MINERALS COUNCIL OF AUSTRALIA

SUBMISSION TO SAFE WORK AUSTRALIA, WORKPLACE HEALTH AND SAFETY INCIDENT NOTIFICATION CONSULTATION

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29 SEPTEMBER 2023

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1. BACKGROUND

Introduction

On 28 July 2023, Safe Work Australia (SWA) released its consultation paper on *'Options to improve WHS Incident Notification'* (the consultation paper).[1]

The consultation paper proposes several options to change the incident notification requirements, over a broad range of topics, which will be addressed in this response to the consultation paper.

The Minerals Council of Australia (MCA) supports changes to the Workplace Health and Safety (WHS) Incident Notification framework, where such changes are required based on:

- Risk-based necessity
- Clear, established criteria to ensure they are outcome-focused and flexible to promote continuous improvement
- The wide range of different operating environments.

The health and safety of industry workers is the highest priority of MCA members. The industry's aim is to eliminate risks to workers in the workplace. However, the MCA holds significant concerns for the proposed options, as set out in the consultation paper. Primarily these concerns centre on the reporting of non-work-related illnesses or mental health issues or incidents. This causes a great deal of confusion, blurs the lines on workplace responsibilities and those responsibilities of the broader category known as 'person conducting a business or undertaking' (PCBU), and invades privacy. Additionally, there are many foreseeable legal problems with some of the proposals.

Further, the MCA holds concerns that the proposals would have an unreasonable burden on the capacity and capability within the safety and mining regulators and that such an increase of reporting, without identifying the health benefits, would only exhaust an already stretched resource for industry.

As such, the MCA requests that SWA consider the matters raised in this submission and would appreciate an opportunity for further consultation with SWA on this topic.

The MCA also notes that a Regulatory Impact Statement (RIS) had commenced on these recommendations, and highlights concerns that this was not finalised prior to the release of the consultation paper.

The MCA received an extension to file the submission until 11 October 2023. SWA subsequently confirmed that the position of SWA would be reached on this subject matter by the end of September, for decision of the WHS ministers in December 2023. The MCA is concerned that a lack of genuine engagement given the short time frames will result in a flawed and unachievable policy with detrimental effects to many industries, including mining.

Applicability to mining

The mining industry already has a rigorous incident reporting framework, which exceeds the obligations of other industries.

In addition to the current notifiable incident reporting requirements to WHS regulators in each jurisdiction, mining also has additional reporting requirements to mining regulators. The regulators and the reporting requirements vary across the jurisdictions in Australia.

[1] Safe Work Australia consultation paper for options to improve WHS Incident Notification.

Reporting requirements are currently prescribed in:

- New South Wales (NSW)
  - *Work Health and Safety (Mines) Act 2013*
  - *Health and Safety (Mines) Regulation 2014*
- Western Australia (WA)
  - *Work Health and Safety (Mines) Regulations 2022*
  - *Mines Safety and Inspection Act 1994*
- Victoria (VIC)
  - *Chapter 5.3 of the Occupational Health and Safety Regulations 2017*
- Queensland (QLD)
  - *Mining and Quarrying Safety and Health Act 1999*
  - *Mining and Quarrying Safety and Health Regulation 2017*
  - *Coal Mining Safety and Health Act 1999*
  - *Coal Mining Safety and Health Regulation 2017*
- South Australia (SA)
  - *Chapter 10 of the Work Health and Safety Regulations 2012 (SA)*
- Tasmania (TAS)
  - *Mines Work Health and Safety (Supplementary Requirements) Act 2012*
  - *Mines Work Health and Safety (Supplementary Requirements) Regulations 2022*
- Australian Capital Territory (ACT)
  - *Work Health and Safety Act 2011*
  - *Work Health and Safety Regulation 2011*
- Northern Territory (NT)
  - *Work Health and Safety (National Uniform Legislation) Act*
  - *Chapter 10 (Mines) of the Work Health and Safety (National Uniform Legislation) Regulations*

Futher, mining has three regulators, in addition to the safety regulators in each states:

- NSW Resources Regulator
- QLD Department of Resources
- WA Department of Mines, Industry, Regulation and Safety

Unintended consequences

The most significant consequence of the proposed changes is the potential to cause harm to affected persons through the proposed reporting requirements.

The proposed options, particularly those in chapters 5 to 9 of the consultation paper, are not trauma-informed and do not consider the needs and wants of the affected individuals. They do not consider the issue of worker rights to privacy and the protection of personal information. Nor do they address how a breach of any data obtained would or could be managed to ensure workers, and businesses, are protected. Without such guarantees and protections, it is foreseeable there would be a reduction in reporting for fear of further psychological and physical harm. This would therefore undermine one of the intents of incident

notification, and the ability of the employer to fully understand the prevalence of specific risks in the workplace.

The right of workers to feel safe and secure at work is a priority for MCA members. Mandating a requirement to report specific matters would effectively strip an individual of this right, by forcing them to supply personal information in order to determine whether the matter was work-related and therefore should not be considered.

Aside from impacting the affected person with the proposed mandatory reporting, there is no detail on how family members and communities would be protected, or how they would be required to comply with mandatory reporting requirements, as for example with the reporting of non-work-related suicides or attempted suicides.

The minerals industry has worked hard to raise awareness and provide resources to prevent harassment, sexual harassment, bullying and other harmful behaviours in the workplace. The proposed reporting requirements are likely to breach procedural fairness, as mandatory reporting is proposed to be required 'immediately', before a full and complete understanding of the alleged incident has been achieved. This will have significant implications for respondents, and accusers/ affected persons, if an alleged event is notified to the regulators. This notification could lead to further harm, which would be entirely preventable if notified after appropriate evidence has been gathered and investigated by the appropriate parties. The minerals industry's duty of care to prevent harm would be in direct conflict with the proposed notification requirements. This would, additionally, foster an environment of reduced reporting.

The *'2019 Review of all fatal incidents in Queensland Mines and Quarries from 2000 to 2019' (*the Brady Review*)* conducted by Dr Sean Brady, highlights the importance of simple safety legislation, reporting frameworks and investigations. The proposed options within the consultation paper are contrary to the recommendations made in the Brady Review.

The MCA acknowledges that collection of some information, as proposed in the consultation paper, may inform regulators of potential 'hot spots', prevalent behaviours and psychological risk factors that could be the focus of improvement efforts. However, it is likely that companies will be at varying levels of maturity and, as such, collective and overarching reporting requirements may become overly complex, and not easily understood by all industries. The options proposed within the consultation paper do not factor or acknowledge the continuing leading and best practices established, and continually improving within businesses.

Supporting companies by proactively focusing on further developing preventative measures will have a more demonstrable positive impact to worker health and safety.

Finally, the options proposed do not appear to demonstrate any health and safety benefits which would outweigh the significant concerns outlined above.

2. MCA RECOMMENDATIONS

General recommendations

The MCA recommends:

- A regulatory impact assesment be undertaken regarding the proposed changes to the WHS incident notification framework, as previously recommended by the Office of Impact Analysis (OIA), as detailed in 'Section 3 – Concerns regarding the consultation' of this submission
- Consultation be held to examine improvements to improve existing reporting requirements
- The adoption of national consistency of timeframes (such as when to report and by what method), definitions (for terms such as 'serious' and 'immediate') and approaches to data gathering (such as guidance, other government agencies, regulation etc)
- Clarifying the overlap of other legislation, such as the *Crimes Act 1914.*

Chapter 5 – Periodic reporting of incapacity periods

Not supported.

Any regulator intervention, whether by interview or investigation, can cause further harm to an affected person. This needs to be balanced through legal notification duties and appropriate trauma-informed responses by all parties.

Chapter 6 – Attempted suicide, suicide and other deaths related to psychological harm

Not supported.

There is no identifiable causal link to the workplace to require such guidance material being developed.

Chapter 7 – Capturing workplace violence

Option 1 is supported, only if:

- 'Immediate notification' is amended to 'immediate notification once the PCBU becomes aware'
- A clear threshold for notification of a serious physical assault, as a physical incident may or may not result in physical or psychological harm
- The 'deprivation of a person's liberties' should also be amended to '*unlawful* deprivation of a person's liberty' as there will be circumstances where this is lawful, such as a site lockdown for safety for security reasons.

Further clarification on how privacy and consent will be managed is required.

Chapter 8 – Periodic reporting of exposure to traumatic events

Not supported.

The case for including a new notification requirement has not been made.

Chapter 9 – Periodic reporting of bullying and harassment

Not supported.

Signficant amendments would be required for this option to be supported in principle.

These changes are:

- 'Immediate notification' is amended to 'immediate notification once the PCBU becomes aware'
- A clear threshold for notification of a serious physical assault, as a physical incident may or may not result in physical or psychological harm

- The ‘deprivation of a person’s liberties’ should also be amended to ‘*unlawful* deprivation of a person’s liberty’ as there will be circumstances where this is lawful, such as a site lockdown for safety for security reasons.

Chapter 10 – Long-latency diseases – exposure to substances

The MCA supports the reporting of exposure to substances that cause long-latency diseases, so long as that reporting is aimed at preventing adverse health outcomes and is implemented in a way thay is effective at reducing risk and improving compliance.

This might be better explored in the health monitoring regulations.

Chapter 11 – Serious head injuries

Supported.

The MCA supports option 3 of the proposed options, noting that additional guidance material will need to be provided to industry and workers on what qualifies as ‘immediate’.

The MCA considers the current reporting requirements sufficiently address serious head injuries but is always supportive of additional guidance and education.

Chapter 12 – Other potential gaps in ‘serious injury or illness’

Supported with amendments.

Option 2 would only be supported if there were changes to the wording, to specify ‘serious crush injuries’ or ‘serious bone fractures’ that *require surgical intervention.*

Chapter 13 – Capturing incidents involving large mobile plant

Supported.

The MCA supports this requirement for notification, and notes it is already supported in mining regulations across WA, QLD, and NSW.

Chapter 14 – Capturing the fall of a person

Supported.

The MCA would support an update to the reporting requirements to provide further clarity on this matter. However, careful consideration must be given to the wording and prescriptiveness to ensure there is no further complexity and confusion.

Chapter 15 – Addressing minor gaps and ambiguities in the current incident notification provisions

The MCA supports the development of additional and improved guidance material and educational resources for workers and industry.

The MCA strongly urges SWA to consult further for a more extensive feedback on proposed changes to the model WHS laws.

3. CONCERNS REGARDING THE CONSULTATION PAPER

The MCA recognises the importance of continual review and improvement. There are concerns expressed from within the minerals industry that continual change without improvement may prove detrimental to both the health and safety of workers and the positive safety cultures businesses have invested heavily in to establish.

The consultation paper refers to the purpose of the WHS incident notification review being in line with the reommendations made in the 2018 *Review of the model WHS laws – Final Report* (*Boland Review*), and refers to parts of the *Boland Review* that highlighted the current notification provisions '*were not working'*.[2] Later in the report, though not referenced in the consultation paper, the *Boland Review* presumed the regulator had implemented properly and regulated effectively.[3] We do not see this as accurate, and many of the regulators have provided feedback to SWA during the WES review process that they do not have the resources, or the necessary training, to implement additional changes. The MCA does not discern this as any different for dramatic incident notification changes, particularly in regard to psychological injuries and illnesses, where additional and specific training is required, and necessitates a very different approach during investigation and reporting than safety incidents resulting in physical harm alone.

The MCA has a number of concerns with the proccess that has informed the consultation paper. These are set out below.

Consultation

The MCA holds significant concerns with this consultation process.

Industry was initially advised in the *Decision RIS – 2018 Review of the model WHS laws* that a Regulatory Impact Assessment (RIA) was to be undertaken for changes to the incident notification provisions.[4]

> *Option 2 is assessed as having minor to nil regulatory impact, as it would not involve regulatory change at this time. Three submissions to the Consultation RIS disagreed with the assessed regulatory impact of this option. As this recommendation was only for a review at this time, the regulatory impact is nil. If Option 2 is preferred and as an outcome of the review process, regulatory change is proposed, a further assessment of regulatory impacts would be conducted.*

This advice was welcomed by the mining industry.

On 28 April 2023 National Cabinet decided to change the role of the Office of Impact Analysis (OIA).

The National Cabinet decision did not identify that any decision already made by the OIA for a RIA was to be withdrawn, and therefore there was an expectation that the RIA for this process would continue. Considering the release of this consultation paper, it appears that SWA does not believe a RIA is required, nor has it been put to the WHS Ministers for a decision for or against the RIA.

A RIA provides a necessary assessment of the impact the regulation will bring, and also determines if regulatory intervention is required.

The significant changes that are proposed in the consultation paper would have enormous impacts to businesses and regulators, as well as duplicate and complicate existing regulatory incident notification frameworks and requirements, which again, highlights the need for a RIA.

The MCA requests clarification on the decision by SWA to proceed with the consultation paper and not defer to the previous OIA advice for a RIA to be completed.

Further, we understand that SWA agreed to have the recommendation on the Incident Notification Consultation to the WHS Ministers for decision in December 2023. The implication is that a decision will be

[2] Pg 101 of the *Boland Review.*

[3] Pg 88 Section 4.1 of the *Boland Review.*

[4] Recommendation 20: Incident Notification provisions, pg 119 of the *Decision RIS – 2018 Review of the model WHS laws.*

made prior to the conclusion on the consultation process. and particularly so for organisations, like the MCA, who had received an extension on the consultation until 11 October 2023.

The consultation paper does not discuss ways to improve existing reporting requirements. The quality of analysis is poor. The first step to be undertaken, before any additional regulatory requirements are mandated, is to analyse the existing reporting requirements and their effectiveness and discuss ways to improve capturing relevant data and reporting for compliance.

Adequate consultation, and time to provide responses to consultation, is required to ensure genuine engagement and ensure that the information being provided is educated, targeted, and detailed.

Implementation

The consultation paper states:

> It is also important that the requirements, and related definitions and thresholds:
>
> - effectively capture incidents that indicate a failure or potential failure of a PCBU to meet their WHS duties (or inadequacy of WHS laws)
> - reliably, accurately and consistently captures incidents that are work-related and may disclose potential breaches of WHS laws
> - apply appropriately and provide sufficient clarity about the notification obligations to diverse PCBUs, and
> - balance sufficient WHS regulator visibility with the risk of overreporting and regulatory burden.
>   - Setting the threshold too low makes the process of WHS regulator triaging difficult while creating significant burden on PCBUs without necessarily bringing a commensurate safety benefit.
>   - Setting the threshold too high risks missing critical opportunities to prevent further harm to workers and others at the workplace or support WHS regulators to effectively perform their functions.

The proposed changes in the consultation paper do not provide solutions for:

- Effectively capturing incidents that indicate a failure or potential failure of a PCBU to meet their WHS duties (or inadequacy of WHS laws)
- Reliably, accurately and consistently capturing incidents that are work-related and identify potential breaches of WHS laws
- Appropriately applying and providing sufficient clarity about the notification obligations to diverse PCBUs
- Balancing sufficient WHS regulator visibility with the risk of overreporting and regulatory burden.

The proposed options pose many practical and administrative challenges which will have significant implementation implications. The proposals introduce further complexity, uncertainty, and a compliance expense, though not defining the problem, or the added health benefits to workers and workplaces. The purpose and benefit of additional reporting has not been outlined in the consultation paper, nor was a cost benefit analysis provided to fully inform the consultation process.

Many of the proposed options overlap with state and mining specific legislation, which will cause unnecessary duplication. Any proposed changes to the *model WHS Act* need to be net-reductive or net-equivalent.

The changes proposed encourage assumptions to be made and are subjective in testing and application, for both workers and businesses. The best legislation is objective-based to inform continuous improvement and best practice. Prescriptive legislation sets a minimum standard and does not encourage adopting a leading practice and innovative approach to worker safety and wellbeing. Similarly, changing legislation without a demonstrable benefit to the workforce will only cause unnecessary confusion and added complexity.

The proposals infringe on a PCBU (‘Officer’) rights (human and legal) where reporting requirements and PCBU duties are specific to ‘actual harm’, not ‘reasonable suspicion of harm’, and ‘treatment’, opposed to ‘suspected treatment’.

Further resources will be required within the state Safety and Mining Regulators to be able to investigate sensitive complaints adequately and appropriately, particularly those around sexual harassment, sexual assault and attempted suicide. The *Respect@Work: Sexual Harassment National Inquiry Report (2020)*, undertaken by the Australian Human Rights Commission (AHRC) highlighted there were insufficiencies in this space.

There is a risk of multiple jurisdictions and agencies applying varying approaches to address incidents of workplace violence, sexual harassment and more. The involvement of agencies, such as the regulators, police, AHRC, medical professionals and the Equal Opportunity Commission, have different jurisdictional requirements that often overlap, or contradict, other state or commonwealth legislation. Adopting an intersectional approach to addressing workplace behaviours and workplace violence is fundamental to acknowledge and respect the distinct roles of persons involved, including subject matter experts, medical professionals, each regulatory body and police throughout the process.

Further to the above, there are overlaps on reporting of the proposed options within other (non WHS specific) legislation, such as the *Crimes Act 1914* for sexual assault and workplace violence (for example), and health legislation (and regulators) for reporting of zoonoses and infectious disease.

The MCA urges SWA to consider the existing reporting frameworks, the capacity of the regulators and the intended added health and wellbeing benefit to workers before implementing changes to the model incident notification framework.

The proposed options trend towards self-incrimination, reverse onus of proof and breach of legal privilege. It is not appropriate for a PCBU to become a proxy regulator and government statistical agency. Some of the proposed options require a PCBU to determine the 'seriousness' of incidents, and the consultation paper goes further to suggest that a PCBU also determine whether an incident meets the 'serious' definition – imposing a requirement on PCBUs that should be undertaken by medical professionals. This is of particular concern in matters relating to psychological health, as a PCBU cannot be expected to work outside their area of expertise and provide a mental health diagnosis as well as determine the severity of the psychological impact to a worker. In doing this, as proposed, it may also expose a PCBU to penalties under other legislation such as the *Australian Human Rights Commission Act 1986 (cth)*.

The use of the word 'hazard' throughout the consultation paper, is implied as the event or an incident. Exposure to trauma is not an event, it is a hazard and an impact of the reportable event.

Improvement of workplace health and safety

The consultation paper has not demonstrated what improvements to workplace safety and health would arise from the proposed incident notification options. It appears to be an exercise of gathering data for purposes that expand well beyond the work environment and the scope of safety, workplace and resource regulators in Australia. Regulators regularly fail to turn current mandatory data collection requirements, across an enormous range of topics, into meaningful information that could be provided back to employers, so that meaningful and informed changes can be made by businesses. This approach to data gathering is the epitome of regulatory burden for no benefit. Unfortunately, there is no confidence that the proposed new data points would be treated any differently.

A focus is required on the existing reporting requirements within current federal and state regulations, to ensure:

- Consistency of definitions and approaches
- The state reports can be aggregated into a national database.

These options have not been discussed or proposed within the consultation paper.

There is a foreseeable risk that the proposed reporting will represent a distraction, and not have the safety and wellbeing of workers as the priority. The focus should be on effective preventative controls.

As highlighted above, it is unclear how confidentiality and issues of consent will be managed. There is a risk to workers that the proposed psychological reporting will result in a breach of their privacy. The MCA is concerned that the options provided in the consultation paper do not address this, nor provide reasons as to why the proposed reporting benefits outweigh the risk to worker privacy.

The consultation paper has failed to identify how the proposed changes will improve workplace health and safety.

4. CONSULTATION QUESTIONS

Chapter 5 – Periodic reporting of incapacity periods

As with reports of sexual harassment, there is likely to be significant underreporting of a range of psychological injuries or illnesses. Until there is societal and workplace maturity and the importance of psychosocial safety is well educated, the ability of an employer to 'predict' that an incident resulted in psychological injury without direct input from the affected person is extremely limited and an unreasonable regulatory burden.

New codes of practice on managing psychological risks have emerged over the last three years at both the commonwealth and state levels, all with differing 'language' and approaches. Until there is consistency in the education of:

- psychological risks – those that could affect a workers mental health – such as role clarity, work demands and control over work for example

and how these risks contribute to and inform

- psychosocial safety – the environment is which a worker feels open to speak freely, make mistakes without fear of reprimand and to be vulnerable

then there is no place for complex legislative changes that are detrimental to workplace psychosocial safety.

Tension is also created between an employer reporting an incident when the affected person does not want this to occur.

Do you support the assessment of current gaps and impacts of addressing those gaps? Please provide any supporting information and evidence.

The MCA acknowledges that there may be some gaps in incident reporting, but any means to reduce gaps must consider the impact that reporting may have on affected persons, such as compelling an employer to undertake a formal investigation simply to satisfy the regulator, when it may not be in the best interests of the impacted persons.

This may also jeopardise the ability of the PCBU to comply with the whistleblower rights and protections as set out in the *Corporations Act 2001 (i.e., if investigating a matter would place the employer in breach of the legislation).*[5] In addition, any regulator intervention, whether by interview of affected person or investigation, can cause further harm to an affected person. This needs to be balanced through legal notification duties and appropriate trauma-informed responses by all parties.

Do you support the proposed option(s)? Please explain why or why not and provide relevant evidence to support your views where possible.

Option number	Description
1	Amend the model WHS Act to require periodic reporting (six monthly) of periods of incapacity from normal work for ten or more consecutive days due to a **psychological or physical injury, illness or harm** arising out of the conduct of the business or undertaking

Not supported.

The causes of psychological injury, illness or harm can be due to many factors, including family, social and cultural relationships, non-work-related trauma, genetics or biophysical circumstances (such as living environment, socio-economic factors, location etc.). Understanding the root causes of this harm can take considerable time (well beyond six months) through an individual's treatment plan generally applied by private counsellors, employee assistance programs, physicians and or clinicians. Periodically reporting a

[5] Division 2, Part 9.4, protections for whistleblowers – *Corporations Act 2001*.

period of incapacity from normal work alone is unlikely to be meaningful with respect to any specific conduct of the business or undertaking.

In addition to the above, there is no measurability of 'harm caused' by the PCBU. This would cause confusion as to when 'harm' becomes a notifiable incident. As outlined in *Section 3 – Implementation* in this submission, any proposed changes to legislation must be objective.

What practical impact, including costs and benefits, would the option(s) have on you, your organisation or your stakeholders? Please provide any details or evidence supporting your views, including the option's likely impact on WHS outcomes or any compliance costs or concerns.

The practical impact of reporting as per the proposed options, would not only cause confusion and create added unnecessary complexity, there is also a risk that the proposed options would significantly increase the number of unfounded or unsubstantiated workers compensations claims and, as a result, not only would this increase the workers compensation insurance premiums for businesses unjustly, it also creates risk for a business's insurability, as the increased number of notifications and claims will unfairly identify businesses as too risky to insure.

Further, because of the risk of increased unsubstantiated or unverified claims and notifications, there is potential for a 'trend' to be seen by the regulator that does not exist, and a spike in reports would incentivise the regulator to intervene and potentially prosecute or otherwise penalise.

Given the above, it is not clear whether there would be any benefit to WHS outcomes.

Periodic reporting is unlikely to have any positive impact on WHS outcomes, as:

- The data will be lagging and aggregated
- It will not indicate to the regulator any preventative or corrective actions
- The likely inconsistencies of the data gathered would not identify any trends within specific businesses or industries.

Are there any likely unintended consequences of the proposed option(s)? How could these be best mitigated?

Without knowing the extent of harm (if any) arising from the conduct of a business or undertaking, reporting periodically on an incapacity will divert resources and time to reporting of harm, that, in fact, the business or undertaking did not contribute to.

Do you have another suggestion or preferred option for addressing the gap in WHS regulator visibility?

- Regulators should review the existing reporting requirements, including definitions, thresholds, timeframes, etc to enable businesses across jurisdictions to report a single set of metrics. This will also enable consolidations into a national data set.
- Developing further and improved guidance on notifiable incidents is welcomed by the minerals industry. This guidance should include the criteria and rationale for notification, as well as what how this will inform the regulator to provide further industry learning.
- Outline the importance of compliance with existing reporting requirements.

Chapter 6 – Attempted suicide, suicide and other deaths related to psychological harm

Do you support the assessment of current gaps and impacts of addressing those gaps? Please provide any supporting information and evidence.

While notification obligations already apply, their validity remains questionable, and the data received by regulators on this would be extremely low given that determining the driver behind a person's attempted suicide or suicide, takes time, and an immediate notification does not allow for investigation into the conduct of the business or undertaking.[6]

The causal link to the workplace, if any, takes considerable time to ascertain, and require access to records and information that a PCBU may not have the right or ability to access.

Do you support the proposed option(s)? Please explain why or why not and provide relevant evidence to support your views where possible.

Suicide or other death due to work-related psychological harm

Option number	Description
1 Suicide and other deaths	Amend the guidance material to clarity that the 'death of a person' (s 35(a)) captures: • suicide of a person due to psychological harm arising out of the conduct of the business or undertaking • other death of a person due to exposure to psychosocial hazards (e.g. heart attack from work stress) arising out of the conduct of the business or undertaking • suicide of a person at a workplace where there is an identified risk of suicide in the workplace.
2 (Optional add-on) Suicide of a worker	Amend the definition of notifiable incident (s 35) in the model WHS Act to specifically capture: • the suicide of a worker, whether or not the suicide arose out of the conduct of the business or undertaking.

Not supported.

The proposed options are not supported. The requirements have the potential to be very intrusive and are not at all trauma-informed.

The consultation paper provides examples to be included in the guidance material as indicators that the conduct of a business or undertaking is directly responsible for the harm. The consultation paper cites five examples of evidence or circumstances that might be relevant. Two of these examples are particularly concerning:

- There is evidence of a direct link to work (e.g. notes, testimonies)
- There had been recent difficulties at work.

The MCA assert that these examples to be included in the guidance material are unlikely to be relevant to the circumstances.

The first example would require the PCBU gathering evidence from an individual under duress or requiring the PCBU to interrogate the family and friends of the individual affected, at a time of immense grief. There is no other suggested avenue of how a PCBU could obtain a copy of a suicide note or gather testimonies from persons who may have knowledge of contributing factors. Additionally, it is not reasonable to make that a requirement or responsibility of a PCBU, and likely exposes officers of the PCBU to 'work related trauma'.

[6] The suicide of a person or death due to psychological harm is notifiable under s 35(a) ('death of a person') if it arises out of the conduct of the business of undertaking.
A suicide attempt 'arising out of the conduct of the business or undertaking', requires notification in circumstances where the person requires immediate treatment as an inpatient in a hospital (s 36(a)) or immediate treatment for specific injuries listed in s 36(b) or (c).

The second example suggests that recent difficulties at work would be significant enough to establish a causal link and determine this as the cause for suicide. However, the suicide may be completely unrelated and does not consider any other contributing factors.

A thorough investigation whereby the contributing factors are identified, along with any root causes or causal links, takes time by those agencies already tasked with this (such as police) to ensure the integrity of the investigation. Immediate reporting of an incident where the causal link has not been identified will not lead to meaningful data, and may only expose additional workers to psychological risks.

The proposal that reporting be based on 'an identified risk of suicide in the workplace' will lead to significant over reporting. It is conceivable that *any* workplace could fit these criteria.

Based on the identified psychological hazards in the *Work Health and Safety Act 2011*[7] and the *Model Code of Practice: Managing Psychosocial Hazards*, the majority of workplaces would have to identify suicide as a potential risk given the intersection of psychological risks in a workplace which overlaps with risk factors outside of the workplace, such as interactions with people, societal culture, socio-economics and more. The consultation paper notes that:

> *the guidance will clarify that it would not be appropriate for a PCBU to investigate the causes of the incident to determine if it is notifiable – any reasonable suspicion that work may have contributed would trigger notification.*

The proposition 'reasonable suspicion' is difficult to define and is likely to result in significant reporting increases of non-work related incidents, as PCBUs will be forced to err on the side of caution. This will not have any value add to the regulators, businesses or workers.

Finally, reporting the suicide of a person, where the suicide was not the result of contributing factors from the workplace, is not relevant to workplace laws, nor is it appropriate for regulator intervention.

Attempted suicide

Option number	Description
1 Attempted suicide	Amend the definition of notifiable incident (s 35); or serious injury or illness (s 36) in the model WHS Act to capture: • attempted suicide of a person due to psychological harm arising out of the conduct of the business or undertaking, and • attempted suicide of a person (where the attempt carries a high risk of death or serious harm) at a workplace where there is an identified risk of suicide in the workplace.
2 (Optional add-on) Attempted suicide of a worker	Amend the definition of notifiable incident (s 35); or serious injury or illness (s 36) in the model WHS Act to specifically capture: • attempted suicide of a worker whether or not the attempted suicide arose out of the conduct of the business or undertaking.

Not supported.

The MCA reiterates the same concerns outlined above, with the additional concern of the impact on the affected person who attempted suicide by virtue of this reporting notification, and the lack of capability of regulators to respond appropriately to these notifications.

It is unacceptable that the consultation paper references the French system of a reverse onus of proof as support for its recommendations.[8] The Australian system has a long-held legal basis that a person/business is innocent until proven guilty of an offence.

[7] Section 3, part 5, page 238 of 285 of the *Work Health and Safety Act 2011*.

[8] Details of the French system can be found at Fair Work Legal Advice.

What practical impact, including costs and benefits, would the option(s) have on you, your organisation or your stakeholders? Please provide any details or evidence supporting your views, including the option's likely impact on WHS outcomes or any compliance costs or concerns.

Refer to our response to Chapter 5.

Further, the consultation paper in Chapter 8 states that:

> The incident notification provisions do not provide WHS regulators with visibility of incidents involving exposures to trauma in relation to serious injuries and fatalities that do not arise out of the business or undertaking.

There is little value in notifying WHS regulators of exposures outside of the workplace that an employer could not reasonably be expected to manage. Therefore, there is no place for the optional add-on proposed that an employer notify of an attempted suicide that was not directly linked to the conduct or business undertaking.

Reporting the suicide of a person, where the suicide was not the result of contributing factors from the workplace, is not relevant to workplace laws, nor is it appropriate for regulator intervention.

Are there any likely unintended consequences of the proposed option(s)? How could these be best mitigated?

Consistent with comments as per Chapter 5, without knowing the extent of the harm (if any) arising from the conduct of a business or undertaking, reporting periodically on an incapacity will divert resources and time to reporting of harm that the PCBU did not contribute to.

The MCA recommends that SWA diverts their focus and resources to develop and improve workplace support and guidance.

Do you have another suggestion or preferred option for addressing the gap in WHS regulator visibility?

As already highlighted in this submission:

- Regulators should review the existing reporting requirements, including definitions, thresholds, timeframes, etc to enable businesses across jurisdictions to report a single set of metrics. This will also enable consolidations into a national data set.
- Developing further and improved guidance on notifiable incidents is welcomed by the minerals industry. This guidance should include the criteria and rationale for notification, as well as what how this will inform the regulator to provide further industry learning.
- Outline the importance of compliance with existing reporting requirements
- Additionally, enabling data sharing between other relevant agencies such as the police or a coroner's court etc.

Chapter 7 – Capturing workplace violence

Do you support the assessment of current gaps and impacts of addressing those gaps? Please provide any supporting information and evidence.

While the consultation paper did not make the case for change on this item, inclusion of this data is warranted.

Do you support the proposed option(s)? Please explain why or why not and provide relevant evidence to support your views where possible.

Option	Description
1	Amend the model WHS Act to require immediate notification (de-identified) to the WHS regulator of: a. a **sexual assault** - including any sexual behaviour or act which is threatening, violent, forced, coercive or exploitative and to which a person has not given consent or was not able to give consent[9] b. a **serious physical assault** - including where a worker or other person in the workplace is assaulted with a weapon, punched, kicked, struck, beaten, shoved or bitten by another person c. the **deprivation of a person's liberty** - including being trapped, confined or detained by another person, and d. an **express or implied threat of serious violence** that causes genuine and well-founded fear of death, serious sexual assault or serious injury or illness arising out of the conduct of the business or undertaking and that exposes a worker or any other person to a serious risk to a person's health and safety.
Optional add-on	Introduce a power to permit WHS regulators to approve alternative reporting arrangements for certain PCBUs with specific conditions.

The MCA broadly supports Option 1 with amendments:

- 'Immediate notification' will not be practicable unless it is amended to 'immediate notification once the PCBU becomes aware'
- There is no clear threshold for notification of 1b (serious physical assault) as a physical incident may or may not result in physical or psychological harm. The action does not necessarily lead to harm.
- Option 1c (deprivation of a person's liberty) should also be amended to '*unlawful* deprivation of a person's liberty' as there will be circumstances where this is lawful, such as a site lockdown for safety or security reasons.

The MCA supports the acknowledgement in the consultation paper that de-identified data would be provided, consistent with the ACT for notifications of sexual assault, where PCBUs must not provide any information to the WHS regulator that discloses the identify of any person involved. However, further consideration should be given to how any sensitive or personal information that is gathered or compelled can be managed and restricted.

The MCA would also encourage cooperation between WHS regulators, police and other government agencies and set out when those parties will notify each other when certain incidents occur.

What practical impact, including costs and benefits, would the option(s) have on you, your organisation or your stakeholders? Please provide any details or evidence supporting your views, including the option's likely impact on WHS outcomes or any compliance costs or concerns.

The complications of identifying costs and the lack of definition of many aspects do not allow a proper assessment of costs to any individual PCBU at this stage.

Are there any likely unintended consequences of the proposed option(s)? How could these be best mitigated?

Yes, outlined above:

- 'Immediate notification' will not be practicable unless it is amended to 'immediate notification once the PCBU becomes aware'
- A clear threshold for notification of a serious physical assault is required, as a physical incident may or may not result in physical or psychological harm. Additionally, the affected person may choose to take the matter outside of the workplace and report directly to police without the PCBU's knowledge.
- The 'deprivation of a person's liberties' should also be amended to '*unlawful* deprivation of a person's liberty' as there will be circumstances where this is lawful, such as a site lockdown for safety for security reasons.

The proposed option would only be supported *if* appropriate safeguards are included to note that reporting in and of itself does not imply a breach of law.

Do you have another suggestion or preferred option for addressing the gap in WHS regulator visibility?

As detailed in Chapter 6:

- Regulators should review the existing reporting requirements, including definitions, thresholds, timeframes, etc to enable businesses across jurisdictions to report a single set of metrics. This will also enable consolidations into a national data set.
- Developing further and improved guidance on notifiable incidents is welcomed by the minerals industry. This guidance should include the criteria and rationale for notification, as well as how this will inform the regulator to provide further industry learning.
- Outline the importance of compliance with existing reporting requirements.
- With the addition of enabling data sharing between other relevant agencies such as the police or a coroner's court etc.

Additional question – Are there particular types or circumstances of workplace violence that you think should or should not be notifiable to the WHS regulator that are not dealt with by the proposed option and descriptions? What would be the implications of including or excluding these incidents?

It is unclear if Option 1 includes incidents of domestic violence while at the workplace (or work-related events, accommodation etc) and if they would be captured here.

Chapter 8 – Periodic reporting of exposure to traumatic events

Do you support the assessment of current gaps and impacts of addressing those gaps? Please provide any supporting information and evidence.

No.

Understanding the impact of trauma in the workplace on a person's psychological wellbeing at work is important. However, the case for including a new notification requirement has not been made.

Do you support the proposed option(s)? Please explain why or why not and provide relevant evidence to support your views where possible.

Option number	Description
1	Amend the model WHS Act to require periodic reporting (six monthly) to the WHS regulator of instances where workers, or other persons at the workplace, **are exposed to serious injuries, fatalities, instances of abuse or neglect that are likely to be experienced as traumatic by the worker or other person**, where the exposure arises out of the conduct of the business or undertaking.
Optional add-on	Assess the need for WHS regulators to have the ability to approve **alternative reporting arrangements** for certain PCBUs with specific conditions.

Not supported.

Option 1 is not supported, as this is a duplication of current reporting requirements with respect to serious injuries and fatalities. Reporting the same incidents under different legal provisions is redundant.

The consultation paper proposes that this would include exposures to situations, materials and reports. This is very broad and would unreasonably capture exposure to external material and reports such as a news item, hearsay, movies etc.

The very proposal of the 'optional add-on' reflects that the proposed options are too prescriptive and therefore adjustments would be required, highlighting the issues with this being legislated.

What practical impact, including costs and benefits, would the option(s) have on you, your organisation or your stakeholders? Please provide any details or evidence supporting your views, including the option's likely impact on WHS outcomes or any compliance costs or concerns.

The MCA strongly questions what, if any, benefit would arise for WHS reforms.

Are there any likely unintended consequences of the proposed option(s)? How could these be best mitigated?

Yes, outlined throughout the responses above.

Do you have another suggestion or preferred option for addressing the gap in WHS regulator visibility?

Enable data sharing between other relevant agencies such as police, or a coroner's court, etc.

Chapter 9 – Periodic reporting of bullying and harassment

Do you support the assessment of current gaps and impacts of addressing those gaps? Please provide any supporting information and evidence.

Building on the considerable data already available through compensation claims would be valuable provided there was not an additional costly and inefficient imposition placed upon PCBUs.

Do you support the proposed option(s)? Please explain why or why not and provide relevant evidence to support your views where possible.

Option	Description
1 Unreasonable behaviours	Amend the model WHS Act to include a duty to periodically report (six-monthly, de-identified data) to the WHS regulator on **complaints OR instances,** arising out of the conduct of the business or undertaking **Of** a) **repeated and unreasonable** behaviour (bullying) towards a worker or group of workers, or b) **unreasonable behaviour** towards a worker(s) that a reasonable person would consider is abusive, aggressive, offensive, humiliating, intimidating, victimising or threatening *[including sexual harassment or harassment of any other kind]* where the behaviour may reasonably be considered to have occurred (excluding vexatious or frivolous claims), and that exposes a worker(s) to a risk to their health and safety.
2 Bullying; sexual harassment and harassment on protected grounds	Amend the model WHS Act to include a duty to periodically report (six-monthly, de-identified data) to the WHS regulator on **complaints OR instances** **Of** a) workplace **bullying** *repeated, unreasonable behaviour towards a worker(s) or group of workers* b) workplace **sexual harassment** of a worker(s) *that that involves unwelcome sexual advances, unwelcome requests for sexual favours or unwelcome conduct of a sexual nature* c) workplace **harassment** of a worker(s) *because of protected characteristics (e.g. race, sex, gender, sexual orientation, age, disability)* where the behaviour may reasonably be considered to have occurred (excluding vexatious or frivolous claims), and that exposes a worker(s) to a risk to their health and safety.

The MCA supports Option 1 in principle, *only if*:

- The notification is for events that have actually occurred and not just complaints
- The definitions specifically state 'bullying' and 'harassment' rather than using language of 'unreasonable behaviour'
- There is no duplication with existing reporting requirements, including the Workplace Gender Equality Agency (WGEA) and the *Sex Discrimination Act 1984* to the AHRC.[10]

Option 2 is **not supported** due to the inclusion of language on 'protected attributes'. This introduces concepts from industrial law such as the *Fair Work Act 2009.*

[10] Fact Sheet - Complaints under the Sex Discrimination Act.

What practical impact, including costs and benefits, would the option(s) have on you, your organisation or your stakeholders? Please provide any details or evidence supporting your views, including the option's likely impact on WHS outcomes or any compliance costs or concerns.

Periodical reporting is unlikely to have any impact on WHS outcomes:

- The data will be lagging and aggregated
- It will not indicate to the regulator any preventative and corrective actions
- The likely inconsistencies of the data gathered would not identify any trends within specific businesses or industries.

Are there any likely unintended consequences of the proposed option(s)? How could these be best mitigated?

The proposed option would only be supported *if* appropriate safeguards are included to note that reporting in and of itself does not imply a breach of law.

Do you have another suggestion or preferred option for addressing the gap in WHS regulator visibility?

As identified in Chapter 5:

- Regulators should review the existing reporting requirements, including definitions, thresholds, timeframes, etc to enable businesses across jurisdictions to report a single set of metrics. This will also enable consolidations into a national data set.
- Developing further and improved guidance on notifiable incidents is welcomed by the minerals industry. This guidance should include the criteria and rationale for notification, as well as what how this will inform the regulator to provide further industry learning.
- Outline the importance of compliance with existing reporting requirements.

Chapter 10 – Long-latency diseases – exposure to substances

Should exposure to hazardous substances in the workplace that cause latent diseases be recorded and reported? If so, for which substances?

No.

Recording and reporting of all individual exposures may result in breaches of privacy and may result in workers being hesitant to report health issues related to any occupational exposure if they could foresee their personal data being disclosed.

It is also foreseeable that the data provided on one-off exposures could be misinterpreted without a full context of the exposure, including duration, frequency, and levels of exposure, resulting in the implementation of ineffective or ill-targeted safety measures, regulatory or otherwise.

The MCA has contributed to many of the SWA activities and consultations targeted at workplace exposures of substances, including respirable crystalline silica, which included the National Occupational Respiratory Disease Register (NORDR), the National Silicosis Prevention Strategy (NSPS) and National Action Plan (NAP) as well as the prohibition on the use of engineered stone; diesel particulate matter; non-threshold genotoxic carcinogens (NTGCs) and carbon dioxide. The MCA supports the purpose behind national initiatives to improve worker health and safety.

The MCA supports a risk-based approach, that is flexible in allowing individual companies to work within their areas of concern. The mining industry invests heavily in not only achieving best-practice but also establishing and sharing leading practice to manage risks posed by occupational exposures.

Where a worker is exposed to a substance in exceedance of the workplace exposure standard, schedule 14 of the WA *Work Health and Safety (Mines) Regulation 2022* identifies the substances that trigger health monitoring.[11] Schedule 24 of the same regulations also identify these exposures as reportable, specifically stating 'where a reportable incident is *likely* to result in' any form of incapacitation of a worker.[12] Reportable incident is defined in Part 1.1 r.5, and the duty is highlighted in part 10.6, 675v. [13] [14]

It would be worth considering criteria on when a report of exposure is required. For example, there are many different criteria used around the world, such as the Korean *Serious Accident Prevention Act 2021* and the Taiwan Center of Occupational Accident Prevention and Rehabilitation system for tracking 'notifiable' and 'suspected' occupational diseases.

How are exposures to hazardous substances currently measured in the workplace (for example, air and health monitoring)? Do you have suggestions for options to improve monitoring to provide a better understanding of exposure to hazardous substances in the workplace?

Current practice in mining for measuring substances in the workplace includes:

- Personal and biological monitoring: this includes devices fitted to the worker measuring for substances within 30 cm of the workers breathing zone. Biological monitoring invbolves pre-employment medical tests and ongoing health surveillanve which may include xray, HRCT, lung function tests, blood tests and urine tests.
- Atmospheric testing (stagnant and mobile): measuring airborne contaminants as dusts, vapours, gases and mists
- Surface sampling: sample gathering off a surface and analysing under microscope in a laboratory setting.

[11] Schedule 14 – Requirements for Health Monitoring, Table 14.1 Hazardous Chemicals (other than lead) requiring health monitoring, Work Health and Safety (Mines) Regulations 2022, page 678 of 746.
[12] Schedule 24 – Information to be included in notification of reportable incidents, Work Health and Safety (Mines) Regulations 2022, page 660 of 746.
[13] Part 1.1 Introductory matters, r.5, Work Health and Safety (Mines) Regulations 2022 page 38 of 746.
[14] Part 10., 675V Work Health and Safety (Mines) Regulations 2022, page 495 of 746.

Additional monitoring and reporting would create an unnecessary burden to both workers and employers without fully understanding the scope of what the reporting would achieve to improve health and safety outcomes.

It would be desirable if the regulators, state and commonwealth, could provide information to industry on any specific exposure trends based on the reporting that is already required, so industry could focus on preventative measures.

With regards to air monitoring, how are exceedances of the WES captured? Do you think recording and reporting WES exceedances is a good way to identify exposure to hazardous substances in the workplace? What other ways could exposures be recorded and reported?

All air monitoring results are reported to the mining regulator in Western Australia. Air monitoring data is uploaded into the Safety Regulation System (SRS) and the Department of Mines, Industry Regulation and Safety (DMIRS) sends an electronic message to operators whenever there is an exceedance of the WES.

This response is the same, irrespective of whether the exceedance is for 1 or 100 times the WES, so exceedances are captured when reported.

In NSW and QLD, mining operations are required to report the exceedance of a WES in accordance with Section 41(1)(b) of the *NSW Work Health and Safety (Mines and Petroleum Sites) Regulations 2022* and Section 195(2)(b) of the *QLD Mining and Quarrying Safety and Health Regulation 2017* respectively.

Risks to worker health should be determined by statistical means, not using single samples. Statistical analysis based on log-normal distribution is the most appropriate for workplace exposure data according to well established exposure science principles, published by peak professional bodies such as the American Institute of Industrial Hygienists (AIHA) and the Australian Institute of Occupational Hygienists (AIOH).

Should PCBUs be required to keep records of statement of exposure documents and make them available for inspection by the regulator? Should the statement of exposure requirement be broadened from prohibited or restricted carcinogens to include other substances which are known to cause long latency diseases? If yes, how should these substances be identified?

The MCA does **not support** any changes to any existing requirements, for which no case has been made to inform any such changes.

For Schedule 14 substances in WA, PCBUs are required to produce statements (typically letters with an individual's monitoring results) and supply them to workers and maintain records of these statements for 20 years or more.

There is no supporting evidence provided to suggest that additional reporting on exposure of substances that are not prohibited or restricted is required.

An example of where this would create complexity and would not be feasible to implement would include chlorine. Chlorine is a common chemical used in water treatment for a multitude of reasons, including for drinking water, swimming pools, waste treatment and more. No further health benefit would be provided to workers if this was recorded on a statement and maintained when they are likely to be exposed a number of times a day.

Given that almost 700 WES reviews have been conducted by SWA, with many of these resulting in a recommendation for a WES of more than five times lower than the previous WES, this appears to have designed a future in which there will be multiple reports for workers daily, as the WES limits are so low that any kind of exposure would result in an exceedance. This this will have the opposite effect of gaining meaningful data, as the reports would be so excessive that the regulators will not be able to discern any.

Chapter 11 – Serious head injuries

Option	Description
1	Amend the model WHS Act (s 36) to capture 'serious head injuries' (without applying the threshold of requiring 'immediate treatment').
2	Amend the model WHS Act (s 36) to capture 'suspected serious head injuries' requiring immediate treatment.
3	Address this potential gap through other options, including: • updating the guidance material to explain what is meant by 'immediate treatment' and how this applies to serious head injuries (refer Chapter 15), and • capturing serious head injuries through an incapacity period (Chapter 5).

Option 3 supported in principle

The MCA supports option 3 of the proposed options, noting that additional guidance material will need to be provided to industry and workers on what qualifies as 'immediate'. Further, the MCA does not agree with periodical reporting of incapacity periods without significant amendments to not capture unintended circumstances.

Amending the legislation to capture 'serious head injuries without applying the threshold of requiring immediate treatment' or 'suspected head injuries' as proposed in options 1 and 2 will introduce confusion as it introduces a subjective determination to be made prior to reporting, while also capturing the complexity of 'immediate reporting' (as outlined in chapter 7) where there is both a physical and psychological injury or incident.

The MCA strongly believes the current reporting requirements sufficiently address serious head injuries but are always supportive of additional guidance and education.

Chapter 12 – Other potential gaps in 'serious injury or illness'

Option	Description
1	Amend the model WHS Act (s 36) to require immediate notification of all work-related injuries and illnesses requiring treatment as an outpatient in an emergency department.
2	Amend the model WHS Act (s 36(b)) to specifically capture 'serious bone fractures' and 'serious crush injuries' requiring immediate treatment.

Not supported

The location of the emergency care facility, type of treatment or medical professional rendering the treatment, is not indicative of the serious nature of the event, noting that remote mining locations have triage and treatment on site, but do not categorise them as an 'emergency department'. Therefore, any data captured by option 1 will be only specific to certain industries and not have any meaningful purpose.

Further, many businesses implement policies that require any worker who has any injury at work to present for medical assessment at a hospital emergency department or casualty clinic to determine their suitability and fitness to continue working. The proposed reporting requirement would result in a huge number of reports that would be difficult to navigate, as they would have no useful data regarding the seriousness of the injury.

It would be more appropriate for the relevant authorities to coordinate data on the number of presentations to emergency departments that were from a work-related incident and were categorised as a category 3 or higher on presentation, in accordance with The Australasian Triage Scale (ATS) currently used in Australian emergency medicine.

Option 2 would only be supported if there were changes to the wording, to specify 'serious crush injuries' or 'serious bone fractures' that *require surgical intervention*, as opposed to 'immediate treatment', given that if a person sustains a crushed fingertip and presents to a hospital, they will receive 'immediate' treatment, albeit minor, and this would capture data that will not inform regulatory and guidance decisions and does not fall within the definition of 'serious injury or illness'.

Chapter 13 – Capturing incidents involving large mobile plant

Option	Description
1	Amend the dangerous incident provisions (s 37) in the model WHS Act to require immediate notification of the malfunction or loss of control of powered mobile plant that exposes a worker or any other person to a serious risk to a person's health and safety.

Supported.

The MCA supports this requirement for notification and notes that it is already supported in the Work Health and Safety (Mines) Regulations 2022.[15]

This is also specified as a requirement within the NSW and QLD mining regulations.[16]

Chapter 14 – Capturing the fall of a person

Option	Description
1	Amend the dangerous incident provisions (s 37) in the model WHS Act to include the fall of a person that exposes a person to a serious risk to health and safety (death or serious injury).

Supported in principle.

Mining regulations across all jurisdictions where mining operations occur capture the fall or release from a height of any plant, substance, or thing. Though not specifically referring to people, this does capture people. To expand the scope of this requirement to exposure to the risk of serious injury from a fall would result in large numbers of reports being made.

The national framework does have a gap regarding notifiable and dangerous incidents, being the defined threshold on the 'level of danger' of falls. The MCA would support an update to the reporting requirements to provide further clarity on this. However, careful consideration must be given to the wording and prescriptiveness to ensure there is no further complexity and confusion.

[15] Part 1.1 Introductory matters r.5(r) Work Health and Safety (Mines) Regulations 2022, page 87 of 749.

[16] Schedule 3, 6(4) of NSW Work Health and Safety (Mines and Petroleum Sites) Regulation 2022 and Schedule 2, part 1 of the QLD Mining and Quarrying Safety and Health Regulation 2017.

Chapter 15 – Addressing minor gaps and ambiguities in the current incident notification process

Causal link principle

Option	Issue
Amend the model WHS Act to prominently reflect the 'causal link principle' and provide greater clarity for PCBUs on what is (and is not) notifiable.	PCBUs must notify the WHS regulators of notifiable incidents 'arising out of the conduct of the business or undertaking has occurred'. This is known as the 'causal link principle'. The intention is to prevent PCBUs notifying incidents that are unrelated to the work activity of the business or undertaking (e.g. a customer has a heart attack while in the workplace that is not caused by work carried out by the PCBU). The incident notification review confirmed that PCBUs are either notifying incidents that are not work-related, or readily finding that the 'arising out of the conduct' threshold has not been met. The incident notification review identified a need to strengthen reference to the causal link principle in the model WHS Act and provide greater guidance for PCBUs on applying the principle.

Not supported.

In the mining context, 'work adjacent' locations, such as accommodation, mess halls or connecting roads, are often blurred in the current context of 'causal link principle'. For example, an evening meal at home that results in choking does not result in a workplace incident as there is no 'causal link principle'. However, if a mine worker eats an evening meal at a mess hall well after the completion of shift, but is consuming the food onsite (whether food is prepared by the PCBU or not), does this then meet the threshold of the 'causal link principle'? There would need to be different thresholds within the 'causal link principle', such as causally related, partially related, or not related.

Guidance material addressing this would be required and supported, and more appropriate than amending legislation as proposed.

Objective test

Option	Issue
Amend the incident notification provisions in ss 35-37 of the model WHS Act to ensure they clearly reflect that the test for serious injury or illness is an objective test. Improved guidance for PCBUs on the intention and application of the objective test.	Under the incident notification provisions a 'serious injury or illness' is defined as an injury or illness requiring a person to have treatment of a kind specified in paragraphs (a)-(d). The test is an objective one. It does not matter whether a person received the treatment. The test is whether the injury or illness could reasonably be considered to warrant such treatment. The incident notification review confirmed that the objective test is not well understood by PCBUs and causes confusion. While the objective test is explained in the Explanatory Memorandum, it is not expressly provided for by the model WHS Act.

Not supported.

Instead, the MCA supports further guidance material and resources across all jurisdictions, to appropriately define the 'objective test' process and ensure effective implementation. This should be done in consultation with appropriately qualified and competent medical professionals.

Amending the description of 'immediate treatment' in guidance

Option	Issue
Amend the description of 'immediate treatment' in guidance material to reflect the urgent medical care provided following a serious injury or illness.	The incident notification review identified that PCBUs can fail to notify the WHS regulator of a notifiable incident if they narrowly interpret what is meant by 'immediate treatment'. This option would amend the current description of 'immediate treatment' in guidance material to reflect the types of medical intervention commonly received immediately following a serious injury or illness. This would clarify that the legal meaning of 'treatment' includes urgent medical care to both relieve and cure an injury or illness. It is not limited to a particular intervention (e.g. surgery) that may be delayed (and not provided 'immediately') for clinical reasons. It could also include a specific description of 'immediate treatment' for the purposes of serious head injury to capture those injuries that require immediate medical attention but are not diagnosable at the time. The avoidance of doubt in legal interpretation, it may also be appropriate to include the description of 'immediate treatment' in the Explanatory Memorandum to the model WHS Act to avoid any ambiguity. However, this would be informed by legal advice.

Not supported.

As outlined in Chapter 11, the MCA agrees that there was a need for further guidance and clarification around the definition of 'immediate treatment'. Where there is an incident, that results in an injury, the definition of treatment as 'immediate' is straightforward. However, where there is an injury or illness over prolonged exposure, or where the injury is not evident (or worsens over time) and eventually results in a treatable injury – the meaning of 'immediate' is lost.

Further clarity and guidance around regarding this definition is supported by the MCA.

Immediate treatment as an inpatient in a hospital

Option	Issue
Amend the guidance material to provide information for PCBUs on how treatment is commonly provided to patients and define key terminology.	This option would amend guidance material to provide an overview of how a patient commonly progresses through the hospital system and explain the terms used in the provisions, including 'inpatient' and what is considered a 'hospital'. It is thought that explaining these key concepts and definitions may assist PCBUs in better understanding the notification requirements. Guidance would also explain the application of the objective test to 'immediate treatment as an inpatient in a hospital'. This includes capturing circumstances where it may be clear the person needs inpatient hospital treatment, but either: • admission is delayed • a hospital is not close by (including in remote settings), or • treatment is provided at a facility that does not have the status of a hospital but is providing the type of treatment usually performed at a hospital (e.g. field hospital, medical facility on board a vessel and a medical centre in an offshore detention centre).

Supported.

As outlined above, the MCA supports additional guidance on 'immediate treatment' and would additionally support using diagnoses (the objective test) as the baseline of reportability, rather than the location of the treatment.

Improving understanding of 'loss of bodily function'

Option	Issue
Amend guidance material to better describe the injuries and illnesses that are notifiable under 'loss of bodily function'.	The incident notification review identified that the term 'loss of bodily function' creates confusion for PCBUs. It is thought that this may lead to under-reporting in some circumstances, although the extent to which this occurs is unknown. The review identified better explanation is needed of the types of injuries and illnesses that are notifiable (and what is not notifiable) under the current categories of: • loss of consciousness • loss of movement of a limb • loss of the sense of smell, taste, sight or hearing, and • loss of function of an internal organ. The wording of these categories could also be amended if more clearer descriptions were identified.

Supported.

The mining industry would welcome further clarification on the meaning of 'loss of bodily functions'. MCA members raised questions around the distinction between temporary loss of bodily function (such as sight, hearing or temporary limb numbness) versus permanent loss of bodily functions.

Further guidance would be supported that focuses on notifiable injuries and illnesses that have a causal link to work being performed.

Medical treatment for exposure to a substance

Option	Issue
Amend the definition of medical treatment in the model WHS Act for the purposes of s 36(c) to capture the health professionals (in addition to doctors) who provide urgent treatment following exposure to a substance.	The definition of serious injury or illness includes 'medical treatment within 48 hours of exposure to a substance' (s 36(c)). 'Medical treatment' is defined in the model WHS Act as 'treatment by a medical practitioner registered under [the relevant registration Act]'. The information sheet states that "Medical treatment' is treatment provided by a doctor", and that "exposure to a substance includes exposure to chemicals, airborne contaminants and exposure to human and/or animal blood and body substances". The incident notification review identified that the definition of 'medical treatment' in the model WHS Act ('treatment by a medical practitioner') does not capture circumstances where a person has been exposed to a substance and requires treatment by a health professional other than a doctor. The review identified that this may need to include Paramedics, Registered Nurses, Nurse Practitioners and Aboriginal and Torres Strait Islander Health Workers and Practitioners. Specific examples given include: • where paramedics administer oxygen treatment to workers following carbon monoxide exposure, and • treatment for exposure to blood and body substances (e.g. vaccination, immunoglobulin and prophylactic medication), which may be managed by Registered Nurses and Nurse Practitioners.
Specific questions: What health professionals should be covered by the definition of 'medical treatment'? Please provide reasons, including examples of what treatment the health professional is likely to provide for which type of exposure.	

Not supported.

Without consultation on what the broadened definition would capture, it is unclear whether this approach would appropriately address the issue raised by SWA. The provision poses a risk to employers losing oversight of the process, and not allow compliance with the obligations a PCBU has under legislation. The proposal presented by SWA appears to lean towards the definition of "health practitioner". SWA must consider the broad scope of professions that fall under this definition, including physiotherapists, pharmacist, and chiropractors, for example.

Noting the examples given above '*where paramedics administer oxygen treatment to workers following carbon monoxide exposure'*, a First Aider holding either an advanced resuscitation competency or occupational first aid competency is permitted to issue oxygen to any person requiring it. First Aiders should not be captured because of the type of treatment being provided. Rather, the MCA recommends the medical professional types be prescribed.

Part 3, section 37 of the Work Health and Safety Act 2011 states *'medical treatment means treatment by a medical practitioner'.* The MCA urges SWA to adequately define what constitutes a medical practitioner, and adopt the definition used by the Australian Department of Health and Aged Care and the Medical Board of Australia '*List of specialties, fields of specialty practice and related specialist titles'.*

Further consultation on broadening this definition should be undertaken.

Exposure to human blood and body substances

Option	Issue
Improve guidance for PCBUs on the exposures to blood and body substances that require notification to WHS regulators.	The incident notification review confirmed that s 36(c) (exposures that require medical treatment within 48 hou+rs) effectively captures the exposures to human blood and body substances that should be notified to WHS regulators. That is, higher risk exposures that pose a serious risk to health and safety, and indicate controls may be inadequate. However, the review confirmed that further guidance is needed to improve PCBU understanding. Note that the option to amend the definition of 'medical treatment' (refer above) is also relevant here.

Supported.

There is a consensus in mining and other related industries, that there is reporting of Needle Stick Injuries (NSIs), however members raised concerns that the requirement to report outside of this is not well-understood and confusing. There are many roles and workplaces where workers are continuously exposed to blood and body substances, such as nurses, aged care, pathologists etc, however there is no requirement to report such exposures.

The MCA would support improved guidance to workers and PCBUs on exposures to bodily substances.

Infections and zoonoses

Option	Issue
Improve guidance for PCBUs to prominently describe notification requirements for infections and zoonoses prescribed in the model WHS Regulations (reg 699).	The incident notification review confirmed that reg 699 captures the range of infections that WHS regulators need to be immediately notified of. However, the lack of PCBU awareness of these requirement is likely to result in under-reporting. The review confirmed more prominent guidance is needed to improve compliance with these notification requirements.

Supported.

After COVID-19, there was a better understanding to PCBUs on the requirement to notify the state health departments for infectious diseases. During the pandemic, updates on the reporting requirements were provided by some of the regulators which caused confusion on duplication of reporting.

Improved guidance of the notification requirements to the health departments and regulators would be supported.

Dangerous incident provisions - reducing complexity and improving PCBU understanding

Option	Issue
Amend guidance material to provide improved general explanation of the dangerous incident provision and what circumstances require notification. Amend s 37 to simplify the opening words to reduce complexity for duty holders but ensure the policy intention does not change.	The incident notification review confirmed that the wording of the dangerous incident provision is complex and may create confusion for PCBUs. It requires there to be an 'incident' arising out of the conduct of the business or undertaking; the incident must be 'in relation to a workplace'; the incident must 'expose' a worker (or any other person) to a 'risk to the person's health or safety'; the risk must be a 'serious' risk; the risk must 'emanate' from 'exposure' to one of the listed hazards, and the exposure must be 'immediate or imminent'. In addition, the current guidance material only provides basic information on the dangerous incident provisions and could be further improved.

Supported.

The MCA supports improved guidance material that provides a simplified definition of a dangerous incident to reduce complexity and ambiguity for PCBUs.

Improving the electric shock provision

Option	Issue
Amend dangerous incident provisions (s 37(e)) in the model WHS Act to 'electric shock, electrical explosion and arc flash explosion' to better capture exposures to electrical hazards. Amend guidance material to better explain the types of incidents involving electric shock and exposure to electrical hazards that require notification.	The incident notification review identified that in some jurisdictions there is under-reporting of dangerous incidents involving exposure to electrical hazards that expose a person to a serious risk to their health and safety. It was reported that some PCBUs take a narrow view on what is considered notifiable. In some jurisdictions there is over-reporting of minor incidents, predominantly incidents involving shocks from static electricity and other extra low voltage exposures. Improved guidance is needed to address this.

Supported.

The MCA supports additional and improved guidance material to better inform workers and PCBUs of incidents involving electric shock and electrical hazards that are notifiable.

Duty to notify and site preservation requirements

Option	Issue
Amend the model WHS Act to include a duty for the PCBU and person with management or control of a workplace to notify the other (where that is a different person) when they become aware that a notifiable incident has occurred.	The model WHS Act does not expressly require the PCBU (who notifies the WHS regulator) to also notify the person with management or control of the workplace that a notifiable incident has occurred, or about their site preservation obligations. The person with management or control of a workplace must be aware of their own legal obligations in relation to site preservation. However, an issue may arise if the person with management or control of a workplace was not aware that a notifiable incident had occurred. For clarity, an express mutual obligation would be included in the provisions requiring the PCBU and person with management or control of a workplace to notify the other (if that is a different person) when they become aware that a notifiable incident has occurred. Exact wording would depend on legal advice.
Amend the duty to preserve incident sites (s 39(1)) in the model WHS Act so that it provides that a site must not be disturbed until an inspector directs.	The wording of s 39(1) states that the site must not be '…disturbed until an inspector arrives at the site or any earlier time that an inspector directs'. Some PCBUs interpret this as meaning the site can be disturbed upon the arrival of the inspector, rather than waiting for the direction of the inspector. A simple amendment would address. Exact wording would depend on legal advice.
Amend guidance to provide more detailed information to PCBUs about the duty to notify and site preservation.	The incident notification review identified support for more detailed guidance on the duty to notify and site preservation requirements. For example, to clarify: • what is meant by 'immediate', including examples of circumstances that do not warrant a delay in notification • that notification to other government bodies is not sufficient • what constitutes a 'site' for the purposes of site preservation, and • how the site preservation requirements work in practice for different incident types.

Support in principle.

The first option is supported. There is redundancy in reporting between operators and contractors, with both entities currently being required to report on the same incident, leading to unnecessary duplication in reporting. This is a significant area of concern that should be addressed, particularly as there are financial penalties for failure to report a notifiable incident. At times, contractors or labour hire workers notify their employer and not the host, where a notification is then made to the regulator, where the host had no knowledge of the incident, but is then financially or otherwise penalised.

The MCA does not support the second option. The current regulations already sufficiently address site preservation.

The requirements for site preservation vary depending on incident, and are primarily applied in acute incidents, rather than cumulative injuries and conditions that occur over a longer period.

The MCA supports further guidance and clarification on distinguishing between acute and cumulative incidents and addressing the issue of redundant reporting.

Further consultation required

The MCA strongly encourages SWA to engage in further discussions with industry and allow further input to the incident notification review.

Further enquiries can be directed to:

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