24 Jun 20

Dr Sally Talbot
Chair, Standing Committee on Legislation
Parliament House
4 Harvest Tce
WEST PERTH WA 6005

Email: lclc@parliament.wa.gov.au

Dear Dr Talbot,

COMMITTEE INQUIRY: WORK HEALTH AND SAFETY BILL 2019

My name is Amanda Fox and I have 5 years' experience in health and safety coordination/management in the resources sector across a range of operations and commodities.

I write to you regarding the Standing Committee on Legislation's current Inquiry on the Work Health and Safety Bill 2019 (the Bill), specifically with regards to the proposed introduction of Industrial Manslaughter offences.

- I recognise and agree appropriate laws are needed to respond to workplace fatalities and to hold officers and PCBU's responsible for reckless and intentional acts. However, I am concerned the Government's proposal to introduce the broadest of all industrial manslaughter offences in Australia, Part 2, s30B *Industrial Manslaughter – simple offence*, is not a proportionate offence. Additionally, it may have significant unintended consequences which undermine the most important objective of the WHS; to protect worker health and safety.
- My sense is there is a general acceptance of the move to implement industrial manslaughter offences in WHS laws in jurisdictions across Australia, further to recommendations from national reviews. These should be drafted and introduced further to careful consideration to ensure no unintended consequences. My view is they must only be reserved for gross disregard for known risk to an individual's life.
- No fatality is acceptable. As a health and safety professional for most of my adult life, I have witnessed firsthand the devastating impact fatalities and serious injuries have - on families, workers and within communities and organisations. You do not pursue a career in health and safety without a genuine desire to keep people safe and improve workplace health and safety.
- The factors which contribute to safety incidents are complex, this is something I see firsthand. Individuals work in complex, high-risk environments as part of a team. When things go wrong, it is rarely the result of one individual's error – modern accident prevention models and empirical research in this area reinforces this. Incidents often arise from a combination of factors. Decisions and conduct of individuals occur in the context of broader organisational and systems failures. Risks to health and safety often may arise when a series of weaknesses or failures align across a whole system of activity.
- 30B proposes a low threshold of "any neglect" and as drafted is likely to capture all fatalities able to be prosecuted, regardless of the contributing factors. To elaborate, section 19 of the WHS Bill enshrines an overarching 'primary duty of care' for PCBU's to ensure the health and safety of workers. To prosecute a 'simple' offence, the WorkSafe Commissioner would simply need to prove there was a failure of this general duty and that this failure had a clear causal link to the death of the individual. DMIRS prosecutions to date shows the similar duty in current legislation (section 9, The Mines Safety Inspection Act 1994) is regularly successfully prosecuted, demonstrating the likely broad application of the offence.
- From my perspective, there are legal and procedural fairness issues relating to the proposed offence. The maximum penalty for 30B is 10 years and a fine of $2.5 million. These are significant charges to be brought by the WHS regulator and heard in the magistrates court. It is unclear if defendants would have access to defences available under WA's criminal code - for example, accident and mistake of fact. I question whether this application of industrial manslaughter and lower bar of culpability under the 'simple' offence meets community expectations
- My broader concern is the potential damage these provisions could unintentionally cause to the way in which workplace health and safety is managed. While it is important to have penalties for breaches of

legislation, fostering positive and cooperative safety cultures is far more impactful in improving health and safety 'on the ground'. An example is through improving broader areas of operations that often lead to accidents. Targeted leadership and/or communication training are examples I have seen work exceptionally well in the safety space. The Influencer Model[1] is another example of effectively being able to change safety behaviours across an organisation (One of the key objectives of the Bill is to foster cooperation and consultation [Part 1 s.3(c)]). Overly punitive approaches may hinder efforts to foster collaborative safety cultures, discourage the sharing of information and create an exceptionally risk adverse and individualistic culture. The sort of culture that these punitive approaches foster are ones in which individuals become primarily concerned and focused on just protecting themselves from potential legal outcomes, as opposed to the bigger picture; broadscale behavioural, cultural and organisational change for better health and safety outcomes.

Thank you for your consideration of this important matter. My details are outlined below should you need any further information.

Yours sincerely

Amanda Fox

Capability & Culture Specialist

Gold Road Resources

1 Grenny, J., Patterson, K., Maxfield, D., McMillan, R.& Switzler, A (2013) Influencer. New York: McGraw Hill Education.