

Legislative Approach:

Fundamental Principles

- The objective is to make workplaces as safe as practicable
- The Act and regulations should be written so that it is possible for all well intentioned duty holders to understand what their obligations are
- The Act should be applicable and compliance should be possible for all duty holders
- Regulators must have sufficient power to prosecute when there is clear ongoing disregard for health or safety but the legislation should not be written specifically so a successful prosecution will occur whenever there is a fatality or injury even where the duty holder has good intent and made a reasonable effort to comply

Q1

The appropriate regulatory approach depends on what is included within the Act. ie the ideas required in a specific piece of legislation should be defined first, then the best regulatory approach to specify them decided according to the following

Principles allow important points to be made that cannot be defined in terms of process or outcome eg continual improvement, commitment,

They also provide useful background to aid understanding for duty holders and courts

Are general duties principles or outcomes? Either way they are needed in the Act

Performance based standards are appropriate

- where the outcome is clear and measureable (eg 85db limit for noise) They become less useful as the outcome becomes more intangible and less measureable
- where it is reasonable to expect the duty holder to be able to work out how to achieve the outcome without the need to employ costly experts.
- Where it is not essential for compatibility reasons that the same method is used to achieve the outcome

Process based standards are appropriate

- Where a process can be defined unambiguously(so that the regulator can judge whether an acceptable process exists or not)
- where there is evidence that the process produces a safe outcome
- or where the existence of the process is the required end point. (Eg communication and consultation)

Where steps cannot be clearly defined and there could be arguments about the degree to which it occurs (such as a process of continual improvement) it may be better stated as a principle

Problems with process based legislation are:

- If a process is legislated it becomes perceived to be an end rather than a means leading to a focus on documenting the process rather than acting on its outcome
- A process (including the risk management process) may be followed so an organization complies, but the way the process is followed and the quality of decisions which emerge from the process may be poor resulting in poor safety
- Many processes need to be adapted to an organization's needs and risks, so cannot be described in detail but if left flexible they are then difficult to enforce
- Too much focus on processes and procedures detracts from the fundamental principle that hazards and risks should where practicable be designed out

Prescriptive standards are needed where

- Uniformity or compatibility of approach across organizations and individuals enhances safety
- Where a significant level of technical understand is required to achieve a safe outcome
- Where there is a body of knowledge to suggest that one particular way of doing something is safer than others

Prescriptive standards are not effective where

- there are many different ways to a achieve a safe outcome and the best approach will vary with circumstances
- Where the situation is difficult to specify to cover all cases
- Where the safety issue is more about work organization than workplace design.

Robens saw as a defect in prescriptive standards that they focused exclusively on physical hazards while the causes of most injuries were associated with “habits of work , general site tidiness and human error” (Robens report p 8) We are now on danger of an over focus on human error as a cause of injury and need more emphasis on design for a safe place of work and safe systems.

Q3

The term OHS has come to mean a sub-set of all safety and health eg technical companies often have an engineering safety department separate from OHS. A title which does not include the word “occupational” makes the broad scope of the Act clearer

Q4 and Q5

Yes both help explain the content to the reader

Scope, Application & Definitions:

Q7 – 9

The OHS Act should be overarching legislation that applies to all industries; all sectors, all sizes. Requirements that do not apply to all should be in subordinate regulations or codes.

Specific industries such as rail or electricity may need a separate regulator eg for accreditation or because elements of public safety are not covered by the OHS. The boundaries from the point of view of enforcement can be negotiated between legislators rather than written into legislation as relative resource may differ from State to State.

Q11

Members of the public should be protected from harm from activities associated with work. (this includes major hazards as well as those mentioned in the issues paper) Since these are a safety responsibilities of the employer it makes sense to include them in a workplace Health and Safety Act. This avoids possible incompatibilities of requirements for control of the same event that might harm workers or the community

Q13

Psychological hazards and risks should be identified assessed and controlled. Psychological health should be included in the definition of health or wellbeing

This is a matter of clarity of definition so they are included under general duties

Definitions

Since the aim is that the duty holder understands what their duties are, all terms used in the act or regulation which are open to interpretation should be defined. The number of terms left to a judge to determine should be minimized

Q14

All risk related terms are critical see later section

Q15

The terms safe and healthy work place should be used rather than freedom from risk Freedom from risk has multiple interpretations some of which are impossible for example freedom from uncertainty.

Duties of Care – Who owes them and to whom?:

Q16 - 19

The term control is used in two senses in legislation

- (i) persons in control of a workplace where it means people with responsibility
- (ii) control risk –w here it means act to reduce risk (in some jurisdictions according to a hierarchy of control)

It would add clarity if the same term was not used.

All people who have a designated responsibility for an activity or place should have also a responsibility for safety of that activity or place

If the term “persons in control” is retained a clear definition should be given with a separate definition of control in the sense of risk control

Responsibility for safety should not be able to be relinquished. An individual should do what is in their power to control risks to safety regardless of what is also in the power of someone else.

Q 24 and 26

Duty of care should be owed to all people that the employer can reasonably foresee that they might affect – ie the Queensland definition is good but should also include members of the public eg in the case of dangerous goods transport or major hazards. A duty should also be owed to volunteers by directors or whoever is responsible for the volunteer organisation

Q27

No hence 28 and 29 N/a

Justification

The duty holder should be allowed to work out how best to achieve the requirements of legislation and how to split roles between line managers and any safety managers/coordinators or experts and how to achieve a required level of consultation. (Ie This is a case for performance regulation saying what has to be achieved not how the duty holder has to allocate roles and train their staff)

Current practice (derived from current legislation) often has safety coordinators or safety committees where too much responsibility for managing safety is left to people with far too low a level of safety training and no organizational authority. Arrangements intended as consultation mechanisms are used as a management mechanism

Best practice has line management genuinely managing safety with guidance and assistance from technical experts and consultation with employees. Legislation should not enforce a lesser solution or try for a one size fits all solution

Q31

It is important that all individual managers /decision makers understand that they have responsibility for safety in the way they work and the decisions they make. The current wording is not very clear.

3.2 Activities which Impact on Health and Safety

Q33- 36

Principles

Something should be designed to be safe throughout its lifecycle. Decisions made by a designer often cannot be reversed at later states in the life cycle. However the designer should not be held responsible for things foreseeable only retrospectively which may occur many years later in a different context.

All people who are making money out of a product (defined broadly) including designer, manufacturer, seller, on seller etc should be responsible for the safety of the product ie a manufacturer has a responsibility to specify safety requirements and check the safety of a design before manufacture and should be liable if they manufacture an unsafe design. They

may not reasonably have the expertise to assess design safety so the requirement for safety should not be an absolute duty but they and all others in the chain should be required to make a reasonable attempt to assure themselves an item is safe.

It is not uncommon for a purchaser to claim they cannot buy equipment with certain specified safety requirements and manufacturers to claim there is no call for them or that the purchase would not pay the extra. We thus continue with designs that kill people. The purchaser is doing everything reasonably practicable to minimise risk but still buys unsafe equipment. This deadlock needs to be broken. However this may be a matter of prosecution practice rather than a change in the law. It should be an offence to sell something which is unsafe (including second hand equipment)

Once something comes up for sale the standards in place at the time of sale should apply rather than the standards at the time of manufacture. (This is probably a matter for regulation rather than the Act.)

'Reasonably Practicable' & Risk Management:

Q37

An absolute requirement for safety in general duties require some form of moderation such as reasonably practicable. Absolute safety is impossible to achieve so a law requiring it is manifestly unjust and is counterproductive. (if you have broken the law what ever you do why bother to try?)

However the form of words "reasonably practicable" comes with legal precedent which is not helpful, creates considerable debate even among experts, and does not provide a basis for a duty holder to decide what they need to do.

The act should avoid forms of words that require people to approach their decision about how safe is safe enough as a risk based decision (eg weighing risk to life against money) and encourage a controls based decision which they can easily conceptualise and act upon

A form of words such as reasonable precautions would achieve this

Justificatiuon

Our precedent for "reasonably practicable" requires a calculation of the levels of risk reduction to be weighed against the sacrifice in terms of time money and effort of implementing the control. This is a possible judgment to make in a court of law retrospectively when the precise circumstances of an accident are know but not sensible as a decision rule in the workplace for how safe is safe enough

Consider the following :

The real risk for a fatality from all causes even in a hazardous industry is around one in 10,000 /employee per year. ie a small business of 10 employees expects a fatality once in 1000 years . If there are 100 possible causes of a fatality the actual risk of a fatality from one cause for which a control is being considered is 1 in 100,000/year. The control won't reduce the risk to zero so the quantum of risk reduction is a fraction of this. Our consequences are pain and suffering and life so one must weigh a tiny probability of loss of life against the dollar and effort cost of control.

This is not the reasoning (whether qualitative or quantitative) that is wanted. Risks at an individual level for an individual activity are tiny. The problem is there are many individuals and many activities and one should not make such risk based decisions on an individual activity basis

What we are really concerned about is that controls for health safety risks should be the best available. The test we want people to apply in deciding how safe is safe enough is to ie review all their controls for risks and see if more controls or better ones are available. If they are available the onus should be on the duty holder to demonstrate why it is not reasonable to take further precautions

The Victorian and WA guidance on reasonably practicable in the Act does not say how regard is given to these things so it does not really provide useful information. If this term is retained it would be better to provide useful guidance in more detail and in a terms that can be acted upon

Q40 , 41

In the context above, the standard should be controls based Better controls means higher up the hierarchy of control (as defined in the NSW regulations) More controls means multiple layers of control (eg control in depth as in James Reason's Swiss Cheese model) ie a failure in one layer of defense does not lead to a serious incident – This should be specified in regulations (so it is legally enforceable) more detail is required to explain the requirement than is likely to be appropriate in an Act

Risk Management

Q42

Yes this is essential and having defined the terms they should then be used in the legislation according to their definition This is not the case at present in any jurisdiction

When ever risk related words are used within the Act or Regulations a check should be performed to make sure the word can be replaced by its definition.

All definitions should follow ISO guide 73 *Risk management definitions* This is the terminology used in AS4360 and in the draft ISO 31000 *Risk management Principles and Guidelines* which will replace AS4360 in 2009

Justification

The different use of risk management terminology in safety regulation compared with general risk management practice makes it difficult to incorporate safety adequately within enterprise risk management and hence to integrate safety with other management systems.

At present some definitions of hazard in legislation is not the same as in ISO guide 73 or ISO Guide 51 "*Safety Aspects - Guidelines for Their Inclusion in Standards*" This means that definitions in the legislation differs from that in safety standards they call up !

Hazard and Risk

It is difficult to comply with a requirement to identify hazards/risks and assess risks when the terms hazard, risk and assess risk are not defined.

Confusion between hazards and risks and control failures results in risk registers and risk information systems which are of very limited use. Apples are ranked against pears resulting in very poor decisions on priorities

The confused definition of hazard and risk means that problems are not specified sufficiently to be managed adequately. If hazard is interpreted to mean a source of harm and risk to mean a combination of consequences and their likelihood (as in some legislation) Then the legislation means one is asked only to decide that electricity is a high risk.

If risk means a description of what might happen and its consequences, and identifying risk means identify what might happen, when where why and how.(as in AS4360) one communicates sufficient information to explain risks to managers so they can act and to employees so they understand the problems.

Some jurisdictions have overcome the problem of a narrow definition of hazard by broadening the definition to mean anything harmful including events and activities. However one can't rank an event against an activity against a source of harm and get a sensible priority so all prioritization systems become nonsense

Hazard is a source of harm as a result of which there is a **risk** (something that might happen to cause harm.) Legislation should require hazards and their risks to be identified

Risk Assessment

At present to “assess risk” is defined in most cases to exclude identifying hazards and risks but carrying out “a risk assessment” is considered to include identifying hazard and/or risk. This confusion should be removed. In Guide 73 risk assessment includes identifying risks

Risk assessment is often interpreted to mean rating or ranking risk using a consequence likelihood matrix then applying standard controls starting with the highest risks. This is contrary to the requirement that the work place is so far as reasonably practicable safe and without risk to health. This criteria requires that all risks are dealt with to the extent practicable

It is also not compatible with AS4360 2004 or draft ISO 31000 which, contrary to popular opinion, does not require or contain a consequence likelihood rating system

The interpretation of risk assessment as risk rating is bad practice because

- The essence of risk assessment is that controls are selected based on understanding of the nature of the risk and its causes (see AS4360) Controls are applied until the risk is acceptable (ie it is safe enough) It is not good risk management practice to simply apply standard controls in an order defined by a ranking.
- A consequence likelihood matrix is an inappropriate rating tool for health risks as consequences depend on the individual and usually arise due to long term variable exposures rather than an “event” with a definable probability It is not therefore appropriate for two of the biggest risks manual handling and chemicals exposure. Both require a dose - response type of assessment
- Setting priorities for control based on a qualitative level of risk does not lead to the most effective allocation of a budget to reduce risk (which requires priorities to consider where the greatest risk reduction can be achieved) It treats each risk independently and ignores linkages where one control reduces multiple risks.

- Rating matrices are entirely arbitrary, need to be organization and risk specific and require more expertise to design properly than is usually available

Q 43

This question appears to be asked backwards. In managing safety risks it is necessary to decide how safe is safe enough in order to decide whether more control is needed. (The activity of assessing a risk means understanding risks and deciding whether the risk is acceptable.) Guidance on what is acceptable needs to be given. If this guidance is controls as good as reasonably practicable, or all reasonable precautions taken, or risks as low as reasonably practicable, the terms need to be defined as part of specifying that the risk management process should be applied.

Q44

Risk management principles should be required by the Act. The risk management process is how one tries to ensure that the workplace is safe and without risk to health –It would therefore appear that risk management is necessarily tied to the general duties.

Risk management activities may be specified within the Act but should be compatible with the draft ISO 31000 (or AS4360 -the changes are not great). Alternatively the relevant part of the standard could be referred to.

True risk management includes

- processes to anticipate and recognize risks to health or safety in the workplace
 - This includes recognizing what is harmful (hazards) and what might happen to cause harm and the nature of the harm (risks)
- Accessing information, undertakes research or formal techniques as appropriate to understand the nature of risks and causes
- Reviewing current controls and identifies potential new controls using information on nature of risks and their causes
- Implementing controls until the level risk is acceptable
- Checking controls work and do not introduce new risks
- Checking the level of risk is now acceptable

Understanding background and context and constraints, defining acceptability criteria communication and consultation and monitoring and review are also essential to effective risk management but usually covered separately in legislation and guidelines from the risk assessment and control steps

Prioritisation systems (not necessarily a consequence likelihood matrix) may be useful as screening to decide which risks need more detailed assessment first, or as one input to deciding priority for improvement. Unless having assessed risk to be of low priority is an acceptable defense ranking should not be required by legislation and care should be taken how it is recommended in guidelines

Other Issues:

General Comment on Standard Setting

Robens suggested that detailed specifications and guidance on implementation should be in non statutory codes and standards. Ie there is no suggestion that they are not needed at all. (This view was also reinforced by Cullen in the Pipa Alpja report) However this requires that there is a standards setting mechanism which is adequately funded, takes account of best available data and knowledge and expert opinion, has input from all relevant stakeholders and is not left to industry to produce (as they have little motivation to produce what could be a rod for their own back and often do not have all the relevant expertise)

Australia currently does not have a good system for this. There is poor cooperation between Standards Australia and the legislators but neither have both the resources and all of the above requirements There is a significant risk that technical standards deteriorate – particularly those which are hard for industry but good for safety

Legislating for an SMS

Gunningham and Johnstone (among others) argue that the next development in OHS legislation is to move to legislation based on SMS. The argument is that investigation of incidents invariably identifies management system failures as contributory causes However to assume from this that a formal SMS will reduce those failures it is a gross over simplification

There is no evidence that the processes required by conventional safety management lead to safe outcomes. This is not just that no one has looked - There is a growing body of research indicating that there is no correlation between safe outcomes and most individual elements of a conventional safety management measured by audit

Correlations are found in the research between safe outcomes and visible demonstrated management commitment and involvement in safety, autonomy of workers, and safety integrated into general management systems rather than a separate entity

Legislating for an SMS is counterproductive because

- safety should be embedded in an organisation's general management system and not exist as a separate entity. To legislate an SMS implies a separate safety manual which can be audited by the regulator. Rather than requiring a separate SMS it would be better to require safety to be considered in all relevant management decisions and processes
- The requirements of a good SMS are set by the way the organization undertakes its business and the risks it faces. Requirements set by an audit process will almost certainly not be appropriate.
- A small,medium and big business have quite different management structures and activities. A large percentage of employers in Australia are SMEs that have no formal documented management system .One cannot superimpose a conventional safety management system where there is no conventional management system and expect it to work.
- Conventional safety management systems do not include critical elements for safety, for example design (of work systems or equipment) maintenance, asset management etc , gathering and processing of safety related information (not only incident data), Training

of managers, etc etc. Since we know conventional wisdom on what should be in an SMS is weak we should not specify it in legislation

- Some elements of the conventional system (or at least the way it is implemented run counter to research on what improves safety) ie empowerment is better than close supervision, on the job training by showing and helping is better than auditable training sessions (research shows training is of no value without reinforcement and positive feedback)
- The aim is for all employers to take responsibility for safety in their workplace ie the required outcome is commitment, involvement and empowerment of both managers and employees, An SMS may demonstrate this but it does not achieve it.
- One cannot legislate for commitment
- an understanding of the nature of risks and ingenuity to fix them is required but is covered by requiring a risk management process to be applied
- Many people in groups with high injury rates (and many employers in small businesses) are not paper people. They don't read and don't make a link between words and theory and actions (if they did they would probably be in a different job)) They are people who learn through doing. The contents of the SMS prepared by a safety professional or by management for audit don't help them make the workplace safer
- No SMS can provide a safe workplace the fundamental to that is understanding risks and fixing them. The way managers establish systems to achieve this cannot be specified across all size and type of organisation.