

Article

Employment, Workplace Relations & Safety

Taking Reasonable Care to Ensure Your Acts or Omissions Don't Land You in Court

By Patrick Walsh

In a previous article, '[Pivot in Enforcement Strategy to Create Safer Workplaces](https://www.dwfoxtucker.com.au/2022/11/pivot-in-enforcement-strategy-to-create-safer-workplaces)'¹, I suggested that regulators are increasingly looking to prosecute individuals for breaches of work health and safety laws and that the motivation for this is the perception that such prosecutions have a greater impact on general deterrence for risky behaviour.

More commonly, the individuals that are prosecuted for breaches of work health and safety laws are going to be those who meet the definition of being an "officer". Individuals who are accountable under section 27 of the *Work Health and Safety Act 2011* (Cth) (and the various state and territory iterations of this legislation) for exercising due diligence to ensure the Person Conducting the Business or Undertaking (PCBU) meets its obligations.

It is critical, however, that everyone within the PCBU understands and accepts that every person has a duty – even if they do not meet the definition of an officer. Recent prosecutions of individuals pursuant to section 28 of the relevant *Work Health and Safety Act* and Industrial/Workplace manslaughter laws illustrate important considerations for workers seeking to ensure they meet their obligations.

Once a risk is identified, it MUST be assessed

On 16 January 2019, an employee of the Queensland Museum was diagnosed with a spinal abscess as a result of Q Fever. On 22 February 2019, a second employee was diagnosed with Q Fever.

Although the source of the bacteria that causes Q Fever was not identified, the taxidermy of native animals and

fieldwork with respect to collecting specimens was identified as the likely source.

The defendant was employed by the Museum in the role of Work Health, Safety and Risk Manager. From at least 2015, the defendant had been aware of the risk of Q Fever to Museum staff who carried out taxidermy work as she had attended a Workplace Health and Safety Presentation on biological hazards. The Inspector who conducted the presentation had also spoken with the defendant about the risk of various illnesses associated with taxidermy work on native animals. On 15 and 16 October 2015, the defendant exchanged communications with the Inspector that, amongst other things, referred explicitly to the risk of Q Fever to employees of the Museum. Following these communications, the defendant commenced a risk assessment but failed to finalise it. The sentencing Magistrate accepted that the defendant's workload at the time was large, contributing to the failure to complete the risk assessment.

In imposing a good behaviour bond of \$1,500 and declining to record a conviction, the Magistrate noted the very low to remote probability of the risk materialising and a range of other factors that helped mitigate the level of the defendant's offending.

Any person employed in a work health and safety role needs to be mindful that their acts and omissions are more likely to impact the health and safety of other persons in the PCBU simply by virtue of the position that they hold. It is critical in these roles to ensure that, where risks to the business or undertaking or persons within the PCBU have been identified, the management of the risk is finalised

¹ <https://www.dwfoxtucker.com.au/2022/11/pivot-in-enforcement-strategy-to-create-safer-workplaces>

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and then reviewed as needed. If the management of an identified risk is delayed (because of workload or funding, for instance), this itself becomes a risk to the PCBU. In this instance, one of the findings made by the Magistrate was that the defendant ought to have raised the information with the line manager and undertaken or ensured a risk assessment was finalised.

Don't be pressured to work in an unsafe manner

In [R v Watts \[2020\] ACTSC 91](#), the defendant was employed as a crane operator and was performing duties at the University of Canberra Hospital when the offending occurred. The worker was instructed to transport a large generator and, while performing the lift, the crane overturned.

Importantly, there was a range of circumstances which, on the face of it, might have reduced the culpability of the worker, being that the worker:

- had sought, but was not provided with, a safety induction for the site because of the pressure to perform the job quickly;
- had received no training or instruction from the employer as to the correct operation of the crane in “super lift” mode, and when he called for advice, his calls were unanswered;
- was under pressure from his employer and the developer to carry out the lift that day, and he reasonably believed that, if he did not carry out the lift, his employment might be threatened; and
- he was unaware that the previous operator of the crane had told his employer that he did not consider it safe to use the crane to move the generator.

The sentencing Judge, however, found that the defendant's conduct demonstrated a relatively high degree of recklessness and noted, amongst other things, that:

- the offending occurred over a prolonged period in that the defendant had failed to properly plan the lift and had operated the crane beyond its capacity on three occasions during the lift;
- the defendant knew there were people in the vicinity when he operated the crane;
- the defendant repeatedly overrode a critical safety system; and

- from the outset, the defendant had genuine and reasonable safety concerns but still allowed others to pressure him into performing the lift.

Workers engaged in high-risk work, similar to those who are employed in a health and safety role, are involved in tasks that present a much higher risk to the health and safety of other persons in the PCBU. As such, any reckless conduct or behaviour that adversely affects the health and safety of other persons in the PCBU is much more likely to attract a prosecution in respect of a breach of section 28 of the *Work Health and Safety Act*.

Don't cut corners

On 7 April 2017, work was being performed on a construction site in Trevallyn, Tasmania, and a crane was being used to lift pallets of plaster to the first floor of the building. The crane had a safety system that stopped the crane from moving when it sensed it had reached 75% of capacity. When the crane reached 100% of its capacity, a visual and oral alarm system was activated. This alarm could be observed both inside and outside of the crane.

The crane driver overrode the safety system such that the crane operated beyond 75% of capacity, and the oral and visual alarms were not activated. On the fourth lift, the weight of the load caused the boom to collapse, causing severe injuries to another worker.

Notably, the investigation undertaken by WorkSafe Tasmania established that the manual override of the alarm system had been used on 100 prior occasions.

This is another instance of a worker undertaking high-risk duties in an objectively reckless manner. In this instance, the crane drivers received a 6-month suspended jail sentence.

Don't become complacent

[WorkSafe Victoria](#) commenced its first prosecution pursuant to “Workplace manslaughter” provisions contained in section 39G of the [Occupational Health and Safety Act 2004](#) (Vic) (**the OHS Act**) in October 2022. WorkSafe Victoria has accused the director of a stonemasonry business of negligence with respect to the manner in which they operated a forklift. The director was operating the forklift on a sloping driveway when it tipped over, landed on top of a 25-year-old sub-contractor, and killed him.

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Although the matter has not been finalised, it is noteworthy that, in its press release, WorkSafe Victoria stated that, where reasonably practicable, forklifts should be eliminated from the workplace and substituted with other suitable loading equipment. The press release went on to state that where forklifts remain in use, *“the risks associated with using forklifts must be reduced, using engineering or administrative controls, such as traffic management plans”*.

Section 39G of the OHS Act requires the prosecution to establish that the defendant has engaged in negligent conduct. It is likely in this particular matter that there was no reason for the sub-contractor to be in the vicinity of the forklift at the time of the incident, and the director has failed to implement a traffic management plan or any control designed to ensure that pedestrians keep a safe distance from any forklift, while it is in use.

In a further media release, WorkSafe Victoria noted that pedestrians make up almost half of all people injured by forklifts. It is, therefore, not surprising that this issue has been a recent focus for the regulator.

In my experience, it can be easy for operators of heavy machinery (such as forklifts) to become complacent about the potential risks associated with operating the machinery in circumstances where the machines are so frequently used and usually without any issue. This familiarity with the operation of the machines in the workplace can lead both operators and bystanders to forget the very real potential for catastrophic injury.

Ensuring that risk assessments and control measures are up-to-date, understood by all relevant stakeholders, and being adhered to is critical to ensuring PCBU’s and persons within the business or undertaking are not accused of negligent conduct of the type likely to attract a prosecution under the range of Industrial/Workplace manslaughter laws in most jurisdictions.

Conclusion

The matters referred to in this article share some common themes with respect to decisions made by the regulator to prosecute individuals for breaches of workplace safety laws. In each of these cases:

- the consequences for the victims were significant and generally catastrophic. Either requiring extensive hospitalisation or resulting in death;
- there was a clear link between the individual’s conduct, or failure to act, that resulted in the victim being injured or killed;
- the risk of injury to others was obvious; and
- the outcome would have been avoided had the offender adhered to basic principles of workplace safety, being:
 - whenever a risk is identified, complete a risk assessment and determine what (if any) controls are appropriate;
 - do not engage in conduct that you know is unsafe;
 - do not override or remove a control measure without good reason **and** updating the applicable safety protocols etc., to take into account the change in risk; and
 - never engage in a high-risk activity (such as operating heavy machinery) without ensuring appropriate control measures are in place.



[MORE INFO](#)

Patrick Walsh Director

p: +61 8 **8124 1941**

patrick.walsh@dwft.au

DW Fox Tucker Lawyers

L14, 100 King William Street, Adelaide, SA 5000

p: +61 8 **8124 1811** e: info@dwfoxtucker.com.au dwfoxtucker.com.au

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