Victorian Chamber of Commerce and Industry

New Workplace Manslaughter Laws

GENERIC GUIDE

How to prepare for the New Workplace Manslaughter laws commencing 1 July 2020

SIGNIFICANT NEW OHS PENALTIES

The Victorian Parliament recently passed a new workplace manslaughter law that will impose fines and jail terms for employers responsible for negligently causing death. The Victorian Workplace Safety Legislation Amendment (Workplace Manslaughter and Other Matters) Bill 2019 includes fines of up to 100,000 penalty units currently equating to $16,522,000 for bodies corporate, and jail terms currently of up to 25 years for corporate 'officers' (defined by the Corporations Act 2001) and others.

In order to guide employers on how to prepare for this law, the Chamber has developed this and other online resources to provide insights from our health, safety and wellbeing experts and policy team on how employers can better prepare and respond to these new laws.

SUMMARY OF THE AMENDMENTS TO THE VICTORIAN OCCUPATIONAL HEALTH AND SAFETY (OHS) ACT 2004

The stated objects of these amendments are to prevent workplace deaths, deter persons who owe duties under Part 3 (general duties) and reflect the severity of conduct that places life at risk in the workplace. While the laws will not impose any new safety obligations on business, they will significantly increase the penalties where a person is killed in a workplace incident.

The New Offences – (New Section 39 G)

1. A person *(including organisations and self-employed)* who is not a Volunteer, must not engage in conduct that is negligent, and is a breach of an applicable duty that a person owes another person, and causes the death of that other person.

   Penalty – Indictable offence – 25 years (currently) imprisonment or <100,000 Penalty Units ($16.522 Million in 2019/20)

2. A person who is an *officer* of an applicable entity. (Section 9 of the Corporations Act & not a Volunteer) - must not engage in conduct that is negligent, and is a breach of an applicable duty that a person owes another person, and causes the death of that other person.

   Penalty – Indictable offence – currently up to 25 Years Imprisonment

APPLICABLE DUTY

The term *'applicable duty'* is important as it indicates these new penalties apply to the 'Employer' and 'officer' as defined by the Victorian OHS Act 2004 and the Corporations Act 2001, but may also apply to others in an organization that are not specifically excluded under the statement below:

'a duty imposed by Part 3 (OHS Act 2004 - general duties) other than –

'the duty imposed by section 25;' (duties of employees),

'the duty imposed by section 32 on an employee, but not an officer;' (reckless endangerment)

By excluding these two groups from the applicable duties of care, as they apply to employees only, the changes then potentially include all other Part 3 duties applying to employers and those that manage and control various aspects of workplaces such as:

- Duties of Employers to employees and contractors in workplaces (S21)
- Duty to monitor workplace conditions and health (S22)
- Duty to 'Others' in the workplace (S23)
- Those who manage and control workplaces (S26)
- Designers of workplaces, plant and equipment (S27/28)
- Manufacturers of Plant or Substances (S29)
- Importers, Suppliers, Installers of plant and equipment (S30/31)

WorkSafe Victoria has also stated that the 'Applicable Duties' can also capture trustees, corporate partners, sole traders and so-called 'shadow' directors. The clear objective here is to target those who hold significant power in organisations and 'focus on and hold to account those with the power and resources to improve workplace safety'.

The government's stated intent is also that an organisation should not be held liable for the acts of 'rogue' employees who act outside the scope of their employment. These laws are not focused on an employee who has failed to comply with the organisation's prudent OHS based procedures, practices and instructions, but employees can still potentially be charged and prosecuted under existing OHS and criminal laws.

THE NEGLIGENCE" TEST

One of the key criteria for a prosecution gaining approval to proceed in this case is that the prosecution proves that 'negligent' conduct has occurred, and that conduct (acts or omissions) directly led to a person's death.

Negligence is described as involving 'a great falling short of the standard of care that would have been taken by a reasonable person (or corporation) in the circumstances in which the conduct was engaged in, and creates a high risk of - death; serious injury; or serious illness.'

A "REASONABLE CARE" DEFINITION

"...requires one to act with the same degree of care, knowledge, experience, fair-mindedness, and awareness of the law that the community would expect of a hypothetical reasonable person."

‘CONDUCT’ DEFINED

The new laws also provide the legal definition of the term ‘conduct’ with a new Section 39 C (1 & 2) stating that ‘Conduct means - an act or omission, or failure to perform an (preventative) act’, even if an earlier preventative opportunity (pre dating these laws) arose and was not acted on.

Reminder – This also includes psychological workplace-based hazards and risks, and could include a situation where negligent psychological conduct causes an injury or illness to another person, who then later dies from that injury or illness.

S39 (2) states that in determining if conduct is negligent:

- ‘what matters is the conduct itself and it does not matter whether the conduct is/is not imputed to the body corporate by an employee, agent or officer, … it is also conduct by the body corporate’
- it does not matter whether any of the body corporate’s officers were involved
- the “reasonable care” performance standard is applied.

This section is aimed at overcoming an historical legal problem that a corporation could only be found liable where the conduct could be attributed to an individual of sufficient authority, referred to as the ‘identification doctrine’ or the ‘directing mind and will’ theory of corporate liability. This doctrine does not work well in today’s decentralised organisations.

This section would allow for direct liability of a body corporate (or other entity) without pinpointing individual fault.

INSIDE AND OUTSIDE VICTORIA

These laws have been designed to ensure that offences capture conduct that occurs outside Victoria but results in a fatality inside Victoria, and conduct occurring inside Victoria but results in a fatality outside Victoria.

For example, if a person is killed in Victoria due to the negligence of an organisation, partly due to its OHS policies, it is intended that the organisation or its officer/s, can be prosecuted for the offence in Victoria even if the policies were drafted interstate.

Similarly, the laws are meant to apply where an employee is injured at work due to negligent conduct in Victoria, and then dies in hospital outside of Victoria because of that injury or illness.

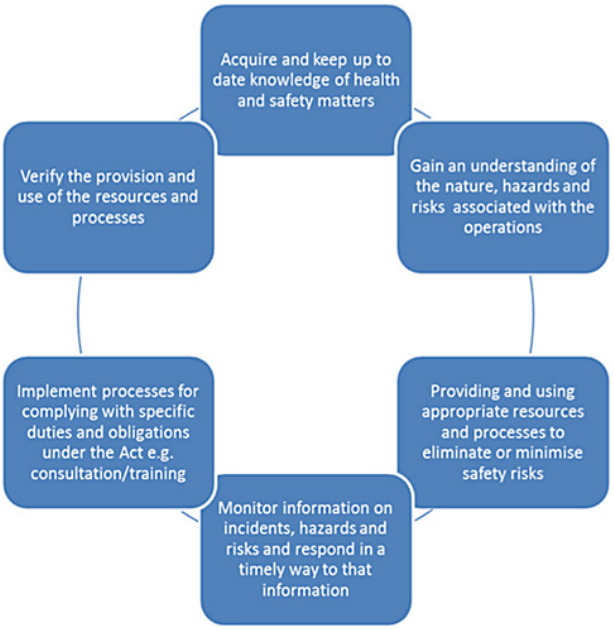
STATUTE OF LIMITATIONS IS REMOVED

The new laws amend Section 132 that provides for a 2-year limitation on commencing legal proceedings for indictable offences under the Victorian OHS Act 2004, removing this 2-year limitation due to Workplace Manslaughter Investigations often taking much longer, based on the experience in the United Kingdom, to effectively investigate and requiring much more time and resources to bring a case to a point of progressing to the courts.

WHAT SHOULD ALL EMPLOYERS DO?

Although these laws will not impose any new OHS duties on businesses, the threat of significantly increased penalties should motivate all small, medium and large businesses to review and ensure their high or extreme risk rated hazards and controls are either fully eliminated or effectively minimize those risks that can potentially result in a workplace death.

An organisation with robust OHS practices and procedures that comply with OHS obligations should not be found guilty of these offences.

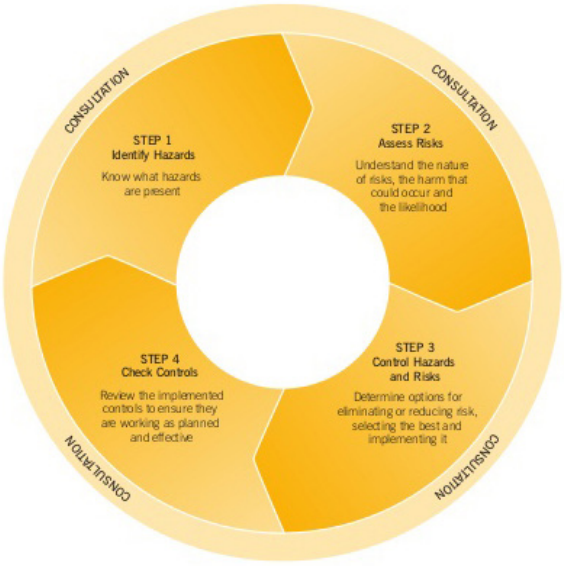


A 'Due Diligence' Approach.

In most State, Territory and the Commonwealth workplace health and safety legislation requires 'officers' to provide focused 'due diligence' behaviours as shown in the diagram (across).

The way to achieve this is to review and revise the organisation's hazard and risk management for potential fatality and serious Injury/illness by following the systematic approach outlined in the diagram (across).

What is safety risk management?



LIKELIHOOD *How likely is this incident to happen?*	CONSEQUENCE *If the incident happened, how bad would it be (type of injury)?*				
	1 Insignificant e.g. No treatment required	2 Minor e.g. First Aid treatment	3 Moderate e.g. Medical treatment	4 Major e.g. Extensive injuries / single fatality	5 Catastrophic e.g. Multiple serious injuries / loss of life
Certain to occur 5	Significant Risk	Significant Risk	High Risk	Extreme Risk	Extreme Risk
Very likely 4	Moderate Risk	Significant Risk	Significant Risk	High Risk	Extreme Risk
Likely 3	Low Risk	Moderate Risk	Significant Risk	High Risk	High Risk
Unlikely 2	Low Risk	Low Risk	Moderate Risk	Significant Risk	High Risk
Rare 1	Low Risk	Low Risk	Moderate Risk	Significant Risk	Significant Risk

THE SYSTEMATIC HAZARD AND RISK MANAGEMENT APPROACH ACCORDING TO ISO 31000

As with any hazard and risk management approach, this required systematic identification and management of hazards and risks is mandated and the best way to ensure hazards and risks are effectively controlled and OHS compliance is achieved.

As a result, businesses should be seeking to review their OHS hazard and risk registers, policies, practices and training relating to work that could foreseeably result in a fatality or serious injury or illness.

REVIEWING AND DOCUMENTING HIGH RISK ACTIVITIES, HAZARDS AND CONTROLS

1. Develop or Conduct a Fatality Hazards and Risks Review

All organisational boards, directors or executive teams, whether they are small, medium or large businesses, need to have crystal-clear 'lines of sight' of their potential serious injury, illness and fatality risks usually documented in an Injury Risk Register (spreadsheet) that details each class of fatal hazards, risks and their suite of effective control strategies. E.g. Fatal electrocution or death from a fall of 2 metres or more.

It is also important that risk assessment tables used for this are closely based on standard ISO 31000 – Risk Management, or other widely well-regarded templates, as this provides a known and consistent benchmark for all.

Take a long-term view

In assessing the chance or likelihood of a fatality, serious injury or illness, organisations must think 'longer term' and industry wide, rather than only considering the next few months, years or only thinking about their own incident history.

It is often the 'one in 10 or 20' year organisational occurrence that may provide the catalyst for these fatalities, and boards, directors and executive teams need to seriously consider the 'rare' and 'catastrophic' situations when identifying hazards and developing risk elimination or management strategies.

2. Enhance the Business Risk Register and Action Plans

A due diligence approach is required in order to plan and resource an organisation's capabilities and practices to avoid the occurrence of these 'rare and potentially fatal' hazards and risks, and do everything in your capacity to reduce and control them so they no longer create high or extreme risk rated risks.

Once the most effective blend of controls are in place, then the risks can be re-assessed as moderate or low based on the specific blend of targeted control strategies.

3. Ensure this is conducted in a consultative way

Because risk assessment is a subjective assessment it is critical that all the 'experts' are engaged and listened to. The hands on, technical and process experts all need to have the opportunity to contribute to these critical hazard and risk assessments.

This consultative approach provides a higher degree of reliability and consistency to the risk register and its outcomes and, remember, it's also a legal requirement in the OHS Act 2004. (Section 35)

4. Strengthen corporate attitudes against accepting High Risk activities

The conduct that may lead to serious injury or fatality often occurs during abnormal or urgent business activities. The attitude of "getting things done" at the expense of doing them safely often dominates management and supervisory thinking during busy periods.

Strong leadership standards, clear decisions and communication, and effective accountability are all critical to achieving this type of proactive safety culture on an ongoing basis, especially when significant business pressure and changes occur.

5. Gain documented evidence and assurance.

Gain documented evidence and assurance that fatality, serious illness, and injury risks are either completely removed or fully controlled, and regularly monitor and gain targeted feedback to confirm this is the case for the long-term future of the organization.

This should be conducted through both regular internal reviews, and independent external periodic audits.

HOW WE CAN HELP?

The Victorian Chamber's Health Safety and Wellbeing (HSW) team are highly qualified and experienced in reviewing, preparing and improving your policies, procedures and practices, and upskilling your staff in these complex safety management needs.

For more information on our HSW consulting, training and other support services, please contact us on **03 8662 5333** or **hsw@victorianchamber.com.au** to discuss your needs.