Submission No 53

INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

Organisation: Transport Workers' Union of NSW

Date Received: 17 December 2021

Select Committee on the Coronial Jurisdiction in New South Wales

Submission – Transport Workers' Union of New South Wales

Transport Workers' Union of NSW
Richard Olsen State Secretary | P: 1800 729 909 | F: 02 8610 8099 | E: info@twunsw.org.au | W: www.twunsw.org.au
ABN: 77 710 588 395

Table of Contents

Transport Workers' Union of NSW
Richard Olsen State Secretary | P: 1800 729 909 | F: 02 8610 8099 | E: info@twunsw.org.au | W: www.twunsw.org.au
ABN: 77 710 588 395

1. Introduction

The Transport Workers' Union of New South Wales (TWU) represents tens of thousands of men and women in Australia's road transport, aviation, oil, waste management, gas, passenger vehicle and freight logistics industries.

With over one hundred years' experience representing the workers who conduct Australia's crucial passenger and freight transport, the TWU has been proactive in advocating for the establishment and improvement of industry standards which advance the lives and safety of transport workers, their families and the community at large.

The TWU welcomes the opportunity to make this submission to the Inquiry into the coronial jurisdiction in NSW being conducted by the Select Committee (the Inquiry).

As an industrial organisation representing members in one of Australia's deadliest industries (road transport), the TWU is uniquely positioned to comment on the interplay between the coronial jurisdiction and work health & safety (WHS) laws in NSW, which will be the particular focus of this submission.

2. Worker Fatalities in the Road Transport Industry

The transport, postal and warehousing industry consistently ranks among the highest in terms of worker fatalities. The *Work-related traumatic injury fatalities Australia 2020* report produced by Safe Work Australia[1] found that between 2016 and 2020, there were an average of 7.7 worker fatalities per 100,000 workers each year in the industry – compared to a national average of 1.4 worker fatalities per 100,000 workers.

Furthermore, due to the large relative size of the transport, postal and warehousing industry (just under 500,000 workers as at the 2016 Census)[2], the industry consistently records the greatest number of worker fatalities in actual terms (an average of 49 fatalities per year between 2016 and 2020).

While the rate of worker fatalities in the transport, postal and warehousing industry is undoubtedly a national problem, the statistics do point to a disproportionate problem within NSW. Between 2016 and 2020, there were 81 worker fatalities in the transport, postal and warehousing industry in NSW – compared to 165 in all other states and territories combined[3].

Of the total 246 fatalities in the transport, postal and warehousing industry between 2016 and 2020, more than 70% (175) occurred in the road transport industry specifically[4]. Between 2016 and 2020, the road transport industry accounted for 19% of all worker fatalities in Australia[5].

---

[1] *Work-related traumatic injury fatalities Australia 2020,* Table 3
[2] Census 2016, G51 Industry of employment by age by sex, Table G51
[3] *Work-related traumatic injury fatalities Australia 2020,* Table 24
[4] Ibid, Table 4
[5] Ibid, Figure 6

There are a number of factors contributing to the relatively high incidence of worker fatalities in the road transport industry, however at the core of the issue is the increasing cost-pressures facing the road transport industry – from owner-driver small businesses right through to the major transport operators.

Truck drivers and transport operators continue to face significant increases in many of their key costs of operation, including fuel, road tolls, registration & associated taxes, and insurance. While all these costs have all steadily increased over recent years, the remuneration of transport workers has not kept pace. For example, the hourly rate for owner-drivers of vehicles weighing two tonnes or less was set at approximately $27 in 2007[6]. Fifteen years later, this rate remains unchanged. After recovering operating costs, many owner-drivers of vehicles in this category are left earning an income well below the award rate, and in some cases below minimum wage altogether.

In addition to these cost pressures, transport workers are increasingly feeling the squeeze of extreme pressure from major retailers at the top of the supply chains. Major multinationals such as Amazon, as well as significant domestic retailers and supermarkets, are waging a race-to-the-bottom in terms of pay and conditions in the transport industry. This trend is set to accelerate with the encroachment of the gig economy into more traditional transport and freight industries, through platforms such as Amazon Flex and Uber Freight.

While it is important for action to be taken to alleviate the cost pressures on the transport industry outlined above, such as reigning in out of control toll costs, this alone will not be enough. Just as in a medical context it is vital to address the root cause of the problem, not the symptoms at the surface, the same is true for the transport industry. Until governments at all levels take constructive action to address cost pressures in the transport industry, the major retailers at the top of the supply chain will continue to apply pressure throughout the entire transport supply chain, which will in turn have significant implications for road safety, including worker fatalities in the industry.

Concerningly, the only significant Government action taken in recent years in relation to cost pressures in the transport industry was the Federal Government's decision to abolish the Road Safety and Remuneration Tribunal in 2016. Since the abolition of the RSRT, there have tragically been 982 deaths in crashes involving trucks – including 228 worker fatalities[7]. While beyond the scope of this inquiry, the TWU welcomes the recent *Without Trucks Australia Stops* Senate report[8], which provides a comprehensive set of recommendations to improve safety in the road transport industry.

3. Overlap Between Police, Coronial and WHS Jurisdiction

Workplace fatalities in NSW are governed by an overlap of the coronial, criminal and WHS jurisdictions, with the NSW Police Force, the Coroner and SafeWork NSW all possessing investigatory functions in relation to workplace deaths. This section of the submission will

[6] Transport Industry - Courier And Taxi Truck Contract Determination, Schedule I
[7] TWU Fatal Truck Crash Database, as at 17 December 2021
[8] *Without Trucks Australia Stops: the development of a viable, safe, sustainable and efficient road transport industry*

focus primarily on the overlap between the three jurisdictions, and will seek to paint a picture of the blurred lines of responsibility when it comes to the investigation of workplace fatalities.

Practically every worker fatality in the road transport industry would satisfy at least one of the various criteria provided in s6 of the *Coroners Act 2009* (the **Coroners Act**) for a death to be considered a 'reportable death'. The NSW Police Force are required under s35 of the Coroners Act to report any such death to the Coroner – which is generally done using a standardised '*P79A – Report of death to the coroner'* form. Upon receipt of such a report, the Coroner is then empowered under the Coroners Act to either hold an inquest (s21), or dispense with an inquest (s25).

In addition to this coronial jurisdiction for worker fatalities, s35 of the *Work Health and Safety Act 2011* (the **WHS Act**) deems a death to be a 'notifiable incident' for the purposes of the WHS Act. If such a death arises 'out of the conduct of the business or undertaking', s38 of the WHS Act requires the person conducting the business or undertaking (PCBU) to notify the regulator (SafeWork NSW) of the incident immediately after becoming aware of it.

Even at this most preliminary stage of responding to workplace fatalities, the overlap in the coronial and WHS jurisdictions in relation to workplace fatalities is evident.

Following the receipt of such reports, both the Coroner (s51 of the Coroners Act) and SafeWork NSW (s160(e) of the WHS Act) are empowered to take investigatory steps in relation to the fatality. Furthermore, if the circumstances of the fatality are such that may justify a charge of manslaughter under the *Crimes Act 1900* (the **Crimes Act**), the NSW Police Force may also conduct their own investigation into the matter.

According to the *SafeWork NSW Prosecution Guidelines*[9], SafeWork NSW and the NSW Police Force "*have agreed on certain investigative principles aimed at maximising the expertise and resources of each agency to ensure that the most appropriate charges are laid in the circumstances"* when determining whether to pursue a charge of manslaughter under the Crimes Act or charge(s) under the WHS Act, with this decision being made at the commencement of the process to assist in deciding which agency will lead the investigation.

The extent to which these three bodies in practice share information and coordinate their actions during the course of their respective investigations is not clear, however there is no legislated requirement in either the Coroners Act or the WHS Act for such information sharing or coordination. The closest reference to any such coordination that can be found comes from section 3.30 of the *SafeWork NSW Prosecution Guidelines* referenced above, which states that both the NSW Police and SafeWork NSW *"on completion of their respective investigations, will provide the Coroner with a brief of evidence to assist the Coroner in his or her deliberation as to whether an inquest is to be held*[10]*."*

The effect of this overlap in the respective jurisdictions of the NSW Police Force, the Coroner and SafeWork NSW is the potential for two or three investigations into the same workplace fatality to be occurring concurrently, which raises significant concerns about the

[9] SafeWork NSW Prosecution Guidelines, section 3.30
[10] Ibid

efficient use of resources in investigating such matters, as well as significant practical concerns about the collection of evidence during the course of such investigations.

The TWU believes that greater certainty about the jurisdictional responsibility for workplace deaths is urgently needed. Whether such certainty is achieved by legislative amendment, memoranda of understanding or other means, it is vital that the function of each of the three bodies in the investigation of workplace fatalities be clarified, and how that function operates in connection with the function(s) of the other bodies.

4. Effect of Delays in Coronial Inquests on Prosecutions

In broad terms, a workplace fatality can lead to prosecution for two kinds of offences: manslaughter offences, under the Crimes Act, and WHS offences, under the WHS Act**.**

The principles agreed upon by SafeWork NSW and the NSW Police Force, as described above, act to ensure there is a mutual understanding on the part of both agencies as to which kind of offence a particular investigation is being conducted with a view to establishing. In this sense, the jurisdictional overlap in the investigation stage (as outlined in the previous section) is not as significant in the prosecutorial context. However, there remains a number of inconsistencies relating to prosecutions in relation to the Coroner and SafeWork NSW which this section of the submission will seek to explore.

Division 5 of Part 2 of the WHS Act creates the three 'main' offences under the WHS Act, which are outlined in the table below:

Offence Category	Section of WHS Act	Elements of offence	Maximum PCBU Penalty	
			Individuals	Corporations
1	s31	(a) the person has a health and safety duty, and (b) the person, without reasonable excuse, engages in conduct that exposes an individual to whom that duty is owed to a risk of death or serious injury or illness, and (c) the person— (i) engages in the conduct with gross negligence, or (ii) is reckless as to the risk to an individual of death or serious injury or illness.	$712,928 and/or 5 years' prison	$3,565,158
2	s32	(a) the person has a health and safety duty, and (b) the person fails to comply with that duty, and (c) the failure exposes an individual to a risk of death or serious injury or illness.	$356,721	$1,782,579

3	s33	(a) the person has a health and safety duty, and (b) the person fails to comply with that duty.	$118,907	$594,021

Section 230 of the WHS Act establishes the process by which prosecutions for the above offences may be brought. While subsection (5) permits the Director of Public Prosecutions to bring such a prosecution, the general effect of s230 is that the power to bring a prosecution rests with the regulator (SafeWork NSW). Furthermore, in establishing the limitation period for prosecutions to be brought, s232 of the WHS Act provides that a prosecution may be brought within a period of 1 year after the ending of a coronial inquest, ensuring that any delays in the conduct of a coronial inquest do not preclude a prosecution from being brought.

In the context of prosecutions brought by SafeWork NSW, the operation of these sections of the WHS Act appear relatively straightforward. However, s230(3) and s231 of the WHS Act also enable the secretary of an industrial organisation of employees to bring a prosecution for Category 1 and 2 offences (subject to a somewhat convoluted process). While such circumstances are likely to be exceedingly rare in practice, this does not excuse the provisions from scrutiny.

The process by which the secretary of an industrial organisation of employees can bring a prosecution must be commenced no sooner than 6 months and no later than 18 months after the incident occurs, per s231(1)(b) of the WHS Act**.** However, as was outlined above, the regulator is given a period of 12 months beyond the conclusion of a coronial inquest (which itself may take several years) to bring a prosecution.

In effect, this means that if SafeWork NSW makes the reasonable decision to wait until the conclusion of an ongoing coronial inquest relating to a workplace fatality before deciding whether to bring a prosecution, and if the coronial inquest takes 18 months or longer, the secretary of an industrial organisation of employees will not be able to bring a prosecution in the event the regulator decides against doing so.

This concern is far from theoretical. A 2015 study into the duration of death investigations that proceeded to coronial inquest[11] found that, from a sample of more than 2,200 cases in NSW between 2007 and 2013 that proceeded to inquest, 26% remained open 2 years after the date of report to the coroner, and 7% of cases remained open after 4 years. While the study did not specify how many of these cases were workplace fatalities, it is clear that it is by no means uncommon for a coronial inquest to not be concluded within the 18 month window required by s231(1)(b) of the WHS Act**.**

This inconsistency in the WHS Act is clearly contradictory to the intended purpose of s230(3) of the WHS Act – being to enable the secretary of an industrial organisation of employees to bring a prosecution in circumstances where the regulator decides against doing so. The TWU believes urgent amendment of the WHS Act is needed to ensure the timeframe imposed by s231(1)(b) of the WHS Act allows for the secretary of an industrial organisation of employees to wait until the completion of a coronial inquest – as is similarly provided for in s232(1)(b) in relation to prosecutions brought by SafeWork NSW.

[11] Studdert DM, Walter SJ, Kemp C, et al, Duration of death investigations that proceed to inquest in Australia, Injury Prevention 2016;22:314-320.

In addition to a legislative amendment to remedy this inconsistency, it is abundantly clear that the Coroner is in desperate need of significant extra resources. A situation where more than 1 in 4 coronial inquests remain open 2 years after the death being reported to the Coroner is not acceptable by any means. While it is important in the short-term to make the necessary legislative amendments to ensure that delays in the completion of coronial inquests do not have unintended adverse consequences on the ability for prosecutions to be brought under the WHS Act, the longer-term and more substantive solution required is for the Coroner to be sufficiently well-resourced that inquests are more promptly resolved in the first place.

5. Information Sharing Between Coroner and SafeWork NSW

The previous section of the submission has focused on the problems that can potentially be caused when SafeWork NSW decides to wait until the conclusion of an inquest before commencing a prosecution. The remainder of this section will operate under the reverse assumption – that is, will focus on a potential problem that can arise in circumstances where SafeWork NSW commences a prosecution before a coronial inquest can be completed – with the main concerns addressed relating to the sharing of information between the Coroner and SafeWork NSW.

Section 78 of the Coroners Act deals with the process for inquest or inquiries involving potential indictable offences. In essence, s78(1)(a) and (2) require the Coroner to suspend an inquest if a person has been charged with an indictable offence in connection with the death subject to the inquest, with certain exceptions. While s229B of the WHS Act requires Category 2 and 3 offences to be dealt with summarily, it also requires prosecutions for Category 1 offences to be taken on indictment. As such, if SafeWork NSW were to decide to commence prosecution against an individual and/or corporation for a Category 1 offence in relation to a workplace fatality, the Coroner would be required to suspend any inquest until the conclusion of such a prosecution.

In such circumstances where a Coroner is required to suspend an inquest because a person has been charged with an indictable offence, s78(4)(a) of the Act requires the Coroner to provide the Director of Public Prosecutions a copy of all depositions taken at the inquest in question. However, no similar clause exists requiring the Coroner to provide SafeWork NSW with copies of depositions in cases where it is acting as the prosecutor for Category 1 offence(s) under the WHS Act. While one may assume (or at least hope) that this would still occur in practice, the TWU believes that a minor legislative amendment is needed to clarify that the Coroner is under a similar obligation to provide SafeWork NSW with copies of depositions if they are prosecuting the charges, to ensure evidence can be shared without the risk of recourse on the Coroner for doing so.

In a similar vein, s81 and s82 of the Coroners Act deal with findings and recommendations relating to inquests. While s82(4)(d) does require the Coroner to provide a copy of any recommendations to any Minister "*that administers legislation, or who is responsible for the person or body, to which a recommendation relates*", it is unclear whether this would include providing the Minister responsible for SafeWork NSW with a copy of any recommendations made in relation to the work health & safety practices of a particular PCBU following an inquest into a workplace fatality. While such recommendations would not directly relate to

SafeWork NSW as an entity itself, any recommendations served on a PCBU regarding improvements to their work health and safety practices in response to a workplace fatality should be provided to the regulator for enforcement and compliance purposes at minimum. Again, it is unclear whether legislative amendment is required to ensure this is the case, or whether such a change could be made by the Coroner at an operational level.

Section 81 of the Coroners Act also requires the Coroner to record in writing any findings relating to a coronial inquest, including the manner and cause of the person's death (if the inquest is being concluded). While the Coroner generally makes these findings publicly available on its website, in cases where the Coroner is publishing findings relating to a workplace death, it is concerning that there does not appear to be, at least at a legislative level, a requirement for the Coroner to proactively provide a copy of such findings to SafeWork NSW. The TWU believes that, in relation to an inquest relating to a workplace fatality, the Coroner should be required to proactively provide a copy of any findings to SafeWork NSW upon the conclusion of the inquest, to assist SafeWork NSW in making a decision to prosecute in accordance with s232(1)(b) of the WHS Act.

6. Conclusion

As the industrial organisation representing workers in an industry that is significantly over-represented in workplace fatalities – road transport – the TWU has a keen interest in the relationship between the coronial and WHS jurisdictions in NSW. While significant improvements have been made in this area of law in recent years, including the 2020 changes to Category 1 offences under the WHS Act based on the Boland review, there still remains a concerning level of ambiguity, uncertainty and inconsistency in relation to the investigation and prosecution of workplace fatalities.

The TWU hopes the Committee finds its submission helpful in its Inquiry, and would welcome the opportunity to elaborate on any aspects of the submission at a hearing if the Committee feels that would be of benefit.