QUEENSLAND
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Standing for fairness

The workplace death investigations report

An investigation into the quality of workplace death investigations conducted by the Office of Fair and Safe Work Queensland.

September 2015

Report of the Queensland Ombudsman

The workplace death investigations report

An investigation into the quality of workplace death investigations conducted by the Office of Fair and Safe Work Queensland

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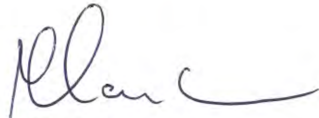
September 2015

The Honourable Peter Wellington MP
Speaker
Parliament House
George Street
BRISBANE QLD 4000

Dear Mr Speaker

In accordance with s.52 of the *Ombudsman Act 2001*, I hereby furnish to you my report, *The workplace death investigations report: An investigation into the quality of workplace death investigations conducted by the Office of Fair and Safe Work Queensland.*

Yours faithfully



Phil Clarke
Queensland Ombudsman

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Foreword

This report presents the findings of an investigation into the quality of a sample of workplace death investigations conducted by the Office of Fair and Safe Work Queensland (OFSWQ).

A workplace death investigation is a complex activity. An investigation must determine the cause of death, whether the death was preventable and whether any person breached a work health and safety duty that they owed, thus committing an offence which may have contributed to a death. In addition, the OFSWQ has the responsibility of liaising with a deceased person's next of kin in order to provide them with timely and relevant information about the progress and outcome of the investigation.

This investigation reviewed 20 OFSWQ investigations into workplace deaths that occurred in Queensland between 1 January 2012 and 30 June 2013. The investigation also reviewed 19 notifications of potential workplace deaths received and triaged by the OFSWQ as out of jurisdiction or not work-related within the same period.

It is in the public interest that workplace deaths are investigated in a timely, comprehensive and transparent manner and that compliance with work health and safety laws is enforced appropriately. It is also important for the public to have confidence that the learnings and outcomes from each workplace death investigation help prevent the occurrence of similar deaths as well as assist with the elimination or minimisation of risks at Queensland workplaces.

I acknowledge the significant distress caused by a workplace death to the families, friends and work colleagues of the deceased.

I would like to thank the many officers from the OFSWQ who cooperated with my investigation by making themselves available for interview and assisting my Office gather evidence to inform the investigation.

Finally, I would like to thank my staff and particularly acknowledge Assistant Ombudsman, Peter Cantwell, and Senior Investigator, David McMurtrie, for their hard work and professionalism in conducting the investigation and preparing the report.

Phil Clarke

Queensland Ombudsman

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Dictionary

Term	Meaning
ASU	Assessment Services Unit within the OFSWQ
CLO	Coronial Liaison Officer, a position within the OFSWQ
CLU	Coronial Liaison and Investigations Support Services Unit within OFSWQ responsible for liaising with a coroner during a workplace death investigation
COAG	Council of Australian Governments
coroner	A judicial officer responsible for investigating certain reportable deaths under the *Coroners Act 2003*
Coroners Act	*Coroners Act 2003* (Qld)
Deputy Director-General, OFSWQ	The officer responsible for the OFSWQ and the work health and safety regulator under the *Work Health and Safety Act 2011*
Director, LPS	Director, Legal and Prosecution Services, a senior officer position within the OFSWQ with delegated responsibility for deciding whether to commence prosecution action for an alleged offence under the WHS Act or other relevant legislation
DPP	Director of Public Prosecutions
DTMR	Department of Transport and Main Roads
duty holder	Person holding a duty of care under the WHS Act
file review	Queensland Ombudsman review of 20 OFSWQ workplace death investigations which informed this investigation
the investigation	Queensland Ombudsman investigation into the quality of workplace death investigations conducted by the OFSWQ
JAG	Department of Justice and Attorney-General, the agency responsible for the OFSWQ before 1 July 2015
legal officer	Principal Legal Officer employed by the OFSWQ
LPS	Legal and Prosecution Services Unit within the OFSWQ
Model Codes of Practice	Codes of Practice developed by Safe Work Australia to support the WHS Act
Model Work Health and Safety Act	Commonwealth Act which was drafted as a result of recommendations made by the National Review into Occupational Health and Safety Laws
MOU	Memorandum of Understanding between the OFSWQ and the Queensland Police Service and the Department of Transport and Main Roads with regard to the investigation of serious traffic incidents
National Compliance and Enforcement Policy	Policy that outlines the approach work health and safety regulators will take to compliance and enforcement
National Review into Occupational Health and Safety Laws	Review established in 2008 by the Council of Australian Governments to achieve a nationally consistent regulatory framework of work health and safety laws
Next of kin	The next of kin of a deceased person who is the subject of the workplace death investigation

Term	Meaning
OFSWQ	Office of Fair and Safe Work Queensland, responsible for workplace death investigations prior to 1 July 2015
OIR	Office of Industrial Relations, responsible for workplace death investigations from 1 July 2015
PCBU	Person conducting a business or undertaking under the WHS Act
Principal Inspector (Investigations) or inspector	OFSWQ officer responsible for the investigation of workplace deaths and serious incidents
QPS	Queensland Police Service
Queensland Treasury	The agency responsible for the OFSWQ from 1 July 2015
regional office or region	One of seven regional offices of the OFSWQ responsible for conducting workplace death investigations
RIM	Regional Investigations Manager of a regional office of the OFSWQ
Safe Work Australia	Commonwealth agency that develops policy to improve work health and safety and workers' compensation arrangements across Australia
Safety in Recreational Water Activities Act	*Safety in Recreational Water Activities Act 2011* (Qld)
WHS Act	*Work Health and Safety Act 2011* (Qld)
WHS Regulation	Work Health and Safety Regulation 2011
Workplace Electrocution Project	Series of nine investigations conducted between 1999 and 2005 by the Queensland Ombudsman regarding the death by electrocution of 12 people, including seven at their workplace
Workplace Health and Safety Act	*Workplace Health and Safety Act 1995* (Qld) (repealed)

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Executive Summary

Background

On 30 June 2005, the former Queensland Ombudsman Mr David Bevan published the Workplace Electrocution Project (WEP), a report into the adequacy of the responses of government agencies to nine fatal electrical incidents in Queensland.

The findings of the WEP, which identified a number of systemic shortcomings, resulted in significant reform to Workplace Health and Safety Queensland[1] and a focus on improved training for inspectors and enhanced investigative procedures. However, the Office of the Queensland Ombudsman has continued to receive complaints regarding the quality of investigations undertaken by the Office of Fair and Safe Work Queensland (OFSWQ) into serious workplace incidents. There have also been a number of coronial inquests which have continued to deliver critical findings regarding the quality of the OFSWQ's workplace death investigations.

These complaints and coronial findings concerned similar issues to those addressed in the WEP.

Accordingly, I decided to commence a fresh investigation to review the quality of investigative work and processes carried out by the OFSWQ. My investigation focused solely on workplace deaths, as the death of a person at a workplace is an extremely serious and tragic event and one that should be given priority by the OFSWQ, both in the quality of its response and also in determining the appropriate regulatory response.

Jurisdiction, investigation scope and objective

The OFSWQ is an office within Queensland Treasury and, as a public sector agency, the Ombudsman may investigate its administrative actions.

The principal objectives of the investigation were to determine:

- the adequacy of investigations into workplace deaths conducted by the OFSWQ
- the adequacy of the assessment and triaging of notifications of workplace deaths received by the OFSWQ.

During the investigation my officers:

- analysed 20 OFSWQ workplace death investigations which occurred between 1 January 2012 and 30 June 2013
- analysed 19 notifications of potential workplace deaths which occurred between 1 January 2012 and 30 June 2013, and which were received and triaged by OFSWQ as out of jurisdiction or not work-related
- analysed memorandums of advice provided to the Director, Legal and Prosecution Services (LPS), which included recommendations about whether to take enforcement action in each of the 20 workplace death cases
- reviewed a selection of coronial inquests which made critical findings and recommendations regarding the OFSWQ's investigations
- reviewed relevant legislation and the OFSWQ's policies, procedures and work practices regarding workplace death investigations
- reviewed relevant procedures, policies and codes of practice developed by Safe Work Australia as part of harmonised work health and safety laws
- interviewed relevant OFSWQ officers.

[1] Workplace Health and Safety Queensland was formerly a division of the OFSWQ and since 1 July 2015 has been a division of the Office of Industrial Relations (OIR) within Queensland Treasury. See section 1.7 of this report for an explanation of the recent Machinery of Government changes.

Findings

My investigation identified both positive and negative features of the workplace death investigations undertaken by the OFSWQ. The OFSWQ's processes for notification and referral, triaging, responding to a workplace death and initial investigation activities were assessed as generally appropriate and greatly improved since the publication of the WEP report. However, deficiencies were identified in investigation planning, issue identification and evidence gathering, and the sufficiency of advice provided by legal officers to support prosecution decisions.

The time taken by the OFSWQ to complete the investigation in many of the cases reviewed was poor. Timeliness in decision-making by LPS on whether to commence prosecution proceedings against any person following the investigation was also poor in many of the cases reviewed.

In addition, the investigation examined a number of issues related to the OFSWQ's processes. These included liaison and communication with next of kin during the investigation process and the OFSWQ's interpretation of its jurisdiction, particularly with respect to deaths which occur as part of a commercial recreational activity.

In particular, the investigation identified that following a workplace death where the OFSWQ declined to prosecute a duty holder, but the next of kin reasonably considers that an offence has been committed, the OFSWQ does not provide sufficient advice to the next of kin regarding the statutory right that exists under the *Work Health and Safety Act 2011* (WHS Act) to request that the OFSWQ refer the matter to the Director of Public Prosecutions (DPP) for review. The investigation also determined that where a next of kin does request a review by the DPP, the OFSWQ requires that they meet onerous evidentiary requirements before determining that a valid application has been submitted.

Finally, the investigation determined that there is inconsistency by the OFSWQ in the application of its jurisdiction to workplace incidents involving the death of a person who is not a worker at a workplace, particularly when the person is participating in a commercial recreational activity. This latter issue was also the subject of a recent coronial inquest where the Northern Coroner found that the lack of any relevant OFSWQ policies and procedures relating to the investigation of commercial recreational activities resulted in a deficient investigation outcome.[2]

To address these issues, this report makes a number of recommendations to improve the way the OFSWQ conducts its investigations. This report also focuses on ensuring that the OFSWQ undertakes its investigations and regulatory actions in a way that is timely, consistent, transparent, accountable and proportional to the seriousness of the event.

Opinions

I have formed the following opinions:

Opinion 1

Many of the 20 workplace death investigations reviewed were not conducted in a timely manner, in particular:

(a) in only five cases was the regional investigation completed within six months of the commencement of the investigation, as required by the OFSWQ *Operational Procedure: Investigation Management*

(b) the time taken by the OFSWQ to complete the workplace death investigations and make a decision about whether to commence a prosecution in Case Studies 3, 9 and 15 was excessive.

These delays are unreasonable administrative action for the purposes of s.49(2)(b) of the Ombudsman Act.

[2] Inquest into the death of Navina Friedericke Villinger.

Opinion 2

The current OFSWQ notification and triage processes are generally appropriate and reasonable.

Opinion 3

The OFSWQ's notification, referral and first response actions, including the use of enforcement notices, are generally appropriate and timely.

Opinion 4

Investigative planning by the OFSWQ was inadequate, often of a poor quality and contributed to unsatisfactory investigation and regulatory outcomes in many of the investigations reviewed. This is unreasonable administrative action for the purposes of s.49(2)(b) of the Ombudsman Act.

Opinion 5

Case management of many of the investigations reviewed was inadequate and recordkeeping did not demonstrate the case management processes that had occurred in many cases. This is unreasonable administrative action for the purposes of s.49(2)(b) of the Ombudsman Act.

Opinion 6

The OFSWQ investigation in Case Study 3 was inadequate because:

(a) the OFSWQ failed to identify and address multiple issues regarding whether the duty holders had complied with their work health and safety duties under the WHS Act

(b) the outcome leaves potential material questions unanswered regarding whether an offence was committed by one or both of the duty holders under the WHS Act.

The failure by the OFSWQ to conduct an adequate investigation is unreasonable administrative action for the purposes of s.49(2)(b) of the Ombudsman Act.

Opinion 7

A significant number of investigations failed to identify breaches by duty holders and relevant investigation issues, and were not supported by adequate evidence gathering. These deficiencies adversely affected the quality of these investigations. This is unreasonable administrative action for the purposes of s.49(2)(b) of the Ombudsman Act.

Opinion 8

Investigation reports were poorly presented, in varying formats and failed to address all significant evidence relevant to the investigation. This is unreasonable administrative action for the purposes of s.49(2)(b) of the Ombudsman Act.

Opinion 9

Memorandums of advice prepared by legal officers do not provide clear and sufficient reasons to allow the Director, LPS to make an informed decision about whether to commence a prosecution. This is unreasonable administrative action for the purposes of s.49(2)(b) of the Ombudsman Act.

Opinion 10

A review of LPS is required to ensure its continued capacity to manage the volume and range of work it is expected to perform.

Opinion 11

Written advice provided to next of kin does not adequately communicate the outcome of an investigation and reasons for the decision not to prosecute any person for an offence. This is unreasonable administrative action for the purposes of s.49(2)(b) of the Ombudsman Act.

Opinion 12

Inadequate advice is provided to next of kin regarding their right to request a prosecution under s.231 of the WHS Act. This is unreasonable administrative action for the purposes of s.49(2)(b) of the Ombudsman Act.

Opinion 13

Requiring a person making a s.231 application to identify the relevant offence category, act, omission or duty, and how a duty holder's actions have exposed a person to a risk of death or serious injury, is unreasonable administrative action for the purposes of s.49(2)(b) of the Ombudsman Act.

Opinion 14

The action taken by the OFSWQ in Case Study 16 with respect to:

(a) determining that the s.231 application, submitted by the deceased's next of kin, was not valid when the next of kin had provided evidence to support a reasonable belief under s.231(1)(a) of the WHS Act

(b) failing to refer the request to the DPP as required by s.231(3)(b) of the WHS Act

was administrative action taken contrary to law for the purposes of s.49(2)(a) of the Ombudsman Act.

Opinion 15

There is inconsistency by the OFSWQ in the application of its jurisdiction to workplace incidents involving the death of a person at a workplace who is not a worker, particularly when the person is participating in a commercial recreational activity.

Opinion 16

In Case Study 9 there was no evidence of any information sharing or collaboration by the OFSWQ with DTMR or QPS, as required by the MOU regarding the investigation of workplace deaths occurring in a serious traffic incident.

Opinion 17

Commencing an investigation of a workplace death without first determining jurisdiction is an inefficient use of public resources and is unreasonable administrative action for the purposes of s.49(2)(b) of the Ombudsman Act.

Recommendations

I have made the following recommendations:

Recommendation 1

The Under Treasurer:

1.1 establish appropriate target timeframes to complete workplace death investigations

1.2 establish appropriate target timeframes for LPS to make a decision about prosecution

1.3 publicly report on OIR's performance in meeting each of these target timeframes on an annual basis.

Recommendation 2

The Under Treasurer:

2.1 review the investigation planning requirements contained in the current *Fundamental Inspector, Investigation and Witness Skills* manual to ensure they represent current and best practice

2.2 establish a mandatory process of investigative planning and provide appropriate training to inspectors about these requirements

2.3 ensure that quality assurance processes evaluate the use and effectiveness of investigative planning in workplace death investigations.

Recommendation 3

The Under Treasurer review current case management procedures for workplace death investigations to ensure they represent current and best practice and provide appropriate training to inspectors in these requirements.

Recommendation 4

The Under Treasurer appoint a suitably qualified independent person to review the investigation and regulatory outcome in Case Study 3, and provide advice to the State Coroner regarding the outcome of that review.

Recommendation 5

The Under Treasurer:

5.1 review the requirements relating to the identification of breaches by duty holders and the identification of causal factors potentially impacting on a workplace death contained in the *Fundamental Inspector, Investigation and Witness Skills* manual, to ensure they represent current and best practice

5.2 provide appropriate training to inspectors regarding identifying breaches and potential causal factors during an investigation

5.3 ensure that quality assurance processes include the sufficiency of the identification of breaches and relevant causal factors in an investigation.

Recommendation 6

The Under Treasurer:

6.1 review the OIR's current investigation report template to determine whether it is adequate, considering the issues identified with respect to the quality of investigation reports reviewed

6.2 ensure that all workplace death investigation reports are prepared in a standard report format

6.3 ensure that quality assurance processes include assessment of the quality of investigation reports.

Recommendation 7

The Under Treasurer:

7.1 continue the external review and evaluation program of workplace investigations

7.2 provide the outcome of each investigation reviewed to the inspector and RIM responsible for the investigation to facilitate continuous improvement in investigations and professional development of inspectors.

Recommendation 8

The Under Treasurer:

8.1 require that all memorandums of advice provided to the Director, LPS by a legal officer about whether to commence a prosecution, following a workplace death investigation, include an assessment of the following:

(a) whether there is sufficient evidence to prove that a duty holder breached a duty under the WHS Act or other legislation

(b) whether there is sufficient evidence to successfully prosecute a category 1, 2 or 3 offence under the WHS Act, or an offence under another Act

(c) whether prosecution for any offence is in the public interest.

8.2 implement a quality assurance process to periodically review the quality of the memorandums of advice prepared by legal officers for consideration by the Director, LPS.

Recommendation 9

The Under Treasurer engage an independent person (preferably a senior legal practitioner) to conduct a comprehensive review of LPS, addressing each of the following matters:

(a) the adequacy and appropriateness of the current LPS model

(b) whether the current delegation to commence a prosecution for an offence under the WHS Act or other legislation is appropriate

(c) the adequacy of prosecution decisions made with respect to a workplace death

(d) the adequacy of memorandums of advice prepared by a legal officer for consideration by the Director, LPS with respect to a workplace death investigation

(e) the adequacy of current resourcing and training provided to legal officers relevant to the requirements of their role

(f) the timeliness of decision-making.

Recommendation 10

The Under Treasurer implement a process, in cases finalised as 'no further action', to ensure that next of kin are provided with timely written advice regarding the outcome of the investigation and the reasons for the decision not to prosecute any person for an offence under the WHS Act or other legislation.

Recommendation 11

The Under Treasurer implement a process to advise a person whose workplace injury is subject to an OIR investigation, or the next of kin following a workplace death, of their right to request that a prosecution be brought under s.231 of the WHS Act, at the commencement of the OIR investigation and that this advice includes the requirements that need to be met in making the application.

Recommendation 12

The Under Treasurer seek legal advice about what constitutes a valid application under s.231(1)(a) of the WHS Act and amend OIR policy and procedures as necessary, based on the outcome of this advice, to ensure the proper functioning of s.231(1)(a) of the WHS Act.

Recommendation 13

The Under Treasurer develop necessary policies and procedures to guide future OIR investigations into workplace deaths in instances where the deceased was a participant in a commercial recreational activity.

Recommendation 14

The Under Treasurer:

14.1 clarify with the Director-General of DTMR the respective responsibilities of each agency under the MOU regarding a workplace death occurring in a serious traffic incident

14.2 provide advice and training to all inspectors involved in investigating, reviewing and approving workplace death investigations about the OIR's responsibilities under the MOU.

Recommendation 15

The Under Treasurer implement a policy to ensure any question of jurisdiction regarding the investigation of a workplace death is determined by the OIR before investigation activities commence and provide appropriate training about the policy to inspectors.

Chapter 1: Introduction

1.1 Background

This report summarises the findings of an investigation into the adequacy of investigations conducted by the OFSWQ into a sample of workplace deaths in Queensland (the investigation). The sample consisted of 20 workplace deaths which occurred between 1 January 2012 and 30 June 2013.

The OFSWQ is the Queensland work health and safety regulatory agency responsible for improving workplace health and safety in Queensland. One of the methods employed by the OFSWQ to achieve this goal is the enforcement of work health and safety laws by investigating workplace fatalities and serious injuries and prosecuting breaches of legislation based on the outcome of its investigations.

Accordingly, the investigation has focused on the steps taken by the OFSWQ to investigate workplace deaths, the quality of its investigative practices, whether the regulatory outcomes of the investigation (including the decision whether to prosecute any person for a breach of a duty) were appropriate and how the OFSWQ engages with key stakeholders during and after the investigation process.

This report makes a number of recommendations to improve the way the OFSWQ conducts its investigations. This report also focuses on ensuring that the OFSWQ undertakes its investigations and regulatory actions in a way that is consistent, transparent, accountable and proportional to the seriousness of the event.

1.2 Issues for investigation

The principal objectives of the investigation were to determine:

- the adequacy of investigations into workplace deaths conducted by the OFSWQ
- the adequacy of the assessment and triaging of notifications of workplace deaths received by the OFSWQ.

As part of this investigation, the following issues were considered:

- the timeliness in completing investigations (Chapter 4)
- the notification and triaging framework for workplace deaths, the quality of the first response to a workplace death and whether immediate safety concerns at the workplace were addressed (Chapter 5)
- whether there was appropriate investigation planning and case management (Chapter 6)
- the quality of evidence gathering, including identification of breaches and investigation reports (Chapter 7)
- the quality of decision-making about whether to commence a prosecution (Chapter 8)
- whether the engagement with the next of kin during the investigation was appropriate (Chapter 9)
- the interpretation of aspects of the OFSWQ's jurisdiction to investigate workplace deaths (Chapter 10)
- similar coronial findings regarding workplace death investigations conducted by the OFSWQ (Chapter 11).

1.3 Ombudsman jurisdiction

The Ombudsman is an officer of the Queensland Parliament empowered to investigate complaints about the administrative actions of Queensland public sector agencies. As Queensland Government departments are 'agencies' for the purposes of the *Ombudsman Act 2001*[3] (Ombudsman Act), it follows that I may investigate the administrative actions of the OFSWQ, an office located within Queensland Treasury as of 1 July 2015.

[3] Section 8(1), Ombudsman Act.

Under the Ombudsman Act,[4] I have authority to:

- investigate the administrative actions of agencies following a complaint or on my own initiative (without a specific complaint)
- make recommendations to an agency being investigated about ways of rectifying the effects of its maladministration and improving its practices and procedures
- consider the administrative practices of agencies generally and make recommendations, or provide information or other assistance to improve practices and procedures.

The Ombudsman Act outlines the matters about which the Ombudsman may form an opinion before making a recommendation to the principal officer of an agency.[5] These include whether the administrative actions investigated are contrary to law, unreasonable, unjust or otherwise wrong.[6]

Although the Ombudsman is not bound by the rules of evidence,[7] the question of the sufficiency of information to support an opinion by the Ombudsman requires some assessment of weight and reliability. The standard of proof applicable in civil proceedings is proof on the balance of probabilities. This essentially means that, to prove an allegation, the evidence must establish that it is more probable than not that the allegation is true. Although the civil standard of proof does not strictly apply in administrative decision-making (including the forming of opinions by the Ombudsman), it provides useful guidance.[8]

'Unreasonableness' in the context of an Ombudsman investigation

It is important to note that, in expressing an opinion under the Ombudsman Act that an agency's administrative actions or decisions are 'unreasonable', I am applying the meaning of the word in the context of the Ombudsman Act. In this context, 'unreasonable' bears its popular or dictionary meaning, not the far narrower 'Wednesbury' test of unreasonableness, which involves a consideration of whether an agency's actions or decisions were so unreasonable that no reasonable person could have taken them or made them.[9]

1.4 Investigation methodology

The investigation included:

- a file review of 20 OFSWQ workplace death investigations regarding workplace deaths which occurred between 1 January 2012 and 30 June 2013
- a review of the memorandums of advice provided to the Director, Legal and Prosecution Services Unit (LPS), which included recommendations about whether to take enforcement action in each of the 20 workplace death cases
- a file review of 19 notifications of potential workplace deaths which occurred between 1 January 2012 and 30 June 2013, and which were received and triaged by OFSWQ as out of jurisdiction or not work-related
- review of a selection of coronial inquests which made critical findings and recommendations regarding the OFSWQ's investigations
- analysis of the OFSWQ's policies, procedures and work practices regarding workplace death investigations
- review and analysis of relevant legislation, including the WHS Act and the *Safety in Recreational Water Activities Act 2011*
- analysis of the Model Codes of Practice developed by Safe Work Australia as part of the harmonised work health and safety laws

[4] Section 12, Ombudsman Act.
[5] Sections 49 and 50, Ombudsman Act.
[6] Section 49(2), Ombudsman Act.
[7] Section 25(2), Ombudsman Act.
[8] See *Minister for Immigration and Ethnic Affairs v Wu Shan Liang* (1996) 185 CLR 259 at 282. See also the discussion in R. Creyke and J. McMillan, *Control of Government Action – Text, cases and commentary*, 2nd edition, LexisNexis Butterworths, Australia, 2009, at 12.2.20.
[9] See *Re Hospital Benefit Fund of Western Australia Inc* (1992) 28 ALD 25 at 42 for a discussion of statutory unreasonableness.

- analysis of the National Compliance and Enforcement Policy which sets out the approach work health and safety regulators will take to compliance and enforcement under the model WHS Act and Regulations
- review of submissions and associated reports produced by the National Review into Model Occupational Health and Safety Laws
- interviews with Principal Inspectors (Investigations) and Regional Investigation Managers who were responsible for the investigation of a number of the 20 cases reviewed
- interviews with:
  - Director, Work Health and Safety Compliance
  - Director, LPS
  - Manager, Assessment Services Unit (ASU)
  - Manager, Coronial Liaison and Investigations Support Services.

The investigation considered workplace deaths which occurred between 1 January 2012 and 30 June 2013. This period was chosen for the following reasons:

- the WHS Act commenced on 1 January 2012, meaning that all workplace deaths reviewed were investigated under the current legislation
- 18 months was considered sufficient time to ensure an appropriate and diverse sample of workplace death investigations
- there was sufficient time to ensure the investigations selected for the file review were finalised at the time the review was undertaken.

The process used to select the final sample of 20 workplace deaths included the following:

- all investigations which resulted in court action or a coronial inquest (inquest) were excluded from the file review
- the OFSWQ investigation reports of 91 workplace deaths which occurred during the relevant period were assessed and 32 investigations were identified where potential omissions or actions in the investigation process may have contributed to adverse investigation outcomes
- the full case files for these 32 investigations were requested from the OFSWQ
- following receipt of the 32 case files, further assessment was conducted to select the final sample for the file review, ensuring that the sample included a broad regional representation, a range of different causes of death, as well as incidents involving workers and non-workers.

1.5 De-identification

The purpose of this report is to provide the outcome of the Office's investigation regarding the quality of workplace death investigations conducted by the OFSWQ. Naming officers does not assist that purpose. Accordingly, in all of the case studies discussed in this report, I have removed:

- references to the names of OFSWQ officers or former officers
- other information that could identify any officer or former officer unless that information is critical to a purpose of the report.

I have not named anyone who died as a result of a workplace incident, or included workplace names or addresses, with the exception of publicly available coronial inquest findings.

1.6 Proposed report

The terms 'procedural fairness' and 'natural justice' are often used interchangeably within the context of administrative decision-making. The rules of procedural fairness have been developed to ensure that decision-making is both fair and reasonable.

I must also comply with these rules when conducting an investigation.[10] Further, the Ombudsman Act provides that, if at any time during the course of an investigation it appears to me that there may be grounds for making a report that may affect or concern an agency, the principal officer of that agency

[10] Section 25(2), Ombudsman Act.

must be given an opportunity to comment on the subject matter of the investigation before the final report is made.[11]

This report was completed as a proposed report in May 2015.

To satisfy my obligations, I provided the proposed report to Mr David Mackie, Director-General of the Department of Justice and Attorney-General (JAG). Where appropriate I have referred to the Director-General's response throughout this report. I thank the Director-General for his response.

I also provided relevant sections of the proposed report to the Director, LPS. While I do not consider any opinion made in this report is adverse to the Director, LPS, some aspects of the report may be construed as adverse comment about investigation outcomes for which the Director, LPS is responsible. The Director, LPS's response has been referred to throughout this report where appropriate. I thank the Director, LPS for his response.

The purposes of this report are explained above. My investigation was not undertaken with a view to criticising any particular officer. I have therefore not made any adverse comment against any person in this report. Accordingly, my comments in this report should not be taken as reflecting adversely on the reputation, competency or integrity of any OFSWQ officer involved in any of the investigations reviewed as part of this investigation.

1.7 Machinery of government changes

Pursuant to s.26(3) of the Ombudsman Act, I provided my proposed report to the Director-General of JAG as the principal officer responsible for the OFSWQ. The Director-General provided his response to the proposed report on 30 June 2015.

On 1 July 2015, the OFSWQ transferred from JAG to Queensland Treasury as part of machinery of government changes and was renamed the Office of Industrial Relations (OIR). The principal officer responsible for the OIR is now the Under Treasurer.

Accordingly, my recommendations in this report are made to the Under Treasurer. However, as the Director-General of JAG responded to the proposed report in his former capacity of principal officer for the OFSWQ, it is the Director-General's responses, including to each recommendation, that have been included in this report.

For consistency, in this report I have continued to refer to the OFSWQ when discussing the outcome of completed workplace death investigations. However, in making my recommendations to the Under Treasurer I have made reference to the OIR, as this will be the agency responsible for the conduct of workplace death investigations in the future.

[11] Section 26(3), Ombudsman Act.

Chapter 2: The investigation of a workplace death

This chapter will discuss the statutory and regulatory framework which applies to workplace deaths in Queensland.

2.1 *The Work Health and Safety Act 2011*

The purpose of the WHS Act is to protect the health, safety and welfare of all workers at work and other people who may be affected by work.[12] All workers are protected by the WHS Act, including employees, contractors, subcontractors, outworkers,[13] apprentices and trainees, work experience students, volunteers and employers who perform work.[14] The WHS Act also protects members of the public so that their health and safety is not put at risk from work activities.[15]

2.1.1 Person conducting a business or undertaking

The WHS Act places the primary duty of care at a workplace, as well as various other duties and obligations, on a 'person conducting a business or undertaking' (PCBU).[16] The concept of a PCBU was intended to be broad, capturing all types of modern working arrangements.[17] A PCBU may conduct a business or undertaking alone or with others, whether or not for profit or gain.[18] A PCBU can be a self-employed person, a partnership, company, unincorporated association or government department, including local councils.[19]

However, despite placing the primary duty of care at a workplace on a PCBU, the WHS Act does not define what constitutes a 'business' or 'undertaking'. Accordingly, whether a person conducts a business or undertaking is a question of fact to be determined in the circumstances of each case.[20] The common meaning of a business is that of an enterprise usually conducted with a view to making a profit, and having a degree of organisation, system and continuity.[21] An undertaking may have elements of organisation, systems, and possibly continuity, but is usually not profit-making or commercial in nature.[22] It is immaterial whether or not a PCBU conducts a business or undertaking for profit or gain.

2.1.2 The concepts of reasonably practicable and eliminating or minimising risk

The WHS Act requires that all people are provided with the highest level of health and safety protection from hazards arising from work, so far as is reasonably practicable.[23]

The WHS Act uses the term 'reasonably practicable' to describe the health and safety standard that a PCBU must meet to comply with its duty of care to workers and other persons. In this context reasonably practicable means that which is, or was at a particular time, reasonably able to be done to ensure health and safety, taking into account and weighing up all relevant matters.[24]

The reasonably practicable test has two elements. Firstly, a PCBU owing a duty under the WHS Act must consider what can be done in the circumstances to ensure health and safety at the workplace. Secondly, a PCBU must consider whether it is reasonable in the circumstances to do everything possible to ensure health and safety at the workplace.

What is 'reasonable in the circumstances' is an objective test and must be determined by taking into account the particular circumstances of a workplace and the nature of the work being performed. This

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[12] Department of Justice and Attorney-General, *Guide to the Work Health and Safety Act 2011*, p.4.
[13] Outworkers are contractors or employees who perform their work at home or at a place that wouldn't normally be thought of as a business premises.
[14] Section 7(1), WHS Act.
[15] Section 19(2), WHS Act.
[16] Section 5, WHS Act defines 'person conducting a business or undertaking'.
[17] Safe Work Australia, *Interpretive Guideline – Model Work Health and Safety Laws: The meaning of 'person conducting a business or undertaking'*, p.1.
[18] Section 5(1), WHS Act.
[19] JAG, *Guide to the Work Health and Safety Act 2011*, p.8.
[20] Safe Work Australia, *Interpretive Guideline – Model Work Health and Safety Laws: The meaning of 'person conducting a business or undertaking'*, p.1.
[21] Safe Work Australia, *Interpretive Guideline – Model Work Health and Safety Laws: The meaning of 'person conducting a business or undertaking'*, p.1.
[22] Safe Work Australia, *Interpretive Guideline – Model Work Health and Safety Laws: The meaning of 'person conducting a business or undertaking'*, p.1.
[23] JAG, *Guide to the Work Health and Safety Act 2011*, p.9.
[24] Section 18, WHS Act.

requires all relevant matters to be taken into account and a balance achieved that will provide the highest level of protection that is both possible and reasonable in the circumstances.[25]

2.1.3 Work health and safety duties

Section 19 of the WHS Act establishes the primary duty of care and provides specific duties which a PCBU must ensure, so far as is reasonably practicable, including:[26]

- the provision and maintenance of a working environment that is safe and without risks to health, including entering and exiting the workplace
- the provision and maintenance of plant, structure and systems of work that are safe and do not pose health risks
- the safe use, handling, storage and transport of plant, structure and substances
- the provision and maintenance of adequate facilities for the welfare of workers at workplaces under their management and control
- the provision of information, instruction, training or supervision to workers needed for them to work safely and without risks to their health
- monitoring the health of their workers and the conditions of the workplace under their management and control to prevent injury or illness
- the maintenance of any accommodation owned or under their management and control to ensure the health and safety of workers occupying the premises.

In addition to the primary duty of care, the WHS Act also places duties on upstream PCBUs. Upstream PCBUs include designers,[27] manufacturers,[28] importers[29] and suppliers[30] of plant, structures or substances which can affect the safety of products before they are used in the workplace, as well as those responsible for the installation, construction or commissioning of plant or structures.[31] There are also specific duties placed on an officer of a PCBU to exercise due diligence to ensure the PCBU complies with its health and safety obligations.[32]

While at work, workers have a duty to take reasonable care for their own health and safety as well as that of others who may be affected by their actions or omissions.[33] Workers must also comply with any reasonable instruction given by the PCBU and any reasonable policy or procedure of the PCBU relating to health and safety at the workplace.[34]

Finally, any person who is at a workplace for any reason must take reasonable care for their own health and safety and that of others who may be affected by their actions or omissions.[35] They must also comply with any reasonable instructions given by the PCBU relating to health and safety at the workplace.[36]

2.2 *The role of the regulator*

2.2.1 Power to investigate workplace deaths

A regulator may be appointed under the WHS Act to, among other things, monitor and enforce compliance with the requirements of the WHS Act and conduct and defend proceedings under the WHS Act before a court or tribunal.[37] The appointed regulator under the WHS Act in Queensland is the Deputy Director-General responsible for the OFSWQ.

[25] Safe Work Australia, *Interpretive Guideline – Model Work Health and Safety Laws: The meaning of 'reasonably practicable'*, p.2.
[26] Section 19(3) and (4), WHS Act.
[27] Section 22, WHS Act.
[28] Section 23, WHS Act.
[29] Section 24, WHS Act.
[30] Section 25, WHS Act.
[31] Section 26, WHS Act.
[32] Section 27, WHS Act.
[33] Section 28(a) and (b), WHS Act.
[34] Section 28(c) and (d), WHS Act.
[35] Section 29(a) and (b), WHS Act.
[36] Section 29(c), WHS Act.
[37] Section 152(b) and (h), WHS Act.

As the regulatory agency, the OFSWQ is responsible for improving work health and safety in Queensland.[38] The OFSWQ enforces work health and safety laws, investigates workplace fatalities and serious injuries, prosecutes breaches of legislation, and educates employees and employers on their legal obligations with regard to work health and safety.[39]

Inspectors may be appointed under the WHS Act to monitor and enforce compliance with work health and safety legislation.[40] With respect to a workplace death or serious injury, inspectors are responsible for investigating a workplace incident to determine whether there has been a contravention of any part of the WHS Act, particularly a work health and safety duty, by a PCBU, officer, worker or other person (duty holder).

To support the investigation and enforcement of potential breaches, the OFSWQ and inspectors have significant powers under the WHS Act. These include:

- the power to obtain information if the regulator has reasonable grounds to believe that a person is capable of giving information or documents in relation to a possible contravention of the WHS Act, or that will assist in monitoring or compliance[41]
- the power to enter a workplace, or a suspected workplace, at any time with or without the consent of the person with management or control[42]
- the power, following entry to a workplace, to:[43]
  - inspect, examine and make inquiries
  - inspect, examine and seize anything, including documents
  - bring and use any equipment or materials that may be required
  - take measurements, conduct tests, and make sketches or recordings
  - take and remove samples for analysis
  - require a person at a workplace to give reasonable assistance.

2.2.2 OFSWQ's process for investigating workplace deaths

A workplace death investigation is conducted by the OFSWQ to determine both the incident cause and a duty holder's compliance with the WHS Act and/or other relevant legislation, regulations and codes of practice, and to determine whether enforcement action is appropriate.[44]

Notification of a workplace death may be received by the OFSWQ by way of either incident notification arrangements (such as by the Queensland Police Service (QPS) or Queensland Ambulance Service) or advice from a third party such as an employer, family member or other person. Employers have a duty under the WHS Act to notify the OFSWQ of a notifiable incident which occurs at their workplace, which includes a workplace death.[45]

Following notification, the incident is triaged by the OFSWQ to determine whether the workplace death is within the jurisdiction of the WHS Act and whether the death was sufficiently work-related.[46]

A matter assessed as being out of jurisdiction may be work-related, meaning involving a business or undertaking where the work may have contributed to the death, but does not fall within the jurisdiction of the WHS Act.[47] In many cases where a death is assessed as out of jurisdiction, other legislation will apply (such as legislation relating to mining, aviation or maritime safety). Often a death may involve a business or undertaking but the circumstances of the death do not have any relationship with the nature of the work being carried out (such as natural cause deaths).[48]

Incidents which are determined to be within jurisdiction and work-related are referred for a regional response, meaning they are sent to the relevant OFSWQ regional office for allocation to an inspector

[38] JAG, OFSWQ, viewed 1 May 2015, http://www.justice.qld.gov.au/corporate/about-us/fair-and-safe-work-queensland.
[39] JAG, OFSWQ, viewed 25 February 2015, http://www.justice.qld.gov.au/corporate/about-us/fair-and-safe-work-queensland.
[40] Section 156, WHS Act.
[41] Section 155, WHS Act.
[42] Section 163, WHS Act.
[43] Section 165(1), WHS Act.
[44] OFSWQ, *Operational Procedure: Investigation Management*, p.1.
[45] Section 38(1), WHS Act.
[46] Heads of Workplace Safety Authorities, *Framework for a common approach to work health and safety event triaging*, p.4.
[47] OFSWQ, *Operational Procedure: Investigations Governance*, p 25.
[48] OFSWQ, *Operational Procedure: Investigations Governance*, p 25.

for investigation.[49] It is then the responsibility of the allocated inspector to conduct the initial planning activities regarding the investigation and conduct the first response.[50]

The first response consists of the initial activities conducted by the inspector including gathering evidence about the workplace death. First response activities generally consist of securing the incident scene to ensure all evidence is preserved, inspecting the incident site and gathering relevant evidence, identifying relevant witnesses and taking initial statements and ensuring the incident site is safe through the use of relevant enforcement notices.[51]

Once sufficient information and evidence have been gathered about the incident following the first response, an investigation plan to guide the investigation, and ensure that relevant evidence is gathered, is developed in consultation with an OFSWQ legal officer.[52]

Investigation activities then commence, including gathering and reviewing documents, records, policies and procedures from the duty holder or holders, gathering witness statements, conducting formal records of interview, seeking expert opinions and/or any other necessary actions. Case management between the inspector, Regional Investigation Manager (RIM) and the legal officer occurs throughout the investigation process, the frequency of which depends on the complexity of the investigation.[53]

When all relevant issues have been considered and sufficient evidence has been gathered to establish whether a duty holder has breached any duty, an investigation report summarising the evidence is prepared by the inspector.[54] This investigation report is then reviewed by the RIM who, after considering the evidence, makes a recommendation about whether any duty holder should be prosecuted for breaching a duty under the WHS Act or any other relevant legislation or regulation.[55] The RIM's recommendation, as well as the investigation report and file, are then referred to LPS within the OFSWQ, for review by a legal officer.[56]

2.3 Compliance and enforcement

2.3.1 Compliance and enforcement options

When an inspection or an investigation of a workplace incident determines evidence of an alleged breach, the OFSWQ has a number of options available for enforcement action. The type of enforcement action will depend on the circumstances and seriousness of the alleged breach. Enforcement options include:[57]

- giving advice on compliance and seeking voluntary compliance
- resolving or assisting parties resolve work health and safety disputes
- issuing a prohibition or improvement notice
- seeking an injunction
- issuing an infringement notice
- accepting an enforceable undertaking
- commencing a civil or criminal prosecution
- revoking, suspending or cancelling authorisations
- publishing enforcement actions and outcomes.

The following diagram is included in the National Compliance and Enforcement Policy. The lower part of the pyramid illustrates the least serious sanctions and those which are utilised most often by regulators. By contrast, the top of the pyramid, represented by court sanctions (including prosecution), is utilised the least often by regulators and is reserved for the most serious alleged breaches.[58]

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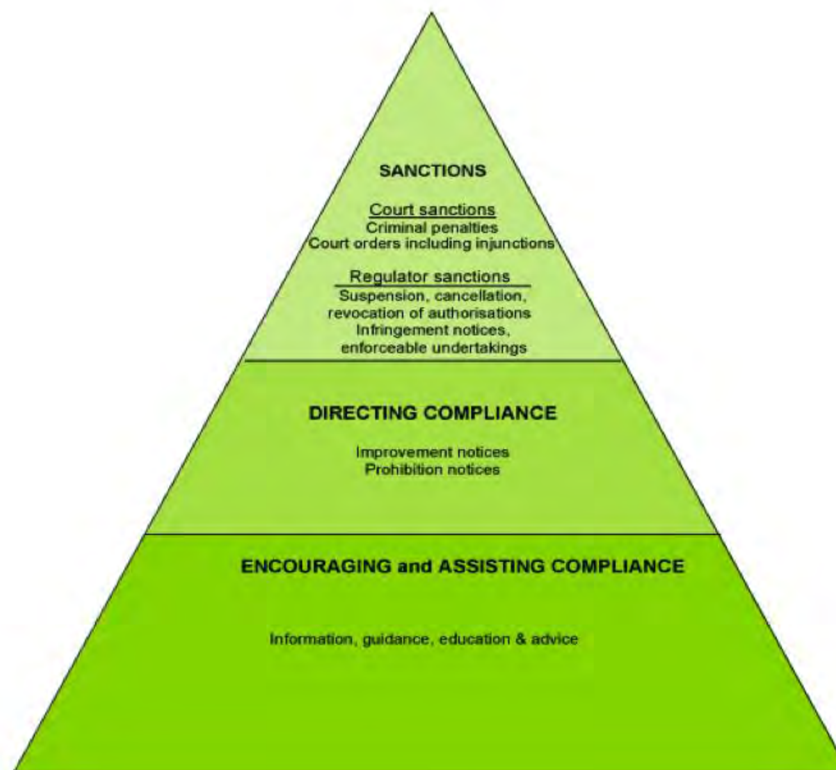
[49] OFSWQ, *Operational Procedure: Event management*, p.3.
[50] OFSWQ, *Operational Procedure: First response to complaints, incidents and other statutory requests for inspector assistance*, pp.4-6.
[51] Enforcement notices include an improvement notice, prohibition notice and non-disturbance notice.
[52] OFSWQ, *Operational Procedure: Investigation management*, p.4.
[53] OFSWQ, *Operational Procedure: Investigation management*, p.6.
[54] OFSWQ, *Operational Procedure: Investigation management*, p.26.
[55] OFSWQ, *Operational Procedure: Investigation management*, p.7.
[56] OFSWQ, *Operational Procedure: Investigation management*, p.7.
[57] Safe Work Australia, *National Compliance and Enforcement Policy*, pp.5-6.
[58] Safe Work Australia, *National Compliance and Enforcement Policy*, p.6.



In determining the most appropriate enforcement action to take in response to an alleged breach, the OFSWQ takes into account the following considerations:[59]

- the adverse effect of the alleged breach, including the extent of the risk, the seriousness of the breach and the actual or potential consequences
- how far below acceptable standards the conduct of the duty holder falls and the extent to which the duty holder contributed to the risk or incident
- the compliance history and attitude of the duty holder
- whether the offence is a repeat offence, or whether there is a likelihood of the offence being repeated
- whether the duty holder was authorised to undertake the type of work
- the impact of enforcement on encouragement or deterrence
- mitigating or aggravating circumstances such as efforts by the duty holder to control risks
- whether the risk to health and safety is immediate
- whether the safety issue can be rectified or whether there is a plan by the duty holder to fix the breach.

2.3.2 Offences under the WHS Act

The WHS Act provides for three categories of offences for a breach of a health and safety duty. The three categories of offences range from the most serious (category 1) to the least serious (category 3):

- category 1 – a duty holder engages in conduct that **recklessly exposes** a person to a risk of death or serious injury or illness[60] [my emphasis]
- category 2 – a duty holder fails to comply with a health and safety duty **that exposes** a person to risk of death or serious injury or illness[61] [my emphasis]
- category 3 – a duty holder **fails to comply** with a health and safety duty[62] [my emphasis].

[59] Safe Work Australia, *National Compliance and Enforcement Policy*, p.7.
[60] Section 31, WHS Act.
[61] Section 32, WHS Act.
[62] Section 33, WHS Act.

These offences attract significant maximum penalties, including five years imprisonment for a category 1 offence:[63]

	Corporation	Individual as a PCBU or officer of a PCBU	Worker or other person
Category 1	$3.53 million fine	5 years imprisonment or $706,800 fine	5 years imprisonment or $353,400 fine
Category 2	$1.76 million fine	$353,400 fine	$176,700 fine
Category 3	$589,000 fine	$117,800 fine	$58,900 fine

Other orders available to sentencing courts include:

- an adverse penalty order requiring the person to publicise the offence, its consequences and the penalty imposed[64]
- a restoration order requiring the person to take steps to remedy anything that occurred as a result of the offence that the duty holder has the power to address[65]
- a work health and safety project requiring the person to undertake a project for the general improvement of work health and safety[66]
- a court ordered work health and safety undertaking requiring the person, for a period up to two years, to appear before the court if required, not commit any offences under the WHS Act, and observe any special conditions imposed[67]
- an injunction requiring the person to cease contravening the WHS Act[68]
- a training order requiring the person to undertake, or arrange for one or more workers to undertake, a specified training course.[69]

2.3.3 Commencing a prosecution for a breach of the WHS Act

A prosecution for an alleged offence under category 2 or 3 of the WHS Act is brought by the OFSWQ by way of a complaint being laid and filed with the Magistrates Court registry. Category 1 offences are referred to the Director of Public Prosecutions (DPP) who decides whether to commence prosecution. Category 1 offences are heard by the District Court.

The WHS Act places a limited period for the OFSWQ to bring a prosecution against a duty holder. Proceedings for an alleged offence must be brought within the latest of the following:[70]

- within two years after the offence first comes to the notice of the OFSWQ
- within one year after a coronial report was made or an inquest ended
- within six months of a contravention of an enforceable undertaking
- if an offence relates to a category 1 offence under the WHS Act, at any time if fresh evidence in relation to the offence is discovered.

Following receipt of a recommendation, investigation report and file material from the RIM, a legal officer is responsible for assessing and making a recommendation about whether any duty holder has breached a duty and if so, whether there is sufficient evidence to support a prosecution for an offence under the WHS Act or other relevant legislation or regulation, and whether a prosecution is in the

[63] Penalty amounts current from 1 July 2015.
[64] Section 236, WHS Act.
[65] Section 237, WHS Act.
[66] Section 238, WHS Act.
[67] Section 239, WHS Act.
[68] Section 240, WHS Act.
[69] Section 241, WHS Act.
[70] Section 232, WHS Act.

public interest.[71] The legal officer's recommendation is provided to the Director, LPS who is the delegated decision-maker about whether to commence a prosecution.

The Director, LPS will either decide to commence a prosecution in relation to the matter, or will advise that the matter should be closed with no further action.[72] If a prosecution is to be commenced, an action will be initiated by the OFSWQ in the relevant court. If there is to be no further action with regard to an incident, the investigation is concluded, the file closed and a record made in the OFSWQ database that no further action will be taken.

The decision by the Director, LPS to prosecute or not prosecute must be based on the evidence, the law and the DPP Guidelines.[73] The DPP Guidelines state that a prosecution should be initiated or continued wherever it appears to be in the public interest.[74] The DPP Guidelines suggest that two questions be posed regarding the decision whether to prosecute:[75]

- is there sufficient evidence?
- does the public interest require a prosecution?

The question of whether there is sufficient evidence requires both the existence of a prima facie case, that is, whether the evidence is sufficient to justify the institution of proceedings, as well as a reasonable prospect of conviction. Determining whether there is a reasonable prospect of conviction will require an evaluation of the quality and likely strength of the evidence when it is presented in court.[76]

However, even if there is sufficient and reliable evidence of an offence, an assessment must be made about whether discretionary factors suggest that a prosecution should not be brought in the public interest. The public interest test may include a consideration of the following factors:[77]

- the seriousness or triviality of the alleged offence
- any mitigating or aggravating circumstances
- the characteristics of the duty holder, such as prior compliance history
- the degree of culpability of the duty holder
- whether prosecution would be counter-productive to the interests of justice
- the potential value of alternatives to prosecution
- the prevalence of the alleged offence and the need for deterrence
- the level of public concern about the alleged offence.

With respect to the public interest test, the DPP Guidelines note that the more serious the offence, the more likely that the public interest will require a prosecution.[78] This is particularly relevant in circumstances where a work health and safety breach has resulted in, or contributed to, a workplace death. The DPP Guidelines further advise that the appropriate decision in most cases will be to proceed with a prosecution if there is sufficient evidence and any mitigating factors can be put to the court at sentencing.[79]

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[71] OFSWQ, *Operational Procedure: Investigation management*, p.8.
[72] OFSWQ, *Operational Procedure: Investigation management*, p.8.
[73] OFSWQ, viewed 26 February 2015, https://www.worksafe.qld.gov.au/laws-and-compliance/prosecutions/guidelines-prosecutions.
[74] Office of the Director of Public Prosecutions, *Director's Guidelines*, p.2.
[75] Office of the Director of Public Prosecutions, *Director's Guidelines*, p.2.
[76] Office of the Director of Public Prosecutions, *Director's Guidelines*, p.2.
[77] Office of the Director of Public Prosecutions, *Director's Guidelines*, pp.3-4.
[78] Office of the Director of Public Prosecutions, *Director's Guidelines*, p.4.
[79] Office of the Director of Public Prosecutions, *Director's Guidelines*, p.4.

Chapter 3: Outcome of the file review

This chapter summarises the outcome of the file reviews for each of the 20 workplace death investigations assessed as part of this investigation. This chapter also provides a brief synopsis of these 20 workplace death investigations.

3.1 Case studies

The following table provides a brief description of the circumstances of each of the 20 workplace death investigations which were reviewed for the purposes of the investigation.

The outcome of the OFSWQ investigation in each of these case studies was no further action, meaning that no enforcement action was taken against any person for a breach of the WHS Act.

Case Study	The incident
Case Study 1	B was using a forklift to move a crate on a bushland property. As B was manoeuvring the forklift, the rear wheel went over the side of an embankment, causing the forklift to roll down the embankment. B died after being crushed by the forklift.
Case Study 2	C was a passenger on a commercial airline flight who tripped down the stairs while disembarking and hit his head on the concrete tarmac. C later died in hospital from his injuries.
Case Study 3	D was a plant operator working to install wick drains on reclaimed land who died after being hit by the boom of an excavator which tipped over after sinking into a soft sand surface.
Case Study 4	E was a truck driver who fell from the back of his truck and hit his head after climbing up to attach labels to the cargo. E later died in hospital from his injuries.
Case Study 5	F was an elderly person who was invited onto a demolition site by an owner builder to view some timber. F was left alone on the site and was later found lying on the ground with a head injury. F died from his injuries.
Case Study 6	G was found deceased at his home. The QPS established the cause of death as suicide. The OFSWQ received allegations that G had been a victim of bullying and harassment at his workplace.
Case Study 7	H was an international tourist who drowned while snorkelling on an organised reef tour.
Case Study 8	J was an international tourist who drowned while snorkelling on an organised reef tour.
Case Study 9	K was a truck driver who died after being crushed under the wheels of a semi-trailer after climbing under the truck to attempt to fix a problem with the braking system.
Case Study 10	L was a factory worker who was found in a dazed state in a warehouse after working to move material from the ground to a mezzanine floor using a ladder. L later died in hospital from suspected head injuries.
Case Study 11	M was working at a height fixing a piece of equipment on a rural property. M fell from the equipment and died from his injuries.
Case Study 12	N was a participant in a motorcycle ride day at a racetrack who died as a result of falling from his motorcycle following a collision with another rider.
Case Study 13	O was a worker at a construction site who suffered the effects of suspected heat stroke after working in temperatures in excess of 42 degrees Celsius. O died soon after being admitted to hospital.
Case Study 14	P was the operator of a front end loader who was found deceased at a sand washing plant. P had been suffocated by sand after being found in a hopper bin.
Case Study 15	Q died after falling from the upper level of a boiler house while working to clear debris from a conveyer belt.
Case Study 16	R was a field officer at a remote station who died after attempting to walk back to the station in temperatures in excess of 47 degrees Celsius after his car became stuck on a sand dune.
Case Study 17	S was a member of the public who died after being run over by a cane train.
Case Study 18	T was a truck driver who died after his semi-trailer truck crashed into the back of another truck which was stopped at construction works on a highway.
Case Study 19	U was a farmer who was crushed by a bag of fertiliser as a result of equipment failure.
Case Study 20	V was a participant in an organised car race event who died after the vehicle he was driving collided with a tyre wall at a racetrack.

3.2 *Outcome of the file review*

The areas of the investigation process reviewed by the investigation can be broadly categorised into four key areas. These are:

- actions following notification of a workplace death and the first response
- quality and timeliness of the investigation
- sufficiency and timeliness of the regulatory response by LPS
- quality of liaison and engagement with next of kin.

For the purpose of the investigation, these four areas have been categorised to identify key investigative actions that contribute to a complete and sufficient workplace death investigation. Each of these investigative actions represents a significant step in the investigation process.

Each of these areas is represented in the tables below. A tick means the investigative element was generally appropriate and there was sufficient evidence to make an assessment. A cross means that the investigative element was not assessed as appropriate or insufficient evidence existed to make an assessment.

3.2.1 Actions following notification and the first response

This section provides the outcome of the investigation with respect to the referral of an incident for investigation and the first response activities. Chapters 4 and 5 of this report address these outcomes in detail.

Case study	Timely referral for investigation	Appropriate first response actions taken	Appropriate scene security	Immediate safety concerns addressed	Relevant witnesses identified
Case Study 1	✓	✓	✓	✓	✓
Case Study 2	✓	✓	✓	✓	✓
Case Study 3	✓	✓	✓	✓	✓
Case Study 4	✓	✗	✗	✗	✓
Case Study 5	✓	✓	✓	✓	✓
Case Study 6	✓	✓	✓	✓	✗
Case Study 7	✓	✓	✓	✓	✓
Case Study 8	✓	✓	✓	✓	✓
Case Study 9	✓	✓	✓	✓	✓
Case Study 10	✓	✗	✗	✓	✓
Case Study 11	✓	✓	✓	✓	✗
Case Study 12	✓	✓	✓	✓	✗
Case Study 13	✓	✓	✓	✓	✓
Case Study 14	✓	✓	✓	✓	✓
Case Study 15	✓	✓	✓	✓	✓
Case Study 16	✓	✓	✓	✓	✓
Case Study 17	✓	✓	✓	✓	✓
Case Study 18	✓	✓	✓	✓	✗
Case Study 19	✓	✓	✓	✓	✓
Case Study 20	✓	✓	✓	✓	✓

3.2.2 Quality of the investigative processes and timeliness

This section provides the outcome of the investigation with respect to the planning and conducting of essential investigative activities and the time taken to complete the investigation and provide a recommendation for review by LPS. Chapters 6 and 7 of this report address these outcomes in detail.

Case study	Evidence of sufficient investigation planning	Evidence of sufficient case management	Relevant duty holders identified	Potential breaches identified	Sufficient evidence gathered and relevant issues addressed	Adequate investigation report	Regional investigation completed in less than 12 months
Case Study 1	✗	✗	✓	✗	✗	✗	✗
Case Study 2	✗	✗	✓	✓	✓	✓	✓
Case Study 3	✗	✗	✓	✓	✗	✗	✗
Case Study 4	✗	✗	✓	✓	✗	✗	✓
Case Study 5	✗	✓	✓	✗	✗	✗	✓
Case Study 6	✗	✗	✓	✓	✗	✗	✓
Case Study 7	✓	✓	✓	✓	✓	✓	✓
Case Study 8	✓	✓	✓	✓	✓	✓	✓
Case Study 9	✗	✗	✗	✗	✗	✗	✗
Case Study 10	✗	✓	✓	✗	✗	✗	✓
Case Study 11	✗	✓	✓	✗	✗	✗	✓
Case Study 12	✗	✗	✓	✓	✗	✗	✓
Case Study 13	✗	✓	✓	✗	✗	✗	✓
Case Study 14	✗	✗	✓	✓	✓	✓	✓
Case Study 15	✗	✗	✓	✓	✓	✓	✓
Case Study 16	✓	✓	✓	✓	✓	✓	✓
Case Study 17	✓	✓	✓	✓	✓	✓	✓
Case Study 18	✗	✓	✓	✓	✗	✗	✗
Case Study 19	✓	✓	✓	✓	✓	✓	✓
Case Study 20	✗	✓	✓	✓	✗	✗	✓

3.2.3 Quality of the LPS regulatory response and liaison with next of kin

This section provides the outcome of the investigation with respect to the sufficiency of memorandums of advice prepared by LPS and the timeliness of LPS's decision-making. This section also provides the outcome of the investigation with respect to information provision and liaison with next of kin. Chapters 8 and 9 of this report address these outcomes in detail.

Case study	Sufficient memorandum of advice provided to the Director, LPS	LPS prosecution decision made in less than 3 months	Appropriate contact with next of kin throughout investigation	Advice about outcome of investigation provided to next of kin
Case Study 1	✗	✓	✗	✗
Case Study 2	✗	✗	✗	✓
Case Study 3	✗	✗	✓	✗
Case Study 4	✗	✓	✗	✗
Case Study 5	✗	✗	✗	✗
Case Study 6	✗	✗	✗	✗
Case Study 7	✗	✗	✗	✗
Case Study 8	✗	✓	✗	✗
Case Study 9	✗	✓	✗	✗
Case Study 10	✗	✓	✓	✓
Case Study 11	✗	✓	✓	✗
Case Study 12	✓	✗	✗	✗
Case Study 13	✗	✗	✓	✓
Case Study 14	✗	✗	✗	✗
Case Study 15	✓	✗	✓	✗
Case Study 16	✓	✓	✓	✓
Case Study 17	✗	✓	✗	✗
Case Study 18	✗	✗	✗	✗
Case Study 19	✗	✗	✗	✗
Case Study 20	✗	✓	✗	✗

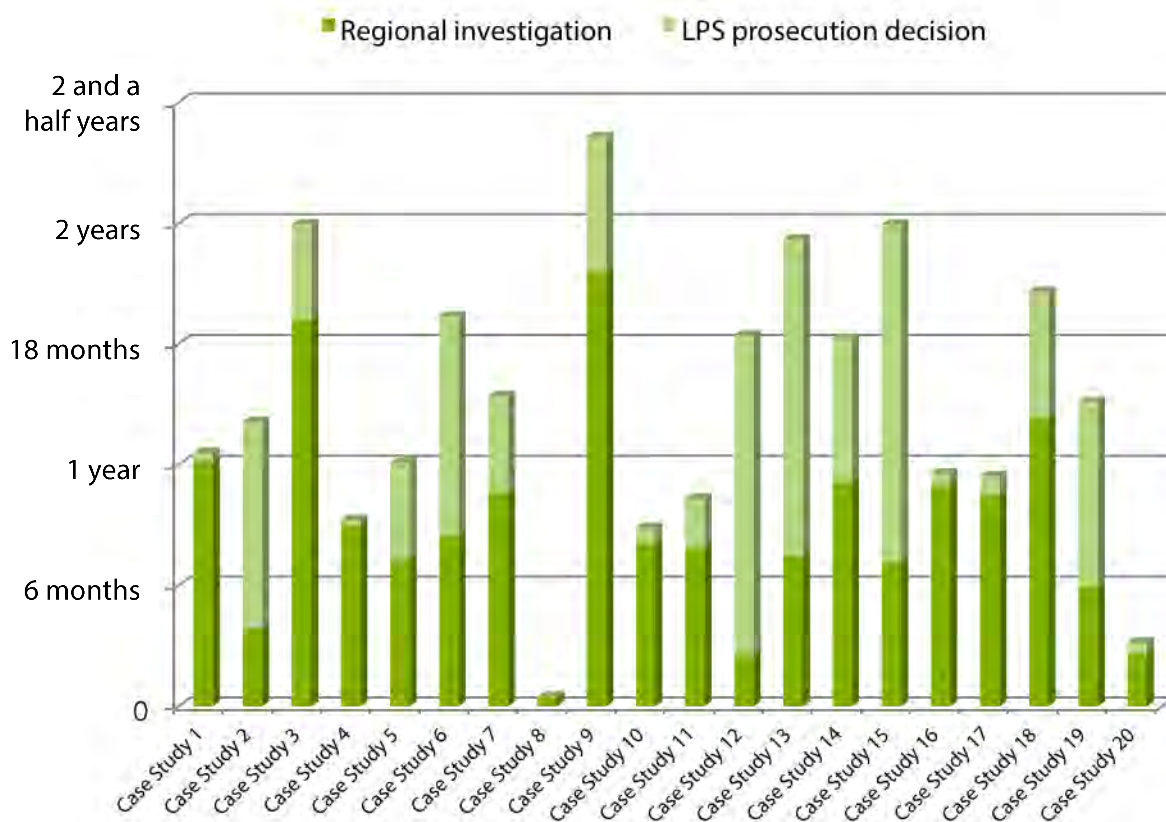
Chapter 4: Timeliness of investigations

The WHS Act does not set specific timeframes for a workplace death investigation to be completed. However, the WHS Act does provide a limitation period to bring a prosecution for an offence under the Act. This is generally two years after the workplace death first came to the notice of the OFSWQ, although additional limitation periods may apply if a coronial inquest is held or an enforceable undertaking has been given in respect to an offence.[80]

Accordingly, in order for the OFSWQ to be able to satisfactorily perform its regulatory functions, timeliness in the investigation process is essential. Generally, the OFSWQ has two years following notification of a workplace death to complete an investigation, determine whether any person will be prosecuted for any alleged offence and commence proceedings in the relevant court.[81]

Timeliness in completing a workplace death investigation is important, particularly due to the adverse impact a protracted regulatory process can have on relevant stakeholders including next of kin, employers, insurers, workplace compensation processes, coroners, co-workers, unions and legal representatives. The investigation identified that next of kin were particularly adversely impacted by a lengthy investigation process and in some cases became increasingly frustrated and angry in their communications with the OFSWQ as their expectations were not met.

The graph below illustrates the time taken by the OFSWQ to complete the workplace death investigations in the review sample, from the date the notification of the death was received to when the decision was made by the Director, LPS about whether to commence a prosecution against any person.



The OFSWQ's *Operational Procedure: Investigation Management* provides that all regional investigation activities (meaning until the investigation is referred to LPS) should be completed within six months of the commencement of the investigation.[82] There appear to be no internal timeframes for a prosecution decision to be made once the investigation has been referred to LPS.

[80] See section 2.3.3 for further information about limitation periods under the WHS Act.
[81] Section 232(1)(a), WHS Act.
[82] OFSWQ, *Operational Procedure: Investigation Management*, p.5.

In only five of the 20 cases reviewed was this timeframe for completion of the regional investigation met. Overall, the average time taken by the OFSWQ to complete the workplace death investigations to a decision about prosecution in the file review was approximately one year and three months.

There were also significant variations in the time taken to complete the 20 investigations reviewed.

The longest investigation, Case Study 9, took two years and four months before a final prosecution decision was made. This is outside the two year statutory timeframe to bring a prosecution in the absence of a coronial inquest. Accordingly, the OFSWQ would not have been able to bring a prosecution for an offence in Case Study 9, had the investigation determined that any person had breached a duty under the WHS Act.

In a further two investigations, Case Studies 3 and 15, the final regulatory decision was made the day before the expiry of the two year statutory timeframe. Once again, it would have been extremely difficult to take any regulatory action.

By contrast, in Case Study 8, a decision about prosecution action was made 15 days after the death occurred. In Case Study 20, the investigation was completed in just over three months.

Overall, in only eight of the investigations reviewed was a decision about prosecution action made within 12 months following the workplace death.

Opinion 1

Many of the 20 workplace death investigations reviewed were not conducted in a timely manner, in particular:

(a) in only five cases was the regional investigation completed within six months of the commencement of the investigation, as required by the OFSWQ *Operational Procedure: Investigation Management*

(b) the time taken by the OFSWQ to complete the workplace death investigations and make a decision about whether to commence a prosecution in Case Studies 3, 9 and 15 was excessive.

These delays are unreasonable administrative action for the purposes of s.49(2)(b) of the Ombudsman Act.

JAG's response to Opinion 1

The Director-General accepted my opinion.

Recommendation 1

The Under Treasurer:

1.1. establish appropriate target timeframes to complete workplace death investigations

1.2. establish appropriate target timeframes for LPS to make a decision about prosecution

1.3. publicly report on the OIR's performance in meeting each of these target timeframes on an annual basis.

JAG's response to Recommendation 1

The Director-General accepted my recommendation.

Chapter 5: Triaging framework and first response actions

This chapter will discuss the investigation outcomes in relation to the OFSWQ notification and triaging framework and the quality of the OFSWQ first response to a notification of a workplace death with respect to the following requirements:

- attendance at the incident scene by an inspector following notification, referral of a workplace death and undertaking essential preliminary investigation activities
- identifying relevant witnesses
- securing the integrity of an incident scene by an inspector to ensure the preservation of relevant evidence
- actions taken to address immediate safety concerns at a workplace
- actions taken to address potential safety concerns at a workplace.

5.1 Notification and triaging framework

The investigation assessed 19 workplace death notifications that were triaged by the OFSWQ as out of jurisdiction or not work-related. These 19 cases were reviewed in addition to the 20 workplace death investigations which were comprehensively investigated by the OFSWQ, and are the subject of the remainder of this report.

Some of these 19 notifications were assessed and closed by the OFSWQ Assessment Services Unit (ASU), which is the reception point for workplace death notifications. The remaining notifications were referred to the relevant OFSWQ region so additional information could be gathered to make an informed triage decision about whether the death was within jurisdiction and sufficiently work-related.

The key aspect to the OFSWQ triaging framework is the triaging decision-making model. This model is used to triage all notifications of workplace incidents which are received by the OFSWQ, taking into consideration the following factors:[83]

- whether there is sufficient information to triage
- whether the event falls within jurisdiction of the WHS Act
- whether the event relates to a matter to which the OFSWQ has a statutory obligation to respond
- whether the event has the potential to be escalated as a result of external pressure
- whether the event relates to an investigation priority identified within the National Compliance and Enforcement Policy
- the duty holder's compliance history
- the OFSWQ's enforcement policies
- the likelihood of intervention resulting in a positive compliance result.

The triaging decision-making model provides that, for a critical event such as a workplace death, investigation by way of a first response by the region will be the appropriate outcome, unless the event is not a notifiable event, not within jurisdiction, not work-related or the responsibility of another agency.

For example, a person may suffer a natural cause death, such as death resulting from a heart attack while at work. While under the provisions of the WHS Act this is a workplace death, a natural cause death may not have any relationship with the nature of the work being carried out, or relate to any breach of a work health and safety duty owed by any person. The death may therefore be assessed as not work-related and the OFSWQ will take no further action.

However, there may be circumstances where work-related factors have contributed to a natural cause death. The deceased may have been working in extreme conditions, working long hours and be fatigued or using non-prescription drugs at the workplace. As a result, before any workplace death can be triaged as requiring no further action, the OFSWQ seeks confirmation by way of medical advice that the cause of the death is natural causes, and there are no other factors that may give rise to a work health and safety duty.[84]

[83] Heads of Workplace Safety Authorities, *Framework for a common approach to work health and safety event triaging*, 2012, p.2.
[84] Interview with the Manager, ASU on 12 January 2015, transcript p.24.

The investigation found that the OFSWQ's notification and triaging processes were adequate and reasonable. In the 19 workplace death notifications reviewed, no cases were identified where the triaging outcome was evidently incorrect or unsound, although minor instances were identified where further information could have been gathered to support and substantiate the triage outcome.

Opinion 2

The current OFSWQ notification and triage processes are generally appropriate and reasonable.

JAG's response to Opinion 2

The Director-General accepted my opinion.

5.2 Incident referral and first response actions

First response activities are the initial actions taken by an inspector immediately following notification and referral to the regional office of a workplace death. First response activities are potentially the only opportunity for an inspector to obtain essential information about the incident scene. Essential first response activities include ensuring that relevant evidence is preserved, incident scene inspection, identifying potential duty holders and witnesses and gathering information about factors that may have contributed to the workplace death.

The first response is also an opportunity for inspectors to assess the safety of the workplace following the incident that resulted in the workplace death. Inspectors have powers under the WHS Act to issue notices to prohibit or require workplaces to improve workplace activities or practices. These notices provide inspectors with on-the-spot authority to address immediate or potential safety concerns.

First response activities are a critical aspect of a workplace death investigation. If the first response is conducted poorly, or not at all, essential evidence may be lost, affecting the quality of the entire investigation. Should inspectors also fail to take immediate action to address work practices that may have caused or contributed to the workplace death, other people at the workplace may be further exposed to the risk of death or serious injury.

5.2.1 Referral of a notification of a workplace death for investigation

The adequacy of the first response is largely dependent on the timeliness and efficiency of the referral of the workplace death from ASU to the RIM, and the allocation of the matter to an inspector. A timely and efficient referral process means that an inspector can be allocated the matter and be in attendance at the scene immediately following the incident.

The investigation found that the efficiency and timeliness of the referral of workplace deaths for investigation was excellent. In all 20 cases reviewed, the referral of the workplace death from ASU to the OFSWQ regional office for investigation was timely and appropriate.

5.2.2 Adequacy of the first response actions

The first response of the OFSWQ to a workplace death was assessed taking into account the following considerations:

- whether there were any avoidable delays in an inspector attending the scene of the incident
- whether the inspector's initial inspection of the scene gathered sufficient evidence about significant issues impacting on the workplace death.

The investigation found that the adequacy of the OFSWQ's first response actions were generally appropriate. In 18 of the cases reviewed, the first response was appropriate taking into account the circumstances of the death and the nature of the investigation.

In the two cases where the first response was assessed as not appropriate, the quality of the first response was reduced by delays in attending and inspecting the scene of the incident. In both cases, OFSWQ inspectors were not able to gather evidence at the scene that may have been relevant, relying instead on evidence provided by witnesses sometime after the incident or evidence gathered by the QPS.

5.2.3 Identifying relevant witnesses

The investigation assessed whether during the first response, or during the planning of the OFSWQ investigation, inspectors identified all relevant witnesses who could provide information about the incident causing the workplace death, or the duty holder's actions in complying with their obligations under the WHS Act.

The identification of witnesses who may be able to provide evidence to determine if there has been a breach of a duty by any person following a workplace death is one of the most important initial steps in the investigation process. Potential witnesses may include:

- witnesses to the incident
- persons working for the duty holder, including management
- persons who hold or potentially hold a duty under the WHS Act
- a designer, manufacturer, importer or supplier of plant involved in the incident
- technical experts
- family members.

The range of witnesses who may be able to provide evidence to inform the investigation will depend on the circumstances of the workplace death.

The investigation found that the identification of potential witnesses by inspectors was generally appropriate. In 16 of the cases reviewed it was determined that all relevant witnesses were identified either during first response activities, or in the early stages of the investigation. In the remaining four cases the following deficiencies were identified:

- inspectors failed to identify relevant witnesses (Case Studies 6, 11 and 12)
- inspectors failed to interview the duty holder, despite advice from the legal officer that the duty holder should be interviewed (Case Study 18).

5.2.4 Securing the evidence at an incident scene

Inspectors have broad powers under the WHS Act to ensure that incident scenes are preserved so that an investigation can be conducted. Failure to ensure that an incident scene is preserved until all the relevant evidence is gathered can have potentially detrimental consequences for the integrity of an investigation and the ability of the OFSWQ to determine whether any person has breached their work health and safety duties.

With respect to the preservation of an incident site prior to the inspector's arrival, in some cases it will be reasonable for the inspector to contact the person in control of the incident site and take steps to ensure that:[85]

- nothing concerned with the incident is disturbed
- any plant involved in the incident is not used, moved or interfered with unless it is necessary to remove a trapped or injured person, or a body, or to prevent further injury or damage to property.

An inspector may issue a non-disturbance notice to a person with management or control of the workplace if the inspector reasonably believes it is necessary to do so.[86] A non-disturbance notice requires a person to preserve the incident site or prevent the disturbance of the site, including the operation of plant, for a stated period.

The investigation found that the preservation of evidence at an incident scene was satisfactory. In 18 of the cases reviewed, it was determined that the actions taken by inspectors, both prior to their arrival at the scene and after their arrival, were appropriate and sufficient to ensure that the relevant evidence was preserved.

In Case Studies 4 and 10, where the actions taken to ensure scene security were assessed as not appropriate, there were unreasonable delays by inspectors in attending the incident scene. As a result, no action was taken to secure the evidence at the incident scene which had been cleared by the time inspectors arrived.

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[85] OFSWQ Induction Manual (May 2013) Version 1, *Fundamental Inspector, Investigation and Witness Skills*, p.59.
[86] Section 198, WHS Act.

5.2.5 Actions taken to address immediate safety concerns – prohibition notice

During the first response following a workplace death, it is the primary responsibility of an inspector to take necessary steps to ensure that the workplace is safe. If during the first response or at any other time, an inspector forms the reasonable belief that an activity is occurring or may occur at the workplace which involves or will involve a serious risk to health or safety of a person emanating from an immediate or imminent exposure to a hazard, the inspector may issue the workplace with a prohibition notice.[87]

A prohibition notice prohibits the carrying on of the activity, or the carrying on of the activity in a stated way, until the inspector is satisfied that the matters that give or will give rise to the risk have been remedied.[88]

The investigation found that the use of prohibition notices to address immediate safety concerns at a workplace following a workplace death was excellent. In 19 of the cases reviewed, it was assessed that a prohibition notice was issued by an inspector if it was identified as necessary to address a safety concern arising from the workplace death.

The one case where it was assessed that a prohibition notice could have been issued, Case Study 4, this was not done due to a delay in the inspector attending the incident site and commencing the investigation.

5.2.6 Actions taken to address potential safety concerns – improvement notice

During the first response, or at any other time, inspectors may issue an improvement notice to a workplace to remedy identified contraventions of the WHS Act if the inspector reasonably believes the contravention will likely continue to be repeated.[89] An improvement notice is not appropriate if the contravention of the WHS Act involves a serious risk to health or safety. In those cases a prohibition notice is used.

Accordingly, while a prohibition notice is used to address immediate risks to health and safety, an improvement notice is used to remedy situations where a duty holder has contravened, or is contravening a requirement of the WHS Act, which if continued may give rise to a risk to health and safety in the future.

The investigation found that the use of improvement notices to address potential safety concerns was excellent. In all 20 cases reviewed it was assessed that an improvement notice was issued by an inspector if it was appropriate to address an identified contravention of the WHS Act that was likely to have been repeated by the workplace.

Opinion 3

The OFSWQ's notification, referral and first response actions, including the use of enforcement notices, are generally appropriate and timely.

JAG's response to Opinion 3

The Director-General accepted my opinion.

[87] Section 195(1), WHS Act.
[88] Section 195(2), WHS Act.
[89] Section 191(1), WHS Act.

Chapter 6: Investigation planning and case management

This chapter discusses the extent to which there was adequate planning for the workplace death investigations reviewed and whether the level of case management was sufficient to adequately guide the investigation.

6.1 Investigation planning

Planning is the first step in the investigation process and an investigation plan is an essential tool to a successful investigation of a workplace death. An investigation plan should also be flexible and able to be reviewed and updated during the course of the investigation as new information or evidence emerges.

Investigation planning is addressed in detail in the OFSWQ's Induction Manual (May 2013) Version 1, titled *'Fundamental Inspector, Investigation and Witness Skills'* (the Induction Manual). The Induction Manual provides an investigation plan template for inspectors for use during an investigation.[90] The template is comprehensive and addresses the relevant issues necessary in an investigation plan.

In assessing the quality of investigation planning for each workplace death case reviewed, the investigation took into account two factors:

- whether there was evidence of an adequate investigation plan which outlined, at a minimum, the investigation's objectives, the issues to be addressed and potential avenues of inquiry
- in the absence of an investigation plan, whether there was evidence of informal investigation planning such as notes of a case management meeting which addressed investigation planning matters or notes made by an inspector evidencing that a degree of planning occurred in the investigation.

The investigation found that the quality of investigation planning by the OFSWQ was poor. Only five of the cases reviewed showed evidence of sufficient planning. In the remaining 15 cases, there was either no evidence of any investigation planning, or negligible attempts at planning which failed to provide any advantage to the investigation.

Significantly, the investigation determined that the five workplace death investigations that had adequate investigation planning all resulted in a comprehensive investigation that identified all duty holders and potential breaches, gathered sufficient evidence and addressed the relevant issues. Each of these five investigations also concluded with a satisfactory investigation report which discussed the evidence gathered and addressed whether there was evidence of a breach of a duty by any duty holder.

In contrast, in the remaining 15 cases where there was inadequate investigation planning, only three resulted in a comprehensive investigation which identified all duty holders and potential breaches, gathered sufficient evidence, addressed all relevant issues and concluded with an adequate investigation report.

This outcome provides strong support for the principle that investigation planning is critical to the success of a workplace death investigation. Further evidence of this principle is that the most comprehensive investigations reviewed had a comprehensive and practical investigation plan, while the poorest investigations contained no evidence of planning.

Case Study 7 provides an example of how comprehensive investigation planning can guide and support an investigation, resulting in a satisfactory outcome.

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[90] OFSWQ Induction Manual (May 2013) Version 1, *Fundamental Inspector, Investigation and Witness Skills*, p.238.

Case Study 7

The incident

H was an international tourist who drowned while snorkelling on an organised reef tour.

The investigation

The investigation was of a high quality.

An extensive investigation plan was prepared which identified all potential duty holders, the relevant duties owed by each duty holder and what evidence was needed to be gathered in respect of each breach. Interviews were arranged and well-structured interviews were conducted. The investigation plan was supported by good case management and regular input from a legal officer.

An investigation report was completed which contained a recommendation that proceedings be brought against the principal duty holder, the dive operator. The recommendation was well assembled and argued and dealt with all elements of the potential offences that had been correctly identified.

Case Study 8 was an investigation into an incident similar to that in Case Study 7, the drowning death of an international tourist on an organised snorkelling tour. In Case Study 8, while there was no formal investigation plan, there was evidence of a case planning meeting between the inspector and the RIM before the first response where issues regarding investigative strategy were discussed. Case Study 8 was also a comprehensive and high quality investigation.

Accordingly, while an investigation plan is usually the most appropriate planning strategy, any type of planning before an investigation commences, formal or informal, will likely result in a more focused and methodical investigation that has clear objectives.

In contrast, Case Study 6 demonstrates how an investigation which is poorly planned can result in an investigation that fails to achieve its objectives.

Case Study 6

The incident

G was found deceased at his home. The QPS established the cause of death as suicide. The OFSWQ received allegations that G had been a victim of bullying and harassment at his workplace.

The investigation

The OFSWQ commenced an investigation. At interview, OFSWQ officers confirmed that they had not previously undertaken an investigation of this nature and had no experience dealing with an allegation that bullying at work had been a contributing factor to a suicide. There was no investigation plan produced at the commencement of the investigation and no evidence of any planning or case management meetings.

During the investigation 42 statements were obtained by the OFSWQ. At interview, inspectors advised that these statements were taken as part of a strategy to develop an understanding of the culture that existed at the workplace. However, while significant evidence was gathered, it was not obtained with any particular view as to what might be needed to prove any breach of duty by a duty holder.

Eventually, the material gathered from the statements was provided to LPS for assessment and advice about whether any breaches had been identified. No recommendations regarding prosecution or enforcement were made by the region and no investigation report was prepared. At interview, it was apparent from the relevant OFSWQ inspectors that the investigation had become too complex and the region was expecting LPS to review the evidence and provide guidance about what the next steps in the investigation should be.

Case Study 6 is an example of how an investigation can meander off course and fail to achieve its objectives in the absence of a clear investigation plan. Had inspectors, the RIM and the legal officer conducted relevant planning activities before inspectors began gathering statements from witnesses, there may have been a clearer view about the objective of the investigation, the potential breaches that needed to be proved, the evidence that needed to be gathered to prove those breaches and the persons who may have been able to provide that evidence.

In contrast, inspectors took 42 statements over a period of months gathering much irrelevant evidence, but failed to gather any evidence sufficient to establish whether any breaches had occurred.

While gathering sufficient evidence to prove a breach in Case Study 6 may have been challenging given the nature of the investigation, the investigation did gather evidence to suggest that there was a problem with bullying and conflict between staff at the workplace. A well-planned and targeted investigation may have been able to further pursue specific evidence with a view to ascertaining whether the duty holder had breached s.19(3)(a) of the WHS Act[91] and whether the officer in charge of the workplace had breached s.27(1) of the WHS Act.[92]

The lack of a plan providing a clear outline of the investigation's objectives also resulted in the investigation taking an excessive period of time to complete, which resulted in significant distress for the deceased's next of kin.

As discussed, the current OFSWQ investigation plan template is comprehensive and addresses the relevant issues which should be included in an investigation plan. The quality of investigation planning by the OFSWQ would be considerably improved if more use was made of the investigation plan template.

Opinion 4

Investigative planning by the OFSWQ was inadequate, often of a poor quality and contributed to unsatisfactory investigation and regulatory outcomes in many of the investigations reviewed. This is unreasonable administrative action for the purposes of s.49(2)(b) of the Ombudsman Act.

JAG's response to Opinion 4

The Director-General accepted my opinion.

Recommendation 2

The Under Treasurer:

2.1 review the investigation planning requirements contained in the current *Fundamental Inspector, Investigation and Witness Skills* manual to ensure they represent current and best practice

2.2 establish a mandatory process of investigative planning and provide appropriate training to inspectors about these requirements

2.3 ensure that quality assurance processes evaluate the use and effectiveness of investigative planning in workplace death investigations.

[91] Section 19(3)(a) of the WHS Act requires a PCBU to ensure, so far as is reasonably practicable, the provision and maintenance of a work environment without risks to health and safety.

[92] Section 27(1) of the WHS Act requires an officer of a PCBU to exercise due diligence to ensure the PCBU complies with a duty of obligation.

JAG's response to Recommendation 2

In response to the proposed report, the Director-General advised:

> Recommendation 2.1 – Agreed.
>
> Recommendation 2.2 – Redundant. A mandatory process of investigation planning is required for all comprehensive investigations, including workplace deaths. Performance measures to ensure these processes are followed have been implemented.
>
> Recommendation 2.3 – Redundant. Quality assurance processes addressing all comprehensive investigations, including investigations of workplace deaths, have been implemented and articulated with a performance management system.

I am pleased with the Director-General's advice that the OFSWQ has established a mandatory process of investigative planning, provided appropriate training to inspectors about planning requirements and ensured that quality assurance processes evaluate the use and effectiveness of investigative planning. However, it is a concern that these processes do not appear to have significantly improved the quality or use of investigation planning in the workplace death investigations reviewed.

In particular, the OFSWQ Advanced Investigations Training Manual (which was current during the period the OFSWQ investigations in the review sample were conducted) provides an investigation plan template for use by inspectors. There was minimal use of this template in the investigations reviewed.

While I acknowledge the OFSWQ has strengthened investigation planning requirements in the more recent Induction Manual, based on the poor outcomes of the file review with respect to the quality and use of investigation planning for OFSWQ workplace death investigations, I do not agree that Recommendations 2.2 and 2.3 are redundant.

6.2 Case management

An appropriate case management process is important to ensuring that a workplace death investigation is timely, is accountable, addresses relevant issues and meets the objective of determining whether any person has breached their duties under the WHS Act or other legislation or regulations.

The OFSWQ has a number of procedures regarding how a workplace death investigation should be case managed, who should be involved and timeframes about when case management should occur, including:[93]

- an initial case management meeting should occur within 24 hours or as soon as practicable following notification of a workplace death to the OFSWQ
- the case management team should include the inspector, RIM and the legal officer, with the legal officer required to participate, at a minimum, in the initial and final case management meeting
- case management meetings should occur throughout the investigation as required, with the frequency depending on the complexity of the investigation
- a final case management meeting should be held at the conclusion of the investigation (attended by a legal officer) to consider the outcome of the investigation and whether a recommendation will be made for prosecution.

Appropriate case management during a workplace death investigation was assessed on whether:

- there was evidence of some case management throughout the investigation involving the RIM and the legal officer
- the level of case management appeared appropriate for the complexity of the investigation.

Adequacy of case management was a difficult area to review because the quality of recordkeeping by OFSWQ officers was often inadequate. In some cases it appeared that case management meetings were held, but records were not sufficient to determine who attended the meetings, what was

[93] OFSWQ, *Operational Procedure: Investigation Management*, pp.6-7.

discussed and what was decided. In other cases there was no record of case management meetings, but from the file records it appeared that the RIM had extensive involvement with the investigation and had been involved in supervision and case management during the investigation.

The investigation found that there was sufficient evidence of case management in 11 of the workplace death investigations reviewed. The quality of case management in these 11 cases varied widely. In some cases, there were comprehensive notes taken of discussions and decisions and it was clear who had attended the case management meetings. In other cases there were only indications on the file that some degree of case management had occurred.

Opinion 5

Case management of many of the investigations reviewed was inadequate and recordkeeping did not demonstrate the case management processes that had occurred in many cases. This is unreasonable administrative action for the purposes of s.49(2)(b) of the Ombudsman Act.

JAG's response to Opinion 5

The Director-General accepted my opinion.

Recommendation 3

The Under Treasurer review current case management procedures for workplace death investigations to ensure they represent current and best practice and provide appropriate training to inspectors in these requirements.

JAG's response to Recommendation 3

The Director-General accepted my recommendation.

Chapter 7: Identification of potential breaches, evidence gathering and investigation reports

This chapter discusses the investigation outcomes with respect to the identification of relevant duty holders, the identification of potential breaches of duties of the WHS Act by duty holders and whether the investigation gathered sufficient evidence and addressed all relevant issues with respect to the investigation of a breach of a duty. These issues all relate to establishing the incident causation of the workplace death.

This chapter also discusses the adequacy of investigation reports completed by the OFSWQ at the completion of an investigation.

7.1 Identification of relevant duty holders

A primary task of an inspector commencing a workplace death investigation is to identify the relevant duty holders. The principal duty holder under the WHS Act is a PCBU, whether the PCBU does this alone or with others and whether or not for profit or gain.[94] There may be multiple PCBUs who are duty holders in relation to a workplace death, and they may include designers, manufacturers, importers, suppliers or installers of products or plant used at work.[95] Officers and workers may also be duty holders.[96]

Because there may be multiple duty holders all holding different responsibilities and duties under the WHS Act, it is important that an attempt is made to identify all potential duty holders at the beginning of the investigation before substantial evidence gathering commences.

The investigation found that the identification of duty holders by the OFSWQ before an investigation commenced was very good. In 19 of the cases reviewed, it was determined that all relevant duty holders were identified.

7.2 Incident causation and evidence gathering

Work health and safety deaths can occur as a result of a single cause or multiple causes. The purpose of a workplace death investigation is to determine all of those causes, and then assess whether a breach of a work health and safety duty by a duty holder was a sole or contributing factor. The Induction Manual provides comprehensive information and direction to inspectors regarding identifying breaches and incident causation, and how to gather evidence to address potential causation factors.[97]

The cause of a workplace death is usually the result of one of the following:[98]

- actions taken by the worker that contributed to their death, and whether these actions were influenced by the worker's knowledge, qualifications and skills, instructions provided to the worker and/or the worker's capacity to understand instructions
- training deficiencies and whether sufficient instruction and training was provided to the worker to carry out the work
- the work method and safe systems of work and whether a duty holder had sufficient policies and procedures to identify potential hazards at a workplace and seek to minimise or eliminate them
- the environment where the work is being conducted and whether a duty holder has identified potential environmental hazards and if necessary put in place measures to manage the risks they create
- the equipment or plant being used by the worker and whether the equipment or plant was designed for the work it was being used for, maintained to the required safe working standard and inspected for any faults and defects on a regular basis
- organisational structure regarding the systems a duty holder has in place to address workplace incidents, including proactive measures in place to ensure worker health and safety, and where incidents do occur, reactive measures to address and improve processes

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[94] Section 5(1), WHS Act.
[95] Sections 22 to 26, WHS Act.
[96] Sections 27 and 28, WHS Act.
[97] OFSWQ Induction Manual (May 2013) Version 1, *Fundamental Inspector, Investigation and Witness Skills*, Chapter 6: Investigation of workplace incidents.
[98] OFSWQ Induction Manual (May 2013) Version 1, *Fundamental Inspector, Investigation and Witness Skills*, p.57.

- the workplace climate at the time of the incident including factors such as budget restraints, use of untrained and/or incompetent supervisors, inadequate safety culture and confrontational relationships between workers and management.

To ensure the investigation has addressed all possible causes of a death, each of these potential causes should be considered by an inspector during their evidence gathering.[99] While not all of these causes will be a factor in each workplace death, a careful consideration of all possible causes will ensure no relevant issues are overlooked.

In reviewing each of the 20 workplace death cases in the file review, these seven causation factors were used to inform the assessment of whether the identification of potential breaches, evidence gathering and issue identification by the OFSWQ were appropriate and sufficient.

7.2.1 Identification of potential breaches

Identifying whether there has been a potential breach or breaches of the WHS Act by any person will influence the future course of the investigation, the nature of evidence that will need to be gathered and the issues that will need to be addressed.

The investigation found that all potential breaches of the WHS Act were identified in 14 of the workplace death cases reviewed. In the remaining six cases, critical potential breaches were either not identified or overlooked by the OFSWQ, often resulting in significant adverse outcomes for the quality of the investigation.

It is important to clarify that just because potential breaches were not identified and investigated in these six cases does not necessarily mean that a duty holder should have been prosecuted for an offence under the WHS Act. There was insufficient evidence gathered by the OFSWQ in relation to these overlooked potential breaches. The failure to identify all potential breaches in six workplace death cases reviewed means the quality of the investigations was adversely affected and avenues of inquiry left unexplored.

The following two case studies demonstrate some of the deficiencies found by the investigation with respect to the identification of potential breaches by the OFSWQ.

[99] OFSWQ Induction Manual (May 2013) Version 1, *Fundamental Inspector, Investigation and Witness Skills*, p.61.

Case Study 1

The incident

B was using a forklift to move a crate on a bushland property. As B was manoeuvring the forklift, the rear wheel went over the side of an embankment, causing the forklift to tumble down the embankment. B died after being crushed by the forklift.

The investigation

The OFSWQ established that B held the appropriate qualification to operate a forklift and the forklift was in good mechanical order. At this point in the investigation, it appears the OFSWQ determined that the duty holder had not breached any duty under the WHS Act.

However, based on evidence gathered during the investigation, the OFSWQ did not identify that there were also potential breaches of the WHS Act by the duty holder that may have occurred with respect to:

- the provision and maintenance of safe plant and structures, having regard to whether the forklift was fitted with appropriate tyres for the bushland environment it was being used in and whether it had, or was required to have, a safety belt[100]
- the provision and maintenance of safe systems of work, as it appeared that the duty holder had no systems regarding the safe use of the forklift, including instructions about its use, who may use it, what it may be used for and how it may be used[101]
- the safe use, handling and storage of plant, structures and substances, having regard to whether the forklift was safe to use on soft, uneven ground in a bushland setting.[102]

The failure of the OFSWQ to consider these potential breaches resulted in an unsatisfactory investigation that did not consider all the relevant issues.

[100] Section 19(3)(b), WHS Act.
[101] Section 19(3)(c), WHS Act.
[102] Section 19(3)(d), WHS Act.

Case Study 5

The incident

F was an elderly person who was invited onto a demolition site by an owner builder to view some timber. F was left alone on the site and was later found lying on the ground with a head injury. F later died from his injuries.

The investigation

The OFSWQ investigation established that F was not a worker at a workplace. However, it was identified that the WHS Act applied as a duty holder must ensure, as far as is reasonably practicable, that the health and safety of other persons are not put at risk when carrying out a business or undertaking. F was a person to whom duties were owed by the duty holder.

Due to a lack of witnesses to the incident, the investigation was unable to determine how F came to be lying on the ground with a head injury. The investigation was ended on this basis.

However, the OFSWQ did not identify that there were potential breaches of the WHS Act by the duty holder that may have occurred with respect to:

- the provision and maintenance of a work environment without risks to health and safety, considering that the duty holder failed to provide F with any safety equipment or clothing while F was on site, in contravention of the duty holder's own work methods which require all persons on the site to wear a safety helmet, high visibility clothing, safety boots and eye protection[103]
- the provision of any information, training, instruction or supervision that is necessary to protect all persons from risks to their health and safety, having regard to the lack of any supervision of F while he was on the site, the failure of the duty holder to provide F with any safety induction when entering the site (in contravention of the duty holder's own work methods) and the failure of the duty holder to provide any instruction to F about safety and what he was permitted to do while on site.[104]

In addition to these issues, it was apparent that the OFSWQ inspectors failed to give this investigation sufficient attention and resources due to F being an acquaintance of the duty holder who was invited onto the demolition site. At interview, the OFSWQ inspector agreed that because F was not a worker at the site, the investigation was given lesser priority than would have occurred had F been a worker.[105]

The failure of the OFSWQ to consider these potential breaches resulted in an unsatisfactory investigation that did not consider all the relevant issues potentially impacting on the death of F.

7.2.2 Evidence gathering and issue identification

The cause of each workplace death, the factors potentially impacting or contributing to the death and the evidence that will be required to be gathered to establish these causes vary from case to case. A comprehensive workplace death investigation will identify all potential and relevant causation factors and then gather sufficient and relevant evidence to determine whether those factors caused or contributed to the incident.

The investigation identified significant problems with issue identification and evidence gathering processes by the OFSWQ. In only eight of the OFSWQ investigations reviewed was it determined that all relevant issues were addressed and sufficient evidence gathered to establish whether a duty was breached by any person. The remaining 12 cases, to varying degrees, failed to identify all the relevant issues potentially causing or contributing to the death, or failed to gather sufficient evidence to determine whether a breach of the WHS Act or other legislation had occurred.

[103] Section 19(3)(a), WHS Act.
[104] Section 19(3)(f), WHS Act.
[105] Interview with an OFSWQ inspector on 13 January 2015, transcript p.13.

The following two case studies provide examples of key issues that were not addressed by the workplace death investigations, and the potentially relevant and significant evidence that was not gathered.

Case Study 3

The incident

D was a plant operator working to install wick drains on reclaimed land who died after being hit by the boom of an excavator which tipped over after sinking into a soft sand surface.

The investigation

The OFSWQ attended the scene and commenced an investigation. A notice was issued to ensure that the scene was not disturbed until it could be examined by a geotechnical expert engaged by the OFSWQ to form an opinion about the cause of the incident. The expert prepared a report which was provided to the OFSWQ.

The geotechnical expert found that an irregularity during the placement of sand and other soils and water ponding some years before the incident may have created a weak point in the surface. The expert stated that it was inconclusive whether additional testing or examination of the area by the duty holders would have identified this weakness. However, the geotechnical expert also noted that it was not known whether the soil testing that had been recommended in the original design brief for the project had been carried out by the duty holders.

With respect to the quality of evidence gathering by the OFSWQ, two potential duty holders declined to attend voluntary interviews with the OFSWQ. The WHS Act contains a wide range of coercive powers which allow an inspector to enter a workplace, ask questions and inspect or examine anything, including documents. A person is required to provide reasonable help to an inspector, unless that person has a reasonable excuse. These powers were not used to compel the duty holders to give evidence. When interviewed, OFSWQ officers were unable to reasonably explain why these powers were not used in this case.

Secondly, the fundamental question raised by the geotechnical expert about what testing was done on the stability of the surface prior to moving an excavator onto it was never pursued or determined by the OFSWQ. The fact that the geotechnical expert stated that additional testing may or may not have identified any weakness appears to have been given significant weight by the OFSWQ as justification for ending the investigation. However, the question of what, if any, testing was undertaken by the duty holders on the stability of the surface was never determined.

At interview, OFSWQ officers could not reasonably explain why this issue was not addressed before ending the investigation.

Case Study 3 represents one of the poorest examples of a workplace death investigation reviewed, where the key issue potentially contributing to D's death was not explored. The OFSWQ was aware that there was uncertainty regarding whether the duty holders had carried out the recommended testing about the stability of the sand, but inspectors did not seek the required evidence from the duty holders. The OFSWQ had the necessary powers under the WHS Act to answer this question, but did not use them.

Potentially, if the duty holders had not carried out the recommended testing to determine the stability of the sand, or had carried out testing which had determined the surface was not stable, a serious breach of the WHS Act may have occurred. As the OFSWQ did not seek to determine the extent of the testing that had been carried out, it was not able to properly assess whether any breach of the WHS Act occurred in this case.

Opinion 6

The OFSWQ investigation in Case Study 3 was inadequate because:

(a) the OFSWQ failed to identify and address multiple issues regarding whether the duty holders had complied with their work health and safety duties under the WHS Act
(b) the outcome leaves potential material questions unanswered regarding whether an offence was committed by one or both of the duty holders under the WHS Act.

The failure by the OFSWQ to conduct an adequate investigation is unreasonable administrative action for the purposes of s.49(2)(b) of the Ombudsman Act.

JAG's response to Opinion 6

The Director-General accepted my opinion.

Recommendation 4

The Under Treasurer appoint a suitably qualified independent person to review the investigation and regulatory outcome in Case Study 3, and provide advice to the State Coroner regarding the outcome of that review.

JAG's response to Recommendation 4

The Director-General accepted my recommendation.

Case Study 13

The incident

O was a worker at a construction site who suffered the effects of suspected heat stroke after working in temperatures in excess of 42 degrees Celsius. O died soon after being admitted to hospital.

The investigation

The investigation gathered evidence regarding the work methods in place and the level of training provided to workers regarding the systems of work but failed to conduct any analysis about these systems to determine whether they were sufficient for the conditions experienced by workers, and implemented appropriately by the duty holder on a day when there was extreme heat.

There was also insufficient evidence gathered about the sufficiency and implementation of the duty holder's safe work methods regarding extreme heat conditions.

Significant issues were not addressed by the investigation including:

- whether the duty holder was monitoring actual temperatures where workers were working
- what assessments were conducted by the duty holder around the appropriate maximum temperatures to expose workers to
- whether workers were provided with adequate measures to protect against heat stress (i.e. no cooling clothing or electrolyte drinks were provided even though these were in the safe work method)
- how workers were supposed to monitor their own symptoms of potential heat stress and whether they had been trained to do so
- whether the first aid procedures in place were appropriate for dealing with potential heat stress.

With regard to Case Study 13, a review of the regional investigation was conducted by a legal officer as a quality assurance measure. This review was critical of many aspects of the investigation and recommended further investigation of key issues and feedback provided to the officers concerned. Despite this review, it appears that no action has been taken by the OFSWQ to address any of these issues.

Opinion 7

A significant number of investigations failed to identify breaches by duty holders and relevant investigation issues, and were not supported by adequate evidence gathering. These deficiencies adversely affected the quality of these investigations. This is unreasonable administrative action for the purposes of s.49(2)(b) of the Ombudsman Act.

JAG's response to Opinion 7

The Director-General accepted my opinion.

Recommendation 5

The Under Treasurer:

5.1 review the requirements relating to the identification of breaches by duty holders and the identification of causal factors potentially impacting on a workplace death contained in the *Fundamental Inspector, Investigation and Witness Skills* manual, to ensure they represent current and best practice

5.2 provide appropriate training to inspectors regarding identifying breaches and potential causal factors during an investigation

5.3 ensure that quality assurance processes include the sufficiency of the identification of breaches and relevant causal factors in an investigation.

JAG's response to Recommendation 5

In response to the proposed report, the Director-General advised:

> Recommendation 5.1 – Agreed.
>
> Recommendation 5.2 – Agreed.
>
> Recommendation 5.3 – Redundant. Quality assurance processes have been implemented and articulated with a performance management system.

I do not agree that Recommendation 5.3 is redundant, considering the file review determined there were deficiencies in the identification of breaches by duty holders, issue identification and evidence gathering, which adversely affected the quality of these OFSWQ investigations. As demonstrated in this report, the adequacy of these processes is essential for ensuring a comprehensive investigation outcome.

I am pleased with the Director-General's advice that quality assurance processes are now in place. However, this recommendation provides an opportunity for the OFSWQ to ensure these processes are sufficient to rectify the deficiencies identified in this investigation.

7.3 Adequacy of investigation reports

When all relevant evidence has been gathered, the OFSWQ procedures require that an investigation report is prepared to summarise the findings of the investigation and for the RIM to make a recommendation to the Director, LPS about what, if any, enforcement action should be taken with respect to any breaches identified.[106]

The majority of the investigation reports reviewed during the investigation were in a format contained as a template in the OFSWQ Training Manual (September 2010), Version 10. A new investigation report template is included in the OFSWQ *Operational Procedure: Investigation Management* (January 2013). No investigation reports reviewed during the file review were in the new template format.

Any recommendation made by a RIM regarding enforcement action is required by the report to be supported by a statement of reasons. This requirement is not interpreted by OFSWQ officers in any formal way, but generally as an opportunity for the RIM to provide a logical explanation for a recommendation, having regard to the findings on material questions of fact and the evidence on which those findings were based.

The investigation found that eight investigations in the file review contained satisfactory investigation reports. These eight investigations were also assessed to be generally competent investigations. Of the 12 investigation reports considered to be unsatisfactory, the following deficiencies were evident:

- no investigation report was completed (Case Study 6)
- multiple duty holders and evidence and potential breaches relating to each duty holder were not clearly identified (Case Studies 3, 4, 9, 12, 18, 20)

[106] OFSWQ, *Operational Procedure: Investigation Management*, p.7.

- significant issues including potential breaches were not adequately addressed (Case Studies 1, 3, 5, 9, 10, 11, 12, 13, 18)
- inadequate analysis of the evidence gathered to support the findings of the investigation report (Case Studies 1, 3, 4, 5, 9, 10, 11, 12, 13, 18, 20)
- findings on material questions of fact were missing (Case Studies 3, 5, 13)
- findings were based on assumptions or irrelevant evidence (Case Studies 3, 5, 9, 20)
- relevant legislation, policies and/or procedures were not referred to (Case Studies 10, 20).

The investigation also identified some variation in the investigation report format. As mentioned above, the majority of cases reviewed used the investigation report template in the superseded OFSWQ Training Manual (September 2010), Version 10. However, in other cases, no template was used and the investigation report was simply presented as a statement providing the outcome of the investigation.

The investigation report is an important document that should bring together the evidence gathered during the investigation and provide a logical, evidence-based recommendation about potential enforcement actions. It should also provide prompts for an inspector regarding the evidence that needs to be gathered and included in an analysis of whether there has been any breach of the WHS Act.

The investigation report should also be a distinctive document that is used consistently by each region. The new investigation report template included in the OFSWQ *Operational Procedure: Investigation Management* (January 2013) is a comprehensive document that, if used correctly and consistently with all sections completed, should address the issues that were identified during the investigation.

Opinion 8

Investigation reports were poorly presented, in varying formats and failed to address all significant evidence relevant to the investigation. This is unreasonable administrative action for the purposes of s.49(2)(b) of the Ombudsman Act.

JAG's response to Opinion 8

The Director-General accepted my opinion.

Recommendation 6

The Under Treasurer:

6.1 review the OIR's current investigation report template to determine whether it is adequate, considering the issues identified with respect to the quality of investigation reports reviewed

6.2 ensure that all workplace death investigation reports are prepared in a standard report format

6.3 ensure that quality assurance processes include assessment of the quality of investigation reports.

JAG's response to Recommendation 6

In response to the proposed report, the Director-General advised:

> Recommendation 6.1 – Agreed.
>
> Recommendation 6.2 – Redundant. See response to recommendation 6.3.
>
> Recommendation 6.3 – Redundant. Quality assurance processes addressing all comprehensive investigations, including workplace death investigations, have been implemented and articulated with a performance management system. This process addresses quality of investigation reports.

I do not agree that Recommendations 6.2 or 6.3 are redundant.

As discussed in this report, the OFSWQ investigation reports were generally poorly presented, in varying formats and failed to address all significant evidence relevant to the investigation. Evidence gathered during investigations was not always presented in investigation reports in a clear, structured or logical manner. Findings and outcomes were often not supported by evidence that was clearly set out in the report (although the evidence was gathered during the investigation). There was also inconsistency between regions about how reports were assembled and formatted or how evidence and findings were presented.

The new investigation report template is comprehensive and the OFSWQ should ensure that this template is used consistently by inspectors in each region to present their investigation findings. Despite the Director-General's advice that current quality assurance processes address this issue, there was limited evidence of any consistency of use in the 20 cases assessed in the file review.

There was also no evidence that the use of the report template had improved over the 18 month period covered by the file review. This raises questions about whether current quality assurance processes are sufficient to address and improve upon the deficiencies identified in this investigation.

7.4 Evaluation and review of investigations

The finalisation and approval of the investigation report by the RIM marks the completion of the regional workplace death investigation process. The quality of the evidence gathered during this process, and the quality of the analysis of this evidence are significant factors determining whether enforcement action is taken by the OFSWQ.

Accordingly, the quality of the regional investigations is of significant importance to the OFSWQ. During the investigation, the OFSWQ advised that it had commissioned a review program by external independent reviewers of a sample of workplace incidents investigated by the OFSWQ. The purpose of this external review program is to 'quality assure' completed workplace investigations and provide an opportunity for continuous improvement and learnings to staff.

This external review program should continue and has the potential to provide a valuable feedback tool for the OFSWQ. The learnings from such reviews should be provided on a regular basis to OFSWQ inspectors responsible for the investigations concerned.

Recommendation 7

The Under Treasurer:

7.1 continue the external review and evaluation program of workplace investigations

7.2 provide the outcome of each investigation reviewed to the inspector and RIM responsible for the investigation to facilitate continuous improvement in investigations and professional development of inspectors.

JAG's response to Recommendation 7

In response to the proposed report, the Director-General advised:

> Recommendation 7.1 – Redundant. The investigator examined investigations into workplace deaths that occurred between 2 and 3.5 years ago. OFSWQ has implemented a comprehensive external audit process and intends continuing both this and internal mechanisms.
>
> Recommendation 7.2 – Redundant. All preliminary audit findings are released to regional operational staff before being finalised. Once finalised, audit findings inform both performance management measures and broader communication in relation to organisational improvement.

The Director-General may have misinterpreted the intent of my recommendation. I commend the OFSWQ for implementing a comprehensive external audit program of its investigations. The purpose of my recommendation was to express my view that the audit program should continue on an ongoing basis.

I am pleased that the Director-General has confirmed that the external audit program will be an ongoing practice and that review outcomes are, and will continue to be, provided to relevant staff to facilitate learning and continuous improvement.

Chapter 8: Decision-making by LPS

This chapter will discuss issues relating to decision-making by LPS regarding workplace deaths, including the timeliness of decision-making, the quality of advice provided to the Director, LPS about whether to commence a prosecution, the prosecution of offences under the WHS Act and the adequacy of the current LPS model.

8.1 Role of LPS

Once an investigation report is completed by a region, it is provided to LPS for a decision about whether a prosecution should be commenced against any person for a breach of the WHS Act or other legislation. The OFSWQ practice is that once an investigation is received by LPS, the file is reviewed by a legal officer who considers the merits of the case and prepares a memorandum of advice to the Director, LPS, recommending whether a prosecution should be brought.[107] The Director, LPS is the sole delegated decision-maker in respect of the decision about whether a prosecution for breach of a duty by any person should be initiated.[108]

At interview, the Director, LPS stated that he is routinely required to deal with between 700 and 900 matters a year, mainly decisions about workplace investigations, union right of entry to workplaces and licensing matters.[109] LPS is also required to provide strategic and prosecution advice to the investigation and prosecution functions within the OFSWQ, provide legal advice to the Minister and OFSWQ executives and manage appearances before the courts, tribunals and other hearings relevant to the operations of the OFSWQ.[110]

At the commencement of this investigation, LPS had a complement of 12 positions, including the Director, six Principal Legal Officers, one Senior Legal Officer, one Legal Officer (shared by two part time officers), two part time Paralegal Officers and an Executive Assistant.

The investigation identified a number of significant issues with the performance of LPS across a range of indicators.

8.2 Timeliness of decision-making

In the 20 workplace death investigations reviewed, the average time taken by LPS to make a decision about prosecution was approximately six months.

Only nine of the 20 investigations had prosecution decisions made by LPS in less than three months. Some cases were with LPS for longer than it took the region to investigate the incident and complete an investigation report. For example, in three of the investigations reviewed, the case was with LPS for a prosecution decision for longer than 12 months.

During interview, a number of reasons were offered by OFSWQ officers for the lack of timeliness in LPS decision-making. These included resourcing, workload and the practice that files likely to be the subject of a no further action decision were identified early by legal officers, but not promptly reviewed because attention was devoted to matters intended for enforcement action.

There also appears to be no key performance indicators and measurement dealing with the timeliness of decision-making within LPS. The absence of such performance measures may be a contributing reason affecting timely decision-making by LPS. This issue is addressed by Recommendation 1.

[107] Interview with the Director, LPS on 5 February 2015, transcript p.8.
[108] Interview with the Director, LPS on 5 February 2015, transcript p.8.
[109] Interview with the Director, LPS on 5 February 2015, transcript p.8.
[110] Interview with the Director, LPS on 5 February 2015, transcript pp.6-7.

The Director, LPS's response

In response to the proposed report, the Director, LPS advised:

> The investigation found the average time taken to make a decision by LPS was approximately 6 months. However, in many instances a decision on a recommendation is often made early during case management and prior to the formal written recommendation from the Region. Case management notes should reflect this and be on file. It is accepted that some matters where a decision for NFA [no further action] is to be recommended are not given priority.
>
> To improve timeliness of decision making, the written procedure on advices includes time frames as to preparation of relevant memoranda. All legal officers are [sic] prepare memoranda as per the templates and adhere to time frames. If a legal officer is unable to provide a memorandum of advice within designated time, written reasons must be given.
>
> The investigation identified a lack of performance indicators and measurement dealing with decision-making, suggesting this might be a contributing factor affecting timeliness. This should be amenable to resolution through the mandatory provision of memoranda.

I acknowledge that in many instances a decision about whether prosecution action is to be taken may be made early during case management and prior to the written recommendation from the region. However, a formal and final decision on prosecution action can only be made by the Director, LPS. Next of kin and other interested parties are also only advised of the investigation outcome after the Director, LPS has made a decision.

Accordingly, the timeframes determined by this investigation are relevant and an accurate reflection of the time taken by LPS to make a prosecution decision.

8.3 Prosecution of offences under the WHS Act

The WHS Act provides for three categories of offences for a breach of a health and safety duty. The three categories of offences range from the most serious (category 1), involving reckless conduct by a duty holder causing death or serious injury, to the least serious (category 3), involving a simple failure by a duty holder to comply with a health and safety duty.

Information provided by the OFSWQ identified that all prosecutions brought by the OFSWQ since the commencement of the WHS Act on 1 January 2012 have been for category 2 offences.[111] A category 2 offence relates to a duty holder who failed to comply with a duty under the WHS Act, and that failure exposed an individual to the risk of death or serious injury.

Investigation reports and memorandums of advice by legal officers reviewed during the file review often referred simply to an 'offence' rather than specifying the particular offence which was being considered. At interview, the Director, LPS agreed that there was an assumption within the OFSWQ that when a potential offence was being discussed in a recommendation, opinion or advice, it was a potential category 2 offence that was being considered.[112]

The file review also identified a continual failure by the OFSWQ to consider potential category 3 offences, both during the regional investigation and during review by LPS. The file review identified instances where on the evidence gathered, it appeared that a potential category 3 offence may have been committed by a duty holder. However, these offences were neither identified by the OFSWQ, nor any consideration given to prosecuting the offence.

At interview, OFSWQ officers were unable to explain why category 3 offences were not considered in relation to potential breaches. The Director, LPS explained that category 3 offences were not prosecuted by the OFSWQ because matters considered by LPS generally involved a workplace death or serious injury.[113] In these cases, it appears LPS determines whether there is evidence a category 1 or category 2 offence has been committed that directly relates to the death or injury, rather than seeking to prosecute a breach of a duty that may not be directly related.

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[111] Director, Work Health Safety Compliance, email, 5 January 2015.
[112] Interview with the Director, LPS on 5 February 2015, transcript p.40.
[113] Interview with the Director, LPS on 5 February 2015, transcript p.39.

However, while category 3 is the lowest offence category for a breach of a work health and safety duty, it still attracts a considerable penalty if a person or corporation is found guilty of the offence. The maximum penalty for a corporation found guilty of a category 3 breach is 5,000 penalty units ($589,000). For an individual duty holder, the penalty is 1,000 penalty units ($117,800).[114]

At minimum, in the memorandums of advice to the Director, LPS, legal officers should identify all instances where the evidence suggests that a category 3 offence may have been committed by a duty holder, and provide reasons why prosecution of that potential offence is not appropriate, having regard to the DPP Guidelines.

The Director, LPS's response

In response to the proposed report, the Director, LPS advised:

> Your office's investigation identified that memoranda of advice by legal officers often referred simply to an "offence" rather than specifying the offence being considered and in most instances legal officers did not consider a potential category 3 offence.
>
> It is suggested at minimum, memoranda from legal officers should canvass evidence suggesting category 3 offence may [sic] and provide reasons why prosecution of that potential offence is not appropriate, having regard to DPP Guidelines.
>
> Legal officers are familiar with DPP guidelines and utilise them, however it is acknowledged that the material may not ordinarily reference them explicitly.
>
> The written procedure now incorporates a link to DPP guidelines and ensures that memoranda specify their consideration.
>
> Because Category 3 offences do not incorporate an element of "exposure to risk" it is relatively rare such matters will be referred to LPS. Relevant findings at investigation might be addressed by regional response and lower statutory enforcement, generally through Improvement or Prohibition Notice under the WHS Act or infringement under the *State Penalties Enforcement Act 1999* (and regulation thereunder).
>
> This is under continuing discussion within OFSWQ. Appropriate section 33 matters will be considered. Examples might be regulation offences which can be read through to a duty under the Act, or more likely failures to comply with duties such as those of "workers" (section 28), "others" (section 29) and "officers" (section 27). Your office may hold a different legal view, however, scenarios under those sections would be likely sounding boards for Category 3 offences.

I am pleased that LPS's written procedures now incorporate a link to the DPP Guidelines and require that memorandums of advice consider them.

A category 3 offence may be committed by a duty holder with respect to any duty under the WHS Act. My view is that in all workplace death investigations reviewed by LPS, legal officers should consider whether any alleged category 3 offence has been committed by any duty holder, and if so, whether prosecution is the appropriate enforcement action, having regard to the DPP Guidelines.

As stated by the Director, LPS, prosecution may not be the appropriate response to an identified alleged category 3 offence. I acknowledge that in many cases the OFSWQ may choose to address a category 3 offence by way of a regional response and alternative enforcement action. However, in such cases, legal officers should still address in their memorandum of advice that while a prima facie case for a category 3 offence may exist, it is not in the public interest to prosecute or that enforcement action by alternative means was preferred.

[114] Penalty amounts current from 1 July 2015.

8.4 Adequacy of memorandums of advice prepared by legal officers

It is important that persons affected by government decisions understand the reasons for those decisions. Providing reasons for decisions is essential to fairness, ensures transparency and promotes accountability in decision-making. Every decision should be capable of a logical explanation so that a person seeking an explanation can understand how it was reached. This is particularly important when decisions are made about whether a prosecution action should be brought following the completion of an investigation which followed the death of a person.

The quality and adequacy of the memorandums of advice prepared by legal officers for consideration by the Director, LPS are also critical to the reliability of the prosecutorial decision made by the Director, LPS.

The Director, LPS has a demanding role within the OFSWQ and carries a substantial workload. At interview, the Director, LPS stated that the demands of his role mean that he does not have the capacity to review the material on the investigation file and relies significantly on the advice provided by legal officers in making a decision about whether to commence a prosecution.[115] Accordingly, a memorandum of advice from the legal officer which is insufficient or inaccurate may have a significant adverse impact on the quality of prosecution decisions made by the OFSWQ.

All 20 workplace death investigations reviewed during the investigation had an outcome of no further action, meaning that no prosecution action was taken. Accordingly, when assessing the quality of the memorandums of advice prepared by legal officers, a number of factors were taken into consideration. These included:

- whether the memorandum of advice contained sufficient reasons for the Director, LPS to make an informed decision about whether to commence a prosecution
- whether the memorandum of advice addressed whether any person breached a duty under the WHS Act or other legislation
- whether the memorandum of advice addressed why there was insufficient evidence to support a category 1, 2 or 3 offence under the WHS Act having regard to the DPP Guidelines
- if there was sufficient evidence to support a category 1, 2 or 3 offence under the WHS Act, why prosecution was not in the public interest having regard to the DPP Guidelines.

These four factors are grounded on two fundamental principles in the National Compliance and Enforcement Policy:

- transparency – regulators demonstrate impartiality, balance and integrity
- accountability – regulators are willing to explain their decisions and make available avenues of complaint or appeal.

It should be noted, having regard to the following discussion, that the Director, LPS is entitled to rely on the advice of his legal officers in making a decision regarding prosecution and have confidence that the advice he receives is both comprehensive and accurate.

However, in only three cases reviewed during the investigation was it determined that the memorandum of advice to the Director, LPS provided sufficient reasons for the Director, LPS to make an informed decision whether or not to commence a prosecution. This is not to suggest that the decision to take no further action was unsustainable or necessarily wrong in any of the cases reviewed. However, due to the lack of information and reasoning provided in most of the memorandums of advice, it was not possible in most instances to determine the reasons for the prosecution decision that was ultimately made.

Typically, the memorandums of advice reviewed were brief, did not refer to specific evidence, possible breaches or even reference sections of the WHS Act or other legislation where appropriate. Specifically, there was an absence of any analysis about whether a potential breach of a duty may have constituted a category 1, 2 or 3 offence under the WHS Act.[116] Most memorandums of advice provided no analysis about whether a potential breach constituted a potential offence under the WHS Act, and if so, whether a prosecution was appropriate, having regard to the DPP Guidelines.

[115] Interview with the Director, LPS on 5 February 2015, transcript p.8.
[116] Sections 31, 32 and 33, WHS Act.

Some cases did not contain memorandums of advice from a legal officer at all, simply a note from the Director, LPS that there would be no further action. It was also not clear in these cases the reasoning for the decision.

The following three case studies provide examples of some of the common problems identified by the investigation with regard to decision-making within LPS.

Case Study 7 provides an example where the memorandum of advice from the legal officer to the Director, LPS was insufficient. This is a particularly relevant example as in this matter the legal officer did not agree with the recommendation from the region that prosecution action should be taken against the duty holder.

Case Studies 1 and 5 have already been discussed in section 7.2.1 regarding the failure of the regional investigation to identify all relevant breaches of the WHS Act. These two case studies are repeated here as in both of these matters there is no evidence that a legal officer reviewed the investigation before a decision of no further action was made by the Director, LPS. This is particularly relevant given the deficiencies in these investigations identified in Chapter 7.

Case Study 7

The incident

H was an international tourist who died while snorkelling on an organised reef tour.

The prosecution decision

The investigation by the region was of a very high quality. An investigation report was completed which contained a recommendation that a prosecution be brought against the principal duty holder, the dive operator. The recommendation was based on findings of the investigation that:

- there was an absence of an adequate emergency plan for rescue and first aid
- workers were not adequately trained in or holding first aid qualifications
- lookouts were not adequate to identify a snorkeller in difficulty
- staff did not have the necessary skills to undertake the roles assigned to them.

The recommendation was well assembled and argued and dealt with all elements of the potential offences that had been correctly identified.

Following consideration by LPS, a decision was made that no further action would be taken. The memorandum of advice from the legal officer to the Director, LPS provided the following reasons:

> In my opinion on the … facts and evidence it would be extremely difficult to successfully prosecute the obligation holder. The deceased was snorkelling with his wife and then fell behind. His wife was not concerned. He was noticed by the lookout who was not in any way concerned. At no time was he in water where he could not stand up.
>
> The autopsy result would further pose extreme difficulty in any prosecution and I consider it could not be proven that the obligation holder failed to provide, as far as reasonably practicable, that the health and safety of persons for whom the activities are provided are not put at risk by the provisions of the recreational activity.
>
> I recommend that no further investigation is necessary.

The legal officer who formed this view was the same legal officer who had advised the region during the investigation and had been supportive of the region's recommendation to prosecute.

No specific advice was provided to the region about why its recommendation was not accepted, whether there was a problem with the quality of the evidence or whether additional evidence could be gathered.

The memorandum of advice prepared by the legal officer provides that it would be 'extremely difficult to successfully prosecute the obligation holder' on the basis that H was snorkelling with his wife and fell behind, that his wife was not concerned, that H was noticed by the lookout who was not concerned and that H could stand up in the water.

The legal officer also states that the autopsy result would 'pose extreme difficulty in any prosecution'. The autopsy that was undertaken on H determined that the cause of death was drowning, and that H suffered from an enlarged heart and coronary artery disease. These conditions were said to have contributed to, but were not the cause of, H's death.

However, the reasons provided by the region for recommending prosecution of the duty holder in this case related to the inadequate work methods and safe systems of work in place, as well as the lack of adequate training of staff. The investigation report provides the following reasons for recommending prosecution:

> The failures, and therefore contraventions [of the duty holder], are concerned with a lack of adequate water supervision by a competent lookout to effectively identify and monitor snorkellers, staff not being suitably trained, and an ineffective response to an emergency situation. These failures have resulted in persons partaking in snorkelling being exposed to the risk of serious injury or death.

The memorandum of advice from the legal officer does not address any of these alleged breaches or whether any of these breaches constituted a potential offence under the *Safety in Recreational Water Activities Act 2011*.

While the quality, strength and reliability of the evidence gathered by the region may not have supported a prosecution, or alternatively a prosecution may not have been in the public interest, evidence of this is not apparent from the advice provided by the legal officer. It is also not evident why the legal officer was of the view the actions of the dive operator complied with their work health and safety duties, or that any failure to comply did not expose H or any other person to a risk of death or serious injury or illness. These findings are in direct contrast to the recommendation from the region and, at the very least, required some degree of reasoning by the legal officer about why the region's view was incorrect.

In short, there is no rationale about why a well-reasoned and evidence based recommendation was rejected by the legal officer. The Director, LPS approved the legal officer's recommendation of no further action and the case was closed.

The lack of transparency about why this decision was made leaves the Director, LPS open to accusations that they did not properly or adequately carry out their delegated prosecutorial discretion. This accusation is difficult to rebut in the absence of proper analysis and clear reasons for the decision that was made.

Case Study 1

After recording the facts established by the regional investigation, the RIM wrote an advice to the Director, LPS recommending no further action. There is no clear evidence that the file was reviewed by a legal officer and no memorandum of advice was drafted. In making his decision, the Director, LPS appears to have relied on the RIM's recommendation which stated:

> I submit that there is insufficient evidence to demonstrate that any person has a case to answer for the following reasons:
>
> 1. B was not an employee of [the duty holder].
> 2. B owned the shed and container being moved.
> 3. B held a certificate of competency (forklift operator).
> 4. [The duty holder] owned the forklift but could not reasonably be held responsible for the inadvertent manner in which B had operated the forklift at the time of the incident.
> 5. The forklift had been properly maintained and no mechanical faults were found.
> 6. B was operating the forklift at the time of the incident.
> 7. B had placed the containers that he was about to remove in the location some time prior to the time of the incident.
>
> In all the circumstances I therefore recommend that the Director of Legal and Prosecution Services approves that no further comprehensive investigation be undertaken.

The Director, LPS received the advice and noted in a subsequent memorandum that:

> … Due to operator error as he was manoeuvring the forklift it overturned and B was crushed. There is no breach of the *Work Health and Safety Act 2011* identified in relation to this incident occurrence.

It is not clear from the case records whether the Director, LPS made the decision not to prosecute any person for a breach of the WHS Act based solely on the advice from the RIM, or whether in the absence of a memorandum of advice from a legal officer, the Director, LPS undertook a full review of the file including all the evidence gathered during the investigation.

However, in the absence of a comprehensive review and memorandum of advice from a legal officer, there is no analysis or assessment about:

- the evidence gathered during the investigation
- whether there was any breach of the WHS Act by the duty holder and whether any offence had been committed
- whether there was a reasonable prospect of conviction and whether prosecution action was in the public interest.

This prosecution decision fails to comply with the two fundamental principles of accountability and transparency set out in the National Compliance and Enforcement Policy.

Case Study 5

There is no evidence of any memorandum of advice from a legal officer on the file and no written decision by the Director, LPS regarding the prosecution decision.

The only evidence that the case was considered by any person in LPS to determine whether a prosecution was warranted is a note made by the Director, LPS on a Data Entry Approval Form which states:

> There is no evidence to base any finding of a failure by any person.

In Case Study 5, there is no evidence that there was any consideration by either a legal officer or by the Director, LPS, about whether any offence had been committed by any person under the WHS Act. The Director, LPS provided the outcome of the prosecution decision on a database form, but it is not clear on what basis this decision was made, or who within LPS reviewed the outcome of the regional investigation before this decision was made.

This prosecution decision fails to comply with the two fundamental principles of accountability and transparency set out in the National Compliance and Enforcement Policy.

With respect to the quality of the memorandums of advice prepared by legal officers, the Director, LPS stated at interview that he had recently implemented templates requiring legal officers to complete a preliminary opinion on the evidence following the first response, and a final advice to the Director, LPS on the evidence, including a recommendation regarding prosecution following their assessment of the completed investigation.[117]

The preliminary opinion template is intended to be provided to the RIM, and offer advice to assist the progress of the investigation, including:[118]

- confirmation of jurisdiction
- potential breaches identified and further breaches that may be considered
- any identified gaps in evidence
- the need for expert advice
- whether the matter is one where investigation should continue.

The final advice on evidence and prosecution template is intended to be provided to the Director, LPS as formal advice about the investigation and includes:[119]

- the factual nature of the matter investigated
- the evidence gathered and considered by the region
- what breaches have been identified
- any difficult legal or evidentiary issues identified
- a recommendation about whether any prosecution should occur and an opinion about the gravity of the alleged offence
- advice about whether there is any divergence between the regional recommendation and the legal officer's recommendation.

The level of detail required in the final advice template appears directed towards matters where a prosecution is recommended, although the template also requires legal officers, in matters where no further investigation is recommended, to discuss any potential breaches and why prosecution is not warranted. In cases where an offence is identified, the template requires legal officers to provide reasons why prosecution is not recommended.

These templates, if used correctly and consistently by legal officers, should considerably improve the quality of advice provided to the Director, LPS regarding whether to commence prosecution action following a workplace death investigation.

Opinion 9

Memorandums of advice prepared by legal officers do not provide clear and sufficient reasons to allow the Director, LPS to make an informed decision about whether to commence a prosecution. This is unreasonable administrative action for the purposes of s.49(2)(b) of the Ombudsman Act.

[117] Interview with the Director, LPS on 5 February 2015, transcript pp.10-11.
[118] OFSWQ, *LPS written advices procedure*, p.2.
[119] OFSWQ, *LPS written advices procedure*, pp.3-4.

JAG's response to Opinion 9

The Director-General accepted my opinion.

The Director, LPS's response to Opinion 9

In response to the proposed report, the Director, LPS advised:

> Since formal record of interview with your investigators, all legal officers must prepare memoranda in accordance with the templates.
>
> The investigation found if the templates are used correctly and consistently then there should be considerable improvement.

I am pleased that the Director, LPS now requires officers to use the templates he has implemented to draft their memorandums of advice. I acknowledge the efforts of the Director, LPS to improve the quality of these memorandums within LPS.

Recommendation 8

The Under Treasurer:

8.1 require that all memorandums of advice provided to the Director, LPS by a legal officer about whether to commence a prosecution, following a workplace death investigation, include an assessment of the following:

(a) whether there is sufficient evidence to prove that a duty holder breached a duty under the WHS Act or other legislation

(b) whether there is sufficient evidence to successfully prosecute a category 1, 2 or 3 offence under the WHS Act, or an offence under another Act

(c) whether prosecution for any offence is in the public interest.

8.2 implement a quality assurance process to periodically review the quality of the memorandums of advice prepared by legal officers for consideration by the Director, LPS.

JAG's response to Recommendation 8

In response to the proposed report, the Director-General advised:

> Agreed. A policy requiring (1) mandatory preliminary advice at the early stage of the investigation, including review of any jurisdictional questions and (2) a comprehensive memo of advice including at least that indicated has been implemented. Quality assurance of this will be addressed by an independent area, Inspectorate Governance.

The Director, LPS's response to Recommendation 8

In response to the proposed report, the Director, LPS advised:

> In relation to Proposed Recommendation 8, legal officers are to comply with the written advices procedure and in each matter are to provide a preliminary opinion and later a final advice within allocated time frames. The templates and procedure provided to your investigators have been modified to canvass this recommendation. Use of the preliminary opinion template will ensure that in reasonable time possible duty holders and breaches will be identified. Once investigation is complete, a properly constructed final advice will facilitate better informed decision making.
>
> The quality of memoranda will be more easily reviewed. If a memorandum does not provide clear and sufficient reason to allow informed decision making, the matter will be discussed, and, if necessary, referred back to the legal officer.
>
> If there are any briefings/discussions/conferences between the director and legal officer same is to be documented in file notes.

8.5 Adequacy of current delegations and processes within LPS

Prosecution action for an offence under the WHS Act or other legislation is the most significant enforcement tool available to the OFSWQ particularly for the most serious of alleged breaches. However, a death is the most critical event that can occur at a workplace and each instance requires careful consideration by the OFSWQ to determine whether a potential offence under the WHS Act occurred, and if so, whether prosecution of the alleged offence is appropriate.

The quality and effectiveness of the OFSWQ's regulatory response to a workplace death relies significantly upon the adequacy of review and decision-making by LPS. This investigation has determined that a key aspect of the decision-making by LPS is the memorandum of advice provided by legal officers for the Director, LPS about whether to commence prosecution action. This investigation identified significant issues with the quality of these advices, although it is acknowledged that the Director, LPS has identified some of these issues and has taken some steps to remedy them.

My most significant concern following review of each of the memorandums of advice in the file review is that, in all but three cases, it was not possible from the information provided to reach a clear understanding of why the OFSWQ determined not to commence prosecution action. While prosecution may not have been the appropriate response in all the cases reviewed, most memorandums of advice failed to particularise or demonstrate why this was the case. In other cases, there was no evidence that any review of the file had even occurred by any person in LPS before a decision not to prosecute was made.

These deficiencies represent a critical issue for the OFSWQ to address, as the quality and comprehensiveness of the memorandums of advice prepared by legal officers on a workplace death investigation are essential to the ultimate OFSWQ regulatory outcome. The Director, LPS indicated at interview that due to workload pressures he is unable to independently review each workplace death investigation before making a decision regarding whether to commence a prosecution.[120] As a consequence, the Director, LPS substantially relies on the quality and accuracy of the advice provided by the legal officer.[121] Based on the quality of the memorandums of advice reviewed during the investigation, it is not clear how the Director, LPS is able to rely solely on this advice in the absence of further verbal briefings, evidence of which is not apparent in the file records.

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[120] Interview with the Director, LPS on 5 February 2015, transcript pp.10-11.
[121] Interview with the Director, LPS on 5 February 2015, transcript p.10.

While this report has been critical of aspects of LPS, it should be noted that the Director, LPS has a demanding role. At interview, the Director, LPS stated that he is required to deal with many matters relating to the business of the OFSWQ in addition to his role as the delegated decision-maker for prosecutions and that this aspect of his role took up a considerable amount of his time.[122]

The role of the decision-maker tasked with determining whether to prosecute an alleged offence relating to a workplace death or serious injury is significant and critical to ensuring that the OFSWQ upholds its role to enforce compliance with the WHS Act. The person tasked with this responsibility should have the capacity to thoroughly consider the circumstances of each case, review the relevant evidence and gather sufficient knowledge to adequately discharge their delegation.

Opinion 10

A review of LPS is required to ensure its continued capacity to manage the volume and range of work it is expected to perform.

JAG's response to Opinion 10

The Director-General accepted my opinion.

Recommendation 9

The Under Treasurer engage an independent person (preferably a senior legal practitioner) to conduct a comprehensive review of LPS, addressing each of the following matters:

(a) the adequacy and appropriateness of the current LPS model

(b) whether the current delegation to commence a prosecution for an offence under the WHS Act or other legislation is appropriate

(c) the adequacy of prosecution decisions made with respect to a workplace death

(d) the adequacy of memorandums of advice prepared by a legal officer for consideration by the Director, LPS with respect to a workplace death investigation

(e) the adequacy of current resourcing and training provided to legal officers relevant to the requirements of their role

(f) the timeliness of decision-making.

[122] Interview with the Director, LPS on 5 February 2015, transcript p.6.

JAG's response to Recommendation 9

The Director-General accepted my recommendation.

The Director, LPS's response to Recommendation 9

In response to the proposed report, the Director, LPS advised:

> If the Director-General accepts proposed recommendation 9, then a comprehensive review of LPS by a senior legal practitioner, preferably with a criminal/prosecution background would be appropriate. Such a review would consider the variety of work done in LPS, including matters prosecuted where complaints & summonses are drafted by legal officers, prosecution at trial and sentence by legal officers, appeal work involving drafting outlines, submissions, appearing/instructing counsel, including silk.
>
> Your office's investigation did note that the director has a demanding role and in addition to having to consider in excess of 700 matters per year as to prosecution, must also provide other legal advice. The director also appears in court on some of LPS's more important matters, generally appeals, usually against silk.
>
> It might be the role of LPS would be enhanced if the director was placed in a "Senior Director" position and had the support of a deputy at SO1 level. This would assist in administrative monitoring and organisation. That, of course, is probably more in the province of the OFSWQ's Senior Executive Service as opposed for a matter for your office's investigation.

While the selection of a senior legal practitioner to lead the review of LPS is a matter for the Under Treasurer, the suggestion by the Director, LPS that the person have experience described is reasonable.

As indicated in the recommendation, the review of LPS should be comprehensive, addressing, at minimum, the six matters listed in the recommendation. Subsection (a) states the review should address the adequacy and appropriateness of the current LPS model. I anticipate that this would include the functioning of, and roles performed by LPS generally, which would include the matters identified by the Director, LPS.

Chapter 9: Liaison with next of kin

This chapter discusses the investigation outcomes of the OFSWQ's liaison and involvement with next of kin during a workplace death investigation. This chapter will also discuss how the OFSWQ interprets and applies the review procedure set out in s.231 of the WHS Act, which provides that any person, including next of kin, may request that a prosecution be brought under the WHS Act.

9.1 Liaison with next of kin during investigations

Liaison with next of kin during a workplace death investigation is the responsibility of the Coronial Liaison and Investigations Support Services Unit (CLU) within the OFSWQ.

Following a workplace death, it is the responsibility of the CLU to ensure the deceased's next of kin is provided with timely and factual information about the investigation process. This includes providing information about probable timeframes, possible outcomes, how the next of kin can be involved and remain updated while the investigation is progressing and any statutory rights of review the next of kin may have if they do not agree with the outcome of the regulatory decision. It is also the responsibility of the CLU to ensure that next of kin are provided with information regarding the outcome of the investigation, including the findings of the investigation report and information about why a specific decision was made in relation to enforcement proceedings.

The first contact with a next of kin following a workplace death is generally by way of a phone call by an officer from the CLU. The purpose of this contact is to provide a brief overview of the role of the OFSWQ and to provide the details of the nominated liaison officer so the next of kin have a contact point for information about the investigation process.

Within a week following a workplace death, a letter is usually sent to the deceased's next of kin attaching the factsheet '*A death in the workplace: A guide for family and friends*.' The letter and factsheet explain in greater detail the role of the OFSWQ, QPS, the coroner and unions following a workplace death and provides a brief explanation of the investigation and prosecution process and relevant superannuation, worker's compensation and insurance information.

Following this initial contact, the CLU maintains contact with the next of kin throughout the course of the investigation providing information about the progress of the investigation. The degree of contact during the investigation process depends largely on the wishes of the next of kin and how much information they have asked to receive.

When a decision has been made by the Director, LPS about whether to prosecute any duty holder as a result of the workplace death investigation, the CLU will contact the next of kin to provide notification of the decision, and if requested, provide information about why the decision about prosecution was made. Next of kin are usually provided with a copy of the investigation report if they request it.

In instances where a matter is proceeding to prosecution, the CLU will provide support to the next of kin during the court process. If a matter is not proceeding to prosecution, the next of kin are provided with reasons why this decision was made. In some circumstances, the Director, LPS will also meet with the next of kin to further explain that decision.

9.2 Next of kin contact outcomes

In reviewing the quality of the OFSWQ's liaison with next of kin during a workplace death investigation, the investigation considered two key issues, whether:

- there was evidence of appropriate contact with next of kin during the investigation, and
- appropriate information about the outcome of the investigation was provided to the next of kin following the decision not to prosecute.

9.2.1 Contact with next of kin during the investigation

The assessment as to whether the OFSWQ's contact with the next of kin during the investigation was appropriate is based on whether evidence existed that:

- there was contact initiated by the OFSWQ with the next of kin following the workplace death, including either phone contact by the CLU or a letter

- next of kin who contacted the OFSWQ about the investigation were provided with clear, timely and consistent information
- next of kin were provided with factual information about the progress of the investigation, range of outcomes and timeframes
- undertakings or commitments given to next of kin were followed through.

In six cases, it was assessed that contact with the next of kin was appropriate. In each of these six cases, there was some evidence of contact with the deceased's next of kin following the workplace death in order to provide information about the investigation process. There was also some evidence in each case of sufficient contact with the next of kin throughout the investigation.

In four of these cases, the next of kin were heavily involved in the investigation process and raised concerns and additional evidence about safety at the workplace where the death occurred. The CLU provided this additional evidence to the relevant investigators and in most cases it appears to have been addressed as part of the investigation. In one case, the next of kin's concerns about safety issues at the workplace were addressed at a meeting between the OFSWQ and the next of kin.

In the remaining 14 cases, the investigation found that contact by the OFSWQ with the next of kin was unsatisfactory. In the majority of these cases, there was no evidence of any meaningful contact with the next of kin, either immediately following the workplace death, or during the investigation. Other cases were assessed as unsatisfactory because there were significant issues with the quality of the contact by the OFSWQ.

Case Study 2 is one such example of contact that was unsatisfactory.

Case Study 2

<u>The incident</u>

C was a passenger on a commercial airline flight who tripped down the stairs while disembarking and hit his head on the concrete tarmac. C later died in hospital from his injuries.

<u>OFSWQ contact with next of kin</u>

C's son made multiple contacts with the CLU to attempt to determine when the investigation report would be completed. The CLU provided the most accurate and up-to-date advice it had available from the regional investigators, but continual delays in the investigation meant that the notified timeframes were not met. The delays in completing the investigation, the inability of OFSWQ to keep to advised timeframes and failure to take a proactive approach to advising of further delays caused significant distress to C's son who emailed the OFSWQ with the following concerns:

> I understand these things are never easy and do take time … I have sent numerous emails asking for answers and I am told we will get answers in a few weeks then it never happens. Please understand my frustration with this. The family and Mum in particular just want some closure. I have attached all the emails along with all the responses I have got for the last 6 months. I have heard of these things taking years however the most frustrating thing is consistently being told it will be in a couple of weeks then it just never happens. What makes this worse is I then have to be the one to call or email you guys when it doesn't happen.

While responsibility for the continual failure to meet advised completion timeframes lies with the regional investigators, it is the responsibility of the CLU to ensure that next of kin are provided with the most up-to-date timeframes regarding when they can expect advice about the outcome of an investigation. While the CLU responded appropriately and in a timely manner to requests for information from C's next of kin, there was no attempt to proactively contact C's next of kin to inform them that previously advised timeframes would not be met.

With Case Study 2, it was not the delays in completing the investigation that caused the most frustration for C's next of kin, but rather the OFSWQ's failure to keep them advised of changes to investigation timeframes so that when further delays occurred, they had to follow up with the OFSWQ seeking further advice.

The Manager, CLU was interviewed as part of this investigation. The Manager, CLU acknowledged the lack of evidence regarding next of kin contact in the majority of the cases reviewed and advised that inadequate recordkeeping systems were in place during the period reviewed by the investigation.[123] The recordkeeping systems that were in place during the relevant period were also not accessible to all OFSWQ staff.[124] The Manager, CLU advised that the email records (from the OFSWQ officer who was the next of kin contact for the majority of the cases reviewed) were currently unable to be accessed.[125]

To address these issues, the Manager, CLU advised that a new recordkeeping system has recently been put in place to ensure that all contact with next of kin during a workplace death investigation is recorded and easily accessible.[126] This system involves a running sheet which is mandatory for each file, and includes a record of all significant telephone contact with next of kin including a record of the information provided.[127] None of this information was available for the cases reviewed during the investigation.

This system, if used appropriately by OFSWQ officers, should ensure that a more comprehensive record of next of kin contact by OFSWQ is available for future workplace death investigations.

9.2.2 Provision of advice to next of kin about the outcome of the investigation

The assessment about whether advice was provided to the next of kin about the outcome of an investigation is based on whether there was evidence of advice from the OFSWQ about the outcome, including whether the matter would proceed to prosecution, whether an alternative regulatory response would be undertaken, or whether no further action would be taken.

The investigation found minimal evidence that next of kin were provided with advice about the outcome of an investigation. In only four of the cases reviewed, it was determined that the information provided by OFSWQ to next of kin about the outcome of the investigation was appropriate. In these four cases, next of kin were provided with a copy of the investigation report and advised that they had the right under the *Right to Information Act 2009* to make an application for the entire investigation file.

There was no written advice provided to next of kin in any of the cases reviewed regarding the prosecution decision by the Director, LPS, particularly about why no prosecution action was being taken.

The Manager, CLU stated at interview that depending on the circumstances of the case, there may be a meeting with next of kin to discuss the details of the investigation and why prosecution action was not being taken.[128] The Director, LPS also stated at interview that if required, he attends meetings with next of kin to discuss the prosecution decision.[129]

Section 9.2.1 discussed how poor recordkeeping impacted on the quality of evidence available about the degree of contact with next of kin. While these recordkeeping issues may also have impacted on the availability of evidence about whether outcome advice was provided to next of kin, there were cases reviewed during the investigation where the next of kin were clearly not advised about the outcome of an investigation.

For example, in Case Study 7 the Director, LPS rejected a recommendation from the region to commence a prosecution against the duty holder for breaches of the *Safety in Recreational Water Activities Act 2011* with respect to the death of H, who drowned while snorkelling on an organised reef tour.

There is no evidence H's wife was informed about the prosecution decision.

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[123] Manager, CLU, email, 4 February 2015.
[124] Manager, CLU, email, 4 February 2015.
[125] Manager, CLU, email, 4 February 2015.
[126] Interview with the Manager, CLU on 3 February 2015, transcript p.37.
[127] Interview with the Manager, CLU on 3 February 2015, transcript p.37.
[128] Interview with the Manager, CLU on 3 February 2015, transcript p.24.
[129] Interview with the Director, LPS on 5 February 2015, transcript p.49.

Case Study 7

Contact with next of kin

H's wife contacted OFSWQ seeking advice about issues that had been raised at a coronial inquest in her own country of residence, but also requested advice about whether a prosecution would be commenced as a result of her husband's death. The Director, LPS had made the decision not to prosecute nearly two months earlier. It was clear that H's wife had not been provided with this information.

Waiting for a decision about whether a prosecution will be brought following the death of a relative at a workplace is stressful. It is important that next of kin are not only provided with advice about a prosecution decision as soon as possible after it is made, but also that they are given reasons for the decision. It was not apparent from the investigation that these tasks are being adequately undertaken by the OFSWQ.

Opinion 11

Written advice provided to next of kin does not adequately communicate the outcome of an investigation and reasons for the decision not to prosecute any person for an offence. This is unreasonable administrative action for the purposes of s.49(2)(b) of the Ombudsman Act.

JAG's response to Opinion 11

In response to the proposed report, the Director-General advised:

> Not agreed.
>
> This opinion does not consider the complexity of NOK [next of kin] liaison …
>
> …
>
> A dedicated position of Investigation Liaison and Support Officer (ILSO) exists within the Coronial Liaison Unit (CLU) and has done for approximately 5 years. The main responsibilities of the role are:
>
> - establishing and maintaining an effective relationship with family members impacted by workplace death and serious injury with a view to ensuring they are sufficiently apprised of the status of investigations;
> - highlighting the potential to access external counselling services; and
> - identifying issues affecting the quality of the OFSWQ's investigation activity and developing solutions to such issues and, where nominated, taking responsibility for implementation of such solutions.
>
> It is the OFSWQ's understanding that no other Queensland regulator responsible for the investigation of workplace deaths or serious incidents have such robust and well established processes for contact with NOK.
>
> In the 5 years since commencement of this initiative, and through contact with in excess of 100 NOK, varied expectations of NOK have been experienced. The stages and cycles of grief are extremely complex and there is no "typical" response to the loss of a loved one. Some family members focus on the prosecution process; others are satisfied upon securing a coronial inquest and others simply want to be contacted when the investigation is complete. In stark contrast, some NOKs are not interested in ongoing contact with OFSWQ; or actively argue against the regulators involvement; or seek that a prosecution or inquest not be commenced.
>
> Once a prosecution decision has been made, the OFSWQ provides information about the decision to NOK verbally, either face to face or over the telephone. In the event that the NOK are seeking further information after being advised of the decision the NOK are offered (and in all

situations have accepted) a meeting face to face (or in some instances via phone). This meeting is organised, and attended by the ILSO, the Principal Legal Officer and the Director, Legal and Prosecution Services. During this meeting the NOK are able to ask any questions that they may have in relation to the decision. It is the OFSWQ's view that this interaction is far more important and more personal than formal correspondence which can be clinical, legalistic and misinterpreted.

The OFSWQ understands the needs and expectations of NOK can be variable and complex and that a blanket approach that does not adequately consider the wishes of each NOK would be unhelpful and in some cases cause additional stress and angst to people already navigating through a traumatic and difficult period.

The Director-General also advised that to ensure that the OFSWQ continues to meet the needs and expectations of next of kin, the following initiatives have been commenced:

- The OFSWQ has commissioned the Work and Health Research Team at the Faculty of Health Sciences, University of Sydney, to conduct research to determine the expectations, experiences and outcomes of persons who have been significantly impacted by a workplace death in Queensland. The research will include consultative forums with next of kin as well as research into the expectations, experiences and outcomes of persons who have been impacted by a workplace death.
- The OFSWQ hosted a *Families Forum* on 2 June 2015 for next of kin and other family members impacted by a workplace death or serious injury. The aim of the forum was to identify areas for improvement across the whole-of-government when responding to, investigating and supporting families following a workplace death or serious injury. A working group was established to develop prospective models and options for an ongoing Families Consultative Forum.
- The OFSWQ has established the *Serious Workplace Incidents (Government) Interagency Group* (SWIIG) to ensure a consistent, appropriate and comprehensive whole-of-government response to serious and fatal workplace incidents by all agencies involved in the investigation of such incidents and in providing support to next of kin. It is proposed that SWIIG will lead the development of a whole-of-government information kit for those affected by a workplace death or serious injury as well as a stocktake of counselling services currently available for affected families and those impacted by a workplace death or serious injury.

The Director-General's response describes a comprehensive strategy for liaison and communication by the OFSWQ with next of kin during a workplace death investigation. This information corresponds with evidence provided by relevant OFSWQ officers during my investigation. I welcome the initiatives that have been implemented by the OFSWQ to enhance engagement and communication with next of kin affected by a workplace death.

I acknowledge that verbal contact with next of kin (either face to face or by phone) to advise about the outcome of a workplace death investigation is an appropriate approach. However, there was minimal evidence of such verbal contact with next of kin in the file review, with only four cases demonstrating sufficient evidence of contact. However, as acknowledged in the report, it is possible insufficient record keeping by OFSWQ officers about their contact with next of kin may have contributed to this. The OFSWQ has advised it has taken steps to address this record keeping issue.

I am of the view that written advice about the outcome of an investigation should also be provided to next of kin, after OFSWQ officers have verbally communicated the decision. There was no evidence of any written advice provided to next of kin about an investigation outcome in any of the 20 cases in the file review. Written advice would promote transparency and accountability in decision-making, in that the reasons for the decision to take no further action would be clearly set out, and next of kin would have the opportunity to consider the reasons in detail before deciding whether to take any further action (such as an application for review by the DPP under s.231 of the WHS Act). Written advice may also assist next of kin in seeking further specific information about the investigation should they decide to meet with

representatives of the OFSWQ.

I remain of the opinion that it is unreasonable administrative action for the OFSWQ to provide no written advice of an investigation outcome to next of kin. This opinion does not preclude verbal advice being provided by the OFSWQ to next of kin before any formal written correspondence is provided.

Recommendation 10

The Under Treasurer implement a process, in cases finalised as 'no further action', to ensure that next of kin are provided with timely written advice regarding the outcome of the investigation and the reasons for the decision not to prosecute any person for an offence under the WHS Act or other legislation.

JAG's response to Recommendation 10

In response to the proposed report, the Director-General advised:

> Partially agreed.
>
> OFSWQ agrees that NOK should be provided with timely written advice regarding the outcome of the investigation and the reasons for the decision not to prosecute any person for an offence under the safety laws it administers, however, this should be restricted to NOK that have requested or indicated a desire for this information.

I agree that next of kin who have indicated to the OFSWQ that they do not wish to have any contact, or receive any information about the investigation, should not be provided with written advice about the investigation outcome.

However, in circumstances where the OFSWQ has liaised and communicated with next of kin during an investigation and has provided verbal advice about the investigation outcome, I remain of the view that written advice should be provided.

9.3 Request for prosecution under s.231 of the WHS Act

In certain circumstances, s.231 of the WHS Act provides a person with the ability to make a written request to the OFSWQ that a prosecution be brought for certain offences under the WHS Act. If the OFSWQ decides against bringing a prosecution, s.231 provides that the person may request that the matter be reviewed by the DPP.

Section 231 of the WHS Act is intended to promote accountability by regulators for their decisions, generally the decision not to prosecute.[130] Under s.231 a person who reasonably considers that a particular action or inaction constitutes a serious breach of a duty owed (a category 1 or 2 offence) under the WHS Act may make a written request that a prosecution be brought. A request under s.231 may only be made between 6 and 12 months after the date of the incident.[131]

Within three months after receiving the request, the OFSWQ must advise the applicant whether the investigation is complete and whether a prosecution will be brought.[132] If a prosecution is not going to be brought, the OFSWQ must advise the applicant they may request the matter be referred to the DPP.[133] If the applicant requests the matter be referred, the OFSWQ must refer the matter to the DPP[134] and the DPP must consider the matter and advise within one month whether the DPP considers that a prosecution should be brought.[135]

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[130] National Review into Occupational Health and Safety Laws, Second Report to the Workplace Relations Ministers' Council, January 2009, p.433.
[131] Section 231(1)(b), WHS Act.
[132] Section 231(2)(a), WHS Act.
[133] Section 231(3)(a), WHS Act.
[134] Section 231(3)(b), WHS Act.
[135] Section 231(4), WHS Act.

The OFSWQ has a written procedure that contains a template request form and a collection of template letters to implement s.231 requests.[136] However, the procedure is silent about what might happen if a review request is received outside of the six month statutory time limit. Not one of the OFSWQ officers who were asked at interview was able to indicate if a request would be rejected if it was out of time. This is an important issue because the investigation found that the OFSWQ would in many cases not have completed its investigation by the expiration of the review period. Accordingly, by the time a decision was made not to bring proceedings for a breach, the six month review timeframe would have ended.

The investigation also found considerable problems with the OFSWQ's interpretation and application of s.231.

9.3.1 Advice provided to next of kin about s.231 of the WHS Act

Section 231 of the WHS Act has had very limited use since the commencement of the WHS Act on 1 January 2012. In that time, only three requests have been received by the OFSWQ.[137] One of these requests was in regard to an incident arising under the repealed *Workplace Health and Safety Act 1995*, which did not contain a similar section to s.231 of the WHS Act. The OFSWQ mistakenly referred this matter to the DPP and it was subsequently returned. Neither of the remaining two requests were referred to the DPP by the OFSWQ.[138] Accordingly, the DPP has not considered a s.231 request since the commencement of the WHS Act.

One likely reason why s.231 has been underutilised is that potential applicants are not aware the provision exists. The OFSWQ website contains information that a person can request that the OFSWQ commence a prosecution under the 'Laws and Compliance', 'Prosecutions' link.[139] The information on the website may assist someone to make an application under s.231 provided they are able to locate the page.

The OFSWQ operational procedure also provides that a person may make a specific request in writing that a prosecution be brought under s.231, or alternatively if a person does not specifically refer to s.231, it must be apparent the person is requesting that a prosecution be brought.[140] The operational procedure also provides that if a person requests reasons why OFSWQ is not intending to commence a prosecution, the OFSWQ will respond to the request by referring the person to s.231 of the WHS Act.[141]

The operational procedure does not provide any guidance about how or when applicants should be advised about the review right under s.231. The OFSWQ appears not to take any proactive steps to advise affected persons or next of kin about the existence of the section, or how an application under s.231 should be made.

The investigation found that the OFSWQ did not take adequate steps to advise next of kin about the right of review under s.231. The investigation also found that the OFSWQ on occasion failed to properly assess statements, both verbal and written, made by next of kin to officers as being comments that indicated their view that proceedings for a breach should be brought. This is despite the OFSWQ operational procedure requiring that such statements be considered as possible s.231 applications.

One example from the investigation where the OFSWQ clearly failed to respond to a query by a next of kin about why a prosecution was not brought is Case Study 10.

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[136] OFSWQ, *Operational Procedure: Request for a prosecution to be brought.*
[137] Director, Work Health and Safety Compliance, email, 5 January 2015.
[138] Director, Work Health and Safety Compliance, email, 5 January 2015.
[139] OFSWQ, *Request that the regulator commences a prosecution*, accessed 8 April 2015, https://www.worksafe.qld.gov.au/laws-and-compliance/prosecutions/request-that-the-regulator-commences-a-prosecution.
[140] OFSWQ, *Operational Procedure: Request for a prosecution to be brought*, p.2.
[141] OFSWQ, *Operational Procedure: Request for a prosecution to be brought*, p.2.

Case Study 10

The incident

L was a factory worker who was found in a dazed state in a warehouse after working to move material from the ground to a mezzanine floor using a ladder. L later died in hospital from suspected head injuries.

Contact with next of kin

L's wife received notification from OFSWQ that prosecution would not be brought following the OFSWQ investigation. In response, L's wife submitted a complaint to the Attorney-General and Minister for Justice regarding the quality of the OFSWQ investigation. The complaint raised a number of issues and potential breaches L's wife considered had not been adequately investigated.

While the OFSWQ responded appropriately to the specific issues raised by L's wife regarding these potential breaches, it did not provide any advice regarding the existence of s.231 or that she had a statutory right to have the decision not to commence a prosecution referred to the DPP for review. This is despite clear concerns being raised by L's wife about breaches that were not adequately addressed by the OFSWQ in its investigation and why these breaches did not result in a prosecution.

Good administrative practice requires that potential applicants who are likely to be adversely affected by a decision not to institute proceedings should be advised of their statutory right to request a review of that decision. This can be done at various stages throughout the investigative process, perhaps initially in the information brochure and letter which is sent to the next of kin following commencement of an investigation, and again a month before the commencement of the request window and perhaps prior to the expiration of that period.

9.3.2 The OFSWQ's interpretation of the requirements of a s.231 application

The investigation identified a significant issue with the way the OFSWQ interprets the reasonable belief test required by s.231(1)(a). This issue was identified in Case Study 16, where a s.231 request was made by the deceased's (R's) next of kin. This was the only instance in the cases reviewed where OFSWQ did advise the next of kin about their rights under s.231.

Case Study 16

The incident

R was a field officer at a remote station who died after attempting to walk back to the station in temperatures in excess of 47 degrees Celsius after his car became stuck on a sand dune.

Contact with next of kin

During the investigation, R's next of kin made a specific query to the OFSWQ about their options if the OFSWQ decided not to bring a prosecution. The OFSWQ advised R's next of kin about their review right under s.231. Following this advice, R's next of kin provided a written application under s.231, stating they wished the OFSWQ to bring a prosecution against R's employer, and if a prosecution was not brought, that the matter be referred to the DPP for consideration. At the time this application was made, the OFSWQ investigation was incomplete, but it was made within the required statutory period, that is, after six months but not more than 12 months following the incident.

To support their application, R's next of kin provided details of the employer as well as a number of persons they believed had breached duties owed under the WHS Act and provided considerable supporting documentation about the conduct of persons they believed had adversely contributed to the incident.

The OFSWQ responded to the application by advising:

> In respect to each, the offence category, relevant act(s), omission(s) or duty said to be held by the nominated duty holders have not been identified by you. Further for each person you have not identified how their act or omission (conduct) has exposed a person to a risk of death or serious injury.
>
> As these matters have not been identified I do not consider you have satisfied section 231(1)(a) of the Act.
>
> I do note that some of the material you have forwarded refers, in part, to particular acts or omissions of particular persons. However the manner in which the material and argument is presented does not make it possible to clearly attribute particular acts or omissions to particular persons at particular times.

The letter went on to state that because of these issues, the s.231 request was not valid. The matter was not referred to the DPP following the decision not to commence a prosecution.

This approach suggests the OFSWQ holds the view that it is the relevant decision-maker about whether a person holds a reasonable opinion that a category 1 or 2 offence has been committed, and if it is not so satisfied, is entitled to regard the request as not having been validly made. As occurred in Case Study 16, this approach means the request is not referred to the DPP as required by s.231(3)(b), and there is no independent review of the decision.

There are a number of difficulties with the OFSWQ's interpretation and the level of detail required by the OFSWQ in order to constitute a valid request.

Firstly, it appears that s.231(1)(a) refers to the reasonably held view of the potential applicant, not the OFSWQ's assessment of whether the view is reasonably held or not. OFSWQ officers confirmed that no legal advice had been obtained with respect to this aspect of s.231(1)(a).

Further, the OFSWQ's view that R's next of kin had not satisfied s.231(1)(a) in this instance was unreasonable, as R's next of kin had provided the OFSWQ with a 39 page statement to support their s.231 application. This statement was assembled by R's next of kin following a visit to R's workplace and the incident scene and also discussions with the police officers who had attended the incident. The statement clearly identifies the next of kin's concerns with the duty holder's work health and safety methods and identifies why they believed these deficiencies contributed to R's death.

Secondly, the level of detail required by the OFSWQ in Case Study 16, before it would consider that a valid s.231 request had been made, generally far exceeded the detail of investigative work undertaken by the OFSWQ in the cases reviewed during the investigation. The investigation found in many cases,

especially in instances of multiple duty holders owing multiple duties, that investigation reports did not demonstrate such a degree of expertise or assembly.

It is not reasonable for the OFSWQ to expect next of kin, or other potential applicants, to demonstrate a level of competency equal to or greater than that demonstrated by its own officers.

Thirdly, the OFSWQ s.231 template request form, which was not used by the next of kin in Case Study 16, also does not specify or require such a considerable level of detail to support the application. The OFSWQ's website, while containing information about how to make a request for prosecution under s.231, does not provide any information that would suggest to potential applicants that a s.231 application needs to include evidence to establish how an act or omission by a duty holder or duty holders exposed a person to a risk of death or serious injury.

The website simply provides that a s.231 application should set out the facts of the event, including:[142]

- the date
- the place
- the names of the people concerned
- the nature of the offence the applicant believes has occurred
- the identity of the person the applicant believes has committed the offence
- the applicant's contact details
- a statement or other information in support of the applicant's request (if the regulator asks the applicant to provide one).

The website provides no suggestion that the failure of a person making a s.231 request to provide certain information in a particular way will result in the OFSWQ determining that the request has not been validly made.

It is difficult to see how a potential applicant could gather the degree of information required by the OFSWQ within the statutory timeframe, especially in the absence of a completed investigation report. At the time the s.231 application was made in Case Study 16, an investigation report had not been completed by the OFSWQ and no information had been provided to R's next of kin about the potential breaches that had been considered as part of the investigation. R's next of kin relied on their own inquiries to make their s.231 request.

Finally, the response by the OFSWQ to the s.231 application by R's next of kin was unnecessarily legalistic and lacking in compassion for a family that was clearly mourning the death of a loved one and attempting to understand the cause of the death.

The OFSWQ also provided little practical assistance to R's next of kin either in making their initial application, or in making a second application after the first application had been rejected. This was despite R's next of kin making a specific request for assistance from OFSWQ after their application had been rejected. There is no evidence that the OFSWQ responded to this request and it appears that R's next of kin did not make a second application.

The OFSWQ subsequently decided not to commence a prosecution.

Opinion 12

Inadequate advice is provided to next of kin regarding their right to request a prosecution under s.231 of the WHS Act. This is unreasonable administrative action for the purposes of s.49(2)(b) of the Ombudsman Act.

[142] OFSWQ, *Request that the regulator commences a prosecution*, accessed 17 March 2015, https://www.worksafe.qld.gov.au/laws-and-compliance/prosecutions/request-that-the-regulator-commences-a-prosecution.

JAG's response to Opinion 12

In response to the proposed report, the Director-General advised:

> Agreed.
>
> The advice provided to NOK is consistent with other harmonised jurisdictions. However OFSWQ agrees that all potential applicants, not just NOK, should be provided with more detailed information on what they need to provide to adequately satisfy the onerous requirements of section 231.

Opinion 13

Requiring a person making a s.231 application to identify the relevant offence category, act, omission or duty, and how a duty holder's actions have exposed a person to a risk of death or serious injury, is unreasonable administrative action for the purposes of s.49(2)(b) of the Ombudsman Act.

Opinion 14

The action taken by the OFSWQ in Case Study 16 with respect to:

(a) determining that the s.231 application, submitted by the deceased's next of kin, was not valid when the next of kin had provided evidence to support a reasonable belief under s.231(1)(a)of the WHS Act

(b) failing to refer the request to the DPP as required by s.231(3)(b) of the WHS Act

was administrative action taken contrary to law for the purposes of s.49(2)(a) of the Ombudsman Act.

JAG's response to Opinions 13 and 14

In response to the proposed report, the Director-General advised:

> Not agreed.
>
> The report suggests s231 of the Act is "underutilised". The basis of that view is not known as s231 applications across all harmonised jurisdictions are universally low. Queensland actually has more s231 applications than harmonised counterparts.
>
> OFSWQ believes s231 requires an objective belief or consideration on behalf of the applicant and follows the test posited in *George and Rockett & Anor* (1990) 170 CLR 104 at page 113.
>
> OFSWQ applies the same test it applies to its own inspectors when assessing the reasonableness of an enlivening belief to issue enforcement notices.
>
> Not requiring an applicant to identify the relevant duty holder, duty, offence and relevant acts or omissions makes it impossible for OFSWQ to know for what alleged contraventions matters it is providing reasons for decisions.
>
> In relation to the case study, OFSWQ urged the applicant to obtain urgent independent legal advice. This was the appropriate advice given the impartial independent position of the regulator.
>
> For these reasons OFSWQ does not believe its general position is unreasonable or that a particular position was contrary to law and asks the ombudsman to reconsider this position.

Section 231 of the WHS Act was a recommendation of the National Review into Model Occupational Health and Safety Laws, with the intention of promoting accountability by regulators in respect of their decisions, generally the decision not to prosecute.[143] The process recommended by the National Review is based on s.131 of the Victorian Occupational Health and Safety Act 2004 which provides a similar review provision to s.231 of the WHS Act.[144]

Since 1 January 2012, WorkSafe Victoria has received 27 requests under the Occupational Health and Safety Act 2004 for a prosecution to be brought, with two of those matters subsequently proceeding to prosecution following review by the Victorian DPP.[145] In the same period, the OFSWQ has received only three requests for review, with only one matter referred to the DPP (later determined to be in error).

I acknowledge that Victoria is not a harmonised jurisdiction, but s.231 of the WHS Act is based on a near identical provision of the Victorian Occupational Health and Safety Act 2004 and the two powers are directly comparable. There has clearly been a greater use of the review power in Victoria than Queensland, which is potentially due to the Victorian workplace safety regulator, WorkSafe Victoria, taking a much more proactive approach to advising potential applicants of the statutory right of review under its legislation.[146]

With respect to the Director-General's response to Opinion 13, I accept that s.231(1)(a) requires a person to have an objective belief that an act or omission constitutes a category 1 or category 2 offence. In George v Rockett (cited by the Director-General) the High Court of Australia found that:

> **For there to be reasonable grounds for a state of mind – including suspicion or belief – there must exist facts which are sufficient to induce that state of mind in a reasonable person.**
>
> **…**
>
> **A suspicion that something exists is more than a mere idle wondering whether it exists or not; it is a positive feeling of actual apprehension or mistrust amounting to a slight opinion, but without sufficient evidence. Belief is an inclination of the mind towards assenting to, rather than rejecting, a proposition and the grounds which can reasonably induce that inclination of the mind may, depending on the circumstances, leave something to surmise or conjecture.**

Establishing a reasonable belief for the purposes of s.231(1)(a) may require the applicant to describe the broad nature of the offence which they believe has been committed and why, and the identity of the duty holder or duty holders who allegedly committed the offence. The information provided by the applicant should be sufficient to establish that the applicant has reasonable grounds, based on the evidence available to them, for believing an offence has been committed, notwithstanding the fact that aspects of that belief may be based on speculation or assumption.

However, what is apparently required by the OFSWQ goes far beyond these obligations. It is unreasonable for the OFSWQ to require s.231 applicants to adhere to the same evidentiary requirements as a trained inspector in establishing that they hold a reasonable belief.

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[143] National Review into Occupational Health and Safety Laws, Second Report to the Workplace Relations Minister's Council, January 2009, p.433.
[144] National Review into Occupational Health and Safety Laws, Second Report to the Workplace Relations Minister's Council, January 2009, p.433.
[145] Director, Work Health and Safety Compliance, email, 5 January 2015.
[146] WorkSafe Victoria, Letter, 11 February 2015, p.1.

The OFSWQ requires applicants (who in most cases will be members of the public with no background in work health and safety law and limited access to the evidence gathered by the OFSWQ during its investigation) to structure their application in a manner similar to what would be expected of an OFSWQ legal officer. These are also unreasonable expectations.

In addition, without access to the completed investigation report, the evidence the report relied on and potentially costly legal advice, a person would not be able to particularise the relevant offence category, acts, omissions or duties, or how a duty holder's actions exposed a person to a risk of death or serious injury. This would result in nearly all s.231 applications being rejected by the OFSWQ, completely defeating the intent of the provision.

With respect to the OFSWQ's specific rejection of the s.231 application in Case Study 16, I maintain my opinion that the applicants in that case provided more than sufficient evidence to establish that they held a reasonable belief that an offence under the WHS Act had been committed. The Director-General has not provided any reasons to justify why that application was assessed as not valid.

The fact that the applicants were advised to seek independent legal advice is immaterial to the fact that they had already submitted a valid application under s.231(1), supported by sufficient evidence establishing why they had formed the view that an offence had been committed. Once this application had been submitted and the decision made not to prosecute, the OFSWQ was bound pursuant to s.231(3) to refer the matter to the DPP.

Recommendation 11

The Under Treasurer implement a process to advise a person whose workplace injury is subject to an OIR investigation, or the next of kin following a workplace death, of their right to request that a prosecution be brought under s.231 of the WHS Act, at the commencement of the OIR investigation and that this advice includes the requirements that need to be met in making the application.

JAG's response to Recommendation 11

In response to the proposed report, the Director-General advised:

> Not agreed.
>
> Many people have interest in whether a prosecution is brought or not brought following an investigation.
>
> OFSWQ accepts that injured workers and NOK arguably have a greater interest than co-workers, friends, safety representatives or union officials in whether a prosecution is brought.
>
> However given its independent position as the agency that must both assess the s231 application and otherwise decide whether to prosecute or not, OFSWQ does not believe any particular class of person should be particularly advised by it (OFSWQ) of this statutory right.

There is no conflict with respect to the OFSWQ's differing roles in investigating and potentially prosecuting following a workplace death, and receiving and assessing a s.231 application.

In any respect, the statement by the OFSWQ that it has a role in assessing a s.231 application when received is questionable, having regard to s.231(3) of the WHS Act which states that the OFSWQ must refer a matter to the DPP if a person making the application so requests. It is not clear that there is any substantial role for the OFSWQ in assessing the merits of a s.231 application, but I anticipate this question may be resolved as a result of Recommendation 12.

To suggest that injured workers and next of kin are not a class of people with a clear and enhanced right to advice about a statutory right of review that directly affects their interests is unreasonable. Injured workers and next of kin have a special and personal interest in the outcome of an OFSWQ investigation, which is not present to the same degree in respect of other interested parties.

There is no point having a statutory right of review if the OFSWQ does not take active steps to advise people that the section exists.

WorkSafe Victoria advises injured people and next of kin about their right of review to the DPP in the written correspondence which provides information about the outcome of the investigation. WorkSafe Victoria has determined it has no conflict in providing advice to injured workers and next of kin about their right of review under the Victorian legislation. There is no reason the OFSWQ should determine that it has any conflict.

Recommendation 12

The Under Treasurer seek legal advice about what constitutes a valid application under s.231(1)(a) of the WHS Act and amend OIR policy and procedures as necessary, based on the outcome of this advice, to ensure the proper functioning of s.231(1)(a) of the WHS Act.

JAG's response to Recommendation 12

In response to the proposed report, the Director-General advised:

> Agreed. Notwithstanding the rejection of opinion 13 and 14, OFSWQ will seek this advice and consider its position in light of the same.

I am pleased the Director-General has agreed to seek legal advice regarding what constitutes a valid application under s.231(1)(a) of the WHS Act. The legal advice may assist to resolve some of the outstanding questions regarding the role of the OFSWQ in the s.231 application process.

Chapter 10: Jurisdictional interpretation by the OFSWQ

This chapter will discuss issues identified during the investigation regarding the OFSWQ's interpretation of its jurisdiction. This particularly relates to whether the OFSWQ has an obligation to investigate deaths which occur when a member of the public has paid to participate in a recreational activity, and has died in the course of that activity.

This chapter will also discuss the timing of when issues of jurisdictional interpretation are determined by the OFSWQ during an investigation and the training that has been provided to inspectors about how to interpret the requirements of the WHS Act.

10.1 Jurisdictional interpretation of non-standard workplaces

A work health and safety duty of care at a workplace is placed on a 'person conducting a business or undertaking'. The WHS Act does not define what constitutes a 'business' or 'undertaking' and so whether a person conducts a business or undertaking for the purposes of the WHS Act is a question of fact to be determined based on the circumstances of each case.[147]

There are a number of points which can assist in determining whether a person is conducting a business or undertaking, and therefore bound by the requirements of the WHS Act with respect to duties of care, including:

- a business is that of an enterprise usually conducted with a view to making a profit, and having a degree of organisation, system and continuity[148]
- an undertaking may have elements of organisation, systems, and possibly continuity, but is usually not profit-making or commercial in nature[149]
- it is immaterial for the purposes of the WHS Act whether a person conducts a business or undertaking for profit or gain.

10.1.1 Jurisdiction of the OFSWQ for commercial recreational activities

The question of what constitutes a 'business' or 'undertaking' was particularly relevant in a number of workplace deaths reviewed during the investigation. Case Study 12 provides one particularly relevant example.

Case Study 12

The incident

N was a participant in a motorcycle ride day at a racetrack who died as a result of falling from his motorcycle following a collision with another rider.

The investigation

The investigation determined that N was participating in a motorcycle ride day at a privately owned and operated racetrack. The event was not a race and the riders were not timed, but rather provided riders with the opportunity to ride their own (or a hired) motorcycle in groups around a racetrack.

The event was organised by a company which charged each rider an entry fee, required riders to attend a pre-ride briefing on safety issues and have their motorcycle and protective equipment scrutinised to ensure they were adequate and mechanically sound. Riders were required to self-assess their riding ability so they could be placed in groups with similarly experienced riders. A flag system operated by race marshals was also in place to direct riders to either slow down or stop while they were on the racetrack.

[147] Safe Work Australia, *Interpretive Guideline – Model Work Health and Safety Laws: The meaning of 'person conducting a business or undertaking'*, p.1.
[148] Safe Work Australia, *Interpretive Guideline – Model Work Health and Safety Laws: The meaning of 'person conducting a business or undertaking'*, p.1.
[149] Safe Work Australia, *Interpretive Guideline – Model Work Health and Safety Laws: The meaning of 'person conducting a business or undertaking'*, p.1.

Following the investigation, the recommendation of the RIM was for no further action on the basis that there was sufficient evidence that the company that had organised the race day had implemented appropriate safety systems to minimise the risk of injury to riders and workers. The investigation report also found that the racetrack was of a safe standard. The investigation report concluded that it was not clear what caused N to collide with the other rider.

In his decision regarding whether to commence a prosecution, the Director, LPS questioned why the region had investigated the incident, stating:[150]

> The Region conducted its investigation in accordance with the WHSQ enforcement framework and there appears an underlying assumption that this event and its conduct are captured by the 2011 legislation.

The Director, LPS then outlined the evidence gathered by the region, namely that the duty holder and organiser of the ride day had implemented sufficient safety systems and there was no evidence of any breach of a duty under the WHS Act.

However, after establishing that there would be no further action in respect to the investigation, the Director, LPS again queried whether the incident was captured by the WHS Act and whether the OFSWQ investigates some matters that are out of jurisdiction to avoid criticism for not investigating:[151]

> It might be accepted there is some nexus with the jurisdiction on the basis of “business of undertaking” and WHSQ has investigated on the assumption that there is jurisdiction under the *Work Health and Safety Act 2011*.
>
> …
>
> It seems it is difficult to develop any policy with perfect clarity with respect to these matters. Sometimes WHSQ will find an incident notified, will investigate and even take enforcement action. On other occasions it may not occupy any investigative space at all. Unfortunately WHSQ might sometimes investigate matters outside its jurisdiction out of fear that it is better to do something rather than nothing. The basis for that probably lies in a fear of criticism from stakeholders including coroners.

The Director, LPS then stated that persons who suffer death or injury voluntarily participating in inherently dangerous activities should not fall under the jurisdiction of the OFSWQ and such incidents are more appropriately investigated by other agencies:[152]

> The basic issue is that these types of events involve individuals voluntarily participating in what could be dangerous activities which might be made “dangerous” by their own actions, or the actions of others. This is particularly in any track events, and those involving difficult environmental conditions. They participate lawfully and are lawfully on particular premises.
>
> In that sense, and on the basis of the investigation, this particular incident is not be [sic] within jurisdiction under the *Work Health and Safety Act 2011*.
>
> Whatever the case, the fact of voluntary involvement in dangerous activities, and the contractual relationship between/amongst parties should see these incidents more appropriately investigated by other bodies or agencies.

There was a similar issue with the OFSWQ’s jurisdiction in Case Study 20, relating to the death of a participant in an organised car race event.

[150] Case Study 12, Director, LPS, *Investigation Complete Notification*, p.2.
[151] Case Study 12, Director, LPS, *Investigation Complete Notification*, p.3.
[152] Case Study 12, Director, LPS, *Investigation Complete Notification*, pp.3-4.

Case Study 20

<u>The incident</u>

V was a participant in an organised car race event who died after the vehicle he was driving collided with a tyre wall at a racetrack.

<u>The investigation</u>

The investigation gathered evidence about the safety systems in place by the race organiser and whether the safety of the tyre wall or mechanical default with the car contributed to the incident.

However, despite gathering evidence about whether any duty holder breached a duty under the WHS Act, the investigation report prepared by the RIM concluded that the incident was not within the jurisdiction of the WHS Act:

> It is opined the [racetrack] was a 'workplace' as defined under the auspices of section 8 of the Work Health and Safety Act 2011 … I do not believe however the deceased's activity of motor racing at the [racetrack] was an activity that is captured within the spirit of the health and safety legislation nor within the object of this Act …

At interview, the RIM stated that he formed this opinion following discussions with the legal officer, and that because V was a voluntary participant in an inherently dangerous recreational activity, it was not the object of the WHS Act that this type of event should be captured by work health and safety laws.[153] The RIM did acknowledge that had a member of the public watching the race, or a worker at the racetrack, died as a result of something that had occurred during the race, that would fall within the jurisdiction of the WHS Act.[154]

The manner in which these investigations were handled by the OFSWQ indicates some confusion about the extent of the jurisdiction of the WHS Act, particularly as it relates to participants in potentially risky commercial recreational activities.

However, while questions were raised by the OFSWQ regarding whether these two events involving the deaths of participants involved in motorsports were within jurisdiction, no jurisdictional questions appear to be asked about investigating deaths or injuries of people involved in other types of potentially risky commercial recreational activities.

For example, the investigation reviewed the OFSWQ investigations of two deaths involving participants who died while snorkelling with reef tour companies (Case Studies 7 and 8). While these two snorkelling deaths were investigated with respect to duties owed under the *Safety in Recreational Water Activities Act 2011*, it is accepted within the OFSWQ that companies providing recreational snorkelling or diving tours owe work health and safety duties to their customers. However, this view does not appear to be consistently applied to other commercial recreational activities.

At interview, the Director, LPS reiterated his view that the OFSWQ should limit its investigations to events where there is a clear duty holder under the WHS Act, and that duty holder owed work health and safety duties to workers and other persons at a workplace:[155]

> … if you read our legislation globally, with all the regulations, codes and practice, the objects of the Act like good relations between unions, when it comes to public safety issues and entrance upon land, even in for instance the Villinger case,[156] are you sure you have a duty holder under our [WHS] Act? Because the last thing I want to do is see us involved in all slip and falls, all the other things …
>
> I am actively trying to close the doors with our jurisdiction and keep it confined to what occupational safety legislation is. If we choose - if the Government, I beg your pardon, if the legislature chooses to regulate some sort of activity, they will do something like Safety and Recreational Water Activities Act and do diving. No other State has that. In Queensland, we chose to regulate that activity and so we

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[153] Interview with the Case Study 20 RIM on 19 January 2015, transcript p.7.
[154] Interview with the Case Study 20 RIM on 19 January 2015, transcript p.7.
[155] Interview with the Director, LPS on 9 February 2015, transcript p.15.
[156] See Chapter 11 for further discussion about the coronial inquest into the death of Ms Navina Villinger.

> introduced specific regulations, and then we had to introduce our own Act because of - no one else under the harmonised laws was interested.

As the safety regulator, the OFSWQ has an obligation under the WHS Act to monitor and enforce compliance with the Act.[157] It is not appropriate for OFSWQ officers to allow their personal biases about what does or does not constitute a workplace death to influence their decision-making.

If the OFSWQ has formed a view that the jurisdiction of the WHS Act is too vague or excessive and that the investigation and potential prosecution of duty holders providing certain recreational activities to the public is not within jurisdiction, this is an issue that should be addressed with the Government of the day with a view to seeking legislative clarification.

Opinion 15

There is inconsistency by the OFSWQ in the application of its jurisdiction to workplace incidents involving the death of a person at a workplace who is not a worker, particularly when the person is participating in a commercial recreational activity.

JAG's response to Opinion 15

Proposed Opinion 15 in the proposed report stated the following:

> There is confusion within the OFSWQ about its jurisdiction regarding workplace incidents involving the death of a person at a workplace who is not a worker, particularly when the person is participating in a commercial recreational activity.

In response to this proposed opinion, the Director-General advised:

> Disagreed.
>
> OFSWQ triages, responds to and comprehensively investigates many thousands of matters each year. It does this across the full interaction of commercial and human activity in Queensland. OFSWQ balances the breadth of scope of the safety laws with organisational priorities. As a regulator OFSWQ practices targeted enforcement, that is, OFSWQ makes decisions about which matters within its jurisdiction to which it will devote organisational resources. In the context of finite resources and an incredibly broad jurisdiction, it is necessary that OFSWQ does so.
>
> There is a high degree of consistency between the triaging, investigating and prosecuting areas of OFSWQ in relation to how these matters are addressed.
>
> Your investigation has relied on two matters, case study 12 and case study 20, to support the stated opinion. In one case, possibly two (the purported case study 20 does not appear in your proposed report), DLPS expresses a view contrary to what might be considered a standard organisational approach.
>
> In that context, a blanket opinion that there is confusion within OFSWQ on how its jurisdiction operates is made. This broad statement is not supported by evidence.

The Director, LPS's response to Opinion 15

In response to the Proposed Opinion 15, the Director, LPS advised:

> Although the writer may express a contrary view with respect to jurisdiction or a standard organisational response, it is noted that your office's investigation has relied upon two matters, case studies 12 and 20, to support the opinion which might be a little broad.

I have incorporated additional information and discussion about Case Study 20 into this report.

[157] Section 152(b), WHS Act.

The Director-General rejects that there is any confusion within the OFSWQ regarding its jurisdiction involving the death of a person at a workplace who is not a worker, particularly when the person is participating in a commercial recreational activity. While I acknowledge that my proposed opinion was primarily based on the outcome of the investigations in Case Studies 12 and 20, the circumstances of these two case studies strongly demonstrated a degree of confusion by some OFSWQ officers regarding the extent of their jurisdiction.

For example, in Case Study 20 the RIM who conducted the investigation was of the opinion that the organised car racing activity was not captured by the WHS Act. However, the Director-General's response suggests that the OFSWQ's view is the incident was within the jurisdiction of the WHS Act, but because of the OFSWQ's targeted enforcement strategy, it was not one to which the OFSWQ chose to direct its resources.

Similarly, in Case Study 12 an investigation was completed by the region (having seemingly formed the view that the incident was within jurisdiction), but the Director, LPS later determined that the incident was not within jurisdiction. In this instance, the Director-General suggests that the Director, LPS may have expressed 'a view contrary to what might be considered a standard organisational approach.'

It should also be noted that in both case studies, considerable OFSWQ resources were devoted to the investigations. A comprehensive investigation was conducted in both cases, and an investigation report provided to LPS for consideration about whether any offence had been committed.

However, I remain of the view that there is inconsistency by the OFSWQ in the application of its jurisdiction, and I have amended my opinion accordingly.

Recommendation 13

The Under Treasurer develop necessary policies and procedures to guide future OIR investigations into workplace deaths in instances where the deceased was a participant in a commercial recreational activity.

JAG's response to Recommendation 13

Proposed Recommendation 13 in the proposed report stated the following:

> The Director-General seek legal advice on the extent of the OFSWQ's jurisdiction over workplace deaths in instances where the deceased was a participant in a commercial recreational activity. Based on the outcome of this advice, the Director-General develop necessary policies and procedures to guide future OFSWQ investigations into these events.

In response to this proposed recommendation, the Director-General advised:

> Disagreed.
>
> OFSWQ considers that it has jurisdiction in almost every, if not every, area of commercial recreational activity. The question as to what areas of jurisdiction are targeted or given priority is a matter to be determined by policy considerations, not legal advice (the legal position is not disputed).
>
> OFSWQ accepts that there should be consistency in its identification of areas of enforcement across the organisation. This is adequately caught by your proposed recommendation 15 (which is agreed).

I acknowledge the Director-General's advice that the OFSWQ has jurisdiction with respect to commercial recreational activities. This statement would seem to support my view expressed in Opinion 15, with respect to the lack of consistency by the OFSWQ in applying its jurisdiction in this area.

The Director-General also states that the question about what areas of jurisdiction are to be targeted or given priority is a matter to be determined by policy considerations.

With respect to the OFSWQ's jurisdiction over commercial recreational activities, in his response to the proposed report, the Director, LPS made the following statement:

> **Since its inception, WHSQ [Workplace Health and Safety Queensland] has encountered difficulty with investigation and enforcement with respect to … recreational activities, including sporting and other pursuits as well as interactions with the environment.**

The Director, LPS also expressed a similar view to Coroner Bentley while giving evidence at the inquest into the death of Ms Navina Villinger (discussed in further detail in Chapter 11). Ms Villinger drowned while swimming in a creek at a commercial nature park. Coroner Bentley made the following comment in her findings:

> **[The Director, LPS] stated that in its investigative and prosecutorial role OFSWQ grapples with incidents involving paying visitors as opposed to employees.**
>
> **In relation to businesses which offer tourists experiences interacting with nature, such as the park, he said that he is not sure that it was the intention of the government that OFSWQ have the jurisdiction that it presently exercises in relation to such undertakings.**
>
> **OFSWQ has not developed any guidelines or regulatory frameworks in relation to such ventures and there are no policy documents.**
>
> **[The Director, LPS] is of the opinion that OFSWQ should be given an opportunity to investigate the extent of such a jurisdiction. If the government decides that OFSWQ should be responsible for regulating these types of ventures then a Code of Practice or similar policies and procedures would have to be developed so that duty holders could be made aware of their obligations under that framework.**

If, as the Director-General states, the investigations of deaths occurring as a result of a commercial recreational activity are determined by way of policy considerations, it is important the OFSWQ has clear policies and procedures to guide the circumstances of when such deaths are investigated.

Accordingly, I have amended my recommendation.

10.1.2 Jurisdiction of the OFSWQ in serious traffic incidents

The following Case Study addresses issues relating to the OFSWQ's investigation of serious traffic incidents.

Case Study 9

The incident

K was a truck driver who died after being crushed under the wheels of a semi-trailer truck after climbing under one of the trailers to attempt to fix a problem with the brake cables between the two trailers.

The investigation

The OFSWQ investigated the event and the RIM determined that there was no evidence of breach of a duty by any person, and recommended no further action.

The investigation was considered by the Director, LPS approximately two years after the incident occurred. In his decision, the Director, LPS noted that the region's investigation did not identify any breaches of the WHS Act by any person.

However, the Director, LPS also stated in his decision that other agencies were the more appropriate regulatory body to examine the circumstances of the death, and that the incident did not fall within the jurisdiction of the WHS Act:

> It might be accepted there is some nexus with jurisdiction on the basis of "business or undertaking" and the fact that a 'vehicle' can be a 'workplace'.
>
> However, first, the QPS are far better qualified to investigate this species of incident and, secondly, the operation, maintenance and many other features of the use of heavy vehicles is very specifically the subject of transport operations legislation and relevant dedicated transport inspectors.
>
> …
>
> Accordingly, the legal view, as an adjunct to any 'NFA' [no further action] on the evidence is that this tragic incident … does not fall within the jurisdiction of the Work Health and Safety Act 2011.

While certain aspects of workplace deaths that occur on gazetted roads may be more appropriately investigated by the QPS and other regulatory agencies, the incident still falls within the jurisdiction of the WHS Act. The deceased died while at work (driving a truck) and at a workplace (the truck). Work health and safety duties were owed to the deceased by his employer, who was also the owner of the truck, as well as the owners of the two semi-trailers.

The OFSWQ has a Memorandum of Understanding (the MOU) between the QPS and the Department of Transport and Main Roads (DTMR) with regard to the investigation of serious traffic incidents. The MOU states that QPS is the lead agency for the investigation of all serious traffic incidents occurring on gazetted main roads. DTMR has responsibility for certain matters relating to heavy vehicles and passenger transport vehicles under the *Transport Operations (Road Use Management) Act 1995*.[158]

However, the MOU states that the OFSWQ will investigate events where a person is fatally injured while operating a road vehicle and where QPS notifies the OFSWQ of the potential for work-related causes such as fatigue, maintenance and training being a contributory factor.[159] The review of Case Study 9 during the investigation determined that there were potentially work-related issues that contributed to the death, relating particularly to driver training and maintenance that was conducted on the trailer's braking system. Under the MOU, these matters should have been investigated by the OFSWQ.

[158] MOU between the OFSWQ and QPS and DTMR, December 2013, p.12.
[159] MOU between the OFSWQ and QPS and DTMR, December 2013, p.13.

Case Study 9 suggests a degree of confusion within the OFSWQ about its investigative responsibilities regarding work-related traffic events as well as the responsibilities of QPS and DTMR. The responsibilities and obligations of each agency are clearly outlined in the MOU, but these were not followed in Case Study 9. The MOU further sets out information sharing and collaboration between the agencies that should occur in the event of a potential work-related traffic event, but there is no evidence this occurred in Case Study 9. There is no evidence that the OFSWQ was aware of the issues that other relevant agencies may have been investigating.

Accordingly, the relevant issue in Case Study 9 would appear to be not, as the Director, LPS indicated, whether other agencies are more appropriate or qualified to investigate vehicle-related traffic deaths, but rather how the MOU is interpreted by the OFSWQ and whether it is being appropriately implemented. The outcome of Case Study 9 suggests there is room for considerable improvement as to how these types of deaths are investigated.

Opinion 16

In Case Study 9 there was no evidence of any information sharing or collaboration by the OFSWQ with DTMR or QPS, as required by the MOU regarding the investigation of workplace deaths occurring in a serious traffic incident.

JAG's response to Opinion 16

Proposed Opinion 16 in the proposed report stated the following:

> There is confusion within the OFSWQ about its jurisdiction to investigate workplace deaths resulting from traffic incidents.

In response to the proposed opinion, the Director-General advised:

> Disagreed.
>
> Workplace deaths involving traffic incidents are, as indicated in the proposed report, addressed by a comprehensive MOU.
>
> The opinion expressed in this matter is based upon a finding in one file. A blanket opinion that there is confusion within OFSWQ in these matters in not supported by evidence.

The Director-General has not addressed why the responsibilities of the OFSWQ to investigate particular matters relating to the death of K in Case Study 9, which were outlined in the MOU, were not followed. The Director-General has also not addressed why the deficiencies which were evident in Case Study 9 with respect to the OFSWQ's lack of awareness about the issues other agencies were investigating are not reflective of wider systemic failings.

However, I have amended my opinion to focus on the specific deficiencies with regard to the MOU identified in Case Study 9.

Recommendation 14

The Under Treasurer:

14.1 clarify with the Director-General of DTMR the respective responsibilities of each agency under the MOU regarding a workplace death occurring in a serious traffic incident

14.2 provide advice and training to all inspectors involved in investigating, reviewing and approving workplace death investigations about the OIR's responsibilities under the MOU.

JAG's response to Recommendation 14

In response to the proposed report, the Director-General accepted this recommendation and stated:

> This recommendation will help ensure consistency of application of the MOU.

10.2 Decision-making regarding jurisdiction

Generally, the first step for a regulatory agency to take before devoting resources to an investigation is to determine whether the incident falls within its jurisdiction.

Case Studies 9, 12 and 20 discussed above all had questions raised by either the RIM or Director, LPS, about whether the event fell within the jurisdiction of the WHS Act. It is notable that in each of these three case studies, the jurisdictional question was asked at the end of the investigation rather than at the start.

In each of the three cases, significant time, effort and cost went into investigating each death and preparing an investigation report on the outcome. Next of kin in each matter would have been aware that the OFSWQ was investigating to determine whether to prosecute any person, and the duty holders who were the subject of the investigation may have spent considerable time and money responding to the OFSWQ's investigation. This represents a considerable allocation of resources towards an investigation for a decision (correctly or not) to be made that the OFSWQ does not have jurisdiction.

The appropriate time for jurisdiction to be determined with respect to a workplace death investigation is at the start of the investigation, ideally prior to, or immediately following the first response. At the very least, once sufficient evidence about the event has been gathered following the first response and before any substantial investigative work commences, a decision must be made regarding whether the event falls under the jurisdiction of the WHS Act.

Any decision about jurisdiction should be made having regard to advice from the legal officer, who should in turn consult with the Director, LPS if necessary.

The OFSWQ should not be carrying out investigations into workplace deaths in cases where there will be no regulatory outcome due to a decision being made at the end of the investigation that the event was not within jurisdiction. Such an outcome represents a significant waste of public money and resources.

Opinion 17

Commencing an investigation of a workplace death without first determining jurisdiction is an inefficient use of public resources and is unreasonable administrative action for the purposes of s.49(2)(b) of the Ombudsman Act.

JAG's response to Opinion 17

The Director-General accepted this opinion.

Recommendation 15

The Under Treasurer implement a policy to ensure any question of jurisdiction regarding the investigation of a workplace death is determined by the OIR before investigation activities commence and provide appropriate training about the policy to inspectors.

JAG's response to Recommendation 15

In response to the proposed report, the Director-General advised:

> Redundant. A centralised investigation process and dedicated Inspectorate and Policy and Support unit will ensure jurisdictional questions are resolved before comprehensive investigations commence. It is sometimes necessary to undertake some investigative activity to clarify whether jurisdiction is either founded or to be enforced.

I welcome the Director-General's advice that the Policy and Support Unit will ensure jurisdictional questions are resolved before investigations commence.

I acknowledge that some initial investigative work may be necessary to establish jurisdiction, but note that the issue identified in the file review was that full comprehensive investigations were undertaken by the OFSWQ before jurisdiction was questioned.

Chapter 11: Criticism by coroners

This chapter will discuss criticism by coroners regarding the adequacy of the OFSWQ's workplace death investigations. This chapter will specifically focus on the outcome of a recent coronial inquest which addressed a workplace death which occurred while the person was participating in a commercial recreational activity.

11.1 Role of the coroner

Under the *Coroners Act 2003* (Coroners Act), coroners are responsible for investigating reportable deaths in Queensland. A reportable death includes a death which was violent or otherwise unnatural, usually a common factor for most workplace deaths.[160] Accordingly, most workplace deaths will also be the subject of a coronial investigation and in some cases an inquest.

Once a coroner has completed an investigation, they will consider whether to hold an inquest into the death. A coroner must hold an inquest in certain circumstances under the Coroners Act, but may also hold an inquest if the coroner is satisfied it is in the public interest to do so.[161] An inquest is a court hearing conducted to gather information about the cause and circumstances of a death. At the end of an inquest, the coroner can make recommendations and comment about matters raised at the inquest relating to public health and safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.[162] If an inquest is not held, the coroner will make written findings regarding the outcome of the investigation, but not recommendations.

The OFSWQ created a position known as the Coronial Liaison Officer (CLO) in 2010 to manage liaison with coroners and to ensure the relationship was both collaborative and constructive. The Coronial Liaison and Investigation Support Services Unit was also established to support the work of the CLO. The CLO is responsible for liaison with coroners, undertaking or arranging any investigation required to assist coroners, providing relevant information about OFSWQ investigations to coroners and coordinating the OFSWQ's involvement in inquests.[163]

A coronial investigation is informed by the investigation report completed by the OFSWQ about the outcome of the workplace death investigation. Generally, the coroner will not commence an investigation until all regulatory proceedings are finalised by the OFSWQ, meaning that a final prosecution decision has been made by the Director, LPS. However, while the focus of a workplace death investigation is generally about gathering sufficient evidence to determine whether an offence has occurred, the coroner also has the focus of identifying changes to laws or practices that could prevent similar deaths in the future.[164]

11.2 Coronial inquests into workplace deaths

One of the terms of reference for this investigation was to consider previous recommendations or critical comments about the quality of an OFSWQ investigation made by a coroner following an inquest into a workplace death.

As part of this process, the investigation reviewed a number of inquests into workplace deaths held between 2007 and 2014. These included inquests into the deaths of:

- Maurice Henry Bauer who died as a result of electrocution
- Muraka Jenny Vearncombe who died after being struck by debris ejected during the operation of a slasher
- Graham Tait who died as a result of electrocution
- Paul Gerard Joseph Robinson who died as a result of a truck rollover
- Ian Robinson, Natarsha Charlesworth, Georgina Hatzidimitriadis, Sang Won Park and Seongeun Choi who died as a result of entrapment and drowning while white water rafting
- Gregory Clifford Paterson who died after being struck by a concrete pump
- Colin Arthur Greaves who died as a result of a fall from height

[160] Section 8(3)(b), Coroners Act.
[161] Section 28(1), Coroners Act.
[162] Section 46(1), Coroners Act.
[163] OFSWQ, *Operational Procedure: Investigations Governance*, p.2.
[164] State Coroner, *Coroner's Guidelines 2013: Investigations*, p.7.

- Casey Andrew Frizzel who died as a result of heat stroke
- a child who drowned in a public swimming pool
- Matthew Colin Case who drowned in a public swimming pool
- Navina Friedericke Villinger who drowned while swimming in a creek in a nature park.

In each of these inquests, coroners were critical of aspects of the OFSWQ investigation. The critical comments and recommendations made by coroners as a result of these inquests have also informed the specific issues that have been examined by this investigation.

This chapter focuses specifically on the inquest into the death of Ms Villinger as it is the most contemporary inquest. The inquest also addressed the issue of what constitutes a workplace death, which was identified as a significant deficiency during the investigation. In particular, Chapter 10 identified that there is inconsistency by the OFSWQ with investigations into the deaths of people participating in commercial recreational activities. This was a specific theme which was considered during the inquest.

11.3 Inquest into the death of Ms Navina Villinger

On 29 October 2014, the Northern Coroner based in Cairns, Coroner Jane Bentley, delivered her findings into the death of Ms Navina Villinger. Ms Villinger was a 19 year old German backpacker who was holidaying in Cairns in January 2011.

On 10 January 2011, Ms Villinger and a group of friends travelled to the Granite Gorge Nature Park (the park) near Mareeba. The park is privately owned by a family business but is able to be accessed by the public for a fee. While this incident occurred under the repealed *Workplace Health and Safety Act 1995*, in which the park would be regarded as a workplace, the park would also appear to fall within the definition of a business or undertaking contained in the WHS Act. Activities at the park include wallaby watching and feeding, bird watching, swimming and walking.[165] There is also cabin style accommodation for overnight stays.

Ms Villinger and a group of her friends entered the creek that flows through the park for a swim. The water in the creek was shallow and the current was not very strong.[166] However, while Ms Villinger was moving downstream, she suddenly disappeared underwater. At the same time, one of her friends (Ms Jennifer Connell) was also swept downstream by the current.

Ms Connell attempted to hold onto a rock but was swept by the water into an underwater cave system known as the bat caves. She was able to stand up with her mouth against the roof of the cave and breathe from a pocket of air. After about 15 minutes she blacked out and was swept through the boulders out of the cave system and into a rock pool. Ms Connell was rescued by other friends from the group.

Tragically, Ms Villinger drowned in the underwater cave system. Her body was only able to be retrieved the next day by emergency swift water specialists once a dam had been constructed to reduce the volume of water in the creek.

The OFSWQ attended the park once it was notified of the incident. Improvement and prohibition notices were served upon the principal duty holders, the park owners. The OFSWQ was apparently satisfied with the steps taken by the duty holders to address those notices. Following completion of the investigation, the region recommended that no further action be taken and that recommendation was supported by the Director, LPS.

The death was listed for inquest. The matter came before Coroner Bentley in December 2013, but was adjourned to allow the OFSWQ to initiate a judicial review application in the Supreme Court in relation to the coroner's jurisdiction to ask questions regarding the OFSWQ's decision not to prosecute any person following the investigation. The Supreme Court later ruled that a coroner may investigate an agency's reasoning about why a prosecution was brought or not brought because that decision would fall within the subject matter of the administration of justice, upon which a coroner is expressly able to comment under s.46(1)(b) of the Coroners Act.[167]

[165] Granite Gorge Nature Park, *Our Activities*, viewed 27 February 2015, http://granitegorge.com.au/wordpress/?page_id=11.
[166] Inquest into the death of Navina Friedericke Villinger, p.2.
[167] *Goldsborough v Bentley* [2014] QSC 141.

The inquest resumed in October 2014. In her findings, Coroner Bentley was very critical of the quality of the OFSWQ investigation and the duty holders' attitude to safety at the park. Coroner Bentley made a number of recommendations including that the OFSWQ re-open its investigation and that the OFSWQ consider whether further prohibition notices should be issued. The OFSWQ has since agreed to re-open the investigation and consider the recommendations made by Coroner Bentley.[168]

Coroner Bentley's criticisms about the quality of the OFSWQ investigation into the death of Ms Villinger exhibit a number of similarities to those identified during this investigation. In particular, Coroner Bentley found that the OFSWQ's first response was generally appropriate. The OFSWQ acted quickly following notification of the incident to issue prohibition and improvement notices to the park.

However, Coroner Bentley subsequently found considerable deficiencies with how the investigation was conducted, particularly with regard to insufficient evidence gathering, a failure to follow up on potential breaches and how the OFSWQ assessed the park's compliance with the prohibition and improvement notices:[169]

> None of the OFSWQ inspectors who visited the map [sic] attempted to explore the park using the map [originally provided by the park's owners to Ms Villinger and her friends]. Had they done so they may have been able to better recognise its limitations as a guide to visitors.
>
> Although OFSWQ commenced their investigation with a view to enforcing better signage and risk management processes, by the time the investigation was concluded and it was decided that no further action was warranted, little had been done by Mrs Bryde [the duty holder] to address the risks posed to visitors. That remains the case.
>
> The decision of OFSWQ to close the investigation and subsequently, the decision not to commence a prosecution was based, in part, on the premise that Mrs Bryde had no history of non-compliance with OFSWQ or past breaches of the legislation. Investigators were unaware of the numerous incidents which had occurred in the park prior to Ms Villinger's death which had resulted in visitors to the park being injured and/or requiring rescue.

Coroner Bentley also identified significant issues with how the OFSWQ investigates workplace deaths which occur as a result of a commercial recreational activity:[170]

> OFSWQ has not previously investigated an incident at a tourist park and does not have any regulatory framework or guidelines in place for such undertakings. It is likely that it is this lack of experience, policies and procedures which resulted in investigators prematurely closing the investigation and was the real basis for the recommendation that no prosecution be commenced.

In her findings, Coroner Bentley made a number of statements regarding the safety of the park, in stark contrast to the outcome of the OFSWQ investigation:[171]

> The park poses a significant risk to the health and safety to persons who visit it. Visitors should be prohibited from undertaking activities in the park including swimming, bushwalking and "rock-hopping" until the risks posed to the visitors have been addressed. Mr and Mrs Bryde have shown that they are unable and/or unwilling to address those risks in any appropriate way.
>
> …
>
> It is possible, especially considering the risk of unexpected flash flooding, that it will never be deemed safe for visitors to swim in the gorge or walk through the gorge.

Coroner Bentley found that the duty holder, the park's owner, had taken no meaningful action to improve the park's safety, despite the OFSWQ determining that the park had satisfied the requirements of the prohibition and improvement notices:[172]

> Despite the tragic and preventable drowning of Ms Villinger and the horrific experience suffered by Ms Connell in January 2011, Mr and Mrs Bryde, those directly responsible for the park and its day to day running, have done practically nothing to address the risk that the park poses to the safety of the people who pay to enter upon their land.

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[168] Director, Work Health and Safety Compliance, email, 14 January 2015.
[169] Inquest into the death of Navina Friedericke Villinger, p.38.
[170] Inquest into the death of Navina Friedericke Villinger, p.38.
[171] Inquest into the death of Navina Friedericke Villinger, p.37.
[172] Inquest into the death of Navina Friedericke Villinger, p.35.

> Mrs Bryde … has chosen to abdicate responsibility for the tragedy to Ms Villinger and Ms Connell. She has continuously, obstinately and unreasonably refused to address, in any meaningful way, the issue of safety at her business.

Finally, Coroner Bentley concluded that:[173]

> Granite Gorge Nature Park poses a clear and present danger to public health and safety.

These findings from Coroner Bentley highlight the inadequacies of the OFSWQ investigation in this matter, and how as a consequence of inadequate investigation work, serious safety deficiencies at the park were permitted to continue, placing other people at risk of harm.

Evidence provided to the inquest also determined that the OFSWQ does not have any regulatory framework or guidelines in place for the investigation of deaths which occur as a result of a commercial recreational activity. As discussed in Chapter 10, my investigation also made this finding and I have made Recommendation 13 to address this issue.

11.4 Regulatory capture and the public interest

The findings of the coronial inquest into the death of Ms Villinger leave open the allegation of regulatory capture by the OFSWQ. Regulatory capture means the following:[174]

> The term 'regulatory capture' describes the situation whereby a public interest regulator … becomes so identified with the industry or sector it is intended to regulate that it can no longer effectively discharge its regulatory functions. The theory is that once a regulator has been 'captured', it is more sympathetic to the interests of the regulated industry than to the public interest it was created to protect.
>
> This leads to a situation where necessary compliance action is not taken or, when taken, is less severe than the circumstances warrant. To put it simply, once captured, a regulator goes easy on the industry. The issue is one of objectivity in making decisions to carry out enforcement action.
>
> Another way of explaining the term is that the regulator and industry build working relationships that lead to the regulator becoming unwilling to perform its compliance tasks diligently and impartially in respect of that industry so as to avoid jeopardising the relationship.

For example, in the investigation report into the incident, the RIM opined that while there was sufficient evidence to demonstrate that there had been a potential breach of the Act and that there was a reasonable prospect of a successful conviction, alternative enforcement strategies should be preferred to prosecution action because of public interest considerations.[175] The RIM addressed some of the public interest considerations he took into account in making this recommendation at the inquest:[176]

> [The RIM] re-stated at inquest his opinion that any breach of the legislation by the duty holders was not a serious breach as it was not a blatant disregard of their obligations and the park was a small business with a low income and a prosecution could have the effect of closing it down. [The RIM] agreed that he had obtained no information on which he based his conclusion that the park generated only a low income.

The RIM also provided the following as a public interest consideration in the investigation report that was provided to Coroner Bentley:[177]

> … prosecution action "would serve no useful purpose other than to possibly close this private tourist enterprise. It is a family run small business that offers a unique experience to visitors, but is operating in a current economic climate that can be described as a 'down turn' in terms of tourism."

This comment was described by the RIM as a public interest consideration and was made despite the fact that he also formed the concurrent view that there was sufficient evidence to demonstrate that the park had a case to answer and there was a reasonable prospect of a successful conviction.

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[173] Inquest into the death of Navina Friedericke Villinger, p.33.
[174] Queensland Ombudsman, *The Regulation of Mine Safety in Queensland - A Review of the Queensland Mines Inspectorate*, June 2008, p.123.
[175] Inquest into the death of Navina Friedericke Villinger, p.19.
[176] Inquest into the death of Navina Friedericke Villinger, p.30.
[177] Inquest into the death of Navina Friedericke Villinger, p.20.

The reasons offered by the RIM for not commencing a prosecution, namely the continued viability of a low income family business offering a unique experience to visitors, is not an appropriate or relevant public interest consideration for a safety regulator such as the OFSWQ. It may be appropriate for an agency promoting tourism, but not work health and safety. It is generally accepted, as a fundamental prosecutorial principle, that a decision to prosecute must not be influenced by the possible effect of that decision on the personal or business circumstances of those likely to be involved in a potential prosecution.[178]

The public interest comments provided by the RIM also appear to have been given significant weight in forming the recommendation that no further action should be taken. The fact that no senior officer within the OFSWQ questioned or challenged this reasoning is concerning. There appears to be a general misunderstanding within the OFSWQ of what the phrase 'public interest' means and how it should be assessed. The National Compliance and Enforcement Policy outlines the factors that might be included in an assessment of public interest, namely:[179]

- the seriousness or, conversely, the triviality of the alleged offence or whether it is only of a technical nature
- any mitigating or aggravating circumstances
- the characteristics of the duty holder, including prior compliance history and background
- the age of the alleged offence
- the degree of culpability of the alleged offender
- whether the prosecution would be perceived as counter-productive, that is, by bringing the law into disrepute
- the efficacy of any alternatives to prosecution
- the prevalence of the alleged offence and the need for deterrence
- whether the alleged offence is of considerable public concern.

Although this list was intended to be indicative rather than exclusive, the reasoning offered by the RIM does not sit comfortably with the National Compliance and Enforcement Policy.

[178] Rowena Johns, *Independence and Accountability of the Director of Public Prosecutions: A Comparative Survey*, Briefing Paper 9/2001, New South Wales Parliamentary Library Research Service, p.4.
[179] Safe Work Australia, *National Compliance and Enforcement Policy*, p.10.

Chapter 12: Conclusion

This report has provided the findings of an investigation into the adequacy of investigations conducted by the OFSWQ into a sample of 20 workplace deaths which occurred between 1 January 2012 and 30 June 2013.

The investigation determined that there are a number of areas of the investigation process that need improvement, particularly investigation planning, ensuring an investigation identifies all potential breaches and all potentially relevant issues impacting on a death and the format and method in which investigation findings are addressed in an investigation report.

Significant improvements also need to occur in the way that LPS provides its advice and recommendations about whether a prosecution should occur and the time it takes for LPS to make this decision. I acknowledge the significant workload within LPS and that legal officers have other duties and responsibilities other than assessing and making recommendations about prosecution action. The Director, LPS has identified that there are issues with memorandums of advice by legal officers being provided for his consideration, and has taken steps to address this. This system, if adopted and used consistently by legal officers, should result in improvement in the quality of these advices.

However, I am of the view that the functioning of LPS should be independently reviewed in order to ensure its continued capacity to manage the volume and range of work it is expected to perform. Accordingly, I have recommended a broad review of the current LPS model.

The investigation identified that inconsistencies and confusion exist within the OFSWQ about the extent of its jurisdiction over certain types of workplace deaths not involving a worker, particularly where the deceased was participating in a commercial recreational activity.

The investigation of commercial recreational activities was also recently addressed by the Northern Coroner in her findings in the inquest into the death of Ms Navina Villinger. The Northern Coroner found that the OFSWQ does not have a regulatory framework or guidelines in place for such investigations, and the lack of appropriate guidelines resulted in deficiencies with the OFSWQ's investigation into Ms Villinger's death.

My report supports these findings and I have made a recommendation that the Under Treasurer develop necessary policies and procedures regarding investigations where the deceased was participating in a commercial recreational activity.

There are also areas for improvement for the OFSWQ in information provision to next of kin and the length of time taken to finalise some investigations to a decision about prosecution.

This report has made a number of recommendations to address these issues.

Significantly, since the introduction of the WHS Act in 2012, the OFSWQ has undertaken extensive work to attempt to improve its processes and the quality of its workplace investigations. It has commenced a quality assurance system of external review and evaluation of its investigations, and I acknowledge this work.

The OFSWQ has also introduced a suite of new templates for investigation planning, case management and reporting. These templates are both comprehensive and appropriate and, if used consistently by inspectors and RIMs during all future investigations, should result in further improvements in the quality of investigation outcomes.

QUEENSLAND
OMBUDSMAN
Standing for fairness