Health Services Union Submission to the 2018 Review of the Model WHS laws.

Introduction

The Health Services Union NSW/ACT/Qld Branch (HSU) welcomes the opportunity to contribute to this review. Our union represents some 36,000 members in both public and private health as well as aged care and the ambulance service, which affords us a uniquely broad perspective on work health and safety issues within the healthcare and social assistance industry.

There are between 3000 and an estimated 8,168 work-related fatal disease and traumatic fatalities every year, with the vast majority of these being industrial disease deaths, which escape our limited national data sets based on compensable injuries and diseases, so this Review must set out to recommend the highest standard of protection[i]. It is unfortunate that since the Australian Safety and Compensation Commission published these figures in 2003, its successor Safe Work Australia has not replicated these essential frame-setting numbers.

It is noted that the Issues Paper – *National Review into Model OHS Laws* – May 2008, paragraph 11, under the scope of the 2008 National Review, called for its panel *to* 'examine the principal OHS legislation of each jurisdiction to identify areas of best practice.' Unfortunately, both reports of the 2008 National Review failed to undertake this fundamental element of their work. With respect to this failure, there were aspects of the preceding Occupational Health and Safety Act (2000) New South Wales (OHS Act), which were regarded by the union movement as best practice. This submission will point to some of these.

It is also noted that this review's discussion paper states the following with respect to the healthcare and social assistance industry:

> *When it comes to workplace injuries and diseases, the Health care and social assistance industry accounted for the highest number of serious claims in 2015-16 (15 per cent), followed by Manufacturing (12 per cent) and Construction (12 per cent). Together, these industries accounted for almost 40 per cent of all serious claims but represent less than 30 per cent of the workforce.*

The Safe Work Australia statistics[ii] from which the above quote is drawn, show that across all industries in recent years, there has been a 15% decrease to workplace injuries and diseases. While for the healthcare and social assistance industry there has been a 15% increase. The discussion

paper further notes that the Health care and social assistance industry has grown 20% between 2012 and 2017.

Most alarmingly with respect to these figures, it is still generally the case with work-related injury and disease that the: '…majority of the cost (95%) was borne by individuals and society. Workers bore 77%, the community 18% and employers 5%[iii].'

It is unfortunate that the last of these figures are drawn from the 2012-13, financial year. It would be useful not only for this review, but more generally for public policy pertaining to work health and safety, that such figures were calculated on an annual basis.

So, it is clear that with respect to the healthcare and social assistance industry, the model WHS laws (WHS laws), have failed to fulfil their Object 3 (2):

> *…that workers and other persons should be given the highest level of protection against harm to their health, safety and welfare from hazards and risks arising from work…*

This submission also presents a long-term failure of health and safety regulation by policy in the NSW health system. Which is why the HSU is calling for a new section in Chapter 4 - Hazardous Work, 4.9 Healthcare Work, to be inserted into the WHS Regulations. The specific recommendations presented here do not prescribe the terms of such a chapter, however they do set out the essential elements for hazard identification, risk management and the application of the hierarchy of control.

In having such a chapter, it will be much simpler for health and safety representatives (HSRs), and union officials representing them, to seek WHS Act-type consultation over implementing, monitoring, evaluating and amending risk assessments and safe work practices with respect to safe systems of work.

This submission is based around a number of recent surveys we have run with HSU members, plus an independent audit of NSW Health Emergency Departments, a survey by the NSW Public Service Commission and some papers by academics. It is also in these surveys that the voice of the often-unheard is expressed. So along with the statistics presented here, just as important are the direct quotes from our members.

This submission supports the submissions made by Unions NSW and the ACTU. Also, this submission supports the submission made by the Cancer Council of Australia - Occupational and Environmental Cancer Committee, with respect to workplace carcinogens.

The focus of this submission

So, the focus of this submission, will be on the last three of the six key questions, set out in the discussion paper:

> *What doesn't work?*
>
> *Why doesn't it work? and*
>
> *What could we do to make it work?*

In addressing these questions the HSU will present the following evidence from the healthcare and social assistance industry of the following systemic problems:

1. Understaffing in residential aged care facilities (RACF);
2. Violence & aggression in NSW Health Emergency Departments (EDs);
3. Bullying in NSW Health facilities; and
4. Musculoskeletal injuries and violence in the NSW Ambulance Service (NSWA).

What doesn't work? – Tripartism in NSW & Nationally

SafeWork NSW RoadMap 2017-2022

The HSU is aware of the SafeWork NSW RoadMap 2017-2022, (the RoadMap), which was released in August 2016. The RoadMap was developed under the auspices of the Australian Work Health and Safety Strategy 2012-2022, and it calls out the healthcare and social assistance industry as a priority industry. Since the release of the RoadMap, the HSU has actively participated with SafeWork NSW in the development of the draft Work Health and Safety (WHS) Government Sector Plan 2018-2022. This covers the NSW Ambulance Service but not the rest of the NSW health system, despite the fact that the healthcare and social assistance industry is nominated as a priority area in the RoadMap. No development that the HSU is aware of has occurred in this sector.

While a useful Government Sector Plan Self-Assessment (audit) Tool has also been developed, no properly tripartite activity has occurred under the RoadMap. This draws attention to the lack of any legislated tripartite elements in the NSW Work Health and Safety Act 2011 (NSW WHS Act). The return of tripartism in NSW was a recommendation in the 2016 review of the NSW WHS Act, but to date this has not occurred. Most recently the HSU has been informed that the NSW Centre for WHS is conducting research into best practice tripartism. This call for tripartism lies at the heart of many of the following recommendations.

Recommendation 1.

That the WHS laws contain a specific object that refers to tripartism, where each of the social partners are represented equally to oversee the operation of the model WHS laws in each jurisdiction.

That the WHS laws contain a provision that requires each jurisdiction and industry within that jurisdiction, to convene a regular tripartite forum to bring together a work health and safety regulator's (WHS Regulator) principal inspector, senior administrator and policy officer with the relevant unions and employer organisations to properly implement the objects of the model WHS laws and to drive urgently-needed efforts at continual improvement. This would most usefully become part of WHS law's Section 152: Functions of Regulator.

Question 2. Have you any comments on whether the model WHS Regulations adequately support the object of the model WHS Act?

Section 19 (3) (c) of the WHS laws requires 'the provision and maintenance of safe systems of work.' However, the model WHS Regulations do not directly address the necessary elements of safe systems of work. It is noted that Section 9: Employer to Identify Hazards of the Regulations under the previous NSW Occupational Health and Safety Act 2000 (NSW OHS Act 2000), contained the following sections that were lost to the WHS laws:

> *(b) work practices, work systems and shift working arrangements (including hazardous processes, psychological hazards and fatigue related hazards;,*
>
> *(j) the potential for workplace violence;*

With respect to the potential design of a Regulation pertaining to safe systems of work, clause 6.1.2.1 of the new global health and safety system standard, *ISO 45001 Occupational health and safety management systems*, has a hazard identification clause, that is a model for the WHS laws to follow, it contains the following items that are to be subject to hazard identification:

> *a) how work is organized, social factors (including workload, work hours, victimization, harassment and bullying), leadership and the culture in the organization;*
>
> *f) 1) (the design of work areas, processes, installations, machinery/equipment, operating procedures and work organization, including their adaptation to the needs and capabilities of the workers involved;*

Recommendation 2.

If Regulations 32 – 38 are not moved into the WHS laws, then insert two new Regulations in the WHS Regulations, containing the following elements:

Managing risks arising from systems of work, as follows:

how work is organized, including the following factors;

- *a) staffing levels;*
- *b) workloads;*
- *c) staff/client ratios;*
- *d) work hours;*
- *e) shift work arrangements;*
- *f) victimization;*
- *g) harassment;*
- *h) violence;*
- *i) bullying;*
- *j) fatigue related hazards;*

k) *leadership;*

l) *organizational culture;*

Managing risks arising from the design of systems of work, including:

a) *work areas;*

b) *processes;*

c) *installations;*

d) *machinery/equipment;*

e) *operating procedures and work organization;*

f) *the adaptation of these to the physical and psychological needs and capabilities of the workers involved.*

As part of this submission the HSU ran a general survey of members. The key finding with respect to staffing levels was that 50% of members had never been consulted over safe and healthy staffing levels. Another 25% reported that this type of consultation happened rarely. Only 4% reported this type of consultation happening all the time.

Regarding actual staffing levels, 25% reported that they never had enough staff to work with safe and healthy staffing levels and 29% reported that they rarely had enough staff to work with safe and healthy staffing levels. Accentuating this were the 29% of members who reported that unplanned leave was never backfilled and 26% reporting that planned leave was rarely filled.

Digging deeper into this survey 33% report unachievable deadlines sometimes, 22% often and 12% always:

- Very fast work affects 31% sometimes, 32% often and 12% always;
- Being unable to take enough breaks, 30% sometimes, 23% often, 15% always;
- Neglecting some tasks – having too much to do, 33% sometimes, 27% often, 18% always;
- Pressured to work long hours - 23% sometimes, 15% often, 10% always;

When asked 'How do these conditions in general compare to where you were working five years ago?' the responses were:

5% Strong Improvement, 10% Some improvement, 26% No change, 24% somewhat worse, 28% much worse now. Public Health specific figures are comparable.

Staffing levels in Residential Aged Care Facilities (RACFs) If there is one sector of the healthcare and social assistance industry that epitomises the failure of health and safety regulation with respect to safe systems of work, it is residential aged care facilities, (RACF).

Since 2013, prior to the commencement of enterprise bargaining with RACF persons conducting a business or undertaking (PCBUs), the HSU has conducted a survey of members. In these surveys a standard set of questions are asked with respect to staffing levels. The result of these surveys is that 85% of respondents nominate their workload as excessive and unreasonable. Within this number 72% of respondents report that insufficient staff are rostered to work, 26% say that staff leave is not backfilled and 41% state that an increase in the complexity of work is another contributing factor. This increase in complexity is a result of an increasing number of high care/dementia care residents. These figures need to be seen in the context of a massive shift in the way RACFs are organised.

According to 2015 figures produced for the NSW parliament[iv], 'Between 2002 and 2013 the number of facilities decreased by 8.2%, while the number of places increased by 31%. The proportion of facilities with more than 60 beds doubled to 48.6%.'A typical facility will now be constructed in 3 or 4 wings with 20-30 beds in each wing. On the day and afternoon shift there may be 2 care staff employees (CSEs) per wing and on the night shift, 1 CSE per wing. With 1 Registered Nurse on shift during the day and afternoon and none on the night shift.

So, there is an increasing industrialisation of work in this sector that is well described in the following quotes from HSU members:

> *The ratios of staff to residents are dreadful. You've normally got 2 staff to 35 people, including those with chronic needs and in palliative care. You're pushed with work, you can't fulfil all your duties in the 7.5 hours. It's not fair. It's not fair on the workers or the residents.*
>
> *One-night shift I had a resident in a lifter; the resident collapsed and was 'clinically dead'. I performed CPR for a significant period. Only 3 staff were on duty. One staff member was in the dementia ward so couldn't leave. Two of us had to remain with the resident who eventually survived. It was extremely traumatic.*
>
> *You cannot look after and attend to the care needs of between 25 to 30 residents with 3 staff (26 hours) over two units in one shift, you have to work like the wind to get finished by your end of shift time putting yourself at risk of injury. Things don't always run to a time plan, they usually never do when you're working with the frail and aged.*
>
> *We simply can't spend enough time with the residents who made our country what it is today and can't ensure that their care needs are met…it's just not right'.*
>
> *Residents don't get quality care as they should. Staff can't even spend bit of quality time with residents who need them as some residents spend most of their times in their rooms only. Also, staff don't have enough time to do other tasks out for residents except their duties involved in a morning shift due to just enough time to accommodate busy schedules. Other than that not enough linen - towels, bedsheets, pillow covers. Staff always has to run around everywhere to look for linen to change the linen for residents. Things are always shortage.*
>
> *It is very bad because when we are understaffed, we get tired and over worked ourselves. Then people start calling sick. It is not good for our residents because they're paying their*

money and it is their home. So they should get all good care and properly looked after. We are still doing our best working very hard to take good care of them anytime we go to work.

Residents express feelings of frustration when certain services are promised but not delivered. Residents disadvantaged by understaffing i.e. missing appointments, left short of supplies for daily living, meal prep not undertaken, medication not taken, bills not paid, stress of waiting for someone to turn up and doesn't.

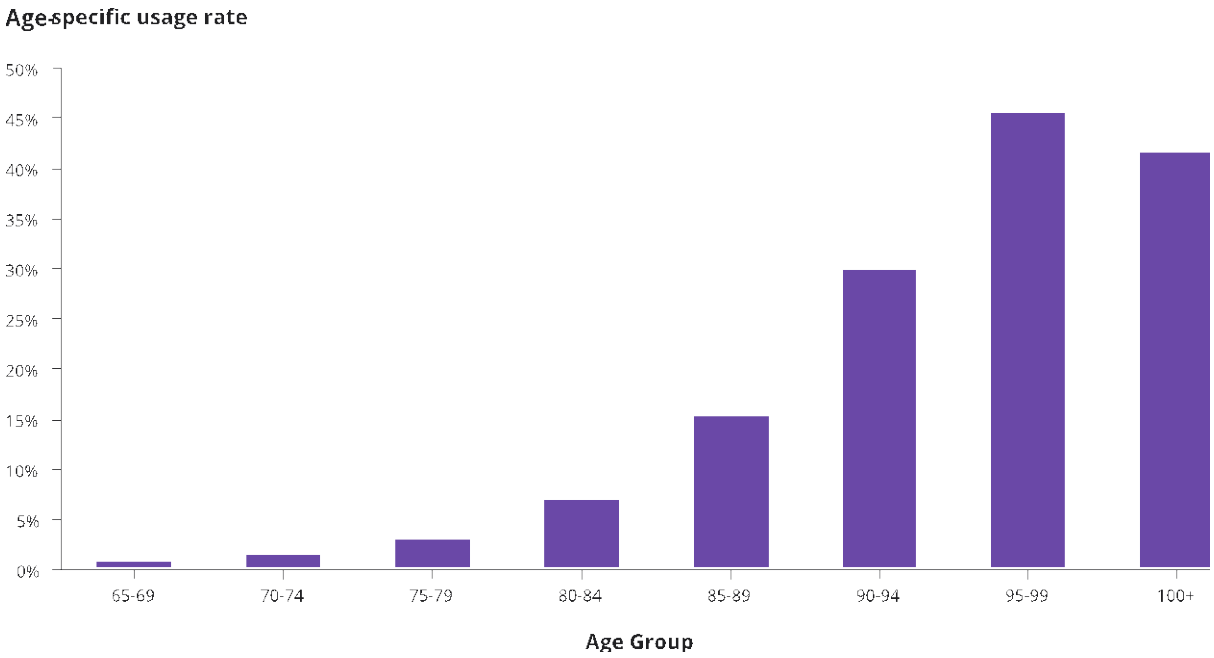
The full set of comments from which these are drawn is attached at **Appendix 1.**

> The bitter irony of RACF sector is that it is*…subject to 144 state and federal statutes and reports to 19 government entities and 74 other agencies. (Holman Webb research, 2013 and ACSA National Report 2009)*[v]

Despite this apparently comprehensive regulatory network, there is one federal statute that matters to RACFs, rather than compliance with the model WHS laws. Information on this statute is contained in the Annual Report on the *Operation of the Aged Care Act 1997*. It is telling that the documents that are sampled do not include rosters or any detailed consideration of staffing levels and staffing ratios.

Even if these matters were considered, the auditing process is a one-way information gathering and reporting modality, vastly different to the requirements for proper model WHS laws consultation under sections 47, 48 & 49 with respect to the Section 19 (3) (c) duty to provide a safe system of work. The model WHS laws are the only statute, of the apparent144, that gives the workers of the RACF sector the right to participate in the design of safe systems of work. This right desperately needs the type of regulation sought above.

> **Ageing Client Base, Dementia & Violence – Excerpt from the 2016-17 Annual Report on the *Operation of the Aged Care Act 1997.***
>
> *The ageing of the population and the associated increasing number of people with dementia are the two main factors driving increased demand for aged care services. As age increases, the likelihood of needing care increases, as shown in Figure 1.*
>
> ***Figure 1: Age-specific usage rates of residential aged care, 30 June 2017***



> *At 30 June 2017, half of all residential aged care residents with an Aged Care Funding Instrument (ACFI) assessment had a diagnosis of dementia. Page 15.*
>
> *With many residents in aged care facilities suffering from illnesses such as delirium, depression, and dementia, their mental states are likely to be changeable and unstable due to the results of drugs, therapy, pain, and indeed the illness itself. As a result, aggressive behaviour is not uncommon.*[vi]

So, within this age profile dealing with dementia is part of the job and with this comes the acceptance of assaults by residents on CSEs. Most of the time our members do not bother to report these incidents. This links back to the 41% of RACF survey respondents stating that the increasing complexity of their work is driving work overload. In effect there is little low-care work done in RACFs now, but in the home care setting instead.

The problems of no reporting go deeper though, than just an acceptance of violence as part of the job, as the following quote shows;

> *Some 61 per cent of respondents said they feared repercussions if they reported an incident of assault, which the union said was consistent with previous research undertaken with assistants in nursing that found they feared they would be blamed for the incident or found management unresponsive to their concerns.*[vii]

Research in the sector has clearly outlined the factors that can minimise violence in dementia affected RACF residents, as follows:

- *minimise the amount of stress the patient is under;*
- *try not to change the surroundings as this may confuse the patient;*
- *avoid rushing and keep a consistent routine;*

- *keep the patient as comfortable as possible;*
- *be aware of any warning signs of aggression;*
- *do not provoke or confront them; and*
- *ensure they are getting enough exercise and stimulation through participation in activities.*[viii]

Most of these strategies are nearly impossible for unreasonably overworked CSEs to implement, so instead their lack becomes a violence risk factor in itself.

The HSU has this year run another survey that asks about workers' best and worst days in RACFs. For their best experiences, 57% nominated Interacting and caring for residents, with the next most nominated, 17%, being appropriate staff to meet residents' needs. By way of contrast 0.28% nominated pay or leave entitlements. The following comments from this survey illuminate these statistics:

> *I love giving support to people who need it, and I do it with all of my best effort in any way I can. Every day, I strive to put in my best to give residents the quality services they deserve, so they can be comfortable at the end of their life.*
>
> *The best days are the days I can see that I have achieved improving someone's day/week/life. Making that connection with someone with dementia, or assisting a carer's capacity to care, or successfully advocating for someone who cannot advocate for themselves. Their lives can sometimes be lived only hour by hour, or week by week so even connections that may be temporary and insignificant to others can be life changing for someone who is ageing.*
>
> *I work in a high care residential facility and residents get sick and die. I visited a lady who had been active throughout her life and suddenly got a stroke and lost everything - personal health, house, possessions, was left with the reality of a bed in a shared room of a nursing home and an oxygen machine. We had a chance to talk a bit about issues that were still important or relevant, I was able to lend her a book which she liked to look at and one Friday I was able to call the pastoral care person on her behalf and she talked with her. A few days later she died.*
>
> *I work as an activities coordinator, and recreational officer. making a cup of tea and having a walk in the sun brings a smile to a resident's face. this is the best day. making them feel special by giving them a hand massage and sharing a story makes them feel human when they don't have family that regularly visit. this is the best day.*

Axiomatically the ability to have a rich interaction with an RACF resident rests on reasonable workloads and staffing levels. By way of contrast, when asked to nominate their worst day the most common responses were 'Stress/overwork due to lack of staff/resources' (39%); 'Resident suffering fatality/illness/accident (21%); and 'Lack of resources leading to lack of care/ neglect' (15%).

> *Just recently, management suddenly turned the floor I'm on in my facility to high care, without putting on any additional staff. We just couldn't cop the extra workload and*

demands, and it meant residents couldn't get the care they needed. Staff didn't turn up to work because they were getting so tired and sick from working so hard, which meant we became even more short staffed. That's when accidents happen. If you don't look after your staff, you're not taking care of your residents.

I came into work and started my round. I went to the room of one of the residents and put away their pads and then did my visual check like I always do and noticed something was not right with the resident. I went over to the resident and noticed that they were not breathing. I checked for a pulse and there wasn't one. I got the RN and they checked them and they were indeed dead. I had to wash the resident and changed their clothes and bed and get them ready for the family. The whole time I was doing it I kept thinking I just saw them the day before and they were fine. We had a little conversation with them and got them a cup of tea and biscuits and they were happy and now they are gone. I kept thinking I wonder if they knew how much happiness they brought me every day. I thought about them the entire shift. At work and when I got home I was sad. You can't help but get attached to these people and when they pass away it moves you. It's like you are losing a friend.

They've got ratios in hospitals, ratios in childcare, why not in aged care?

When asked 'what are the barriers to providing a high standard of care?' 90% of our respondents nominated staffing levels, 29% management support and communication, 16% training, and 10% inadequate facilities/design/equipment. All of these are essential elements of a healthy and safe workplace for CSEs and residents.

The depth of the vocation expressed by HSU members emerges in these quotes from this survey, showing the special and massively underpaid work that these workers do;

Had a fellow who was very unwell, vomiting and incontinent. His wife was coming to visit, so I cleaned him up quickly before she arrived. After a while she came to me and said it had happened again, so I cleaned him up again. It continued to happen, and it was clear we had to take him to hospital. I stayed with him and continued to take care of him like I had been until he passed away. His wife thanked me for not only taking care of him, but also still stopping to see if she was okay.

We had one old lady, Marilyn, and she had used to work in the hostel years before and then came in as a resident with dementia. When her son died she was really distraught, and we used to go into our shifts early or stay back just to spend extra time with her and be there for her through her grief because she needed extra care. We did it off our own back, we didn't get paid we just cared. And then when she passed away, her family were really appreciative and thanked us a lot and they bought us a bbq for the hostel.

I sat with a resident whose family member could not make it in time to see him before he passed. the family member was happy someone was there with him.

Too many times family thanks us for our work. but the reality is that Australians treat migrant workers in aged care as slaves. Clients don't understand that we are over worked

and have too many patients to look after and treat us badly. I have experienced racism in the work place.

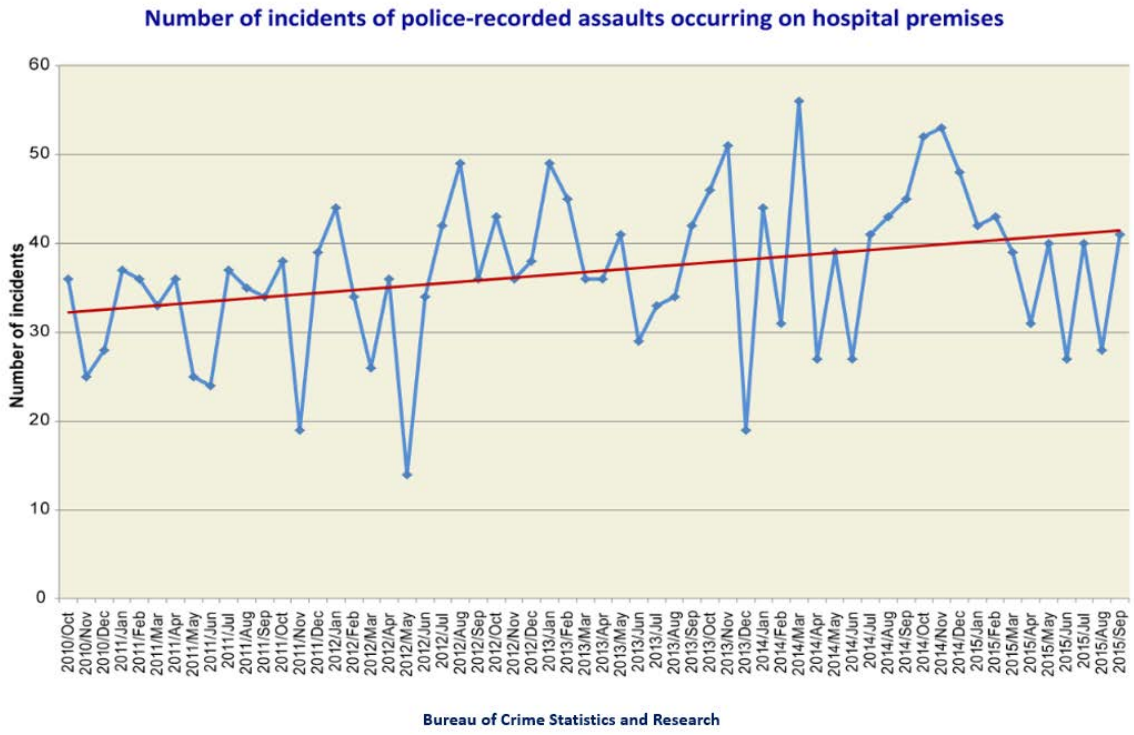
health care staff receive very low wages, living conditions in Australia is very high and my wages in age care are not enough to survive in Australia. Age care workers are living on the breadline. we work so hard, do a lot of tasks and get paid very little.

Our members working in RACFs deserve more respect for the vital work that they do. Chronic systemic understaffing cheats residents and carers of the dignity they should share.

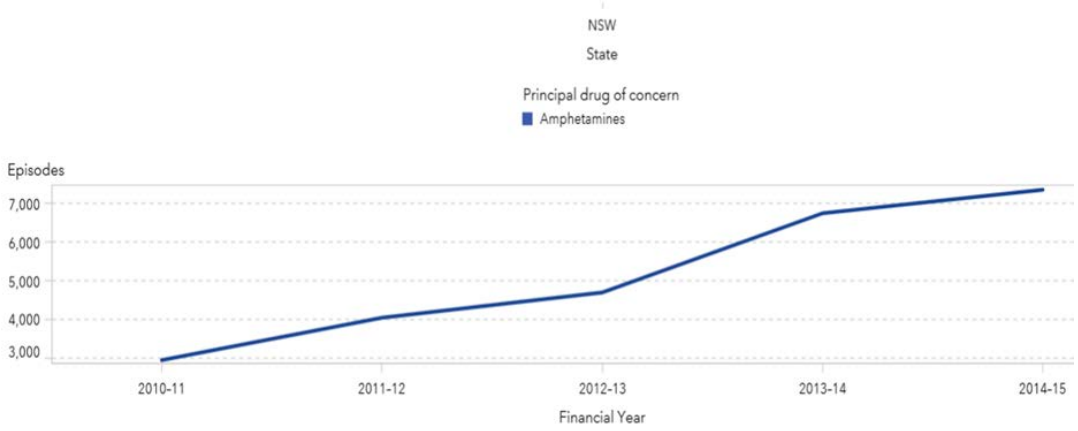
Violence and aggression in the NSW Public Hospital Sector

Hospitals, particularly emergency departments and mental health facilities, are stressful places. People are under pressure, and tempers can fray even without the contribution of drugs and alcohol. The combination of this stressful environment with mental health issues and the substance abuse that often accompany it can create a potentially explosive situation.

Between October 2010 and September 2015 in NSW, the number of police-recorded assaults occurring on hospital premises increased by an average of 5.8 per cent per year.



Statistics from the Australian Institute of Health and Welfare show that amphetamine use in NSW more than doubled over the period from 2010-11 to 2014-15. Over roughly the same period, amphetamine-related hospitalisations more than doubled from 136 per million persons to 341 per million persons. The picture for alcohol is similar: according to the National Drug and Alcohol Research Centre, alcohol-related violence is increasing in this country even though there's been no real increase in alcohol consumption.



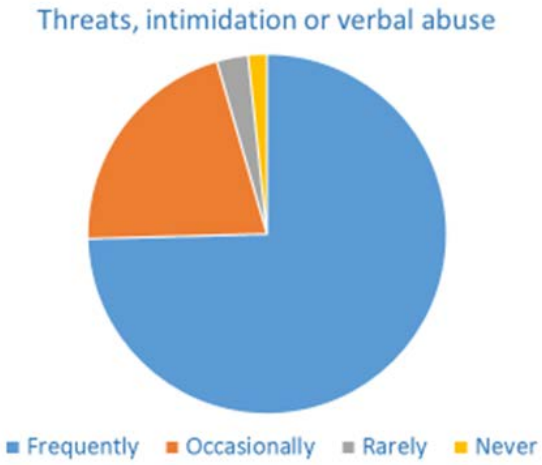
Source: AIHW Alcohol and other drug treatment services in Australia report

In January 2016 there was a shooting of a police officer and a security guard by a violent methamphetamine addict who'd arrived at Nepean Hospital earlier that day in police custody.

After the Nepean incident we conducted a major survey of our members in hospital security in March 2016 . It paints an alarming picture of the day-to-day working lives of security workers in the NSW Health system. These tables show how often they have been subjected to a range of intimidating and violent behaviours.

HSU NSW / ACT

Hospital security officers' survey



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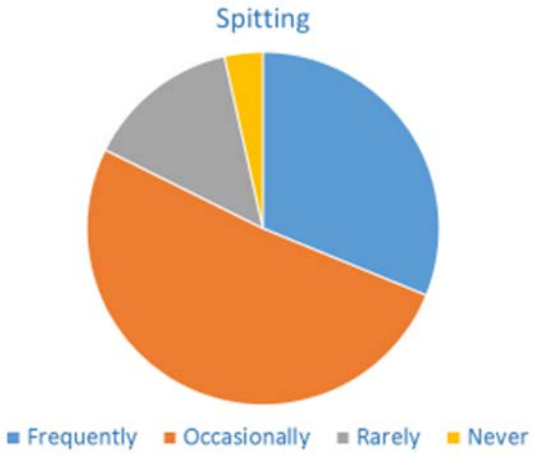
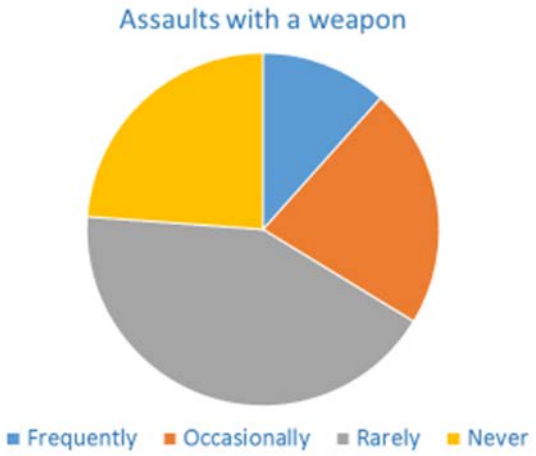
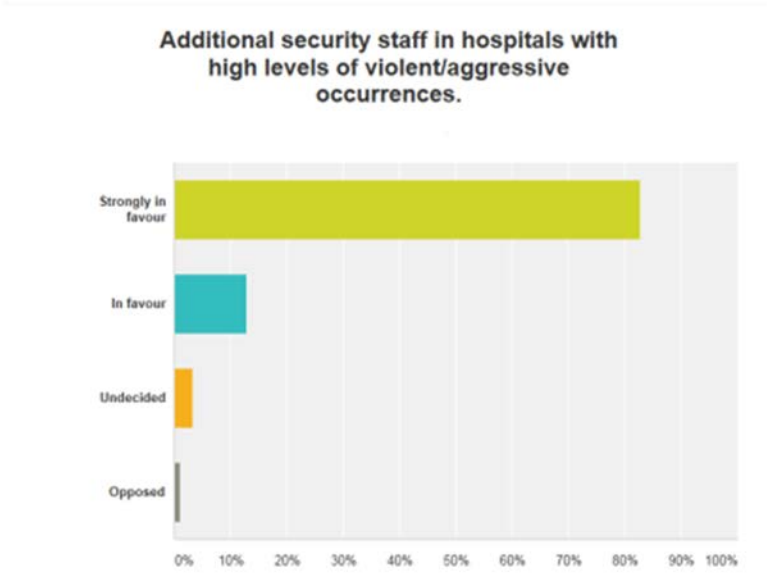


Hospital security officers' survey



All hospital staff survey



To summarise the charts above; 83% were strongly in favour of additional security staff in hospitals with high levels of violent/aggressive occurrences. Likewise, 83% were strongly in favour of designing EDs to suitably manage 'Ice'-affected patients and 73% wanted legislation for health specific powers of restraint and detention for security staff. Finally, 73% were strongly in favour of security staff being able to use soft restraints, similar to those used by by NSWA Paramedics.

In detailing incidents in their workplaces, members reported that emergency departments are badly designed and under-resourced. The following quotes from the March 2016 survey bear witness to the everyday hazards faced in emergency departments (EDs).

June 2013: Patient came to my window in Emergency Reception, pulled out a large syringe filled with fluid, pointed it at my face through the hole in glass window, and squirted it on me.

Female administration officer, South Eastern Sydney

September 2010: Trying to restrain a violent patient with the assistance of two police officers and four security. I was kicked to the ground and my head was stomped on multiple times. I sustained a fractured skull, traumatic brain injury bilateral hearing loss, tinnitus, neck and back injuries. The environment within the emergency department was inadequate…no policies existed to cover such an occurrence. There were also no safe assessment rooms.

Female administration officer, South Western Sydney

March 2015: We have not had 'take-down' training for over seven years. The reason given, is we haven't enough staff members for a take-down team.

Male Health and security assistant, Mid North Coast

June 2016: I was rostered on duty by myself as usual. With the current level of increasing violence in my work place it is imperative that we have a long overdue and immediate increase in staff to a bare minimum of two security officers on a shift. Why should I not be provided with a safe work environment every day when I come to work? Apparently I am expected to be a punching bag as part of my role.

Male security officer, Northern NSW

Work health and safety considerations in hospital emergency departments

Security staff then, are subject to threats, intimidation and verbal abuse frequently for 78% of respondents to another HSU Security survey, conducted in January 2016. The results are disturbing; frequent physical assault 43%, spitting 42%, threats with a weapon 21% and assaults with a weapon 10%.

When security officers are faced with individuals who seem likely to threaten to or actually assault them, who have been restrained by police officers in an emergency department drop-off situation they, like all workers, have the right to work that is as healthy and safe *so far as is reasonably practical*, (WHS laws Section 19).

As these drop-offs are a regular part of security work in emergency departments, that right means that NSW Health/local health districts have a duty to apply obvious and available risk controls to the situation; for instance, designing the emergency department with a seclusion room and constantly consulting, co-operating and co-ordinating, (WHS Act Section 46), with the NSW Police/local area command to ensure sufficient levels of police officers, so that security officers are not left having to deal with a potentially violent individual in an unsafe manner.

With respect to Section 19 (3) (f) & (g), it is also clear that security officers have following the rights:

(f) the provision of any information, training, instruction or supervision that is necessary to protect all persons from risks to their health and safety arising from work carried out.

(g) that the health of workers and the conditions at the workplace are monitored for the purpose of preventing illness or injury of workers arising from the conduct of the business or undertaking.

It is clear from *Section 19 (3) (f) & (g)* that *the provision of '*any information' and that the 'conditions at the workplace are monitored' requires a well-resourced feedback loop. As per WHS Act Section 46, NSW Health/local health districts and NSW Police/local area commands must be actively and systematically gathering data on the causes of violent behaviour in each and every emergency department and then consulting security officers and their health and safety representatives, to enable continual improvement of security outcomes.

In this Section 19 feedback loop regarding violent patients, NSW Health/local health districts must fully consult with the affected security officers with respect to WHS Act Sections 47, 48 and 49. As is clear from section 48, the consultation processes arising from Section 48 are also iterative ones and are clearly linked to the provisions of Section 19.

With the foregoing consultation processes in mind, every local health district and local area command should be producing regular written reports on the hazards faced by their workers, the hazards eliminated, and the risk controls applied to minimise those hazards that cannot be eliminated.

The HSU and our members are not aware of a best practice example where all these elements of hazard identification, risk management, consultation and reporting occur as an iterative process.

It is no surprise that our members report that after incidents of workplace violence in 76% of cases they have required medical treatment, with 53% needing a short time off work to recover, 26% an extended period off work and 25% then suffering with a permanent impairment. So here is a stark failure of both the requirement for safe systems of work in the WHS laws and, as will be set out in the next section, a failure of policy implementation in a public sector called out to be an exemplar employer in the Australian WHS Strategy 2012-2022 and in the previous 2002-2012 version.

Question 11 of the January 2016 survey asked HSU security members to briefly tell us their stories (see **Appendix 2**). A few of the responses are as follows:

Police will bring in a very violent Person into the Hospital, it's taken 4 to 6 Police Officers to subdue the offender for a Mental Health Assessment, Police will try and leave the person with Security and say they have outstanding jobs and must leave.

So Security are left to deal with this very aggressive person with 2 or 3 Security Officers, we are not trained like the Police but we are expected to act like them but we are only Security Officers.

Each day is an experience at this site, we are constantly, being asked to restrain or detain people however we do not have to power to do this, therefore everyone is at risk.

Violent mental health patients having to be restrained for the safety of all concerned and at times medical staff intervening, complaining about the way these violent-drug induced patients are restrained. Some medical staff fail to grasp the concept that we are there to protect them but still try to tell us how to do our job. we don't tell them how to do their jobs.

They are not trained and need to support rather than hinder and complain. A medical staff member telling security personnel to let go of an aggressive and violent mental health patient, being restrained, with total disregard for the safety of security personnel being further assaulted which has been the case. If Security do not release the patient, some medical staff members, without justification submit IIMS (the NSW Health WHS Incident reporting system) reports.

A male has been brought to ED by police. He was drugged and handcuffed so officers and staff easily restrained him to the bed. As he awoke become a very aggressive toward officers and staff calling them (us) names and threatening to kill. He asked for our addresses and offered a fight outside. He threatened too to kill our families (kids) spitting on us etc. Male patient brought in by corrections officers took a I.V pole attempted to hit staff male subdued by security officers. Another male brought in by family drug affected head butted nurse during conversation security officers tackle him. Male bites security officer on the chest but is subdued. Male later convicted of two assaults given 140 Hours community Service. Same male brought in 2 weeks later under influence of drugs again and has assaulted staff again.

Constant verbal abuse from alcohol and drug affected patients and visitors...mental health patients

NSW Health is placing the security staff safety under clinical direction. They do not have any understanding of the legal minefield for the actions of security staff when directed to "stop that patient" or "restrain that violent, aggressive person with nothing more than two hands. When seven police brought this patient who was tasered and capsicum sprayed to the hospital, two unarmed security are clinically directed to "take over". Two on duty security are then taken off their normal duties for up to seven hours without replacement. Police have the expectation that they can "dump and run" often not liaising with triage nursing staff only intimidating security staff then leaving. We have had up as many as nine drug, alcohol and / or mental health patients in our Emergency department left under the supervision of two "on duty" security staff. NOT GOOD ENOUGH.....

The full eleven pages of incidents and problems in Appendix 3 is essential and depressing reading, especially bearing in mind that our members are liable to prosecution under section 28 of the WHS laws. The HSU notes that NSW Police Officers have recently been relieved of this legislative tension, by an amendment to the NSW WHS Act, that sees the section 28 duty continue to apply, but no longer being a section under which a prosecution can be brought.

In his second reading speech on the NSW Work Health and Safety Amendment Bill 2018, The Hon. Rick Colless MLC made the following arguments, that should also apply to NSW Health security workers:

It is unreasonable to expect police officers responding to such incidents to face potential criminal liability under the Work Health and Safety Act, because they have prioritised public safety over the duties imposed by that Act.

It is also unreasonable for police officers within the chain of command to risk personal liability under the Work Health and Safety Act when meeting legitimate community and government expectations by prioritising public safety during these incidents.

Mr Colless stressed that WHS duties will still apply to police officers involved in active armed offender incidents, but failing to comply with these duties won't constitute an offence.

> *It should also be noted that the Bill does not affect the duties of the State as the person conducting the relevant business or undertaking for the NSW Police Force under the Work Health and Safety Act.*

Recommendation 3.

The HSU seeks that the exemption from prosecution for Police Officers in the NSW Work Health and Safety Amendment Bill 2018 be extended to all workers in the NSW Health System and, those nationally too, who are directed to physically restrain patients and visitors.

It is also notable that no prosecutions under Section 29 have been brought against violent and aggressive patients and visitors by SafeWork NSW.

NSW Health Policy vs Practice – the Business Risks International (BRI Report)

Although NSW Health policies refer to a 'zero tolerance' approach to workplace violence, our members' reports clearly show that incidents of aggressive behaviour are commonplace. In part response to the 2016 shooting at Nepean Hospital, on 8 February 2016 the relevant NSW Minister announced a twelve-point action plan, one component of which was an audit of security and safety in local health districts, both regional and metropolitan.

The report of this audit, conducted by Business Risks International (BRI Report), reflected the experiences reported by our members. It is no longer confidential and is available on the NSW Health website.

The BRI Report found that (page 14):

> *The auditors did not sight any documented risk assessments that were specific to the hazards and risks of that ED (Emergency Department).*
>
> *All sites gave the impression that 'risk' was someone else's responsibility or dealt with at a district level.*
>
> *None of the sites could produce an appropriate risk assessment/register that clearly identifies or justifies the current security staffing level based on any actual or assumed risk, with the number of staff implemented as an effective control measure. It would appear from the information provided and suggested to the review team at each location by the staff participating in the site review, that staffing levels are based on the maximum number of staff available within budget. Staffing levels are not based against any formal risk assessment process…*

These centrally important quotes show long-term chronic breaches of the WHS laws Sections, 17, 18, 19 , 20, 27, 46, 47, 48, 49 and 70. This is not only a failure of the relevant PCBU and persons with management and control of health facilities with respect to the WHS laws but, as the BRI Report

shows, it is also a failure to implement what appears to be a comprehensive principles-based package of NSW Health policies. These are modelled on the principles-based duties in the WHS laws.

This points to the lack of WHS laws and regulations around establishing, maintaining, reviewing and amending safe systems of work with specific reference to risk assessing safe staffing levels. With respect to this, the BRI Report (page 45) sets out the factors to be considered in these risk assessments:

a) Days and times of day when security staff would be most effectively deployed at every location they are required

b) All external and internal threats

c) Current local crime statistics

d) Incident data

e) All duties performed by security staff

f) Site geography

g) Patrol areas

h) Size of campus

i) Any other factors that would influence the security staffing numbers as an effective control mechanism

The most hazardous work within the security function is that of restraining violent or potentially violent patients. With respect to this the BRI Report (page 35) found the following;

> *The reviewed Emergency Departments (ED) did not use a consistent way of restraining.*
>
> *Most staff who restrain have limited or no training. Where staff had been trained, most had not received refresher training.*
>
> *In most locations, the responsibility of restraint falls to the security staff with clinical staff generally taking a 'hands off' approach.*
>
> *Whilst it was suggested by clinical staff that prone restraint is not used, almost all security staff explain the reality of restraint of an aggressive person means that prone restraint does occur. Security staff gave many examples of wrestling a patient / aggressor to the floor or a bed. Due to the inherent risk to the patient in physical restraint, the importance of clinical involvement, oversight and review is paramount, however this was not a regular occurrence at most sites visited.*
>
> *With a lack of training and a lack of consistency in the restraint of patients, the risk of patient and staff injury dramatically increases.*

Some security staff had received PMVA/VPM training (Prevention and Management of Violence and Aggression), but all stated that these methods were not practical or appropriate for use within the ED, as such methods are normally applied to mental health patients as part of a clinically-lead response.

None of the staff in EDs including nursing and security staff when interviewed were clear on who would do what i.e. which limb to take in the event of a physical restraint.

Incident Response to Code Black calls

Within the NSW Health system, a code black is defined as 'a personal threat or physical attack. In the HSU survey conducted in January 2016 our 24% of our security officers and health and safety assistants reported experiencing daily duress alarms and 48% of respondents reported them more than daily . Security officers and health and safety assistants bear the brunt of initiating and leading intervention to restrain patients and visitors, with 59% often initiating and leading intervention and 27% sometimes. This is in the context where our members state that only 25% receive ongoing PMVA/VPM training and only 39% of other staff are educated as to the role of security staff in duress response situations. This is despite 75% of respondents stating that their employer has a documented policy as to the role of security staff in duress response situations.

The BRI Report found with respect to these policies;

> *Some are relatively sophisticated whereas others are effectively non-existent. This is in part due to the 'principles based' policy approach which does not mandate a standard response and/or the lack of local procedures developed out of a risk assessment.*
>
> In addition, there was confusion caused in emergency departments, (page 42);
>
> *Based in part to a culture within EDs that defines an act of aggression as a medical duress and not a personal threat and this had led to the creation of separate ED code response teams.*
>
> *Some locations called a Code Black for acts of aggression only where a weapon is involved…or where the incident occurred outside the ED or for an incident that should be managed by security only.*
>
> *Response time for security staff to respond to a Code Black alarm varied from less than 10 seconds to 15 minutes. This was due to a range of differences in systems found across all sites.*
>
> *None of the locations visited had prearranged entry points or assembly points for a Code Black response*
>
> *Security staff respond to most 'code calls' without any briefings or information on the situation at hand.*
>
> *At every location where security staff were employed the nursing and medical staff believed that only security staff were to respond to a Code Black.*

There was no consistency across any locations of who should be notified when a Code Black is called.

Other departments/staff within the hospital are not notified or made aware of a Code Black situation within ED, which could cause other staff or visitors to walk into an escalating situation.

These findings evidence a lack of a proactive and systematic approach to the prevention and management of violence by NSW Health and the 17 Local Health Districts that make up the public hospital system in NSW.

Post Incident Management

The BRI report stated the following with respect to this issue:

This is poorly understood and implemented in the majority of locations. With the exception of management offering staff the Employee Assistance Program following major incidents, a consistent approach for all staff to learn from incidents was not apparent. The lack of post incident management processes may have also led to the staff feeling that they are not supported against violence, and post incident management needs to be improved.

So, this crucial iterative element required by section 19 (3) (g);

…that the health of workers and the conditions at the workplace are monitored for the purpose of preventing illness or injury of workers arising from the conduct of the business or undertaking…

Is not in place, after each incident of violence including where a Code Black is called, there must be a debriefing session with all the workers involved. So that continual improvement is possible, with lessons learned from mistakes and good practice.

Security Workforce

The BRI report stated the following with respect to this issue:

Security staff in general, do not appear to fully understand their roles or responsibilities, or if they do, they were unable to adequately articulate them to the review team.

Health and Security Assistants or HASAs have a separate reporting line and therefore do not report through security management, so there is little understanding of each other's roles at locations where both classifications are present. In locations where HASAs are employed, they appear to be seen predominately as porters/wards/cleaning staff, whereas security staff have one primary function, that is security.

HASAs and other security staff do not train together and yet they are required at times to respond to Code calls.

It is overwhelmingly the case that Security Officers, Health and Security Assistants and Clinical Staff report to different management, this is a serious obstacle to a well-coordinated, proactive and systematic preventative approach to managing violence.

Another confounding factor is the ad hoc approach to radio communication methods employed in NSW Health facilities, as set out in the BRI Report, (page 49);

> *There is no preferred or state wide approach to the choice of radios used by security. Most sites had either the GME or Motorola hand-sets. None of the sites had any duress functionality built into these radios. The best system found was the one being used at Bankstown, which is the Hytera network system, as this system is used by all other hospital ancillary departments not just security, but all operate under their own channel that can be accessed by everyone.*

Contract staff

Problems of inconsistency are exacerbated by the widespread use of security contractors. Ensuring the timely delivery of information, training, instruction and supervision of contract security staff is a critical part of ensuring healthy and safe work for security officers. No security contractor should start their first shift without receiving the same training on prevention and management of violence and aggression as hospital employees.

The HSU is concerned that this is not the case, and that some local health districts are using security contractors with none, or very little, of the necessary information, training, instruction or supervision to carry out their duties to a satisfactory standard.

Whilst the use of contractors is commonplace throughout the state, the level of training (if any) they receive varies from district to district and, within local health districts, from hospital to hospital, as does the range of duties they are expected to undertake.

Recommendation 4.

That a new section in Chapter 4 - Hazardous Work, 4.9 healthcare work, is inserted into the WHS Regulations. This would contain several subsections.

The first should address the setting of safe staffing levels for hospital security, including these factors, as set out above:

a) Days and times of day when security staff would be most effectively deployed at every location they are required;

b) Annual and seasonal times when security staff would be most effectively deployed at every location they are required;

c) All external and internal threats;

d) Current local crime statistics;

e) Incident data;

f) All duties performed by security staff;

g) Site geography;

h) Patrol areas;

i) Size of campus;

j) Any other factors nominated through consultation, that would influence the security staffing numbers as an effective control mechanism.

The second would address the restraint of patients and other persons, as follows:

a) All hospital emergency department clinical and security workers must receive the same training on prevention and management of violence and aggression

b) Training must include effective liaison between the health facility, ambulance service, the police service and corrective services.

c) Such training to occur before any clinical or security worker starts their first shift in a hospital emergency department or any other part of a health facility.

d) If the potential for incidents of violence and aggression are identified in patient wards and any other area within a health facility, training on prevention and management of violence and aggression must include these areas.

e) Such training to include training with the most effective communication devices available, to enable the fastest response to be made. Communication devices should enable communication with the ambulance service, the police service and corrective services to ensure that emergency department clinical and security workers are aware when any of these services are transporting potentially or actually violent and aggressive persons.

f) Prevention and management of violence and aggression training must subsequently be delivered on an annual basis, or where it is requested by a health and safety representative or a representative nominated by them.

g) Such training must include actual scenario-based elements, where the relevant clinical and security workers in each emergency department, or any other identified area with the health facility, train together.

h) Response planning for the restraint of patients and other persons must include prearranged entry points or assembly points for a violence or aggression response.

i) Systems must be in place to prevent hospital workers and others entering emergency departments or any other location in a health care workplace, where a violence or aggression response is required.

j) Wherever possible briefings or information on the situation at hand are to be provided to response teams before any restraint is applied.

k) Emergency department clinical and security staff participate in planned debriefing sessions after each incident. Including ambulance service, the police service and corrective service where necessary.

l) The outcomes of incident debriefing sessions are to be consulted over and any identified changes made to any element of training on prevention and management of violence and aggression.

m) To allow for continual improvement, health facilities within the same broader administrative unit and between broader administrative units, are to share any identified changes made to any element of training on prevention and management of violence and aggression.

n) To enable continual improvement, every health facility and broader administrative unit (currently called local health districts), local ambulance command and local area police command should be producing and consulting over (see sections 47, 48, 49 and 70 WHS laws) regular written reports on the hazards faced by their workers, the hazards eliminated, and the risk controls applied to minimise those hazards that cannot be eliminated.

NSW Ambulance Paramedics – Musculoskeletal Injury & Violence

As part of this submission the HSU ran a general survey of members. The key finding with respect to staffing levels was that 67% of members had never been consulted over safe and healthy staffing levels. Another 19% report that this type of consultation happened rarely. Only 2% reported that this occurred all the time.

As to current levels, 28% reported that they never had enough staff to work with safe and healthy staffing levels and 34% reported that they rarely had enough staff to work with safe and healthy staffing levels. Accentuating this were the 30% of members who reported that unplanned leave was rarely backfilled and 16% reporting that planned leave was rarely filled.

Digging deeper into this survey;

- 28% report unachievable deadlines sometimes, 25% often and 12% always.
- Very fast work affects 44% sometimes, 30% often and 20% always.
- Being unable to take enough breaks, 26% sometimes, 35% often, 29% always
- Neglecting some tasks – having too much to do, 31% sometimes, 21% often, 21% always.
- When asked Q4 How do these conditions in general compare to where you were working five years ago? 26% nominated much worse now, 21% somewhat worse now, 38% no change, 11% some improvement.

When members were asked to comment on the statement ‘I was bullied’, the answers were; 31% sometimes, 14% often and 6% all the time. In comparison with five years ago, 18% nominate some improvement, 39% no change, 19% somewhat worse now and 20% much worse now.

In addition, the HSU ran its D&D (Death & Disability) safety survey in 2016. In answer to 'Q1 Have you ever been injured or had a muscular strain while performing a manual handling task such as carrying equipment or patients?' 58% replied yes and had time off on workers' compensation, 37% had no time lost, but had suffered muscle strain. Only 5% reported no injury.

In responding to a range of improved manual handling options, 99.98% of respondents supported a four minimum paramedic lift. This a practice almost unheard of in the NSWA.

In response to 'Q9 Have you ever been injured or a near miss such as minor muscle strain and NOT reported due to IIMS being difficult to use?' paramedics find the NSWA IIMS injury reporting system difficult to use, with 76% reporting that they have not reported an injury or near miss.

In response to 'Q12 Have you ever had an injury or near miss due to working in a fatigue state?' 74% responded yes.

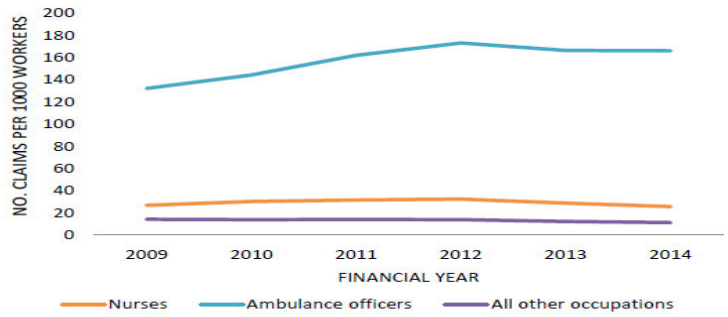
In response to 'Q13 Have you ever been challenged by NSWA when trying to implement fatigue mitigation strategies?' 57% responded yes.

In response to 'Do you believe that the current 6 hour cap for 'rest' under NSWA policy is effective in mitigating your fatigue?' 9% responded yes, 91% no.

In response to 'Q16 Do you believe that the cap for rest should be increased to 10 hours?' 90% responded yes.

The following graphs and text have been extracted from *Gray S, Collie A. Workers' compensation claims among nurses and ambulance officers in Australia, 2008/09-2013/14. Melbourne (Monash University, ISCRR; 2016 May. 26 p. Report No.: 118-0516-R03* (see **Appendix 3).**

Figure 2: The rate of claims for all injury per 1000 workers comparing nurses, ambulance officers and all other occupations over the six year period



Note: denominator data was taken from the 2011 census (the midpoint of the time period)

Amongst ambulance officers, the rate of accepted claims per 1000 workers increased from 132/1000 in 2009 to a peak of 173 per 1000 workers in 2012 and remained steady at 166 in 2014 (Figure 2). The corresponding rate in nurses over the time period were 26/1000 workers in 2009, 32/1000 workers in 2012 and 25/1000 workers in 2014. The rate of claims in ambulance officers is approximately 10 to 12 times that of all other workers (non-healthcare), while the rate of claims among nurses is approximately twice that of all other workers (Figure 2).

Given the responses of our members in the NSWA, the academic figures above come as no surprise and are further evidence of the systemic and chronic lack of health and safety regulation in the NSW Health sector.

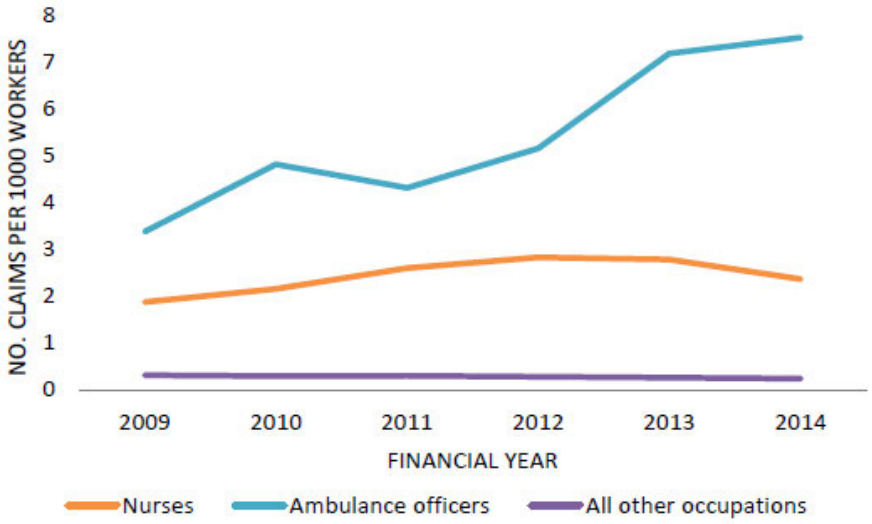
As can be seen from the following table, although overall national statistics show that claims for ambulance workers are 10 to 12 times the national average. NSW leaves the rest of the jurisdictions, behind, for rates of claims per 1000 workers.

Table 1: The number of claims and rate of claims per 1000 workers in each jurisdiction

		Nurses		Ambulance officers	
		N	Rate of claims per 1000 workers	N	Rate of claims per 1000 workers
2009 - 2014	New South Wales	16777	38.6	4321	199.9
	Victoria	6273	16.6	3364	174.7
	Queensland	6772	24.0	1580	91.9
	South Australia	4522	34.7	657	120.1
	Western Australia	4515	34.4	906	193.3
	Tasmania	1099	30.5	310	174.5
	Northern Territory	250	17.8	46	57.6
	Australian Capital Territory	226	12.0	*	*
	Comcare	433	N/A	13	N/A
	Australia	40867	28.7	11197	156.3

The rate of occupational violence-related claims per 1000 workers between occupations is shown in Figure 6. This includes comparison to the rate of occupational violence-related claims among all other occupations. Ambulance officers were between 5 to 14 times more likely to make a workers compensation claim for injury resulting from occupational violence than all other workers. The rate of occupational violence claims in ambulance officers more than doubled in the 6 year period of the study, rising from 3.3/1000 workers in 2009 to 7.5/1000 workers in 2014. Nurses were 3-5 times more likely than other workers to make a claim for injury resulting from occupational violence, however the rate of claims among nurses remained relatively stable over the study period.

Figure 6: The rate of occupational violence-related claims per 1000 workers comparing nurses, ambulance officers and all other occupations



Note: denominator data was taken from the 2011 census (the midpoint of the time period)

Whilst this graph shows that the rate of violence claims has been growing steadily prior to the introduction of the model WHS laws, their introduction coincided with a sharp increase in violence related claims. Musculoskeletal injuries still dominate though, with 64.5% of injuries.

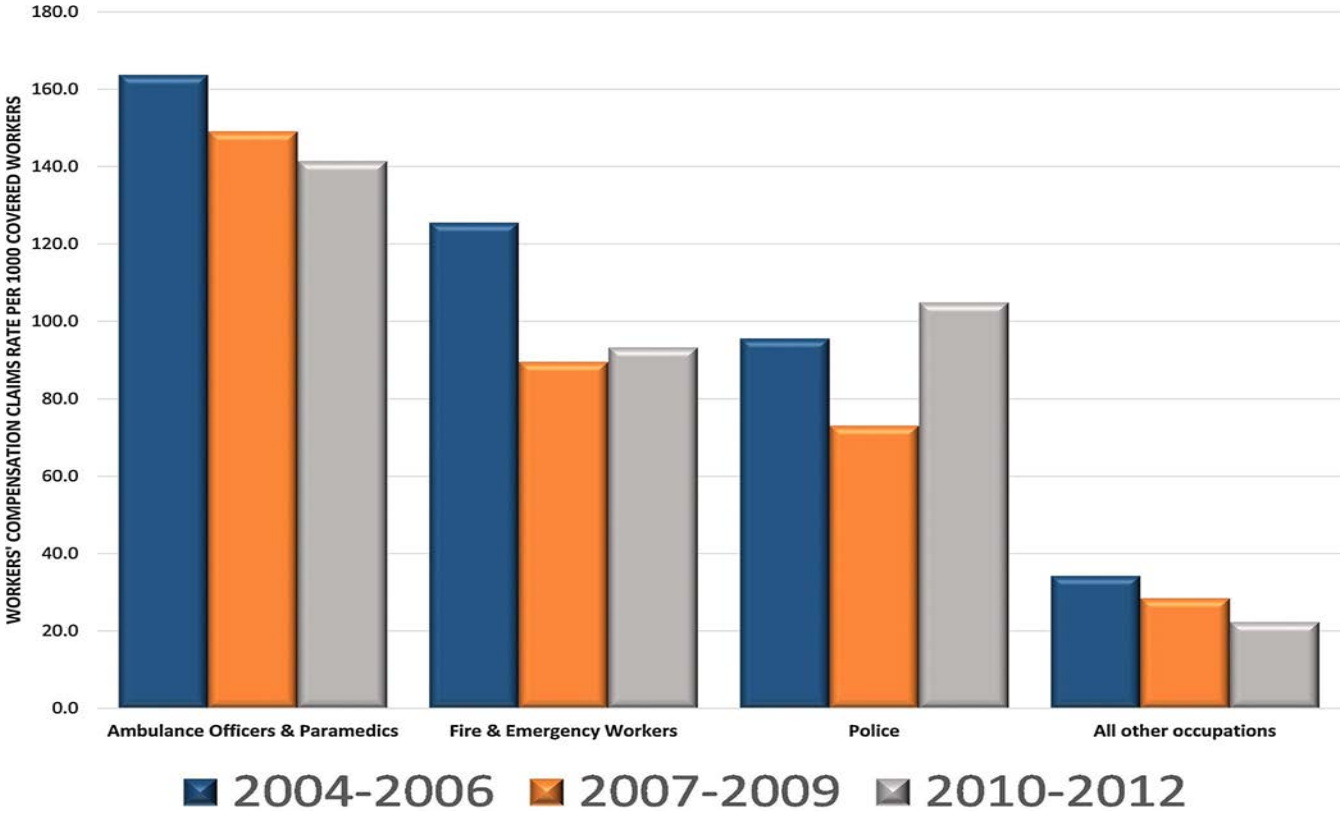
> *Both nurses and ambulance officers were at an even greater risk than other workers for injury claims resulting from occupational violence. Ambulance officers were between 5 to 14 times more likely to make a workers' compensation claim for injury resulting from occupational violence than all other workers, and the rate of violence-related claims more than doubled in the study period. Nurses were 3-5 times more likely than other workers to make a claim for injury resulting from occupational violence. Median time lost due to injury for both occupations was lower than for violence-related claims among all other occupations.*

This paper nonetheless concludes that these figures will be underestimates, relying as they do on workers' compensation statistics.

> *The data are likely to underestimate the true extent of both injury and violence-related injury in the sector, as not all injuries are eligible for workers' compensation, and a proportion of workers choose not to make claims for injuries that may be eligible (Safe Work Australia, 2009). This is consistent with findings that health sector workers under-report violent incidents occurring at work (Arnetz et al, 2015). Developing and/or analysing other relevant data sources, such as population-based hospital incident management systems (e.g., Arnetz et al, 2011), will be necessary to establish the full extent of OHS risk in health sector workers.*

The following graph, extracted from *The nature and burden of occupational injury among first responder occupations: A retrospective cohort study in Australian workers, Shannon E. Gray, Alex Collie, Injury Volume 48, Issue 11, Pages 2470-2477 (November 2017)*, (**Appendix 4**) shows just how

hazardous is the work of ambulance officers and paramedics compared to the other emergency services and all other occupations.



The following quote from this report provides more detail on the graph above;

> *Australian workers compensation claims data demonstrates that ambulance officers had an average rate of 94.6 serious injuries per 1000 workers (those resulting in more than one week time loss), more than seven times the national average. (10) Risk of fatality was six times higher than the national average. Another Australian study compared workers' compensation claims of ambulance officers with other healthcare professionals between 2003 and 2012 in Victoria. (11) This found that there was an upward trend in claim rates and their risk of claiming was significantly higher than other occupations at 102.2 claims per 1000 fulltime equivalent (FTE) workers. This study also found that ambulance officers had a significantly higher risk of musculoskeletal (MSK) injuries and mental health conditions (MHC) than other healthcare professionals. Shannon E. Gray, Alex Collie, pages 2473-4*

From the HSU's perspective there is one single dominant reason for these appalling statistics, that is the prevalence of paramedics who work on their own. This factor alone is the poison pill that overwhelmingly leads to the subsequent musculoskeletal injury and incidents of violence.

Recommendation 5.

We call for the Review to recommend, alongside the other elements of the new section in Chapter 4 - Hazardous Work, 4.9 Healthcare work, that no ambulance paramedic work alone and that four-person lifts of patients are mandatory elements of this new Chapter.

Further development of such a Regulation and a supporting code of practice, would be done using the tripartite approach already called for in this submission.

Question 3: Have you any comments on whether the model WHS Codes adequately support the object of the model WHS Act?

There is clearly a need for supporting codes of practice for the four areas set out above. These will need to be developed in a properly tripartite manner, where the social partners are equally represented. The current national policy-setting body Safe Work Australia (SWA), runs on a sub-optimal tripartite model. This sees each of the nine jurisdictional WHS Regulators having a seat at the table, while unions and their members and employer organisations and their members, have only two representatives each. There is a lack of industry-based tripartite fora at the SWA level.

There have existed Temporary Advisory Groups in the past. What are needed now are permanent properly tripartite national and jurisdiction-based Industry Advisory Groups.

Recommendation 6.

That this Review calls for permanent properly tripartite national and jurisdiction-based Industry Advisory Groups, both as part of the Objects of the WHS laws and specifically required in the statute.

Question 4: Have you any comments on whether the current framework strikes the right balance between the model WHS Act, model WHS Regulations and model Codes to ensure that they work together effectively to deliver WHS outcomes?

Recommendation 7.

Given the foregoing evidence of chronic systemic non-compliance with the WHS laws, the HSU supports the ACTU in its call for '… an urgent and comprehensive reconsideration of the *National compliance and enforcement policy*, a number of amendments to the content of the Model Laws, and an overall strengthening of the status and enforceability of the Codes.'

Question 5: Have you any comments on the effectiveness of the model WHS laws in supporting the management of risks to psychological health in the workplace?

The data already reported in this submission under Question 2 with respect to staffing levels, unachievable deadlines, very fast work, backfilling leave, inability to take breaks and excessive workloads represent a high level of structural violence. This is accentuated by the worsening of these conditions over the last five years for 52% of respondents versus improvement for only 15%. These factors provide fertile ground for bullying across the sector and specifically within NSW Health, which is supposed to be part of an exemplar public sector employer, as previously noted.

The HSU's WHS Act General Member Survey found the following with respect to bullying:

- That 33% were bullied sometimes, 16% often and 7.5% all the time;
- Verbal abuse by a workmate, 27% sometimes, 11% often 2% all the time;
- Verbal abuse by a patient, client, public, 29% sometimes, 16% often, 5% all the time.

To the question 'How do these conditions in general compare to where you were working five years ago?' the answers were; 5% Strong Improvement, 12% Some improvement, 33% No change, 19% somewhat worse, 21% much worse now.

The corresponding figures for bullying in NSW Health are comparable to these.

NSW Public Service Commission People Matter Employee Survey 2017

In NSW the Public Service Commission ran its *People Matter Employee Survey* for the fifth time in 2017. The survey is summarised in **Appendix 5**.

The key findings were that across the broad NSW Public Sector 33% had witnessed bullying and 18% experienced bullying. The corresponding figures for NSW Health were 40% and 22%. Even within the Ministry of Health itself, 28% had witnessed bullying and 16% experienced bullying.

John Hunter Hospital & Central Coast Local Health District Workplace Bullying Surveys

The HSU has run two surveys on bullying in 2018. One covers John Hunter Hospital, the second is for the Central Coast Local Health District.

For John Hunter Hospital, 68% believe they have been bullied in the workplace. The figures for when this occurred are: 29% less than 3 months ago, 12% 3-6 months ago, 13% 6-12 months ago, 1-2 years 19% and 2 years or more 27%.

Only 51% had made a formal complaint. Of those, only 9% were satisfied with the outcome and 43% were not satisfied. When removing the figure of those who did not make a complaint from this figure, which was erroneously counted, the not satisfied figure becomes 84%.

Q10 of this survey asked, 'If you were not satisfied with the outcome of your complaint, please outline why.' The full set of responses is in **Appendix 6**. However, this one comment synthesises the overall tone of the comments made: 'NO ACTION OR FOLLOW UP'.

For Central Coast Local Health District, 69% believe they have been bullied in the workplace. The figures for when this occurred are: 30% less than 3 months ago, 20% 3-6 months ago, 15% 6-12 months ago, 1-2 years 20% and 2 years or more 16%.

Only 56% had made a formal complaint and only 14% were satisfied with the outcome. Whilst 86% were not satisfied.

Q11 of this survey asked, 'If you were not satisfied with the outcome of your complaint, please outline why.' The full set of responses to this question are in **Appendix 7**. However, *NO ACTION OR FOLLOW UP*, would also summarise the vast majority of the comments here as well, along with:

> *Management believes the lies of middle mgt/supervisors. Senior Mgt takes far too long to address issues that are genuine & have direct impact on hospital floor. Middle Mgt/ supervisors are shielded by a wall of lies!*

The bullying that occurred was constant and often, eventually the bully was dismissed, but the process was slow and excruciating and the investigation took years to complete. During this time I had to deal with this person in the workplace.

It is unfortunate that when complaints of bullying are made in NSW Health, and usually in the RACF sector as well, they are governed then by the facility's human resources department. To our members this is a black box process, and they are given little or no information or any input into the design and implementation of the investigation, as the comments from John Hunter Hospital and Central Coast Local Health District show overwhelmingly.

The foregoing evidence illuminates the need for reported incidents of bullying to be dealt with primarily as a health and safety hazard matter, with any disciplinary/ human resource department involvement downstream of this work health and safety approach.

It is noted that the SafeWork NSW RoadMap Government Work Health and Safety Sector Plan Self-Assessment Tool, (see page 16 **Appendix 8**) states with respect to workplace bullying:

- Bullying referred to WHS Department as a WHS incident, as opposed to HR Department

It must be understood that all of this bullying takes place in a policy rich environment that on the surface, would make you think that the issue is properly dealt with. But as is clear from the People Matter Survey and the comments from John Hunter Hospital and the Central Coast Local Health District, these policies overwhelmingly do not resolve the matter, even from a limited human resources perspective.

While the risk management principles and the hierarchy of control remain in the model WHS Regulations 32 to 38, it is necessary to insert a definition of psychological hazards in the Regulations. The WorkSafe Victoria publication *A handbook for workplaces Controlling OHS hazards and risks – Edition No.2 June 2017*, contains the following definition of psychological hazards:

Events, systems of work or other circumstances that have the potential to lead to psychological and associated illness, including work-related stress, bullying, workplace violence and work-related fatigue.

In combination with the broader system of work Regulations already proposed, this definition as amended may be useful in dragging reported incidents of bullying and the other associated psychological injuries from the human resources function into the work health and safety arena. Making them amenable to consultation under the model WHS laws, action through application of the hierarchy of control, provisional improvement notices, and when necessary health and safety cease works.

Recommendation 8.

That the Review recommend that the following definition of psychosocial hazards is inserted as part of the WHS laws Regulation 34:

Such hazards include: events, systems of work or other circumstances, including understaffing and work overload, that have the potential to lead to psychological and

associated illness. And work-related stress, bullying, workplace violence, work-related fatigue and work-related suicide.

Recommendation 9.

That the WHS law's Section 81, Resolution of Health and Safety Issues, includes an element that makes it clear that' where incidents and circumstances are reported as psychosocial hazards, they must be dealt as a WHS law, Section 19, 20 and 47 – 49 & 70 matter, for consultation over the timely application of the hierarchy of control.

Question 7: Have you any comments on the extraterritorial operation of the WHS laws?

None of the WHS Regulators have seen fit to prosecute supply chain breaches of Section 19, despite supply chains being called out as a priority area in the Australian WHS Strategy 2012-2022. It is noted that in NSW the 2018 amendments have extended SafeWork NSW's powers, giving them extraterritorial powers to obtain information from, for example, company head offices or control rooms in other states and territories. Whether these powers apply outside of Australia to support the reach of Section 19 is unclear.

Given the lack of engagement in this area by the WHS Regulators, it is imperative that health and safety representatives (HSRs) and Union Entry Permit Holders have their powers specifically extended to supply chains wherever the work is performed, nationally or internationally.

Recommendation 10.

That the functions and powers of WHS Regulators and Inspectors are specifically extended to apply to supply chains wherever the work is performed nationally or internationally.

In addition, the powers of HSRs and Entry Permit Holders to access documents and workplaces must be specifically extended to supply chains wherever they lead, nationally or internationally.

Question 9: Are there any remaining, emerging or re-emerging WHS hazards or risks that are not effectively covered by the model WHS legislation?

As has been shown already in this submission, safe systems of work, musculoskeletal hazards, violence and the range of associated psychosocial hazards are not effectively covered by the model WHS legislation, Regulations and Codes of Practice. Indeed, the Discussion Paper, supported by our evidence, shows that against a national reduction in incidents, injury and disease, the healthcare and social assistance industry is the most hazardous industry in these respects.

There is also a fundamental lack of willingness on the part of WHS regulators to prosecute other government departments and to prosecute over health and psychosocial hazards.

It is noted that 25 years ago the NSW Occupational Health and Safety Act 1983 contained the following object, in clause 5 (c):

To promote an occupational environment for persons at work which is adapted to their physiological and psychological needs.

This does point to a genuine emerging issue, that is the ageing nature of the workforce. It may be that, suitably amended, this object could form part of the section 19 general duties clause. To make it clear to PCBUs, that workers are not required to be lifelong industrial athletes.

The HSU otherwise supports the ACTU submission, as follows:

> *As outlined, the Codes and Regulations as drafted do not adequately explain the scope and nature of the primary duty of care as it applies to 'non-standard' employment arrangements, such as labour hire and sub-contracting. The Regulations and Codes must provide clear guidance on how organisations can ensure the health and safety of all categories of workers. There is a significant amount of research demonstrating the adverse health and safety consequences of job insecurity, restructures and down-sizing[ix] and guidance material should address these matters in detail. Duty holders should be assisted to identify the major WHS problems associated with each type of working relationship and to develop a systematic approach to managing those issues.*

Recommendation 11.

New Codes and Regulations need to be drafted to cover aspects of WHS that are emerging, worsening or that have been neglected, including:

1. Risks to psychological health;
2. The meaning of safe systems of work - adequate staffing levels in particular;
3. Heat-related illness and exhaustion;
4. Violence at work.

Recommendation 12.

That Section 19 (3) (c) be amended as follows:

> *(c) the provision and maintenance of safe systems of work, including the provision of work which is adapted to the physiological and psychological needs of workers.*

Question 11: Have you any comments relating to a PCBU's primary duty of care under the model WHS Act?

The new global health and safety system management standard, ISO 45001, has a clause that requires a PCBU to make workers aware of their right to cease unsafe work. This is a model for the WHS laws to follow.

Recommendation 13.

That the following is added to the WHS laws Section 19 (f):

Workers shall be made aware of their right to remove themselves from work situations that they consider presents an imminent or immediate serious hazard to their health or safety.

As per the ACTU submission;

> *The Model Act clearly intends to recast the primary duty so that it covers new and emerging work arrangements. However, it is not entirely clear whether or not the general duty in s 19 of the Model Act has the effect of placing an obligation on a PCBU in relation to workers engaged further down a supply chain. This is because it is not clear whether such workers would meet the definition in s 19(1) of being 'at work in the business or undertaking' of the PCBU; or in s 19(2) that their work is 'carried out as part of' the principal PCBU's business or undertaking.*

See also the discussion regarding reversal of the onus of proof at Question 34.

Recommendation 14.

As per the ACTU submission:

> *The ACTU recommends that, for the avoidance of doubt, s 19 be amended to clarify that actors at the top of industry structures (such as retailers and head contractors) are required to identify who is performing work right down to the bottom of these structures and to consult, cooperate and coordinate with workers and other duty holders to identify, eliminate or minimise – as far as reasonably practicable – health and safety risks facing all these workers.*

Question 12: Have you any comments on the approach to the meaning of 'reasonably practicable'?

The section as it stands is legally well crafted and is open to the receipt of new research to allow for continual improvement in the standards required of PCBUs. This does expose a disjuncture between what is a PCBU's duty and what level of protection WHS Regulators will enforce. Also, the HSU is aware that our members are routinely told, when they suggest health and safety improvements by their managers, that their budget does not permit consideration of that idea.

Recommendation 15.

To avoid this disjuncture, the regulatory activities of WHS Regulators should be subject to the same continual improvement in the standards required of PCBUs in WHS laws Section 18. Section 152 should be amended to ensure this is the case.

Recommendation 16.

WHS laws Section 18, should be amended to include a new sub Section (f) making it clear that it is a breach of the Act for a duty holder to refuse to apply an obvious or industry standard risk control, or to conduct a risk assessment on a change to health and safety practices proposed by a; worker, HSR, their nominated representative and a Union entry permit holder.

As per ACTU submission:

> The decision of Judge Curtis in *WorkCover Authority of NSW v Eastern Basin Pty Ltd* [2015] NSWDC 92 suggests that a PCBU can discharge its obligations under the Model Laws simply

by relying on the expertise of independent contractors. The ACTU submits that this interpretation is not consistent with the intention of the Model Laws.

Recommendation 17.

An amendment to the Model Laws needs to be considered to clarify that a PCBU must adopt a systematic approach to WHS management to ensure contractors are working safely.

Question 13: Have you any comments relating to an officer's duty of care under the model WHS Act?

Flowing from our submissions regarding healthy and safe staffing levels, WHS Officers should be specifically required to provide the necessary administrative and financial resources to ensure these.

As per ACTU Submission;

> *The inclusion of new obligations for officers was an important reform introduced by the Model Laws. Poor management is a significant contributor to poor work health and safety outcomes. Senior leaders must be legally required to take responsibility for the health and safety of workers in their organisations. Section 27(1) of the Model Act requires an officer to exercise 'due diligence' to ensure compliance with an organisation's WHS obligations. Section 27(5) sets out the elements of the duty of due diligence in the WHS context, which essentially codifies the content of the due diligence obligation as interpreted by the courts.*
>
> *However, there is no further guidance provided in the Regulations or Codes on what proactive performance indicators would assist officers to meet their obligations. Officers fall into different categories and have different responsibilities within an organisation, for example, human resources, legal, finances, strategic leadership etc. Officers responsible for ensuring adequate staffing, for example, must consider different matters to officers responsible for financial management.*

Recommendation 18.

With respect to Section 27 (5) (c), it needs to be made clear that the:

> *…appropriate resources and processes to eliminate or minimise risks to health and safety from work carried as part of the conduct of the PCBU,* **includes sufficient administrative and financial resources to allow for healthy and safe staffing levels**…

Recommendation 19.

A WHS Officer's Regulation, and Code of Practice and Guidance should be developed in a fully tripartite manner to address the different roles and responsibilities of different categories of officer, as well as standards for reporting on an organisation's health and safety compliance and performance.

Question 16: Have you any comments relating to the 'other person at a workplace' duty of care under the model WHS Act?

It is noted that the foregoing evidence has shown that others, patients and visitors, in healthcare and social assistance workplaces chronically verbally abuse, spit at, threaten and violently attack our members, with and without weapons, causing both physical and psychological harm. Especially when charged with alcohol and other drugs, most hazardously 'ice'.

No regulatory or policy activity by SafeWork NSW has taken place in response to any of these incidents.

Recommendation 20.

That the Review recommend that WHS Regulators engage in a tripartite manner with unions and employers in the Healthcare and social assistance industry, to develop a strategic enforcement approach to preventing such assaults. The HSU suggests that a new infringement notice be developed as part of this activity, with substantial penalties available through these notices.

Question 18: Have you any comments on the practical application of the WHS consultation duties where there are multiple duty holders operating as part of a supply chain or network?

As per ACTU submission:

> *The obligation in s 46 on duty holders to consult with each other, as well as workers and their representatives, is crucial in the context of non-traditional work arrangements such as labour hire, contractor chains and franchises. This 'horizontal' consultation obligation is intended to ensure that the identification and management of WHS risks remains coordinated and comprehensive, even where there are numerous overlapping duty holders.*
>
> *The Model Laws appropriately set out detailed legislative guidance on the duty to consult with workers and their representatives, but fail to do so in relation to the horizontal duty. The Regulations do not address the issue at all, and the Codes of Practice on How to Manage Work Health and Safety Risks and How to Consult on Work Health and Safety address the issue but in insufficient detail.*

Recommendation 21.

A new Regulation and the current supporting Code of Practice, should address in detail matters such as the triggers for consultation, the information to be provided, documentation and reporting, issue resolution and how horizontal consultation interacts with consultation with workers.

Question 19: Have you any comments on the role of the consultation, representation and participation provisions in supporting the objective of the model WHS laws to ensure fair and effective consultation with workers in relation to work health and safety?

The HSU conducted a survey of its HSRs as part of the research for this submission. On the basic issue of whether HSU HSRs feel respected in their role, 24% responded always, 11% Frequently, 21% regularly, 26% rarely, 19% never.

- When asked whether management fixes WHS issues raised by them, 15% responded always, 10% Frequently, 39% regularly, 23% rarely, 13% never.

- On consultation before management makes a WHS decision, 14% responded always, 12% Frequently, 18% regularly, 23% rarely, 33% never.
- On conducting their own investigation into incidents and accidents, 13% responded always, 15% Frequently, 23% regularly, 24% rarely, 24% never.
- On whether the HSR chose their own training provider only 45% responded yes. For the 55% who responded no they were asked to say why. Half of the responses indicated it was because they were given no choice over training provider.
- On whether the HSR had issued a PIN or Cease work only 9% responded yes.
- On whether the HSR had experienced harassment intimidation from management, 12% responded frequently, 16% regularly, 57% never.

The following submission from a NSWA HSR, shows the difficulty they have in exercising their functions and powers, and gives an insight as to the appalling levels of injury among paramedics:

> ***Consultation representation and participation***
>
> *This area is lacking in enforcement. Despite constantly requesting to be involved in processes and decisions that are important to the Safety of Paramedics, I (NSW Ambulance Paramedic and HSR) and other HSR's are ignored. When issues are taken to SafeWork NSW we are dismissed and told that NSWA are compliant. This is despite obvious breaches of the WHS Act.*
>
> ***Compliance and enforcement***
>
> *This area is lacking in enforcement. Despite constantly requesting to be involved in processes and decisions that are important to the Safety of Paramedics, I (NSW Ambulance Paramedic and HSR) and other HSR's are ignored. When issues are taken to SafeWork NSW we are dismissed and told that NSWA are compliant. This is despite obvious breaches of the WHS Act.*

Despite the high importance that 2008 Review placed on the role of the HSR, it is the HSU's experience that SafeWork NSW does not take a proactive approach either to HSR formation or establishing broader engagement with them. For instance, SafeWork should be producing a regular bulletin for HSRs to spread news of best and worst practice and to more generally make HSRs feel like they are fully supported by their WHS regulator. SafeWork NSW has informed Unions NSW and affiliates that it has around 8000 HSRs registered. SafeWork NSW is given HSRs' email addresses as part of the registration process but has made no attempt to engage with them using that information.

This gap in support for HSRs is clear in reading the WHS Laws Section 152 Functions of Regulator. Nowhere in this key section is support for electing and engaging with HSRs through the use of tripartite means. In addition, SafeWork NSW has not developed any further WHS law's Section 72, approved training for HSRs in the dealing with the key areas of musculoskeletal injuries, carcinogens,

hazardous chemicals, psychosocial hazards and violence. All an HSR can access after 5 years of the WHS Laws operation is the same refresher course, year in year out.

It is noted that SafeWork NSW, in 2017 did hold its first Consultation Conference, but did not make it an HSR training course under Section 72. Unions NSW and affiliates did make this suggestion last year when we became aware of the event. The key officials at SafeWork NSW indicated they would try for that next time.

Even at the level of informing SafeWork NSW of the PCBU's HSRs, their online portal is an unnecessarily time consuming process, as the HSU has experienced directly in informing SafeWork NSW of its own HSRs. A much simpler and easier to use format would be via tripartite means, to develop a harmonised standard Excel spreadsheet for PCBUs to use for their WHS Law's Section 74 HSR notification duty. This would then facilitate the formation of HSR industry fora and a proper deeper engagement between SafeWork NSW, HSRs, unions and employers.

The HSU is aware of instances where HSRs have raised WHS issues with SafeWork NSW, but when the inspector attends the workplace to investigate they do not arrange for the HSR raising the issue to be part of the investigation and they take the PCBU's advice to confer with another HSR.

Recommendation 22.

For the Review to recommend that an amendment be made to WHS Law's Section 152 Functions of Regulator, to require WHS Regulators to engage with workers, unions and employers in a tripartite manner, to facilitate the election of HSRs and then engage with HSRs in a tripartite jurisdictional and industry-based manner.

Recommendation 23.

For the Review to recommend that an amendment to be made to WHS Law's Section 152 Functions of Regulator, to require WHS Regulators to develop further training for HSRs to access under the WHS laws Section 72, in the key areas of musculoskeletal injuries, carcinogens, hazardous chemicals, psychosocial hazards and violence.

Recommendation 24.

For the Review to recommend that a much simpler and easier to use harmonised standard Excel spreadsheet for PCBUs to use for their WHS Law's Section 74 HSR notification duty. This would then facilitate the formation of HSR industry fora and a proper deeper engagement between WHS Regulators, HSRs, Unions and Employers.

Recommendation 25.

For the Review to recommend that an amendment to be made to WHS Laws Section 152 Functions of Regulator, to require WHS Regulators to convene an annual HSR Conference, for HSRs to access under the WHS laws Section 72. It is noted that a well-functioning model for such a conference exists in Victoria.

Recommendation 26.

For the Review to recommend that an amendment to be made to WHS Laws Section 160 Functions and Powers of Inspectors. To add a new subsection (g), requiring an Inspector to inspect contraventions raised by an HSR with that HSR and their union assistant or representative where nominated.

Recommendation 27.

For the Review to recommend that an amendment to be made to WHS Laws Section 70 (h) General Obligations of PCBU to HSRs. So that where an HSR calls an inspector in investigate a contravention, the PCBU and inspector must ensure that HSR is available to participate in the inspection and associated activities of the inspector, e.g. meetings with workers, issuing notices.

As per ACTU Submission;

> *Schedule 2 allows (but does not require) a jurisdiction to establish a regulator and provide for local consultation arrangements. This mechanism is not strong enough to ensure adequate consultative structures remain in place. For example, NSW has abolished the tripartite body that was in place previously.*

Recommendation 28.

The ACTU recommends that Schedule 2 be amended to *mandate* the establishment of permanent tripartite consultation arrangements within each jurisdiction, including tripartite sub-committees to address industry specific issues, and compliance with ILO Convention 155 be included in the objects of the Act.

Recommendation 29.

Section 47(2) should be amended to ensure that workers who will be covered by agreed procedures for consultation have a right to be represented while such procedures are being negotiated.

Recommendation 30.

The *Worker Representation and Participation Guide* should be amended to illustrate how workers in a large firm can authorise representatives to represent them in negotiations with a PCBU or group of PCBUs in the process of negotiating for the formation of work groups pursuant to Sections 50-53.

Recommendation 31.

Section 52(2) should be amended to place a maximum time-limit on negotiating a work group, for example, 3 months.

Recommendation 32.

Section 48(c) requires that the views of workers are *taken into account* by the person conducting the business or undertaking. However, it is not clear what this means in practice. The Model Laws should be amended to include a requirement to document workers' views and the ways in which they have been considered.

Question 20: Are there classes of workers for whom the current consultation requirements are not effective and if so, how could consultation requirements for these workers be made more effective?

This is an issue that is relevant to our members working as home care workers. When they enter the home of someone they care for, that becomes their workplace. They can face a range of hazards, including musculoskeletal injuries from lifting a patient, violence and hazardously cramped rooms, especially bathrooms. In addition, they can face sexual harassment. Legally they are stuck between their PCBU and their patient, who is often the Section 20 duty holder, being the person controlling their workplace. This situation is even more complex when the patient is a tenant.

Given that home care workers overwhelmingly work alone as part of the structure of their PCBU, having face to face access with an HSR in these circumstances is very unlikely. For these reasons the HSU supports the ACTU Submission on this point below.

As per ACTU submission

There is no shortage of research outlining why and how traditional WHS consultation mechanisms and enforcement approaches do not work in non-standard workplaces.[x]

Recommendation 33.

> *For this reason, union Entry Permit Holders (EPHs) should be given the powers and responsibilities of a HSR - including in relation to consultation, issuing PINs and directing work to cease - when there are no elected HSRs in a workplace. The extension of these powers is essential to ensure that workers in non-standard workplaces can be represented. Any new powers given to a permit holder should be subject to review in the usual way.*

Question 21: Have you any comments on the continuing effectiveness of the functions and powers of HSRs in the context of the changing nature of work?

As per ACTU submission:

> *There are a number of improvements that need to be made to the provisions of the Model Laws relating to the rights of HSRs.*

Recommendation 34.

Section 62 should be amended to expressly prohibit a PCBU from conducting or interfering in election of HSR, with penalties for a breach.[xi]

Recommendation 35.

Section 72 should be amended to ensure that:

1. HSRs are entitled to attend any course of training relating to occupational health and safety that is approved or conducted by the regulator, on the provision of reasonable notice[1].

[1] See for example Victorian WHS Act, s 69(d)(ii)

Clause 21 of the Regulations both requires the approval of the regulator and unnecessarily limits training to five days initially and one day per year each year after that. HSRs should be entitled to attend any training approved by the regulator on the provision of reasonable notice[xii].

2. HSRs are entitled to choose their preferred training provider, as long as the course is approved by the Regulator. Employers are required by the Act to allow HSRs to attend a course of training in work health and safety chosen by the HSR 'in consultation with the person conducting the business or undertaking'. The Model Laws should clarify that the requirement for consultation does not authorise an employer to veto a HSR's choice of provider, as long as the cost and location are reasonable, and the regulator has approved the course.[xiii]
3. Re-elected HSRs do not go for extended periods without training. The Model Laws should prescribe that a HSR is permitted to take a minimum number of days per year off work per year.[2]

Recommendation 36.

Section 76 should be amended to ensure that:

1. The constitution of a health and safety committee (**HSC**) *must* be agreed between the person conducting the business or undertaking and the workers at the workplace;
2. The person conducting the business or undertaking must, if asked by a worker, negotiate with the worker's representative in negotiations regarding the constitution of HSR committee;
3. Non-HSR committee members are elected (under s 61 of the Act) by the workers they represent, and have access to appropriate training;
4. PCBU interference with the constitution of a HSC is an offence subject to a penalty;
5. The constitution of a HSC must address the functions of the HSC, including meeting processes such as timing, nomination of a Chair, minutes and attendance by the PCBU.

Recommendation 37.

Section 79 should be amended to:

1. Actively discourage cancellation of HSC meetings;
2. Require that PCBUs actively facilitate (not just allow) the attendance of HSC Members particularly for remote, dispersed and shift workers.

Recommendation 38.

Sections 85 and 90 should be amended to allow a HSR to direct that unsafe work cease and/or issue a PIN even if they have not yet completed the required training. Sections 85(6) and s 90(3) enable a PCBU to simply deny training to a HSR in order to prevent them from issuing a PIN or directing work to stop.

Recommendation 39.

[2] See for example South Australian WHS Act, s 72(1)

Section 84 should be amended to ensure that a worker may cease or refuse work if it would expose the worker ***or others*** to a serious risk to health or safety. This would bring workers' rights into line with their obligations under Section 28 (a) and (b), which require a worker to take reasonable care that his or her acts or omissions do not adversely affect the health and safety of other persons, as well as themselves.

Question 22: Have you any comments on the effectiveness of the issue resolution procedures in the model WHS laws?

As per ACTU submission:

> *Section 80 defines the parties to a dispute for the purpose of resolving WHS issues. There is some ambiguity created by this section regarding the role of unions. Section 80(1)(c) provides that if the worker or workers affected by the issue are in a work group, the HSR for that work group or their representative is the party to the dispute.*

Recommendation 40.

This section should be amended to clarify that even if a worker is in a work group, the worker or workers or their representative are parties to the dispute. Feedback from affiliates is that employers have been asserting that workers in a work group can *only* be represented by a HSR.

Recommendation 41.

For the Review to recommend that an amendment be made to WHS Laws Section 82 Referral of WHS Issue to Regulator for Resolution by Inspector, so that any party to the issue can seek their jurisdiction's tribunal e.g. NSW Industrial Relations Commission, to conciliate and arbitrate a WHS issue that is unresolved. This should not affect the rights of workers and HSRs to engage in cease work activity or the issuance of a PIN.

Question 23: Have you any comments on the effectiveness of the provisions relating to discriminatory, coercive and misleading conduct in protecting those workers who take on a representative role under the model WHS Act, for example as an HSR or member of an HSC, or who raise WHS issues in their workplace?

As per ACTU submission;

> *The wording of these provisions is in theory sufficient to protect HSRs. However, feedback from affiliates is that HSRs are still regularly being subjected to discriminatory, coercive and misleading conduct. Despite this, no regulator has taken action on any matter under Part 6 despite repeated breaches being brought to their attention.*

Recommendation 42.

The need to effectively enforce these important provisions should be considered as part of the review of the NCEP.

This problem will also be assisted by amending the Model Laws to empower unions to commence legal proceedings for breaches.

Question 24: Have you any comments on the effectiveness of the provisions for WHS entry by WHS entry permit holders to support the object of the model WHS laws?

As per ACTU submission:

> *Immediate action should be taken to ensure that WHS entry permit holders are recognised nationally, across jurisdictional borders.*

Recommendation 43.

Section 117 of the Model Act should be amended to clarify that an EPH who has lawfully entered a workplace under another law for a different purpose (e.g. to hold discussions with potential members under s 484 of the *Fair Work Act 2009 or equivalent Jurisdiction Industrial Relations Act*) may lawfully remain on the premises to investigate a suspected contravention of the Model Laws where they become aware of safety issues *after* the initial entry.[xiv] It would be absurd and inconsistent with the objects of the Model Laws if an EPH with a reasonable suspicion of a breach had to exit a worksite and re-enter it simply in order to meet technical requirements of the Model Act.[xv]

Recommendation 44.

Section 118 should be amended to ensure that:

1. EPH's can also take measurements, conduct tests, and makes sketches, photographs or recordings;
2. EPHs can request the production of documents *post-inspection*.

Recommendation 45.

Section 141 authorises a party to a dispute about right of entry to ask the regulator to appoint an inspector to attend the workplace to assist in resolving the dispute. However, inspectors are not authorised by the Act to make a final decision about the matter. The Model Laws should be amended to give inspectors the power to make a final decision about right of entry disputes.

Recommendation 46.

Section 142 deals with right of entry disputes. The regulator is authorised to make a series of orders under s 142(3), but the orders all focus on addressing misconduct by the EPH. The provision should also authorise the regulator to make orders to deal with misconduct by the PCBU.

Question 25: Have you any comments on the effectiveness, sufficiency and appropriateness of the functions and powers of the regulator (Sections 152 and 153) to ensure compliance with the model WHS laws?

Recommendation 47.

As per ACTU submission:

> *As outlined, the primary problem is the failure of the enforcement strategy adopted by the regulators. An urgent and comprehensive review of the enforcement strategy should be carried out in consultation with stakeholders.*

Recommendation 48.

In addition, amendments should be made to the Model Act to strengthen the powers of the regulator in the following ways:

1. A new offence of industrial manslaughter;
2. A reverse onus of proof for defences to breaches;
3. Higher penalties.

Question 26: Have you any comments on the effectiveness, sufficiency and appropriateness of the functions and powers provided to inspectors in the model WHS Act to ensure compliance with the model WHS legislation?

Recommendation 49.

Inspectors' functions and powers in each jurisdiction need to be extended to follow Section 19 - 27 duties, all the way to any country where supply chains from the PCBU extend to. In this respect the HSU notes the recent amendment along these lines made in the 2018 NSW WHS Act Amendment Act, but this is silent on overseas functions and powers.

Question 27: Have you experience of an internal or external review process under the model WHS laws? Do you consider that the provisions for review are appropriate and working effectively?

Recommendation 50.

The Model Laws should confirm that the Fair Work Commission (FWC) and state industrial tribunals, have a general jurisdiction to conciliate and arbitrate compliance disputes, not settled through the WHS laws Section 80,81 & Regulation 22 & 23 WHS Issue resolution procedures.

As per ACTU submission:

> *Part 12 provides for internal or external review of certain decisions made under the Model WHS Laws. Section 223 sets out which decisions are reviewable and which people have standing to apply for review in each case ('eligible persons'). Due the complexity of the process involved in applying for review, in practice unions are required to assist members in almost every instance.*

Recommendation 51.

As such, unions should be defined as 'eligible persons' entitled to seek review of every type of reviewable decision listed at s 223 except for Items 5 and 6, which relate to the forfeiture and return of seized things.

Recommendation 52.

The Model Laws should confirm that the Fair Work Commission (FWC) and state industrial tribunals are eligible review bodies for the purposes of external review. The industrial commissions should be authorised to conciliate and arbitrate such disputes[xvi]

Question 29: Have you any comments on the provisions that support co-operation and use of regulator and inspector powers and functions across jurisdictions and their effectiveness in assisting with the compliance and enforcement objective of the model WHS legislation?

As per ACTU Submission

> *Section 152(g) of the Act empowers the regulator to engage in, promote and co-ordinate the sharing of information, including the sharing of information with a corresponding regulator.*

Recommendation 53.

As outlined, the current enforcement regime is failing to ensure compliance. Companies which routinely breach their WHS obligations often breach other laws and regulations. Current levels of coordination between relevant regulators are not sufficient to stop companies phoenixing to avoid legal obligations. Strategies, mechanisms and forums to improve cooperation between WHS regulators and other relevant regulatory bodies, including ASIC, should be considered as part of the review of the NCEP.

Question 30: Have you any comments on the incident notification provisions?

One of the best practice elements of the NSW OHS Act 2000, was Regulation 341, with its detailed list of notifiable incidents, which was much pared back in the WHS laws.

Recommendation 54.

The HSU recommends that this Regulation, as amended below, be the basis for a recommendation as follows;

OCCUPATIONAL HEALTH AND SAFETY REGULATION 2001 - REG 341

Notification of incidents--additional incidents to be notified

341 Notification of incidents--additional incidents to be notified

(a) an injury to a person (supported by a medical certificate) that results in the person being unfit, for a continuous period of at least 7 days, to attend the person's usual place of work, to perform his or her usual duties at his or her place of work or, in the case of a non-employee, to carry out his or her usual activities,

(b) an illness of a person (supported by a medical certificate) that is related to work processes and results in the person being unfit, for a continuous period of at least 7 days, to attend the person's usual place of work or to perform his or her usual duties at that place of work,

(c) damage to any plant, equipment, building or structure or other thing that impedes safe operation,

(d) an uncontrolled explosion or fire,

(e) an uncontrolled escape of gas, dangerous goods (within the meaning of the ADG Code) or steam,

(f) a spill or incident resulting in exposure or potential exposure of a person to a notifiable or prohibited carcinogenic substance (as defined in Part 6.3),

(g) removal of workers from lead risk work (as defined in Part 7.6) due to excessive blood lead levels,

(h) exposure to bodily fluids that presents a risk of transmission of blood-borne diseases,

(i) the use or threatened use of a weapon that involves a risk of serious injury to, or illness of, a person, **use or threatened use of violence that involves a risk of serious injury to, or illness of, a person – HSU amendment**

(j) a robbery that involves a risk of serious injury to, or illness of, a person,

(k) electric shock that involves a risk of serious injury to a person,

(l) any other incident that involves a risk of:

(i) explosion or fire, or

(ii) escape of gas, dangerous goods (within the meaning of the ADG Code) or steam, or

(iii) serious injury to, or illness of, a person, or

(iv) substantial property damage,

(m) in relation to a major hazard facility (as defined in Chapter 6B)--if not already covered by another paragraph of this clause, a major accident or near miss (as defined in that Chapter).

New (n) incidents that require a worker or other person to attend an emergency department of a health facility, but not be admitted as a patient.

New (o) incidents that require later admission as an inpatient after further examination.

Question 31: Have you any comments on the effectiveness of the National Compliance and Enforcement Policy in supporting the object of the model WHS Act?

As per ACTU submission:

> *Enforcement is a crucial element of effective WHS regulation.*
>
> *The NCEP sets out the approach regulators are supposed to take to WHS compliance and enforcement, including the criteria used to guide enforcement decisions. In principle, the ACTU supports a national policy setting out a consistent set of principles and operating protocols to guide compliance and enforcement.*

However, the ACTU has serious concerns about the adequacy and effectiveness of the NCEP. Firstly, the NCEP lacks detail and specificity. It does not provide adequate guidance on when and how the available compliance and enforcement tools should be used in practice. Secondly, the NCEP does not appear to be underpinned by a comprehensive enforcement strategy or methodology. The 'graduated compliance and enforcement principle' is inappropriately prioritising encouraging compliance at the expense of sanctioning non-compliance.

Effective enforcement strategies must address the underlying factors that lead to non-compliance and seek to change the behaviour of those actors at the top of the chain which affect the way in which markets operate. An effective enforcement strategy must ensure that companies at the top of complex industry structures (such as franchising, labour hire, supply chains and other such arrangements) are held accountable for the health and safety of workers all the way down to the bottom of these structures, and are not able to shift health and safety risks to smaller businesses and individual workers who are less able to bear the risks. The focus of the regulator should be on sectors and industries where there are large numbers of vulnerable employees (e.g. low paid and with limited capacity to complain), and deterrence should be prioritised. Prosecutions should target serious and repeated breaches, and/or breaches by high-profile or influential duty-holders and market-leaders. Particular attention should be given to enforcing the protections against victimisation in Part 6. Consideration should be given to amending the Act to authorise the use of Adverse Publicity Orders.

Recommendation 55.

As per ACTU submission:

In light of these concerns, the ACTU recommends the urgent commencement of a comprehensive review of the NCEP - including resourcing, methodology and strategy – which considers the successful aspects of approaches taken by other regulators, including the Fair Work Ombudsman, where appropriate.

Question 32: Have you any comments in relation to your experience of the exercise of inspector's powers since the introduction of the model WHS laws within the context of applying the graduated compliance and enforcement principle?

See answer to Question 31.

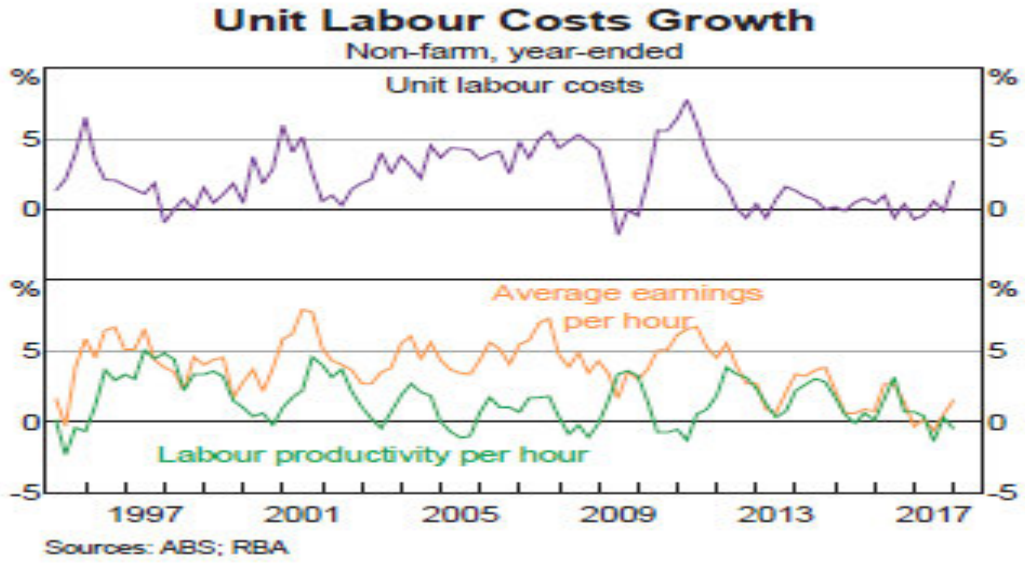
Question 33: Have you any comments on the effectiveness of the penalties in the model WHS Act as a deterrent to poor health and safety practices?

In answering this question, the HSU has appended, (see **Appendix 9)** two documents prepared by WorkSafe Victoria, for 2017 WHS Regulator prosecutions and penalties. these summarise the number, penalties for and percentages, by jurisdiction. However before looking directly at the WorkSafe figures, they need to be seen in the context of the size and productivity of the Australian economy, as follows:

Global forecasts predict Australia will maintain its position as the world's 13th largest economy (in US dollar terms) in 2017. Australia's nominal GDP is estimated at US$1.3 trillion (A$1.7 trillion)[xvii]

…productivity levels of 15 out of 20 Australian industries rate above the average productivity of global competitors in the same sector. Australia is performing 20 per cent above this global average in five key growth sectors – gas, education, oil, tourism and health…

Along with this growth in productivity, April 2018 Reserve bank of Australia statistics[xviii], show that unit labour costs have been relatively flat, since around 2012.



It would appear that these productivity figures, 20% above the global average, are being wrought off the broken bodies and minds of our members.

The total fines levied by the various courts in 2017 were $12.15 million against an annual GDP of $1.7 trillion. They enliven the old cliché that they are a 'drop in the ocean'. These figures do not represent a deterrent, and any actuary will advise a PCBU that they have little to fear from being one of only 25 prosecutions brought by SafeWork NSW, assuming a steady rate going forward. These figures are accentuated for NSW given that: '*New South Wales (NSW) is Australia's largest state economy, with 33% of the nation's GDP in 2015–16. The next largest state, Victoria, …contributes 22%.'*[xix]

So, with a total of $3.7 million in fines levied in NSW in 2017, against an economy of approximately half a trillion dollars, health and safety fines can be seen as a very small cost of doing business.

The percentage of prosecutions in Victoria represent 50% of the total, against 15% for NSW. None of these in NSW occurs in the Healthcare and social assistance industry.

The day after the Discussion Paper was launched, Mr Rod Sims, Chairman of the ACCC gave a speech to the CEDA Conference in Sydney. The comments he made went to the adequacy of penalties under the ACCC legislation, as follows:

Australian Consumer Law

There is now momentum towards greater penalties for breaches of Australian Consumer Law (ACL).

In its final report on the ACL Review, Consumer Affairs Australia and New Zealand (CAANZ) recommended penalties for a breach of the ACL be raised from $1.1 million for companies to the greater of $10 million, three times the value of the benefit received, or where the benefit cannot be calculated, 10 per cent of annual turnover in the preceding 12 months.

… Just last week the bill was introduced to the Parliament by Minister Sukkar and, if passed, will align the maximum penalties under the ACL with the maximum penalties under the competition provisions of the CCA.

This is consistent with a Productivity Commission recommendation into Consumer Law Enforcement and Administration.

This is a profound change that will change corporate behaviour significantly.

The case for tougher penalties has been strong.

Currently, the maximum penalties for breaches of the ACL are, for corporations, approximately one-tenth of the lowest maximum penalty for breaches of the Competition Law.

There is no good reason for this difference. We have seen cases where consumer law breaches have led to very substantial harm to many consumers.

The message needs to be sent that this must stop.

Bigger penalties for big businesses

We have seen penalties in different competition law cases that have barely distinguished between the size of the contravening businesses.

For example, Cabcharge was penalised with a total penalty of $14 million for three contraventions of section 46 whereas Visa Worldwide Pte Ltd, part of the Visa international credit card business that has global turnover that is many, many times larger than that of Cabcharge, ended up with an $18 million sanction for contravening section 47.

We believe this does not adequately send a message of deterrence to the much larger businesses that end up paying proportionately much smaller penalties than small and medium sized businesses...

…Put simply: large businesses should bear penalties which are commensurate to their size, in order to achieve specific and general deterrence. Making this happen is a huge priority and challenge for the ACCC in 2018.

It is noted that the ACTU[xx] and the CFMEU National Office Submission to The National Review Into Model Occupational Health and Safety Laws in 2008, made the same arguments with respect to, at the very least aligning the fines and gaol sentences possible under the WHS laws with those available under ASIC legislation. Clearly this did not happen with the $3 million ceiling put in place, which last year resulted in the national average of penalties applied being $84,409.

Excerpt from ACTU 2008 Submission to Model OHS Laws Review - ACTU 8.7 SENTENCING OPTIONS Fines

> *262. The ACTU considers that monetary penalties should be imposed on all offences under occupational health and safety legislation. Given the grave consequences which can flow from contraventions of occupational health and safety legislation, the ACTU firmly believes that the highest sanctions for breaches of any corporation related law should be available under the model occupational health and safety legislation and that in an appropriate case a pecuniary penalty calculated as a proportion of a corporation's turnover be able to be imposed*
>
> *If we properly value human life and health, there is no justification for the penalties in the WHS laws to not be set at the same level and for the usual WHS offence 'pulverisation' arguments, critiqued in detail in the 2008 CFMEU document, to be subject to a thorough review to ensure that they do not continue to limit WHS offence fines to minimal amounts.*
>
> *Finally, it is noted that the fines available under the UK's Health and Safety at Work Act 1974, seen as the parent piece of legislation to our WHS laws, have been amended in this manner to take account of the size of the organisation prosecuted. The table below sets out the fines available for the worst offence by size of organisation. While these do not seek to set fines based on a percentage of turnover, they are nonetheless much higher that the maximum $3 million available under the WHS laws, with a maximum penalty of 20 million pounds, roughly $40 million.*

Table 4 – Corporate manslaughter fines

Large organisation **Turnover more than £50 million**		
Offence category	**Starting point**	**Category range**
A	£7,500,000	£4,800,000 – £20,000,000
B	£5,000,000	£3,000,000 – £12,500,000
Medium organisation **Turnover £10 million to £50 million**		
Offence category	**Starting point**	**Category range**
A	£3,000,000	£1,800,000 – £7,500,000
B	£2,000,000	£1,200,000 – £5,000,000
Small organisation **Turnover £2 million to £10 million**		
Offence category	**Starting point**	**Category range**
A	£800,000	£540,000 – £2,800,000
B	£540,000	£350,000 – £2,000,000
Micro organisation **Turnover up to £2 million**		
Offence category	**Starting point**	**Category range**
A	£450,000	£270,000 – £800,000
B	£300,000	£180,000 – £540,000

Recommendation 56.

That the Review recommend that maximum penalties for a breach of the WHS laws be raised from $3 million for companies to the greater of $10 million, three times the value of the benefit received or, where the benefit cannot be calculated, 10 per cent of annual turnover in the preceding 12 months, as per ASIC and now ACCC penalties.

That the Review consider the above table now used in the parent UK HSWA Act 1974, with a recommendation for an outcome offence of industrial manslaughter.

That the Review recommend that the usual WHS offence 'pulverisation' arguments, critiqued in detail in the 2008 CFMEU document, to be subject to a thorough review in new sentencing guidelines, to ensure that they do not continue to limit WHS offence fines to minimal amounts.

As per ACTU submission:

> ***Industrial Manslaughter***
>
> *Two jurisdictions in Australia have industrial manslaughter provisions.*
>
> *In 2004, the ACT became the first jurisdiction in Australia to introduce an offence of industrial manslaughter via the Crimes (Industrial Manslaughter) Act 2003, which added a new Part 2.5 to their Criminal Code. "Industrial manslaughter" is defined as causing the death of a worker while either being reckless about causing serious harm to that worker or any other worker, or being negligent about causing the death of that or any other worker.*
>
> *On 12 October 2017, the Queensland Parliament introduced new industrial manslaughter provisions. There are two new criminal offences of industrial manslaughter: an 'employer' and a 'senior officer' offence, if:*
>
> 1. *a worker dies (or is injured and later dies) in the course of carrying out work;*
> 2. *the person conducting a business or undertaking (PCBU) or senior officer's conduct (either by act or omission) causes the death of the worker; or*
> 3. *the PCBU or senior officer was negligent about causing the death of the worker by the conduct.*
>
> *A PCBU found guilty of industrial manslaughter may be liable for a fine of up to $10 million, while an individual (senior officer) may be liable to a term of up to 20 years' imprisonment.*
>
> *The rationale for the enactment of an offence of industrial manslaughter includes the following:*
>
> 1. *Only individuals, not corporations, can be convicted of the offence of manslaughter under the criminal law as it stands;*

2. *A new offence of industrial manslaughter would give due recognition to the gravity of negligence causing death at work;*

3. *A new offence of industrial manslaughter, if rigidly prosecuted, will deter the conduct that is leading to loss of life at work.*

Recommendation 57.

The ACTU recommends adopting an offence expressed in similar terms to the Qld provisions, with additional consideration of the following improvements:

1. *Expansion of the provisions to include any person killed by the negligence of the PCBU. This would cover situations like the fatal wall collapse at the Grocon site in Carlton in 2014, which killed three pedestrians;*

2. *Expansion of the provisions to cover all senior management responsible for the management of WHS decisions, including senior managers below the executive level who are nonetheless responsible for making decisions about WHS matters (see the UK legislation).*

Question 34: Have you any comments on the processes and procedures relating to legal proceedings for offences under the model WHS laws?

As per ACTU submission:

> *The ACTU is deeply concerned about the steep decline in prosecutions under WHS legislation over recent years.[3] For example, sections 144 and 145 of the Model Act prohibit interference with or obstruction of a permit holder. Despite many contraventions being brought to the attention of the NSW WHS Regulator there has never been a single prosecution in 5 years.*
>
> *While a stronger, more effective regulator is crucial, it cannot alone address the enforcement challenges posed by a changing economy. A stronger role for unions is a crucial aspect of effective deterrence of breaches.*

Union enforcement

Recommendation 58.

Unions should have standing to bring proceedings for offences under the Model Act in circumstances where they have a member concerned in the breach in question, and where the regulator has failed to prosecute and does not intend to prosecute within a reasonable period.

A qualified right of private prosecution (i.e. by a person other than a public official) for criminal matters does exist at common law.[4] While it is not a common part of contemporary Australian criminal law practice, it does exist in regimes such as environmental law. In the ACTU's strong submission, it is reasonable, justified and necessary to confer a right of prosecution on workers affected by a breach of the Model Laws and their unions. WHS Law is not traditional criminal law,

[3] Stats from discussion paper

[4] *National Review Into Model Occupational Health and Safety Laws*, Second Report, January 2009 at p 418

and unions have a significant body of expertise in relation to health and safety matters. They are also equipped with a deep knowledge of the WHS issues confronting particular workplaces, industries and sectors. The inspectorate may have limited visibility of WHS breaches, particularly in 'non-standard' workplaces, and limited resources to pursue all breaches worthy of prosecution. The option of union prosecutions also addresses the potential conflict of interest presented by a state regulator having to enforce compliance by government employers. There is evidence that union prosecutions are effective in bringing about cultural and organisational change and do not present a risk of misuse. For these reasons, the state should not have a monopoly on prosecutions for breaches of WHS laws.

Union secretaries had standing to bring a prosecution under NSW laws from 1983 until 2011, when the right was curtailed. There is no evidence of abuse of the right during that period of time.[5] Union-initiated prosecutions were subject to the same legal checks and balances as any other prosecution. In the usual way, cases which are frivolous or vexatious are not permitted to proceed, and the court determines the merits of all matters which do proceed in accordance with established and transparent principles. The cost, complexity, delays and risk associated with legal proceedings also operate in the usual way to deter unmeritorious actions. In NSW, the right was used by union secretaries sparingly and successfully, and often resulted in systemic or industry-wide improvements in safety standards, conferring a significant and lasting public benefit.

Reverse Onus

Under the Model Laws, liability applies to non-compliance with a duty of care, qualified by a standard of reasonable practicality. The question for consideration is, which party should bear the burden of proving that the standard of reasonable practicality has been met.

Under the current model laws, the regulator is required to prove all elements of a breach, including that the employer has *not* taken reasonably practicable measures to prevent the breach. In the ACTU's submission, this is unreasonably onerous. The matters required to prove whether or not an employer has taken reasonably practicable measures are matters entirely within the employer's knowledge. The employer is in the best position to provide evidence of the conduct engaged in and the reasons for it.

While no Australian jurisdiction currently has a reverse onus of proof for duty of care offences, Qld and NSW previously had such provisions. Under the model in those States, the prosecutor was still required to prove non-compliance with the elements of the offence beyond a reasonable doubt, but the onus was on the defendant to make out a defence on the balance of probabilities.

In NSW, the onus was on a duty-holder to prove (on the balance of probabilities) that it was not reasonably practicable to comply with the law or that the offence resulted from causes outside the defendant's control. In Qld, a duty-holder could seek to prove (on the balance of probabilities) that it had applied a relevant Code or Regulation or taken other reasonable precautions and exercised proper diligence to prevent the contravention.

[5] Stein Inquiry, pp 127-128.

In the UK, the *Health and Safety at Work etc Act 1974* places a similar onus on an employer to make out a defence on the balance of probabilities.

The ACTU recognises that this is a contentious matter. The right to be considered innocent until proven guilty is an important aspect of the right to a fair trial. However, like most human rights, it can be limited if the limitation is reasonable, necessary, justified and proportionate in the circumstances. The more severe the penalties for an offence, the harder it is to demonstrate that the reverse onus is justified and proportionate.

Recommendation 59.

> *The ACTU submits that the reverse onus is necessary and justified in this case because of the public interest in ensuring the health and safety of people at work. The measure is proportionate and reasonable in light of the [relatively modest penalties involved?], and the practical difficulty of achieving successful prosecutions when the PCBU has, by definition, all or most of the relevant evidence regarding its own conduct in its possession or control. It is not unfair or unreasonable to require a PCBU to demonstrate to a court how and why it had a reasonable excuse for non-compliance.*

Declaratory Orders

Recommendation 60.

Section 112 should be amended to empower a tribunal to make a declaratory order. A court does not have the power to make a declaratory order unless parliament has expressly authorised them to do so. There is no good reason why the full range of remedies should not be available to a successful claimant in civil proceedings under the Act. Declaratory orders can be a flexible, inexpensive and effective way in which to resolve a WHS dispute.

Question 35: Have you any comments on the value of implementing sentencing guidelines for work health and safety offenders?

See the answers to Questions 33 and 34.

Question 37: Have you any comments on the availability of insurance products which cover the cost of work health and safety penalties?

As per ACTU submission:

> *The deterrent effect of penalties is almost entirely undermined if insurance companies, rather than duty-holders themselves, are able to pay fines.*
>
> *Under the Model Laws, there is no provision expressly prohibiting contracts providing liability insurance against WHS penalties. Section 272 provides that a term of any agreement or contract that purports to exclude, limit, modify or transfer any duty owed under the Act is void. However, it is not clear whether a contract for directors' and officers' liability insurance indemnifying for penalties under the Model Laws would be a contravention of s 272, and this matter is yet to be considered by the courts.*

As a matter of practice, corporations are readily able to, and frequently do, insure against WHS penalties. As a consequence, it is predominantly insurance companies rather than duty-holders paying fines following successful prosecutions.

While no Australian jurisdiction currently prohibits contracts providing liability insurance against WHS penalties, s 29 of New Zealand's Health and Safety at Work Act 2015 provides a precedent. In New Zealand, an insurance policy or a contract of insurance which indemnifies or purports to indemnify a person for the person's liability to pay a WHS fine or infringement fee is of no effect, and persons seeking to enter into such a contract commit an offence.

Recommendation 61.

The ACTU strongly recommends that:[6]

a. the Model Act be amended to expressly prohibit contracts providing liability insurance against WHS penalties and fines;

b. contravention of the prohibition be made an offence.

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[i] Access Economics Pty Limited, Review Of Methodology And Estimates Of Workplace Fatalities For The National Occupational Health And Safety Commission September 2003, P.8

[ii] https://www.safeworkaustralia.gov.au/statistics-and-research/statistics/disease-and-injuries/disease-and-injury-statistics-industry

[iii] https://www.safeworkaustralia.gov.au/statistics-and-research/statistics/cost-injury-and-illness/cost-injury-and-illness-statistics

[iv] https://www.parliament.nsw.gov.au/committees/DBAssets/InquiryOther/Transcript/9768/Aged%20care%20industry%20facts.pdf

[v] Ibid

[vi] https://healthtimes.com.au/hub/aged-care/2/practice/nc1/managing-aggressive-behaviour-in-aged-care-facilities/513/

[vii] https://www.australianageingagenda.com.au/2016/02/19/staff-experience-high-rates-of-aggression-in-aged-care-union-survey/

[viii] **http://www.sageagedcare.edu.au/blog/managing-aggression-in-dementia-patients/**

[ix] See for example, M Quinlan and P Bohle (2008), *Under pressure, out of control or home alone? Reviewing research and policy debates on the OHS effects of outsourcing and home-based work*, International Journal of Health Services, 38*3), 489-525.

[x] [x] For example, Johnstone R, Regulating Health and Safety in 'Vertically Disintegrated' Work Arrangements: The Example of Supply Chains, Chapter in *The Evolving Project of Labour Law*, The Federation Press, May 2017

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[6] See also *Best Practice Review of Workplace Health and Safety Queensland*, Final Report, July 2017 at page 14, para [47].

[xi] [xi] See *Construction, Forestry, Mining and Energy Union v Pilbara Iron Company* (Services) Pty Ltd (No 4) [2012] FCA 894 for an example of an employer who refused to accept an employee's application to be a HSR.

[xii] See for example Victorian WHS Act, s 69(d)(ii)
[xiii] *Sydney Trains v SafeWorkNSW* [2017] NSWIRComm 1009

[xiv] *CFMEU v Bechtel Construction* (Australia) Pty Ltd [2013] FCA 667 at [34]
[xv] See Johnstone, Project 1, p 61
[xvi] See for example Queensland WHS Act, Schedule 2A
[xvii] Why Australia Benchmark Report 2017, https://www.austrade.gov.au/ArticleDocuments/3823/Australia-Benchmark-Report.pdf.aspx.
[xviii] The Australian Economy and Financial Markets Chart Pack https://www.rba.gov.au/chart-pack/pdf/chart-pack.pdf

[xix] Size of NSW economy https://www.industry.nsw.gov.au/invest-in-nsw/about-nsw/economic-growth/Size-of-NSW-economy

[xx] The Highest Standards for Harmonised OHS Law Submission by the Australian Council of Trade Unions for the National Review into Model Occupational Health and Safety Laws

Different circumstances can cause things to run behind - ie if a resident has a fall and therefore more time is taken away from getting on with required tasks

3/26/2018 11:14 AM

ratios not considered in spite of increased numbers of high needs

client 3/22/2018 6:44 AM

Staff can be rostered on by schedulers that don't know the northern beaches as they are based in the western suburbs .Can send staff to areas that too far away with inadequate travel times,

3/17/2018 7:55 PM

management not understanding the needs on the floor, due to the fact that they never work on the floor

3/16/2018 1:29 PM

To give high quality care for the resident. Need more staff

3/15/2018 6:59 AM

Including understaffing for bus outings

3/15/2018 6:57 AM

Not enough staff to do the work. Most of the time workers called in sick. For example in Dementia where they're wandering around we have five staff working on the floor. On weekends and some week days in the evening, we don't have any life style or diversions therapy staff To Help with activities. Too much work to do with less staff. Every day Jobmatch Office will send text messages to all the staff asking for staff members to do extra shifts.

3/14/2018 11:17 PM

90 residents at night to only 3 staff (staff to resident ratio is a complete miss

match) 3/14/2018 4:39 PM

Resignations, sick leave

3/14/2018 4:35 PM

Budget interferes apparently

3/14/2018 4:25 PM

Q4 In your experience, how does understaffing impact on residents?

Answered: 23 Sk pped: 12

#	RESPONSES	DATE
1	More task than res dent focused	3/26/2018 11:14 AM
2	Unab e to cater for the m x of c ents attend ng/ H gh care needs dom nate and prevent mean ngfu act v ty for other attendees	3/22/2018 6:44 AM
3	C ents get staff from other agenc es wh ch often they don t ke.	3/17/2018 7:55 PM
4	They do not get the care that they need.Makes res dents ag tated and staff then hav ng to dea w th behav ours.	3/16/2018 1:29 PM
5	not be ng ab e to shower ,Unab e to get them out of bed they become angry and upset w th staff genera poor care	3/15/2018 7:43 PM
6	Res dents do not rece ve qua ty care when we are understaffed. Staff are rushed to get th ngs done and can not spend appropr ate t me w th each res dent	3/15/2018 7:22 PM
7	Res dents don't get qua ty care as they shou d. Staff can't even spend b t of qua ty t me w th res dents who need them as some res dents spend most of the r t mes n the r rooms on y. A so, staff don't have enough t me to do other tasks out for res dents except the r dut es nvo ved n a morn ng sh ft due to just enough t me to accomodate busy schedu es. Other than that not enough nen - towe s, bedsheets, p ow covers. Staff a ways has to run around everywhere to ook for nen to change the nen for res dents. Th ngs are a ways shortage.	3/15/2018 2:54 PM
8	Dramat ca y, t unfo ds a dom no affect of d ssat sfact on and neff c ency for a part es	3/15/2018 11:23 AM
9	Qua ty of care have not met proper y	3/15/2018 9:36 AM
10	Res dents not happy w th the serv ce they are gett ng as there a ocated t me gets changed	3/15/2018 7:26 AM
11	They fee ke gnore, they d dn't get h gh qua ty care. Staff are focus on f n sh ng there task not to focus and spent t me w th res dent.	3/15/2018 6:59 AM
12	Res dents comp a n ng about wa t ng for ass stance	3/15/2018 6:57 AM
13	It s very bad because when we are understaffed, we get t red and over worked ourse ves. Then peop e start ca ng s ck. It s not good for our res dent because they're pay ng the r money and t s the r home. So they shou d get a good care and proper y ooked after. We are st do ng our best work ng very hard to take good care of them anyt me we go to work.	3/14/2018 11:17 PM
14	Res dnets w th behav ours are not be ng superv sed	3/14/2018 10:59 PM
15	Res dents don't get the qua ty care they deserve.	3/14/2018 9:44 PM
16	poor care, rushed when attended	3/14/2018 8:25 PM
17	Qua ty care not g ven to res dents due to understaff ng	3/14/2018 5:08 PM
18	We don t get to spend a ot of t me w th one res dent	3/14/2018 4:52 PM
19	Late serv ce, stress to both staff and res dent.	3/14/2018 4:45 PM

20	The amount of t me taken for staff to attend a ad 's for res dents s reduced, and the care g ven becomes nadequate, and some m ss ng out on be ng g ven the care they requ re .	3/14/2018 4:39 PM
21	Res dents express fee ngs of frustrat on when certa n serv ces are prom sed but not de vered. Res dents d sadvantaged by understaff ng e m ss ng appo ntments, eft short of supp es for da y v ng, mea prep not undertaken, med cat on not taken, b s not pa d, stress of wa t ng for someone to turn up and doesn t.	3/14/2018 4:35 PM
22	Less 1:1 qua ty t me w th the res dents as we have soo much to do n a short amount of t me.	3/14/2018 4:25 PM
23	Staff can't g ve adequate rythym of fe care n the t me restra nts we have. Res dents are eft n the r own for much of the day.	3/14/2018 4:21 PM

Q5 In your experience, how does understaffing impact on staff?

Answered: 23 Sk pped: 12

#	RESPONSES	DATE
1	Anx ety, mood ness and att tudes	3/26/2018 11:14 AM
2	H gh stress eve s, d ssat sfact on w th emp oyer expectat ons, ow mora e, negat v ty, frustrat on w th attempts to nteract w th c ents and meet the r needs, a ways an uncomp eted st of tasks to be done	3/22/2018 6:44 AM
3	causes stress part cu ar y f too many c ents are rostered on to f n the gaps. cause stress wh e dr v ng as puts pressure to hurry.	3/17/2018 7:55 PM
4	Makes the staff frustrated w th a never end ng work oad.	3/16/2018 1:29 PM
5	Burn out ,anx ety due to fee ng your use ess unab e to care for your res dents.depress on	3/15/2018 7:43 PM
6	Staff are overworked and fat gued.	3/15/2018 7:22 PM
7	In my exper ence, as I work n the morn ng sh ft, work oad s heav er compared to other sh fts, a so the f oor where work, dont get f oater staff to he p on my f oor. A the other foors have f oaters (1 extra staff)for ass stance wh ch I don't have on my f oor. I have to do med cat on for 2 f oors .e. med cat ons for a most 25 res dents and ook after res dents on my f oor at the same t me. I can't focus wh e do ng med cat ons as care superv sor a ways ca me for someth ng or ask me to answer buzzer on my f oor wh e 'm do ng med cat on on the other f oor. I a ways need to rush to comp ete my job on t me and on severa occass ons got too s ck because of push ng myse f too hard at work. I fee menta y t red, phys ca y dra ned and emot ona y fee so he p ess due to what have to face everyday at work. On top of that, the management a ways br ng up top cs ke, staff tak ng too ong to f n sh med cat on, wh e they want us to do everyth ng perfect y - such as answer ng buzzers on t me, focus 'rhythm of fe' for res dents wh ch mean to prov de care needs for res dents whenever they want, do documentat ons, co ect c othes from aundry and put t n wardrobe perfect y! But where s the t me!?? Due to understaff ng/ no he p on my f oor, t has great y mpacted n my festy e as a ways get t red when get home after work, dont want to go out cause a want to do s rest at home. Too much stressed due to management putt ng pressure about everyth ng. I even got nto depress on due to bu y ng at work.	3/15/2018 2:54 PM
8	Staff are burnt out, ho st ca y dra ned and unapprec ated, espec a y when understaffed	3/15/2018 11:23 AM
9	Hard for the staff f not enough staff ng	3/15/2018 9:36 AM
10	the oad work affect a the staff across the board	3/15/2018 7:26 AM
11	Work over oad, stress, more often ca s ck	3/15/2018 6:59 AM
12	Staff become stressed, over worked, unab e to comp ete tasks, th s f ows nto next sh fts, and then staff start comp a n ng about each other that they aren t do ng the r job proper y.	3/15/2018 6:57 AM
13	It makes us get t red, over worked, stressfu and somet mes get s ck.	3/14/2018 11:17 PM
14	We are often rushed to f n sh our work oad	3/14/2018 10:59 PM
15	Staff are be ng over worked and becom ng s ck and stressed out	3/14/2018 9:44 PM

16	overwhe m ng, phys ca y and emot ona y dra ned	3/14/2018 8:25 PM
17	Low mora , whs ssues, staff ook ng for work e sewhere, staff not tak ng adequate breaks, staff work ng extra t me unpa d	3/14/2018 5:08 PM
18	It makes me stressed and very t red and sore	3/14/2018 4:52 PM
19	Stressfu	3/14/2018 4:45 PM
20	On hea th and we be ng , ncreased r sk of njur es , to staff and res dents , documentat on not be ng fu f ed due to ack of t me ,	3/14/2018 4:39 PM
21	Staff don t get breaks. Put up w th comp a n ng c ents. Abus ve c ents. Stress.	3/14/2018 4:35 PM
22	We end up exhausted..... Effort eve s change... Means the res dents don't get the qua ty of care they deserve.	3/14/2018 4:25 PM
23	Staff are overworked and mora e s very ow	3/14/2018 4:21 PM

Q6 What do you think could fix or improve the problem?

Answered: 23 Sk pped: 12

#	RESPONSES	DATE
1	Another "f oater" wou d he p dur ng the morn ng sh ft to he p out where needed - to take some pressure off	3/26/2018 11:14 AM
2	Better commun cat on, more staff, c ent stream ng and a ocat on to spec f c days where the r needs can be met.	3/22/2018 6:44 AM
3	More staff on p us a c earer know edge from rosters regardes t me m tat ons and not squeez ng n too many c ents w th n a sh ft ,	3/17/2018 7:55 PM
4	Management to actua y work the f oor for 2 weeks of the roster before mak ng any dec t ons or changes that w mpact the work oad on staff eg managment dec d ng to ock store room door so staff can not access the equ pment to do the job,such as ncont nence pads,g oves etc w thout staff hav ng to f nd an RN to open the door.K tchen staff shou d be a ocated to tend for breakfast,not care staff.Care staff shou d be attend ng to persona care not serv ng up breakfast.	3/16/2018 1:29 PM
5	more staff ,staff that can do the work so you dont constant y need to do theres. hav ng meet ng about work oads and not fee bu ed about speak ng up.	3/15/2018 7:43 PM
6	Rep ac ng staff when they ca n s ck. Ensur ng correct amount of staff are rostered on.	3/15/2018 7:22 PM
7	I dont th nk anyth ng can f x the prob em at my workp ace. Everyone s boss there.	3/15/2018 2:54 PM
8	Increased staff ng eve s w th appropr ate y exper enced and tra ned staff	3/15/2018 11:23 AM
9	More staff ng	3/15/2018 9:36 AM
10	Ang care needs to ook after and sten to the staff to f x any prob em and that s not happen ng r ght now	3/15/2018 7:26 AM
11	To g ve h gh qua ty care to res dent and fee ke home. Need few more staff not from cut our hour. And not th nk about budget ng.	3/15/2018 6:59 AM
12	Appropr ate staff ng eve s for the eve of care requ red. It seem that now we are an Ag ng In P ace fac ty there are many more H gh Care res dents and nadequate staff.	3/15/2018 6:57 AM
13	Maybe tr ed to get feedback from the staff. Ta k w th the adm n strat on to know what s wrong and why are peop e eav ng the job. A the t me we see new staff.	3/14/2018 11:17 PM
14	Staff pat ent rat o	3/14/2018 10:59 PM
15	Staff to res dents rat o	3/14/2018 9:44 PM
16	h re more qua f ed staffs, mprove management	3/14/2018 8:25 PM
17	We need more staff to carry out our dut es n a safe and stressfree env ronment	3/14/2018 5:08 PM
18	More stuff n the very busy t mes ke morn ng sh ft	3/14/2018 4:52 PM
19	Inform the staff f there s any changes n the r roster.	3/14/2018 4:45 PM

20	By mak ng the p ace more nv t ng and mprov ng atmosphere for staff and res dents , management a so need to be more f ex b e w th staff by sten ng to staff when a prob em occurs, By add ng a dut es st so staff do know what they shou d be do ng da y, by mprov ng safety w th n the work p ace ,	3/14/2018 4:39 PM
21	Roster ng system needs ref n ng. Extra staff emp oyed. Fa rer roster ng t mes. Better commun cat on w th staff and c ents.	3/14/2018 4:35 PM
22	More Pm staff wou d be effect ve and more benef c a for the res dents.	3/14/2018 4:25 PM
23	More fund ng for more staff	3/14/2018 4:21 PM

Appendix 2

Q11 Please tell us about any incidents that you might have experienced recently.

Answered: 92 Sk pped: 85

#	RESPONSES	DATE
1	V o ent menta hea th pat ents hav ng to be restra ned for the safety of a concerned and at t mes med ca staff nterven ng, comp a n ng about the way these v o ent drug nduced pat ents are restra ned. Some med ca staff fa to grasp the concept that we are the r to protect them but st try to te us how to do our job. we don't te them how to do the r jobs. They are not tra ned and need to support rather than h nder and comp a n. A med ca staff member te ng secur ty personne to et go of an aggress ve and v o ent menta hea th pat ent, be ng restra ned, w th tota d sregard for the safety of secur ty personne be ng further assau ted wh ch has been the case. If Secur ty do not re ease the pat ent, some med ca staff members, w th out just f cat on subm t IMMS reports.	6/7/2016 3:59 PM
2	Pat ent try ng to abscond	2/23/2016 6:53 AM
3	Weekend shou d have two HSA ,but I have been by my se f and a f ght started w th fema e and two ma es I had too hand e the nc dent on my own. The worry ng th ng s that I was adv se that doctor cou d g ve d rect ve and was covered under menta act .As other areas examp e ,pubs have by aws and Acts.	2/7/2016 4:36 AM
4	Pat ents whom a affected by a substance and have no m tat ons or contro .	1/31/2016 8:28 AM
5	was phys ca y assau ted be eve the ma n reasons for th s were ength of t me pat ent he d n ED ack of commun cat on etc	1/23/2016 9:26 PM
6	Last December 2015, n the hosp ta car park v s tor reported that a man was wa k ng up and down shout ng and scream ng. When Secur ty arr ved and spoke to h m I was ab e to get deta s of h m by gett ng h s dr vers cence. He sa d that he was under the nf uence of ce. We ca ed the Po ce and nformed them the s tuat on and Po ce sa d that they w be com ng soon. We were ab e to br ng h m to emergency department and she was assessed by A/E manager. he was n A/E for a most 4 hours but d scharge by Doctor. When the pat ent eft the Po ce arr ved. Inc dent report was og n the nc dent data base.	1/23/2016 1:10 PM
7	I have been b tten once before by a pat ent and noth ng was done about t by the hosp ta or po ce	1/22/2016 5:03 PM
8	How ong s a peace of st ng so many to say	1/21/2016 5:10 PM
9	we had a guy br ng a f sh ng kn fe n . n h s bag he handed t over	1/21/2016 5:08 AM
10	As a Secur ty Off cer ts a grey area, n Bankstown Hosp ta we dea and see th ngs that I fee we under pa d and unsafe, Shoot ngs dead body y ng on the road next to the cutter, ce pat ents who are ke Superheros, E der y pat ents who can st pack a punch v s tors caus ng troub e afterhours. F re so at ons that are not n our Job duty t on y says ass st and no pay. For an examp e can a Secur ty Off cer be a Nurse or a Doctor w th a Secur ty L cence? I don't th nk so. I can go on and on,(I don't mean to d srespect) but no one w hear us because we are on y Secur ty Off cer's we are the peanuts n hea th, who s rea y go ng to sten to us? Once a upon a t me there was Spec a Constab e now there's noth ng. It wou d be great f we had that power aga n to ACT ke search and deta n and restra n not to wa k around ke a po ce off cer, you can have the handcuffs n baton, we don't want t. We want the Spec a Constab e so we w be protected under th s ACT. Yes PROTECTION. As Secur ty Off cer's we want to be more than just observe and report we want to be conf dent and that we prov de a better serv ce mean ng I don't have to fee 50/50 for the jobs I do. The Hosp ta prov de po cy for us to fo ow but the quest on s?' sn't our safety suppose to come f rst under the WHS ? What about ast m nute nc dents do you want us Secur ty Off cers to stand there and observe and report wh e a staff member s gett ng beaten by an aggress ve pat ent or v s tor. What wou d you do? Common sense s to he p sn't t. The quest on they a ways say why d dn't you do anyth ng? Secur ty Off cers a ways get the b ame. I be Surpr se f th s go through, but I a ready know the out come. Oh we ! Dreams are for free! You have an awesome day.	1/20/2016 11:46 PM
11	Each day s an exper ence at th s s te, we are constant y, be ng asked to restra n or deta n peop e however we do not have to power to do th s, therefore everyone s at r sk.	1/20/2016 10:32 PM

12	Recent y noth ng am on restr cted dut es but to hear staff have been d sm ssed for do ng there dut es	1/20/2016 8:04 PM
13	guard ng pts on ce for anywhere up to 2hrs. who then become v o ent and requ red 6 presons to restra n. apart from musc e stra ns never been njured. other staff at th s s te at d fferent t mes have been headbutted, punched, b tten and n one nc dent a staff member susta ned a d s ocated shou der and po ce off cer susta ned a fractured eye socket requ r ng surgery.	1/20/2016 6:26 PM
14	We have peop e brought by po ce for menta hea th assessments or other ssues , after treatment f they are to d scharged , po ce are to ca ed before so they can return to be taken nto custody, my po nt s f they are to be n custody ,why are po ce eav ng them w th us to watch over them, shou dn't they rema n f pat ent s n custody...	1/20/2016 1:45 PM
15	I act under c n c an d rect on and wou d not ke to assume respons b ty for mak ng these dec s ons n a c n ca sett ng - Po cy does a ow for ntervent on n extreme s tuat ons by Secur ty Off cers w thout c n c an d rect on. I be eve a new respect for Hosp ta Secur ty teams and the r ro e n C n ca Serv ce De very be better acknow edged.	1/20/2016 12:51 PM
16	We can do the stuff above on y f t w th n the po c es and t ngs ke that. I don't wont us to have guns and th ngs that can get me hurt some t mes t can be the person that you work w th that can get you hurt	1/20/2016 9:41 AM
17	the usua . aggro, ntox cated, drug effected, adu ts & juven es	1/20/2016 8:07 AM
18	Po ce w br ng n a very v o ent Person nto the Hosp ta , ts taken 4 to 6 Po ce Off cers to subdue the offender for a Menta Hea th Assessment, Po ce w try and eave the person w th Secur ty and say they have outstand ng jobs and must eave. So Secur ty are eft to dea w th th s very aggres ve person w th 2 or 3 Secur ty Off cers, we are not tra ned ke the Po ce but we are expected to act ke them but we are on y Secur ty Off cers.Be ng made a Spec a Constab e w not make our job any safer. we need to be tra ned by proffes ona ke the NSW Po ce, not a externa Secur ty prov der. have a ook at the number of workers comp over the ast 5 years at centra coast Gosford and Wyong Hosp ta Secur ty.	1/19/2016 4:05 PM
19	On stat c duty was threatened three t mes by pat ent try ng to punch me w th h s f st.	1/19/2016 1:14 PM
20	Qu te often secur ty s asked to mon tor pat ent's that are under arrest , the po ce eave & ask A & E staff to contact them w th the pat ent s med ca y c eared & they w come & rearrest the pat ent.	1/19/2016 6:03 AM
21	A ma e has been brought to ED by po ce. He was drugged and handcuffed so off cers and staff eas y restra ned h m to the bed. As he awoke become a very aggress ve toward off cers and staff ca ng them (us) names and threaten ng to k . He asked for our addresses and offered a f ght outs de. He threatened too to k our fam es (k ds) sp tt ng on us etc.	1/19/2016 3:43 AM
22	Ma e pat ent brought n by Po ce n custody. Po ce w th ma e a day and was a so on med ca schedu e by med ca staff and was ater g ven court attendance not ce. Po ce eft prem ses and schedu e was fted. Short t me ater pat ent took doctor hostage and threatened to k her w th s zzors. Secur ty and Po ce ca ed v o ent confrontat on occurred 1x Secur ty Off cer shot 1 Po ce off cer shot. Ma e subdued by other Po ce and Secur ty Off cers. Less than 3 weeks pr or ma e pat ent on schedu ed punched secur ty off cers n the face and k cked h m n the head ma e subdued charges pend ng. Ma e pat ent brought n by correct ons off cers took a I.V po e attempted to h t staff ma e subdued by secur ty off cers. Another ma e brought n by fam y drug affected head butted nurse dur ng conversat on secur ty off cers tack e h m. Ma e b tes secur ty off cer on the chest but s subdued. Ma e ater conv cted of two assau ts g ven 140 Hours commun ty Serv ce. Same ma e brought n 2 weeks ater under nf uence of drugs aga n and has assau ted staff aga n.	1/18/2016 3:03 PM
23	menta hea th pat ent handed me a kn fe on request	1/18/2016 11:24 AM
24	D sarm ng a v o ent aggress ve menta hea th pat ent attack ng me w th a pa r of sc ssors. Ma e pat ent n a sec us on room n A/E. Was restra ned to prevent h m from caus ng me and other persons ser ous njury and/or death. .	1/18/2016 9:51 AM
25	Constant verba abuse from a coho and drug affected pat ents and v s tors...menta hea th pat ents	1/18/2016 9:38 AM
26	The Po ce were guard ng a pat ent who was be ng deta ned on a genera ward, when a of a sudden he over powered the Po ce. The Po ce managed to handcuff one arm but myse f and my partner were duresed and responded and were ab e to secure the other arm and p ace the other handcuff on. Pr or to Secur ty arr va the Po ce d scharged 2 fu cans of caps can spray wh ch contam nated the ward and the other pat ents.	1/18/2016 8:27 AM
27	Pat ent Had a Kn fe	1/18/2016 6:12 AM

28	Use of gun by a pat ent n emergency dept of Nepean Hosp ta n wh ch a Secur ty Off cer and a Po ce Off cer njured ser ous y.	1/17/2016 11:29 PM
29	far to many to ment on over ten year per od of emp oyment	1/17/2016 10:19 PM
30	V o ent ce nduced psychos s assau t ng and abus ng secur ty and nurs ng staff DAILY !	1/17/2016 2:06 PM
31	Aggress ve, ag tated e der y pat ents, unsure of the r Hosp ta s tuat on.	1/17/2016 10:36 AM
32	po ce handover of a restra ned ce effected fema e teenager	1/17/2016 9:18 AM
33	Ice / F acca affected ma e pat ent(s) verba y threaten ng, phys ca y harm ng schedu ed menta hea th pat ents be ng adm tted to on s te menta hea th un ts. Psychot c drug affected fema e pat ents scratch ng, b t ng and sp tt ng on a emergency staff dur ng presentat on. Int m dat ng NSW Po ce harrass ng c n ca staff to exped te the r re ease back nto the commun ty w thout regard for hosp ta staff safety.	1/17/2016 8:00 AM
34	On a regu ar bas s pat ents are prone to bouts of aggress on wh ch we are forced to try and de-esca ate to ensure pat ent staff and v s tor safety. We are the ast ne of defence	1/17/2016 7:57 AM
35	NSW Hea th s p ac ng the secur ty staff safety under c n ca d rect on. They do not have any understand ng of the ega m nef e d for the act ons of secur ty staff when d rected to "stop that pat ent" or "restra n that v o ent, aggress ve person w th noth ng more than two hands. When seven po ce brought th s pat ent who was tasered and caps cum sprayed to the hosp ta , two unarmed secur ty are c n ca y d rected to "take over". Two on duty secur ty are then taken off the r norma dut es for up to seven hours w thout rep acement. Po ce have the expectat on that they can "dump and run" often not a s ng w th tr age nurs ng staff on y nt m dat ng secur ty staff then eav ng. We have had up as many as n ne drug, a coho and / or menta hea th pat ents n our Emergency department eft under the superv s on of two "on duty" secur ty staff. NOT GOOD ENOUGH.....	1/17/2016 7:50 AM
36	On occas ons pat ents are brought n by Ambu ance w th Po ce escort restra ned on y for restra nts to be removed on arr va n Emergency and the Po ce depart hosp ta eav ng on y 1 secur ty person and 2 nurses n the department to dea w th pat ent.A so menta hea th pat ent regu ar y have to be kept at the hosp ta because they can't be transported or accepted by a b gger fac ty due to t me of n ght.Scone Hosp ta s not equ pped w th a room or equ pment to dea w th th s type of pat ent.	1/16/2016 11:21 PM
37	Ive been of w th permanent njur es that are a resu t of outdated restra nt methods and tt e to no power to protect ourse ves et a one pat ents staff and v s tors	1/16/2016 8:32 PM
38	I am current y njured through a nc dent n the ED w th an ICE effected pat ent. I have been off for 7 months and w have a permanent njury from th s nc dent. Secur ty are constant y be ng used as punch ng bags and asked to ega y restra n pat ents n neffect ve and Id ot c ho ds dreamt up by peop e that s t beh nd desks and have no dea what works and what doesnt. When Po ce are ca ed to HKH the may use appropr ate force to subdue and restra n V o ent and aggress ve pat ents. Secur ty are not. Secur ty are often ead n ART teams by ncompetent persons and hampered by the c n c ans comp ete d sregard for our safety as shown by the stat st cs of off cers hurt at HKH. Of the 12 off cers at HKH 10 have had njur es from ART or v o ent restra nt of pat ent, 4 of them be ng ong term and on go ng njur es and 1 has been d sm ssed due to h s njur es. Secur ty a need to need to be made Spec a Constab es and be d rected by po ce and not nurs ng or persons w th n the hosp ta who are c n ca y mot vated. Secur ty need to have the powers to deta n restra n and search any pat ent w th out c n ca d rect on. At the moment we have untra ned nurs ng staff w th no pract ca know edge of aggress on or v o ence whose pr or ty s the pat ents safety ead ng teams and d rect ng secur ty when not needed.	1/16/2016 8:14 PM
39	Where do I beg n ? Ser ous y we are dea ng w th fu on aggress on on a da y bas s-the nc dents are m t ess (over 300 th s month so far) I don't have the t me to go to the to et on sh ft et a one answer th s quest on w th the t me t deserves.	1/16/2016 6:13 PM
40	I was to d by management to break up a f ght n the ED wa t ng room. When I eft the ED nto the wa t ng room to see what was go ng on, they ocked the doors beh nd me, ock ng me n the area w th the two offenders. They then to d the other staff not to go out to he p me as t was my job to sort t out, they d dn't want anyone e se hurt.	1/16/2016 5:48 PM

41	A psychot c person tr ed to assau t a Dr who had schedu ed h m to prevent pt eav ng grounds & comm tt ng su c de. I had to tack e the pt & wrest e h m to the ground. WYONG hosp ta has 3 off cers on workers comp from 2 nc dents ast week & a 4th fema e off cer s suffer ng stress re ated ssues. Po ce are a ways dropp ng off the r prob ems & eav ng us on our own. Why do 4-6 Po ce off cers subdue a person w th handcuffs, batons, Po ce dogs,CS spray & tasers then dec de to drop th s cr m na at the nearest ED w th 2-3 secur ty off cers on a ousy $24 per hour??? It has to stop before someone gets k ed !! I've never seen po ce or ED staff conduct r sk assessments, t s a ways "The Po ce have outstand ng tasks to attend, secur ty can stay & he p w th the offender" Hosp ta staff need ncreased sh ft numbers & po ce to ock up v o ent un-co-operat ve offenders. ED shou d be on y for cr t ca y pat ents, not soc a m s-f ts who have no respect for soc ety.	1/16/2016 5:44 PM
42	Hav ng ex ja deta nees brought n to the hosp ta who are v o ent and abus ve	1/16/2016 4:24 PM
43	Sen or Secur ty off cer punched by removed Pt, phys ca y restra ned by Secur ty for over 12m n awa t ng po ce arr va , then cuffed and sat up, cou d have been cuffed by Secur ty and ess t me phys ca y restra ned	1/16/2016 3:04 PM
44	Ass st ng po ce on a number of occas ons w th a v o ent drug affected pat ent n the back of the po ce truck .I a so found out that the po ce were reca ed on th s occas on to ass st med ca staff on a "TAKE-DOWN" when the pat ent woke after after be ng med ca y restra ned , and woke up combatant . Th s s noth ng unusua and has happened to me on a number of occas ons w th n the Southern D str ct hea th area.	1/16/2016 2:51 PM
45	Int m dat on, threats of get ng our fam y's. Po ce dump ng pr soners off at Ed under the menta Heath act because they make threats of se f harm and then stat ng that the r your prob em now. Ca ng for po ce ass stance on y to be to d " we can't be com ng for every v o ent pat ent" " the patent s n your care now" th s s some examp es the st goes on.	1/16/2016 2:50 PM
46	1x Pat ent put a cha r through w ndow on nurses stat on door & r pped door of h nges. 1x Pat ent armed w th syr nge threatern ng to ser ous y njure or k staff, d sarmed by Off cers on sh ft. 1x Pat ent armed w th screwdr ver threatern ng to k staff d sarmed by Secur ty & Po ce. + many many more that have been recorded etc.	1/16/2016 2:09 PM
47	Pat ents armed w th syr nges, kn fes etc n an attempt to ser ous y njure or k staff/others.	1/16/2016 2:02 PM
48	Po ce eave potent a y v o ent pat ents and eav ng before assessment	1/16/2016 10:36 AM
49	A the t me aggress ve pat ents w th m ted power or weapons to used Spec a constab e need to be re nstated and baton and handcuffs to be prov ded or the opt on of taser gun to be used.	1/16/2016 10:21 AM
50	My ma n concern s the amount of v o ent / aggress ve persons that the oca po ce br ng to the ED w th a h gh eve of ntox cat on or for apparent "menta hea th" assessment after comm tt ng ser ous offences and eav ng them n our care. Qu te often t w taken four, s x or even more po ce to escort a person n, and then t s expected that two Secur ty w be ab e to hand e such a person WITHOUT handcuffs, batons, OC spray taser etc.... A so I wou d say that just about everyone n our dept has been off work from an njury rece ved as a resu t of an assau t or v o ent restra nt, and many ke myse f have had to have surg ca ntervent on to repa r njur es and s gn f cant t me off work.....	1/16/2016 10:21 AM
51	I recent y needed the ass stance of the po ce w th a v o ent pat ent affected by the drug ce. E even po ce were needed to restra n the pat ent n order for ED staff to med cate h m. The pat ent was n the ED's safe room (sec us on) and had smashed the w ndows of the room w th h s head before po ce took act on	1/16/2016 9:35 AM
52	Had three pat ents on ce at same t me and no extra he p.	1/16/2016 9:34 AM
53	Po cex6 drop off Pat ents that have been v o ent/aggress ve , take off restra nts thence eave the prem ses. Pt shows aggress on to staff, Pt shou d be rev ewed upon arr va . Po ce shou d be present unt the Pt s med cated and sett ed.	1/16/2016 8:53 AM
54	Noth ng n the past two weeks.	1/16/2016 8:03 AM
55	Watch ng young vo at e pat ents on ce on own very short on staff to back up no protect ve equ pment ke C ty staff have requ red to c ean or other dut es .Hsa staff to do three ro es c eaner wards person and secur ty.	1/16/2016 7:38 AM
56	Incons tent w th po ce seach ng of v o ent pat ents pro r to be ng handed over to hea th empoyees, No power to stop seach & deta n of susp s ous persons or pat ents car ng bacpacks w th n hosp ta s etc. who cou d be carry ng e. weapons or exp os ves w thout the r consent. Unab e to use handcuffs on h gh y v o ent pat ents to protect them and others nc ud ng staff etc.	1/16/2016 7:00 AM

57	A coup e of days ago 4 Secur ty Off cers, 1 Po ce and severa Med ca Staff Restra n a huge muscu ar psychot c ma e pat ent. Ma e presented threaten to s ash h s throat f not seen mmed ate y. He carr ed out t by s ash ng h s throat w th a kn fe he was carry ng. Psychot c ma e pat ent wa ked out of h s room and just started throw ng punches. V rtua y every sh ft am subjected to verba threats and aggress on from the effects of a coho , drugs or psych atr c ssues. In dea ng w th s tuat ons to pac fy the s tuat on the person who I am dea ng w th w be n a confrontat ona stance n a manner that any person wou d perce ve that an assau t w occur. Recent nc dents n wh ch Med ca Staff and Secur ty Off cer has been assau ted n just do ng the r job. 1 Secur ty Off cer got a punch n the mouth and n an separate nc dent a Ma e Nurse a so rece ved a punch n the mouth.	1/16/2016 1:04 AM
58	Fema e menta hea th pat ent became v o ent and absconded when be ng p aced n transport veh c e because she wasn't a oud a c garette. She was had to be manhand ed back to ED and med cated before transfer cou d be comp eted.	1/15/2016 11:17 PM
59	Drug effected c ents smash ng the w ndows of the sec us on room of ED and attempt ng to abscond or mak ng threats, management arrange for contractors to rep ace the smashed w ndow pane w th the same mater a and ts smashed two days ater by another drug effected c ent and once aga n ts rep aced w th the same mater a , p ease, we need he p	1/15/2016 9:30 PM
60	Assau ted by pat ent that shou d have been housed n a spec a ty hosp ta because of behav our prob ems but s be ng housed n a genera hosp ta because of beurocracy.	1/15/2016 9:11 PM
61	A num was k cked and resu ted n 2 broken r bs	1/15/2016 8:51 PM
62	V o ent aggress ve drug affected pat ents want ng to nf ct njury to staff	1/15/2016 8:02 PM
63	I have been a secur ty off cer at Wo ongong Hosp ta for the past 25 years and myse f and other staff have been assau ted severa t mes and t has on y been over the ast 2 years that the management at TWH have been work ng w th secur ty staff and the Po ce to mprove re at onsh ps w th both as we need to work together w th management and Po ce to have a safe work p ace for staff and the pat ent as the pat ent a though aggress ve st s a human be ng and has r ghts as they do not choose to be not we . We w need to have more tra n ng on aggress ve managmen w th ro e p ays and we need to be aware of what our powers are and work under c ear d rect on of the c n ca person and have a co-ord nated approach to do ng a restra nt and r sk access any restra nt for the safety of secur ty staff nurs ng staff and most mportant y the pat ent . We now at TWH have a 5 man take down team for any co-ord nated restra nt and our management and secur ty staff have worked together to try and make a take safe for a . I wou d ke to f n sh w th more powers comes more respons b ty I th nk secur ty staff need ongo ng tra n ng and as we as nurs ng staff not on y staff that work n emergency departments but nurs ng staff on genera wards as th s aggress on s not on y n emergency departments but very often on wards and nurs ng staff rea y strugg e to dea w th the aggress on. Thanks to the HSU for your efforts	1/15/2016 7:57 PM
64	pat ent on ce n ED department a staff cou d of got njured, be ng ab e to restra n (w th restra nts wou d of he ped s tuat on)	1/15/2016 7:43 PM
65	WED 13/01/2016 I was assau ted y a pat ent n our HDU (M/HEALTH). Th s pat ent confronted myse f and then k cked me n the gro n, the pat ent was eventua y escorted to sec us on and med cated. I then reported to tr age and was med ca y checked. I cont nued w th my sh ft.	1/15/2016 7:30 PM
66	hard to st,,,da y restra nts, removes from prem ses due to aggress ve behav our to staff & other pat ents, expectat on that 'secur ty w dea w th t'	1/15/2016 7:21 PM
67	Dea w th very aggress ve pat ent hav ng a kn fe & keep the s tuat on under contro t the arr va of Po ce. After sedat on Po ce handcuffed pat ent to secur ty of after re ease of handcuff.	1/15/2016 6:52 PM
68	Too many to st. B ggest s ng e ssue I have s that we are not to d about potent a prob ems unt th ngs get oud. Obv ous y some s tuat ons are unpred ctab e but often there are pat ents that are known (amongst c n ca staff) to have a h story of v o ence towards out staff, th s nformat on s ava ab e to the nurses, doctors etc... but not us? I don't need to know persona deta s about pat ents but a h story of v o ence and aggress on towards me and my co eagues s re evant to my pos t on.	1/15/2016 6:41 PM
69	We have many nc dents da y. W th on y 1 secur ty off cer on each sh ft t s a most mposs b e to carry out our dut es safe y. Hea th and Secur ty Ass stants are not su tab e for arge fac t es as most HSA's run away from secur ty nc dents eav ng the secur ty off cer to fend for themse ves. WE NEED MORE DEDICATED SECURITY OFFICERS NOT HSA's.	1/15/2016 5:51 PM

70	Troub e w th obta n ng restra nt, Constant y try ng f nd some. When a very aggress ve & V o ent and verba y threaten ng to k secur ty staff and the r fam y th s pat ent was fue ed w th A coho & drugs when he arr ved n Emergency Department, Secur ty Staff wrest ng w th th s person unt a set of restra nts were found.	1/15/2016 5:15 PM
71	How do two secur ty off cers restra n a pat ent when t took 6 po ce off cers to restra n the person n the f rst p ace. The person has been tazed handcuffed then tacked the the hosp ta where two secur ty off cers take over handcuffs removed and there to dea w th the person. Secur ty have no handcuffs noth ng ! Th s has happened to me on more then one accas on.	1/15/2016 5:11 PM
72	not recent y myse f - but I had one not so ong ago where a ma e came at me w th a star p cket, the po ce and dog squad were nvo ved.	1/15/2016 4:43 PM
73	I cou d g ve ots w th documents for the past 6 months or so. Staff gett ng punched ,b tten , abused , da y , fam y br ng ng contraband to the ward , v s tors gett ng host e, cha rs gett ng thrown at staff, f u d gett ng thrown at staff and pa tents , pat ents asu t ng each other .	1/15/2016 4:31 PM
74	We had a fam y who had there ch d taken from them and the mother came n the next day w th a machete took the k d n her arms n the ward and threatened to harm herse f f anyone went near her we evacuated the ward and wa ted for po ce to arr ve	1/15/2016 4:29 PM
75	we have had pat ents go ng off had have ass stance from po ce ho d down a so had someone wa k n w th a kn fe and hand t to hea th and secur ty	1/15/2016 4:03 PM
76	I have recent y returned to pre njury secur ty dut es at BMH.Th s was due to ongo ng and severa seperate nc dents n the ED and MHU nvo v ng MHP's.One nc dent I was assau ted by a MHP - drug affected-who had been BIBP (about four off cers)and under restra nt.The pat ent had been prev ous y v o ent and aggress ve to Po ce and Ambu ance staff.The pat ent was p aced n the E/D Safe Assessment room and handed over to Secur ty.Po ce off s te.I verba y expressed my concern about the pat ents behav our to po ce and nurs ng staff such as h s pac ng n h s room and parano a.Soon after I was assau ted by th s pat ent.Short y after th s nc dent I was on Workers Comp for about 12 months due to th s nc dent and prev ous nc dents ead ng up to th s t me- n BMH ED and the MHU. D agnosed:anx ety,depress on and PTSD.	1/15/2016 3:32 PM
77	Two weeks ago a v o ent pat ent used a deodorant can he t the spray and po nted towards myse f and my offs der. The ma e pat ent was verba y aggress ve as we psy ca y aggress ve towards secur ty.	1/15/2016 3:30 PM
78	Menta hea th pat ents adm tted to genera ward and have assau ted staff.	1/15/2016 3:22 PM
79	We have had pat ents affected by ce that come nto the department n handcuffs. The Po ce sect on the pat ent and as soon as we arr ve and get a br ef handover from them they take the handcuffs off and they go. Th s sn't an so ated nc dent. We are cont nua y requested by staff to stop schedu ed pat ents, phys ca y restra n pat ents wh st the DRs and nurses dec de what to do about med cat on. The work env ronment s becom ng more and more unsafe. We are about to move nto a new hosp ta wh ch has an ncrease of approx mate y 3 t me the f oor space but there sn't an ncrease n our staff ng eve s.	1/15/2016 3:22 PM
80	Had fu bott e of water thrown at me from po nt b ank after offer ng the person a dr nk.cou d not see t com ng.	1/15/2016 3:20 PM
81	PATIENT ESCAPED FROM POLICE 3 TIMES	1/15/2016 3:16 PM
82	I have been punch n the face. My partner has been crash tack e and got njured n the egs. Guards / nurses / doctors are a ways treat ng w th v o ence, a ways gett ng abused. We do not get pa d to get treated ke th s, we a have fam y and want to return to them, somet mes we th nk we won't.	1/15/2016 3:07 PM
83	we have an "ICE" ssue here , tota y den ed by ratbags that run the p ace, secur ty dec s ons are made w th no secur ty off cer nput or when someth ng s sa d , t s usua y gnored...	1/15/2016 3:07 PM

84	A Pat ent refused to eave s te after abus ng staff and aggress ve y punch ng at the secur ty screen n ED. Secur ty wa ted for po ce to eject the pat ent .No one was njured or damaged caused .But the s tuat on was an examp e of a week y aggress ve nc dent n the workp ace.The atest nc dent I be eve that th s s on y the start of many MORE s tuat ons that w come n the future.And we shou d ook at some of the strateg es that are used n the un ted states and the uk.The drug ICE s go ng to be a prob em that s go ng to cause a major nc dent n the hosp ta / ambu ance system. Hopefu y the government w ass st secur ty n hosp ta as every HOSPITAL secur ty off cer I have worked w th over the years has been assau ted n some way or another.Me persona y have had a tooth punched out my mouth. A so hav ng compu sory tra n ng that ALL (INCLUDING CONTRACTORS) secur ty shou d be part of a strategy.At our hosp ta the s tuat on of one fu t me nsw hea th and one contractor s a regu ar occurrence w th the fu t mer be ng eft to carry the oad n a s tuat ons. I cou d ta k about th s a day after 20 years at my p ace of emp oyment thank you	1/15/2016 3:07 PM
85	Young fema es on ce and havent got any fema e secur ty on s te. Usua y cant touch them.	1/15/2016 2:59 PM
86	A guard was punched n the mouth. I was spat at and h t. Am constant y p aced n safe work ng env ronment by work ng w th unsk ed contractors. These contractors dont meet m n mum se ect on cr ter a for the job. Do not have suff c ent eng sh sk s. We are hav ng numerous restra nts per day	1/15/2016 2:57 PM
87	Fema e pat ent n mea room, we d ng cha r and verba y threaten ng 2 Hasa's and 2 secur ty. 2 secur ty had to use mea room cha rs to defend attack, wh st 2 Hasa's effected wr st ock take down. No sanct oned equ pment to dea w th these types of nc dents.	1/15/2016 2:54 PM
88	Too numerous to ment on n ast 10 years.	1/15/2016 2:51 PM
89	Noth ng recent y	1/15/2016 2:36 PM
90	We have recent y occas ons at e y where we have been requ red to use mechan ca restra nts on pat ents and th s s becom ng more common the use of restra nts to protect the pat ent and staff. It has been an ongo ng ssue the ncrease of v o ent/aggress ve peop e present ng to our hosp ta and a sma ncrease of aggress ve peop e throughout the wards. There was one n ght a week ago where we were nvo ved n three takedowns n one sh ft. Someth ng needs happen to ensure the safe of staff,pat ents and pat ents that v s t our fac t es. The ro e of Hea th and Secur ty Ass stant needs to be removed from accross the state and a Hsa's to be regraded as Secur ty off cers	1/15/2016 2:31 PM
91	Too many ma n y ce affected pat ents and menta hea th pat ents that cause us the b ggest concern.	1/15/2016 2:23 PM
92	Secur ty staff at TWH exper ence nc dents da y of threats of v o ence, abuse and frequent y face v o ence and sp tt ng. Hosp ta secur ty need more powers and better equ pment to ass st us. I be e ve we used to be ssued w th hand cuffs and batons and these were a va uab e too , but these were taken off us.	1/15/2016 2:21 PM

Appendix 3

Workers' compensation claims among nurses and ambulance officers in Australia, 2008/09-2013/14

Shannon Gray and Alex Collie

Date: 12 April 2016

ISCRR is a joint initiative with the following three partners:

WorkSafe VICTORIA
TAC TRANSPORT ACCIDENT COMMISSION
MONASH University

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Background and Objective

The Health and Community Services sector is one of the largest industry segments in the Australian labour market, employing approximately 1.57 million people (14% of the labour force) in 2011-12 (Safe Work Australia, 2013). This sector is among the highest risk industry categories for work-related injury and illness in Australia, with an incidence of serious injury 14% higher than all other industries combined (Safe Work Australia, 2013). Consequently, Safe Work Australia has designated Healthcare and Social Assistance as one of its priority industries for Occupational Health and Safety (OHS) prevention activities.

Workers within the sector face some unique risks to their health and well-being. The European Agency for Safety and Health at Work has identified the following main risk factors in the healthcare sector (EU-OSHA, 2016):

- Musculoskeletal loads (poor posture, heavy loads such as lifting patients)
- Biological agents (viruses, micro-organisms)
- Chemical substances (anaesthetic agents, antibiotics, disinfectants)
- Radiological hazards
- Changing shifts and conditions of work including night work
- Violence from members of the public
- Accidents at work including falls, cuts, needle sticks
- Other factors contributing to stress such as exposure to traumatic situations, the organisation of work, and relationships with co-workers.

Recently there has been a focus on exposure to workplace violence in a number of jurisdictions nationally and internationally, including Victoria (VAGO, 2015), as well as Ontario and British Columbia in Canada (Ontario Ministry of Labour, 2015). This follows increasing recognition that healthcare workers may be at increased risk of injury / illness arising from violent incidents, and that some healthcare settings are associated with increased risk of violence (e.g., emergency department, psychiatric hospitals).

In Australia, healthcare is organised primarily at the level of states and territories. Although receiving substantial federal funding, state and territory governments are

responsible for the operation and administration of public healthcare systems including public hospitals and ambulance services. Occupational health and safety, and workers compensation, are also predominantly organised at a state and territory level. There is substantial variability between states with regards to compensation system policy and practice (Safe Work Australia, 2015), and these are likely to have a substantial impact on outcomes for workers (Collie et al, in press). Despite ongoing attempt at policy harmonisation (Safe Work Australia, 2011), OHS policy and practice also varies substantially between jurisdictions, between industries and between employers. This variability creates an environment in which there may be substantial differences between states and territories in exposure to risk, work-related injury and illness and the incidence and outcomes of workers compensation claims for health sector workers.

This short report seeks to:

1. Characterise the incidence, nature and outcomes of work-related injury in nurses and ambulance officers in Australia.

2. Compare the incidence and outcomes of work-related injury to nurses and ambulance officers between Australian states and territories.

3. Describe the incidence, nature and outcomes of compensable work injury claims arising from occupational violence in Australian nurses and ambulance officers.

The analyses uses data from the ComPARE study dataset held by the Institute for Safety Compensation and Recovery Research (ISCRR). ComPARE is a project established by ISCRR with the support of Safe Work Australia and the Australian workers' compensation authorities. More information can be found here:

http://www.iscrr.com.au/recovery-and-return-to-work/factors-affecting-return-to-work/comparing-compensation-policies

Data Selection and Analyses

The ComPARE dataset contains claim level information for an 11-year period between the 2003/4 to 2013/14 financial years. This data was restricted to accepted claims among 15 to 80 year-olds between the 2009 and 2014 financial years (note that all years refer to the last year of the financial year, e.g., 2009 refers to 2008/2009). The restriction in date range was to ensure that all jurisdictions had adopted the latest data coding standards – enabling more accurate case selection and comparison between jurisdictions.

Cases were selected based on the injured workers occupation (according to the Australian New Zealand Standard Classification of Occupations – ABS, 2013) and the industry of the workplace (according to the Australian New Zealand Standard Industrial Classification – ABS, 2013). Cases were selected for inclusion only if their industry of workplace was coded as:

- 8401 – Hospital (Except Psychiatric Hospitals)
- 8402 – Psychiatric Hospitals
- 8601 – Aged Care Residential Services
- 8591 – Ambulance Services
- 8609 – Other Residential Care Services or
- 8599 – Other Health Care Services N.E.C.

and their occupation was coded as one of the following:

- 2543 – Nurse Managers
- 2544 – Registered Nurses
- 4114 – Enrolled and Mothercraft Nurses
- 4111 – Ambulance Officers and Paramedics

ASNZCO codes 2543, 2544, and 4114 were grouped into one category: ‘Nurses’. Those with code 4111 will herein be referred to as ‘Ambulance officers’.

Data from the 2011 census (approximate mid-point of the study period) was used to calculate the total number of nurses and ambulance officers employed in Australia

during the study period. This was used in calculations to estimate rates of injury per 1000 workers.

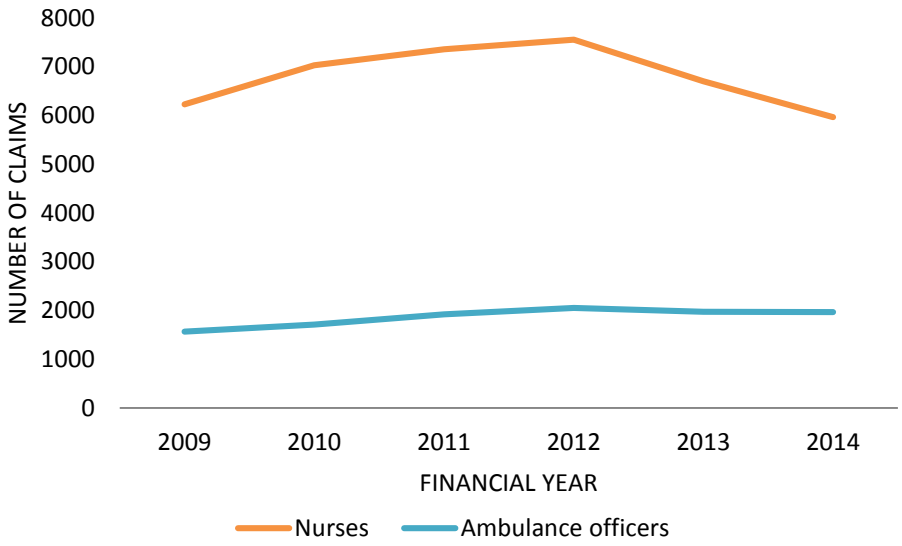
A number of descriptive analyses were conducted. These included calculating numbers and rates of accepted claims per 1000 workers, across the nation and between jurisdictions. The number and percentage of accepted claims by nature of injury and body region were calculated, as were the median durations of time lost from work by jurisdiction. Injuries were coded using the Type of Occurrence Classification System (TOOCS) version 3 (ASCC, 2008).

Results

ALL CLAIMS

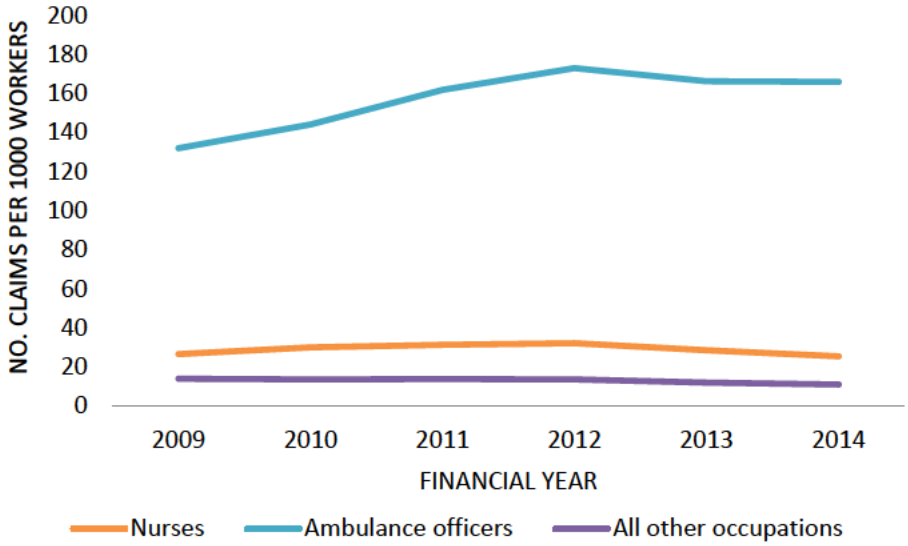
In the six year period 2009 to 2014, there were 52,064 accepted claims for work-related injury among nurses and ambulance officers (3% of all claims) across Australia. More than three-quarters were female (77.2%) and the median age of workers was 45 years (IQR: 35-53). Figure 1 shows the number of claims for each year in each occupation and Figure 2 compares the rate of claims per 1000 workers.

Figure 1: The number of accepted claims for all injury in each occupation over the six year period



Nurses recorded the largest volume of claims of the two occupation groups, with 6,231 being accepted in 2009 rising to 7561 in 2012 before dropping to 5973 in 2014. The number of claims in ambulance officers was 1567 in 2009, rising to 1970 in 2014.

Figure 2: The rate of claims for all injury per 1000 workers comparing nurses, ambulance officers and all other occupations over the six year period



Note: denominator data was taken from the 2011 census (the midpoint of the time period)

Amongst ambulance officers, the rate of accepted claims per 1000 workers increased from 132/1000 in 2009 to a peak of 173 per 1000 workers in 2012 and remained steady at 166 in 2014 (Figure 2). The corresponding rate in nurses over the time period were 26/1000 workers in 2009, 32/1000 workers in 2012 and 25/1000 workers in 2014. The rate of claims in ambulance officers is approximately 10 to 12 times that of all other workers (non-healthcare), while the rate of claims among nurses is approximately twice that of all other workers (Figure 2).

The number of claims of nurses and ambulance officers in each Australian jurisdiction, as well as the rate of claims per 1000 workers is detailed in Table 1. There was substantial variability between jurisdictions, with the highest rate of claims for both occupations recorded in New South Wales. For nurses, Western Australia, South Australia and Tasmania recorded the next highest rate of claims. For ambulance officers, Western Australia, Tasmania and Victoria recorded the next highest rate of accepted claims. It should be noted that there are substantial variations in claim acceptance policy between jurisdictions which significantly affects these rates (for example employer excess period of 10 days in some jurisdictions – Collie et al, in press).

Table 1: The number of claims and rate of claims per 1000 workers in each jurisdiction

		Nurses		Ambulance officers	
		N	Rate of claims per 1000 workers	N	Rate of claims per 1000 workers
2009 - 2014	New South Wales	16777	39.7	4321	204.3
	Victoria	6273	16.9	3364	176.6
	Queensland	6772	24.2	1580	91.8
	South Australia	4522	35.2	657	121.4
	Western Australia	4515	34.6	906	191.1
	Tasmania	1099	30.9	310	180.0
	Northern Territory	250	16.7	46	52.5
	Australian Capital Territory	226	10.6	*	*
	Comcare	433	N/A	13	N/A
	Australia	40867	29.1	11197	157.3

Note: No claims for Ambulance officers in ACT over the entire time period. Prior to 2011, there were no recorded claims coded to 'Nurse Managers' or 'Ambulance Officers' occupations in SA. Comcare does not have denominator data. Denominator data for all other states and territories was taken from the 2011 census.

Injury type and injured body region

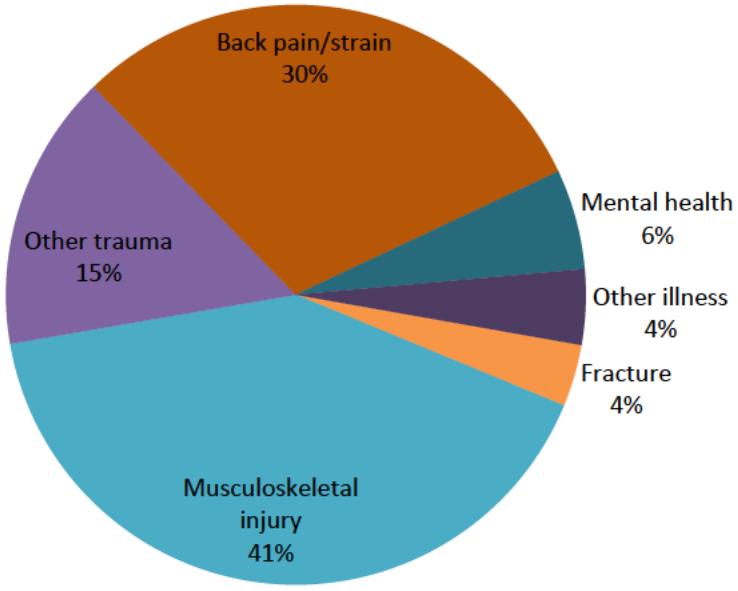
Body stressing injuries were most common across both groups of occupations. Among nurses, body stressing injuries accounted for 46.4% of all claims, and 59.2% of all claims from ambulance officers, whereas it only accounted for 35.7% for all other occupations. Injuries due to falls and assaults were also common (Table 2).

Table 2: The five most common mechanisms of injury for nurses, ambulance officers, and for all other occupations

		N	%
Nurses	Muscular stress while handling objects other	10534	25.8
	Falls on the same level	6158	15.1
	Muscular stress lifting, carry, putting down object	5340	13.1
	Being assaulted by a person or persons	3042	7.4
	Muscular stress with no objects being handled	2396	5.9
	Other mechanism of injury	13397	32.8
Ambulance officers	Muscular stress lifting, carry, putting down object	4171	37.3
	Muscular stress while handling objects other	1817	16.2
	Falls on the same level	738	6.6
	Muscular stress with no objects being handled	498	4.4
	Vehicle accident	459	4.1
	Other mechanism of injury	3514	31.4
All other occupations	Muscular stress lifting, carry, putting down object	242244	14.6
	Muscular stress while handling objects other	219080	13.2
	Falls on the same level	215561	13.0
	Being hit by moving objects	121505	7.3
	Hitting stationary objects	92147	5.5
	Other mechanism of injury	773979	46.5

Figure 3 shows the proportion of each broad injury group of all accepted injury claims from nurses and ambulance officers. Musculoskeletal injuries were the most common, followed by back pain/strain.

Figure 3: The proportion of each broad group of all injuries among nurses and ambulance officers in Australia



Soft tissue injuries were the most common across both occupation types and traumatic injuries were also common (Table 3). The top 5 body sites injured are the same for both nurses and ambulance officers.

Table 3: The ten most common types of injuries and affected body regions among nurses and ambulance officers

		Nature of injury			Body region	
		N	%		N	%
Nurses	Soft tissue injuries due to trauma or unknown mechanisms with insufficient information to code elsewhere	9967	24.4	Lower back	8447	20.7
	Traumatic strain of muscles and tendons - muscle/tendon trauma - not elsewhere classified	4297	10.5	Shoulder	4866	11.9
	Contusion, bruising, crushing and traumatic soft tissue injury, not elsewhere classified	3002	7.3	Knee	2923	7.2
	Trauma to joints and ligaments, not elsewhere classified	2573	6.3	Psychological system	2212	5.4
	Traumatic tear of muscles	2511	6.1	Back - unspecified	2016	4.9
	Back pain, strain (non-traumatic), lumbago, sciatica	1916	4.7	Wrist	1576	3.9
	Other fractures, not elsewhere classified	1479	3.6	Fingers	1383	3.4
	Traumatic joint, ligament injury, not elsewhere classified	1454	3.6	Ankle	1348	3.3
	Trauma to muscles and tendons, not elsewhere classified	1397	3.4	Neck bones, muscles and tendons	1223	3.0
	Medical sharp/needle-stick puncture	938	2.3	Hands	929	2.3
	Other injury	11333	27.7	Other body region	13944	34.1
	Total	40867	100.0	Total	40867	100.0
Ambulance officers	Soft tissue injuries due to trauma or unknown mechanisms with insufficient information to code elsewhere	2435	21.7	Lower back	3023	27.0
	Back pain, strain (non-traumatic), lumbago, sciatica	1447	12.9	Shoulder	1241	11.1
	Traumatic strain of muscles and tendons - muscle/tendon trauma - not elsewhere classified	1078	9.6	Knee	743	6.6
	Trauma to joints and ligaments, not elsewhere classified	796	7.1	Psychological system	733	6.5
	Traumatic tear of muscles	574	5.1	Back - unspecified	611	5.5
	Trauma to muscles and tendons, not elsewhere classified	430	3.8	Upper back	325	2.9
	Contusion, bruising, crushing and traumatic soft tissue injury, not elsewhere classified	417	3.7	Ankle	313	2.8
	Reaction to stressors - other, multiple or not specified	356	3.2	Neck bones, muscles and tendons	296	2.6
	Traumatic joint, ligament injury, not elsewhere classified	332	3.0	Wrist	275	2.5
	Laceration or open wound not involving traumatic amputation	263	2.3	Fingers	269	2.4
	Other injury	3069	27.4	Other body region	3368	30.1
	Total	11197	100.0	Total	11197	100.0

Time lost to injury

The duration of time lost following injury was calculated as the median number of cumulative weeks for which compensation was paid, for all accepted time loss claims. Figure 4 shows that nurses have the highest median number of weeks' time lost to injury than both ambulance officers and all other occupations, although there is substantial variability in all categories. Table 4 compares duration of time loss between jurisdictions.

Note: only time loss claims were included in these analyses. 75% of claims from nurses resulted in time loss, 73% from ambulance officers, and 61% from all other occupations.

Figure 4: Median and interquartile range of compensated time loss for all injury in weeks by occupation in Australia

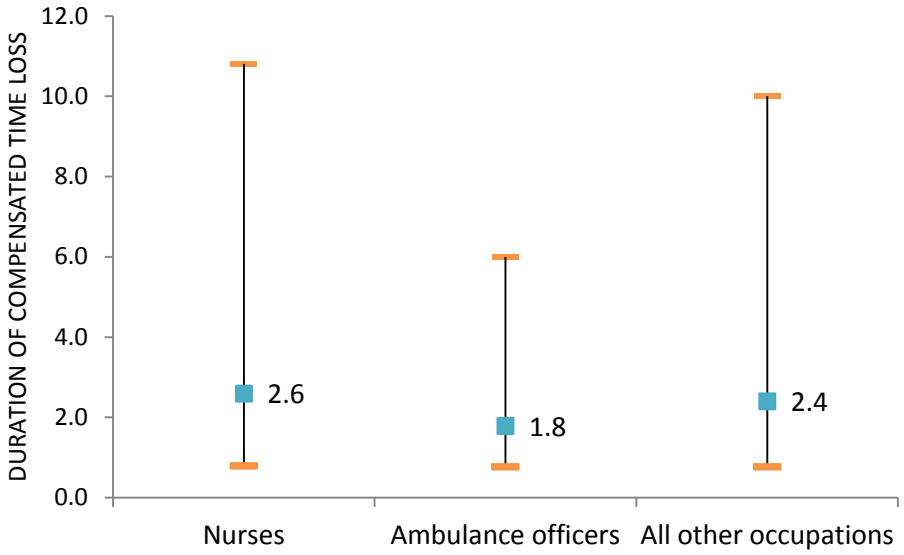


Table 4: The median and interquartile range of compensated time loss for all injury in weeks by occupation comparing jurisdictions

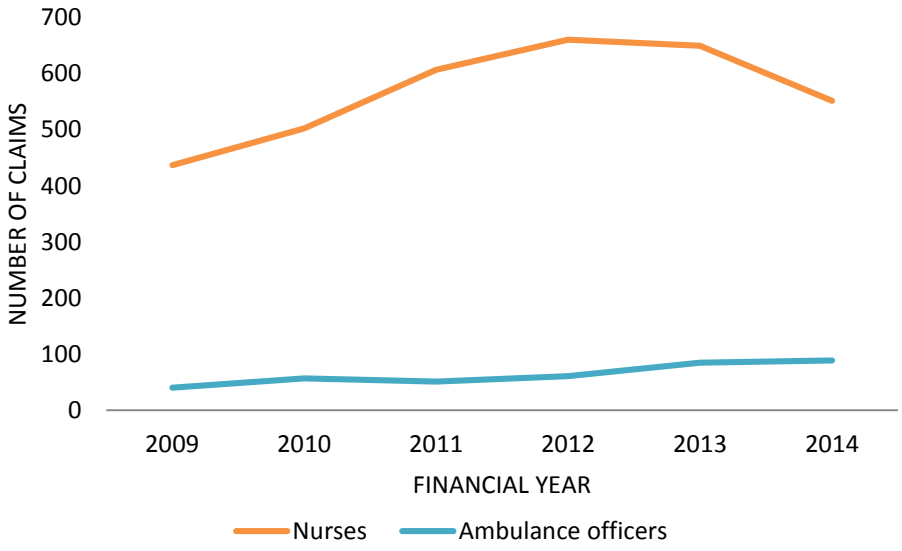
	Nurses	Ambulance officers	All other occupations
New South Wales	2.0 (0.7-7.6)	2.0 (0.9-6.9)	1.9 (0.6-7.6)
Victoria	6.4 (1.2-20.6)	1.7 (0.9-7.0)	6.4 (1.4-24.4)
Queensland	2.4 (0.8-10.0)	1.4 (0.7-4.4)	2.0 (0.6-7.4)
South Australia	2.1 (0.8-8.3)	1.2 (0.4-3.5)	3.3 (0.9-12.6)
Western Australia	3.5 (1.0-16.6)	1.7 (0.6-5.3)	2.2 (0.7-10.2)
Tasmania	2.6 (0.9-8.5)	2.7 (1.0-6.4)	2.8 (1.0-8.7)
Northern Territory	2.4 (1.0-12.0)	2.4 (1.0-5.2)	3.6 (1.2-12.0)
Australian Capital Territory	2.3 (0.9-6.2)	N/A	2.2 (0.7-8.9)
Comcare	5.7 (1.2-24.7)	6.0 (1.3-21.3)	2.7 (0.7-11.4)

OCCUPATIONAL VIOLENCE-RELATED CLAIMS

Accepted workers compensation claims for occupational violence were identified in the dataset by the TOOCS version 3 codes ‘29’ (being assaulted by a person or persons) and ‘82’ (exposure to workplace or occupational violence).

There were 3,793 accepted compensation claims for occupational violence-related injury among nurses and ambulance officers (average of approximately 632 per year), representing 7.3% of all accepted claims in these workers. The median age of claimants was 45 years (IQR 35-53). The majority of accepted occupational violence-related claims were in nurses (n=3410, 89.9%) (Figure 5). Almost three-quarters of occupational violence-related claims from nurses were to females (72.6%), whereas sixty percent of ambulance officers with accepted occupational violence-related claims were male.

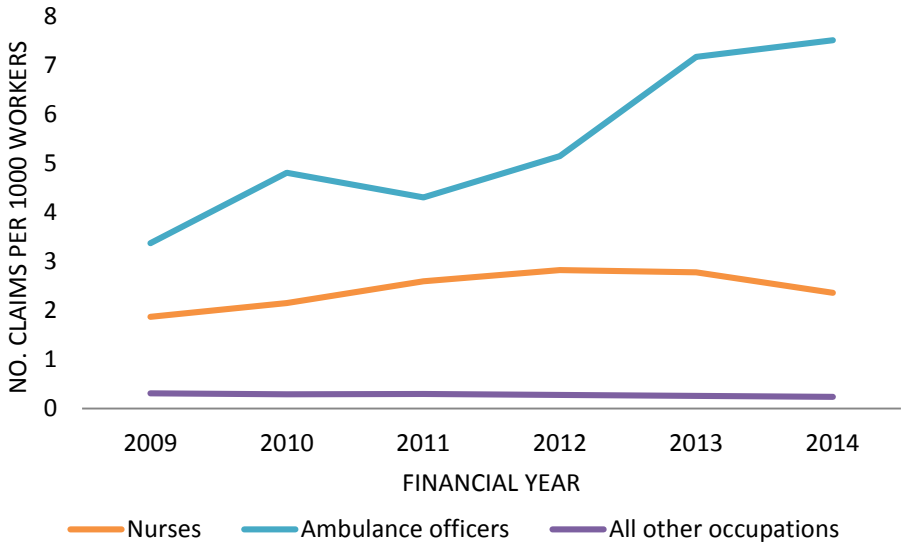
Figure 5: The number of accepted occupational violence-related claims for occupational violence for nurses and ambulance officers over the time period



The rate of occupational violence-related claims per 1000 workers between occupations is shown in Figure 6. This includes comparison to the rate of occupational violence-related claims among all other occupations. Ambulance officers were between 15 to 35 times more likely to make a workers compensation claim for injury resulting from occupational violence than all other workers. The rate

of occupational violence claims in ambulance officers nearly doubled in the 6 year period of the study, rising from 3.4/1000 workers in 2009 to 7.5/1000 workers in 2014. Nurses were 9-12 times more likely than other workers to make a claim for injury resulting from occupational violence, however the rate of claims among nurses remained relatively stable over the study period.

Figure 6: The rate of occupational violence-related claims per 1000 workers comparing nurses, ambulance officers and all other occupations



Note: denominator data was taken from the 2011 census (the midpoint of the time period)

Injury type and injured body region

Traumatic injuries featured prominently among both nurses and ambulance officers. Injury to the psychological system was most common in both occupations. The most common types of injuries and affected body regions sustained by the claimants are summarised in Table 5.

Table 5: The ten most common types of injury and affected body regions among nurses and ambulance officers injured due to occupational violence

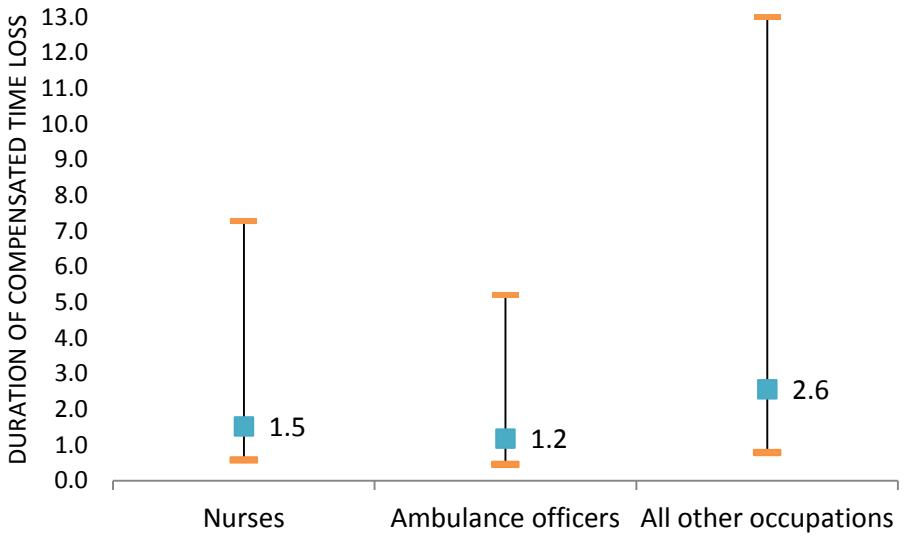
		Nature of injury			Body region	
		N	%		N	%
Nurses	Contusion, bruising, crushing and traumatic soft tissue injury, NEC	755	22.1	Psychological system	499	14.6
	Soft tissue injuries due to trauma or unknown mechanisms with insufficient information to code elsewhere	685	20.1	Shoulder	310	9.1
	Laceration or open wound not involving traumatic amputation	204	6.0	Face, NEC	299	8.8
	Other reaction to stressors	196	5.7	Wrist	165	4.8
	Trauma to joints and ligaments, NEC	160	4.7	Neck bones, muscles and tendons	144	4.2
	Traumatic strain of muscles and tendons - muscle/tendon trauma - NEC	152	4.5	Lower back	127	3.7
	Reaction to stressors - other, multiple or not specified	133	3.9	Forearm	92	2.7
	Other fractures, NEC	116	3.4	Other specified multiple locations	91	2.7
	Traumatic tear of muscles	98	2.9	Cranium	87	2.6
	Post-traumatic stress disorder	95	2.8	Fingers	79	2.3
	Other injury	816	23.9	Other body region	1517	44.5
	Total	3410	100.0	Total	3410	100.0
Ambulance officers	Soft tissue injuries due to trauma or unknown mechanisms with insufficient information to code elsewhere	82	21.4	Psychological system	70	18.3
	Contusion, bruising, crushing and traumatic soft tissue injury, NEC	71	18.5	Face, NEC	41	10.7
	Laceration or open wound not involving traumatic amputation	42	11.0	Forearm	29	7.6
	Reaction to stressors - other, multiple or not specified	27	7.0	Shoulder	21	5.5
	Other reaction to stressors	23	6.0	Wrist	14	3.7
	Superficial injury	19	5.0	Other specified multiple locations	14	3.7
	Trauma to joints and ligaments, NEC	17	4.4	Hands	11	2.9
	Post-traumatic stress disorder	13	3.4	Fingers	11	2.9
	Other fractures, NEC	10	2.6	Lower back	9	2.3
	Traumatic tear of muscles	10	2.6	Chest muscles	9	2.3
	Traumatic strain of muscles and tendons - muscle/tendon trauma - NEC	10	2.6	Thumb	9	2.3
	Other injury	59	15.4	Other body region	145	37.9
	Total	383	100.0	Total	383	100.0

** NEC = not elsewhere classified*

Time lost to injury

Whilst nurses and ambulance officers had a higher rate of accepted claims for occupational violence-related injury, their median time lost was lower than claimants from all other occupations (Figure 7). There was substantial variability within the occupation categories in the duration of time lost.

Figure 7: Median and interquartile range of compensated time loss for occupational violence-related injury in weeks by occupation



Summary and Conclusion

Being employed as a Nurse or an Ambulance officer is associated with a substantially greater risk of making a compensation claim for work-related injury than among other occupations in Australia. Nurses have twice the rate of accepted work injury claims than all other occupations, while ambulance officers have 10 to 12 times the rate of accepted injury claims than all other occupations. Both the number and rate of injury varies substantially between states and territories of Australia.

The most common mechanisms of injury broadly reflect those observed in other occupations and include manual handling and falls and other muscular stress mechanisms. However, unique in the top five mechanisms for nurses was 'being assaulted by a person or persons' and for ambulance officers 'vehicle accidents'.

The median time lost due to injury was equivalent between nurses and other occupations, and slightly lower in ambulance officers. However there was substantial variation between jurisdictions.

Both nurses and ambulance officers were at an even greater risk than other workers for injury claims resulting from occupational violence. Ambulance officers were between 15 to 35 times more likely to make a workers compensation claim for injury resulting from occupational violence than all other workers, and the rate of violence-related claims nearly doubled in the study period. Nurses were 9-12 times more likely than other workers to make a claim for injury resulting from occupational violence. Median time lost due to injury for both occupations was lower than for violence-related claims among all other occupations.

These findings confirm that some health care sector workers are at increased risk of work-related injury than other Australian workers both generally and for injuries resulting from violence specifically. The data also confirm that there are substantial jurisdictional differences in both the number and rate of injury claims, and the duration of time lost to injury, in nurses and ambulance officers. The data are likely to underestimate the true extent of both injury and violence-related injury in the sector, as not all injuries are eligible for workers' compensation, and a proportion of workers choose not to make claims for injuries that may be eligible (Safe Work Australia,

2009). This is consistent with findings that health sector workers under-report violent incidents occurring at work (Arnetz et al, 2015). Developing and/or analysing other relevant data sources, such as population-based hospital incident management systems (e.g., Arnetz et al, 2011), will be necessary to establish the full extent of OHS risk in health sector workers.

Acknowledgments

This study was supported with financial input from Safe Work Australia and WorkSafe Victoria, via the Institute for Safety Compensation and Recovery Research. The data reported in this document has been provided by Safe Work Australia and the Australian Bureau of Statistics. The following workers' compensation authorities have given permission for claims administrative data to be used in the study, and have provided input and assistance with data quality assurance and interpretation: WorkSafe Victoria, WorkSafe WA, ReturnToWork SA, Comcare, Office of Fair and Safe Work Queensland, State Insurance Regulatory Authority of New South Wales, NT Worksafe, WorkCover Tasmania, Australian Capital Territory. The authors would like to acknowledge the contribution of the ComPARE data and policy advisory group who have contributed to the establishment of the database used in this study.

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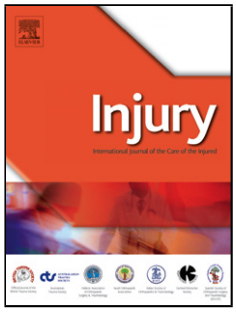
Appendix 4

Accepted Manuscript



Title: The nature and burden of occupational injury among first responder occupations: A retrospective cohort study in Australian workers

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The nature and burden of occupational injury among first responder occupations: A retrospective cohort study in Australian workers.

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Abstract

Introduction: Workers in first responder (FR) occupations are at heightened risk for workplace injury given their exposure to physical/psychological hazards. This study sought to (1) characterise the occupational risk of injury; (2) determine factors associated with injury; and (3) characterise the burden of injury-related disability in police, ambulance officers, fire/emergency workers, compared with other occupations.

Methods: A retrospective cohort of 2,439,624 claims occurring between July 2003 and June 2012 was extracted from the Australian National Dataset for Compensation-Based Statistics. Cases aged 16-75 years working 1-100 pre-injury hours per week were included. Regression models estimated risk of making a workers' compensation (WC) claim by age, gender, occupation and injury type. Injury burden was calculated using count and time loss, and statistically compared between groups.

Results: The risk of making a WC claim among FR occupations was more than 3 times higher than other occupations. Risk of claiming was highest among female FRs and those aged 35-44 years. Ambulance officers had the greatest risk of upper-body MSK injuries and fire and emergency workers the greatest risk of lower-body MSK injuries. The risk of mental health conditions was elevated for all FR occupations but highest among police officers. The total burden of injury (expressed as working weeks lost per 1000 workers) differed significantly between groups and was highest amongst police.

Discussion and conclusions: First responders record significantly higher rates of occupational injury claims than other occupations. Using a national population based dataset, this study demonstrates that not only are first responders exposed to significantly higher rates of occupational injury than all other occupations combined, but they experience differential injury patterns depending on their occupation. This suggests that among FR occupations injury prevention efforts should reflect these differences and be targeted to occupation-specific patterns of injury.

Keywords: injury; compensation; emergency services, occupational health; policy; ambulance

INTRODUCTION

Workers in first responder (FR) occupations, including police officers, fire fighters, emergency service workers, and ambulance officers and paramedics, are often the first workers attending an emergency situation. These occupations respond to medical emergencies, fires, hazardous incidents, alarms, critical incidents, and vehicle accidents. They provide assistance during natural disasters, resolve disputes, investigate crime, and coordinate and assist in search and rescue missions, among others. First responders also help communities prepare for or prevent emergency situations, particularly emergency service workers, and are involved in recovery following adverse incidents.

Workers in these occupations are exposed to a range of physical and psychological hazards that are unique to their roles, and these include heavy lifting, vehicle accidents, physical altercations, direct interaction with drug or alcohol-affected people, and exposure to extreme temperatures, communicable diseases, chemicals, biological factors, trauma and violence.(1-3) These workers are expected to attend emergencies in unfamiliar locations and often do not have a full understanding of the environment, the situation in which they are about to enter or the people with which they must engage. This unpredictability could mean that they are at increased risk of injury. In addition to physical injury hazards, FRs may be exposed to direct or indirect stressors in the workplace. These include witnessing trauma or the suffering of others,(4) potentially contributing to mental health consequences. Additionally, FRs regularly work shifts, which can sometimes result in working lengthy and erratic hours, with some studies finding a link between fatigue and increased injury risk.(5-7)

Previous research has acknowledged that FRs are at an increased risk for work-related injury and fatality.(8, 9) Australian workers compensation claims data demonstrates that ambulance officers had an average rate of 94.6 serious injuries per 1000 workers (those resulting in more than one week time loss), more than seven times the national average.(10) Risk of fatality was six times higher than the national average. Another Australian study compared workers' compensation claims of ambulance officers with other healthcare professionals between 2003 and 2012 in Victoria.(11) This found that there was an upward trend in claim rates and their

risk of claiming was significantly higher than other occupations at 102.2 claims per 1000 full-time equivalent (FTE) workers. This study also found that ambulance officers had a significantly higher risk of musculoskeletal (MSK) injuries and mental health conditions (MHC) than other healthcare professionals.

Studies from the United States (US) have also found high injury rates among emergency workers that were consistently above the national average. Maguire and Smith (2013) used a nationwide dataset to determine ambulance workers reported 453.8 injuries per 10,000 workers.(12) Other studies that have used administrative data from local ambulance organisations found injury rates varied from 4.5 to 81.2 injuries per 100 FTE workers (average 15.6),(13) and 27.6 to 50.2 per 100 FTE workers, averaging 34.6.(14) These rates were higher than a self-report study that observed an injury rate of 8.1 injuries per 100 workers.(14) Injury rates among firefighters were also high at 8.9 to 34.3 injuries per 100 FTE workers (average 18.6).(1) Suyama et al stated that ambulance workers had higher injury rates than police and fire fighters,(15) however another study found among first responders requiring treatment in an emergency department, police and firefighters had higher injury rates (8.5 and 7.4 injuries per 100 FTE workers, respectively) than ambulance workers.(3) The risk of occupational-related fatality is also elevated for first responders, yet it has been found to be similar between emergency personnel.(16)

Injury to FRs also impacts their colleagues, employers and the community. High injury rates among emergency workers may be associated with a high employee turnover rate, increased staff absence, or a shortened career span.(1) Aside from the obvious negative impacts to FRs, all of these factors could lead to a reduction in the quality of emergency response provided to the community, which could therefore adversely impact those relying on their assistance.(9) In contrast to the numerous reports of injury rates, there is very little information regarding the duration of time lost to injury and illness among FRs. Estimates of work disability duration are an important indicator of injury burden and can help to characterise the true impact of work-related conditions.

The objectives of this study are to (1) characterise the occupational risk of injury among first responders across whole of Australia compared to other occupations; (2) determine factors associated with injury in FRs, in particular aspects of their personal characteristics and type of condition; and (3) characterise the burden of disability arising from injury in FRs compared to other occupations.

METHODS

Setting

The vast majority of Australia's labour force (approximately 11.9 million in early 2016) are covered by compulsory workers' compensation (WC) insurance regulated by state, territory and Commonwealth government authorities, which provides coverage should a work-related injury or illness occur.(17) There are nine major workers' compensation schemes in Australia, typically organised geographically by state or territory, with one major national scheme that covers Commonwealth government employees, government employees of the Australian Capital Territory and more than 30 large national companies.

Work-related conditions that are eligible for compensation include acute conditions such as fractures due to a fall, diseases resulting from exposure to biological or chemical agents, and gradual onset or chronic conditions such as back pain. Additionally, jurisdictions can accept 'psychological injury' claims where work or its conditions were a major contributor to a mental health condition.

Injured workers can receive benefits in the form of income replacement, medical expenses or rehabilitation services for their period off work, where reasonable and necessary. Additionally, those who have sustained a permanent impairment or disability may also be eligible to receive lump sum payments.

There are some major and important differences between Australian WC schemes concerning employer excess periods, the duration and rate of income replacement, and the insurance-regulation function relationship, and these have been outlined elsewhere.(18)

Data

The COMPARE (COMpensation Policy And Return-to-work Effectiveness study) dataset, a version of the National Dataset for Compensation-Based Statistics that has been compiled by SafeWork Australia to include WC claims from all nine Australian schemes, was used for analysis and has previously been described.(18, 19)

Cases were restricted to the nine-year period from July 2003 to June 2012 (financial years 2004 to 2012) to allow a minimum 2-year follow-up. Only claimants aged 16 to 75 years with normal weekly working hours prior to injury between one and 100 hours were included. Duplicate cases were removed, as were those with missing occupation information. The dataset does not include injury claims from the Western Australia Police Force, as police officers in Western Australia are not covered under that state's workers' compensation legislation. All cases from South Australia were removed for the 2009 and 2010 years as data quality assurance identified inconsistencies in occupational classification during these years. This resulted in a loss of 52,421 claims or 2.1% of all cases in the dataset. The final number of cases available for analysis was 2,439,624.

Cases were then separated based on their 4-digit Australian and New Zealand Standard Classification of Occupation(20) codes into 'Ambulance Officers & Paramedics' (code 4111), 'Fire & Emergency Workers' (4412), 'Police' (4413) and 'All other occupations' (remaining codes).

The type of condition coding, which is a modified version of the Type of Occurrence Classification System (TOOCS) version 3, was generated by the research team to account for both differences in coding between jurisdictions and coding changes within jurisdictions over time(21) (see table 1).

< Insert Table 1 >

Musculoskeletal conditions were further categorised based on affected body region into upper (including the back), lower and other or multiple body regions for some analyses. The denominator data of the number of covered (insured) workers was provided by Safe Work Australia aggregated by financial year, occupation, gender and age group to calculate the incidence of claims, and has been used previously.(19)

Analysis

The distribution of WC claims across occupation groups were characterised using descriptive statistics over the nine-year period. This was further characterised for each FR group by gender, age group and condition type. Covariates were chosen based on their significant associations with injury risk found in previous studies of first responders. Rate of claims per 1000 covered workers were calculated, as were the relative risks for each variable using Poisson regression, given the count nature of the data. Relative risk describes the risk of making a WC claim in one group compared to another.

To investigate any differences over time in the risk of making a WC claim of a particular type of condition across occupational groups, additional negative binomial regression models adjusted for gender and age were generated over three time periods, 2004 to 2006, 2007 to 2009, and 2010 to 2012. Amalgamating these years was to ensure adequate claim numbers for analysis. The models included the number of claims as the outcomes within each financial year, occupational group, gender, age group, and condition type, with the relevant number of covered workers log transformed and included as the offset. Along with mental health conditions and other traumatic injuries, MSK injuries are reported to be most common among FRs(3, 11) and therefore this category was further divided into subcategories. Results were presented as hazard ratios, or the likelihood of a FR worker making a claim for that time period compared with all other occupations.

Incidence rates were re-calculated using only claims that resulted in time lost from work. Summaries of the median and mean time loss were generated for each of the occupational groups. Time loss is represented as the number of weeks compensated censored at 104 weeks, and is calculated by dividing the number of hours compensated by the number of preinjury work hours per week. The burden of injury was calculated using the following equation to give the total number of weeks lost per 1000 covered workers:

$$burden\ of\ injury = \frac{number\ of\ time\ loss\ claims\ \times mean\ weeks\ lost}{number\ of\ covered\ workers} \times 1000$$

To determine whether there were statistically significant differences in the burden of injury between occupation groups, a Kruskal-Wallis test was used. A test of trend was performed of burden calculations for each FR group using linear regression. All data analyses were performed using SPSS Version 23.

RESULTS

Over the nine-year observation period, there were 2,439,624 claims, of which 2.7% were from first responders (n=65,003). Figure 1 shows the rate of claims over the three time periods for each occupational group. The claim rate was 2.6 times or higher for all FRs than all other occupations. The rate of claims decreased among ambulance officers and all other occupations, however claim rates fluctuated for fire and emergency workers and police. Ambulance officers had the highest rate of claims of all the occupational groups (141.4-163.7 claims per 1000 covered workers), which is between 4.8-6.3 times the rate of all other occupations.

< Insert Figure 1 >

The frequency, rate and relative risk of all WC claims by occupational group are detailed in Table 2 and further for all FR claims by gender, age group and condition type across Australian WC jurisdictions between 2004 and 2012. Female ambulance and police officers had a greater

relative risk of making a claim compared with males, yet this was lower for fire and emergency workers. The rate and relative risk of claiming varied between age groups and FR occupations. Across all FR groups, workers aged <35 and 55+ years had the lowest risk of making a claim. Musculoskeletal injuries accounted for more than half of all claims, with other traumatic injuries and mental health conditions also common.

< Insert Table 2 >

Table 3 shows the rate of claiming and the hazard ratios for risk of claiming for specific condition types by occupational group across three three-year periods. Across all injury types, FRs had higher HRs than all other occupations. The risk of all types of MSK injury to FRs were heightened but were decreasing over the time period (except other and multiple body regions among Police). Ambulance officers had the highest risk of claiming for MSK injuries affecting the upper body, whereas fire and emergency workers had the highest risk for lower body MSK injuries. All FRs were at elevated risks for other traumatic injuries. Whilst all FRs had a considerably higher risk of mental health conditions than all other occupations, this was most evident among police.

< Insert Table 3 >

The burden of injury is summarised in Table 4 for each of the occupational groups. A Kruskal-Wallis test showed that there were significant differences in the total weeks lost per 1000 workers between occupation groups, $X^2(3) = 21.999$, $p < 0.001$. Among FRs, with decreasing incidence rate there was a concurrent increase in the median weeks' time loss over the study period, for every occupational group. The time lost from work increased over the study period for all FR groups, however was consistently highest for police. The total number of weeks lost per 1000 covered workers was 886.1 weeks among ambulance officers and 721.7 weeks among fire and emergency workers, and was more than three times that of all other occupations. The burden of injury was almost five times higher among police than all other occupations, losing 1047.8 weeks per 1000 covered workers, or approximately over one week

per worker. The injury burden remained reasonably constant for all other occupations but fluctuated among fire and emergency workers, and worsened over time for ambulance officers, and police. The burden was significantly increasing among police.

< Insert Table 4 >

DISCUSSION

This study has demonstrated that workers in FR occupations including police, fire and emergency personnel, and ambulance officers, are at significantly greater risk of occupational injury resulting in a WC claim than workers in other occupations. Further, this study demonstrated differential risks among three major FR occupations. Ambulance officers were at greatest risk for upper body MSK injury, fire and emergency workers at greatest risk for lower body MSK injury, and police officers at greatest risk for MHC. This finding suggests that there are unique occupational hazards in these three occupation groups, and suggests that injury prevention and rehabilitation programs need to be tailored to the specific occupation group and for specific occupational injury risk factors. This study also demonstrated that the total burden of occupational injury in FRs, as measured by the duration of time lost to injury per 1000 workers, is up to 7 times higher for FRs than for all other occupations. Further, this burden has been growing in ambulance officers and police officers, while the burden in all other occupations has remained stable over the study period.

Overall, the rate of WC claims among ambulance officers was more than five times higher than all other occupations combined. The rate among police and fire and emergency workers was more than three times higher than other occupations. This pattern is consistent with a US study that found ambulance workers had a higher rate of injury based on WC claims than police and fire personnel.(15) Conversely, a study by Reichard and Jackson (2010) found that police and firefighters had a higher injury rate for those injuries that required treatment at an emergency department than ambulance workers.(3) The latter reflects traumatic injuries that

required immediate treatment and therefore are likely to have a different profile to WC claims, which includes delayed onset and chronic conditions.

The majority of injuries resulting in claims occurred in male FRs, as expected given the male dominated nature of these occupations. However, WC claims occurred at a higher rate among female FRs relative to their male counterparts, consistent with other studies.(1, 11, 22) In this study, the youngest and oldest age groups had the lowest risk of claiming. Given the propensity for MSK injuries among FRs and their cumulative nature, in that treatment or compensation may not be sought until years after they first presented themselves, could explain older age groups having greater risk. Further, it is possible that in these occupations more experienced workers are exposed to greater occupational injury hazards compared to younger workers, although this runs counter to prior research demonstrating higher rates of injury among young and inexperienced workers.(1) It is also possible that older workers may have moved from operational roles and thus are no longer exposed to the same hazards. Further studies of the impact of age on injury and exposure in these high risk occupations are warranted.

Musculoskeletal injuries were the most common of all conditions among FRs, accounting for more than half of all claims. This is consistent with prior studies of WC datasets.(3, 11, 22, 23) This high prevalence of MSK injuries among FRs may reflect the requirement for heavy lifting (e.g. lifting or moving patients) or operating heavy machinery or equipment (e.g. fire hoses or ladders). Lifting-related injuries have been found to be common among FRs,(1, 12), possibly due to the difficulty of applying biomechanically sound lifting techniques due to the sometimes unpredictable environment in which FRs operate.(9)

Upon breakdown of MSK injuries, it became evident that MSK injuries to the upper body (including the back) were of highest risk to ambulance officers, whereas fire and emergency workers were most at risk for lower body MSK injuries. A study of injuries to FRs found this same pattern.(3) Back, neck and shoulder injuries have been shown to be the most prevalent

injury type among ambulance officers globally,(23) and injuries to the leg and foot were the most commonly affected body regions among fire fighters.(3)

Over the study period, the risk of upper body MSK injuries to ambulance officers decreased, which could be due to ambulance organisations implementing injury prevention programs. It is possible that ambulance organisations have implemented programs that have targeted manual handling-related MSK injuries by introducing lifting assistance equipment, encouraging and teaching more ergonomically sound lifting techniques, or conducting dynamic risk assessments to ensure the best approach to certain situations.(24) Despite the reduction, ambulance officers are still at an elevated risk of upper body MSK injury, and therefore targeted injury prevention and rehabilitation strategies should be established.

Whilst the claim rate for lower body MSK injuries to fire and emergency workers was lower than that for upper body MSK injuries, their risk of claiming for lower body MSK injuries was greater than other FR groups. A study by Reichard and Jackson (2010) found that MSK injuries were mostly due to bodily motion (body stressing) for all FRs.(3) Falls were the other major cause of MSK injuries among firefighters, which is expected given the highly mobile nature of their job in sometimes difficult to navigate environments (e.g. smoke-filled rooms), and could explain the increased risk of lower body injuries in this group. However, the mechanism of injury was not detailed in this study and should be the subject of future research to fully understand the reasons for increased lower limb injury risk.

First responders have been shown to be at an increased risk for post-traumatic stress and other psychological conditions than other workers given their exposure to life-threatening, traumatic, stressful and highly dangerous working conditions.(4) This was most evident among police officers where mental health conditions have been reported as being more common.(8) These situations also extend to other FRs, although the relative risk of MHC in ambulance officers and fire and emergency personnel was lower than in police. Further research would be advantageous to investigate specific MHCs encountered by FRs and their causes. This

could lead to targeted injury prevention approaches, as not all MHCs are the same and should therefore be treated differently.

Workers with MHCs remain on compensation schemes longer(18) and incur significantly greater costs of rehabilitation and income support than workers with other types of injury. Preventive measures for MHCs could include providing greater support to FRs following traumatic events to allow early treatment. By providing a sound and supportive work environment, social support from colleagues and managers, and follow-up of employees post trauma, the severity of MHCs could be reduced.(4)

Results showed that ambulance officers were at a significantly higher risk of work-related injuries resulting in a compensation claim, however in general median time loss was less than all other occupations. Burden calculations took into account the number of claims resulting in time off work, the average time lost from work, and the number of covered workers. Ambulance officers and fire and emergency workers had at least 2.5 times the total burden of all other occupations, however police officers had the highest burden and this was increasing. This demonstrates the importance of calculating injury burden as opposed to stand-alone incidence rate or time loss results. Although police have the lowest incidence rate of injury among the three FR occupation groups studied, they had the highest total burden, equating to more than one week lost per worker during the study period. This could be driven by the higher number of mental health claims among police.(18)

The main strength of this research was that it uses a national population-based work injury database that includes comprehensive capture of FR injury claims as well as injury claims from all other occupations. Further, this study illustrates the risk of making a claim within subgroups of FRs and the injury types that are highly prevalent in these occupations, which may aid development of injury prevention initiatives.

Limitations of this study include that COMPARE dataset is an administrative dataset and not compiled for the purposes of research. The different denominators used in other studies

makes direct comparison difficult, however it is clear from all studies that FRs are at a much greater risk of occupational injury than other workers. It is possible but unlikely that the inclusion of Western Australia police and South Australian claims in 2009 and 2010 could change the profile of injuries. All calculations and analyses were adjusted for exclusion of these claims which accounted for a small proportion of all claims in the dataset (2.1%). The data presented in this study represents the number of accepted claims only. It does not reflect the number of workers who have been injured on the job but whom did not seek compensation, which has been shown to be common and can vary between individual and injury characteristics and by occupation and industry,(25-27) nor those who have been injured but their claim was rejected. Therefore, it is assumed that the reported figures underestimate the total incidence and burden of work-related injury in FRs in Australia.

CONCLUSION

Findings from this study show that FRs are at a greater risk of compensated work-related injury than other occupations. Injury prevention efforts should be directed to minimise exposure to occupational hazards in these groups. Based on these results, future research or injury prevention approaches should be directed but not limited to upper body (including the back) MSK injuries among ambulance officers, lower body MSK among fire and emergency workers and mental health conditions among police.

CONFLICT OF INTEREST

The authors declare they have no conflicting interests.

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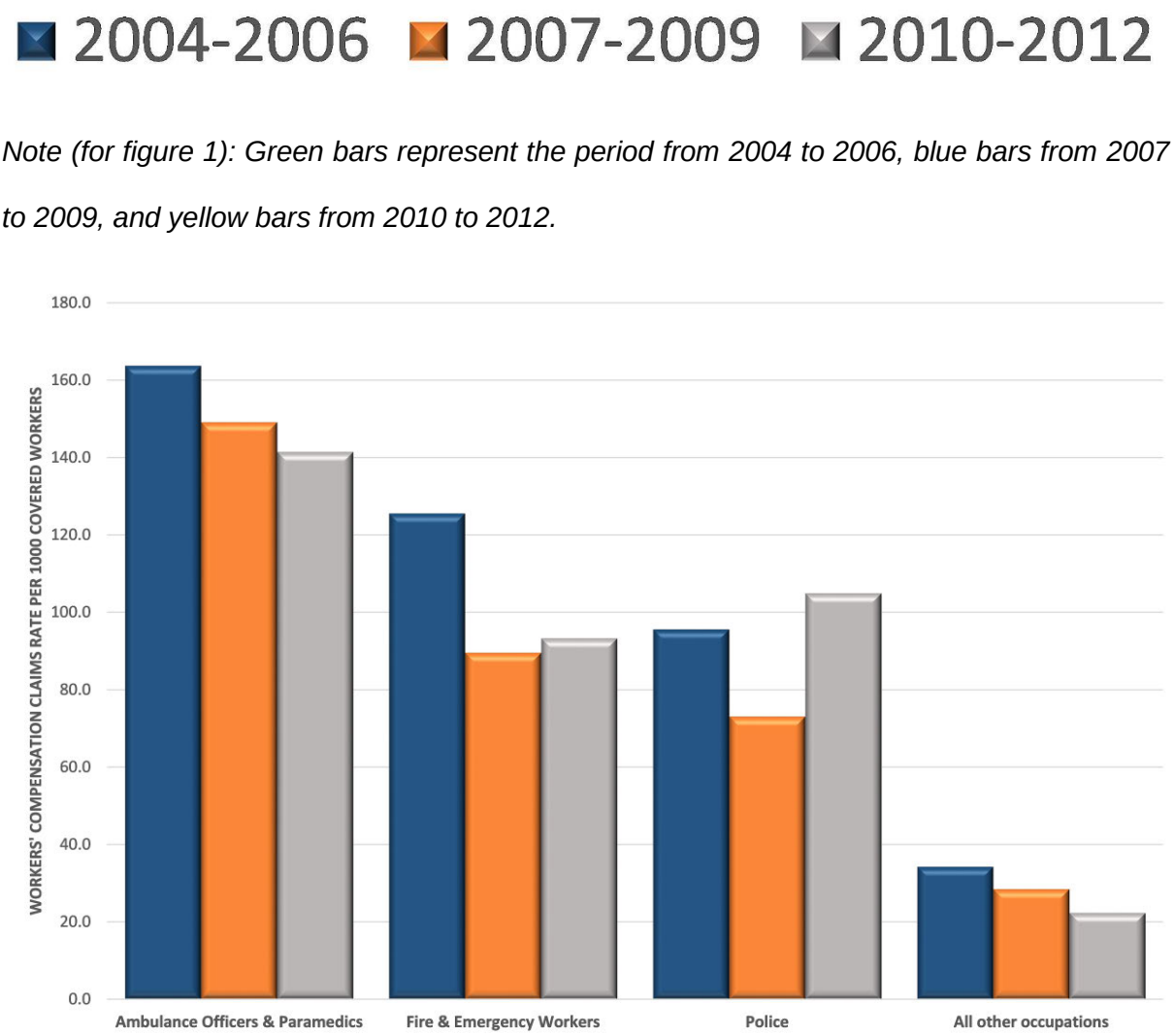
Figure 1: Workers' compensation claim rates for all injuries among each occupational group in Australia over the three time periods



Note (for figure 1): Green bars represent the period from 2004 to 2006, blue bars from 2007 to 2009, and yellow bars from 2010 to 2012.

Table 1: Newly defined condition code with corresponding major Nature of Injury/Disease Classification TOOCS groups

Condition	**TOOCS Nature of Injury/Disease Classification major group**
Fractures	Fractures
Musculoskeletal	Traumatic Joint/Ligament and Muscle/Tendon Injury Musculoskeletal and Connective Tissue Diseases
Neurological	Intracranial Injuries Injury to Nerves and Spinal Cord Nervous System and Sense Organ Diseases
Mental health conditions	Mental Diseases
Other traumatic	Wounds, Lacerations, Amputations and Internal Organ Damage Burn Other Injuries
Other diseases	Digestive System Diseases Skin and Sub-cutaneous Tissue Diseases Respiratory System Diseases Circulatory System Diseases Infectious and Parasitic Diseases Neoplasms (Cancer) Other Diseases
Other claims	Other Claims

Table 2: Frequency, rate and unadjusted relative risk of workers' compensation claims by selected characteristics for FR occupational groups in Australia, 2004 to 2012

	Number of claims	%	Rate per 1000 covered workers	RR	95% CI
Ambulance Officers & Paramedics	14328	0.6	150.3	4.67	(4.59-4.76)
Fire & Emergency Workers	12726	0.5	101.4	3.38	(3.32-3.44)
Police	37949	1.6	90.7	3.16	(3.12-3.19)
All other occupations	2374621	97.3	28.2	1.00	Ref
Ambulance Officers & Paramedics					
Male	9262	64.6	129.2	1.00	Ref
Female	5066	35.4	214.2	1.47	(1.41-1.52)
<24 years	720	5.0	100.2	0.48	(0.44-0.52)
25-34 years	3678	25.7	155.6	0.91	(0.87-0.96)
35-44 years	5033	35.1	152.4	1.00	Ref
45-54 years	3723	26.0	177.2	1.09	(1.04-1.14)
55+ years	1174	8.2	112.0	0.64	(0.60-0.69)
Fractures	234	1.6	2.5	1.00	Ref
Musculoskeletal	10208	71.2	107.1	42.79	(37.32-49.06)
Neurological	162	1.1	1.7	0.66	(0.53-0.82)
Mental health conditions	745	5.2	7.8	3.11	(2.67-3.64)
Other traumatic	1981	13.8	20.8	8.13	(7.04-9.38)
Other diseases	594	4.1	6.2	2.45	(2.09-2.88)
Other claims	329	2.3	3.5	1.37	(1.14-1.63)
Fire & Emergency Workers					
Male	12037	94.6	100.9	1.00	Ref
Female	689	5.4	110.9	0.50	(0.44-0.56)
<24 years	458	3.6	113.3	0.42	(0.36-0.49)
25-34 years	2134	16.8	73.9	0.65	(0.62-0.68)
35-44 years	4512	35.5	107.0	1.00	Ref
45-54 years	4287	33.7	114.3	1.07	(1.03-1.12)
55+ years	1335	10.5	103.6	0.87	(0.82-0.93)
Fractures	395	3.1	3.1		Ref
Musculoskeletal	8584	67.5	68.4	22.94	(20.63-25.50)
Neurological	275	2.2	2.2	0.74	(0.63-0.87)
Mental health conditions	518	4.1	4.1	1.33	(1.16-1.53)
Other traumatic	2458	19.3	19.6	6.24	(5.58-6.98)
Other diseases	317	2.5	2.5	0.81	(0.70-0.95)
Other claims	117	0.9	0.9	0.30	(0.24-0.38)
Police					
Male	28052	73.9	86.6	1.00	Ref
Female	9897	26.1	104.5	1.16	(1.13-1.19)
<24 years	2372	6.3	95.1	0.87	(0.83-0.91)
25-34 years	14374	37.9	97.0	1.02	(1.00-1.05)
35-44 years	14400	37.9	95.0	1.00	Ref
45-54 years	5754	15.2	72.6	0.75	(0.73-0.78)
55+ years	1049	2.8	72.3	0.58	(0.54-0.63)
Fractures	1649	4.3	3.9	1.00	Ref

Musculoskeletal	19266	50.8	46.0	11.65	(11.07-12.25)
Neurological	499	1.3	1.2	0.29	(0.27-0.33)
Mental health conditions	5756	15.2	13.8	3.50	(3.32-3.70)
Other traumatic	8974	23.6	21.4	5.42	(5.14-5.71)
Other diseases	629	1.7	1.5	0.38	(0.35-0.42)
Other claims	946	2.5	2.3	0.57	(0.53-0.62)
Note: Those with unspecified or missing codes for type of condition were not included in table; RR – relative risk; CI – confidence interval					

Table 3: Rate of claiming and age and gender-adjusted HRs for risk of injury categories by occupational group in Australia over three time periods

	2004-2006			2007-2009			2010-2012		
	Rate	**HR**	**95% CI**	**Rate**	**HR**	**95% CI**	**Rate**	**HR**	**95% CI**
Musculoskeletal									
Upper body									
Ambulance Officers & Paramedics	89.4	39.65	(31.90-49.28)	79.4	16.53	(12.89-21.19)	80.8	8.38	(6.73-10.45)
Fire & Emergency Workers	47.6	7.57	(5.90-9.72)	34.2	5.12	(3.99-6.56)	35.0	3.39	(2.68-4.29)
Police	28.4	3.71	(3.00-4.59)	23.0	3.02	(2.46-3.72)	30.9	2.80	(2.28-3.43)
All other occupations	13.0	1.00	Ref	10.8	1.00	Ref	8.7	1.00	Ref
Lower body									
Ambulance Officers & Paramedics	17.2	14.56	(11.09-19.13)	17.6	7.31	(5.58-9.58)	16.9	4.94	(3.87-6.30)
Fire & Emergency Workers	33.4	17.55	(13.58-22.68)	23.5	10.22	(7.93-13.15)	24.1	7.32	(5.75-9.32)
Police	15.1	6.15	(4.97-7.60)	12.8	5.56	(4.49-6.89)	15.8	4.52	(3.66-5.59)
All other occupations	3.7	1.00	Ref	3.4	1.00	Ref	2.9	1.00	Ref
Other and multiple body regions									
Ambulance Officers & Paramedics	7.5	12.52	(9.28-16.89)	7.3	7.06	(5.25-9.50)	6.5	6.27	(4.77-8.25)
Fire & Emergency Workers	4.1	4.23	(3.08-5.80)	3.1	3.01	(2.18-4.17)	3.3	2.70	(1.99-3.66)
Police	4.1	4.18	(3.31-5.29)	3.6	3.78	(2.98-4.81)	4.9	4.46	(3.54-5.63)
All other occupations	1.2	1.00	Ref	1.1	1.00	Ref	0.9	1.00	Ref
Mental health conditions									
Ambulance Officers & Paramedics	7.3	14.31	(10.47-19.55)	8.1	9.80	(7.33-13.09)	8.0	6.89	(5.28-8.99)
Fire & Emergency Workers	3.7	4.73	(3.42-6.55)	4.4	5.46	(4.03-7.39)	4.3	4.35	(3.24-5.84)
Police	11.5	17.69	(14.05-22.26)	12.0	13.29	(10.73-16.46)	18.0	15.48	(12.56-19.08)
All other occupations	1.0	1.00	Ref	0.8	1.00	Ref	0.9	1.00	Ref
Other traumatic									
Ambulance Officers & Paramedics	25.5	7.64	(5.92-9.85)	21.8	2.95	(2.27-3.83)	16.5	2.05	(1.61-2.61)
Fire & Emergency Workers	25.5	5.31	(4.07-6.94)	16.6	2.87	(2.21-3.72)	17.7	2.68	(2.09-3.44)
Police	26.0	3.64	(2.96-4.48)	14.3	2.46	(1.99-3.04)	24.6	2.88	(2.35-3.54)
All other occupations	10.9	1.00	Ref	8.8	1.00	Ref	6.1	1.00	Ref

Note: Rate is per 1000 covered workers; HR – hazard ratio; CI – confidence interval

Table 4: The number of claims, incidence rate of time loss claims, median weeks' time loss and injury burden for each occupational group in Australia, 2004 to 2012

	Number of time loss claims	**Incidence rate of time loss claims**	**Median weeks' time loss**	**Total weeks lost per 1000 workers**
Overall (2004-2012)				
Ambulance Officers & Paramedics	11021	115.6	1.4	886.1
Fire & Emergency Workers	9022	71.9	2.2	721.7
Police	25147	60.1	3.0	1047.8
All other occupations	1656879	19.7	2.0	224.8
2004-2006				
Ambulance Officers & Paramedics	3013	110.2	1.3	727.7
Fire & Emergency Workers	2904	79.8	1.6	606.7
Police	7216	52.1	1.8	692.8
All other occupations	573959	21.7	1.7	226.3
2007-2009				
Ambulance Officers & Paramedics	3683	120.7	1.4	918.7
Fire & Emergency Workers	2819	69.7	2.6	837.4
Police	8124	55.3	3.6	1024.6
All other occupations	561335	19.9	2.0	229.2
2010-2012				
Ambulance Officers & Paramedics	4325	115.4	1.7	975.3
Fire & Emergency Workers	3299	67.8	2.8	711.4
Police	9807	73.7	4.0	1442.7
All other occupations	521585	17.6	2.3	219.3
Note: 'incidence rate of time loss claims' refers to the rate of claims resulting in time loss per 1000 covered workers				

Appendix 5

People Matter Employee Survey 2017 Bullying Results

Bullying Across the Sector		Witness Bullying %	Experience Bullying %
Cross Sector Average		33	18
Education	Education Offices	27	15
	Teachers	37	19
	all non-teaching staff in schools	28	14
Family & Community Services		34	17
Justice	**Cluster**	**36**	**20**
	Fire and Rescue NSW	**27**	**16**
	NSW Police Force	**30**	**18**
	NSW Rural Fire Service	**48**	**27**
	NSW State Emergency Service	**36**	**14**
Finance, Services Innovations	Cluster	23	12
	Service NSW	20	10
Industry	Cluster	22	11
	Local Land Service	24	12
Health	Cluster	40	22
	Ministry of Health	28	16
Planning & Environment	Cluster	25	12
Premier & Cabinet	Cluster	17	9
Treasury	Cluster	15	7
Transport	Cluster	23	13
	Road & Maritime Services	22	11

Q10 If you were not satisfied with the outcome of your complaint, please outline why:

Answered: 74 Sk pped: 177

#	RESPONSES	DATE
1	I fe t the person was not dea t w th appropr ate y just moved on	3/31/2018 4:03 PM
2	NO ACTION OR FOLLOW UP	3/29/2018 12:57 PM
3	Other staff member wa ked out of med at on w th no consequence and ssue never d scussed aga n.	3/29/2018 12:47 PM
4	Was to d after I requested an update on the outcome, status that there was no reso ut on for the current s tuat on but t wou d hopefu y be a tered n future s tuat ons.	3/29/2018 12:35 PM
5	I was never contacted w th a response or outcome	3/29/2018 11:45 AM
6	The person nvo ved moved on	3/29/2018 11:38 AM
7	Noth ng was done to reso ve the ssues.	3/28/2018 1:30 PM
8	D dn't make comp a nt. D dn't want to cause any prob ems.	3/28/2018 12:30 PM
9	HARD TO PROVE.BEING MONITORED	3/28/2018 11:47 AM
10	Because th s nd v dua was never spoken too, nor was there any med at on.	3/28/2018 9:34 AM
11	It stopped for a week mybe then started aga n	3/28/2018 7:11 AM
12	Ro e of the sen or anaesthet c techn c an removed w th no consu tat on . Not be ng treated fa r y by management . A respons b t es removed to the po nt of not be ab e to work there anymore . Unfa r treatment d d not go unnot ced as some sen or staff were apo og s ng as th ngs happened. Asked for eave that was not approved so had to res gn	3/27/2018 7:54 PM
13	Not dea t w th as yet	3/27/2018 3:18 PM
14	D dn't make a comp a nt as 1. Management do noth ng to reso ve ssues and 2.wou d have made my fe more d ff cu t	3/27/2018 2:13 PM
15	No contact from management s nce I made comp a nt 3 months.	3/27/2018 1:57 PM
16	I fe t t was not dea t w th accord ng to the po c es out n ng th s behav our I was to d there were actua y 3 nc dents of bu y ng aga nst th s emp oyee ongo ng st the t me but we have (management & HR) dec ded to ro e t nto 1 nc dent, et them know I thought th s was unsat sfactory the r response was sorry about that !	3/27/2018 1:47 PM
17	Behav our was acknow edged but has not changed.	3/27/2018 1:31 PM
18	No po nt n comp a n ng. Management don't do anyth ng	3/27/2018 12:52 PM
19	St n progress	3/27/2018 12:41 PM
20	D dn't make a comp a nt. Noth ng wou d be done anyway	3/27/2018 12:12 PM
21	The person st does t just rude and the they speak	3/27/2018 11:29 AM
22	Unfortunate y t took sen or management too ong to acknow edge the comp ant. HR d dn't acknow edge the comp ant persona y and passed th s on to the sen or manager to dea w th n an unfoema manner	3/27/2018 11:27 AM
23	Noth ng was done	3/27/2018 10:49 AM
24	I have put n a number of comp a nts and noth ng ever gets done about t.The bu es conto the work p ace and the management are power ess to stop t.	3/27/2018 10:29 AM
25	Noth ng was done to address my ssues	3/27/2018 8:31 AM
26	No act on taken,	3/27/2018 8:27 AM

27	rebound effect	3/26/2018 3:43 PM
28	Noth ng was act oned or changed n workp ace	3/26/2018 9:23 AM
29	Noth ng was done	3/25/2018 10:13 PM
30	Noth ng was done	3/25/2018 7:43 PM
31	Noth ng was done	3/25/2018 7:41 PM
32	Spoke to management and HR nforma y but d d not proceed off c a y for fear of retr but on. There s a mobb ng menta ty of subord nates and my management d d not support me but contr buted to the behav our nformed Un on of nc dence but d d not proceed off c a y for fear of reta at on	3/25/2018 9:22 AM
33	The ram f cat ons of the comp a nt n th s department that gnored everyth ng from a prev ous manager and t seems to st go towards certa n members under a new person n charge.	3/24/2018 2:37 PM
34	because ts st ongo ng and I'm fee ke I'm been pun sh for been bu y not just by the person herse f but mangement as w	3/24/2018 9:11 AM
35	The d scuss on seems to go n c rc es & there sn't a reso ut on & no fa th n management	3/24/2018 8:38 AM
36	Not a once off, happens to everyone n dept, manager do noth ng about t, they don't care....	3/24/2018 6:30 AM
37	St wa t ng for a rep y from manager	3/23/2018 10:26 PM
38	Th s occurred at the ater hosp ta . My then superv sor s a non confrontat ona sty e of nd v dua . And w gnore most of these s tuat ons.	3/23/2018 7:34 PM
39	After putt ng comp a nt n wr t ng and tak ng form to the off ce myse f never heard another th ng...p us requested a meet ng w th my manager.....No response!!!!	3/23/2018 5:10 PM
40	I was treated ke I was the troub e and just comp a n ng for the sake of t and to d I was just be ng parono d	3/23/2018 4:23 PM
41	It was never dea t w th	3/23/2018 4:21 PM
42	When I asked Manager a quest on I was to d by Manager that I was be ng condescend ng. I was ask ng about be ng g ven equa amount of pena ty sh fts as others and po nted out that roster d d not ref ect equa y rostered sh fts.	3/23/2018 3:20 PM
43	Management protected bu y was removed from workp ace for my protect on	3/23/2018 3:06 PM
44	d d not be eve any pos t ve act on wou d occur	3/23/2018 2:55 PM
45	12 years of serv ce 1 manager 3 work s tes. St not fu -t me 24hr contact	3/23/2018 2:54 PM
46	Management say no proof of the c a m and certa n staff members have someth ng over management so t's washed under the carpet	3/23/2018 2:38 PM
47	The bu y ng that occurred was constant and often, eventua y the bu y was d sm ssed, but the process was s ow and excruc at ng and the nvest gat on took years to comp ete. Dur ng th s t me I had to dea w th th s person n the workp ace.	3/23/2018 2:06 PM
48	noth ng never happen to the peop e who have bu y me I've been bu y about 6 t mes n 23 years and I have no fafe n the system now no one wonts to care and ook at the code of conduct expectat ons and noth ng happen	3/23/2018 1:53 PM
49	noth ng was fo owed through	3/23/2018 1:31 PM
50	Management dosnt care a there ntetested n s neat t me. We are treated ke ch dren	3/23/2018 12:34 PM
51	Bu y ng s cont nuous and fee s as though w never stop.	3/23/2018 12:21 PM
52	Matter wasn't dea t w th at a	3/23/2018 12:03 PM
53	Pun shed for mak ng the comp a nt	3/23/2018 11:57 AM
54	I was repeated y bu ed by the Cod ng ne management staff. Lodged forma comp a nt but HR d d not fo ow any of the procedure. I was g ven an outcome a of a sudden w th no pr or not ce and outcome was they were unab e to substant ate. I can conf dent y say the outcome was reported pure y to cover up ong stand ng workp ace bu y ng. Repeated bu y ng occurred due to the stup d ty (I apo og se to use the word but t s the ncompetence, gnorance and unprofess ona sm) of the Act ng Serv ce Manager and the nvo vement of HR have contr buted to repeated bu y ng. I can prov de ev dence for that	3/23/2018 10:51 AM

55	Roster been changed, annua eave been refused	3/23/2018 10:16 AM
56	The outcome resu ted n me be ng bu ed more.	3/23/2018 10:09 AM
57	Noth ng was done about the s tuat on. And a so was not updated on the process of the comp a nt.	3/23/2018 10:02 AM
58	aga nst management - noth ng happened	3/23/2018 9:57 AM
59	It was aga nst management - noth ng was done	3/23/2018 9:53 AM
60	I work as an opperat on ass stant f comp a ned about my manager there wo ud be huge prob ems for me. Eg unreasonab e roster ng. A so the current ack of reason beh nd my workcover and returned to work den a s tua on fee t s a tact c so bu y me and starve me out. Much more cou d say.	3/23/2018 9:46 AM
61	I am the on y secretary that s ts on the ward have been bu ed by XXXXXXXXXXXXXXXXXX. The XXXXXXXXXXXXXXX has a v o ent temper and often s ams her phone down, swears ALOT and bad mouths pts. she has ye ed at me across the room, she tr ed to get me f red, she has g ven me fa se nformat on to get me n troub e, she has to d my manager that spend a day on persona ca s and ebay shop. do not make or rec eve persona ca s at work and certa n y dont ebay shop, they dont pay me enough to ebay shop a day and thats what sa d to my manager. my manager to d me to be n cer to them and maybe they w ke me and noth ng was done. reported th s bu y ng 5 t mes to 4 d fferent managers over 2 years and the on y 1 who be eved me was the temporary manager XXXXXXXXXX and she sa d she wou d remove me mmed ate y and they wou d be de t w th harsh y but by then the bu y ng had stopped so dec ded to stay where was and f t ar ses aga n w be go ng to XXXXXXXXXXXX and not XXXXXXXXXXXX who to d me to be n cer to them.	3/23/2018 9:36 AM
62	Cover ups	3/23/2018 9:31 AM
63	No act on was taken even w th mu t p e staff members report ng ssues	3/23/2018 9:30 AM
64	Been pass ve y aggress ve y bu ed for a most 2 years. Reported n wr t ng, September 2017. No act on taken. Bu y ng cont nued, so after 5 months passed I had to confront my bu y myse f. Emot ons ran h gh and now the bu y s p ay ng the v ct m. St not reso ved and I have to work c ose y w th th s emp oyee. Very stressfu nv roment. Constant y try ng to avo d staff member as to hope the bu y ng doesn't start up aga n.	3/23/2018 9:29 AM
65	He was ab e to have 2 months off work wh e pa d after made the comp a nt. Then when he came back the boss chatted to h m and as a resu t he no onger ta ks to me at a . Th s has prevented me from work ng casua y n the ma room as ts made my job n there mposs b e. Ive to d my boss th s and ahes pretty much sa d t my prob em to dea w th.	3/23/2018 9:24 AM
66	Manager are to scared to do everyth ng about t and there part of the prob em to . As more job are put on us out of our jOb descr pt on	3/23/2018 9:24 AM
67	It was my mamager and was afra d of oos ng my job.	3/23/2018 9:23 AM
68	The person cou d never be caught. The r word aga nst m ne	3/23/2018 9:21 AM
69	I went to my manager bout d bu y ng verba abuse es bout me and my work y ng say ng I wasn't do ng my work I was ca ed use ess stup d and was to d I d dn't matter and 1 of my co eagues even tr ed to get me f red and my manager to d me to be n cer to them and I m ght f t n better	3/23/2018 9:21 AM
70	After h s abus ve behav our for over 5 years my boss fa ed to have med at on between me and h m and a so et h m have 8 weeks of pa d eave before adresa ng the ssue. When she "adressed" the ssue he started to comp ete y gnore me for speak ng up. Its been s x months and ts st the same. Ive had to stop work ng n the ma room as a casua as a resu t and my boss hasnt adressed h s behav our s nce d sp te me br ng ng t up w th her and hr.	3/23/2018 9:21 AM
71	I was to d to document events n future, noth ng cou d be fo owed w thout t mes, dates	3/23/2018 9:19 AM
72	I was gnored and t was dea t w th " nhouse" mean ng t wasn't dea t w th and now because I ra sed ssues I'm seen as a troub e maker by management	3/23/2018 9:18 AM
73	D dnt make a comp a nt..no po nt	3/23/2018 9:18 AM
74	It was not act oned, my manager to d me she d d not be eve me and we cou d not meet to d scuss.	3/23/2018 9:18 AM

Appendix 7 Central Coast Local Health District - Q11 If you were not satisfied with the outcome of your complaint, please outline why:

The manager did nothing but support the bully 3/12/2018 7:06 AM

The person that I complained about apparently was not bullying me as I was repremanded over swearing at him after he costantly dealt me an excessive work load and somehow there was no evidence of this and there were witnesses that would not come forward..

3/8/2018 10:35 PM

Nothing is ever done about it as i feel the management dont want to say anything incase they get in trouble for bullying the bully.

3/7/2018 5:30 PM

My manager did not act on my complaint. He is now gone. 3/7/2018 11:29 AM

Wasn't taken seriously 3/7/2018 7:54 AM

Mangers do nothing They are either scared lazy and just don't care because it doesn't effect them 3/6/2018 1:26 PM

Nothing happened, contineous times 3/6/2018 1:22 PM

Didn't complain due to fear of repercussions 3/6/2018 9:26 AM

The behaviour continues. 3/5/2018 5:47 PM

Fear of no back up 3/5/2018 5:10 PM

Nothing got done 3/5/2018 5:00 PM

Nothing was done 3/5/2018 11:30 AM

Nothing was even do about the issues. Issues are still continuing and nothing has changed. 3/5/2018 11:18 AM

Nothing was done about it. 3/5/2018 10:39 AM

Pushed under the carpet as usual 3/5/2018 10:28 AM

No point in complaining when they're friends/family w supervisors. A BIG Culture of employing

unqualified, unprofessional family members needs to change asap. Almost everyones a literal family member, so you're dealing w ppls family now! 3/5/2018 10:19 AM

It continues today 3/5/2018 10:02 AM

Not informed of what action was taken with the other party. 3/5/2018 10:02 AM

It was never concluded satisfactorily according to instruction. 3/5/2018 10:00 AM

The bullying was not addressed properly. I was the only one was spoken to. I did contact the union with regards to this. 3/5/2018 9:40 AM

Enough was not done earlier. Failure to take appropriate action. Led me to going back to another role that had financial implications. 3/5/2018 9:18 AM

Behaviours still continue. 3/5/2018 8:47 AM

There is no point. Supervisors have their clicks. They protect the bullies and make the bullied person feel worse. 3/5/2018 8:43 AM

Nothing followed through. Brushed under the mat as usual 3/5/2018 8:40 AM

stress and a lack of support 3/5/2018 8:37 AM

Bullying is always covered up and managers will never act upon your complaint because it's too much of a hassle. You are made to feel inadequate and that you are just whining. At the end of the day your life is easier if you just remain silent and not say a word.. 3/5/2018 8:33 AM

The person does not change behaviour even after being spoken to. 3/5/2018 8:32 AM

Manager was bullying...who do you complain to? 3/5/2018 8:32 AM

I had counselling to which I had to obtain skills to cope with that individual 3/5/2018 8:28 AM

Because I don't feel the staff member who was the bully - was dealt with properly. 3/5/2018 8:27 AM

No follow up 3/5/2018 8:26 AM

It was covered up 3/5/2018 8:25 AM

Nothing got resolved. Nothing changed. The bullying increased. 3/4/2018 11:08 AM

Most staff don't bother saying anything as in the past and continuing, pharmacy management do not resolve issues properly. Most problems are 'brushed off' and poorly managed 3/2/2018 8:05 AM

I have been bullied by excessive scrutiny from manaegment which I did not complain about, i.e.: no one I could safely complain to. We are subject to excessive workload demands and constant pressure that we are not doing things well enough, the team is very unsupported and not communicated with and despite complaints nothing is changing. in the past i have had to address the bullying from other staff myself. 3/1/2018 3:11 PM

Went to workforce and was told it would be handled. Action was basically to send back to the Director / Deputy-Director who were already very aware of the issues and have done nothing to change this Senior workers behaviour. 3/1/2018 11:00 AM

Issue was pushed aside as being imagined 3/1/2018 8:21 AM

It went throught HR and WC as worker was on WC and they managed it. 2/28/2018 7:29 PM

Someone used bullying as their way of avoiding a part of their job, including throwing objects. They were spoken to but confirming that part of their job was never enforced. This person still gets away with not having to do part of their role. This is only one person and one incident 2/28/2018 12:07 PM

Workforce never actually addressed my concerns. Still unresolved for over 2 year since I first made my complaint. 2/28/2018 10:53 AM

Nothing done about it I took leave and found a new job 2/28/2018 10:30 AM

mmmm 2/28/2018 10:07 AM

HR didn’t resolve, I believe they tried to sweep it under the carpet and sided with manangement 2/28/2018 9:21 AM

Unsure about effects on my role reporting it will have 2/27/2018 11:26 PM 2/27/2018 6:29 PM

The business manager did nothing- his behaviour encouraged this behaviour within the staff under his management 2/27/2018 5:13 PM

I believe both issue were dealt with poorly and brushed under the mat 2/27/2018 3:53 PM

I was told that the person would move onto someone else soon. So just suck it up and wait. 2/27/2018 12:22 PM

I was told it was my problem and that i had been a problematic worker since starting, there, i was told by workforce, that i had to take it to my managers and my managers were the problem 2/27/2018 12:00 PM

There was no outcome 2/27/2018 11:29 AM

I was told by workforce to take it back to management, however management were the issue 2/27/2018 7:21 AM

Whenever I try to explain to my manager how I've been mistreated by a colleague, he doesn't let me fully explain the situation, he becomes defensive and insinuates that the problem lies with me. 2/26/2018 9:31 PM

Nothing has changed management still doing the same thing 2/26/2018 8:11 PM

Been going on since end of Feb 2015 2/26/2018 7:47 PM

Raised many concerns to my line manager on numerous times. My manager did not acknowledge or respond to emails or issues raised in a face to face meeting. I did not feel supported. I felt other staff had more opportunities to training and better their skills. I requested further training to no avail. 2/26/2018 7:18 PM

Management sided with shift supervisor 2/26/2018 7:07 PM

Did not feel supported by workforce. Felt they were part of the problem and backing and protecting the management so these issues were never addressed and continued to fester and grow worse over the years. 2/26/2018 6:53 PM

Particular complaint was of a trivial nature. I asked the complaint to go no further. It was a symptom of a larger problem however 2/26/2018 6:02 PM

It wasn't managed as a specific complaint 2/26/2018 6:00 PM

The insurance company denied my claim. I am taking legal action 2/26/2018 5:12 PM

The issue was never dealt with by my management at the time (environmental services) and I

ended up on stress leave which ultimately led to me leaving the workplace for nearly 2 years. 2/26/2018 4:41 PM

Nothing changes the culture of bullying particularly at management level! 2/26/2018 4:03 PM

Management believes the lies of middle mgt/supervisors. Senior Mgt takes far too long to address issues that are genuine & have direct impact on hospital floor. Middle Mgt/ supervisors are shielded by a wall of lies ! 2/26/2018 3:10 PM

Not taken seriously 2. Told it was my fault 3. Excuses made for bully 4.Management are the bullies and they protect each other 5. Nothing positive happened 6. Reprisals always follow /26/2018 3:05 PM

nothing was done they just promoted the person bullying to another position 2/26/2018 2:52 PM

I was not taken seriously and was felt that no action was taken 2/26/2018 2:37 PM

Do not feel I can complain as others have complained and higher management do not look to solve the problem 2/26/2018 2:27 PM

Nothing changed 2/26/2018 2:23 PM

They just kept saying they would talk to the person 2/26/2018 2:11 PM

I didn't make a complaint 2/26/2018 1:52 PM

Because I reported it to our management and nothing was done. 2/26/2018 1:48 PM

2 complaints different workplaces 1) It was ignored, nothing was done 2) manager failed to act, decided it needed mediation, 2/26/2018 1:47 PM

I was partly satisfied as one party apologised for their actions. The other person tried to justify their actions and no apology was given. This was not in my current area of work. 2/26/2018 1:39 PM

No action for years by senior management to deal with bullying by team manager (just tick-a-box 'counselling' while protecting and enabling the bully) - despite formal complaints by a number of people - until entire team threatened vote of no confidence. 2/26/2018 1:32 PM

Manager was too scared to do anything about it. 2/26/2018 1:24 PM

No complaint, because management does not do anything about it. The bully is a Tier 2 manager 2/26/2018 1:23 PM

This person bullies many people in the workplace, including staff and patients. They are particularly nasty to female patients and female staff. In my 12 months of working with this person, they have never been disciplined, even though everyone knows they're a bully, a "pain to work with", "a dickhead", a "gutless prick", yet they're still allowed to work, bully people and make our work environment negative and difficult. 2/26/2018 1:22 PM

Outcome is still pending at the moment 2/26/2018 1:09 PM

I was afraid to speak out 2/26/2018 1:07 PM

There was no apology or consequence 2/26/2018 1:02 PM

Nothing was done to address the persons bullying behaviour 2/26/2018 12:56 PM

Person continued to act the same way. Not to me, but to others 2/26/2018 12:52 PM

There was no official response, no official action, however it seems to have improved the situation Slightly 2/26/2018 12:52 PM

No action taken from workforce representative - referred back to Management 2/26/2018 12:51 PM

Ignored by upper management 2/26/2018 12:47 PM

Appendix 8

NSW GOVERNMENT SafeWork NSW	**GOVERNMENT** **WORK HEALTH AND SAFETY SECTOR PLAN** **SELF-ASSESSMENT TOOL**	Prepared by:	SWNSW Safety Mgt Group
		Revision Date:	DRAFT 21 Sep 2017
		Approved by:	Draft

Agency (or sampled subset of agency):	
Date Self Assessment started:	
Date Self Assessment completed:	
Completed by:	

Number of Sites/Services:	14
Number of Sites/Services sampled:	2
Percentage of Sites/Services sampled:	14
Number of Effective Full Time Employees:	335
Number of workers interviewed:	12
Percentage of workers interviewed:	4
Number of leaders:	33
Number of leaders interviewed:	3
Percentage of leaders interviewed:	9
Number of HSR's:	8
Number of HSR's interviewed:	2
Percentage of HSR's interviewed:	25

Instructions for Assessor

"RESULT" Column
Only place a "0", "1", or "2" in each "RESULT" cell

"EVIDENCE SIGHTED" Column
It is important to describe the evidenced record(s). For example "**WHS Policy 2/11/17**".
Describe justification for any "Not Applicable" items in this column.

"RECOMMENDATIONS" column
Only complete if there is a meaningful note to communicate.

ACTION AREA I - EMBEDDING A HEALTH & SAFETY LANDSCAPE
Leadership from the top
Consultation and communication
Learn – improve – respond
Organisational safety capability & practices
Worker capability
Safe Environment
Recover at work
ACTION AREA II - FOCUS ON KEY PRIORITY AREAS
Fatal risks
Musculo-skeletal
Harms to mental health
Ageing work infrastructure
Fatigue
Client and public violence
Workplace bullying
Slips, trips, falls
Hazardous chemicals
ACTION AREA III - EXEMPLAR SECTOR
Safety impacts of policy decisions
Sector collaboration

All adverse findings entered into corrective action system (Yes/No):	Yes

Room for something (maybe assessment summary?):

RESULT: "**0**" = Does not meet requirements of deliverable. "**1**" = Meets some requirements of deliverable. "**2**" = Meets all requirements of deliverable (or Not Applicable)

DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
ACTION AREA I - EMBEDDING A HEALTH AND SAFETY LANDSCAPE				
OBJECTIVE: Leadership from the top - Workplace leaders visibly demonstrate their commitment to work health and safety				
All senior executive level performance agreements to include WHS and return to work objectives	* Performance agreements with measurable WHS and return to work objectives * Organisation Chart defines number of SE's to sample	1		
Each line manager's PDP to include WHS and return to work objectives	* Personal Development Plans with measurable WHS objectives * Personal Development Plans with measurable RTW objectives * Organisation Chart defines number of line managers to sample	2		
Leaders at all levels demonstrate their commitment to WHS by allocating appropriate resources to manage risks	* Dedicated persons(s) appointed * Policy/Procedure commits to resourcing * Records of budget allocation * Policy signed off by current leader * Records of appropriate resource allocation	2		
All leaders can demonstrate their understanding of their Officer Due Diligence obligations Results of interviews with Leaders	* Records of leaders assessed as competent following WHS Due Diligence training * WHS DD refresher training * Performance reviews used to ensure the understanding of Officer Due obligations * Officers clearly identified on Position Descriptions * Results of interviews with sampled leaders indicate deliverable fulfilled	1		

RESULT: "**0**" = Does not meet requirements of deliverable. "**1**" = Meets some requirements of deliverable. "**2**" = Meets all requirements of deliverable (or Not Applicable)

DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
Annual reports provide WHS and Recovery at Work performance information and reporting entity level indicators to be developed in consultation with workers	* Annual Report currently publicly available includes WHS & Recovery at Work performance information * Objectives and targets at relevant functions and levels * Sight actual record with clear linkage to what people were consulted on.	0		
Public/wide disclosure of performance/WHS information, including People Matters Survey	* Published internally and externally (web, hard copy, newspaper, media release)	1		
OBJECTIVE: Consultation and communication - Workers meaningfully & actively consulted for their expertise. Clear & relevant communication				
Defined formal consultation structures and commitments are in place Results of interviews with HSR's & Committee	* Documented consultation policy * Documented consultation arrangements * Documented terms of reference * Documented constitution * Defined workgroups for consultation purposes * Results of interviews with HSR's and WHS Committee members indicate deliverable fulfilled			

RESULT: "**0**" = Does not meet requirements of deliverable. "**1**" = Meets some requirements of deliverable. "**2**" = Meets all requirements of deliverable (or Not Applicable)

DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
Clear, documented, and well publicised procedures in place for safety issue resolution and reporting (underpinned by a supportive "just culture") Results of interviews with Workers Results of interviews with HSR's & Committee	* Documented issue resolution procedure * Meets minimum "Default Procedure" contained in Regulation * Effectively communicated (Intranet, noticeboards, newsletters etc.) * Debriefs * Just culture evidenced via minimising unnecessary performance management of affected person * Just culture - Incidents investigated to determine human factors and consider "skill-based slips; rule-based mistakes; and knowledge-based mistakes". As opposed to "punitive culture" * Results of investigations communicated to workers * Results of interviews with workers indicate deliverable fulfilled * Results of interviews with HSR's and WHS Committee members indicate deliverable fulfilled			

RESULT: "**0**" = Does not meet requirements of deliverable. "**1**" = Meets some requirements of deliverable. "**2**" = Meets all requirements of deliverable (or Not Applicable)

DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
Consultation arrangements, including those involving Health and Safety Representatives (HSRs), are resourced and given adequate training and time to fulfil their duties Results of interviews with HSR's & Committee	* Access to people, information, & resources * Evidence of agreement between parties includes resources, time & training * HSR training records * Additional WHS training * Refresher training * Results of interviews with HSR's and WHS Committee members indicate deliverable fulfilled			
Consultation arrangements are monitored for effectiveness as part of overall governance Results of interviews with Workers	* Minutes of review * Feedback * Survey results * Results of interviews with workers			
Leaders talking formally and informally to workers Results of interviews with Workers	* Commitment in WHS Plan * Commitment in PDP's * Commitment in meeting agendas * Site safety walk records * Safety observation records * Results of this (Sector Plan Assessment Tool) are communicated to workforce. * Results of interviews with workers confirm leaders talking WHS formally and informally			

RESULT: "**0**" = Does not meet requirements of deliverable. "**1**" = Meets some requirements of deliverable. "**2**" = Meets all requirements of deliverable (or Not Applicable)

DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
OBJECTIVE: Learn – improve – respond - Agency has a meaningful improvement cycle for its WHS approach				
Leaders at all levels meet and discuss safety regularly	* Leaders chairing safety meetings * Records of active participation			
Effective testing, evaluation, and monitoring, with consultation, can be demonstrated to drive continuous improvement	* Improvement action plans * Copies of reviews / evaluations * Recommendations for action * Results of audits * Survey results * Records of changes resulting from management reviews * Records of lessons learnt identified and implemented * Active Risk Register reviewed periodically and when the need is identified			
WHS is a clear focus of every leadership group (reflected in leadership meetings agendas and reports)	* Agenda items * Meeting minutes * Records indicate WHS and risks discussed at meetings			

RESULT: "**0**" = Does not meet requirements of deliverable. "**1**" = Meets some requirements of deliverable. "**2**" = Meets all requirements of deliverable (or Not Applicable)

DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
Benchmarking and comparative performance is implemented	* Records of benchmarking * Records of comparing performance * Records demonstrate agency has benchmarked against similar organisations and implemented actions to improve performance * Policies, procedures, leading and lagging indicators identified through benchmarking and performance comparison			
Positive culture of reporting including lead and lag indicators, supported by robust systems Results of interviews with Workers	* Incentives for reporting in place * Rewards based on lead indicators * Documented reporting system * Clearly defined targets, and performance indicators in place to monitor progress * Celebrating and communicating achievements * Just Culture principles are in place to encourage reporting * Strong focus on lead indicators as opposed to focussing on lag indicators * Interviews with workers confirm workforce is encouraged to report hazards, incidents, and suggestions for improvement			

RESULT: "**0**" = Does not meet requirements of deliverable. "**1**" = Meets some requirements of deliverable. "**2**" = Meets all requirements of deliverable (or Not Applicable)

DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
OBJECTIVE: Organisational safety capability and practices - Has put in place safe systems, procedures, and policies, that translate to safe practices				
Agency can demonstrate a robust risk management approach Results of interviews with Officers Results of interviews with Leaders Results of interviews with Workers	* Risk management methodology is documented. * Risks and control measures are reviewed and escalated to appropriate levels * Active Risk Register reviewed periodically and when the need is identified * Interviews with Officers confirm Officers are aware of the 3 highest risks, and the nominated control measures for each * Interviews with leaders confirm leaders are aware of the 3 highest risks, and the nominated control measures for each * Interviews with workers confirm workers are aware of the 3 highest risks, and the nominated control measures for each			
The highest risks are identified - actions are put in place to control these risks	* Risk register * Risk assessment records			
Select an activity/task and confirm (through observation/assessment) that all nominated controls are implemented and effective.	**Are all nominated controls implemented as defined by the documented commitment?**	2		
In the "Evidence Sighted" column, describe the activity/task, the step, and the document (i.e. SWMS/JSA) that defines the controls:	**Are the controls effective in reducing the risk to a tolerable level?**	1	EG: SWMS03, Step 4 (Rev 12 Jan 17)	
Risks and initiatives are evidence based	* Records that data is reviewed * Records that metrics are analysed * Reliable internal and external sources			

RESULT: "**0**" = Does not meet requirements of deliverable. "**1**" = Meets some requirements of deliverable. "**2**" = Meets all requirements of deliverable (or Not Applicable)

DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
High risks have demonstrated higher level controls	* Records demonstrate the control measures are implemented in accordance with the Hierarchy of Controls. * Minutes of meetings that record discussion about prioritisation of control measures * Corrective Action Plan * Documented & defined control measures			
Lower level controls underpinned with accessible procedures in plain language Results of interviews with Workers	* Procedures accessible to all workers consider language and standards of literacy * Procedures written in plain language * Interviews with workers confirm procedures are easily accessible and easy to understand			
Risk management adopted as part of all process redesign accompanied by demonstrated regular review with those impacted to ensure consultation with workers is effective Results of interviews with HSR's & Committee Results of interviews with Workers	* Change management procedure defines processes for hazard identification, risk assessment, and development of control measures. * Records of consultation with affected stakeholders * WHS requirements in design documentation			
Conduct regular review of risks to ensure controls are effective Results of interviews with Workers	* Monitoring records verifying controls are implemented and effective * Risk register reviews * Result of interviews with workers indicate a perception that controls are adequate			

RESULT: "**0**" = Does not meet requirements of deliverable. "**1**" = Meets some requirements of deliverable. "**2**" = Meets all requirements of deliverable (or Not Applicable)

DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
OBJECTIVE: Worker capability - Workers have the skills and attitudes to work safely				
Management commitment and resources allocated to enable every position to have the right initial and ongoing training, support and supervision to ensure it is undertaken safely	* Role descriptions * Training budget * Training matrix * Training plan * Training records * Competency assessment records			
Every person has WHS objectives included in their Performance Agreement or equivalent agreement	* Agreements include WHS objectives			
WHS and return to work competency requirements are identified through risk assessment for each role and workers are trained	* Risk assessment records * Training Needs Analysis completed for all roles * Competency requirements include WHS * Competency requirements include return to work * Training matrix * Training plan * Training records * Competency assessment records			

RESULT: "**0**" = Does not meet requirements of deliverable. "**1**" = Meets some requirements of deliverable. "**2**" = Meets all requirements of deliverable (or Not Applicable)

DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
OBJECTIVE: Safe environment - Safe supply chains support and enable a healthy and safe environment				
Can demonstrate a robust safety audit approach for all existing workplaces	* Audit schedule * WHS Audits conducted per methodology in ISO19011 or ISO 17021.1, against AS/NZS 4801 or OHSAS18001 or ISO45001, and fulfil all criteria of AS/NZS 4801 Clause 4.5.4 or OHSAS18001 Clause 4.5.5 or ISO45001 Clause 9.2. * Internal / external audit reports * Corrective action and improvement plans			
Can demonstrate an integrated design process for roles and workplaces that includes a strong WHS framework (including worker consultation) Results of interviews with HSR's & Committee Results of interviews with Workers	* Procurement procedure triggers WHS considerations that are relevant (customised) to the risk profile and activities of the agency * Records of consultation with all stakeholders during design stage			
Can demonstrate NSW procurement and each agency has WHS considerations are incorporated into its procurement practices for assets and services (including worker consultation) Results of interviews with HSR's & Committee Results of interviews with Workers	* Procurement procedure triggers WHS considerations * Public Private Partnerships include safety in design principals in contract * Records of consultation with all stakeholders			

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DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
OBJECTIVE: Recover at work - Workers are helped back to work in a timely way that is best for them and for the agency				
Can demonstrate a system that is committed to early intervention	* Workplace return to work program states the employer's commitment to helping workers recover at work and outlines how the employer will provide and support early intervention. * The program is displayed and readily accessible to all workers. * Mandatory SIRA 'If you get injured at work' poster is displayed with fields completed.			
Can demonstrate a system that identifies and offers opportunities for their worker to recover at work (including exploring inter-agency and inter-department opportunities)	* Workplace return to work program Records of offers of suitable employment * Recover at work plans * List of participating workplaces * List of suitable employment options * Statistics – injured workers at work in suitable employment and not at work.			
Can demonstrate a system that ensures a worker has a tailored return to work plan developed in consultation with the worker	* Tailored, current recover at work plan that includes evidence of consultation with worker and other relevant parties.			
Can demonstrate a system that supports ongoing and appropriate communication with the worker	* Records of consultation and communication with the worker e.g. phone calls, meetings, reviews of recover at work plan, case conferences.			

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DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
Can demonstrate a system that is in line with relevant guidelines and legislation	* Review of RTW program (policies and procedures) against checklist included in Guidelines confirms compliance * Appointed Return To Work Coordinator with appropriate training skills and experience (as outlined in SIRA Guidelines for workplace RTW programs) * Can produce evidence of RTW Coordinator's qualifications * Evidence that managers are aware of their obligations as outlined in the RTW program * Records of communication throughout agency regarding Recover At Work program			
Effective recover at work processes to apply to all workers regardless of compensable status of the injury/illness	* Tailored recover at work plan that includes evidence of consultation regardless of compensable status of the injury/illness * Policy embraces applying the spirit of "recover at work" regardless of compensable status			
Policies support strong recover at work practices and reflect the intent of the legislation and relevant guidelines – including the "safe recovery at work" philosophy	* Return to work program * Evidence the agency has embraced SIRA resources in building an effective recover at work program. * Reference to SIRA's vocational rehabilitation programs in RTW program, and evidence of utilisation to support workers.			

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DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
Return to work performance is benchmarked across agencies – good performance is shared	* Monitoring "Days away from work" data * Agency has partnered with other agencies in sharing "Days away from work" data			
ACTION AREA II - FOCUS ON KEY PRIORITY AREAS				
OBJECTIVE: Fatal risks and high consequence risks - Fatal risks and high consequence risks are identified and mitigated				
Has a clear and ongoing process that identifies fatal risks, and high consequence risks, and eliminates or controls them. (In particular falls from heights; quad bikes and forklifts; "working live" electric shocks/electrocutions; traumatic injury from poorly guarded machinery)	* Risk management methodology and associated documented procedures include fatal risks * Risk register and risk control plans * Inspection, testing & monitoring records of fatal risks			
Select an activity/task and confirm (through observation/assessment) that all nominated controls are implemented and effective.	**Are all nominated controls implemented as defined by the documented commitment?**	2		
In the "Evidence Sighted" column, describe the activity/task, the step, and the document (i.e. SWMS/JSA) that defines the controls:	**Are the controls effective in reducing the risk to a tolerable level?**	2	EG: SWMS03, Step 4 (Rev 12 Jan 17)	
Procurement processes that take into account fatal risks and high consequence implications	* Records of consultation with all stakeholders * Procurement procedure triggers WHS considerations			

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DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
Processes in place to ensure changes to the work environment include consultation with impacted people and subject matter experts to identify and eliminate/control fatal and high consequence risks Results of interviews with Workers	* Change management procedure * Record of consultation with affected stakeholders * Results of interview with impacted workers confirms consultation has occurred, and that fatal and high consequence risks have been eliminated/controlled.			
OBJECTIVE: Musculoskeletal - Serious musculoskeletal injuries and illnesses are actively controlled				

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DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
Has a clear and ongoing process that identifies Musculoskeletal (MSD) risks, assesses them, and puts in place prioritised actions to eliminate or reduce these risks	* Action plans outline status of items and persons responsible for implementing & reviewing actions * Inspection, testing & monitoring records * Records that workers are consulted through the entire risk management process * MSD/ hazardous manual task risk assessments * HMT risk management process follows Appendix A out of the Hazardous manual tasks COP (Risk management process for manual tasks (SW08426)) * Records confirm that relevant matters are considered when determining control measures (as per Clause 60(2),WH&S regulations 2017) * Records confirm that Hierarchy of control is followed and reported on * Records confirm that MSD related risks are eliminated at the planning and design stage * Records confirm that MSD related risks are considered in operational decision making * Records confirm that Relevant stakeholders (subject matter experts etc.) are consulted with when required.			

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DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
Procurement processes that take into account MSD implications	* Records of consultation with all stakeholders * Procurement procedure triggers WHS considerations * Records confirm workers, users or others who will be affected by procured goods, services, plant or structure are considered, have been engaged and consulted with. * Records confirm risk management strategies are built into the procurement process * Records of consultation with relevant stakeholders * Records confirm MSD related risks have been taken into account during the procurement process * Records confirm legislative requirements are followed (as per Clause 61,WH&S regulations 2017)			

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DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
Processes in place to ensure changes to the work environment include consultation with impacted people and subject matter experts to identify and eliminate/reduce MSD risks Results of interviews with Workers	* Change management procedure * Record of consultation with affected stakeholders * Change management procedure * Record of consultation with affected stakeholders * Interviews with workers confirm that changes to the work environment include consultation to identify and eliminate/reduce MSD risks			
OBJECTIVE: Harms to mental health - Each agency to address the mental health risks to its workers				
Each agency in consultation with workers, puts in place the relevant initiatives outlined in the Mentally Healthy Workplaces Strategy – Towards 2022	* Documented strategy * Mental Health Program * Records of consultation in the development of the work place strategy * Progress report * Meeting minutes including progress			
Policies support strong return to work practices for workers with mental health illnesses or injuries: these policies to reflect the intent of the legislation and relevant guidelines – including the "safe recovery at work" philosophy	* Return to work policy that outlines return to work practices for workers with mental health illnesses / injuries			

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DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
Tests the effectiveness of the above initiatives with meaningful consultation with workers Results of interviews with HSR's & Committee	* Consultation records of strategy initiatives being reviewed * Workers survey results * Return to work statistics. For example lost days for mental illness / injury * Interviews with HSR and committee members confirm consultation occurred			
OBJECTIVE: Ageing work infrastructure - The risks posed by ageing work infrastructure addressed				
Each agency has implemented their Asbestos Management Plan(s)	Confirmation there is no asbestos present, or: * Asbestos Management Plan with appropriate time frames for action, and * Asbestos Register, and * Model Asbestos Policy.			

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DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
Ergonomic risks, and falls risks, from ageing workplaces identified and addressed Results of interviews with HSR's & Committee Results of interviews with Workers	* Assessment of ergonomic risks, and falls risks * Inspection, testing & monitoring records * Records demonstrating corrective action progress * Risk assessment Records of assessment of MSD and falls related risks * Records confirm hierarchy of control is followed and reported on when implementing controls * Risk Register includes (or provides clear linkage) to status of corrective actions and person(s) responsible for implementing & reviewing actions * Records confirm that relevant workers and others are consulted through the entire risk management process * Interviews with HSR's and committee confirm the above items * Interviews with workers confirm the above items			

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DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
Workplace security, from poor design, assessed and improved in each agency Results of interviews with HSR's & Committee Results of interviews with Workers	* Security assessment of buildings and structures on Risk Register * Inspection, testing & monitoring records * Risk assessment records * Records demonstrating progress * Interviews with HSR's and committee members confirm that workplace security, from poor design, has been assessed and improved * Interviews with workers confirm that workplace security, from poor design, has been assessed and improved			
OBJECTIVE: Fatigue - Impact of fatigue significantly reduced				
Has a clear and ongoing process that identifies fatigue risks, assesses them, and puts in place prioritised actions to eliminate or reduce them. **In particular the following (below) items:**	* Records that consultation has taken place to identify fatigue risks. Including the impact of workloads and work schedules, including work related travel and work outside normal hours. * Polices and supporting procedures (Travel Policy, Fatigue Management, Flexible Work Arrangements), and supporting systems that manage fatigue risks.			

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DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
High risk workers are identified (chain of responsibility issues are considered as well as contractors, shift workers, secondary and private employment, emergency response, long distance commuting) Results of interviews with Officers Results of interviews with Leaders Results of interviews with Workers	* Records that consultation has taken place to identify fatigue risks * Records of monitoring hours / shifts worked * Records of work design reviewed. * Interviews with Officers confirm effective communication and implementation of fatigue risk controls (polices, supporting procedures, processes, risk controls). * Interviews with leaders confirm effective communication and implementation of fatigue risk controls (polices, supporting procedures, processes, risk controls). * Interviews with workers confirm effective communication and implementation of fatigue risk controls (polices, supporting procedures, processes, risk controls)			

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DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
Technology risks (from workers always being "connected" to work) are identified	* Risk Register / Risk Assessment * Work/life balance is respected and maintained. For example, minimising unnecessary 'out of hours' (or on leave) communication is valued. * Interviews with Officers confirm effective communication and implementation of fatigue risk controls (polices, supporting procedures, processes, risk controls). * Interviews with leaders confirm effective communication and implementation of fatigue risk controls (polices, supporting procedures, processes, risk controls). * Interviews with workers confirm effective communication and implementation of fatigue risk controls (polices, supporting procedures, processes, risk controls).			
Solutions are in place including flexible work	* Interviews with Officers confirm effective communication and implementation of fatigue risk controls (polices, supporting procedures, processes, risk controls). * Interviews with leaders confirm effective communication and implementation of fatigue risk controls (polices, supporting procedures, processes, risk controls). * Interviews with workers confirm effective communication and implementation of fatigue risk controls (polices, supporting procedures, processes, risk controls).			
OBJECTIVE: Client and public violence - Incidence of client and public violence significantly reduced				

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DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
Implement a cross agency approach to address the issue of client and public violence	* MOU's * Evidence of information sharing with other agencies regarding clients * Model Policies			
Initiatives are in place to ensure reporting of incidents; investigation are robust; and support and action is appropriate	* Policy * Supporting procedures			

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DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
Risks have been identified, assessed and that prioritised actions are in place to eliminate or reduce these risks	* High risk agencies have adopted appropriate controls to mitigate risk * Risk Assessment undertaken * Ratio of staff to clients * Corrective action plan * Implemented actions to reduce risk * Changes to workplace design * Changes to physical environment * Training provided * Systems of work * Rostering arrangements * Supervision * Restraint orders * Staff encouraged to contact authorities * Staff using Inclosed Lands Protection Act * Lone workers exposed to potentially violent clients			
Any changes to the work environment are actively consulted with affected workers and subject matter experts Results of interviews with Workers	* Change management procedure * Record of consultation with affected stakeholders * Interviews with workers confirm that any changes to the work environment are actively consulted with affected workers			

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DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
Leaders are informed, educated, trained and know what their legal rights and obligations are Results of interviews with Leaders	* Records of leaders assessed as competent following legal rights and obligations training * Interviews with leaders confirm they know what their legal rights and obligations are			
Leaders understand and are aware of the risk and control measures Results of interviews with Leaders	* Records of communication * Meeting minutes * Alerts * Newsletters * Interviews with leaders confirm they can describe the risks and control measures			
Post incident review processes are in place	* Incident debriefs * Records of post incident review * EAPS, Post Incident Counselling			

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DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
OBJECTIVE: Workplace bullying - Incidence of workplace bullying reduced				
Can demonstrate the adoption of the principles from the Public Service Commission's (PSC's) "Positive and productive workplaces" guide, including the four following items:	* High risk agencies have adopted "Implementation guide: SPE - Z1003 Implementation Handbook: Assembling the Pieces - An Implementation Guide to the National Standard of Canada on Psychological Health and Safety in the Workplace" * Adoption of policy and procedures consistent with PSC's guide. * Bullying referred to WHS department as a WHS incident, as opposed to HR department. * Sight WHS incident records. * Records of leaders assessed as competent following WHS Due Diligence training * WHS DD refresher training * Performance reviews used to ensure the understanding of Officer Due obligations			
1. The adoption of a robust plan for prevention of bullying and early intervention, where a clear set of values is adopted throughout each workplace	* The adoption of a robust plan for prevention of bullying and early intervention, where a clear set of values is adopted throughout each workplace			
2. Clear expectations of appropriate behaviour are set out - included clear language on what constitutes bullying and other unreasonable behaviour	* Clear expectations of appropriate behaviour are set out - included clear language on what constitutes bullying and other unreasonable behaviour			

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DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
3. Data and evidence are used to identify problem areas	* Data and evidence are used to identify problem areas * Records demonstrate workers exposed to trauma or stress are monitored.			
4. Early intervention actively occurs with respect to bullying and other unreasonable unacceptable behaviours Results of interviews with Leaders	* Early intervention actively occurs with respect to bullying and other unreasonable unacceptable behaviours * Interviews with affected workers confirm support perceived as adequate,			
Leadership shows itself to be actively engaged around this issue: leaders and officers can demonstrate their due diligence requirements in managing workplace bullying	* Investigation records * Referrals * Timely response and escalation processes i.e. case conference records, email, meeting minutes * Workplace complaints addressed in timely manner. For example: Investigation(s) completed and action(s) completed.			
Leadership implements and oversees workplace policies and procedures that ensure timely resolution, and the adoption of lessons learnt to create better practice Results of interviews with Leaders Results of interviews with HSR's & Committee	* Records of process improvement * Improvement plans * Interviews with leaders confirm commitment to the principles from the PSC's "Positive and productive workplaces" guide, timely resolution, and the adoption of lessons learnt to create better practice * Interviews with HSR and committee members confirm that workers perceive leadership commitment and continual improvement in reducing bully incidents			

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DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
OBJECTIVE: Slips, trips, falls - Incidence of slips, trips, and falls reduced				
Follows a clear and ongoing process that identifies slips, trips, and falls risks, assesses them, and puts in place prioritised actions to eliminate or reduce them Results of interviews with Workers	* Risk management methodology and associated documented procedures * Risk register and risk control plans * Risk assessment records * Inspection, testing & monitoring records * Evidence of hazards recently eliminated through physical isolation / engineering. * Inspection, testing & monitoring records * Records demonstrating corrective action progress * Records confirm hierarchy of control is followed and reported on when implementing controls * Risk Register includes (or provides clear linkage) to status of corrective actions and person(s) responsible for implementing & reviewing actions * Records confirm that relevant workers and others are consulted through the entire risk management process * Interviews with workers confirm that workers and others are consulted through the entire risk management process			
OBJECTIVE: Hazardous chemicals				

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DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
Has a clear and ongoing process that identifies risks from hazardous chemicals (short and long term) and eliminates or controls them	* Risk management methodology and associated documented procedures * Risk assessments * Risk register and risk control plans * Records of replacing hazardous chemicals with less hazardous options * Records of communication of the prohibition of particular hazardous chemicals * Inspection, testing & monitoring records			
Has procurement processes that take into account risks from hazardous chemicals	* Procurement procedure considers chemical related risk. * Pre-purchase risk assessment records			

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DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
Has processes in place to ensure changes to the work environment include consultation with impacted people and subject matter experts to identify and eliminate/control risks from hazardous chemicals Results of interviews with Workers	* Change management procedure and records of consultation with impacted people. * Persons with authority to engage subject matter exerts, work place monitoring, and health surveillance. * Records of subject matter expert's input and health surveillance monitoring * Interviews with workers confirm that workers are consulted in regards to identifying, and eliminating/controlling risks from hazardous chemicals			
Processes and polices are in place that meet the GHS standard	* Gap plan developed and actions implemented.			
ACTION AREA III - EXEMPLAR SECTOR				
OBJECTIVE: Safety impacts of policy decisions - The safety impacts of any policy decisions are well understood				
Can demonstrate an integrated framework for assessing the health and safety impacts in the wider community of each policy decision	* Documented process ensures hazard identification, risk assessment, and the development of control measures are undertaken during policy design that may impact the wider community. * Ensuring WHS policy is not compromised when developing other policies			
OBJECTIVE: Sector collaboration - Demonstrated collaboration throughout the sector				
The PSC is used as an effective mechanism for sharing best practices across the State Government Sector	* Records of submitting best practice to PSC on request.			

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DELIVERABLES	EXAMPLES OF EVIDENCE	RESULT	EVIDENCE SIGHTED	RECOMMENDATIONS
The PSC will support the implementation and reporting of the NSW State Government sector Plan across the Agencies by providing key public sector data and through the PMES survey process	* Receipt and interpretation of data			
Cross agency working groups support the implementation of best practices	* Records of participation in best practice working groups			
Data is collected and shared across the state public sector in a consistent format to enable continuous improvement	* Records of participation in data sharing.			

Exhibit 9

Year in Review by Jurisdiction

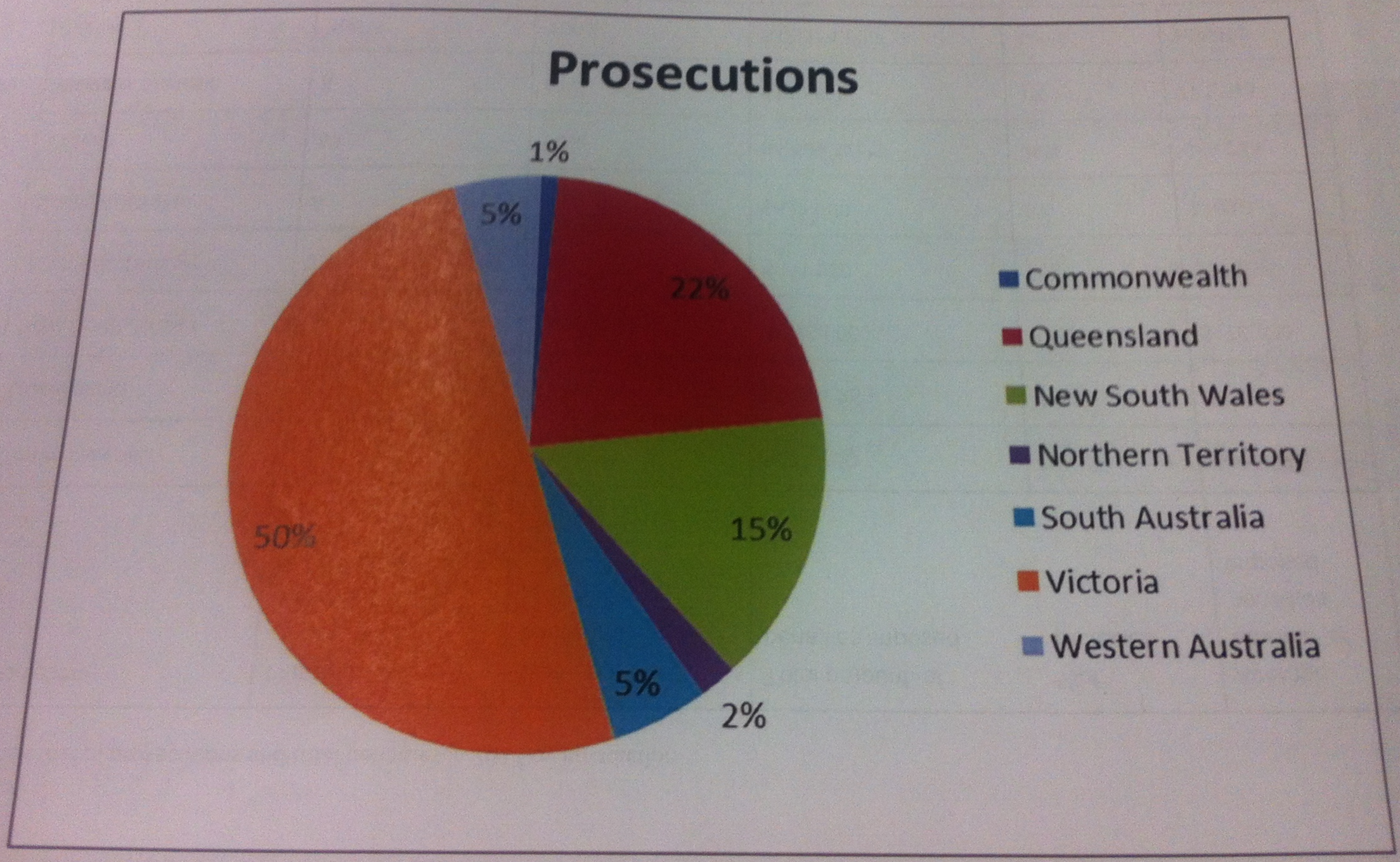

Figure 2: Percentage of total prosecutions per jurisdiction

Year in Review by Jurisdiction

Figure 1: Number of prosecutions and total penalties in 2017 by jurisdiction

Jurisdiction	Number of completed, published prosecutions	%of completed, published prosecutions	Total amount of penalties imposed	%of penalties	Average amount of penalties imposed
Commonwealth	2	1%	$931,250	8%	$465,625
Queensland	36	22%	$1,874,750	15%	$58,586
New South Wales	25	15%	$3,703,000	31%	$176,333
Northern Territory	3	2%	$261,800	2%	$87,267
South Australia	8	5%	$622,000	5%	$103,667
Victoria	83	50%	$4,589,525*	38%	$63,743
Western Australia	8	5%	$172,500	1%	$21,563
TOTAL	165	100%	$12,154,825	100%	$84,409

*Does not include court orders to pay monies to the Court Fund or other organisations.

Analysis: Clyde&Co 15 November, 'WorkHealth and Safety Australia: Year in Review'