Hon Dr Sally Talbot MLC 25 June 2020
Standing Committee on Legislation
Parliament House
4 Harvest Terrace Perth WA 6005

By email: lclc@parliament.wa.gov.au

Dear Dr Talbot,

SUBMISSION - *WORK HEALTH AND SAFETY BILL 2019*

I write in relation to the review of the *Work Health and Safety Bill 2019 (WHS Bill).* I am writing to express my strong support for Part 2, Division 5, Section 30B Industrial Manslaughter – simple offence.

My motivation for advocating for workplace safety reform and seeking the specific inclusion of both s30A and s30B Industrial Manslaughter comes from having suffered the tragic and senseless loss of my son Wesley Ballantine in an industrial incident, and the deep injustice that followed.

On 5th January 2017 my son and only child Wesley Ballantine, aged just 17 fell 12m to his death through an open void in a glass atrium ceiling under construction in the Perth CBD.

The injuries he sustained from the fall caused him to suffer internal bleeding, ruptured organs, a shattered spinal cord and head injuries so severe that the autopsy report labelled the back of his head a 'puttied mess'. He was rushed to hospital and pronounced dead within an hour of his fall.

It was announced on the radio before I even had a chance to receive the phone call from the police to tell me the news. After which, I had the experience of attending the state mortuary to see my son's dead body. A body which I wept over. And I body which I soon laid to rest.

What Happened?

Wesley was working as a trade's assistant for the company sub-contracted to install a glass canopy ceiling for the H&M retail fitout at the Perth GPO Building in Forrest Chase.

Wesley's job at the time was to paint the beams between the steel and glass framework. This work was being carried out 12m above the ground on the atrium ceiling which was in the process of having glass panels installed.

Wesley's only training was an online White Card. He had no working at heights certification which is a mandatory qualification for working at heights above 3m. He had received no onsite safety induction. He had not been required to sign on to a Safety Register, nor review task-specific Job Hazard Analysis. All of which are the most basic administrative safety tools that are fundamental to creating the safe workplace mandated by the *Occupational Safety and Health Act 1984 (OSH Act)* and associated Worksafe guidance for construction work.

The employer, ICS and the two directors were charged with contraventions s.19A(1) of the *OSH Act* leading to Wesley's death. These matters are still before the court and are not due for trial until 2021, 5 years after Wesley's passing.

The head contractor, Valmont, was prosecuted for failing to provide a work environment where workers were not exposed to hazards in accordance with the provisions of s.21C (1).

A causational charge was not available to prosecutors under the architecture of the *OSH Act*.

However, this gap in the law does not mean that Valmont and its officers, through their failure to take any meaningful action, was not equally complicit in the role they played in causing Wesley's death. They simply avoided prosecution.

The incorporation of the definition of a Principal Contracting Business Unit (PCBU) in the *WHS Bill* seeks to close this loophole and is a provision I strongly support.

A $38,000 fine was imposed by the Magistrate following Valmont's a guilty plea. The maximum penalty for the offence (at the time) was $200,000. Yet the penalty imposed was less than a fifth of that, despite these facts detailed in Worksafe WA's prosecution:[1]

Summarized:

- There were several open voids in the structure of the atrium steel framework;
- No adequate fall protection system was in place; *(no coverings over the holes, no edge protection and no anchor points/slack lines for a harness to be hooked onto)*
- No induction presentation was carried out highlighting the high-risk atrium area or the hazard risks register; *(this is a regulated safety procedure)*
- No safe method for performing duties, like standing on top of steel beams to install glass in the atrium, was included in the Safe Work Method Statements applicable to the work; *(this is a regulated safety procedure)*
- Contrary to Valmont policy, no regular safety inspections of the high-risk work were carried out. *(this is a regulated safety procedure)*
- On one occasion, the Valmont Site Supervisor observed Wesley and his Manager to be up on the atrium steel framework not wearing any safety harness whilst there was no other suitable safety measure in place.
    - Although they were called down and told to wear their safety harness and PPE there were no anchor points/slack lines installed for them to connect a harness into.
    - The Valmont site supervisor did not follow the Valmont procedures for dealing with non-conformance and corrective action.

During the court hearing the prosecution stated that Valmont *'was aware of an obvious and fatal risk for three weeks prior'* to Wesley's death.

Simply put, the head contractor (who holds the overarching control of the site) knew that there was a fatal hazard for three weeks, observed Wesley in a high-risk situation, but did nothing to mitigate the hazard which led to his death.

[1]Worksafe Prosecution Summary: https://prosecutions.commerce.wa.gov.au/prosecutions/view/1488

The consequences of this inaction? A $38,000 fine. This was Wesley's justice.
Valmont walked away with nothing more than a slap on the wrist. No audit has been undertaken on their safety practices and procedures, no sanctions applied on their ability to carry out high risk work, no suspension of building licence, no disqualification from being able to bid on Government contracts. Under our current laws it's just a case of minor penalty and then 'play on'.

Meanwhile, I am left behind to pick up the pieces of my broken life and somehow be expected to concede that justice has been served. I will not concede.

The sanctity of life, love and family deserves more protection in our legal system.

Accidents vs Breach of Duty of Care

The circumstances of Wesley's death were neither exceptional nor accidental.

Genuine accidents, by their very nature are unforeseeable – although desperately unfortunate no blame can be attributed.

Accidents do not commit those left behind to endure the torment of knowing that the death of their loved one was preventable. Rather it is was an unpredictable turn of events, random in nature which caused the tragic event.

Some deaths which occur in the workplace are genuine accidents. But for the deaths which are not, and where fault can be attributed to negligent conduct, we need laws which allocate appropriate penalties.

Penalties with two-fold purpose, to deliver meaningful justice to families and as a deterrent strategy to prevent these types of incidents occurring in the first instance.

The Interaction of Government Agencies and Governing Laws at Workplace Death

Groups opposing the introduction of an Industrial manslaughter offence, argue that a sufficient manslaughter provision already exist under the *Criminal Code Act Compilation Act 1902 (Criminal Code)*. And the creation of a separate offence in the *WHS Bill* creates an unnecessary duplication.

This argument fails to take into account a fundamental element of jurisdiction – and in doing so only serves to highlight the widespread lack of knowledge around how workplace and criminal laws interact in real life.

I have the lived experience of dealing with the legal system and since become a reluctant expert in the field of workplace deaths and the corresponding laws and offer unimpeachable insights into how the system and laws actually operate and where it fails.

Critical to this understanding is understanding what occurs in *real life* at the scene of a workplace death.

Investigating Agencies:

GOVERNMENT AGENCIES ATTENDING A WORKPLACE DEATH		
Attending Agency	**Governing Body**	**Governing Legislation**
West Australian Police	Police Department Reporting to Police Commissioner	Powers under the Criminal Code
Coronial Police	Office of the State Coroner Reporting to Coroner	Powers under the Coronial Act
Worksafe Investigators	Worksafe Reporting Worksafe Commissioner	Powers under OSH Act 1984

A. Jurisdictional Framework:

Worksafe maintain jurisdiction over workplace deaths and undertake investigations and prosecutions within their powers under the *OSH Act*.

B. Agency roles and interface:

[Ref Annexure A] – Flow Chart

Annexure A shows the events from the initial 000 call after the occurrence of a workplace death.

Order of Events:

1. Incident occurs.
2. 000 call is received and routed to district officers.
3. Patrol Police attend (usually junior officers, and in the case of my son, a very inexperienced team of two.)
4. Police asses for 'obvious criminality' - specifically foul play/homicide.
    a. Police do not assess scene for manslaughter or any other breaches under the Criminal Code other than obvious homicide. This non-investigation practise has evolved due to the established protocols between the Police and Worksafe wherein workplace deaths are ceded to Worksafe investigators.
5. When the determination is made that the death is not 'obviously criminal', the attending Police contact the Police Command Centre to request the Coronial Police and Worksafe Investigators to attend.
6. Police relinquish control of site and investigation within hours of arriving at the scene, where jurisdiction is handed over to the Coronial Police and Worksafe jointly.
    a. The Coronial Police attend 'reportable deaths', where their primary role is to identify the body and determine a preliminary cause of death where possible and prepare a report for the Coroner. They act in their capacity and duties under the *Coroners Act 1996*, not in a capacity to conduct an investigation for offences under the Criminal Code.

7. When the Coronial Police have finished their assessment of the scene, Worksafe take over as lead agency and take carriage of the investigation for breaches under the *OSH Act*.

Note:

- Worksafe do not have power to investigate or prosecute for breaches under the *Criminal Code* where manslaughter offences reside.
- If a death, (in similar circumstances such as a fall from a building) occurs outside of a workplace, Worksafe do not attend. The Police conduct the investigation and the Department of Public Prosecutions (DPP) prosecute for any offence (manslaughter/murder) under the *Criminal Code*.

In the case of my son, the Coronial Police Report was superficial at best.

Further, the Head of the Major Crime Division has confirmed to me personally that once the attending Police made the determination that the incident was not homicide, they undertook no further investigation into Wesley's death to the point that no photographic or forensic evidence was collected and the site was not preserved.

This process highlights how Workplace deaths are treated very differently to deaths outside of the workplace, in that they are simply not investigated by the Police. And the laws which govern workplace deaths do not have an offence provision for manslaughter by way of criminal negligence.

Thus, when manslaughter is committed in the workplace the public expectation of the right to justice is unduly denied.

I ask you to put yourself in the shoes of a family who has had to live with that.

Proposed Industrial Manslaughter Offence in the *WHS Bill 2019*

As explained, workplace deaths are governed by the *OSH Act* where the act of manslaughter (by way of criminal negligence) is not defined as an offence.

Much in the same way (that until very recently) offences did not exist for wage theft. Notwithstanding the criminality of the behaviour, there were no laws in place and therefore offenders could not be prosecuted for breaches which did not technically exist under law.

Industrial Manslaughter s30A, but particularly s30B – simple offence, seeks to remedy this glaring gap in the law, to include the act of manslaughter (by way of criminal negligence) in the workplace as an offence under the laws and jurisdictions which govern safety in the workplace.

The Conditions of The Worksite

[Ref Annexure B] – Shows photographs of the worksite where Wesley was working, taken in the hours after his death, 5th Jan 2017.

The Worksafe prosecution summary highlighted earlier, does not express the severity of the blatant safety violations shown in these photos.

These photos evoke strong reactions in the community and the circumstances of this scenario raise many questions;

- Was there a duty of care by the employer and the head contractor?
- Was this duty breached?
- Would a reasonable person see that there was sufficient risk that a person may die or suffer catastrophic injury as a result of a safety breach?
- Did the breach of that duty cause the death of Wesley?

If the answers to these questions are affirmation, then is this event considered manslaughter? And if so, the question then becomes – to what degree?

Industrial Manslaughter Category Offences

Unlawful conduct and culpability exist on a spectrum. We see this principal reflected in the category offence provisions which exist for murder, manslaughter and serious driving offences.

The purpose of the category offence provisions Industrial Manslaughter A and B is to define the degree of culpability of an offender on this spectrum. And to attach a tariff which reflects the severity of the crime.

Under current law, only the highest degree of culpability is observed with a 'gross negligence' offence under s.19A (1) and s.21C (1) of the *OSH Act*. A breach which carries a prison sentence of up to 5 years.

s30A largely mirrors these gross negligence offences, with increases to the tariff, from 5 years to 10 years imprisonment, expansion of the definition of who can be held culpable through the inclusion of the definition of PCBU in lieu of employer (s.19) and corporate body (s.21) and upgrading the title of the offence to Industrial Manslaughter.

The elements of the offence remain the same; standard of proof for mens rea (knowingly/knew), a breach in duty and causation.

That is to say; an offender was consciously aware of a substantial risk and unjustifiably disregarded their duty to mitigate the risk knowing that the likely outcome (of the breach) would cause death.

s30A (as under the current law) captures the highest level of culpability on the spectrum of fault and a successful prosecution remains contingent upon being able to prove the defendants' knowing state of mind.

In the case of my son, prosecutors could not access the Level 4 custodial offence provisions under s.19A (1) and s.21C (1) - because of the subjective test of being able to determine and prove the state of mind of the defendants.

It is only in the rarest of circumstances where prosecutors can access this level of proof. Relying on either a confession or evidence of a notification by Worksafe, Union representatives or an internal notice which specifically identified the critical hazard to the duty holder, proving that the offender 'knew'.

When society jails one-punch offenders or drink driving offenders, who kill people on the road, there is no requirement to prove the state of mind of the offender. Rather that the offender breached an obligation and duty of care and 'ought to have known' that in doing so harm may be caused. And that failure to observe that duty caused the death of a person.

s30B adopts these principals and seeks to capture negligent conduct whereby the duty holder 'ought to have known' that harm may be caused. And failure to observe that duty caused the death of a person.

In the case of my son, it is only through a category offence provision, which is an objective test of an offender's conduct (s.30B), rather than a subjective test of a person state of mind (s.30A) that would allow prosecutors an opportunity to respond to the gravity of safety violations with the vigour that the circumstances deserved.

A failure to incorporate a provision of this nature will be yet another failure of justice.

Technical Considerations

I ask the committee to consider the aspects below when evaluating the architecture of the *WHS Bill 2019* and incorporate recommendations which address these concerns particularly under A and B.

A. Statute of Limitations

A three-year statue applies for prosecutions under the *OSH Act*, which will be reduced to a two-year statue under the *WHS Bill*.

To ensure that all deaths are treated equally, the *WHS Bill* should replicate the *Criminal Code*, which applies no statute of limitations for manslaughter offences.

A failure to address this technicality, would preserve the imbalance of how workplace deaths are treated by the legal system. And leave opportunity for an injustice to be served to the families left behind.

B. Powers of Extradition

Again - to ensure that all deaths are treated equally, Worksafe must be given the same powers to seek extradition for manslaughter offences as the Police.

A failure to address this technicality would mean that an offender could simply leave the country and not be held to the same level of account as offender charged under the *Criminal Code*. This too would leave an opportunity for a grave injustice to be served to the families left behind.

Conclusion

Workplace safety reforms are necessary to not only harmonise our laws and improve safety outcomes, but to ensure that other families do not have to suffer the degrading and soul-destroying experience which I have endured because both the custodians of Wesley's workplace and our legal system treated his life as if it were meaningless. The *WHS Bill*, with the inclusion of the industrial manslaughter offences, represents a significant progression on the road towards achieving these outcomes.

In the case of my son Wesley, it is evident that the manslaughter provisions under the *Criminal Code* are not accessible due to the established practices and protocols of attending government agencies and the laws by which they are governed. And that adequate penalties do not exist for negligent conduct which causes death under the current *OSH Act*.

To address this legal void, deliver justice to families and put companies on notice about the gravity of their responsibilities to provide safe workplaces and comply with occupational health and safety regulation, the inclusion of s30A and s30B Industrial manslaughter is critical to delivering an equitable and comprehensive piece of legislation.

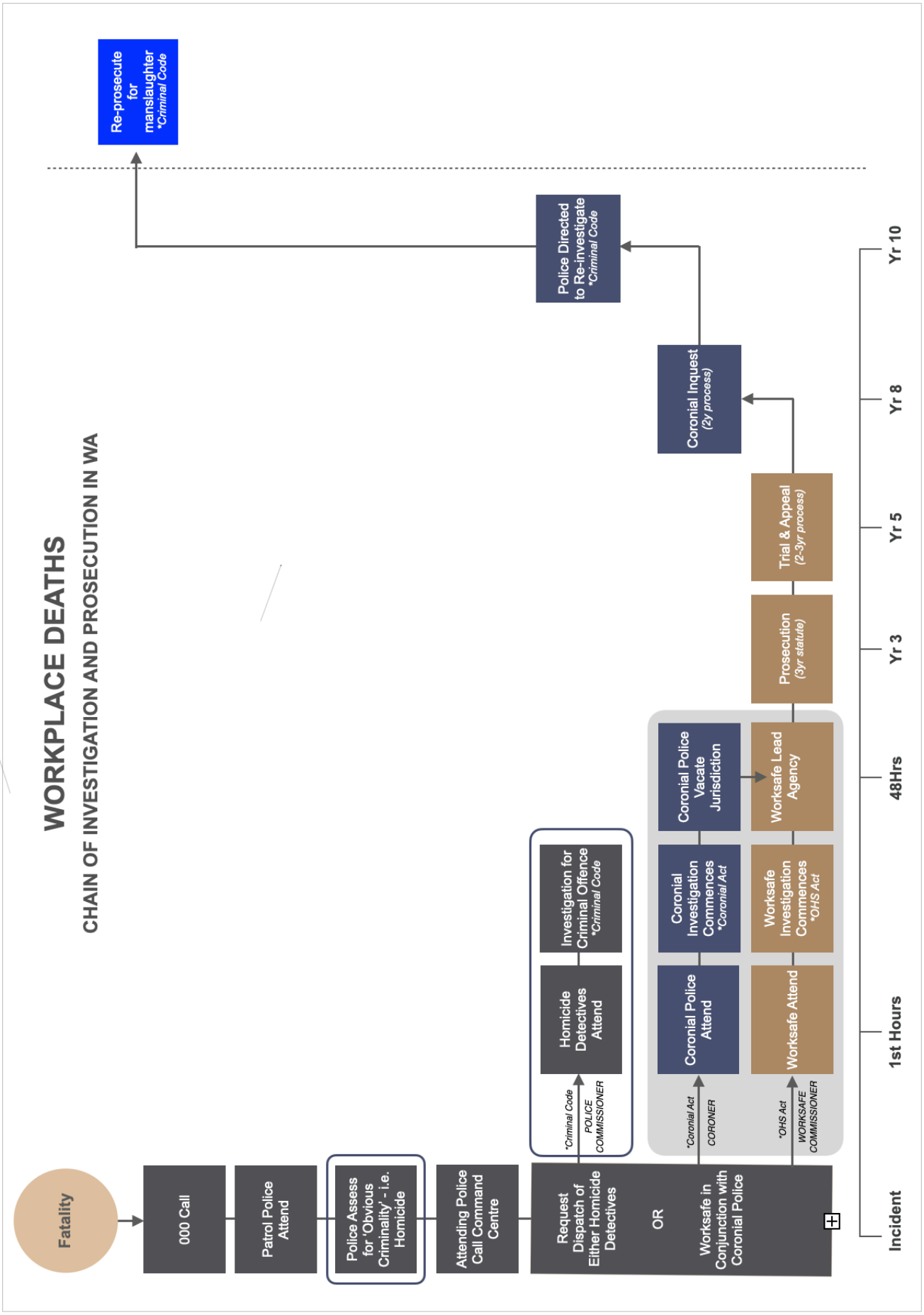
Thank you in advance for your consideration of my comments and for the opportunity to provide a submission. I welcome any opportunity to appear and give evidence directly before the committee.

Yours sincerely,

Regan Ballantine
Mother of Wesley Ballantine

Perth, Western Australia

ANNEXURE A – Flow Chart – Chain of Investigation and Prosecution for Workplace Deaths - WA



ANNEXURE B – Photographs of where Wesley had been working, taken on the day he was killed.