

# WHAT SHOULD THE OPTIMAL STRUCTURE AND CONTENT OF A MODEL OHS ACT BE?

## SPECIFIC COMMENTS

### 1. Legislative Approach:

*Q1. Which regulatory approach or approaches should be taken in the model OHS Act, and why?*

Setting general duties of care and specifying the outcomes required is the correct approach in the model OHS Act. Failure to comply with any of the duties should be a criminal offence.

The only credible alternative to such an approach is a prescriptive regime. The Robens report correctly found this was untenable as it required extensive detailed regulation for each industry. The use of prescriptive legislation also required extensive use of exemptions by the regulatory agencies for all the circumstances, impossible to foresee when drafting the legislation, that made it undesirable to apply the prescription. In contrast, a goal setting regime puts responsibility on each duty holder to find and implement the best OHS risk control solutions for the undertaking in question.

There is a more fundamental question, which is the decision to have an OHS Act at all. It is possible to do without, as everybody did before the first Factories Act in the UK in the first half of the 19<sup>th</sup> Century. In those days employers and employees decided what was acceptable. Employees were free to walk away from what they could not accept. Anyone who was injured could sue for compensation for breach of common law duties of care. The USA has stayed closer to this older model than the UK and Australia, and it goes a long way to explaining the reputation of the USA as a litigious society. That does not make it worse, just different.

I believe OHS legislation is worthwhile because it addresses the imbalance of power between employer and employee in setting the conditions of employment with respect to health and safety. However, I would prefer to see any matters of compensation left to the civil courts so that the enforcement of the provisions of the OHS Act can be purely a criminal matter.

If the regulatory approach is to create and enforce criminal offences for failing to safeguard the health and safety of persons employed or affected by an undertaking it is vitally important that the consequences are recognised and followed through. It is all too common for the basic model - enforcement of criminal law - to be confused, complicated and muddled by additional requirements and contradictory policies to the point where it barely functions. A large part of the rest of my response is concerned with this.

*Q2. How detailed should the model OHS Act be in comparison with the subordinate regulations and codes of practice?*

Ideally the model OHS Act will be just detailed enough to be usable and fit for purpose on its own; understandable by any normally intelligent person and as short as possible. Few people in normal working life have the time or inclination to read huge amounts of complicated legislation. If people do not know what the law says, it should be assumed the law is ineffective for any purpose except possibly punishing those people when they are caught out. A few short but clear laws, even if they are quite crude and imperfect, can do a lot more good than several volumes of legislation, no matter how well conceived and drafted. (In reality, the quality of legislation usually declines in proportion to its volume. The resources for proper drafting, review and parliamentary scrutiny are placed under enormous strain.)

Detailed regulations and codes of practice can be useful in some specialised areas, but it is imperative to be clear about the purpose for which these things are provided. Some purposes are good, others are not. It is often helpful to have a code of practice that prescriptively

describes a possible means of complying with a duty in an Act that is principles or performance based. It is even better if an industry can be persuaded to draw up its own standards or codes in response to a duty in an Act because that will often be more influential on the industry than trying to impose a code of practice, and it will still set a benchmark of accepted practice that can be used to enforce the provisions of the Act. On the other hand, it should not be normal to use subsequent legislation to interpret and correct for shoddy primary legislation.

An example of the sort of thing that easily brings OHS law into disrepute is a duty in an Act to submit a report of each accident or dangerous occurrence where the meaning of dangerous occurrence is given separately in regulations that are mostly about something else entirely, the content of the mandatory report is specified in detail in a direction placed in the Government Gazette and failure to comply is made an offence by a later Act replacing the first.<sup>1</sup>

This approach to imposing duties is unintelligible to any normal person, at least at first sight. The consequence is that those with such a duty rely on the regulatory agency to tell them what to do. This creates a culture of dependency where the duty holders do not look after themselves but expect to be led by the hand. The regulatory agency is placed in the uncomfortable position where a failure of compliance by a duty holder, which should attract enforcement by the agency, might reasonably be seen as no more than a failure of the agency to provide proper advice to the duty holder. Can the agency police itself? I shall return to this point; see in particular the answer to Q83.

*Q3. What is an appropriate title for the model OHS Act?*

I have no strong view, but it would be good to see some consistency. This question is trivial compared to the related issues arising from the plethora of jurisdictions and agencies.

*Q4. Should the model OHS Act specify its objectives? If so, how and what should they be?*

See also the answers to Q 79 and 83 which consider this point in relation to regulatory agencies. The issues paper says that including objects can “guide officials in exercising their powers and performing their functions.” My years of experience as such an official in agencies with multiple objectives set in OHS legislation has convinced me it is counterproductive to have more than objective, role or function. The model OHS Act should specify one objective in any one instance, such as: one objective for the Act itself; one objective for the responsible agency that regulates under the Act; and so on.

Setting more than one objective for any one thing confuses matters. It suggests that those responsible have not decided what they are trying to do, or are making compromises with insufficient regard for the damage and cost that follows. It loses most or all the advantage in stating an objective. It results later in interminable debates about which, if any, is the primary objective; how should the finite resources available be divided between them; can the multiple objectives be pursued simultaneously or are they mutually exclusive; are they contradictory; and so on. If it is not possible to set one objective it might be better to set none. Even such a colossal undertaking as the Allied nation’s war against the Axis powers in World War 2 had only one objective<sup>2</sup> so it should be possible in an OHS Act.

*Q5. Should the model OHS Act include a set of principles of health and safety protection? If so, what should they be?*

The answer to this depends on the objective of the Act and the objective of any regulatory agency, see answers to Q4 & Q83. If the Act and the agency are concerned with advising (or

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<sup>1</sup> For example: Petroleum (Submerged Lands) Act 1967 Sch.7 c.41, which was replaced on 01.07.08 by the Offshore Petroleum Act 2006 Sch.3 c.82, and the Petroleum (Submerged Lands)(Management of Safety on Offshore Facilities) Regulations 1996, reg. 45, the Petroleum (Submerged Lands) (Pipelines) Regulations 2001, reg 39N and the Government Gazette.

<sup>2</sup> The Allies agreed at the Casablanca conference in 1943 that their objective was the unconditional surrender of all the Axis powers.

telling) people how to manage OHS, and not with giving people OHS duties and enforcing their compliance, such principles might be appropriate.

*Q6. Are there any other issues that should be considered in the legislative approach of a model OHS Act?*

As discussed in the answer to Q7, it would be helpful to have a clear separation of OHS at the level where individual injuries occur and OHS for major hazards because they need quite distinct and different management.

## **2. Scope, Application & Definitions:**

*Q7. Should the model OHS Act maintain the status quo in each jurisdiction regarding industry specific safety legislation? If so, what provisions should be made for establishing the relationship between the model OHS Act and industry specific legislation?*

The issues paper makes no mention of regulating major accidents, although it does mention regulation of industry sectors. Major accident regulation is qualitatively different from other OHS regulation and requires a quite different approach. For similar reasons to those given above it is probably best dealt with separately. At present the regulation of major hazards in the offshore petroleum industry is made unnecessarily difficult by some aspects of the legislative framework. The first has already been touched on in the answer to Q4. A related difficulty is the expansion of the definition of 'offshore facility'. The relevant Explanatory Memorandum shows this was originally supposed to be a place offshore where people working are exposed to a major hazard due to petroleum fluids. Somewhere along the line the definition grew to include other things, some with no major hazard due to petroleum fluids.<sup>3</sup> A lot of these so-called petroleum facilities are really vessels, doing what vessels do, but they have to submit a safety case while other vessels do not, thanks to this regrettable growth of the definition. This is without doubt the work of people with good intentions, but the result lacks logic, creates anomalies and wastes a lot of time both for the industry and the regulator as each strives to find pragmatic solutions to the problems that arise.

Another unfortunate quirk of the regulation of major hazards, at least so far as offshore petroleum facilities are concerned, is the expansion of the scope of the safety case to cover all OHS.<sup>4</sup> The use of a safety case for major hazards was already growing in popularity before the Piper Alpha disaster in 1988. After that it was adopted in many jurisdictions. It is entirely appropriate for Australia to regulate major hazard in this industry through a safety case regime. What is not appropriate is to add the management of normal everyday OHS into the safety case. The safety case is not appropriate for routine OHS. It is confusing and distracting to muddle major hazards and other OHS together. It devalues the safety case and makes it more difficult to use it for its intended purpose. If this argument is wrong, and a safety case is a good tool for managing all OHS, the model OHS Act ought to require an accepted safety case for every undertaking, whatever it is - including all vessels, see above.

A model OHS Act should include an appropriate regulatory framework for major hazards, such as offshore oil and gas safety. It should recognise the qualitative difference between major hazards and other OHS. It should give simple and clear definitions of major hazards and apply those definitions with absolute rigour. One problem at present is that the definition used in some Australian legislation<sup>5</sup> sets the bar too low:

*“major accident event... an event... having the potential to cause multiple fatalities”*

The words “having the potential” confuse an accident (which the law says involves death or injury to people) with a dangerous occurrence (which does not), unless the intention of this definition is that an “accident event” is very different from an “accident”. Also, a major

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<sup>3</sup> See Offshore Petroleum Act 2006 Schedule 3 c.4.

<sup>4</sup> See the Petroleum (Submerged Lands)(Management of Safety on Offshore Facilities) Regulations 1996, Reg 9(4)

<sup>5</sup> See the Petroleum (Submerged Lands)(Management of Safety on Offshore Facilities) Regulations 1996, Reg 5

accident should be one where the number of fatalities is enough to make it clearly different from the sort of accident that kills or injures one or two people. The UK's Offshore Installations (Safety Case) Regulations 2005 defines a major accident as any of four distinct very serious events that are particular to that industry and then any event,

*"...arising from a work activity involving death or serious personal injury to five or more persons on the installation or engaged in an activity in connection with it."*

This is a better definition, even though the number five is obviously arbitrary.

*Q8. Alternatively, should a model OHS Act incorporate all industry specific safety legislation?*

That might depend on whether it is desirable to have a single regulator for all industries under the Act. The Issues paper says the UK has brought most industries under a single system. This is true only as a broad simplification. The regulation of OHS in the UK is a complicated subject. When you lift the lid on the UK Health and Safety Executive you find within it several Divisions, most of whose origins long predate the HSE itself, each with its own history, culture and regulations (although all are enforcing the HSWA 1974) and each operating with considerable autonomy. There are also local authority agencies that enforce the HSWA 1974 independently of the HSE.

*If so, how and to what extent (e.g., could industry specific issues be dealt with in regulations, codes of practice or guidance material under the model OHS Act)?*

Industry specific issues can be dealt with that way.

*Q9. Should the model OHS Act contain provisions for improving coordination between safety regulators within jurisdictions? If so, what should be provided?*

No, if this means joint activities of any sort. The widespread belief that great effort should be made to encourage joint working different regulatory and law enforcement agencies is based on a fallacy.

Wherever we have more than one agency, one of two explanations is likely. The first is that these agencies are doing much the same work, with a significant overlap in their jurisdictions. Neither can function properly unless coordinated with the other. This shows they are not independent agencies. Bolting on mechanisms for coordination leaves them like partners in a three-legged race. It is a very clumsy solution. Agencies that are mutually dependent should not be separate agencies. They should merge. The second possibility is that the agencies are functionally independent. The effort put into joint activities is a waste of resources spent on inter-agency sight-seeing and indulging idle curiosity. I know it is very enjoyable to spend a few days seeing what the other agency is up to, but there is little justification.<sup>6</sup>

When agencies opt for coordination there should be close scrutiny of what they put in their Memoranda of Understanding and such like. In particular, before joint activities are proposed, it should be necessary to establish a proper regulatory basis. An inspector from one agency likely has no regulatory standing at all when accompanying inspectors from another agency in another jurisdiction. The agency acting as host might have no authority to bring guests on its operations. The guest inspector might have no legal authority and be in effect just another member of the public. The legal consequences if, for example, the guest inspector is injured, or attempts to exercise powers that do not exist away from the inspector's home patch, should be understood before undertaking the joint activity, and it should all be explained to those expected to admit the guest to their premises.

What is necessary is demarcation between agencies who must work alongside each other on occasions. This is the opposite of joint working. It is putting a line between them so they can both do their job with the minimum of interference from the other. A typical example of a circumstance where this is necessary arises after a workplace fatality when both the police and the OHS regulator must investigate for their own separate reasons.

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<sup>6</sup> One official document I have seen says the objective of joint activities is to "foster inter-agency relationships".

*Q10. Should general duties of care be tied to the conduct of work, to the workplace or to some other criteria?*

In order to establish a comprehensive system for occupational health and safety it is necessary to apply the duties to the conduct of work wherever it takes place. This is better than the alternative, but there is at least one obvious problem. Many people drive on public roads in the course of their employment, not just commuting between home and workplace, but as a work activity. This is already regulated through Road Traffic Act legislation that applies to all road users and is enforced by state police. If it is also regulated by the model OHS Act there are all sorts of jurisdictional issues to resolve. This should be explicitly addressed and resolved in the model OHS Act to minimise the difficulty.

*Q11. Should general duties of care under the model OHS Act be extended to members of the public? If so, how?*

Yes. A person in control of an undertaking must ensure that risks to the health and safety of anyone who may be affected by the undertaking are as low as reasonably practicable. This can be achieved by taking the previous sentence, putting it in the Act and enforcing it. This is important in many ways. A construction site should be adequately fenced to keep out children, and to avoid objects falling on to people passing by. Major hazard facilities can put hundreds or even thousands of adjacent people at risk. It is inadequate to only consider the workforce. It would be helpful to require a person in control of any undertaking of significant size to have made a written risk assessment that includes risks to the public as well as the workforce.

*Q12. Should the scope and application of the model OHS Act be sufficiently broad and flexible to accommodate new and evolving types of work arrangements? If so, how should this be achieved?*

It is very desirable that the model OHS Act is sufficiently broad and flexible, although it less obvious how exactly this can be achieved. There is no doubt that a simplistic model where each workplace is controlled by one employer and all the workforce are employees of that employer is entirely unrealistic. See also the answer to Q16.

*Q13. Are there current or emerging hazards and risks that are not effectively addressed under general duties of care? If so, how should they be provided for under a model OHS Act?*

The general duties are adequate for current and emerging hazards. There are few if any successful prosecutions over issues such as stress and fatigue because the evidence is not good enough. It would be a mistake to skew the law in favour of such prosecutions instead of insisting on proper evidence that illness or injury is caused. The adversarial system must be allowed to do its work, unless it is wholly abandoned in all cases and replaced, for example, by compensation for any incapacity without questions or blame. Serious bullying should be dealt with by the police, not by OHS law. It has more in common with offences such as assault and threatening behaviour.

*Q14. Which terms are critical for achieving national consistency? How should they be defined in the model OHS Act?*

So long as there are different jurisdictions it should be accepted they are different. That is the whole point of them. The only sensible way to end the differences is to unite the jurisdictions into a single jurisdiction. Trying to bolt on mechanisms to prevent the different jurisdictions being different is to wish the end but not the means, and to act in contradiction to the current constitutional arrangements. See also the answers to Q133 and Q152

*Q15. Are there any other issues relating to the scope, application and definitions of a model OHS Act?*

None I can think of.

### **3. Duties of Care – Who owes them and to whom?:**

*Q16. Should the model OHS Act include a 'control' test or definition? If so, why and what should it be?*

The Petroleum (Submerged Lands) Act 1967, and its successor, the Offshore Petroleum Act 2006, try to clarify who is in control of each offshore petroleum facility by requiring each offshore petroleum facility to have a registered operator. The operator must have 'day to day management and control' of the facility. The operator has the bulk of the duties under the relevant OHS legislation. This has some advantages for the regulator but is not a complete answer. Some companies who wish to be involved in operating such facilities might want to adopt management arrangements that are not compatible with this legislation. It is not entirely obvious that the law is justified in preventing them doing so just for administrative convenience, although it is possibly a good thing for OHS that control is placed in just one pair of hands. It is also not certain that a court will accept that a person was in control just because a register says so, without evidence that the person really was in control at the material time. If such evidence is required, a lot of the benefit (to the regulator) of the register is lost. The regulator will have to investigate and prove who was in control just as if there was no register. It is probably beneficial, on balance, to require a registered operator for each facility but it is certainly not a complete answer to the problem of deciding who is in control.

It is unlikely there would be anything gained by including a 'control' test or definition. Being in control is a sufficiently basic and well understood concept. The difficulty is deciding how to apply the concept to an infinite variety of different circumstances where control is divided in all sorts of ways. Constraining the ability to consider each circumstance on its own merits by insisting on the application of a particular test or set of tests could hinder more than it helps. The current arguments over the meaning of 'control' would simply be replaced by arguments over the meaning of the test or definition.

*Q17. What should the role of control be in relation to determining who is a duty holder, the nature of the duty, the extent of the duty and the defences?*

If there is to be any justice, it is necessary that a duty holder is only held responsible for things that are within the duty holder's control if the duty holder chooses. The nature of the duty should reflect the nature of the control the duty holder exercises. The extent of the duty should reflect the extent of the control. Defences should include having done as much as is reasonably practicable. Defences should not include being unaware or ignorant.

*Q18. Should control be able to be delegated or relinquished? If so, in what circumstances and what should the legal effect of doing so be?*

Control cannot be relinquished except by giving up an undertaking entirely, but control can be delegated up to a point. The delegate is in immediate control of the thing delegated so far as the delegator has relinquished that control, but the delegator retains final control and acquires control of and is responsible for the delegate. The exact result can only be determined by looking at the particular circumstances each time.

*Q20. Is primary reliance on employment relationships a valid basis for framing safety obligations?*

Employment relationships tend to be the most significant relationships for OHS obligations, but there are many exceptions. Excessive reliance on employment as the defining relationship in framing the legislation would, for example, understate the importance of having control of places where people work, or of manufacturing and supplying things people use for work. The OHS obligations between parties are dependant on their relationships, and there is no reason to rule out any of them, or make others special.

*Q21. How should the model OHS Act provide for duties owed to non-employees such as contractors, labour hire personnel, volunteers, apprentices/trainees and other persons performing work?*

See the answer to Q11, but in addition to protection from OHS risks the duty should extend to safeguarding welfare.

*Q22. Is there a broader concept that more effectively covers the various work arrangements?*

See the answer to Q21.

*Q23. How and to what extent should the model OHS Act specify an employer's duty of care?*

The model used in the UK HSWA 1974 is adequate.

*Q24. To whom should these duties be owed?*

The duties must be owed to anybody whose health and safety can be affected by the undertaking.

*Q25. How, and to what extent, should the model OHS Act specify worker's duties of care?*

Workers should be expected to bear the responsibilities of competent adults. They should be required to cooperate at work with any measures taken to eliminate, reduce, control or mitigate risks to their own health and safety at work and that of anyone else.

What somebody does when not at work is no business of the employer and no concern of OHS law.

*Q26. Should the model OHS Act include duties of care for persons who are not performing work (e.g. visitors to a workplace, members of the public)? If so, what should the duties be?*

So long as the Act is an OHS act and so by definition is concerned with occupational matters, it should not impose duties on those who are not working.

*Q27. Should the model OHS Act provide a mechanism for persons to be appointed to a position that has specific OHS responsibilities?*

This is a fascinating idea with great possibilities for resolving some of the issues discussed in the answer to Q83, which argues against a regulatory agency providing advice. If it is desirable that a source of OHS advice is always available in a workplace there are big advantages in requiring that somebody is appointed, by the undertaking responsible for the workplace, to provide such advice. A post created for the purpose can be tailored to meet the exact needs of the place, and the person employed in the post should have a better chance than any inspector to become completely familiar with all the OHS issues of the place and understand how they should be managed.

*Q28. What should the liabilities of such appointed persons be if the responsibilities are not met?*

The appointed person should carry full responsibility under criminal law with the threat of the harshest penalties upon conviction for an offence, including penalties equivalent to those for homicide if there is a fatal accident.

*Q29. What should the relationship be between the OHS responsibilities of the duty holder and such appointed persons?*

The duty holder would carry the same responsibilities but penalties would only be fines and not prison for a body corporate. However, the duty holder would not be able to continue its undertaking lawfully if nobody was employed in the position with personal responsibility for OHS. This would make a threat by that person to resign a powerful deterrent to not upholding appropriate standards of OHS.

*Q30. Should the model OHS Act include positive duties for officers of bodies corporate?*

The officers should be required to appoint a suitable person to the post described in the previous answers and to provide that person with the requisite authority and resources to implement appropriate OHS policies. Upon failing to do so they should be jointly and severally responsible for the duties of that person and risk the same penalties.

*Q31. Do current provisions for persons in control of a workplace (and plant and substances) clearly express who owes a duty, to whom, and under what circumstances the duty is owed? If not, how could this be clarified?*

No comment

*Q32. Should the model OHS Act specify that persons in control of a work area or a temporary workplace also have a duty? If so, to whom?*

See the answer to Q17.

*Q33. Should the model OHS Act clearly establish health and safety obligations for various activities which affect health and safety for the whole life of an item, structure or system (i.e., conception to disposal)? If so, what should the duties be in relation to these activities?*

Yes. This is particularly important for major hazard risks, which are largely determined by the decisions taken before the major hazard facility can be operated. A requirement for an accepted safety case is useful, although the legislation to implement this requirement for offshore petroleum facilities in Australia could have been better.

A safety case typically consists of a description of the facility and its risks, an assessment of its major hazards and a description of how they are managed so that risks are as low as reasonably practicable. For this to deliver the expected benefits it is important that the safety case is, so far as possible, written by the duty holder and used by the duty holder. A duty holder that prepares its own safety case gets the benefit of conducting and recording a rigorous and methodical analysis of all its major hazards and how they are managed, and comes out of the process with an invaluable deep understanding of it. However, far too often the safety case is written by consultants and used only as a means of getting regulatory approval. It is essential that the legislation is simple and clear so that the requirements for writing a safety case can be understood without additional guidance or interpretation. It is fatal to the intent of safety cases to issue substantial quantities of guidance about them. We should expect any major hazard facility operator confronted with several hundred pages of guidance to assume, without reading any of it, that the subject is beyond comprehension without years of study and the job should be given to consultants. For example, the requirements for a safety case in the Petroleum (Submerged Lands)(Management of Safety on Offshore Facilities) Regulations 1996 are sufficient by themselves and can be read in a few minutes. It is unfortunate that voluminous additional guidance has been issued anyway. This is intimidating and it has added complexity and imposed various requirements not found in the regulations, such as a requirement for the safety case to comply with a set of "principles". It is an ironic possibility that some operators are grateful for the guidance because otherwise they would not have known about the principles, not realising that no guidance would mean no principles.

It is equally deadly for the regulatory authority to devote excessive effort to minute examination of each safety case and to extensive correspondence with the operator about the contents of the safety case before deciding if it is acceptable. The safety case is only a document. Accepting it only means it is an adequate document; one that passes the tests set by the legislation. The actual risks to OHS are at the facility and that should be the primary focus of regulatory attention. If the regulator spends too much time trying to coach the operators into producing perfect safety cases, the effort of trying to perfect the document tends to detract from improving OHS in the real world, and it reinforces the widespread belief that the safety case is written for the regulator.

If the model OHS Act mentions safety cases it will presumably also mention validation. Validation provides independent assurance that the design, manufacture, construction and installation of plant and equipment meets appropriate standards. Validation can and should be independent of the safety case. Unfortunately the Petroleum (Submerged Lands) (Management of Safety on Offshore Facilities) Regulations 1996 make acceptance of a safety case dependant (among other things) on satisfactory validation. This creates a link that has no logical basis. It causes a lot of needless difficulty because it does not reflect the way things work in the real world, where there might be very good reasons why completion of validation only takes place long after acceptance of the safety case.

Validation is only half a system and would be much improved if it also provided independent corroboration that safety critical systems remain fit for purpose and are being properly maintained during the entire life of the facility. This complete system is verification. Verification does for plant and equipment what auditing does for management systems. Regulation of the UK offshore petroleum industry includes a duty on each operator to implement a verification scheme.

*Q34. How should the model OHS Act deal with situations where the relevant upstream activity occurs in another jurisdiction or outside Australia, for example, where design occurs in one jurisdiction and manufacture in another? Should the manufacturer be responsible for the failings of a designer in this situation?*

This is a major issue for the regulation of OHS in the offshore petroleum industry. The law requires each facility to have a registered operator that carries most of the duties under OHS legislation. However, the operator need not be based in Australia and can be beyond the reach of any enforcement except when it chooses to submit. It is said that free trade rules prevent any discrimination to stop such companies becoming operators. It is not obvious why Australia operates a system that means Australian companies cannot avoid prosecution for an offence but other companies can just walk away. It does not seem unreasonable to require that an operator of a major hazard facility in Australian jurisdiction must be registered locally and have sufficient assets within Australia to make a realistic contribution to pay a penalty and compensate those affected after a major disaster.

Where design, manufacture or supply occur outside Australia the relevant duties must fall on the importer.

See also the answers to Q14 and Q152 concerning the multiplicity of jurisdictions within Australia.

*Q35. How should the activity of supply be defined? Should it occur only once or every time an item changes hands, whether permanently (wholesale, retail, second hand, and gratis) or temporarily (loan or hire)?*

See the answer to Q17.

*Q36. Are there any other issues in relation to the duties of care that should be addressed in the model OHS Act?*

When a regulatory agency is set up with a limited remit, such as OHS in the offshore petroleum industry, there is a tendency to focus on the relationship of the agency to the operators of the major hazard facilities, and perhaps workforce, as the primary concern, to the exclusion of all other duty holders with a duty of care. These other duty holders include the operators' contractors, other employers, suppliers and manufacturers. There might be a quite manageable number of operators, who change infrequently, but the number of contractors, employers, suppliers and manufacturers is much higher and they change far more frequently. The agency will almost certainly be overwhelmed if it attempts to use the same approach to regulate these other duty holders as it uses for operators, unless it has several times the resources needed just for regulating the operators. Also, the regulatory powers given to the agency might be designed with only the operators in mind and quite unsuitable for regulating other duty holders. If the regulatory agency is funded by a levy taken from the operators they might not regard it as appropriate for the agency to use its resources to regulate those who do not pay a levy. A reasonably detailed vision of how such an agency will regulate other duty holders should be available before drafting the relevant legislation.

#### **4. 'Reasonably Practicable' & Risk Management:**

*Q37. Should a test of "reasonably practicable" be included in the model OHS Act?*

Yes.

*Q38. If not, what alternative standard should be included?*

n/a

Q39. *How should the standard be defined? What level of detail should be provided?*

As defined by the courts at present. The Issues paper says some stakeholders have expressed concern that courts and regulators do not consistently interpret and apply the standard. This might show the stakeholders have not considered that reasonable practicability is dependent on particular circumstances. That is its essence and its great advantage. It is always appropriate because it is infinitely flexible. What it is not and never can be is consistent in any simple and obvious way. If consistency is all that matters the law should revert to prescription: everything should be prescribed and there should be no exemptions.

Q40. *Should control be an element of the standard? (see Chapter 3)*

See answer to Q16.

Q41. *Should a test or examples for assessing compliance with the standard be set out in the model OHS Act or in subordinate instruments? If so, what would that contain?*

No. This would be too likely to impose a de facto prescribed standard which would undermine the whole point of having goal-setting legislation.

Q42. *Should 'hazard' and 'risk' be defined in the model OHS Act?*

Yes.

Q43. *Should a definition of 'reasonably practicable', or an alternative standard, include a reference to risk management principles and processes (hazard identification, risk assessment and risk control)? If so, how?*

Yes. The UK HSWA 1974 uses this standard and the Act did not explicitly require a process of risk assessment. Experience quickly persuaded the government that an explicit requirement was justified because the strongly implied requirement in the Act was insufficient in practice. This resulted in the Management of Health and Safety at Work Regulations, last revised in 1999, regulation 3.

Q44. *Should risk management principles and processes be specifically required by the model OHS Act in relation to the general duties, or otherwise?*

See previous answer.

## **5. Consultation, Participation and Representation:**

No comment.

## **6. Regulator Functions, Powers & Accountability:**

Q79. *Should the model OHS Act provide for the establishment, functions, powers and accountability of regulators? If so, what should be provided?*

The list in the Issues paper 6.1 is familiar though it is slightly more specific and therefore clearer than some other lists, which is an improvement.

It would be good to have clear definitions of "promotion" and "advice" and who should be the target for them. An astonishing range of activities can be undertaken under such headings, some overlapping with or including others found in the list in the Issues paper 6.1.

It would be good, for the sake of clarity, to exclude certain functions. This would be a barrier to regulatory or mission creep. As an example, the agency that regulates OHS for the offshore petroleum industry in Australia is a Safety Authority. However, it is under pressure from various external sources to be responsible for matters that are not safety. In particular there are demands that the Safety Authority should be responsible for the integrity, reliability and availability of energy industry assets, such as hydrocarbon wells and pipelines, because there is understandable concern that failures of these assets can have important social, commercial and political consequences even when safety is not an issue. However, it is not clear how or why a Safety Authority should take this responsibility.

The final item in the Issues paper list is a particular concern. The collection and publishing of OHS statistics and data should not be included, but if it is, there must be a clear vision of what is required, a justification for its requirement and a very thorough competent examination to demonstrate that it can be achieved. The present situation, not just in Australia, is a shambles caused by multiple objectives and inadequate legislative provision. The waste of effort that results is extraordinary. I shall explain.

The UK HSE Offshore Safety Division some years ago invented what it called a National Programme on offshore facility process integrity. This was described as “targeting” an area of concern, although that was an odd way to describe a programme that took a blanket approach. Every operator and facility was included. No account at all was taken of the knowledge that over 80% of unplanned releases of hydrocarbon, which was the biggest cause of concern, came from less than 20% of the offshore platforms. Normal inspection planning would have directed inspections towards these platforms, but that was no longer possible, thanks to the National Programme. It was declared the programme would run for three years and 50% of inspector resources would be dedicated to it. It is quite possible the actual front line resource taken was greater. Teams of inspectors with some expertise in process integrity wrote extensive guidance and created check lists on the topics for other inspectors. For years, inspection visits were largely dedicated to completing the check lists. These were written up at some length and passed to the specialist inspectors. They compiled a large report based on all the incoming data. After about three years, the accumulated data were analysed and several months later a report was issued. There was no check on the quality of the data and no standard had been set. There was no proper method statement. Many in the industry, polite in public, commented in private after seeing the report that although it was interesting to see what the inspectors had found some years ago, it was only of historical interest because things had changed. There was no possibility of telling if the report had made any difference to OHS outcomes. What the programme certainly did was distract inspectors from investigating and enforcing against regulatory non-compliance. Naturally, it was proclaimed a great success and the program continued and expanded.

Similar programmes recently introduced here, like many other things people introduced to Australia from abroad, might not be as beneficial as was hoped. The questionnaires have not been designed by competent statisticians. They do not meet any recognised standard. The inspectors are required to rate the answer to each question against a “traffic light” test (red, yellow or green) based on a notion of relevant industry good practice. This is explicitly not a regulatory test. It does not correlate in any understandable way with OHS regulatory compliance. The inspectors undertaking the completion of these check lists are not expressing an opinion on compliance. In any case, the inspectors often ask the duty holder to take the check list away and return it when completed. It is possible for a response to be classed as red or yellow without any related enforcement. It is a mystery what it all means, what difference it is supposed to make and why regulatory inspectors are required to apply a test that is not related to compliance.

It is remarkable that such substantial regulatory programmes are undertaken without first establishing any credible objective measure that can be used to decide if the programmes have succeeded or indeed achieved anything at all. They can be so ill-defined that it is not even clear at the start if they are finite and limited programmes with a definite end-point or else a permanent addition to the inspection procedures. The fact that the inadequacy is not detected or questioned either within the agency or by those charged with exercising oversight of the agency adds to the sense of disquiet.

A similarly great effort goes into making statistics out of the notification and reporting of accidents and dangerous occurrences. The original purpose of a duty to notify was to alert the regulatory agency as soon as possible about an event that might be investigated. The definition of such occurrences, already discussed in the answer to Q2 in relation to offshore petroleum facilities, has some flaws but works reasonably well for this purpose. However, it was subsequently decided that such notifications would be used as a basis for statistics about the safety performance of the relevant industry. This was a bad day for OHS

regulation. The definitions of notifiable occurrences were not designed for that purpose. The categories of occurrences that must be notified and reported are arbitrary.<sup>7</sup> Things defined as dangerous occurrences are not necessarily dangerous by any normal standard. The categories are not mutually exclusive, so identical occurrences can, quite properly, be reported in different categories on the whim of those reporting. There is no effective quality control on what is reported. This guarantees poor quality data.

After an occurrence on an offshore petroleum facility has been notified, there is a requirement to send a written report. This report must include 21 different items, including the root cause or causes. Thanks to the imperative to provide statistics, this requirement tends to displace regulatory investigation of occurrences. Inspectors spend considerable time chasing these reports so the root causes can be entered into the data base. The method used to assign a root cause is decided by the person reporting. If the inspector thinks the root cause lacks credibility, the inspector might ask the person to try again. This can go on for a long time, but it has little or nothing to do with compliance or enforcement.

Even worse, the regulatory agency can focus its own investigations on finding root causes rather than seeking evidence of failures or regulatory compliance. The two things are quite different. Identifying root causes of unplanned events is a duty of the person in charge of the undertaking. It is wasteful duplication or substitution if the regulatory agency takes on the role that lies with the duty holder. When the regulatory agency seeks root causes instead of evidence for enforcement it abandons the regulation of OHS through enforcement. It is all about statistics. Inspectors are counting things instead of regulating them. (See the discussion of the UK HSE Railways Inspectorate in the answer to Q83)

It is safe to assume that reporting of deaths is reliable because it would be very difficult to get away with inaccurate reporting. Serious injury reporting is probably very nearly as reliable. The data on lesser injuries are open to all sorts of distortions and errors, legitimate or not. The amount of time spent by large numbers of people over years and years just debating the definition of a Lost Time Injury and several related terms is astounding. The reporting of dangerous occurrences is inevitably very subjective and wholly unreliable. The reporting of illness is just a joke. Although the law requires any illness resulting in time off work to be reported just like an accident, almost no reports are received. In the UK a few years ago the most prevalent reportable medical condition in one particular year in the offshore oil and gas industry was chicken pox: two cases. Officially, in that year, industrial dermatitis, hearing loss, occupational asthma, hand-arm vibration syndrome and so on were not problems. The equivalent Australian industry is equally free of occupational illness, officially. Perhaps this is cause for celebration.

There is no credible way to eliminate the various sources of error unless the entire reporting system is rebuilt, beginning with a proper design to meet a clearly stated purpose. If the data were merely presented for what they are, it would be more defensible. It would be correct, for example, to state the number of notifications of a category of occurrence received during a year, because that would be a bare fact, making no claim of greater significance. Unfortunately there is a demand for this to be transformed into a statement of how often something actually occurred, and then to extrapolate beyond that with statements about how many incidents are attributable to a particular cause and so on.

Major accidents are probably the least susceptible to statistical treatment. A defining characteristic is their rarity, which leaves little or no data to be plotted in annual graphs. This is recognised, but it does not suppress the enthusiasm for statistics. All sorts of ideas for "leading indicators" are advanced, with varying degrees of credibility. More data is gathered, and more debates are held, to define or refine these indicators and compare them. Their value remains unknown.

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<sup>7</sup> The list of dangerous occurrences found in the regulations reminds me of the categories of animals cited in the "*Celestial Emporium of Benevolent Knowledge*," an encyclopaedia mentioned by Jorge Luis Borges in his excellent essay, "*The Analytical Language of John Wilkins*."

The persistence of such unproven ideas in OHS is of course notorious. Exhibit A must be the safety triangle introduced in H. W. Heinrich's 1931 book, *Industrial Accident Prevention: A Scientific Approach*. The safety triangle illustrated his theory of accident causation: many unsafe acts lead to some minor injuries and, less often, to major injury. The first safety triangle or accident pyramid proposed ratios of 300 unsafe acts: 29 minor injuries: one major injury. It has become ubiquitous. Since then the ratios have been altered many times and the pyramid has morphed into several other shapes but the belief persists that we can predict or even control, say, major injuries, if we know the number of unsafe acts. The idea that we are fixing OHS by counting incidents has flourished.

No demonstration of the utility this work has been made. The dubious data are carefully compiled and analysed in open defiance of the GIGO principle and issued as reports to be picked over at length. Many people say the statistics are "useful" but I have never found any credible description of a use where the statistics are necessary and the result is an improvement of OHS outcomes. Some people seem happy to treat the collection of data and production of statistics as an end in itself. Others apparently desire these statistics because they believe OHS can be managed by epidemiological methods or something very similar.. Anyone with even a little acquaintance with the methods of epidemiology and the difficulties of conducting research worth the name would know that we are nowhere near that standard, and there is not the slightest evidence that such methods can work for OHS as things are. The idea that OHS policy might be influenced by these junk statistics is disturbing.

Strenuous efforts are made, year after year, trying to establish a basis for comparison of statistics across industries and jurisdictions, and even between companies, even though it does not change so much as one safety outcome. Some company managers wish for an OHS league, like in various sports, and want to place themselves against their competitors. This should not be encouraged. It is not good enough for a company to feel satisfied just because it thinks it is less criminal in its management of OHS than another company. Its OHS effort should be directed to being wholly compliant.

Others involved in picking over the statistics seem motivated by a hope that they might not only learn something about what has been happening, but also get some sign about where we are headed. This is often called "looking for trends". It is a modern form of divination, as effective now as it was in ancient times.

It would be better for OHS if duty holder management switched attention from statistics to looking at their own companies, their own management systems and their own compliance with OHS law. By monitoring, review and audit of their own management systems and by verification that plant and equipment meets their safety performance standards they would be able to assure themselves they have done all that is reasonably practicable to reduce risk, or in other words, they are compliant with the general duties. It is unfortunate that these statistics intrude and distract from just getting on with the job that matters. It is very regrettable that often the OHS regulatory agency is the prime source of this distraction.

If duty holders want to collect and analyse such data and report the results, nothing prevents them. There is no law against it. It does not require government intervention.

In conclusion, if data and statistics are required for political reasons that override the above arguments, and if duty holders will not organise themselves to do it, it should be the work of a dedicated expert statistical agency with a carefully established remit and the resources necessary to do the job properly. The Australian Bureau of Statistics is an obvious candidate. In contrast, using regulatory inspectors to gather data as well as carry out enforcement is a prime example of setting confusing and incompatible objectives in one agency, as discussed in the answer to Q4.

Gathering statistics and data should only be undertaken after satisfactory answers are provided for the following questions. Without good answers to all these questions no benefit will be obtained.

1. What is the purpose?

2. What data are required to meet the purpose?
3. What standard is required for the quality of the data?
4. What is the cost of obtaining data of that quality?
5. Who is responsible for gathering the data?
6. Who is responsible for analysing and reporting?
7. Who receives the reports and what do they do with them?
8. Who will pay?
9. Who will decide if the purpose has been met?

*Q80. Should the model OHS Act require regulators to publish enforcement and prosecution policies?*

The policies can be published. Whether it is done to conform to a general public service code or because of a specific requirement in the model OHS Act is immaterial.

*Q81. Should the model Act include provisions that allow the making of interpretative documents?*

It would be better to draft legislation that is clear enough not to require interpretation, but if that is not possible, I see no objection. However, some thought should be given to deciding who should make the interpretation, and what status the interpretation might have.

*Q82. Are there any functions and powers that should be available to an OHS regulator that should not be exercised by an inspector?*

The regulator should set policies and the framework within which the inspectors operate.

*Q83. Should the advisory and enforcement functions of an OHS regulator be separated? If so, how and why?*

Before the legislation is drafted there must be a decision whether the regulating agency is concerned with providing OHS advice or with enforcement. These are different roles and are incompatible. This is normally ignored, so the roles are combined within one regulatory framework. This almost guarantees that neither function will be carried out effectively.

There will be widespread denial that advisory and enforcement roles are incompatible within one regulatory agency. At least a few of those who are regulated probably appreciate that the combination of these functions results in ineffectual and timid regulatory oversight which they secretly find congenial. Many regulatory agencies have been trying to combine the roles for so long they find it entirely normal, cannot picture a separation of the functions and cannot see how each makes it much more difficult to carry out the other. In any case, they are making a living from things as they are, and as Upton Sinclair said long ago,

*“It is difficult to get a man to understand something when his salary depends on his not understanding it.”*

When it seems necessary to have several objectives, the likely reason is that fundamentally different and incompatible things are being muddled together. They should be separated. So, if it is decided that legislation will be enacted to assign both advisory and enforcement roles, it would be far better to have two Acts and two agencies. One Act could tell people how to manage OHS; the relevant agency would provide advice and assistance and would have no inspectors or inspectorial powers, only advisors. The other Act would impose OHS duties. Its agency would investigate and enforce, and that would include investigating the OHS advisory agency if relevant. This model would be a huge advance on most current ones.

There are two main reasons why the roles are incompatible.

The first reason is the blatant impropriety that arises when inspectors of one agency both advise (from a position of power) about managing an undertaking and also investigate and enforce (by measures that can include severe punishment) if something goes wrong. The

agency that has given advice has prior involvement. If something goes wrong the source of advice should be within the scope of the investigation, not running it.

The second reason is that agencies providing advice should work cooperatively with those they advise. The required relationship is often described as partnership. This is good for an advisory body but disastrous for an agency concerned with enforcement, where such a relationship is called “regulatory capture”.

Definitions of regulatory capture go back over 50 years. A fairly typical one by the USA Civil Aeronautics Board is commendably clear. It said:

***Regulatory Capture Defined***

*A regulatory agency is said to be “captured” when it exhibits any of the following:*

- (1) It furthers the industry’s interests at the expense of consumers;*
- (2) It is more responsive to the industry pressures;*
- (3) It has become too identified with the industry;*
- (4) It has become overly protective toward the regulated firms;*
- (5) It is passive, largely rubber-stamping the firm’s decisions; and*
- (6) It adopts the regulated utilities objectives as its own.*

*Simply put, when a regulatory agency brushes aside the common good in favor of private interest or some special groups, then it is guilty of capture.*

There is nothing I would argue against in that definition, although it needs a little adaptation to fit the circumstances of a regulator of OHS. I am mostly concerned with major hazard OHS, where an “operator” is the person in control of the major hazard facility:

An OHS regulatory agency is captured when it exhibits any of the following:

- (1) It furthers the operator’s interests at the expense of other stakeholders, particularly the workforce
- (2) It is overly responsive to operator pressures at expense of other stakeholders
- (3) It is too identified with the operator
- (4) It is overly protective to the operator
- (5) It is passive, largely rubber-stamping the operator’s decisions
- (6) It adopts the operator’s objectives as its own.

It is worth noting that (3) is different to the rest of the list. It is concerned with what others see, i.e. image. The rest relate to what is done.

All the listed items point to the conclusion that policies such as “partnership” with the operators and “light touch” regulation are intrinsically and unavoidably bad. It is wrong to imagine that partnership can be pursued so long as the regulator is careful to avoid capture. Partnership and regulatory capture are identical and inseparable. Trying to have partnership, but with controls against regulatory capture bolted on, is futile.

This is connected with the popular idea that inspectors should not always be negative. Inspectors are told they should find and praise good work and not just find fault. This becomes formal procedure. Some inspectors might try to balance their reports with as much positive as negative comment. Combine this with the requirement to send a report of each inspection to those inspected (this is discussed in the answer to Q103) and the duty holders soon have on file a substantial amount of praise from inspectors for all sorts of things. This is folly by the regulator; it gives a great hostage to fortune. Any duty holder who becomes a defendant should waste no time before scouring these reports for anything relevant that could be at all helpful. The inspectors then become witnesses for the defence. This happened to an inspector I know who only made an encouraging verbal remark to a duty holder; the danger is

far greater when the remarks are given to the duty holder in official reports.<sup>8</sup> How much this should deter the regulatory agency from enforcement is anybody's guess.

There is abundant evidence that major hazard regulators often get close to the operators of major hazard facilities. The operators are treated as the major, if not only, stakeholder, shown great deference and great efforts are made not to ruffle their feathers. It is depressingly common for the major hazard regulator to say it consulted stakeholders when in fact it consulted a range of operators and operator organisations and forgot the workforce, its representatives and the public. This might be almost acceptable for an advisory agency but it is a disgrace to an enforcing agency.

As a case study of a regulator that lost its way, look at the UK HSE Railways Inspectorate at the end of the 1990s. One morning in September 1999 I listened to a short radio news interview with the head of that Inspectorate. The interviewer asked about the extent of regulatory enforcement of safety in the industry now it was privatized. The head of the inspectorate, a very decent man, replied he was sorry (yes, he used that exact word) that the Inspectorate had been obliged to issue one Improvement Notice since privatisation. I was stunned that he showed no pride at all in his inspectorate doing its job, even if it was only once. Instead, he had apologised to the nation! He was embarrassed, perhaps even ashamed, by enforcement – not as unusual as you might think among such agencies with their close relationships with the operators. How were his inspectors supposed to take this?

About one week later, on 5<sup>th</sup> October 1999, 31 people were killed and 227 others taken to hospital after two trains collided head-on at Ladbroke Grove, just outside Paddington station. One of the trains had gone through a red light at signal SN109.

This is known as a "Signal Passed At Danger," or SPAD, incident. By law in the UK every SPAD is reportable. It emerged later that the Railways Inspectorate had received many such reports, including eight SPAD reports for SN109, in the six years before the crash. No enforcement action whatsoever was taken over that signal or any other. Instead, in the accepted spirit of partnership and light touch regulation, the Inspectorate held regular meetings with the rail managers. The Inspectorate raised its concerns, politely of course. The rail managers gave assurances that they were looking at the problem. The managers explained it was a difficult issue. The Inspectorate agreed. The Inspectorate was understanding. Another meeting was scheduled. And so it went on.

It could be argued the Inspectorate was not merely ineffective but was making things worse. Left alone, the rail managers might have been recognized that only they were responsible and they might have felt they must act before something dreadful happened. But, by sharing their concerns with the Inspectorate, they could persuade themselves that as the Inspectorate saw no reason to use enforcement or set deadlines there was no great urgency. Likewise, the Inspectorate was trapped. Having set off on this course, and being sympathetic to the rail managers' difficulties, it was hard to find any reason to switch tactics until there was, literally, blood on the tracks.

On 17<sup>th</sup> October 2000 an intercity express train derailed at Hadfield when the track disintegrated, killing 4 and injuring 70. This exposed shocking and widespread problems with track inspection and maintenance. Again, the Railways Inspectorate was conspicuous for prior inaction. On 10<sup>th</sup> May 2002 a train derailed due to a points failure and crashed into Potters Bar station, killing 7 and seriously injuring 11. The points had apparently not been assembled correctly, and there were grave deficiencies in maintenance generally. Criticism of the Inspectorate and HSE arising mainly from scrutiny of its performance before these three incidents resulted in responsibility for rail safety being taken from the HSE.<sup>9</sup>

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<sup>8</sup> As a matter of basic good practice in regulation by an enforcing agency I would not allow anything more positive than the statement, "No evidence was found of non-compliance on this occasion."

<sup>9</sup> Shortly before HSE lost responsibility for railway safety regulation, the annual public sector wage increases were set at about 2%. That is what all the other major hazard divisions received. However, Railways Inspectors, the only ones to have presided over any recent major incidents, received an

For another example of how the rot sets in, consider the UK HSE “mission”:

*“... to ensure that risks to people’s health and safety from work activities are properly controlled.”*

The UK HSWA 1974 and all the Regulations are absolutely clear that the operators, owners and employers must ensure that risks to people at work are properly controlled. HSE has no such duty. Yet, its mission aligns it completely with the duty holders. It was not necessary to do this. Its mission might instead be,

*“To use regulatory powers to achieve regulatory compliance”.*

That would make clear its proper, independent and separate role. It would accord with the sections of HSWA 1974 that set up the HSE and give Inspectors their powers. Instead, the mission statement says the agency carries the duty holders’ risks and shares their duties. Incidentally, the HSE reports to the Health and Safety Commission and that in turn reports to the relevant Minister of State. The direction taken by the HSE is set by them.

Unsurprisingly, given the willingness of HSE to promote this false idea of being responsible for controlling risk, in recent years it and its Divisions have been given targets for reducing the numbers of certain types of incidents. It is obvious that the workplaces, workforce, equipment, procedures and management systems that determine the probabilities of death and injury are all controlled by the duty holders. It’s a bit like setting the Bureau of Meteorology targets for good weather, except that it’s worse because the regulator is put in the hands not of chance but of the regulated.

The provision of advice by the regulatory agency is widely accepted as a good thing, but the concept is questionable, particularly for major hazard industries. These industries have argued for a very long time that they are competent and capable. They have vigorously opposed prescriptive regulation, demanding instead goal-setting legislation to give them the freedom to implement their own solutions to their own hazards. If this is correct, how can they possibly require advice? The obvious conclusion is that a duty holder who needs advice is not competent and capable. Why should such a duty holder be running a major hazard facility? Once the regulator is providing advice, what has happened to the regulator’s independence? A regulatory agency that provides advice is part of the management system for the major hazard facility. Some operators in their safety cases go so far as to describe the regulator’s activities as part of the operator’s safety management system. The regulator will tell them to remove such statements, but the fact it happens at all is telling.

The widespread acceptance that regulatory inspectors are competent to provide that sort of advice is a puzzle. They cannot be expected to know the undertaking they inspect in very great detail. They are likely to see the place, at most, for several days a year. They have many other places to inspect. They might have some technical expertise and experience to call on, or they might not; it’s unlikely the operator will ask for proof of the inspector’s qualifications. They have probably spent more time than most people becoming familiar with the legislation, but this is not the same as knowing how to run the facility they are looking at. How can the inspector possibly have a depth of knowledge of that specific workplace and its workforce to compare with those who have worked in the place for years? Perhaps the advice given by an inspector is usually treated with respect not because it is necessarily good advice, but because it comes from someone with the power to inflict a lot of misery.

There is another problem with a regulatory agency providing advice. Unless there is a tight definition of the limits of that advice, the role of the regulatory agency spills over into areas that are properly the business of others. In the guise of regulatory advice I have extensive experience of inspectors advising on law, compliance, legal interpretation, safety management, occupational health or hygiene, plant operations, engineering and more. There are highly qualified individuals trying to make a professional living as lawyers, management

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increase several times larger. This presumably reflected a need to attract more recruits rather than a desire to reward failure, but it left a bitter taste in the other divisions.

consultants, safety advisors, occupational hygienists, plant supervisors and engineers. They do not deserve to be undercut by a mandatory government service. Why would the government fund an advisory regulator that can use its statutory clout to compete with these professionals by entering premises and providing advice free at the point of delivery? It's not obvious there's any legitimate justification.

Finally, Australian law, like British law, is supposed to respect the basic right, confirmed by centuries of common law, of anyone to go about their legal business free of interference by those in authority. Is it appropriate that those who run workplaces are obliged to accept a mandatory OHS advice service operated by persons with authority to enter privately owned business premises when they want? If it is, why limit this service to work places? Others could benefit too from intrusive health and safety inspections and advice. For example, homes can be quite hazardous.

See also the answers to Q27 – 30.

*Q84. How should the model OHS Act provide for the appointment, qualifications, powers, functions and accountability of inspectors?*

This depends on the function, objective or purpose of the regulatory agency. I hope it is kept simple. Once that is settled, the answer should be obvious. For example, an agency dedicated to providing some sort of advice should appoint inspectors who are qualified to provide that kind of advice. On the other hand, an agency dedicated to regulatory enforcement should appoint inspectors with regulatory knowledge, training and experience who are competent in exercising regulatory powers. It is often assumed that highly qualified technical specialists will make good regulatory inspectors. They often do not. The roles are very different and it can take several years to make the transition. Not all make it.

It is essential that the powers of inspectors enable them to carry out all their functions. For example, if inspectors are required to investigate incidents and report possible failures of compliance for prosecution by the DPP, the inspectors must have all the powers required to obtain the necessary evidence in accordance with the relevant rules and legislation. It is not enough to give the inspectors a power to take copies of documents if the courts insist that only original documents are admissible. This is not always adequately provided. Perhaps an easy way to address this would be to let inspectors exercise "any other power necessary for the purpose of carrying out a function," though there might be objections.<sup>10</sup>

*Q85. Should the model OHS Act strengthen the role and capacity of inspectors to provide advice and assistance? If so, how?*

As already said in the answer to Q83 (last four paragraphs in particular) it is first necessary to decide if advice and assistance is a role for inspectors. I believe the arguments against are overwhelming; but if it is, it should be their only role. Advice and assistance could be left to the market. If the government is involved, it should provide an OHS advice service which anyone can contact. It might be free or there might be charges. It should publish general advice and it might assist in the production of codes and standards. The service should provide confidential OHS advice to individuals and its staff should be available, on invitation, to visit workplaces for consultations. They should have no inspectorial powers.

*Q86. Are there any circumstances in which an inspector should be independent from direction, instruction or review by a regulator?*

The regulatory actions of the inspector should be independent of the regulatory agency. The Agency would provide direction, support and line management functions, but the inspector would be responsible for all enforcement decisions based in the inspector's own inspection

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<sup>10</sup> The UK HSWA 1974 s.20(1) "...an inspector may, for the purpose of carrying into effect any of the relevant statutory provisions... exercise the powers set out in subsection (2) below..." and s.20(2)(m) says "any other power which is necessary for the purpose mentioned in subsection (1) above."

findings. This is more responsive and encourages a better culture in the inspectorate. The alternative, where the inspector brings back enforcement recommendations to be decided by another, is cumbersome and ineffective. It leaves the inspectors as little more than messengers. It might be argued that central control of regulatory action is good for consistency, but in practice a centralised system provides no improvement. The central controller is effectively operating blind, relying entirely on what the inspectors say. Each decision will still be as inconsistent as each inspector, but will be based on only the fraction of the inspector's experience that is set down in reports, without the benefit of the whole knowledge of the inspector. It will be even worse if the central control is a group of managers, with or without some mechanism for coordination, rather than one individual. Any mechanism for coordination must add to the complexity and slow the responses of the regulator.

Central control of operational deployment, on the other hand, is a good thing. It allows the regulatory agency to prioritise its operations and use its inspectors efficiently.

However, if the regulatory does not, as previously recommended, have one objective, but is burdened with several, it is probably difficult for it to function at all unless it exercises central control of all its inspectors.

*Q87. Should an inspector be able to modify, amend or cancel any notice or instrument issued by the inspector? If so, why and in what circumstances?*

A notice is issued on the basis of the inspector's opinion, which must be dependant on the knowledge of the inspector at the time. If the inspector acquires new knowledge it is desirable that the inspector is able to use it. J M Keynes was accused of being inconsistent and replied,

*"When the facts change, I change my mind. What do you do, sir?"*

It is equally desirable that drafting errors in notices and similar mistakes can be easily rectified.

*Q88. What provisions should be made for the transparent internal review of decisions in the model OHS Act? What matters should be reviewable? What further appeal should be allowed?*

It is desirable to have one system only and not add any unnecessary bureaucratic complexity. A formal appeal against a decision can be made through the courts. This is obviously independent, it is transparent because it is public and it is sufficient. Inspectors are in the public service, so their conduct is subject to the provisions of the Public Service Act. There is no need at all for anything more. There should be the possibility of informal resolution, however, as suggested by the previous answer. If an inspector can reconsider and alter a decision, a poor or erroneous decision can usually be corrected without the enormous difficulty, delay and expense of formal process.

*Q89. Are there any other issues in relation to the powers, functions and accountability of regulators and their inspectors that should be addressed in the model OHS Act?*

Yes. A regulatory agency obviously needs management systems but there is a belief in some quarters that the agency should meet a recognised standard for quality management. This is possibly so, but it does not follow that any quality management standard will do. In practice the agency usually decides it should meet ISO9000 in some form. This suggests a lack of understanding of ISO9000. In the 1950s the US military wrote standards for the suppliers of military equipment in order that the supplies would be predictably uniform and meet the customer's specification. Over the years those standards developed into ISO9000, which is suitable for a wide range of organisations that supply a product or service to a customer. This is explained in the introduction to the standard. The standard is not appropriate for a regulatory agency.

The legislation that establishes the agency and sets out its functions should make it clear that the functions are neither products nor services and the agency does not have a customer. This will help people to understand without doubt that ISO9000 is not a suitable standard for

the agency. This will avoid the waste of effort and resources that results from the substantial exercise of trying to bend the regulatory agency into shape to meet the standard.

The status of the Australian Government Investigation Standards<sup>11</sup> with respect to OHS regulatory investigations might be clarified. Although these standards are explicitly concerned with fraud investigations, they have been pushed for use by other agencies including OHS regulators. The extent to which this is appropriate is not clear, although advocates of the standards apparently expect them to be adopted in their entirety by all regulatory agencies. A review of these standards might be helpful if it led to improvements in the layout and structure, more consideration of their application beyond fraud control if that is government policy, better integration between the standards and the regulatory powers of inspectors and inclusion of a contents page and index.

It is normal for regulatory agencies to be subject to regular external reviews.<sup>12</sup> This might be a requirement every few years for a small team to be appointed, review the agency and send a report of its findings to the relevant Minister. This is a sensible provision but some thought should be given to ensuring that each team has appropriate terms of reference and agrees its methods and plan in some detail with the Minister before it begins. It should, for example, decide what quality of evidence will be required as a basis for any finding, so it is known whether it can be based on hearsay and opinion instead of evidence. It should also be decided which persons will be interviewed and whether these will be individual private interviews. It would devalue the exercise if the regulatory agency was able to take control of the plan. There is something to be said for each review beginning without prior notice to the agency, although that is obviously difficult when the reviews are regular.

## **7. Compliance & Enforcement:**

*Q90. Should the model OHS Act include a hierarchy of enforcement measures in order of escalation? What should such measures consist of?*

A hierarchy in order of escalation implies that each level is tried before moving to a higher level. This is a bad idea. Each enforcement measure is a tool. Nobody thinks there is a hierarchy of hand tools, where for example a hammer comes before a spanner, and that's below a chisel. You just use the right tool for the job. The proposed hierarchy would, it seems, sometimes oblige inspectors to use one or more wrong tools before getting to the one required. Some enforcement measures have more severe consequences than others, but the hierarchy concept does nothing to explain their operational relationship and uses. See also the answer to Q103.

*Q91. Should these be statutory principles or requirements for the appropriate use of enforcement measures? If so, should they be contained in the model OHS Act, regulations or other policy or guidance documents?*

The appropriate use of each enforcement measure is inherent in the measure as it is described in the legislation without any additional principles or requirements. The enforcement measure is used as appropriate by the regulatory agency to achieve the objective of the agency. It is unhelpful to make it more complicated.

*Q92. What provision should be made for PINs, improvement notices and prohibition notices in the model OHS Act?*

I am not convinced that PINs achieve much because HSRs, in my experience, have too little experience or training to gain the confidence to use them. Possibly, despite that, the deterrent effect on others of knowing an HSR might issue a PIN is helpful. Perhaps a review of all PINs issued in the last few years, looking at the circumstances, the quality of drafting in the notice and its outcome, would be informative, although it would tell us nothing of occasions where a PIN might have been issued but was not. Research on the experiences of

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<sup>11</sup> See [http://www.afp.gov.au/national/major\\_fraud/investigation\\_standards.html](http://www.afp.gov.au/national/major_fraud/investigation_standards.html)

<sup>12</sup> For example, see Offshore Petroleum Act 2006 s.405

a representative sample of HSRs might also help to shed some light on the question. Perhaps this has already been done.

Improvement and prohibition notices<sup>13</sup> are essential for inspectors. They are easily the most useful enforcement tools. It should be stated in the Act that improvement notices can be issued in relation to any statutory duty in the Act. At present, some legal advice suggests that these notices should only be issued in circumstances involving serious failings in managing OHS. This appears to rule out issuing a notice for procedural failures such as failing to report an accident or dangerous occurrence. Treating all procedural failings as trivial is wrong. It is essential that the regulatory agency has the means to address such failings and notices should be one of those means. Failing to report can be a particularly serious matter, equal to concealing a crime: an illegal act preventing regulatory investigation and enforcement.

*Q93. Should PINs, improvement and prohibition notices contain recommendations about how to achieve compliance?*

This should be optional, and its use should not be encouraged. As mentioned elsewhere, it is the duty of the person in charge of the undertaking to run it properly. If something is not compliant, or is dangerous, a competent duty holder will either be able to work out how to fix it, or else can find someone with that expertise. A duty holder who cannot cope without being told what to do by an inspector should not be in business. An inspector who crosses the line from saying, "That's not right," to saying, "This is how you'll do it," has gone from enforcement to managing the undertaking and ceases to be independent. Despite that, it would be a mistake to forbid the inclusion of recommendations. Sometimes this is a better option than forcing the duty holder to work out what is wanted through a guessing game. If there are recommendations they must always allow the duty holder an alternative of compliance by "other suitable means," so that the final choice can still be said to lie with the duty holder.

*Q94. What provisions should be made to allow for the review of PINs, improvement and prohibition notices?*

See the answer to Q88

*Q95. Should there be a specified minimum timeframe to allow for compliance with PINs, improvement or prohibition notices?*

It is essential there is a minimum time. Someone who is issued a notice can choose either to accept or else appeal it. There has to be an opportunity to consider that decision and obtain necessary advice. The minimum timeframe for compliance has to be at least as long as the maximum time allowed for that decision. A duty holder has only accepted the notice if no appeal is lodged before the end of the time allowed. Setting the time to achieve compliance shorter than the time allowed for choosing to appeal is obviously oppressive and unfair because it can expose the duty holder to prosecution for non-compliance even though the duty holder might not have accepted the notice.

*Q96. Should the lodging of an application for an internal review or an appeal application affect the continued operation of notices,? If so, what should the effect be?*

A prohibition notice should remain in force pending an appeal because it is served to deal with immediate danger and it would be wrong to risk reinstating the alleged danger until the appeal is heard. An appeal against an improvement notice should suspend the notice pending the hearing of the appeal because it is concerned with taking measures to achieve compliance with legislation rather than removing danger. If there is immediate danger from

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<sup>13</sup> There is an error in the Issues paper on p.31 where it says, "Prohibition notices are issued for a contravention of the OHS Act." An improvement notice must be related to an alleged contravention of OHS legislation, but there is no such requirement for a prohibition notice. A prohibition notice is issued when there is immediate danger, in an inspector's opinion. I understand the original thinking was that an inspector faced with a dangerous situation must be able to intervene immediately without being obliged to dig through all the OHS legislation to find the right sub-paragraph to be cited.

not being in compliance, a prohibition notice should have been served, either in addition or in the place of an improvement notice.

*Q97. Should the model OHS Act provide for infringement notices? If so, when and for what offences should they be issued?*

This might have benefits as an addition to improvement and prohibition notices, but I am not convinced it would be worth it. It is difficult to see what such notices can achieve that the other notices cannot in dealing with OHS issues, unless they are used for lesser failures of compliance. If so, it must mean that inspectors will tend to be directed towards more trivial or superficial matters. The use of such notices runs the risk of discrediting the regulatory agency through a perception it is motivated by raising revenue and discrediting inspectors by making them pettifogging officials. There is a reason why the public often has such hostility and contempt for those who issue infringement notices.

*Q98. Should the administration of infringement notices occur under OHS law or individual state legislation?*

It should be as simple as possible to understand and implement, which probably means OHS law.

*Q99. What amounts should be specified as fines for infringements?*

Infringement fines could presumably be imposed on anyone from a sole trader on the edge of bankruptcy to a giant multinational corporation. It appears impossible that any fairness can be achieved. Perhaps the best that can be done is to keep the fines low enough that in most instances the amount is only symbolic and the enforcement effect is due to the shame and annoyance of paying at all.

*Q100. Should the model OHS Act provide for injunctions to ensure compliance with the model OHS Act? If so, in what circumstances and what evidence should be required to apply for an injunction?*

Injunctions are superfluous if the powers relating to improvement notices are properly designed. An improvement notice states that an inspector has the opinion that a duty holder is not complying with a duty and the notice requires action to achieve compliance within a time limit. Failing to do so is a criminal offence. If the OHS Act is drafted so that failure to comply with the Act is a criminal offence, failing to comply with a notice gives the possibility of prosecution for the original offence and for not complying with the notice. Getting an injunction to require compliance with the notice is a pointless complication.

*Q101. Should the model OHS Act provide for the use of enforceable undertakings as an alternative to prosecution for an offence against the Act? If so, for what offences?*

The argument against this is very similar to the previous answer concerning injunctions. This should be superfluous if the powers relating to improvement notices are properly designed.

*Q102. Should the giving of an enforceable undertaking result in an admission of fault or liability?*

No, just as it does not when an improvement notice is accepted.

*Q103. Are there any other issues in relation to compliance and enforcement that should be addressed in the model OHS Act?*

The Petroleum (Submerged Lands) Act 1967 Schedule 7 has been replaced by the Offshore Petroleum Act 2006 Schedule 3. They each contain the same requirement (OPA Sch.3 c.80) concerning reports of inspections. After each inspection the regulator must send a report to the operator of the major hazard facility, containing conclusions, reasons for conclusions, and recommendations, if any. If the operator is requested to respond to the recommendations then, despite the word "request," the operator must respond within the time allowed. However, a response can be anything. A brave operator could respond by saying it is going to do nothing.

It seems a recommendation need not relate to danger and need not be based on a failure of compliance. This provision inspires the invention of great lists of recommendations, often with little basis in either law or evidence, because it is very hard on an inspector to finish an inspection without anything to show for it. Making a recommendation is much easier than issuing a notice, so it is far more common. It can be distracting for a duty holder who does not have infinite resources to be faced with dozens of such recommendations after each inspection. The duty holder is understandably wary of arguing or responding negatively, even though other work, possibly more important for safety, might have to be delayed or cancelled in order to deal with the recommendations. Also, a recommendation might be used as a substitute when a notice is justified because the inspector thinks it is easier and it can be described as a graduated approach to enforcement. (See the answer to Q90.) This is undesirable, because notices have force and failing to comply has consequences, but the status of inspection recommendations is shadowy and ill-defined. Some say these recommendations are enforcement, others say they are advice.

The duty to send a report and get a response is a bureaucratic burden for everybody. The model OHS Act should make it clear that no report need be sent to those who were inspected. A notice contains all the information about a regulatory issue any duty holder can possibly need. An inspector who cannot find grounds for serving a notice should be silent. After an inspection, an operator who does not get a notice should get nothing. This will be a great improvement.

## **8. Prosecutions:**

*Q104. Should the model OHS Act provide for breaches of duties or obligations to be criminal offences, or be the subject of civil proceedings and penalties, or a mixture of both?*

If, as already discussed, the regulatory agency is an advisory agency or a statistical service, there is no need for any criminal offences. However, I believe there should be enforcement for breaches of criminal law in respect of OHS, see the answer to Q1.

*Q105. Which duties or obligations should be the subject of criminal offences and penalties and which may appropriately be heard as civil matters?*

The model OHS Act should follow a simple and consistent principle: failing to comply with any duty in the Act is a criminal offence by the duty holder. The regulatory agency has the choice, on finding any failure to comply, of warning, issuing an improvement notice or recommending prosecution to the relevant authority.

*Q106. Which courts or tribunals should have jurisdiction to hear prosecutions for OHS offences?*

See the following answer.

*Q107. Is it appropriate for prosecutions to be heard by specialist courts or tribunals (or specialist divisions in courts)? Why?*

It is my experience that courts and tribunals often know little of the more technical matters that often arise in cases concerning major hazard facilities and they often have little experience of the relevant law. Proceedings can become farcical when a case is argued between prosecuting and defending counsels who are both well out of their depth in front of a court that knows even less. It might be entertaining but it does not give much confidence that justice is being served.

Despite that, I am totally opposed to any move away from public hearings in normal courts. I have already argued that regulatory inspectors should be qualified in regulatory matters rather than being technical specialists. One reason is that highly technical inspectors produce highly technical reports. These may be excellent in their way but they are bad as a basis for prosecutions. Nobody should be convicted of a criminal offence on evidence that is beyond the comprehension of normal people, or else the law must fall into disrepute. It has a similar effect to running secret courts. If an understandable case cannot be presented something has gone wrong with the law.

I once worked with an inspector who explained to some expert colleagues that he had investigated the circumstances on a drilling rig that caused a large steel bracket to become detached and fall from a great height. He thought it worth prosecuting the rig operator. His colleagues offered advice: the case could explore the details of the operators extensive and detailed maintenance systems that had failed to find the fault and the competence and training records of all the personnel involved in its implementation; it could also explain how the weld that failed had been subject to stress corrosion cracking because of the metallurgical properties of the particular alloy and the presence of excess hydrogen in the heat affected zone leading to embrittlement; several other possibilities were produced for the display of great technical prowess and learned erudition. The inspector thanked them but said he still intended to prosecute the rig operator for dropping a big lump of metal that could have killed someone.

*Q108. To where should appeals lie? Should the right to appeal be subject to any conditions and if so, what should they be?*

An appeal against a courts decision can be made to a higher court in the same way as any other criminal conviction.

*Q109. Should defendants be entitled to trial by jury in prosecutions for any offence and, if so, which?*

This should be available for serious offences.

*Q110. Who should be entitled to commence criminal proceedings?*

It would be reasonable to reserve this for the Director of Public Prosecutions if the DPP has adequate resources. If not it might be better to let the regulatory agency commence criminal prosecutions. This might reduce the number of bureaucratic hurdles and produce better administration of justice.

It is not appropriate for victims to commence criminal prosecutions, although of course they can bring civil cases for compensation.

*Q111. If the model OHS Act provides for civil proceedings for breach, who should be entitled to commence such proceedings?*

The model OHS Act should not provide for civil proceedings.

*Q112. What should appropriate time limits be for the commencement of a prosecution and why?*

It is true that justice delayed is justice denied. It would be much better for everyone if most prosecutions could commence within a few days or a couple of weeks at most of the investigation starting and so be done with, but to allow for the current complexity of bringing a case to court and all the rules and procedures some leeway is necessary. I'm tempted to suggest that prosecution must commence no later than the death of the last person who had any involvement in the events, but more realistically an upper limit of one or two years might be applied. This is an attempt to balance the need of the regulatory agency to have enough time to complete an investigation in compliance with current requirements and the interests of justice in concluding matters without delay.

*Q113. Should the model OHS Act include specific provisions for the conduct of prosecutions, and what should they be? Alternatively, should that be left to the rules of criminal law and rules of the relevant court or tribunal?*

Although there might be some good reasons for writing specific provisions, experience suggests that more would be lost than gained. If the specific provisions amount to a completely independent system of courts with all their own rules and procedures and dedicated full-time personnel it would be possible to maximise the benefit of this approach, but it seems inconceivable that the resources for constructing and maintaining such a system would be available. If instead specific provisions and rules are grafted on to the existing system it is likely to result in a semi-detached area of legal practice even less understood

generally than it is at present and even more prone to errors and baffling outcomes in consequence. As argued previously, offences under the OHS Act should be standard criminal offences and tried like any others.

*Q114. Should the model OHS Act contain specific evidentiary procedures for OHS prosecutions? If so, why and what procedures?*

See previous answer; the examples of specific evidentiary procedures given in the Issues paper are either good enough for general application or they are not good enough to be used at all.

The use of statements or answers obtained by an inspector using a power to compel answers seems to cause some confusion. Everyone agrees that such information cannot be used in evidence against the person who was compelled. There is less consensus that the compelled person gains any immunity from prosecution using other evidence, even if that other evidence is only obtained as a result of the compelled information. Some people advise that a compelled statement is inadmissible as evidence even when the defendant is somebody else entirely. It would be helpful to have clarity on the evidential status of compelled statements and answers.

*Q115. Should the proof of any elements of an offence be affected by specific provisions in the model OHS Act? If so, which elements and how?*

This might be helpful to everyone involved by clarifying the requirements. I regret I do not have the time now to specify the elements.

*Q116. What should be the evidentiary status of codes of practice, regulations and other subordinate instruments?*

As I have argued elsewhere, the Act itself should contain the offence provisions and penalties so that any prosecution would be in relation to the Act, not regulations. Ideally the Act should be sufficient without regulations. If there are regulations, proving a failure to comply with a regulation should be sufficient to prove an offence under the Act. Codes of practice are helpful. The four examples given in the issues paper of the evidentiary status given to codes in some jurisdictions are in effect not very different. It is possible that each example is entirely appropriate within its jurisdiction because presumably the codes of practice there are written taking account of the legal status they will have.

My own preference is for the first example, where breach of the code is breach of the Act unless the duty holder demonstrates otherwise, although this can be viewed as reversing the burden of proof and imposing a quasi-prescriptive OHS regime. Care should be taken to minimise that. The last example, where the code may be used as evidence of what could be done to meet the duty, should be obvious enough to be assumed without having to be explicitly stated in the legislation.

*Q117. Is 'reasonably practicable' an appropriate standard for the model OHS Act?*

Yes.

*Q118. Should the prosecutor or the duty holder be required to prove whether the standard was met? Why?*

The prosecution is required to prove the guilt of the accused. The accused is not required to prove innocence.

The Issues paper says that in the UK the burden of proof is on the duty holder. This refers to the UK HSWA 1974 s.40 which applies only to the question of whether the measures taken by a duty holder amounted to all that was reasonably practicable. This is not a requirement to prove innocence. Rather, it is a requirement that the duty holder provides evidence if the duty holder claims that the measures taken were all that was reasonably practicable. In goal setting legislation, where the duty holder is responsible for managing the risks created by the undertaking in order to achieve a specified outcome, a compliant duty holder will have these answers readily available. It would be an enormous burden for the regulatory agency

independently to conduct all the same analysis and risk assessment itself during each investigation. In practice, if the duty holder produces such answers during the investigation, there is no reason for a prosecution.

*Q119. Should the burden of proving elements of an offence differ between different types of offences (e.g. duties of care and procedural obligations)? If so, why?*

See the previous answer.

*Q120. What, if any, defences should the model OHS Act provide?*

It seems quite likely the examples given in the Issues paper would be seen as defences or at least as powerful mitigation whether or not they are stated in the proposed Act, and they would be taken into account when preparing a case and considering proceedings, for example when applying a public interest test.

The suggestion mentioned in the Issues paper for a duty holder to be able to comply by relying on the expertise or conduct of another person should be treated very carefully. The decision in the UK 'Port of Ramsgate' prosecution in 1997, after a walkway collapsed and killed 6 people in September 1994, is relevant. The Port authority denied responsibility, saying it had engaged appropriate contractors to undertake and verify the design and construction. It was not itself competent or expert in such matters. The unanimous verdict of the jury found the Port authority guilty along with the other parties. The critical failing of the authority seems to have been not supervising or monitoring its contractors, or showing enough interest in what they were doing. It would be a mistake to introduce into the model OHS Act a defence for someone who behaves like that. See also the answer to Q18.

*Q121. Should the burden of proof or defences be different for a corporation and an individual (officer or employee)? If so, why?*

The proof or defences should be appropriate to the duty.

*Q122. Should 'officers' of a corporation be liable to an offence because the corporation has committed an offence?*

This often attracts public support, but seems very difficult to arrange in practice and courts seem very reluctant to convict an individual of a criminal offence just for being an officer of a company that committed an offence without evidence of specific personal involvement in the commission of the offence. See the answer to Q30

*Q123. How should officer be defined?*

No comment

*Q124. Should liability of an officer, if any, be subject to the prosecution proving that an act or omission by the officer contributed to the offence of the corporation? Alternatively, should the officer be automatically guilty of an offence, subject only to proving a defence? Why?*

See the answer to Q122

*Q125. Should the model OHS Act provide for a test for determining liability of an officer? If so, what should the test be or contain?*

I doubt this would help, because any officer conscious of committing or intending to commit an offence would use the test as advice for avoiding liability.

*Q126. Should the model OHS Act provide for specific defences to be available to an officer? If so, what?*

No comment.

*Q127. What should the approach to officers of unincorporated associations or volunteer officers be?*

No comment.

*Q128. For which offences should monetary penalties (fines) be imposed?*

All, although prison should be an alternative where appropriate.

*Q129. Should maximum fines be provided in the model OHS Act, or is there an alternative approach?*

Alternatively, fines can be unlimited.

*Q130. Should the level of fines be different for the various offences? If so, for what offences and at what levels?*

The court should set the penalty according to the circumstances of each offence.

*Q131. Should there be a statutory minimum fine for some offences? If so, what?*

I do not see any advantage in this.

*Q132. Should the level of penalties depend on culpability (recklessness) or outcome (death) or repeat offences?*

The court should have regard to such circumstances.

*Q133. Are there options that could facilitate more consistent outcomes across the jurisdictions, such as a national register of decided cases?*

See answers to Q14 and Q152.

*Q134. What penalty options should be available in addition to or instead of fines?*

Offences by natural persons should where appropriate result in prison. A person who requires permission or a licence to conduct an undertaking should face the possibility of the permission or licence being withdrawn at the discretion of the regulator if an offence is committed. It should be possible for officers of a regulatory agency to impound, destroy or make safe without compensation things that are used in the commission of an offence or which cause an unacceptable risk to OHS. The regulatory agency or the DPP should be able to issue a warning to a duty holder instead of going to prosecution but this must be dependant on the duty holder making a formal admission on record that an offence was committed. It is not appropriate for an inspector to issue some kind of warning or advice in place of an improvement or prohibition notice.

*Q135. Should the model OHS Act provide for terms of imprisonment for specified offences? If so, which offences and what maximum periods of imprisonment?*

See previous answer.

*Q136. Should there be specific offences relating to workplace death or serious injury? If so, what?*

See following answer.

*Q137. Should breaches of OHS duties resulting in death or serious injury be dealt with in OHS legislation or in the Crimes Act?*

Any offence of homicide or corporate manslaughter should be dealt with in the Crimes Act, not the OHS Act. This does not of course prevent enforcement for breaches of OHS legislation where death or serious injury has resulted.

*Q138. Should the consequences of the breach, rather than only the degree of culpability, determine the penalties to be imposed for some offences? If so, which offences and how should this be dealt with in the model OHS Act?*

It is theoretically attractive to base sentencing solely on the degree of culpability and without regard to consequences of the breach which are dealt with by compensation through civil proceedings. Yet, despite all efforts explaining the distinction to the public, it still expects retribution in the criminal courts for injury or death, so to keep public confidence in the justice system the penalty must also take account of the consequence.

*Q139. What, if any, provisions should be included in the model OHS Act for the enforcement of penalties imposed by a court?*

The arrangements should be the same as those for enforcing penalties under any other Act. The Issues paper mentions the problem of enforcing fines on a company which chooses to be wound up rather than pay. This is not an OHS problem. It is a problem of company law because the same tactic is used in any circumstance where a company's officers decide it is worth doing in order to avoid a financial or legal liability. How to solve this without removing the limited liability status that is the essence of being a company is not obvious. If the law was changed so that certain liabilities, such as fines for offences committed by the company, fall jointly and severally on the officers of the company if the company is wound up, the consequences might be quite dramatic.

*Q140. Should the model OHS Act provide for the enforcement of penalties against officers or other persons? If so, how and subject to what conditions, limitations, defences or requirements?*

See previous answer.

*Q141. Are there any other issues in relation to prosecutions that should be addressed in the model OHS Act?*

None that I can think of.

## **9. Other Issues:**

*Q142. Should the power to make regulations be limited and if so, in what way?*

Yes. The exponential (I use the word in its proper mathematical sense) growth of legislation in the last hundred years appears to reflect the uninhibited exploitation of enabling Acts. This has destroyed the natural bottleneck caused by the limited ability of one Parliament to consider more than a certain number of bills in any one session. That constraint was healthy. It forced the government to prioritise its programme, it discouraged hasty action and it helped maintain decent standards of legislation. Now that Ministers can sign into law great quantities of regulations under a huge range of enabling Acts there is no effective upper limit on quantity and no lower limit on quality. To prevent such proliferation in this area the model OHS Act should not be an enabling act and not allow regulations to be made. I doubt very much this suggestion will be accepted, so the next best solution is to draft the Act so as to restrict as narrowly as possible the ability to make regulations. Either approach should help to focus attention on good administration of the laws we have instead of trying to solve all problems by adding more legislation at an ever-increasing rate.

*Q143. Should regulations provide for summary offences with lower penalties, or should some breaches under regulations also be taken to be a breach of the model OHS Act?*

It is undesirable to create a range of petty offences. It would vastly increase the complexity of the legislation and would tend to focus the regulatory agencies on relatively trivial matters. See also the next answer and the answer to Q97.

*Q144. What provisions should be made in the model OHS Act relating to the development and approval of codes of practice?*

As argued previously, the OHS Act should make any failure to comply with any of the duties into an offence. If it is beneficial to provide detailed explanations or advice on how to comply with the duties it should be done through codes of practice, as advocated by the Robens report. Not complying with a code of practice would not be an offence, but it could be cited as evidence towards proving an offence under the Act.

*Q145. How should an effective reporting system be provided for in the model OHS Act without an unnecessary compliance burden?*

The answer to Q79 provides a comprehensive response to the suggestion in the Issues paper that reporting is about statistics. The compliance burden can be minimised by not

collecting data for statistics. A reporting system is required so that the regulatory agency is informed of events that might if investigated provide evidence for enforcement. This is absolutely essential and fundamental for proper regulation of OHS.

*Q146. What provisions should be made in the model OHS Act for the external review of regulatory decisions?*

See the answer to Q88

*Q147. Should the model OHS Act include provisions for the resolution of OHS issues by conciliation or arbitration?*

I am not convinced that any new tribunals or arbitration services are needed. If parties to a dispute can agree to take it to a third party for a hearing on mutually acceptable terms, legislation is not required to compel them. If they cannot agree to such a hearing, they can go to court. The Issues paper mentions disputes concerning pay or entitlements. These are IR issues not OHS issues and should not be confused.

*Q148. Should the model OHS Act facilitate tripartism in the administration of OHS regulation, and if so, how?*

A direct tripartite involvement in administration is not desirable, but involvement in developing policy and as a buffer between the regulatory agency and Ministers would be useful.

*Q149. Should there be some provision for tripartite committees that deal with OHS matters in particular industries?*

See previous answer.

*Q150. What areas should be subject to formal mutual recognition provisions in the model OHS Act?*

No comment

*Q151. What is the most appropriate way for a model OHS Act to provide for permits and licensing for workers engaged in high risk work that results in:*

- better OHS outcomes;*
- greater efficiency and effectiveness;*
- lower regulatory compliance and enforcement burdens; and*
- improved harmonisation of the requirements for such permits and licensing for industry across Australia?*

No comment

*Q152. How should the model OHS Act be framed to reduce or remove the extent of overlap between federal and State or Territory OHS laws, or minimise the difficulties of such overlap?*

See also answers to Q14 and Q133. Assuming that abolition of states and territories is not an option in the short term, every possible measure short of it should be taken to eliminate as many differences as possible between jurisdictions and remove the barriers to working across jurisdictions. The authority of any regulatory officer from one state or territory should be recognised in every other state or territory; anything that is an offence in one state or territory should be an offence in all; evidence admissible in one should be admissible in all (so for example any witness statement signed with a valid jurat in one state or territory would be recognised in every court in Australia) and so on.

As a more practical solution, perhaps the states and territories could agree that the model OHS Act in Commonwealth law will also be their law without any change whatsoever, for example by them enacting a law that says, as briefly as possible, that the OHS Act of the Commonwealth is also the law of the state or territory, and the states and territories will make no other law in this area.