L
Shepparton Terrazzo Works P/L
Silcar P/L
Skilled Engineering Ltd
Sleep Better Bedding P/L
Southcorp Holdings Ltd
Specialised Concrete Pumping Victoria P/L
Stanley Guthrie (director of Manumatic Industries)
State Electricity Commission of Victoria
State Emergency Service
Staunton Industries (Aust) P/L
Stephen Wallace Rodger (trading as CTM Engineering)
Steven Kovac
Structural Systems (Southern) P/L
TCMH Holdings P/L
Tabro Meat P/L
The JMAL Group P/L
The Pasta Master P/L
Tim Campbell Moore
Toll Transport P/L
Tooradin Excavations P/L
Tornado Pumps and Sprayers P/L
Trans Ocean Terminals P/L
Transfield P/L
Turi Foods Farming Division P/L
Tyremarketers P/L
United Energy Ltd/Skilled Engineering Ltd
Unique Excavations P/L
Van Leer Australia P/L
Vibro-Pile (Aust.) P/L

Interbuild Resources P/L
J&K Zausa Investments P/L
JD Coates P/L
J. Anderson & Co P/L
Jacbe Builders P/L
Jalor Tools P/L
Jarle Knitting Mills P/L
John Ewan Wilkie
John Tormey (officer of Inghams Enterprises)
KT Preston and Sons
Kakos Trolley Services P/L
Vicgrain
Vox Retail Group Ltd
WCA (Vic) P/L
Wayne Robert Pollard
We Fix M P/L (trading as Inverloch Motor Body Works)
Wiltshire and Rattray Haynes Industry P/L
Wing Cheon Chan (trading as Wing Furniture)
Winnipeg Textiles P/L
Wolfstep Projects
Wootanga Park P/L
World Services and Construction P/L/Shell Company of Australia Ltd
Yarra Valley Water Ltd

Source: VWA/interpreted by OHSIntros
**no OHS prosecutions have been recorded by the VWA or related bodies between 1985-1990*
NOTE: Pleas and penalties varied. Some fines were never paid

Appendix 3

Major prosecutions in Victoria over a fatality

These are the highest fines handed down by the courts as a result of a prosecution by the Victorian WorkCover Authority/WorkSafe Victoria under the OHS Act since 1985 over a death at work in Victoria ($300,000 or more).

Shading denotes highest fines in main industry sector. Bold denotes most recent cases.

Note: The list does not fully reflect the seriousness of earlier cases. Higher fines were available to Victorian courts in later years, particularly after the revision of the OHS Act in 2004. More recent cases will therefore be over-represented in this ranking by severity of the penalty.

Largest fines imposed under the OHS Act for a prosecution brought by the Victorian WorkCover Authority over a death at work: to June 30, 2018 NOTE: Some fines were not paid.			
Offender	*Industry*	*Incident**	*Court fine/case date*
Esso Australia	Manufacturing	September 1998. Explosion and fire at Longford plant resulting in two workers being killed.	$2,000,000 (2001)
AAA Auscarts P/L	Recreation	October 2006. Woman driving a go-cart slowly around a track during a work function struck a tyre barrier resulting in fatal injuries.	$1,400,000 (2009)
Downer EDI Works P/L	**Construction**	**November 2011. Traffic management worker struck by a road sweeper that reversed into an exclusion zone. VicRoads also fined. Plant operator convicted and given bond.**	**$1,300,000 (2017)**
CK Crouch P/L (in liquidation)	**Agriculture**	**December 2015. Worker hit and killed by a forklift during chicken catching and loading cages.**	**$1,137,525 (2017)**
Fosters Australia P/L	Manufacturing	April 2006. Worker trapped while undertaking maintenance on an inadequately guarded palletising machine.	$1,125,000 (2008)
Toll Transport P/L	Stevedoring	May 2014. Stevedore run over and killed by plant at the docks.	$1,000,000 (2016)
Australian Box Recycling P/L	Recycling	August 2014 Hoist failed and fell on worker during loading.	$800,000 (2016)
Frankipile P/L	Construction	May 2011. Dogman fell when top mast snapped on drilling rig.	$750,000 (2015#)
Vibro-pile (Aust) P/L	Construction	May 2011. Dogman fell when top mast snapped on drilling rig (same incident as Frankipile, above).	$750,000 (2015#)
Orbit Drilling P/L	Construction	December 2006. Employee from Western Australia died when an unsafe drill rig truck he was driving crashed down a steep incline.	$750,000 (2010)
Hajel P/L	Community services	October 2006. Worker cleaning an ironing machine caught his glove in a roller and was dragged into the machine.	$750,000 (2009)
Jacbe Builders P/L	**Construction**	**August 2013. Floors collapses under weight of trusses during loading and onto apprentice below. Company director also prosecuted.**	**$700,000 (2017)**
Barro Group P/L	Quarrying	July 2005. Man died carrying out maintenance on a mobile rock crusher.	$650,000 (2009)
P&O Ports Ltd	Stevedoring	June 2003. Worker struck by container and fell into hold of ship.	$500,000 (2006)
Depot Vic P/L (formerly Hyde Park Tank Depot P/L)	Plant maintenance	August 2007. Worker overcome by chemical fumes in a tank during cleaning.	$500,000 (2009)
Coates Hire Operations P/L	Plant hire	February 2007.Truck driver crushed while loading an EWP onto the trailer of his truck.	$500,000 (2010)
Specialised Concrete Pumping Victoria P/L	Construction	December 2015. Worker crushed by load being lifted unsafely by forklift in materials yard.	$500,000 (2018)
Hanson Yuncken	Construction	September 2010. Ground underneath an EWP was unstable causing glazier to fall.	$475,000 (2013)
Silcar P/L	Mining	October 2006. Worker crushed by steel beam during maintenance on an overburden conveyor.	$475,000 (2010)

Nationwide Towing & Transport P/L	Transport	January 2007. Worker sustained fatal injuries when an excavator fell off his truck as he was loading it.	$450,000 (2011)
Lilford Farms P/L	Agriculture	November 2014. Teenager working for his fatherÕs labour hire business was killed when a forklift he was using at a farm tipped over.	$450,000 (2016)
Ambulance Victoria	**Community services**	**January 2015. Employee found dead at Heywood Ambulance Station after accessing inadequately stored and secured dangerous drugs.**	**$400,000 (2018)**
DMP Poultech P/L	Manufacturing	December 2005. Truck driver died when a steel module fell on him during unloading by a forklift driven by an unlicensed operator.	$400,000 (2008)
Elliott Engineering P/L	Manufacturing	February 2011. Employee fatally crushed by a steel panel while inside a shipping container.	$400,000 (2014)
Melbourne Water Corporation	Utilities	December 2011. Contractor fell through a loose walkway grate into a sewer channel while taking samples and drowned.	$400,000 (2014)
Rapid Roller Co P/L	Manufacturing	June 2007. Worker suffered fatal injuries when he was dragged into a lathe while cleaning a roller.	$376,000 (2009)
Baulderstone Hornibrook P/L	Construction	August 2001. Crane counter-weights dislodged and fell. They struck an Alimak occupied by a construction worker.	$375,000 (2004)
AirRoad P/L	Transport	January 2010. Truck driver died when computer fell on him while it was being removed from his truck by forklift.	$375,000 (2012)
Amcor Packaging (Australia) P/L	Manufacturing	March 2003. Worker died after being caught in an unguarded paper-making machine.	$350,000 (2005)
Permanent Erection Constructions P/L	Construction	June 2006. Worker fell to death after partially built floor collapsed under weight of building blocks loaded on it.	$350,000 (2010)
Australand Industrial Construction P/L	Construction	April 2008. Steel frame collapsed on worker at warehouse construction site.	$350,000 (2011)
Phelpsys Constructions P/L	**Construction**	**June 2015. Man found dead at controls of an unsafe skid steer loader left unsecured at residence during works.**	**$350,000 (2018)**
Tooradin Excavations P/L (formerly t/a TGS Sand and Soil P/L)	Quarrying	November 2010. Quarry wall face collapsed on excavator, killing operator.	$340,000 (2014)
L. Arthur P/L	Stevedoring	July 2010. P&O employee crushed by a metal beam that fell while unloading large steel drum at docks.	$330,000 (2013)
Leighton Contractors Construction	Construction	November 2002. Bridge under construction collapsed, killing one and injuring four others.	$325,000 (2004)
Pilkington (Australia) Operations Ltd	Manufacturing	November 2001. Worker crushed by load falling from reversing forklift he was guiding. Died from injuries.	$310,000 (2004)
Camden Neon P/L	Electrical	April 2006. Worker electrocuted while changing bulbs on sign.	$300,000 (2007)
B&D Australia P/L	Manufacturing	November 2006. Worker lifting a large, long tube when it fell and killed him.	$300,000 (2009)
Fonterra Australia P/L	Manufacturing	September 2009. Forklift driver died when a one tonne bag of salt fell on him.	$300,000 (2011)
Nufarm Australia Ltd	Manufacturing	May 2013. Contractor died after being exposed to toxic chemical while working under a pipe without PPE.	$300,000 (2013)
Bilic Homes P/L	Construction	June 2014. Wall collapsed on carpenter.	$300,000 (2016)
Cool Dynamics Refrigeration P/L	Construction	December 2011. Explosion in worker's van due to lack of venting of flammable gas. Died in hospital.	$285,000 (2015)+
Baxters Concrete P/L	Construction	December 2009. Worker killed when hit on the head by the boom of a concrete pump.	$280,000 (2012)
Monst P/L (formerly Lloyd Brewer Marine P/L)	Manufacturing	December 2011. Contractor killed when the hoist of a gantry crane fell on him after becoming entangled in the mast of a forklift.	$275,000 (2013)
The JMAL Group P/L	**Transport**	**August 2015. Delivery van collided with a crane being loaded onto a low loader by the driver.**	**$275,000 (2017)**
Ricegrowers Ltd	**Agriculture**	**September 2014. Worker fatally injured when screw conveyor operated inside surge bin during maintenance.**	**$260,000 (2018)**
Interbuild Resources P/L	Construction	January 2005. Host worker fell through penetration in floor on to slab. Supervisor also fined $20,000.	$250,000 (2008)

R&M Mascitti Developments P/L	Construction	March 2006. Tilt-up panel fell on worker at a factory construction site.	$250,000 (2009)
Wootanga Park P/L	Agriculture	March 2007. Truck struck quad bike being ridden by stable hand, killing him.	$250,000 (2009)
Australian Aluminium Shopfitters P/L	Construction	January 2010. Worker fell seven storeys to death from a mobile platform as it was being raised.	$250,000 (2012)
Grocon (Victoria Street) P/L	Construction	March 2013. Brick wall on site perimeter and hoarding collapsed on street killing three pedestrians.	$250,000 (2014)
Frewstal P/L	Manufacturing	September 2013. Abattoir gangway collapsed on delivery driver fatally injuring him.	$250,000 (2015)
Aussie Signs P/L	Construction	March 2013. See Grocon wall collapse	$250,000 (2016)
Roads Corporation T/A VicRoads	**Construction**	**November 2011. Traffic management worker struck and killed by road sweeper reversing into exclusion zone. See Downer EDI Works P/L case. Plant operator also convicted and given bond.**	**$250,000 (2017)**

* Reported fatality
# Total following DPP appeal in March 2016
+ fine under the DG Act
Source: VWA/interpreted by OHSIntros

Appendix 4

Official inclusions and exclusions.
Reported fatalities in Victoria

What is included?
Definition of reported fatalities (traumatic deaths at work notified to and investigated by WorkSafe Victoria) and counted as 'reported fatalities':

1. Death notified to WorkSafe Victoria*, and occurred at a workplace or arises out of the conduct of an employer's/self-employed person's undertaking, within the jurisdiction of the OHS Act:
   a) an employee of an employer
   b) a self-employed person working on own premises (eg farmer)
   c) a self-employed person engaged to do work at a workplace controlled by an employer
   d) a self-employed person engaged by a Victorian private citizen to do work at premises controlled by the private citizen
   e) any other person present in a workplace (eg visitor to the workplace; family member of an employer/self-employed person; contractor and his/her employee engaged to do work at a workplace controlled by an employer in WorkSafe 's jurisdiction; Commonwealth contractor and his/her employee engaged to do work at a workplace controlled by an employer in WorkSafe's jurisdiction - if the Commonwealth contractor is not covered by OHS [Commonwealth Employment] Act 1991
   f) any person, as a consequence of faulty work or unsafe practices performed by an employer, employee or self-employed person (eg faulty electrical work)
   g) any person, as a consequence of the acts or omissions of a designer, manufacturer, importer, supplier, erector or installer of plant for use in a workplace, or of a manufacturer, importer or supplier of a substance for use in a workplace.

2. Death is notified to WorkSafe of any person as a consequence of the operation of equipment prescribed under the Equipment (Public Safety) (General) Regulations 2007.

3. Death notified to WorkSafe of any person as a consequence of an incident involving dangerous goods defined under the Dangerous Goods Act 1985.

**s38 of the OHS Act 2004 – an employer or self-employed person must notify the regulator of any incident at work resulting in a death. See Table for details.*

Duty to notify the regulator after an incident at a workplace – s38	
Notification required following work harm (ie harm from serious incident that could have resulted in a death):	Notification required of the following incident near a person (ie serious incident that could have been fatal):

• any death at work
• medical treatment within 48 hours of exposure to a substance
• treatment as an in-patient in a hospital
• medical treatment for:
  ○ an amputation
  ○ serious head injury
  ○ serious eye injury
  ○ separation of skin (eg de-gloving or scalping)
  ○ electric shock
  ○ spinal injury
  ○ loss of a bodily function
  ○ serious lacerations.
	• the collapse, overturning, failure or malfunction of, or damage to any licensed or registered plant
	• the collapse or failure of an excavation or of any shoring supporting an excavation
	• the collapse of all or part of a building or structure
	• an implosion, explosion or fire
	• the escape, spillage or leakage of dangerous goods
	• in a mine, the fall of any plant, substance or object, the overturning or collapse of any plant, inrush of water, mud or gas or interruption of ventilation.

Note: notification is not required if the employer or self-employed person is the only person harmed.	

What is excluded?
a) deaths determined to be strictly of natural causes or by suicide
b) traffic accidents (unless WorkSafe becomes aware there are or are likely to be work-related causes)
c) police, security guards, bank staff and shop staff etc. killed in the course of traditional crime (eg armed robbery)
d) deaths of persons other than those employed or engaged to work on railway lines as a result of train incidents
e) deaths of employees, self-employed persons or other persons covered by legislation not administered by WorkSafe (eg fatalities in mineral mines, or on ships subject to the Occupational Health and Safety [Maritime Industry] Act 1994).

Note: Also excludes deaths involving work at sea and during air transport in Victoria and where the workplace is in the jurisdiction of Comcare eg federal public service, including operational agencies such as AFP and some national employers including those delegated/contracted by government to deliver public services.
Source: WorkSafe/datavic

Safe Work Australia national data - inclusions and exclusions.

What is included?

The scope of the collection includes everyone:

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

The report includes everyone killed:

- while working including unpaid volunteers and family workers, carrying out work experience, and defence force personnel killed within Australian territories or territorial waters or travelling for work (worker fatalities)
- as a result of someone else's work activity (bystander fatalities).

What is excluded?

The collection excludes those who died:

- of iatrogenic injuries (due to medical intervention)
- due to natural causes such as heart attacks and strokes, except where a work-related injury was the direct cause of the heart attack or stroke
- as a result of diseases, such as cancers
- by self-inflicted injuries (suicide)
- of injuries caused by someone else's work activity while they are classified as a worker rather than a bystander.

Source: SWA 7

Appendix 5

Announcement by government commitment to industrial manslaughter in Victoria.

Media Release

The Hon Daniel Andrews MP
Premier

Saturday, 26 May 2018

WORKPLACE MANSLAUGHTER LAWS TO PROTECT VICTORIANS

Employers whose negligence leads to the death of an employee will face up to 20 years in jail under tough new laws to be introduced by a re-elected Andrews Labor Government.

Up to 30 people are killed at work in Victoria every year – this is 30 deaths too many.

The penalty must be a strong enough deterrent to make employers take workplace safety seriously, and not rely on deep pockets to avoid accountability while cutting corners on safety.

That's why a re-elected Andrews Labor Government will create a new criminal offence of workplace manslaughter in the *Occupational Health and Safety Act 2004*.

Under the proposed new law, employers will face fines of almost $16 million and individuals responsible for negligently causing death will be held to account and face up to 20 years in jail.

A re-elected Andrews Labor Government will make sure all Victorians are safe in our workplaces, with the offence to also apply when an employer's negligent conduct causes the death of an innocent member of the public.

This new law sends a strong message that putting people's lives at risk in the workplace will not be tolerated.

WorkSafe will be responsible for prosecuting employers who do the wrong thing and will be given the powers and resources needed to carry out justice.

This law will save lives and it's vital we get it right – that's why a re-elected Labor Government will establish an Implementation Taskforce, including business and unions, to consult on the detail of the proposed laws.

All Victorians deserve to come home from work each day, safe and sound – a re-elected Andrews Labor Government will help make sure they do.

Quotes attributable to Premier Daniel Andrews

"It couldn't be more simple: no one should die at work. These laws will help make sure that every Victorian makes it home to their loved ones."

"Families who have lost a loved one at work deserve justice – and that means jail, not a slap on the wrist."

Appendix 6

Senate report: recommendations

Senate Education and Employment References Committee inquiry report, *They never came home - the framework surrounding the prevention, investigation and prosecution of industrial deaths in Australia,* October 2018.

Recommendations from the senate report relating to all OHS/compensation bodies, October 2018, and Australian Government response to the report, December 2018.

Senate committee recommendations	Government response
Recommendation 1 3.14 Safe Work Australia expands the work-related traumatic injury fatalities data set to capture data on deaths resulting from industrial diseases.	**Supported in principle**
Recommendation 2 3.24 Safe Work Australia maintains a public list of amendments that jurisdictions make to the model WHS laws.	**Supported**
Recommendation 3* 3.32 Safe Work Australia works with WHS regulators in each jurisdiction to collect and publish a dataset which provides annually updated and detailed information on the prosecution of industrial deaths.	
Recommendation 4 3.38 The Boland review[37] considers the recommendations of this inquiry in its review into the model WHS laws	
Recommendation 5 3.62 Safe Work Australia works with Commonwealth, State and Territory governments to: • update the model WHS framework to cover precarious and non-standard working arrangements (including labour hire) to clarify the extent, scope and nature of the primary duty of care and the obligation under the model WHS Act on duty-holders to consult with each other, as well as workers and their representatives; and • pursue approval of these arrangements in other jurisdictions through the formal harmonisation of WHS laws process.	**Noted**
Recommendation 6 4.39 Commonwealth, State and Territory governments ensure that their WHS regulators are adequately funded and resourced to allow them to complete investigations in a timely, thorough and effective manner.	**Supported**
Recommendation 7 4.40 Safe Work Australia works with Commonwealth, State and Territory governments and WHS regulators to develop and deliver standardised training modules to ensure that all investigators have the appropriate skills, experience and attitude to carry out high-quality investigations of industrial deaths and other serious breaches of WHS laws. 4.41 In the absence of a joint approach, the committee encourages all Commonwealth, State and Territory governments and WHS regulators to pursue this recommendation individually.	**Supported in principle**
Recommendation 8 4.42 Safe Work Australia works with Commonwealth, State and Territory governments and WHS regulators to: • establish best practice guidelines for the conduct and duration of investigations of serious WHS law breaches, including workplace deaths, which include guidance on the criteria that must be satisfied if an investigation needs to be extended past the usual allocated timeframe; and • ensure that each jurisdiction is able to fully implement these guidelines. • 4.43 In the absence of a joint approach, the committee encourages all Commonwealth, State and Territory governments and WHS regulators to pursue this recommendation individually.	**Supported**
Recommendation 9 4.44 Safe Work Australia works with WHS regulators to develop a policy to formalise collaboration and evidence sharing between WHS regulators and law enforcement agencies during investigations following an industrial death.	
Recommendation 10 4.45 Safe Work Australia works with WHS regulators in each jurisdiction to develop a policy which stipulates that all industrial deaths must be investigated as potential crime scenes.	**Supported in principle**
Recommendation 11 4.56 Safe Work Australia pursue amendments to the model WHS laws to enable a regulator or law enforcement agency in one jurisdiction to assist a second regulator or law enforcement agency in a cross-border investigation, including in the sharing of evidence and other relevant information.	

[37] *Review of the model WHS laws: Final report*, Safe Work Australia 2018
https://www.safeworkaustralia.gov.au/doc/review-model-whs-laws-final-report

Recommendation 12 4.62 Commonwealth, State and Territory governments ensure that adequate funding and resourcing is allocated to their WHS regulators to allow for increased, more effective preventative activities in workplaces.	
Recommendation 13 5.54 Safe Work Australia works with Commonwealth, State and Territory governments to: • introduce a nationally consistent industrial manslaughter offence into the model WHS laws, using the Queensland laws as a starting point; and • pursue adoption of this amendment in other jurisdictions through the formal harmonisation of WHS laws process.	**Noted**
Recommendation 14 5.66 Safe Work Australia works with Commonwealth, State and Territory governments to: • amend the model WHS laws to include the establishment of a dedicated WHS prosecutor in each jurisdiction, similar to the model introduced in Queensland; and • pursue adoption of this amendment in other jurisdictions through the formal harmonisation of WHS laws process.	
Recommendation 15 5.67 Safe Work Australia works with Commonwealth, State and Territory governments to: • amend the model WHS laws to provide that a WHS regulator must in all relevant circumstances provide a published, written justification for why it chose not to bring a prosecution following an industrial death; and • pursue adoption of this amendment in other jurisdictions through the formal harmonisation of WHS laws process.	
Recommendation 16 5.68 Safe Work Australia works with Commonwealth, State and Territory governments to: • amend the model WHS laws to provide that a WHS regulator must provide a published, written justification for why a coronial inquest following an industrial death was not conducted; and • pursue adoption of this amendment in other jurisdictions through the formal harmonisation of WHS laws process.	**Supported in principle**
Recommendation 17 5.76 Safe Work Australia works with Commonwealth, State and Territory governments to: • amend the model WHS laws to provide for unions, injured workers and their families to bring prosecutions; and • pursue adoption of this amendment in other jurisdictions through the formal harmonisation of WHS laws process.	**Not supported**
Recommendation 18 5.82 Safe Work Australia works with Commonwealth, State and Territory governments to: • amend the model WHS laws to revise the definition of 'officer' to better reflect the capacity of the person to significantly affect health and safety outcomes; and • pursue adoption of this amendment in other jurisdictions through the formal harmonisation of WHS laws process.	**Noted**
Recommendation 19 5.89 Section 232 of the model WHS Act be amended to broaden the limitation period for prosecutions of industrial manslaughter.	**Supported in principle**
Recommendation 20 5.106 Safe Work Australia works with Commonwealth, State and Territory governments to: • develop national sentencing guidelines, with direction from the UK experience, and look to undertake consultation with relevant stakeholders about the matter; and • review levels of monetary penalties in the model WHS legislation to consider whether there should be increased penalties for larger businesses or repeat offenders.	
Recommendation 21 5.122 Safe Work Australia works with Commonwealth, State and Territory governments to: • amend the model WHS laws to make it unlawful to insure against a fine, investigation costs or defence costs where they apply to an alleged breach of WHS legislation; and • pursue adoption of this amendment in other jurisdictions through the formal harmonisation of WHS laws process.	
Recommendation 22 5.134 Commonwealth Government works to implement its announced reforms to combat phoenixing, such as the Director Identification Number scheme, as swiftly as possible.	**Supported**
Recommendation 23 6.14 Safe Work Australia engages with WHS regulators and emergency services providers in each jurisdiction to develop clear guidelines for the notification of families of an industrial death, with a focus on timeliness and the manner in which the notification is made.	**Strongly supported**
Recommendation 24 6.31 Safe Work Australia collaborates with WHS regulators in each jurisdiction to review, improve and formalise their practices to make the investigation processes as transparent as possible to impacted families, including by providing written guidance on the formal stages of the investigation, regular updates on the progress of an investigation, the reasons for decisions and the future direction of the investigation.	
Recommendation 25 6.32 Safe Work Australia collaborates with governments and WHS regulators in each jurisdiction to provide for dedicated liaison officers to supply information to families about the process of investigations, prosecutions and other formal processes following an industrial death.	

Recommendation 26 6.33 Safe Work Australia looks to establish a forum for families to submit and publish impact statements in order to give them a voice and outlet for their experiences in the processes that follow an industrial death.	
Recommendation 27 6.47 Safe Work Australia works with the WHS regulator in each jurisdiction to establish advisory committees designed to give advice and make recommendations to the relevant minister about the information and support needs of persons who have been affected directly or indirectly by a workplace incident that involves a death, serious injury or serious illness.	
Recommendation 28 6.62 Safe Work Australia works with the WHS regulator in each jurisdiction to identify and formalise family outreach mechanisms to ensure that all impacted families receive information about the formal processes that follow an industrial death and the associated support that is available to them.	
Recommendation 29 6.63 Safe Work Australia works with the WHS regulator in each jurisdiction to create and maintain a centralised web portal which links to all relevant resources that impacted families may need in the aftermath of an industrial death.	
Recommendation 30 6.64 Safe Work Australia works with the WHS regulator in each jurisdiction to fund a support group or service that is experienced in working with people bereaved by a fatal workplace incident to support impacted families through all formal processes following an industrial death.	**Noted**
Recommendation 31 6.65 Safe Work Australia works with the WHS regulator in each jurisdiction to make funding available for impacted families to access a range of mental health and counselling support options, including in rural and regional areas.	
Recommendation 32 6.66 Safe Work Australia collaborates with the WHS regulator in each jurisdiction to develop an initiative (similar to the Coronial Legal Assistance Service in operation in Queensland) to provide for pro bono legal assistance to families during coronial inquests.	
Recommendation 33 6.67 Safe Work Australia work with the WHS regulator in each jurisdiction to ensure that all staff with access to impacted families have adequate training in working with grieving family members.	**Supported**
Recommendation 34 6.68 Safe Work Australia collaborates with each jurisdiction to review the adequacy of workers' compensation legislation with regard to all work related deaths.	**Supported in principle**
**abbr. See full report for details*	

VICTORIAN
TRADES HALL
COUNCIL

weareunion.org.au

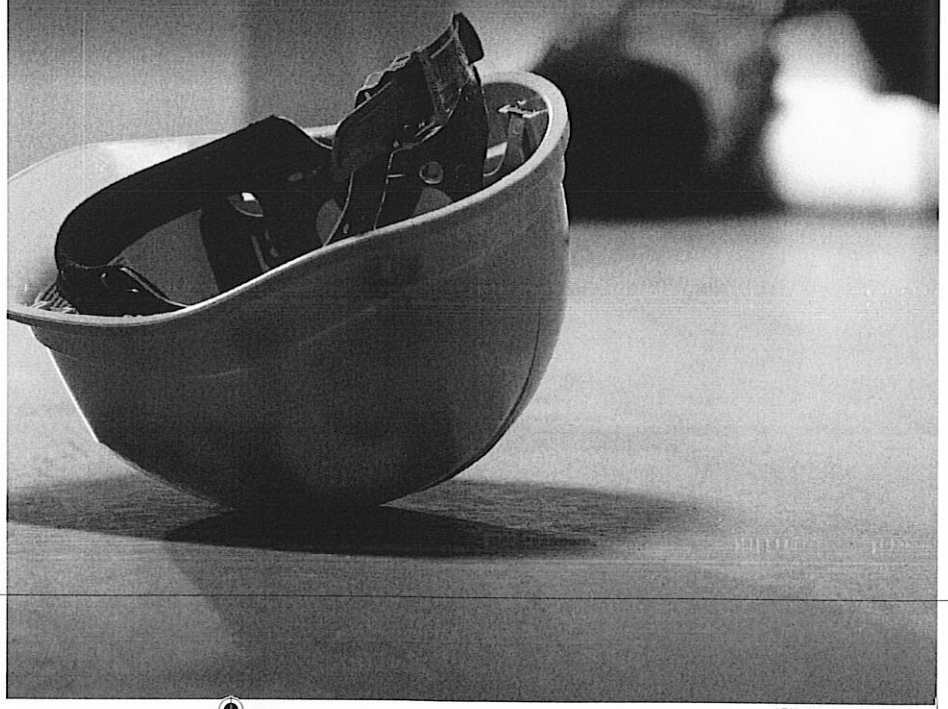
INDUSTRIAL MANSLAUGHTER

Ministerial Brief

INTRODUCTION

Urgent reform is required to ensure that Victorians are provided with the best protection possible from corporate negligence. Our current laws are manifestly inadequate to deal with corporate negligence which kills innocent people. Following Queensland, the United Kingdom, Canada and the ACT, it is time Victoria made corporate and industrial manslaughter a crime.

CONTENTS



REDBACK TREE SERVICES

On 1 May 2014, 22 year old Scott Gamble was killed when a branch he was working on hit a nearby powerline. Mr Gamble died working on a tree removal job for Redback Tree Services. When Redback Tree Services quoted for the job on 2 April 2014, the manager observed that powerlines were within 2-3m of the tree in question. WorkSafe alleged that while a SWMS noted the risk of the powerlines, the SWMS did not provide any control for the risk of hitting the powerlines.[1] The Court held:

> *Although the risk the existence of live powerlines had been identified by Redback, no real steps were taken to deal with that risk. The power was not shut down or suppressed.*
>
> *There was a clear risk identified of death and/or serious injury, created by working so close to the live powerlines...it appears to me that virtually nothing was done to reduce or eliminate that risk. It would appear that the company relied upon the skill of Mr Gamble to avoid having branches coming in touch with the electric wires. Obviously that failed.*[2]

[1] WorkSafe Prosecution Summary: https://www.worksafe.vic.gov.au/pages/laws-and-regulations/enforcement/prosecution-result-summaries-and-enforceable-undertakings

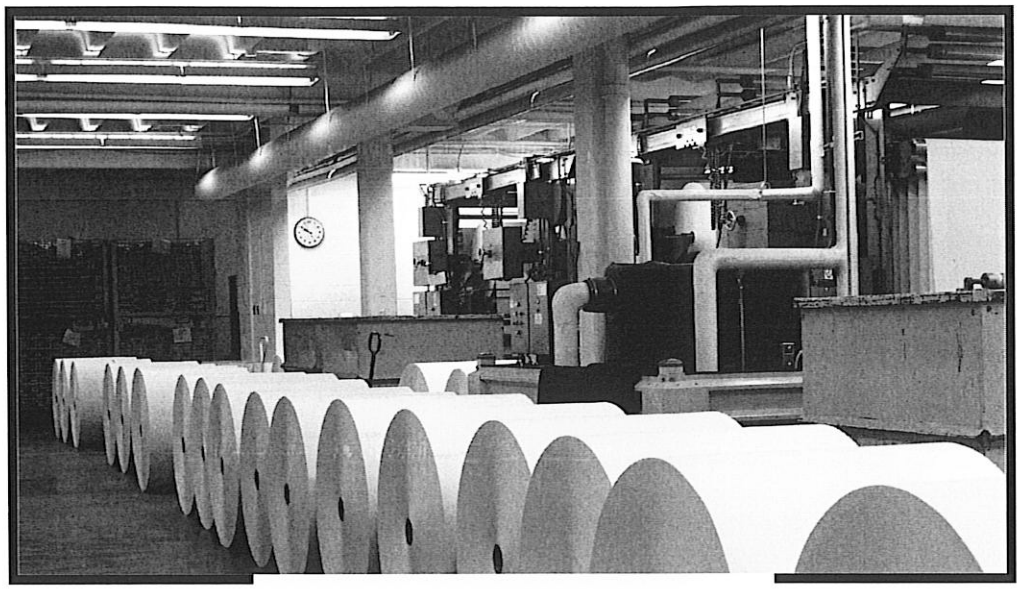
[2] Director of Public Prosecutions v Redback Tree Services [2017] VCC 1602

MELBOURNE WATER CORPORATION

Tim Bakerov died when he fell through a missing grate on a walkway and drowned in the Return Activated Sludge channel at Melbourne Water Corporation's Eastern Treatment Plant. Melbourne Water Corporation had prior knowledge of grates being dislodged or missing on at least two previous occasions. Melbourne Water Corporation also knew that the grates ought to be bolted down in what was an inexpensive procedure. The court held:

> *There are two aspects of the failures of Melbourne Water relating to the death of Mr Bakerov that are of particular significance. The first is that there were a number of incidents going back three years where there were clear reports of missing or displaced grates on the walkways...Despite the evidence of reports of these prior occasions no steps were taken to investigate the risk of slatted grates becoming dislodged and no consequent steps taken to secure them. In my view this was a clear and substantial failure, in particular in a workplace where there were considerable hazards and occupational health and safety matters were said to be important.*
>
> *The second significant issue in my view is that the potential consequence of the failure to take adequate steps to properly secure the grates was dire. A missing or displaced grate in this plant with hazards such as water courses and channels would likely result, to anyone who gave the matter a moment's thought, in the death of a worker by drowning, if he stood upon an uncovered hole or attempted to lift the heavy grate back into place. Tragically in this case that indeed occurred.*[3]

[3] DPP v Melbourne Water Corporation [2014] VCC 184 [22]-[23]



AMCOR PACKAGING PTY LTD

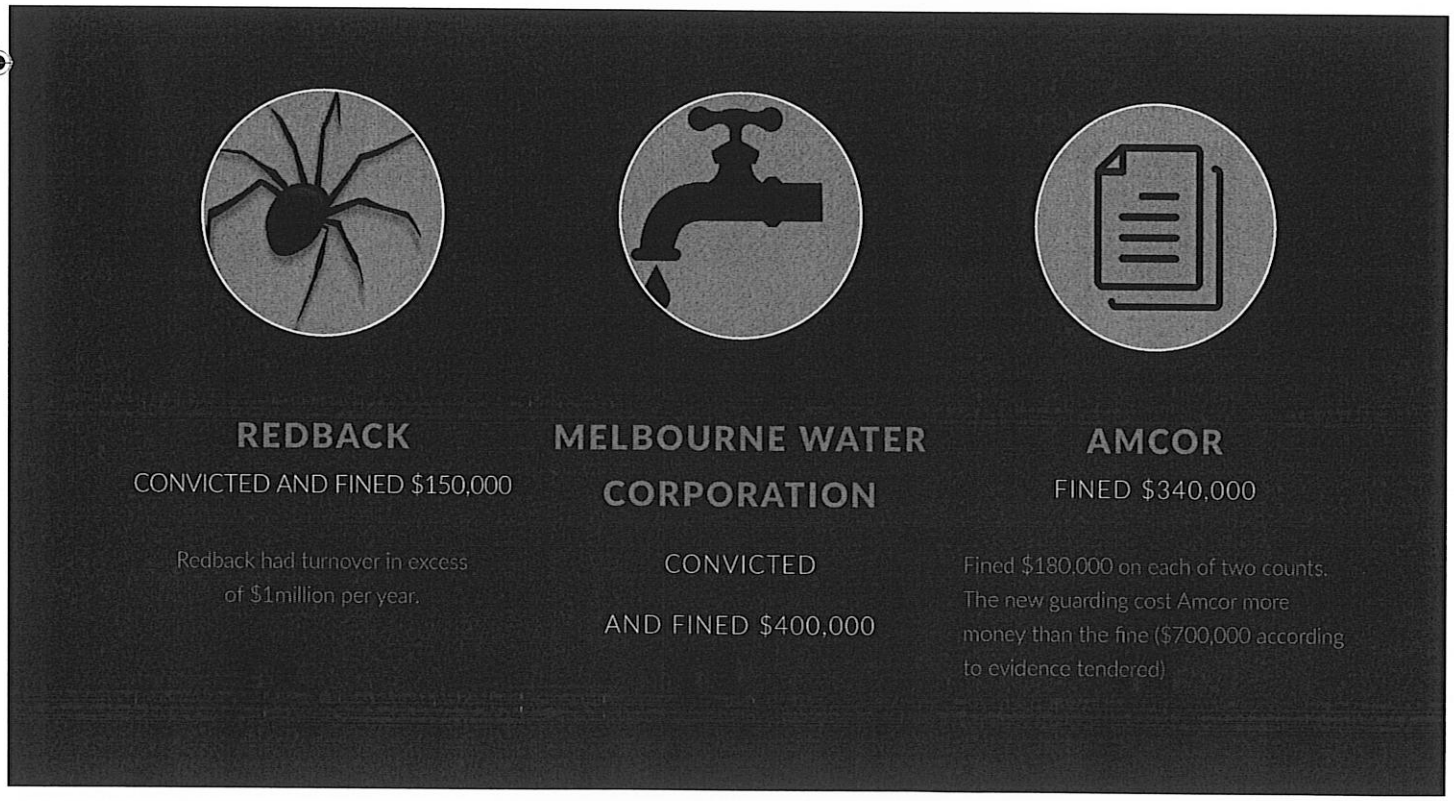
Darren Moon was killed when he was caught drawn against unguarded large rollers – part of a paper manufacturing machine which occupied the entire floor of the building. The machine had been unguarded since 1966. HSRs, through several near misses and risk assessments in the years preceding the fatality, drew attention to the risk of being dragged into the machine The company refused to put guarding in place. After Mr Moon was killed, the Amcor very quickly had guarding installed on all its machines. The court of appeal held:

> *Despite the assertions advanced on behalf of the respondent about its concern for the safety of its workforce, and despite the claimed difficulties in fitting a guard, the fact is that a guard was able to be fitted within a very short time of the occurrence of a serious accident. Furthermore, while the cost of installation was plainly substantial, the factor which seems to have been of greatest importance to the respondent was that installation of the guard and the adoption of safe working practices significantly increased the costs of operating the machine and otherwise conducting the respondent's operations.*
>
> *In our opinion, the inference is irresistible that the respondent approached the situation from the viewpoint that as little untoward had happened over a long period of operation, it could be assumed that nothing ever would and therefore that the substantial expenditure and increased operating costs involved in the removal of the danger were not regarded as justified. A degree of complacency based upon the acceptance of that assumption can be seen to have contributed to the death of one of its employees.*

[4] DPP v Amcor Packaging Pty Ltd [2005] VSCA 219 [30], [33]

NO JUSTICE

In each of these cases, serious managerial and corporate negligence resulted in the death of human being. In each case, the outcomes, even when appealed to the Supreme Court, were manifestly inadequate:



Corporate and Industrial Manslaughter

VTHC and the Victorian union movement want the Andrews Labor Government to commit to pass legislation which:

- Inserts a crime of Corporate and Industrial Manslaughter into the Occupational Health and Safety Act 2004.
- Will adequately punish corporate negligence where that negligence results in the death of a person;
- Will adequately punish negligent decisions by senior managers in control of a substantial part of the business where that negligence results in the death of a person;
- Bind the Crown in its role as an employer;
- Provides two exceptions for:
  - Emergency services employees operating in good faith;
  - Family run small businesses where the deceased is a family member of the business owner/operator.

Crime of Corporate and Industrial Manslaughter into the OHS Act 2004

Jurisdictions which have industrial manslaughter regimes have traditionally included them under their general crime legislation. Queensland was a notable exception to this when last year it legislated an industrial manslaughter provision into its Work Health and Safety Act.
Jurisdictions with industrial manslaughter legislations

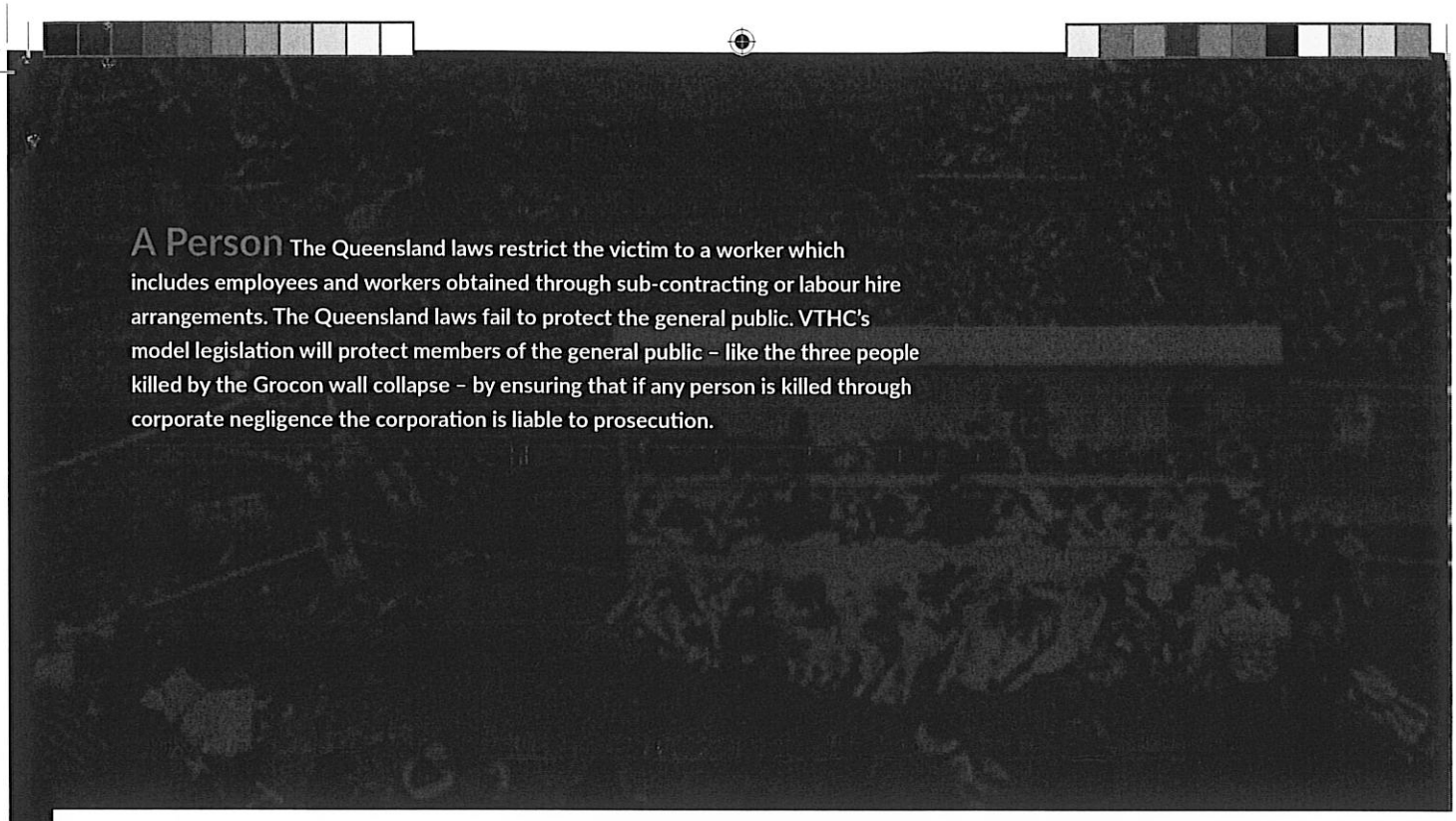
Jurisdiction	Legislation containing industrial manslaughter provision
ACT	Crimes Act 1900
Canada,	Criminal Code
Queensland	Work Health & Safety Act 2011
United Kingdom	Corporate Manslaughter and Corporate Homicide Act 2007

Why the OHS Act?

The ACT has notably failed to prosecute any cases of industrial manslaughter since it enacted its laws. The UK, on the other hand, has prosecuted at least 25 cases of industrial manslaughter cases since its laws were enacted (see Appendix 1 for more information). The following table outlines why WorkSafe Victoria is the organisation best placed to prosecute corporate or industrial manslaughter offences, including several cases where individuals have been jailed since November 2015 (see Appendix 1 for more information).

Investigation/ Prosecution	Pro	Con
VIcPol & DPP	Prosecute manslaughter under the Crimes Act.	No experience in proving negligence in a workplace OHS context. Likely to require assistance from WorkSafe to determine what is and is not negligent in a workplace OHS context.
WorkSafe	Understand OHS context Experienced in proving negligence in OHS context in a court of law Already investigate and prosecute all workplace fatalities Prosecute some workplace fatalities under s21 of the OHS Act.	

Given that WorkSafe is the expert in proving negligence in the occupational health and safety context, the new crime of corporate and industrial manslaughter should be put into the Occupational Health and Safety Act 2004.



A Person The Queensland laws restrict the victim to a worker which includes employees and workers obtained through sub-contracting or labour hire arrangements. The Queensland laws fail to protect the general public. VTHC's model legislation will protect members of the general public – like the three people killed by the Grocon wall collapse – by ensuring that if any person is killed through corporate negligence the corporation is liable to prosecution.

Adequate punishment of corporate negligence

The Queensland legislation provides penalties of 20 years imprisonment for a natural person and 100,000 penalty units for a corporation. This level of penalty sends the right message to all employers that profit should not be put before the safety of their employees. It also signals to the court how seriously the crime is to be taken and will ensure just fines are levied against guilty parties. Any corporate or industrial manslaughter crime should include punishments that fit the crime:

- 20 years imprisonment for an individual
- 100,000 penalty units ($15, 857, 000) for a body corporate

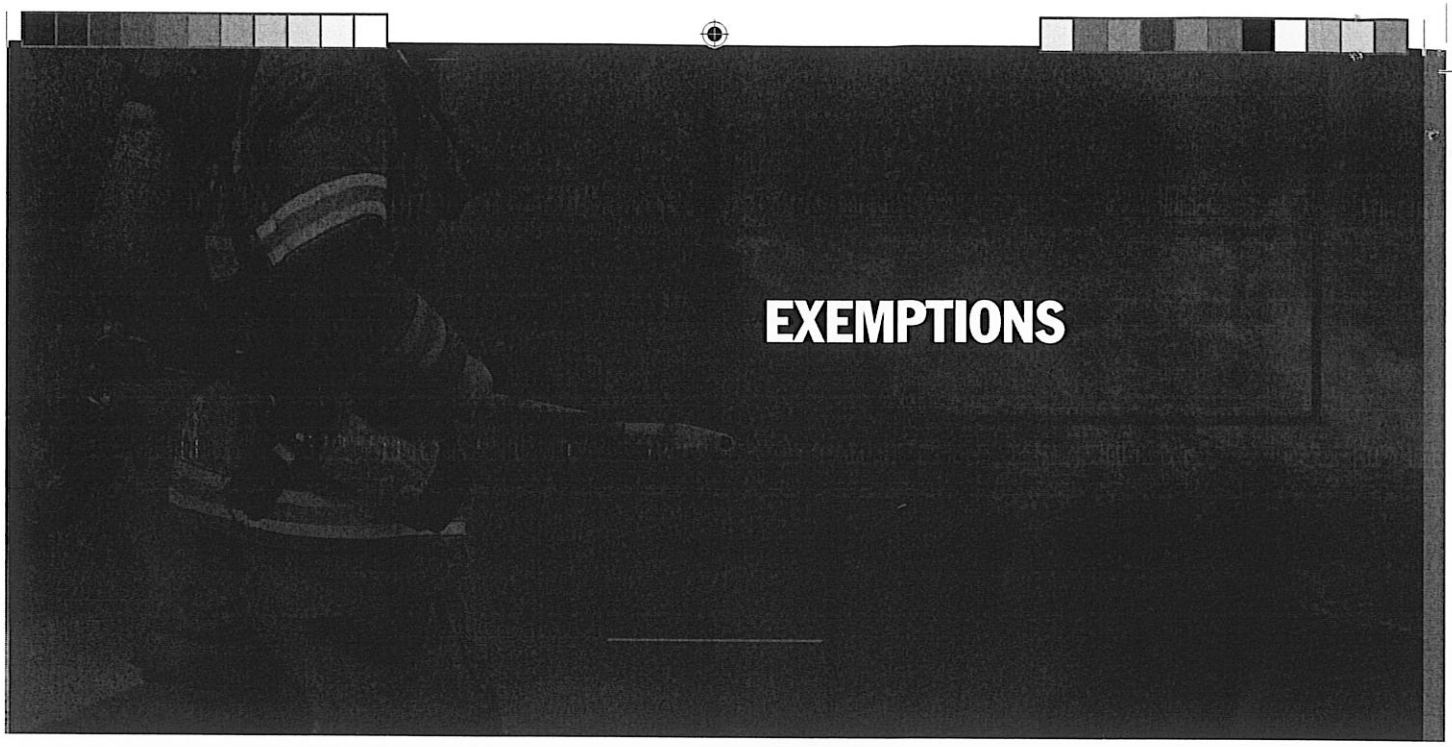
Senior Managers

Traditionally in Australia, piercing the corporate veil to hold decision makers accountable has been restricted to senior officers. In effect, company directors and C-Suite executives have been potentially caught by such legislation. An unintended consequence of this is that SMEs, where sole directors or CEOs have a more hands on role in the business, have been liable to prosecution but in large corporations where the senior officers are removed from day to day decision making, individuals have escape liability. The United Kingdom and Canada have extended their laws to include senior managers who have actual managerial control over a substantial part of the business. This allows for a broader range of decision makers at a large company to be found liable and will, when required, help prosecutors pierce the corporate veil in larger organisations to hold key decision makers accountable. VTHC's model legislation varies the Queensland laws to extend liability to senior managers.

Bind the Crown

As a model employer, the Crown ought not to be exempt from these laws. The laws in the United Kingdom bind the Crown. Government authorities undertake dangerous complex work on behalf of the Victorian public and the people who undertake that work deserve the same rights as any other worker in Victoria.

We note here that we propose an exemption for emergency services employees acting in good faith.



EXEMPTIONS

Emergency services employees acting in good faith

We understand that responding to emergency situations involves decision making under immense pressure, often with imperfect information, in a highly dynamic environment where bodily harm is constant reality. Emergency services employees acting in good faith ought to be exempt from corporate or industrial manslaughter laws to preserve their ability to act without fear or favour in emergencies.

Small family businesses

The aim of a corporate or industrial manslaughter crime is to prevent corporate negligence. The laws are not intended to lock up the dad of a family farm who loses his son in a preventable quad bike accident. The family has suffered enough. Therefore, our proposed legislation includes an exemption for small businesses where a family member is killed as the result of negligence.

OPPOSITION TO CORPORATE AND INDUSTRIAL MANSLAUGHTER REFORM

EMPLOYER GROUPS ARE AGAINST THESE CHANGES. THE TABLE BELOW SUMMARIZES THEIR MAIN OBJECTIONS AND OUR REBUTTALS.

Employer Objections	What we say
There is no gap in the law, our current laws already adequately deal with cases where people are killed at work.	If you negligently kill someone while driving a car, you face a prison sentence. If you send a 22 year old up a tree without adequate protection from nearby powerlines, you face a fine. Our laws clearly do not adequately deal with corporate negligence that results in the death of a human being.
Do not strike the right balance between prevention and the cure. Purely retributive legislation that is moral and symbolic don't prevent non-compliance.	Fines that are less than the cost of rectifying the OHS breach are insufficient to encourage corporations to put safety ahead of profit.
Higher penalties are not a deterrent.	In cases where the fines are less than the cost of rectifying the OHS breach, then the penalties are not an incentive to improve the health and safety of the workplace at all. There is no point in laws which do not give senior managers pause when assessing their safety budgets. Deterrence is only one reason for a penalty. Large penalties help provide a measure of justice to the family and community who have lost an irreplaceable human being.
Will reduce health and safety by targeting individuals, prevent information sharing for fear of prosecution and will result in more lawyers around the table rather than fixing OHS issues.	These laws will focus senior managers on the risk to their person and company should a person be killed through negligence at a workplace. It will force corporations in high risk workplaces to take health and safety seriously. Health and safety culture changes when those at the top take it seriously. Under our current system, 20-30 Victorians are killed at work each year – corporate and industrial manslaughter laws send the very clear message that such negligence will no longer be tolerated.
Not appropriate to link a penalty to the outcome of an incident	In circumstances where an irreplaceable human being has had their life ripped away through corporate negligence, it is completely appropriate to link the penalty to the outcome. There is no bringing that victim back. The penalty has been designed to provide justice.
Higher penalty applies to lower culpability	The reckless offence under the OHS Act does not require that a person be killed or seriously injured. It only requires another be subjected to the risk of serious injury. Under VTHC's proposed legislation, the higher penalties only apply where a person has been killed. It is the gravity of the outcome which demands the higher penalty.
Industrial fatalities are decreasing so our current system is working.	This is only true if you view the trend over the last 15 – 20 years. In recent years, the decline has flatlined :

Year	2012	2013	2014	2015	2016	2017
Fatalities	35	33	42	38	31	27

One workplace fatality is too many. Without further reform, we risk going backwards.

DRAFT CORPORATE AND INDUSTRIAL MANSLAUGHTER LEGISLATION

PART XX CORPORATE AND INDUSTRIAL MANSLAUGHTER

XX DEFINITIONS FOR THIS PART

(1) In this part –

conduct means an act or omission to perform an act.

emergency services means:

- Victoria Police
- Ambulance Victoria
- Metropolitan Fire Brigade
- Country Fire Authority
- State Emergency Services

executive officer of a corporation, means a person who is concerned with, or takes part in, the corporation's management, whether or not the person is a director or the person's position is given the name of executive officer.

senior manager, in relation to an organisation, means the persons who play significant roles in—

(a) the making of decisions about how the whole or a substantial part of its activities are to be managed or organised; or

(b) the actual managing or organising of the whole or a substantial part of those activities.

victim means a person who is killed or injured as a result of work being carried out by an employer or person with management or control of a workplace.

(2) For this part, a person's conduct causes death if it substantially contributed to the death.

XX EXCEPTIONS

(1) A volunteer does not commit an offence under this part.

(2) Despite section 34 (2), an executive officer or senior manager of an unincorporated association (other than a volunteer) may commit an offence under this part.

(3) An employee of the Emergency Services acting in good faith does not commit an offence under this part.

(4) This part does not apply where the deceased is a family member of the person and the person is carrying on a small business of 15 or less employees.

XX CORPORATE AND INDUSTRIAL MANSLAUGHTER –

(1) A person, either an employer or a person who has—to any extent—management or control of a workplace, commits an offence if —

(a) A victim—

(i) dies as the result of work being carried out for the employer or person with management or control of a workplace; or

(ii) is injured as the result of work being carried out for the employer or person with management or control of a workplace and later dies; and

(b) the person's conduct causes the death of the victim ; and

(c) the person is negligent about causing the death of the victim by the conduct.

Maximum penalty

(a) for an individual—20 years imprisonment; or

(b) for a body corporate—100,000 penalty units.

(2) An offence against subsection (1) is a crime.

XX CORPORATE AND INDUSTRIAL MANSLAUGHTER—EXECUTIVE OFFICER AND SENIOR MANAGER

(1) An executive officer or senior manager of a employer or a person who has —to any extent— management or control of a workplace, commits an offence if —

(d) a victim —

(iii) dies as the result of work being carried out for the employer or person with management or control of a workplace; or

(iv) is injured as the result of work being carried out for the employer or person with management or control of a workplace and later dies; and

(e) the executive officer or senior manager's conduct causes the death of the victim ; and

(f) the executive officer or senior manager is negligent about causing the death of the victim by the conduct.

Maximum penalty—20 years imprisonment; or

(2) An offence against subsection (1) is a crime.

XX CROWN IS BOUND

(1) An organisation that is a servant or agent of the Crown is not immune from prosecution under this Part for that reason.

(2) This part binds the Crown –

a. In the State of Victoria; and

b. To the extent that the legislative power of the Parliament permits, in all its other capacities.

(3) To avoid doubt, the Crown is a body corporate for the purposes of this Part.

CONCLUSION

ONE WORKPLACE FATALITY IS TOO MANY

Victoria has a shameful history of corporate negligence killing innocent people with no justice being provided. The Esso gas explosion. Amcor's negligent killing of Darren Moon. Melbourne Water Corporation's negligent killing of Tim Bakerov. Redback Tree Services negligent killing of 22 year old Scott Gamble. These are merely a handful of the hundreds of examples of corporate negligence that have cost Victorian's their lives and irreparably harmed the fabric of our society.

With Queensland leading the way, it is time for Victoria to take a stand against employers who put profit ahead of safety, employers who cut corners, employers who fail to protect their employees from preventable risks and hazards in the workplace. Corporate and Industrial Manslaughter Laws send a strong message to corporations that their negligence, malfeasance and lack of care for Victorians will no longer be tolerated. Every human being is precious and deserves the highest standard of safety from those who would conduct business in Victoria.

Get tough on crime. Now is the time to legislate on Corporate and Industrial Manslaughter.

APPENDIX

On 3 November 2015, the UK Sentencing Council published a new guideline for sentencing individuals in respect of offences under the Corporate Manslaughter and Homicide Act 2007. As a result of these new guidelines, people have been sentenced to prison when their negligence has caused the death of a person in the workplace. Notably, the director of an aged care facility received 3 years and 2 months for negligence which resulted in the death of an aged care client (see Sherwood Rise Ltd) below. Recently, as a consequence of the negligent killing of Nikolai Valkov, three directors were imprisoned for their role in his death.

Company name	Conviction date	Victim's name	Cause of death	Prison Term
Sherwood Rise Ltd	February 2016	Ivy Atkin	Died in a care home.	3 years, 2 months.
Bilston Skips Ltd	August 2016	Jagpal Singh	Fell from the top of a skip	2 years suspended sentence
SR and JR Brown Ltd	March 2017	Benjamin Edge	Roof fall	12 Months
Koseoglu Metalworks Ltd	May 2017	Nikolai Valkov	Roof fall	8 months
Odzil Investments Ltd	May 2017	Nikolai Valkov	Roof fall	Director 1: 12 months Director 2: 10 months
Martinisation London Ltd	May 2017	Tomasz Procko and Kyrol Szymanski	Lifting operations at height	Due to be sentenced in July.

We Are Union

SIA CONFERENCE 2018 – LANA CORMIE

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

The reality is that in this country, our society is willing to accept deaths in the workplace.

Do you think that this is right?

I would like to share with you some of the statements made by families of those killed at work during the recent senate Inquiry into Industrial Death.

Jack Brownlee was killed in the same incident as my husband. His Dad Dave said:

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

Beforehand, I had a friend who worked in Geelong. He rang me and informed me Things were on Facebook about a trench collapse in Ballarat and he thought our son Jack was involved. I raced up there to the site and was met at the roadblock by the police. We weren't allowed in. Jack had just been evacuated, they said, and they were putting him in an induced coma. I was informed by the police that the best thing to do was to hightail down to Melbourne and meet him at the hospital. We still had not heard from the company.

Mrs Janine Brownlee Jack's Mum said:

The hardest thing for us was to leave our son and drive home. The hardest thing was to drive there in the first place, getting updates telling us, 'Hurry up. Your son mightn't make it.' And then the hardest thing was to drive home the next day, leaving our boy at the hospital. That was one of the hardest things I've ever had to do: knowing he was there on his own; leaving my baby there ... Things need to change. How we were treated was so wrong.

Mr Robert Cunico was killed at work in 2018, aged 60, his daughter, Ms Ashlea Castle said:

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

Luke Murrie was killed at work in 2007, aged 22. Luke's Dad Mark said:

Luke was 22 when he was killed. He was killed in an unsafe work environment where inexperienced workers were instructed to do an unsafe lift. The unsafe method was quicker and therefore it was cheaper. There was no meaningful deterrent for the employer to do it safely. He put the dollar before safety.

Ben Catanzariti was killed at work in 2012, aged 21. His Mum kay said:

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

Jason Garrels was killed at work in 2012, aged 20. Jason's Mum Lee said:

My son Jason Garrels aged 20 was fatally electrocuted on the 27th February 2012 in Clermont, Queensland. My son was employed as a labourer for approx 9 days with Daytona Trading Pty Ltd ... I went to assist at the resuscitation not knowing it was my son. Words cannot describe the impact that it has had on me and my family; I was thrown into a life that was a surreal nightmare which became my reality.

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

I ask you again, do you think that this is right?

The families I have mentioned and the families of those pictured behind me have recently been involved in providing evidence at the Senate Inquiry into Industrial Death and Serious Injury.

Through hearing evidence from families, industry stakeholders, lawyers, unions, Worksafe and more, this Inquiry has made 34 recommendations. It found without doubt that we need Industrial Manslaughter legislation in this country.

And I will tell you why.

First, I would like you to consider the following inconsistency in our laws. If a driver runs a red light and kills a person, they will be charged and sent to jail. The scene will be treated as a crime scene, taped off and investigated by a specialised team.
In contrast, if a company kills a worker, we don't charge the driver, we charge the car. Not only that, but our OHS laws are risk based, not outcomes based. So we charge the car for running a red light, not for actually killing a person.
But this is not how the rest of our laws in this country work.
I think that most of us feel comfortable that if we drink drive, or discharge a firearm and kill somebody then we will face penalties for that action.
It is a privilege to hold a license to drive a car or to own a gun, and if you and I break the rules then this privilege will be taken away.

So, I put it to you that companies are not driverless cars, they are made up of real people. And those real people must take responsibility for steering that car, or else they must give up the right to drive one. With great priviledge comes great responsibility. And if you aren't prepared to take that responsibility seriously, then don't run a company.

The current state of our OHS laws means that even if an employer is found guilty of conduct causing the death of a worker, the penalty simply does not match the crime.
They may receive a small fine and then go on to continue the same unsafe practices and put more workers at risk.
They will be rewarded for entering an early guilty plea and they will be applauded for being a good corporate citizen.
Even worse than that, businesses can insure against fines, so actually their penalty is totally negated. The fact that this type of insurance exists is absolutely disgusting and only adds to the fact that there is no disincentive against undertaking work in an unsafe manner.

The weakness in our laws and in their application means that
when we walk into work we lose all the rights and protections that we have in the public arena.
And these laws condone the fact that bosses can put profits ahead of safety.
I believe that this does not meet the expectations of the Australian public and that these laws are failing to uphold the moral standards in this country.
Coming home from work alive is a human right and the laws should treat it as such.

Directors need to be held accountable for outcomes in their company, including the safety of their workers. They must be able to be personally charged with negligence, with a law that can be meaningfully implemented to provide a real incentive. Until directors and senior officers see themselves as personally responsible for safety, they will fail to consider OH&S as a priority. It should be the first thing on their meeting agendas, not the last. Only when directors face personal prosecution will they put safety above profits. . It will make safety equally or more important than profitability – and so it should be.

The introduction of industrial manslaughter laws will have flow on effects which will raise safety standards in all workplaces.

If it is good enough for Queenslanders and the British, then it is good enough for Victorians. The life of a Victorian worker should be treated as equally important as a paramedic or indeed an animal – with penalties for those found guilty including jail time, significant fines and consequences for the company directors.

I would now like to address some of the arguments opposing the introduction of Workplace Manslaughter Laws, which I believe are fundamentally unsound.

It is claimed that increasing penalties is unfair to business owners who will be penalised for the conduct of employees. This is not the case. The rules which the companies need to comply with are not changing, they should be following the rules now. These laws only change the penalty, not the rules, and the penalties will only be handed out if they are found guilty in a court of law. To claim that bosses will be unfairly charged with Manslaughter is to question the judicial system in this country. If we feel we can trust our courts to decide if a person is guilty of rape, murder, perjury or any other

crime, then I think that we can trust them to decide if a director is guilty of Industrial Manslaughter too.
Some will also claim that we already have sufficient penalties in place to effectively charge those causing death in the workplace. It is true that there are some existing laws which can be used, such as section 32 (Reckless endangerment) and Manslaughter under the crimes act. However, in Victoria, section 32 is rarely used and to my knowledge only once in Australia has Manslaughter under the crimes act been charged.
Clearly these laws are not framed in a meaningful and usable way.
Workplace manslaughter deserves specific mention in our laws in much the same way as bullying or driver offences.

It is also claimed that Workplace Manslaughter Laws will not lead to an improvement in safety standards. At no point is it suggested that new laws will be a silver bullet to resolve all the safety issues in our workplaces. However, they form a part of the picture by motivating change from the top. This needs to be coupled with change from the bottom, including education and training. Changing the legislation is the only way to change attitudes towards safety within workplaces as we all know that company culture starts from the top. Those in management need to be sent a clear message that the government is serious about workplace safety and this should be followed up with wider OHS reforms.
Eg:
For those who don't believe that laws shape behaviour, I will give you an example. I recently met with a headmaster of a school in my town. He related to me the story of what happened in his school following the introduction of Mandatory Reporting Laws in Schools. He told me that as soon as these laws were announced, this was the first item on the next meeting agenda. In every meeting since, it has also been an agenda item. Why? Because the introduction of laws which hold individuals accountable for neglecting to report a child safety concern created a cultural change. All of a sudden, we had a change led from the top which meant all Principals and School Boards made sure all their staff had the training to know their legal obligations.
I believe that this is a good example of what should be happening in our workplaces. We should have laws which hold individuals accountable for safety outcomes and they should have to prove that they have the systems in place to keep their workers safe. After all, is Mums safety and Dads safety worth less than that of their children? I think not.

I would also like to draw your attention to the experience in the UK where Corporate Manslaughter Laws have been in place since 2008. Since then, the statistics show a clear drop in Workplace Fatalities. I think this is evidence enough to bring these laws into effect here.

Another reason that you will hear as to why we don't need Workplace Manslaughter Laws is that there has been a drop in work related deaths in the last 10 years in Australia. In fact, this was the argument that Senator Brockman of the Liberal Party gave us at the tabling of the senate inquiry as to why the coalition do not support these laws. Noteably he then proceeded to leave the senate immediately after his speech and failed to listen to the other senators presentations on this topic. I think that says a lot about his party's attitude to workers being killed in this country.
My answer to senator Brockman and those like him is this:
Safework Australia's Statistics are wrong.
They grossly underestimate the magnitude of the problem by reporting approximately 200 deaths a year.
They don't include thousands of fatalities including work related illnesses such as Mesothelioma and Silicosis, which alone kill thousands every year, or work related suicides, or many road traffic deaths.

There are an unknown number of deaths which are not counted due to occurring after work, for example I know of 2 deaths ruled not-work related when men died from Heat Stroke after 5o'clock following a days work in extreme heat.
It is impossible to know how many Australians die due to work in this country, but I can guarantee you that is at least 10 fold the supposed figure quoted by those blinded to the reality of this problem.
However, even if the likes of Senator Brockman choose to only acknowledge the official figures, I ask this? What would the governments response be if 200 people were killed in a bomb blast? It would be a national disaster. But those same number of human beings are killed 1 or 2 at a time as a matter of course in this country and you choose to turn away. I believe that is inexcusable.

While we are talking about statistics, I would like to draw you attention to one which I find very alarming:
41 Australian soldiers were killed in Afganistan. This is less than a quarter of those killed every year at work in this country. We would be safer going to war than going to work.
What a shocking reality and what an indictment on our safety standards.

In conclusion, I would like to make it clear that Industrial Manslaughter is not a solve-all to the problem of workplace deaths in this country. However I do believe that it plays an integral role in creating a greater cultural change in workplace safety.
Laws do shape behaviour.
These laws then need to be supported by a properly resourced regulator, with Worksafe investigations treated as a potentially criminal investigation. And this must be followed by a serious prosecution, not watered down through lack of funding or negotiations with employers.
The regulators need to be funded appropriately in order to police workplace safety effectively.
I believe that with Stronger Laws and a Stronger Regulator we will see a cultural shift long overdue in our workplaces.

It is disappointing that in this country we have a basic human rights issue being treated as a political issue.
The right to come home alive from work is something that should have bipartisan support in our parliament.
However, given that this is not the case, I can only hope that on the 24th of November Victorians will vote for those who believe that something needs to change. Those who believe that our fellow human beings deserve to come home to their families.

Finally I would like to be very clear about one thing. The introduction of Industrial Manslaughter Laws is not about sending bosses to jail. It is about shining a spotlight on the safety culture in this country. It is about upholding the values of our people. It is about each and every one of us having the right to expect to come home from work alive.